State of New Mexico

Susana Martinez
Governor

December 6, 2017

The Hon. Eric D. Hargan, Acting Secretary
U.S. Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Hargan:

I am pleased to submit to the U.S. Department of Health and Human Services the final Section 1115 Demonstration Waiver renewal application for New Mexico's managed care program, Centennial Care.

Since launching in 2014, the State's goals for reforming Medicaid through Centennial Care have been to:

- Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, and in the right setting;
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
- Slow the growth rate of costs or "bend the cost curve" over time without reductions in benefits, eligibility or provider rates; and
- Streamline and modernize the Medicaid program in the State.

Today, New Mexico's Medicaid managed care program features an integrated, comprehensive Medicaid delivery system in which the member's MCO is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and-community-based services (HCBS). This waiver renewal application builds upon the program's accomplishments and maximizes opportunities for targeted improvements and other modifications in the following key areas: care coordination, benefit and delivery system refinements, payment reform, member engagement and cost sharing responsibilities, and administrative simplification. In summary, the improvements and modifications include:

- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to LTSS and maintain the progress achieved in rebalancing efforts;

State Capitol • Room 400 • Santa Fe, New Mexico 87501 • 505-476-2200 • fax: 505-476-2226

- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health, and improving the continuum of care for substance use disorders;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Building upon and incorporating policies that seek to enhance beneficiaries' ability to become more active participants in their own health care, including the introduction of modest premiums for adults with higher income; and
- Further simplifying administrative complexities and implementing targeted refinements to eligibility.

Over the course of the demonstration waiver renewal, New Mexico will continue to introduce progressive quality goals focused on improving health outcomes, implement initiatives that advance program goals, and challenge its MCO partners to work cooperatively with the provider community to achieve a health care delivery system that is efficient and value-driven, while reducing health disparities across all populations.

We look forward to working with the Centers for Medicare and Medicaid Services as we develop and implement the innovative approaches to enhance the Centennial Care program and achieve the goals of the demonstration waiver.

Sincerely,

[redacted]

Susana Martinez
Governor

State of New Mexico
Human Services Department

Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0

to

The Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Nancy Smith-Leslie, Director
Medical Assistance Division

December 5, 2017

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The New Mexico Human Services Department (HSD) is pleased to submit this Section 1115 Demonstration Waiver renewal application for New Mexico's Medicaid managed care program known as Centennial Care. Centennial Care was initially approved for a five year period, from January 1, 2014 through December 31, 2018.

Prior to Centennial Care, the Medicaid system in New Mexico was fragmented. In 2013, some 520,000 individuals, more than a quarter of the state's population, received health care through the Medicaid program. The challenges included:

- An expensive program, consuming about 16% of the State budget, up from 12% the previous year;
- An administratively complex program operating under 12 separate federal waivers in addition to a fee-for-service (FFS) program for those who either opted out of or were exempt from managed care;
- A fragmented program with seven different health plans administering different benefit packages for defined populations making it difficult for individuals, providers, and managed care organizations (MCOs) to manage complex medical and behavioral conditions; and
- A system that paid for the quantity of services delivered without emphasis on the quality of care that was being delivered.

The State's goals in implementing Centennial Care, as specified in the special terms and conditions (STCs), were to:

- Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, and in the right setting;
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
- Slow the growth rate of costs or "bend the cost curve" over time without reductions in benefits, eligibility or provider rates; and
- Streamline and modernize the Medicaid program in the State.

Today, New Mexico's Medicaid managed care program features an integrated, comprehensive Medicaid delivery system in which the member's MCO is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and-community-based services (HCBS). Centennial Care's accomplishments during the past four years are listed below.

Centennial Care Accomplishments
• *Streamlining administration of the program* by consolidating a myriad of federal waivers that siloed care by populations. Today, four MCOs administer the full array of services in an integrated model of care. • *Building a care coordination infrastructure* that promotes a person-centered approach to care. Lower costs associated with inpatient stays and increased utilization of primary care office visits, preventive care and behavioral health services is evidence of the success. • *Increasing access to long term services and supports (LTSS)* for people who previously needed a waiver slot to receive such services. Today, more than 29,750 individuals are receiving HCBS, which is an increase of 11.4% per year between 2014 and 2016. • *Continuing to lead the nation* in spending more of its LTSS dollars to keep members in their homes and in community settings rather than institutional settings. • *Demonstrating both cost-effectiveness and improved utilization of health care services.* Enrollment in the Medicaid program has grown by 8.5% per year while per capita costs have decreased by 1.5% between 2014 and 2016.

This renewal application builds upon the program's accomplishments and maximizes opportunities for targeted improvements and other modifications in the following key areas: care coordination, benefit and delivery system refinements, payment reform, member engagement, cost sharing responsibilities, and administrative simplification. Details of the program modifications for the waiver renewal are described in Section 3--Concepts for Renewal. In summary, the improvements and modifications include:

- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to LTSS and maintain the progress achieved in rebalancing efforts;
- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Building upon and incorporating policies that seek to enhance beneficiaries' ability to become more active and involved participants in their own health care, including the introduction of modest premiums for adults with higher income; and
- Further simplifying administrative complexities and implementing refinements in program and benefit design, some of which will be achieved with the replacement of the Medicaid Management Information System, including advanced data analytics capability.

Over the course of Centennial Care 2.0, New Mexico will continue to introduce progressive quality goals focused on improving health outcomes, implement pilot projects (based on both geography and specific populations) to advance program goals, and challenge its MCO partners to work cooperatively with the provider community to achieve a health care delivery system that is efficient and value-driven, while reducing health disparities across all populations. The renewal application is organized according to the following sections:

- A review of the program as designed under the 1115 waiver, including innovative features;
- A summary of initiatives to be implemented in Centennial Care 2.0;
- A description of the requested waiver and expenditure authorities;
- A description of the state's compliance with approved 1115 STCs;
- An overview of the planned budget neutrality methodology;
- A summary of quality evaluation for waiver and quality activities for demonstration; and
- A description of HSD's comprehensive public input process.

SECTION 1: CURRENT PROGRAM DESIGN AND INNOVATIVE FEATURES

Centennial Care provides a comprehensive benefit package to eligible populations through an integrated, managed care model that includes a number of innovations. The following is a description of the current eligible populations and covered benefits and what makes Centennial Care unique from other Medicaid programs.

A. Current Populations Covered

Table 1 represents the eligibility groups currently served in Centennial Care. At the end of 2016, New Mexico's Medicaid program covered approximately 900,000 individuals, with 700,000 enrolled in Centennial Care. Since the end of 2013, HSD has enrolled more than 390,000 new individuals into the program, with the largest growth attributed to the Medicaid adult expansion program.

Table 1 – Eligibility Groups Covered in Centennial Care

Population Group	Populations
TANF and Related	Newborns, infants, and children Children's Health Insurance Program (CHIP) Foster children Adopted children Pregnant women Low income parent(s)/caretaker(s) and families Breast and Cervical Cancer Refugees Transitional Medical Assistance
SSI Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years old up to 133% of MAGI

The following populations are excluded from Centennial Care:

- Qualified Medicare Beneficiaries;
- Specified Low Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in ICF/IIDs;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only; and
- Mi Via 1915(c) waiver participants for HCBS.

Appendix F illustrates the complete table of mandatory and optional populations covered in the current waiver.

B. Current Demonstration Benefits

Centennial Care provides a comprehensive package of services that include behavioral health, physical health, and long term care services and supports. Members meeting a nursing facility level of care (NF LOC) are able to access LTSS through Community Benefit (CB) services (i.e., home and community-based services) without a waiver slot. The CB is available through agency-based community benefit services (ABCB) (services provided by a provider agency) and self-directed community benefit services (SDCB) (services that a participant can control and direct).

Centennial Care also included services only available for individuals enrolled in Centennial Care including the Community Interveners for deaf and blind individuals. A Community Intervener is a trained professional who works one-on-one with deaf-blind individuals who are older than four years of age to provide critical connections to other people and the community.

The comprehensive benefits currently available to Centennial Care members are listed in Appendix G.

C. Unique Features of the Current Program Design

Centennial Care transformed how Medicaid services are delivered to the most vulnerable populations in New Mexico. The current delivery system delivers the right amount of care, at the right time, and in the right setting. To achieve this goal, the program design includes the following key features and innovative elements.

1. Care Coordination

Fundamental to Centennial Care is a robust care coordination system that requires coordination at a level appropriate to each member's needs and risk stratification. The care coordination program creates a person-centered environment in which members receive the care they need in the most efficient and appropriate manner while advancing the integration of physical health, behavioral health and LTSS.

The approach to care coordination in Centennial Care includes:

- Assessing each member's physical, behavioral, functional, and psychosocial needs;
- Identifying the specific medical, behavioral and LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet a member's needs;
- Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare.

Centennial Care establishes levels of care coordination support that range from a low level of care coordination for members requiring a "light touch" (i.e., periodic service utilization monitoring) to higher levels of care coordination for members with the highest needs (i.e., members with chronic conditions and high utilizers) who require more intensive, hands on care coordination. The intent is for members to receive the care coordination level of support

that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to make the corresponding change in the member's care coordination level.

Each member in Centennial Care receives a standardized health risk assessment (HRA) to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or 3 care coordination and is followed by the development of a comprehensive care plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members designated to care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs routinely monitor claims and utilization data for all members to identify changes in health status and high-risk members in need of a higher level of care coordination.

Centennial Care transformed New Mexico's Medicaid managed care program with its focus on integrated, person-centered care. Beginning in 2014, HSD procured new MCOs capable of providing the entire suite of covered Medicaid services and included prescriptive contractual requirements regarding the care coordination activities to be conducted by the MCOs. The program requirements include:

- Timeframes for when the HRAs and CNAs must be completed;
- Clear expectations of care coordination tasks for each care coordination level;
- Specific CCP criteria;
- Qualifications for care coordinators;
- Frequency of touch points between care coordinator and members; and
- Specific care coordination requirements for members participating in a Health Home model.

Furthermore, MCOs are encouraged to build care coordination systems that maximize local community supports, such as Community Health Workers (CHWs). In the past four years, MCOs have been increasing their use of CHWs in care coordination roles as well as using CHWs to educate members about appropriate use of the delivery system.

MCOs have also effectively used PCMHs as an additional tool for delivery of care coordination. PCMHs have long been a part of the New Mexico Medicaid program landscape. However, with the implementation of Centennial Care, the four MCOs have increased the availability and use of in Patient Centered Medical Homes (PCMHs). Currently, more than 300,000 members are receiving care PCMHs.

As a result of these care coordination efforts and other innovations in Centennial Care, the average cost associated with inpatient hospital stays has decreased, while the use of more appropriate services such as primary care office visits and preventative care services increased.

2. Benefit and Delivery System

a) Physical Health and Behavioral Health Integration

Centennial Care changed how members access benefits and how benefits are managed. Prior to Centennial Care, a member's care was managed and delivered by multiple MCOs. Members were enrolled with a physical health or a LTSS MCO, as well as with the statewide behavioral health MCO for mental health and substance abuse services (MH/SA). This fragmentation created barriers for treating the whole-person. Centennial Care changed the delivery of care by creating a person-centric model and placing the responsibility of the member's holistic care with a single MCO.

Three new behavioral health services were added in Centennial Care for eligible participants: family support, behavioral health respite, and recovery services. Prior to Centennial Care, these services were not otherwise available in the Medicaid program.

- Family Support — This service is a community-based, face-to-face interaction with the eligible beneficiaries and family members/significant others to identify the recovery and resiliency service needs within a recovery plan to enhance their strengths, capacities, and resources so as to promote their ability to reach the recovery and resiliency behavioral health goals they consider most important.
- Behavioral Health Respite — This service provides supervision and/or care of children and youth (up to 21 years of age diagnosed with a serious emotional or behavioral health disorder as defined by the DSM V) residing at home in order to provide an interval of rest and/or relief to the person and/or their primary care givers. The service may include a range of activities to meet the social, emotional, and physical needs of the caregiver(s) during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.
- Recovery Services — These services are peer-to-peer individual and group services that assist individuals with serious mental illness, severe emotional disturbance and substance use disorders to develop the skills they need to maximize their potential for a successful recovery.

HSD also implemented the "Treat First" model of care as an innovative approach to BH clinical practice improvement. It began with a six month trial within six provider organizations. The organizing principle has been to ensure a timely and effective response to a person's needs as a first priority in the approach. It has been structured as a way to achieve immediate meaningful engagement while gathering needed historical, assessment and treatment planning information over the course of four therapeutic encounters as opposed to the expectation that these functions be completed within the first encounter. The results of this trial achieved significant improvements in patient and provider satisfaction including the quality of treatment planning, early resolution of presenting problems and the reduction of subsequent "no show" appointments. As a result, HSD has implemented this approach as standard BH practice.

b) Long-Term Services and Supports (LTSS)

A central goal of the Centennial Care program is assuring that members receive the right amount of care, at the right time, and in the most cost effective or "right" setting. Since 2008, HSD has administered its LTSS program through a managed care model designed to serve members in the most appropriate setting. New Mexico continues to lead the nation in spending more of its LTSS dollars to keep members residing in their homes and in the community rather than institutional settings. The American Association of Retired Persons' historical reporting contained in *The State Scorecard on LTSS for Older Adults, People with Physical Disabilities and Family Caregivers* has demonstrated that between the years of 2014 and 2017, New Mexico has ranked in the top five of states spending more of their LTSS dollars on CB services rather than institutional care. Centennial Care significantly advanced this trend. Today, approximately 30,000 members are receiving LTSS in their homes or in the community.

Prior to Centennial Care, the state's LTSS program, known as the Coordination of Long-Term Services (CoLTS) program, restricted members who met the NF LOC criteria to receiving only Personal Care Services (PCS). It also required members who needed additional CB services to place their name on a central registry list and wait for a waiver allocation.

Centennial Care expanded the availability of CB services to individuals who qualify for full Medicaid coverage and meet a NF LOC by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. As part of this change, HSD removed the PCS benefit from the State Plan and included it as one of many services available in the CB service array, which resulted in increased access to PCS for eligible members. HSD continued to provide access to HCBS for those members who did not meet standard Medicaid financial eligibility due to having household income that is higher than program guidelines by establishing 4,289 slots as allocations to the Centennial Care waiver.

While such efforts result in improved member outcomes, they also result in reduced occupancy rates for nursing facilities and higher average costs to care for those who are residing in nursing facilities. According to a report by the New Mexico Legislative Finance Committee released in October 2016 , *Cost, Quality and Financial Performance of Nursing Homes in New Mexico* (report #16-10), the number of individuals living in New Mexico nursing homes declined by 12% between 2011 and 2015 as options for home and-community-based care have expanded under Centennial Care. "As such, nursing homes are caring for residents who are gradually becoming more dependent on others for activities of daily living, leading to higher costs of care. This has considerable implications in New Mexico, where 64 percent of nursing home residents rely on Medicaid to pay for their care." HSD will continue to work with the New Mexico Health Care Association, which represents the nursing home industry in New Mexico, to address the impact of the changing environment for how members prefer to receive LTSS and to advance quality and performance metrics for nursing home care.

Additionally, HSD created an independent system that links together resources throughout the state to assist LTSS members. The New Mexico Independent Consumer Support System (NMICSS) provides Centennial Care beneficiaries, their advocates and counselors with information and referral resources in the following areas:

- Centennial Care health plan choice counseling;

- Grievance, appeals rights and fair hearings; and
- Understanding care coordination and levels of care.

The NMICSS provides informational brochures to inform beneficiaries and advocates on how to access the NMICSS and which participating organizations can help with specific topics. HSD partners with the NMICSS advisory team in planning and hosting semi-annual regional roundtable discussion groups with a focus on LTSS. The purpose of these meetings is to offer an environment conducive to open discussion regarding LTSS for Centennial Care members. These discussions have led to increased MCO trainings for care coordination; process improvements between the MCOs, HSD and LTSS providers; and trust building at the community level with MCOs, members and provider advocates.

3. Native American Members in Centennial Care

Several protections were implemented in Centennial Care to ensure that Native Americans continued to have access to Indian Health Service, Tribal health providers, and Urban Indian providers (I/T/Us) and to facilitate access to timely, quality care. The following protections are addressed in the Special Terms and Conditions STCs of the 1115 waiver and in the MCO contracts:

- Each MCO must have a full-time staff person to work directly with I/T/Us and be proficient in at least one New Mexican Native American/pueblo language;
- MCOs are encouraged to use local resources, such as I/T/Us, PCMHs, Health Homes, Core Service Agencies (CSAs) and tribal services to perform care coordination activities;
- The MCO cannot impose cost sharing on Native Americans;
- Members can choose I/T/Us to serve as their primary care provider;
- At least one FQHC shall be an Urban Indian FQHC in Bernalillo County;
- MCOs must allow members to seek care from any I/T/U whether or not the I/T/U is a contract provider;
- MCOs must track and report quarterly reimbursement and utilization data related to I/T/Us;
- MCOs must reimburse I/T/Us at least 100% of the rate currently established for IHS facilities (with a few exceptions);
- Services provided within I/T/Us are not subject to prior authorization requirements;
- Native American members accessing the pharmacy benefit at I/T/Us are exempt from the MCO's preferred drug list; and
- Native Americans may self-refer to an I/T/U for services.

Additionally, the STCs of the waiver required that HSD form an advisory group, the Native American Technical Advisory Committee (NATAC), comprised of representatives from New Mexico's tribal organizations and Indian Health Services. The group has been meeting quarterly since the planning phase of Centennial Care in 2013 and, more recently, held meetings dedicated to reviewing concepts and developing recommendations for the waiver renewal application. HSD plans to continue the NATAC group and maintain all of the current protections for Native Americans in Centennial Care 2.0.

HSD collaborates with the NATAC to better understand and improve the member experience for Native Americans in Centennial Care. As of April 2017, there are 44,426 Native American

enrolled in Centennial Care with about 12,000 members enrolled in the Medicaid adult expansion. While not all Native Americans who are eligible for Medicaid are required to enroll in Centennial Care, those in need of LTSS are required to participate in the managed care program. Consistent with the non-Native American Medicaid population, PCS continues to be the most utilized CB service by Native Americans. Native American members are able to seek care from IHS and/or tribal providers regardless of whether those providers are contracted with a MCO.

In response to the NATAC's recommendation that the MCOs better utilize Community Health Representatives (CHRs) working with Tribal organizations, HSD included specific contractual requirements to increase the use of CHRs as part of the initiative to expand the work of CHWs. Additionally, the MCOs have implemented a variety of programs in Native American communities throughout New Mexico including a resource center in Shiprock, New Mexico, and Tribal opportunities to perform specified care coordination activities.

In addition to the NATAC, HSD and the MCOs receive ongoing input from the Native American Advisory Boards (NAAB). The NAAB meets quarterly in tribal communities that have high enrollment in Centennial Care to discuss issues related to service delivery and operations. Each MCO is also required to employ a full-time Native American liaison that works directly with IHS, Tribal 638 providers and HSD's Native American liaison.

4. Member Engagement and Personal Responsibility

One of the core principles of the Centennial Care program is to encourage greater personal responsibility of members to facilitate their active participation and engagement in their own health so they can become more efficient users of the health care system. Centennial Care required the MCOs to provide a member rewards program that offers incentives to members to become more actively engaged in managing their health.

a) Centennial Rewards

Centennial Care established a member-based rewards program known as Centennial Rewards, which was designed to encourage members to actively participate in their health care and drive improvements in health outcomes. It required the MCOs to collaborate and procure a vendor to implement a member rewards program. The MCOs selected the company Finity to administer the program, which was launched in the spring of 2014.

Any Centennial Care member enrolled in a MCO may participate in the Centennial Rewards program and receive points for engaging in and completing healthy activities and behaviors, including:

- Healthy Smiles, which rewards annual dental visits for adults and children;
- The Step-Up Challenge, which rewards completion of a three-week or nine-week walking challenge;
- Asthma Management, which rewards refills of asthma controller medications for children;
- Healthy Pregnancy, which rewards members who join their MCO's prenatal program;
- Diabetes Management, which rewards members who complete tests and exams to better manage their diabetes;

- Schizophrenia and/or Bipolar Disorder Management, which rewards members who refill their medications; and
- Bone Density Testing, which rewards women age 65 or older who complete a bone density test during the year.

Members who complete these activities earn credits, which may be redeemed for items in a Centennial Rewards catalog.

In 2016, approximately 70% of Centennial Care members participated in the Centennial Rewards program. Some of the demonstrated health outcomes for these members have been:

- Inpatient admissions have decreased among participants in the rewards program, resulting in a cost-savings of approximately $23 million in 2015;
- The average redemption rate of earned rewards is 24%, with the notable exception of the Step-Up Challenge, which has a redemption rate of 85%. This suggests that the proactive enrollment required for the Step-Up Challenge has had a substantial positive impact on member use of their rewards;
- Overall cost-savings attributed to the Centennial Rewards program increased by one-third from 2014 to 2015. Reduced inpatient admissions and costs per admission have been the dominant driver behind cost-savings across conditions;
- Participants across all conditions had higher compliance with Healthcare Effectiveness Data and Information Set measures and other quality outcomes than non-participants; and
- A comparison of risk scores indicates that higher risk members tend to participate in the Centennial Rewards program.

b) Member Engagement

In addition to Centennial Rewards, the MCOs continue to increase member engagement through implementation of the care coordination program, disease management programs, member advisory committees and Ombudsman programs that assist members with understanding MCO processes and address concerns not resolved through standard appeals and grievance procedures. MCO care coordinators remain critical in educating members about appropriate use of the delivery system and helping them to navigate the system. For example, CHWs employed by the MCOs engage members who frequently use the emergency department and connect them with primary care physicians. In addition, members in need of LTSS are able to review and discuss available CB services with their care coordinators who utilize a Community Benefit Services Questionnaire to determine which CB services members may be interested in receiving. Members who receive LTSS through the SDCB are actively engaged in developing their care plans, hiring their own caregivers and developing their payment rates. These members are responsible for completing employer-related tasks, such as approving and submitting employee timesheets to the fiscal management agency for payment.

In addition, the MCOs continue to develop strategies that promote member engagement through:

- Diabetes self-management programs and other disease-specific education classes;
- Wellness programs;
- Communication coaching;

- Physician video visits;
- Wellness benefits offering up to $50 per year in health/wellness purchases;
- Care coordination targeting specific chronic conditions;
- Targeted education and self-help materials; and
- Use of CHWs to engage members in meeting their care needs and addressing social determinants of health.

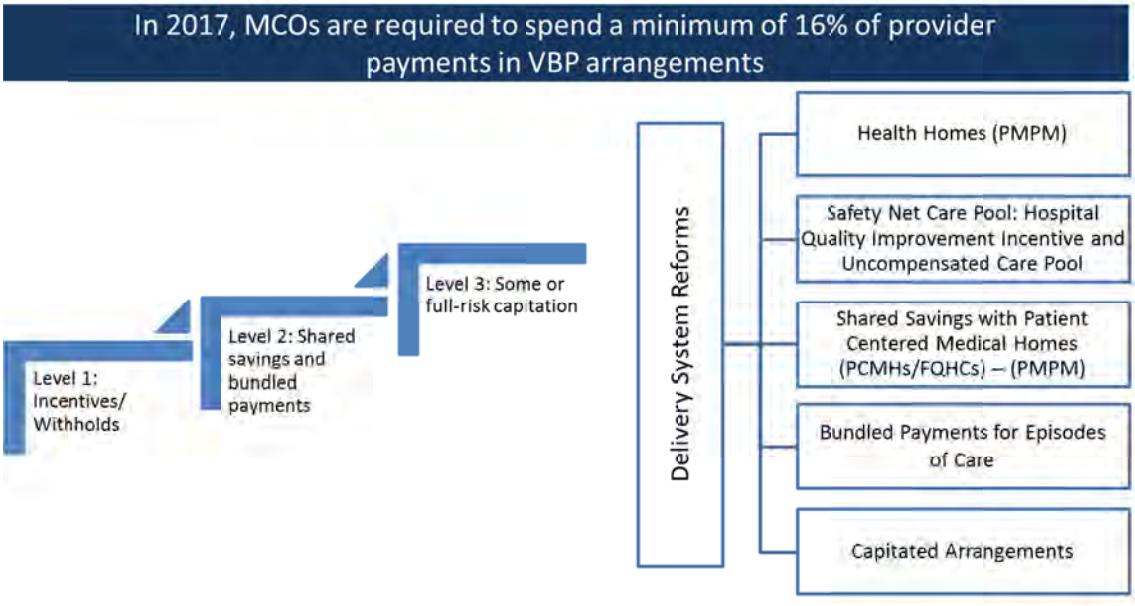
5. *Payment Reform*

A key program goal of Centennial Care has been to pay for value and not solely for volume of services rendered by rewarding providers for achievement in quality of care and improved member health outcomes. In 2015, HSD implemented payment reforms through a variety of pilot projects to test their effectiveness and to begin to engage providers in changing reimbursement methodologies to more effectively align with quality outcomes.

a) Value Based Purchasing

After testing a variety of payment reforms through multiple pilot projects implemented by the MCOs, HSD required, through specific contractual provisions, that the MCOs have a prescribed percentage of all provider payments in one of three levels of VBP payment arrangements. For Centennial Care 2.0, HSD will continue to increase the overall percentage of provider payments covered under a VBP arrangement and expand the types of providers covered in various models while also focusing on arrangements for behavioral health, long term care and nursing home providers. In Calendar Year 2017, the MCOs are required to have 16% of provider payments in value-based arrangements across three different levels, with level one at the lower end of the risk continuum and level three at the higher end as illustrated in Figure 1.

Figure 1 – Value Based Purchasing



MCOs are permitted to tailor their program to their covered population.

b) Safety Net Care Pool

As part of its delivery system reform initiatives, HSD has implemented other payment reforms through Health Homes and the Safety Net Care Pool (SNCP) Hospital Quality Incentive Initiative (HQII) pool. It has also required the MCOs to increase the number of members receiving care in PCMHs.

The SNCP is comprised of two programs: the Uncompensated Care (UC) pool and the HQII pool. Today, the UC pool provides funding to 29 eligible hospitals (formerly known as sole community provider program hospitals) for their uncompensated care. The payments are structured to provide funding to the smallest hospitals first, and then to medium-sized and lastly to largest hospitals, based on available funding.

The HQII Program incentivizes participating hospitals to meaningfully improve the health and quality of care of the individuals they serve who are Medicaid eligible or are uninsured. Beginning in 2015, the HQII Program evaluated and rewarded hospitals based upon essential quality measures for urgent improvements in care including:

- All cause readmissions;
- Obstetrical adverse events (without instrument);
- Postoperative deep vein-thrombosis or pulmonary embolism;
- Surgical site infections;
- Ventilator associated events;
- Adverse drug events;
- Catheter-associated urinary tract infections;
- Central line associated blood stream infections;
- Injury from falls and immobility; and
- Obstetrical adverse events (with instrument) and pressure ulcers.

Each hospital's HQII activities are consistent with HSD's quality goals, as well as CMS' overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities).

As HQII advances into the final years of the current Centennial Care waiver, measures are evolving toward population-focused improvements including diabetes short-term and long term complication rate, adults with asthma admission rate, heart failure admission rate and bacterial pneumonia admission rate. HSD continues to work collaboratively with the New Mexico Hospital Association to develop outcome measures with agreed upon definitions and calculations that are applied consistently by hospitals and reported uniformly to such national organizations as the National Healthcare Safety Network.

In 2018, the percentage of funding available to the UC pool is 85%, or $68.9 million of the total available funding of $80.9 million, leaving $12.0 million or 15% available for HQII pool. Notable achievements include:

- From 2014 to 2016 there was a 41% decrease in requests for UC funding by the 29 SNCP hospitals participating in the UC program; and
- For 2015, the defined need for UC funding was fulfilled, with $1.6 million subsequently flowing from the UC pool to the HQII pool.

6. Telehealth

As part of Centennial Care, HSD focused on improvements in the utilization of telehealth for both physical and behavioral health care. MCOs were required to implement telemedicine initiatives for the convenience and benefit of members and to improve access to care in rural areas. The efforts of HSD and the MCOs have resulted in annual increases in telemedicine utilization; active recruitment initiatives to pursue qualified telehealth providers; recruitment of behavioral health medication management providers; and the purchase of block time services of behavioral health medication management providers through an external vendor. Table 2 exhibits the number of telehealth visits and percent of increase in visits for years 2015 and 2016.

Table 2 – Telehealth Visits in 2015 and 2016

Medicaid MCO	2015 Behavioral Health	2015 Physical Health	2015 Total	2015 % Increase	2016 Behavioral Health	2016 Physical Health	2016 Total	2016 % Increase
MCO 1	1,213	803	2,016	73%	2,362	2,803	5,165	156%
MCO 2	2,132	754	2,886	69%	3,579	98	3,677	27%
MCO 3	3,809	134	3,943	25%	5,045	280	5,325	35%
MCO 4	1,833	236	2,069	81%	1,786	1,000	2,786	35%
Total	8,987	1,927	10,914	57%	12,772	4,181	16,953	63%

7. Community Health Workers

CHWs are trusted members of the community who work within the local health care system in rural, frontier, tribal and urban areas. CHWs have been referred to as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives, peer health promoters, peer educators, and community connectors. They are in a unique position to provide interpretation and translation services, culturally appropriate health education, and, informal counseling and guidance on health behaviors, while encouraging self-efficacy. CHWs also serve as liaisons between the member and the health care system by assisting them in obtaining needed care. Additionally, Centennial Care MCOs have been required to increase the use of CHWs by 10% annually and have effectively been employing and contracting with more than 100 CHWs. New Mexico's Medicaid program has been featured in several recent articles about advancing the use of CHWs, which can be found at the links below:

- https://west.stanford.edu/news/blogs/and-the-west-blog/2017/community-health-workers
- http://healthaffairs.org/blog/2017/07/25/diffusion-of-community-health-workers-within-medicaid-managed-care-a-strategy-to-address-social-determinants-of-health/

SECTION 2: CONCEPTS FOR RENEWAL

The Centennial Care waiver renewal provides opportunities for HSD to build upon the accomplishments achieved since implementation of Centennial Care. At the same time, HSD has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system. Based on feedback received over the past three years at the annual Centennial Care public forums and through recent input sessions with advocacy groups and stakeholders, HSD has identified key areas of refinement for Centennial Care 2.0.

The following list is a summary of program modifications for Centennial Care 2.0 that leverage successful elements of the existing program design, expand initiatives that directly benefit members, and ensure the financial viability and sustainability of the program over the long term.

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions of settings of care.
- Continue to expand access to CB in the LTSS program and maintain the progress achieved in rebalancing efforts while collaborating with the nursing home industry to advance quality initiatives and performance.
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health.
- Continue to expand payment reform through VBP arrangements to achieve improved quality and better health outcomes.
- Build upon and incorporate policies that seek to enhance beneficiaries' ability to become more active, responsible and involved participants in their own health care.
- Further simplify administrative complexities and implement refinements in program design and benefit design, some of which will be implemented with the replacement of the Medicaid Management Information System. A summary of this project may be found at the following link: http://www.hsd.state.nm.us/uploads/files/The%20MMIS%20Replacement%20Project%20Overview.pdf.

This section of the renewal application outlines the program design proposals for Centennial Care 2.0.

1. Care Coordination Proposals

Care coordination remains a main focus for the Centennial Care program. Through continued evaluation of the care coordination program and feedback from advocates and members, HSD modified its approach to Care Coordination in 2016 to place greater emphasis on members with the highest needs– those assigned to Level 2 and Level 3 care coordination -- while minimizing Level 1 requirements. This change made sense at the three year mark, since most members had received a HRA and were designated to a specific care coordination level.

For Centennial Care 2.0, HSD aims to further refine care coordination by maximizing resources to target members with the highest needs and those experiencing transitions in settings of care. HSD plans to transition more care coordination activities from the MCOs to providers with the capacity to manage subsets of the population and enter into VBP arrangements. Furthermore, in Centennial Care 2.0, HSD will continue to require that all MCOs offer a Dual Eligible Special Needs Plan (D-SNP) to promote better outcomes for dually-eligible members through coordinated care. HSD plans to maximize opportunities for improved coordination in collaboration with CMS as federal enrollment policies evolve for this population.

The following modifications are proposed for Centennial Care 2.0:

- Increase care coordination at the provider level;
- Strengthen transitions of care;
- Expand successful programs that target high-need populations;
- Initiate care coordination for justice-involved individuals prior to release; and
- Obtain 100% federal funding for covered services delivered to Native Americans in Centennial Care that are "received through" IHS or Tribal facilities per the federal guidance.

Care Coordination Proposal #1: Increase care coordination at the provider level
HSD will continue to move forward with the expansion of its health home initiative, CareLink NM. At the same time, the PCMH model remains a viable and important model of care. Centennial Care has increased the number of members participating in PCMHs from 180,000 at the end of 2014 to more than 300,000 in 2017. PCMH models emphasize quality, access to care, appropriate use of health care that avoids unnecessary utilization (non-emergent emergency room visits etc.) and leads to better outcomes and cost savings. National studies suggest that patients served by PCMHs are more satisfied than those served in traditional primary care practices and that physician practice staff are happier in PCMHs. One group health study found that only 10% of staff in PCMH pilot programs felt high levels of exhaustion compared to 30% in control practices. The same study also found better retention and satisfaction among primary care physicians compared to non-PCMH practices (Grumbach & Grundy, 2010). For a state such as New Mexico with a shortage of providers, this is a particularly important outcome. PCMH providers play a critical role as they engage directly with their members and have the most frequent opportunity to build trusting relationships, which has a high impact on successful integration of physical and behavioral health. As part of the expansion of the PCMH model, the MCOs are engaging PCMH providers to conduct care coordination activities for their attributed members through VBP arrangements.

Centennial Care 2.0 seeks to expand on this initiative by continuing to transition care coordination functions from the MCOs to the provider level through delegated arrangements. As providers become more willing to accept risk for a subset of members, delegation of care coordination is critical to successful management of members. Under Centennial Care 2.0, HSD proposes to leverage opportunities to build on these successful models by supporting providers with the capacity to conduct care coordination activities and allowing MCOs to delegate care coordination functions.

Two approaches for care coordination delegation will be available – a Full Delegation Model and a Shared Functions Model. In the Full Delegation Model, the MCO delegates the full set of care

coordination functions to the provider/health system (the delegate) for an attributable membership and retains oversight and monitoring functions. This model is only permitted when included as part of a VBP arrangement with the provider that outlines the payment arrangement for the full delegation of care coordination as well as other requirements associated with improving quality and healthcare outcomes. In the Shared Functions Model, the MCO retains some care coordination functions and allows other care coordination activities to be conducted by a provider or partner, such as a local/community agency, CHW, Community Health Representative (CHR) working with a tribal organization, school-based health center (SBHC), paramedicine program, and/or personal care service agency. In this model, the partner may or may not have a VBP arrangement with the MCO.

Care Coordination Proposal #2: Improve transitions of care

Care coordination, when implemented timely and effectively, assists members through transitions of care by connecting them to local providers and stabilizing them in the new setting so that they are able to improve and thrive. Well-planned care coordination provides a variety of supports during transitions, including but not limited to: assistance with eligibility; addressing safety concerns in their home environment; and assistance with addressing housing issues. Transitional needs are identified and addressed in a transition of care plan developed by the care coordinator and the member. HSD intends to improve transitions of care by implementing measures that enhance the MCOs' ability to identify and provide situation-specific assistance for short-term transition periods, including, but not limited to:

- Discharge from an inpatient or nursing home stay;
- Frequent emergency department visits within a short period of time;
- Release from Crisis Triage Centers (a new NM service);
- Release from incarceration or detention facilities among justice-involved individuals;
- Community placement from a residential or institutional facility; and
- Children returning home from a foster care placement.

This initiative includes requirements for the MCO to conduct in-home assessments for members in need of CB services after transitions from facilities. In addition, HSD proposes to work with the MCOs to construct VBP initiatives and other member incentives that support positive outcomes of a successful discharge, such as:

- Continuing reductions in unnecessary emergency department visits post discharge for 30 days;
- Continuing reductions in preventable readmissions post discharge for 30 days;
- Ensuring timely follow-up primary care physician or behavioral health visits; and
- Encouraging timely medication reconciliation and prescription fulfillment.

Care Coordination Proposal #3: Leverage partnerships to expand successful programs that target high-need populations

With a focus on directing resources in areas where the most potential for impact exists, Centennial Care 2.0 will continue to expand and initiate successful programs that target high-need populations. HSD proposes to advance key initiatives through supporting collaborations and expanding programs that have demonstrated quality results in phase one of Centennial Care, and by leveraging successful community-based programs to initiate new opportunities in Centennial Care 2.0. These proposals include:

- Continuing to incentivize innovative collaborations between the MCOs and community agencies, such as paramedicine providers, wellness centers, PCS agencies and Project ECHO;
- Continuing efforts to build capacity and provide flexibility for the use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists, to provide care coordination functions;
- Continuing to promote use of CHWs and CHRs as extenders of care coordination to educate members about using the health care system;
- Implementing the full functionality of the Emergency Department Information Exchange (EDIE) to improve care coordination at the community level between EDs and community providers;
- Expanding the Health Home program, which serves children and adults with complex behavioral health needs, to other counties; and
- Piloting a wraparound approach (intensive care coordination) for youth involved with the CYFD to improve health outcomes and reduce stays in residential treatment centers.

Finally, as MCOs continue to demonstrate a thorough understanding of the requirements for basic care coordination activities, such as conducting needs assessments, face-to-face visits with members and regular updates to plans of care, HSD will shift its resources from compliance and monitoring of care coordination activities to focus on measurement of quality and healthcare outcomes. For example, evaluating the success of full delegation care coordination models will occur by monitoring outcome based performance measures established by MCOs. As part of its replacement of the Medicaid Management Information System (MMIS), HSD will procure advanced data analytics capability, which will provide additional opportunities to improve monitoring and reporting activities.

Begun in 2017, the MMIS will change many of HSD's business processes and provide new opportunities to improve the program. MCOs under contract during that time must exhibit flexibility and nimbleness in working with evolving systems. Opportunities will develop to capture and analyze data relevant to member-specific and population health outcomes (physical, behavioral, and social), quality metrics, and total cost of care. With such capability, HSD will be able to implement continued improvements in the care coordination program that are informed by meaningful data.

Care Coordination Proposal #4: Initiate care coordination for justice-involved individuals prior to their release from incarceration

HSD has developed and implemented the IT systems, policies and processes to facilitate eligibility "suspensions" for individuals who are involved in the criminal or juvenile justice system, and to ensure timely and automated eligibility reactivations upon the release of these individuals from custody.

HSD proposes to expand its engagement of individuals being released from correctional facilities to improve health care outcomes and, potentially, reduce recidivism. HSD will allow care coordination activities with justice-involved individuals to begin prior to their release in order to establish appointments, referrals and pharmacy services to ensure continuity of care. The pilot may also include:

- Allowing for MCO delegation of care coordination to the county or facility for activities that occur prior to release; and
- Strengthening MCO contract requirements regarding after-hour transitions to address spontaneous or unplanned discharge from custody, often occurring during evening or weekend hours. HSD will require the MCOs to have a dedicated staff position to serve as a liaison to the participating facilities in order to address this complex issue.

Care Coordination Proposal #5: Obtain 100% federal funding for covered services delivered to Native American members in Centennial Care that are received through IHS or Tribal Facilities
HSD proposes that when Centennial Care 2.0 MCOs enter into a care coordination agreement with Indian Health Services (IHS) and/or Tribal health providers (I/T/Us) for their Native American members, the Centennial Care MCO shall maintain the referrals, care plans and member records for all covered Medicaid services that are referred and provided by the MCO's provider network. This is particularly important for long term care services, which traditionally do not receive referrals through IHS. Since Native American members in need of long term care services are required to enroll in Centennial Care, the MCOs have contractual relationships with long term providers, including nursing facilities and personal care service agencies, while IHS does not have such contractual relationships nor traditionally refer for such services. Additionally, the MCOs are responsible for developing and maintaining the care plans of those members, and having them serve as the responsible party for record custody for those members but share the records with IHS/ITUs will reduce administrative burden and barriers to care in such circumstances. The services and referrals included in those member's record shall be eligible for the 100% federal Medical Assistance Percentage (FMAP) rate per the federal guidance for services "received through" an IHS or Tribal facility (SHO #16-002).

2. Benefit and Delivery System Proposals

HSD has made notable advances under Centennial Care in developing a comprehensive delivery system. Centennial Care 2.0 will enable the state to continue to promote person-centered care, expand the availability of LTSS while ensuring improved quality and long term sustainability, pilot a new home visiting benefit for eligible pregnant women and implement a new supportive housing benefit for adults with Serious Mental Illness (SMI).

Essential to Centennial Care is the availability of CB services for members who require LTSS and wish to remain in the community or in their own home. As service utilization continues to increase in the LTSS program, HSD's proposals for modifications to the CB services are focused on the long term sustainability of the program without jeopardizing the gains achieved in improved access to care and health care outcomes derived from the program's innovative policy. Note that the maximum allowable cost of care for CB services will continue to be tied to the HSD's average annual cost of care for persons serviced in a private nursing facility.

HSD proposes the following benefit and delivery system modifications in the Centennial Care 2.0 Waiver renewal:

- Cover most Medicaid adults under one comprehensive benefit plan (the Alternative Benefit Plan). This includes a waiver of the federal EPSDT rule for 19 and 20 year olds enrolled in the Alternative Benefit Plan (ABP) to further streamline the adult benefit package *(note: individuals who meet the federal "medically frail" criteria are exempt*

from the ABP and able to receive the traditional Medicaid benefit package that includes EPSDT services);

- Develop a buy-in program (riders) for dental services and vision services for adults, if necessary;
- Add Nutritional Counseling as an option under ABCB to better align CB packages;
- Establish a one-time allowance for the cost of start-up goods when a member transitions from ABCB to SDCB;
- Address the need for additional respite hours for caregivers of CB members (both adults and children) by increasing the number of hours available;
- Establish limits on costs for certain services in the SDCB model;
- Require inclusion of nursing facilities in VBP arrangements and leverage the University of New Mexico's Project Extension for Community Healthcare Outcomes (Project ECHO) to provide expert consultation to nursing home staff working with members with complex conditions to improve quality of care and healthcare outcomes for such members. In addition, work with Project ECHO and The University of New Mexico (UNM) Section of Geriatrics to improve quality of care (and quality ratings) in participating New Mexico nursing facilities;
- Pilot a home visiting program that focuses on pre-natal, post-partum and early childhood development services;
- Develop a housing support service to provide some peer-delivered, pre-tenancy and tenancy support services to active adults who are Seriously Mentally Ill (SMI);
- Add services for substance abuse disorders including waiver from limitations on the use of IMD for members with SUD;
- Request waiver authority to allow 30 day use of an IMD for members who have a non-SUD diagnosis;
- Secure enhanced administrative funding to maintain an inventory of Long-Acting Reversible Contraception (LARC) for certain providers;
- Expand the Health Home model; and
- Establish an alternative payment methodology to support workforce development.

While HSD has sufficient authority to continue advancement of physical and behavioral health integration, it has identified several strategies aimed at improving existing practices in Centennial Care that reduce the fragmentation of care through patient-centered practices. HSD will pursue State Plan Amendment to implement the health home expansion, but is seeking waiver authority to have more flexibility in the methodology for the alternative payment to support workforce development.

Benefit and Delivery System Proposal #1: Modify the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered Adults

Most adults who are enrolled in the Medicaid Expansion Category receive services under the ABP. The ABP is a comprehensive benefit package that covers all services that are defined under the ACA as "essential health benefits" and includes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals who are age 19 and 20. The ABP is closely aligned with the types of benefit packages that are available on the commercial market, meaning that there are limitations on certain services, such as: physical, occupational and speech therapy and home health services; and that some services are not covered, such as routine vision care and hearing aids. In addition to meeting the Essential Health Benefits standard articulated in the

ACA, the New Mexico ABP also includes adult dental services that are aligned with the Medicaid State Plan.

Although most adults in the Medicaid Expansion receive the ABP, individuals who are considered "medically frail" are exempt from the ABP and may receive the standard Medicaid benefit package which includes access to EPSDT services, CB services and nursing facility care for individuals who meet the NF LOC criteria.

Non-expansion Medicaid adults (Parent/Caretaker category) receive the standard Medicaid benefit package, which does not have certain coverage limits as the ABP does. To ensure the Medicaid program's long term affordability and sustainability, HSD requests waiver authority to cover adults in the Parent/Caretaker category under the ABP, essentially providing one benefit package to most Medicaid-covered adults. Individuals who are determined "medically frail" will still be able to receive the standard Medicaid benefit package.

As it exists today, the ABP is "HHS Secretary-approved" coverage, which provides the flexibility to offer a comprehensive benefit package with approved limitations on certain services. HSD seeks to maintain the comprehensive coverage as it exists today in the ABP with several modifications as follows:

- Create options for new service providers and leverage new technologies for the delivery of non-emergency medical transportation by including rideshare services and mobile applications;
- Continue to provide habilitative services and include a limited vision benefit, which will provide a vision benefit to more than 240,000 adults in ABP who currently do not have such a benefit; and
- Waive the federal EPSDT rule for 19-20 year-olds who are covered under the Expansion Adult and Parent/Caretaker categories in the ABP. As stated previously, any adult who meets the medically-frail criteria is able to receive the standard Medicaid benefit package, which would provide EPSDT services for 19 and 20 year olds as well as LTSS for individuals meeting the NF LOC criteria.

Benefit and Delivery System Proposal #2: Develop buy-in premiums for dental and vision services for adults, if needed

HSD may need to scale back benefit design for adults to ensure the ongoing sustainability of the Medicaid program, contingent upon State budget allocations and potential changes in federal financing. Should HSD need to eliminate or reduce optional dental and vision services for adults, it will develop dental and vision riders that adults may purchase at an affordable premium, similar to those available in the commercial market.

Benefit and Delivery System Proposal #3: Better align Services between ABCB and SDCB Models

HSD proposes to align the CB service packages by adding Nutritional Counseling to the ABCB benefit package. In addition, HSD proposes to change the name of the self-directed Homemaker service to self-directed PCS to lessen confusion and better align with the ABCB benefit package. See Appendix H for comprehensive proposed CB benefits.

Benefit and Delivery System Proposal #4: Allow for one-time start-up goods when a member transitions from ABCB to SDCB

HSD proposes to establish a one-time funding amount of up to $2,000 for members who are transitioning from ABCB to SDCB to allow for items that are necessary for successful management of services in self-direction, such as a computer and printer. For periods after transition, the annual budget will be reduced for the one-time costs and an annual limit established for subsequent purchase of goods and services as described in LTSS proposal #4. See Appendix H for comprehensive proposed CB benefits.

Benefit and Delivery System Proposal #5: Address the need for additional caregiver respite

Currently, respite services available under the CB are limited to 100 hours in most circumstances. HSD is proposing to increase the limit from 100 to 300 hours. This increase will allow caregivers of CB members (both adults and children) to access over 30 days of respite per annual period. See Appendix H for comprehensive proposed CB benefits.

Benefit and Delivery System Proposal #6: Establish limitations on costs for certain services in the SDCB model

HSD proposes to establish annual budget limitations for the following services for members in the SDCB model (see Table 3 below): related goods and services, non-medical transportation and specialized therapies. These three services are only available in the SDCB model. As this program continues to experience increased enrollment, the limitations will help to ensure long term sustainability of the program and continue to allow HSD to offer access to the CB to all eligible Medicaid members who meet a NF LOC without needing a waiver allocation for such services. As part of implementation, HSD will "grandfather" the existing SDCB members with budgets that exceed the limits in any of these three services in order to ensure continuity of care. Their approved amounts over the proposed cost limits will establish their on-going cost limits for these services for as long as they remain in the SDCB model. See Appendix H for comprehensive proposed CB benefits.

Table 3 – SDCB Annual Service Limitations

SDCB Service	Description	Annual Limit
Related goods and services	Separate from the one-time funding for start-up goods and for members who transition from ABCD to SDCB. HSD proposes that for periods after transition an annual limit be established for continued purchase of goods and services.	$2,000
Non-medical transportation	HSD proposes an annual limit for non-medical transportation (carrier passes and/or mileage).	$1,000
Specialized therapies	HSD proposes to include an overall annual limit for the following specialized therapies such as: • Acupuncture • Chiropractic • Hippotherapy • Massage therapy	$2,000

Benefit and Delivery System Proposal #7: Require inclusion of nursing facilities in VBP arrangements and leverage Project ECHO and the UNM Section of Geriatrics to provide expert consultation to nursing home staff working with members with complex conditions, systematic improvements in nursing home quality of care, and reductions in avoidable readmissions from Nursing Facilities to hospitals

As New Mexico continues to increase the number of members receiving LTSS in home and community settings, nursing facility occupancy rates continue to decline resulting in higher average costs to care for those who are residing in nursing facilities. HSD proposes, as funding permits, to continue to work with the New Mexico Health Care Association to explore alternative reimbursement methodologies and to mandate inclusion of nursing homes in MCO VBP arrangements. Additionally, HSD plans to expand upon its work with the University of New Mexico's Project ECHO program to provide consultation services to nursing facility staff working with members with complex conditions, particularly behavioral health issues. Project ECHO is a collaborative model that provides medical education and care management to primary care and other physicians in order to help them treat complex medical and behavioral health conditions. While Project ECHO does not provide direct care to patients, it expands access to specialty treatment for front-line clinicians treating complex conditions, such as Hepatitis C, HIV, tuberculosis, chronic pain, endocrinology, diabetes, and behavioral health disorders. HSD will establish expectations for the MCOs to expand Project ECHO consultations for nursing home staff working with members with complex conditions. In addition, given that 64 percent of New Mexico nursing facility patients are Centennial Care members, there are significant opportunities to develop statewide efforts to identify key opportunities for improvement of quality of care across the entire state, and to develop a system to evaluate all readmissions from nursing facilities to hospitals and substantially reduce the number of avoidable readmissions.

Benefit and Delivery System Proposal #8: Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood development in collaboration with the New Mexico Department of Health and the Early Childhood Services Program of the New Mexico Children, Youth and Families Department

In collaboration with New Mexico Children, Youth and Families Department (CYFD) and New Mexico Department of Health (DOH), HSD proposes to implement an evidence-based, early childhood home visiting pilot project that focuses on pre-natal care, post-partum care and early childhood development. The services will be delivered to eligible pregnant women residing in HSD-designated counties (up to four and including Bernalillo County) by agencies providing the evidence-based early childhood home visiting delivery model as defined by the US Department of Health and Human Services (DHHS) and as contracted with the Centennial Care managed care organizations. The services to be provided are described in Table 4 below: Description of Services, which are based on evidence-based program requirements.

The Centennial Home Visiting (CHV) pilot program will align with two evidence-based early childhood home visiting delivery models focused on the health of pregnant women and their infants and promote parenting skills and child development. The two programs are:

- Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The 1115 demonstration NFP pilot program will adhere to the NFP national program standards in services delivery to approximately 300 eligible pregnant women. The services will be suspended once the child reaches two (2) years of age.

- Parents as Teachers (PAT): The goals of the PAT program are to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. The PAT pilot program will adhere to the PAT national model and curriculum and serve approximately 200 families beginning during pregnancy and up to when the child reaches five (5) years of age / kindergarten entry.
- Centennial Care MCOs may propose other evidence-based home visiting models, with similar services, in lieu of the Parents as Teachers model if available in the designated service delivery areas.

Table 4: Description of Services

Service	Description of Service
Prenatal Home Visit	The CHV Pilot Project will provide home visit services to expectant mothers during their pregnancy. The prenatal home visit services will provide: • Monitoring for high blood pressure or other complications of pregnancy (NFP only); • Diet and nutritional education; • Stress management; • Sexually Transmitted Diseases (STD) prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; and • Domestic and intimate partner violence screening and education.

Postpartum Home Visits	The CHV Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period. • Diet and nutritional education; • Stress management; • STD prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; • Domestic and intimate partner violence screening and education; • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); • Guidance and education with regard to well woman visits to obtain recommended preventive services; • Nursing assessment of the postpartum mother and infant (NFP only); • Maternal-infant safety assessment and education e.g. safe sleep education for Sudden Infant Death Syndrome (SIDS) prevention • Counseling regarding postpartum recovery, family planning, needs of a newborn; • Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/ newborn visit scheduled); • Parenting skills and confidence building.
Infant Home Visits	The CHV Pilot Project will provide home visit services to newborn infants born to CHV Pilot Project beneficiaries until the child reaches two (2) years of age for NFP and five (5) years of age or kindergarten entry for PAT. • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); and • Child developmental screening at major developmental milestones from birth to age two (2) for NFP according to model standard

The NFP program model meets the criteria established by the Department of Health and Human Services (DHHS) for an "evidence-based early childhood home visiting service delivery model." The program model is designed for first-time, low-income mothers and their children, and is designed to improve 1) prenatal health and outcomes; 2) child health and development; and 3) families' economic self-sufficiency and/or maternal life course development. NFP home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development. The NFP program model, therefore, may also address both teaching basic

parenting skills, as well as training parents on how to manage a child's medical, behavioral, and/or developmental treatment needs.

The PAT model also meets the criteria established by DHHS for an "evidence-based early childhood home visiting delivery model." The program model features : 1) comprehensive assessment on maternal (prenatal and postpartum) and child health, parent-child interactions and early literacy; 2) family goal setting; and 3) personal visits and group connection practices that home visitors partner, facilitate and reflect with families to reach their goals. Parent educators use the PAT *Foundational Curriculum* in culturally sensitive ways to deliver services that emphasize parent-child interaction, development-centered parenting and family well-being. The Program's outcomes include increased healthy pregnancies and improved birth outcomes as well as improved child health and development, prevention of child abuse and neglect, increased school readiness and increased parent involvement in children's care and education. The provider qualifications for the services provided are described in Table 5 below.

Table 5: Provider Qualifications

Home Visitor Provider Qualifications				
Home Visitors	Education (typical)	Experience (typical)	Skills (preferred)	Training
Nurse Family Partnership (NFP) Nurse Home Visitors – Hired by approved NFP implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife, current licensure.	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Technical skills: Providing care mgmt. and care coordination to high-risk pops; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment; Leadership skills, interpersonal and relationship building; communication and quality improvement analysis skills.	Comprehensive training and preparation as required by NFP model, and the NM Home Visiting Program Standards.

NFP Nurse Home Visitor Supervisor – Hired by approved NFP implementing agency	RN with Baccalaureate degree in nursing. Preferred that nurse supervisors have additional degrees beyond BSN such as MSN or other related/advanced practitioner designations e.g., nurse practitioner, nurse midwife.	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association HealthCare provider CPR and valid AED certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Nurses must receive reflective supervision weekly to meet requirements of the evidence based program. This nurse supervision is part of the direct services provided. Nurse supervisors may conduct home visits as required to support nurses and/or beneficiaries level of care needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate level of care.	Comprehensive training and preparation as required by NFP model, and the NM Home Visiting Program Standards.
Parents as Teachers (PAT) Home Visitors – Hired by approved PAT implementing agency	High School Diploma or GED	At least 2-years of experience working with children/families in a related field	Certification in Family and Infant Studies; Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model, and the NM Home Visiting Program Standards.

PAT Clinical Manager – Hired by approved PAT implementing agency	Licensed Master Social Worker	A Master's degree in a relevant discipline, 1-3 years in related program oversight experience.	Bilingual Spanish and English	Comprehensive training and preparation as required by PAT model, and the NM Home Visiting Program Standards.

Benefit and Delivery System Proposal #9: Develop Peer-Delivered Pre-Tenancy and Tenancy Support Housing Services

HSD proposes to create a supportive housing service that provides pre-tenancy and tenancy support services to Centennial Care members with Serious Mental Illness (SMI). The aim of the housing support proposal is to assist members in acquiring, retaining and maintaining stable housing, making it more conducive for members to participate in ongoing treatment of their illness and improve the management of mental and physical health issues. Housing support services do not include tenancy assistance in the form of rent or subsidized housing; instead they expand the availability of basic housing supports provided today through comprehensive community support services (CCSS).

Pre-tenancy support services (acquiring housing) include:

- Screening and identifying preferences and barriers related to successful tenancy;
- Developing an individual housing support plan and crisis plan;
- Finding and applying for housing;
- Ensuring that the living environment is safe and ready for move-in;
- Tenancy orientation and move-in assistance;
- Landlord advocacy; and
- Securing necessary household supplies.

Tenancy support services (maintaining housing) include:

- Early identification of issues that undermine housing stability, including member behaviors;
- Coaching to the Medicaid member about relationships with neighbors and landlords and tenancy compliance;
- Education about tenant's responsibilities and rights;
- Advocacy and assistance in resolving tenancy issues;
- Regular review and updates to housing support plan and crisis plan; and
- Linkages to other community resources responsible for maintaining housing.

HSD will use its existing program infrastructure and network of provider agencies associated with the Linkages Supportive Housing Program to deliver supportive housing services. Linkages providers will be expected to utilize peers for service delivery. This approach builds upon a successful statewide supportive housing model; expands the peer workforce; and improves the engagement, service delivery and outcomes for individuals with SMI.

Supportive housing services under the demonstration will be limited to eligible Medicaid individuals who:

- Have a Serious Mental Illness (SMI);
- Are enrolled in a Centennial Care managed care organization, and
- Are not receiving similar services through a separate waiver authority.

Housing support services will be limited to approximately 180 individuals for each annual period during the scope of the demonstration. Individuals may use housing support services for an average of three years; however, the length of time is dependent on the availability of Section 8 housing vouchers. HSD will be responsible for determining the providers that are eligible to deliver and receive payment for housing support services. Providers of housing support will be required to submit claims and will receive a per diem reimbursement for delivering supportive housing services.

HSD expects that housing services will have a beneficial impact for members and will evaluate to what extent housing support services result in improved integration of BH/PH services, care coordination effectiveness through improved and long term treatment participation, improvement in health outcomes, and reductions in unnecessary or inefficient use of health care, including unnecessary hospitalizations and use of emergency room for non-emergent issues.

Benefit and Delivery System Proposal #10: Substance Abuse Disorder (SUD) Continuum of Care and waiver from limitations imposed on the use of Institutions for Mental Disease (IMD) for members with SUD

New Mexico has a long experience of addressing opioid and other substance misuse, with significant progress made in relation to national trends. Other states are newly experiencing significant opioid misuse and dependency challenges. New Mexico currently supports a robust continuum of care for SUD prevention, treatment and recovery. Within that continuum, there are three opportunities for supporting the current system. The following three opportunities will strengthen access to the full spectrum of SUD care and improve care transitions for managed care and fee for service Medicaid recipients.

- Opportunity #1: Enhance early intervention and integrated care efforts -- New Mexico plans to build on its decade of experience and extend Screening, Brief Invention, and Referral to Treatment (SBIRT) services to Medicaid members through primary care, community health centers, and urgent care facilities across the state. SBIRT is an evidence-based, comprehensive public health approach for delivering early intervention and treatment services to people with, or at risk of developing, SUD. SBIRT will improve the ability to identify those in need of SUD services and to transition them to the appropriate level of care. NM is proposing the addition of SBIRT services through a State Plan Amendment and exploring the option to add AMA-approved service codes for screening and brief intervention to the Medicaid fee schedule. See program Appendix J for program details and the array of services currently available.

- Opportunity #2: Provide SUD treatment for adults who require an enhanced level of care -- New Mexico intends to include SUD residential treatment for the adult population who require ASAM Level 3. A recent survey of eleven publicly funded RTC providers indicated a

total of 199 beds, with 126 for men and 73 for women, far less than the State's current need. Nine of the ten responding RTC providers report using ASAM admission criteria, but only two of the ten are CARF accredited, with others in process. Appendix I details current non-Medicaid provision. Adding Medicaid coverage for SUD treatment within adult RTCs would help to close a gap in New Mexico's continuum of care, while providing an incentive for provider accreditation by a nationally-recognized body. The proposed benefit would only apply to accredited RTCs from a nationally-recognized accrediting body, require state approval of policies and procedures, and demonstrate use of ASAM placement criteria.

Opportunity #3: Expenditure authority for members in managed care and the fee-for-service program, with a SUD diagnosis, to receive inpatient services in an IMD for up to 30 days, allowing transition to community based SUD treatment -- Analysis of IMD utilization among adults with a SUD diagnosis has identified a small number of members and approximately $1 million dollars in costs attributed to stays in excess of 15 days. Currently, federal financial participation is limited to 15 days for members between the ages of 21 and 64 who are institutionalized in an IMD for short-term stays. This proposal will improve the availability of residential inpatient treatment services, with federal financial participation, for members with SUD and allow for appropriate transition to community based SUD treatment as well as simplifying the administration of the program for both HSD and the MCOs.

Table 6, below outlines the continuum of substance abuse services categorized by CMS Milestones per SMD #17-003 that New Mexico already supports through Medicaid and non-Medicaid funding. Non-Medicaid funding includes State General Funds (SGF), federal grant funds, and county and city funded-initiatives. The information in Table 6 is augmented by program details in Appendix I and demonstrates the array of services currently available, thereby highlighting the remaining gaps that can be filled through opportunities to provide SBIRT, SUD coverage for adults within RTCs and allowing up to 30 days in an IMD for SUD diagnosis. New Mexico proposes to include these services through a combination of State Plan Amendment and waiver authority to address the needs of Medicaid members, including Native American members and tribal providers.

Table 6 – Continuum of Substance Abuse Services by CMS Milestone

Milestones	Current Continuum of Care
1. Access to Critical Levels of Care for Opioid Use Disorder (OUD) and other SUDs	Medicaid: ASAM Level 1 Outpatient; ASAM Level 2 Inpatient; ASAM Level 2.1 Intensive Outpatient; ASAM Level 2.5 Partial Hospitalization Services (rule change in progress to include SUD); Medical Detoxification; Opioid Treatment Services; Recovery Support Services; HSD direction to MCOs to cover buprenorphine for OUD treatment without prior authorization. Non-Medicaid: Statewide media campaign on treatment availability; Opioid STR grant support for Methadone Assisted Treatment (MAT) training to improve availability/access to services and enhance workforce capacity; grant-funded SBIRT; state-funded programs for justice-involved Individuals with SUD; Supportive Housing programs for SUD; BH investment zones in two counties with high OUD; peer-centered recovery services and training.
2. Use of Evidence-based, SUD-specific Patient Placement Criteria	Medicaid: Use of ASAM level placement criteria for covered benefits. Non-Medicaid: Programs funded by federal grants and SGF outline required use of EBPs in provider scopes of work.
3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Non-Medicaid: 11 adult RTCs currently state funded, serving 1,027 distinct clients in 2016. New Mexico encourages RTC providers to become accredited and plans to include Medicaid coverage of SUD within adult RTCs to incentivize national accreditation and improved standardization of policies and procedures, including ASAM placement criteria. RTCs for children with SUD are currently covered.
4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	Medicaid: 19 licensed OTPs, *CareLink Health Homes* Non-Medicaid: Opioid STR training of MAT providers; training on medical detoxification; licensing of OTPs; state and county-funded MAT programs for incarcerated individuals.

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Medicaid: ASAM Level 1 Outpatient; ASAM Level 2 Inpatient; ASAM Level 2.1 Intensive Outpatient; ASAM Level 2.5 Partial Hospitalization Services (rule change in progress to include SUD); Medical Detoxification; Opioid Treatment Services; Recovery Support Services. Non-Medicaid: Overdose prevention education training to first responders; distribution of naloxone to priority networks; statewide media campaign about overdose prevention, naloxone use, and treatment availability; technical assistance to 100 NM pharmacies on dispensing naloxone; statewide MAT training; medical detoxification training at NM hospitals; collaboration between the state, pharmaceutical and medical community on prescription drug monitoring; support for community strategic planning and implementation on underage drinking and prescription drug abuse; PAX Good Behavior Game; programs for Justice-Involved individuals, Supportive Housing; Peer-centered recovery services and training of peer specialists; creation of Behavioral Health investment zones; strong collaboration with counties & municipalities on BH services, including with Bernalillo county on new BH initiative funded by increase in GRT tax.
6. Improved Care Coordination and Transitions between Levels of Care	Medicaid: MCO care coordination; PCMHs; CareLink NM Health Homes Non-Medicaid: grant-funded SBIRT; BH investment zones; peer-centered recovery and certified peer training

Benefit and Delivery System Proposal #11: Request waiver authority to allow 30 day use of an IMD for members who have a non-SUD diagnosis
HSD requests expenditure authority for members in managed care and FFS to receive inpatient services in an IMD so long as the cost of care is the same as, or more cost effective, than a setting that is not an IMD. Currently, federal financial participation is limited for when individuals between the ages of 21 and 64 are institutionalized in an IMD. This proposal will improve the availability of residential inpatient treatment services and ensure federal financial participation while simplifying the administration of the program for both HSD and the MCOs.

Benefit and Delivery System Proposal #12: Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers
HSD has made access to LARC a high priority over the past several years, successfully "unbundling" LARC reimbursement from other services in FQHCs, Rural Health Clinics (RHCs), SBHCs and at point of labor/delivery or during postnatal care to safeguard adequate payment and to ensure that providers are not discouraged from informing women about LARC or making it readily and immediately available.

HSD requests authority to receive increased administrative funding (90%, in line with the federal matching rate for Family Planning services and contraceptives) to expand the availability of LARC for certain providers, such as SBHCs. Under this proposal, HSD would reimburse the New Mexico Department of Health or other sponsoring agencies for the cost of purchasing and maintaining LARCs to use for Medicaid beneficiaries.

Benefit and Delivery System Proposal #13: Expand the Health Home model
New Mexico's Health Home model, known as CareLink NM, provides a comprehensive system of care coordination for members with chronic behavioral health conditions. The model provides intensive and coordinated care for adults with a serious mental illness and children with severe emotional disturbance. In 2016, HSD implemented the model with two sites that are enrolling both FFS and managed care members, serving a total of 400 members. HSD is currently developing an expansion of the CareLink NM model to additional sites, including a site with a Native American provider, beginning in calendar year 2018. In Centennial Care 2.0, HSD intends to continue to expand the CareLink NM model through State Plan Authority, evaluating outcomes from existing sites and tailoring new sites to populations and conditions suited for the Health Home model. The Centennial Care 2.0 MCOs will be expected to continue to collaborate with HSD in the expansion of this program.

Benefit and Delivery System Proposal #14: Establish an alternative payment methodology to support workforce development
HSD proposes an alternative payment methodology for graduate medical education to enhance current payment rates, with the goal of improving access to care in rural and frontier regions of New Mexico by increasing the number of primary care, family medicine, and psychiatric residents in community-based clinic settings. Under the proposed methodology, HSD will fund the total cost of up to ten residencies statewide in community-based provider settings with high numbers of attributed Medicaid patients. The community-based clinic will be required to meet HSD-established criteria to be eligible for the alternative payment. The criteria may include the type of residency program offered, numbers and types of Medicaid clients served, and other categories of residency programs. HSD will work with the New Mexico Primary Care Association and the New Mexico Primary Care Training Consortium to develop the specific criteria for funding these residencies and the terms of agreement among the community-based clinics, hospitals and HSD.

3. Payment Reform Proposals

HSD has implemented requirements for MCOs to increase the portion of provider payments in VBP arrangements in CY17 and CY18. With Centennial Care 2.0, HSD has included a long term and expanded VBP strategy that outlines incremental increases in the percentage of provider payments that must operate under a VBP arrangement. For Centennial Care 2.0, HSD proposes the following initiatives related to payment reform:

- Continue to drive value by improving provider readiness to participate in risk-based payment arrangements and increasing the percentage required for managed care provider payments that are risk-based;
- Leverage VBP arrangements that drive key program goals in the areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes; and

- Advance the SNCP program with the goal of improving quality outcomes and include requirements for providers that participate in SNCP initiatives to be contracted network providers with each Centennial Care MCO.

Payment Reform Proposal #1: Pay for value versus volume and increase the share of provider payment arrangements that are risk-based

As HSD continues to expand requirements for MCOs to shift payments from volume of services to paying for quality and improved outcomes, HSD recognizes that it must continue to develop requirements for the MCOs, identify areas for providing technical assistance to interested health care providers and promote aligned quality metrics. As part of this opportunity, HSD proposes to:

- Increase the total percentage of MCO provider payments that are in VBP level 2 (shared savings and bundled payments) and level 3 (partial or full risk) arrangements;
- Improve provider readiness to participate in risk-based payment arrangements;
- Require that VBP arrangements incrementally increase for behavioral health providers, LTSS providers and smaller volume providers, including options for small providers to build collaborative partnerships;
- Reduce administrative burden and complexity wherever possible;
- Eliminate barriers to data sharing and improve the availability of actionable and reliable data for providers participating in VBP strategies;
- Align quality metrics and technical specifications across MCOs and health care payers (noting that in many instances Medicare and commercial insurance quality measures do not necessarily align with Medicaid populations); and
- Identify best practices to evaluate and quantify the success of VBP strategies.

Payment Reform Proposal #2: Leverage VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization

HSD understands the importance of aligning programmatic goals with its VBP initiatives so that incentives remain aligned among payers, providers and members. It intends to leverage VBP arrangements to drive certain initiatives, including:

- Expanding the CareLink NM Health Home model to additional counties and evaluating other types of Health Homes that may align with Centennial Care initiatives to improve specific healthcare outcomes in certain populations;
- Pursuing options to expand Health Homes to tribal organizations through VBP strategies that support their ability to provide enhanced care coordination interventions;
- Broadening MCO VBP requirements to test strategies that target key program goal areas; and
- Exploring VBP strategies to improve provider shortage issues, particularly within primary care.

Payment Reform Proposal #3: Advance SNCP Initiative

In pursuit of improved quality at New Mexico hospitals, HSD proposes that funding in future periods for the Uncompensated Care (UC) pool and HQII pool grow at the level of annual cost trend as calculated in budget neutrality, and the funding ratio between the two pools

incrementally adjusts so that 43% of the funding is allocated for the UC pool and 57% for the HQII as outlined in Table 7.

Table 7 – SNCP Funding Ratios Between Funding Pools by Demonstration Year

SNCP Component	CY2019 (DY6)	CY2020 (DY7)	CY2021 (DY8)	CY2020 (DY9)	CY2020 (DY10)
UC Pool	60.0%	50.0%	48.0%	46.0%	43%
HQII Pool	40.0%	50.0%	52.0%	54.0%	57%

This ratio aligns with Centennial Care's goal to prioritize paying for quality versus volume. The HQII Program will continue to evaluate urgent improvements in care and continue to evolve toward the evaluation of population focused improvements. Areas of increasing importance are obstetrical adverse events, all cause readmissions and uncontrolled diabetes admission rates.

In addition to the revised allocation of funding, HSD proposes:

- Better alignment of HQII measures and program design with other VBP initiatives that are required in the MCO contractual agreements, which may include hospital specific proposals;
- Expanded flexibility to modify or update measures that factor into funding of the HQII pool;
- Continue increases to the enhanced rates but realign between inpatient and outpatient rates; and
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network for the Centennial Care MCOs.

4. Proposals to Advance Member Engagement and Cost Sharing Responsibilities

For Centennial Care 2.0, HSD seeks to build upon and incorporate policies that enhance members' ability to make informed decisions about their health and health care, and to become more active and involved participants in the health care system. In addition, HSD is proposing initiatives to increase the financial responsibility of adults in the higher-income Medicaid category and to incentivize appropriate use of the delivery system by charging a copayment when Centennial Care members utilize the emergency department for a non-emergent issue and choose a non-preferred drug when a preferred and equivalent drug is available. Proposals include:

- Advance Centennial Rewards;
- Implement premiums for the adult expansion population with household income that exceeds 100% of the federal poverty level (FPL);
- Require co-payments for two distinct services for most Centennial Care members;
- Allow providers to charge nominal fees for three or more missed appointments; and
- Expand opportunities for Native American members in Centennial Care.

Member Engagement and Personal Responsibility Proposal #1: Advance the Centennial Rewards Program

To advance Centennial Rewards, HSD proposes to restructure rewards to focus on new conditions and to promote more proactive engagement. HSD proposes modifications that include:

- Designing rewards criteria to promote proactive participation, such as lowering blood pressure, meeting weight loss goals or smoking cessation;
- Utilizing earned rewards to apply toward monthly premium payments;
- Leveraging the Centennial Rewards vendor to assist with collection of proposed premiums; and
- Improving the promotion of Centennial Rewards by requiring targeted outreach, including mobile app technology to expand member engagement and participation.

Member Engagement and Cost Sharing Proposal #2: Implement premiums for the adult expansion population with household income that exceeds 100% FPL

The ACA expanded Medicaid eligibility to adults with income up to 138% FPL. In 2012, the U.S. Supreme Court issued a ruling that effectively made Medicaid expansion optional for states. As of January 1, 2017, a total of 32 states — including New Mexico — have expanded Medicaid. The expansion of Medicaid to the newly eligible has resulted in significant enrollment growth compared to enrollment of low-income adults before the Adult Expansion. Under today's Centennial Care program, Medicaid Expansion Adults are not subject to any form of cost-sharing.

For Centennial Care 2.0 and in the draft waiver application, HSD had proposed to apply premiums to three categories of eligibility: the CHIP program, the Working Disabled Individuals program and the Adult Expansion population with income greater than 100% of the FPL. In response to public comments received about this proposal, HSD is instead proposing to implement premiums only for the Adult Expansion population with household income above 100% FPL, as outlined below in Table 8 below.

Table 8 – Proposed Monthly Premiums for Expansion Adults with Income above 100% FPL

FPL Range	Annual Household Income (HH of 1)	Applicable Categories of Eligibility (COE)	Monthly Premium 2019	Monthly Premium Subsequent Years of Waiver (state's option)
101-138%	$12,060-$16,644	OAG	$10	$20

HSD proposes that the premium amount in the initial year is set at approximately one percent (1.0%) of income at the lowest end of the income bracket in the premium structure, and HSD is seeking the flexibility to implement premiums on an incremental basis up to two percent (2.0%) of income during the term of the demonstration. The incremental implementation will allow HSD to evaluate the effectiveness of premiums in demonstrating personal responsibility and

member engagement, and to adjust accordingly as the population becomes more accustomed to making payments.

Additional Premium Policy Proposals

The state seeks to develop premium enforcement policies based on the state's experience operating a premium-based coverage program for adults known as the State Coverage Insurance (SCI) program. Where applicable, the state also seeks to align Medicaid premium policies with policies for subsidized health insurance coverage through the federal Marketplace. As such, individuals in a Medicaid category of eligibility that includes premiums must pay the required premium to maintain coverage. The state will develop hardship criteria, such as homelessness, to waive premium payment requirements.

The premium policies are as follows:

- Native American members will be exempt from premiums, in accordance with federal requirements;
- Implementation Date of Premium Requirements: HSD proposes to implement the premium payment requirements within six months of the effective date of the Centennial Care 2.0 program;
- Effective Date of Coverage for Individuals with Premium Requirements: Covered benefits will be provided on a prospective basis for individuals who are required to pay premiums. Once determined eligible for Medicaid, individuals in the Other Adult Group (OAG) category of eligibility that owe a premium must pay the first month's premium payment before enrollment and services will begin. Benefit coverage begins on the first day of the first month following receipt of the required premium by the premium due date. Coverage will not be retroactive;
- Grace Period for Premium Payment: Failure to pay premiums will result in a loss of benefits. Loss of benefits occurs after a three-month grace period. At expiration of the grace period, enrollees will be disenrolled from the Medicaid managed care organization for nonpayment of premiums;
- Lock-out Period: Failure to pay required premiums will result in a three-month lock out from the program. Medicaid eligibility will be suspended rather than terminated during the three-month lock out. Individuals may begin receiving covered benefits after the lockout period is completed and upon receipt of required premiums. The individual's benefit coverage will begin per the coverage policy timelines outlined in the Effective Date of Coverage section above; and
- Premium Payment Options: HSD proposes to leverage the Member Rewards vendor to assist with premium collection and to administer a program that allows use of earned rewards to offset the premium payment.

Member Engagement and Cost Sharing Proposal #3: Require co-payments for two distinct services for most Centennial Care members

In response to multiple public comments received about proposed co-payments, HSD will implement co-payments for only two specific services in order to drive more appropriate use of services. Most Centennial Care members will have co-payments when they utilize the emergency department for a non-emergent issue or when they demand a non-preferred drug when a preferred and equivalent drug is available (will not apply to psychotropic drugs and family planning drugs/supplies). Table 9 below provides a summary of the proposed co-

payments. *It is important to note that co-payments in the Medicaid program today, for the CHIP and WDI programs, would be repealed through the State Plan Amendment process and replaced with the co-payments being proposed below.*

Table 9 – Proposed Co-payments in Centennial Care

Copayment	Most Centennial Care Members
Non-preferred prescription drugs Psychotropic drugs and family planning drugs/supplies are exempt	$10/prescription All FPLs and COEs, certain exemptions will apply
Non-emergency ER visits	$25/visit All FPLs and COEs, certain exemptions will apply

The following populations would be exempt from the copayments:

- Native American members in accordance with federal requirements;
- ICF-IID individuals;
- QMB/SLIMB/QI1 individuals;
- Individuals on Family Planning-Only;
- Individuals in the PACE program;
- Individuals on the DD waiver; and
- People receiving hospice care.

Copayment for Non-Emergent Use of the Emergency Department
Copayments will be waived if the member is found to have an emergency condition, as defined in section 1867(e)(1)(A) of 42 CFR 438.114. Non-emergency care is defined as any health care service provided to evaluate and treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. If it is determined that the condition is not an emergency and that care could have been provided appropriately elsewhere, and the individual still opts to be treated in the hospital emergency department (ED), then the individual will be required to pay the co-payment. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under Section 1867 of the Social Security Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services.

When a Centennial Care member enters the ED, the provider will verify member eligibility as is routine. The New Mexico Provider Portal will confirm eligibility and also indicate if the member has a co-payment. If the ED provider completes the initial assessment of the member's condition, and it meets the requirements of 42 CFR §447.54(d), and the member is not exempt from copayments, then the provider may assess the copayment.

In accordance with federal regulations at 42 CFR §447.54(d), hospitals and ED providers are required to meet the following requirements before they may impose cost sharing:

- Conduct an appropriate medical screening under §489.24 subpart G to determine that the individual does not need emergency services;

- Inform the individual of the amount of his or her co-payment obligation for non-emergency services provided in the emergency department;
- Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser co-payment or no co-payment if the individual is otherwise exempt from co-payments; and
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

If the member chooses to continue with the service at the ED for the non-emergent service, then the provider may collect the co-payment at the point of service or charge the co-payment to the member and make arrangements for payment. If the member chooses to receive services from the alternative provider, the co-payment may not be assessed.

Centennial Care members will be educated about the co-payment responsibilities associated with visiting the ED through member notices and outreach materials, member handbooks, and online materials provided by the MCOs. Members will also receive education about the ED co-payment requirements when they call the MCOs' call centers or the Nurse Advice Lines.

Copayment for Non-Preferred Drug when Preferred Drug is Available
Medicaid rules give states the ability to use out of pocket charges to promote the most cost-effective use of prescription drugs. To encourage the use of lower-cost drugs, states may establish different co-payments for drugs included on a preferred drug list. The Centennial Care Managed Care Organizations have preferred drug lists (PDLs), which is similar to a formulary. A preferred drug is a medication that has been clinically reviewed and approved by the Pharmacy and Therapeutics Committee. The medication has been included on the PDL based on its proven clinical and cost effectiveness. Most PDLs include generic substitutes and less costly innovative medications within the same class as more expensive ones. However, brand name drugs may also be included on a PDL.

A non-preferred drug is a medication that has been determined to have an alternative drug available that is clinically equivalent at a lower cost, thus it is not a "preferred" drug for the MCO. If a Centennial Care member opts to have a non-preferred drug, rather than a generic or preferred drug, then a $10 copay will be assessed for the non-preferred drug with the exemption of psychotropic drugs and family planning drugs/supplies.

The co-payment for non-preferred prescription drugs does not apply if the following conditions are met:

- In the prescriber's estimation, the lower-cost alternative drug item available on the PDL is either less effective for treating the member's condition or would have more side effects or a higher potential for adverse reactions; and
- The prescriber has stated that the non-preferred drug is medically necessary on the prescription.

Centennial Care members will be educated about the co-payment responsibilities associated with non-preferred drugs through member notices and outreach materials, member handbooks,

and online materials provided by the MCOs. Members will also receive education about the co-payment requirements when they contact the MCOs' call centers.

Member Engagement and Cost Sharing Proposal #4: Waive the tracking requirements for cost sharing

HSD seeks authority to waive tracking of cost-sharing toward the five percent aggregate out-of-pocket maximum. Since premiums will be set at fixed amounts ranging from one to two percent of income, it is clear that individuals will never exceed the five percent out-of-pocket maximum from premiums. Further, the Department is removing all co-payments (including existing co-payments in the CHIP and WDI programs) with the exception of two for inappropriate use of service. Since such co-payments will only be imposed based on the choice of the beneficiary to access such services, HSD proposes that these cost-sharing requirements should always apply and not be counted toward an out-of-pocket maximum.

Member Engagement and Personal Responsibility Proposal #5: Seek authority for providers to charge nominal fees for three or more missed appointments

With the Adult Expansion of Medicaid, providers have expressed concerns about the rates of missed appointments. Under current rules, Medicaid recipients cannot be required to pay fees or sign financial responsibility forms for missed appointments. HSD will request authority to allow providers to charge a nominal fee of $5.00 after a member misses three scheduled appointments in a calendar year without prior notification by the member to the provider. Medicaid providers will be required to have policies that outline how this change will be implemented for their members. HSD will develop annual provider surveys to understand if the missed appointment fee changes behavior or impacts a reduction in no show appointments.

Member Engagement Proposal #6: Expand opportunities for Native Americans enrolled in Centennial Care

HSD is committed to improving the member experience for Native Americans enrolled in Centennial Care. It will continue to engage the Tribes, Tribal providers and Centennial Care MCOs in efforts to improve the delivery system including resolution of issues that have occurred. As mentioned previously, HSD will maintain all protections and requirements established in the current Centennial Care waiver as well as:

- Continue to require the MCOs to expand contractual or employment arrangements with CHRs throughout the State;
- Work with tribal providers to develop their capacity to enroll as LTSS providers and/or as a Health Home provider; and
- The state seeks authority to collaborate with Indian Managed Care Entities (IMCE) as defined in Section IV of the federal Indian Health Care Improvement Act, section 1932(h)(4)(B) of the Social Security Act, and 42 CFR 438.14, including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements, including but not limited to, financial solvency, licensing, provider network adequacy and access requirements. An IMCE in New Mexico must be able to demonstrate compliance with the requirements in the Centennial Care Managed Care Professional Services Agreement, including delivery of all Medicaid services as listed. The Department will assess compliance and readiness prior to permitting enrollment of

Medicaid members. Implementation may also require several phases during the demonstration waiver.

5. Administrative Simplification through Refinements to Eligibility Proposals

One of the core principles of the Centennial Care program is to improve administrative effectiveness and simplicity. In Medicaid, this is a difficult challenge — the program currently subsumes nearly 40 different categories of eligibility, multiple complicated eligibility determination methodologies, and multiple benefit packages for both children and adults. HSD proposes opportunities to streamline some of these administrative complexities and, at the same time, is examining innovations in program design aimed at addressing and resolving issues that will reduce Medicaid administrative costs, reduce health care expenses and help HSD maintain a financially viable and sustainable program. Proposed benefit and administrative refinements include:

- Incorporate eligibility for Family Planning into the waiver so that it covers men and women through the age 50 who do not have other insurance coverage, with certain exceptions;
- Allow one month of retroactive eligibility for most (non-SSI) Centennial Care members;
- Accelerate the transition off Medicaid and into coverage through the private or health insurance exchange for individuals who lose eligibility due to increased earnings by requesting a waiver of the Transitional Medical Assistance program;
- Cover former foster care individuals up to age 26 who aged out of foster care in another state; and
- Continue to provide access to Community Interveners for deaf and blind individuals.

Administration Simplification through Eligibility Refinements Proposal #1: Phase out the Medicaid retroactive eligibility period for most Centennial Care members
HSD proposes to reduce the three- month retroactive eligibility period for most Centennial Care members to a one month period of retroactive eligibility for the first year of the waiver then eliminate with the start of the second year (2020).

HSD received numerous public comments recommending that the Department not eliminate the three-month retroactive eligibility period. In consideration of those comments, HSD has opted to phase out the retroactive period of eligibility by reducing it to one month in 2019, then eliminating it entirely at the start of the second year of the demonstration (2020). Providing one month of retroactive eligibility for one year allows ample time for the delivery system to develop the necessary processes to secure coverage at point of service. Additionally, HSD is moving toward an environment in which Medicaid eligibility, both initial determinations and renewals, is streamlined where possible. Real-Time eligibility is scheduled to roll-out by the end of 2018, meaning that many individuals will receive an eligibility determination at the point of application. Additionally, the ACA and expansion of Medicaid to adults who were previously uninsured have dramatically changed the landscape of coverage options.

New Mexico hospitals have substantially reduced their uncompensated care needs and are able to make individuals presumptively eligible for Medicaid at the time of service. In calendar year 2016, only one percent of the Medicaid population requested retroactive coverage (10,000

individuals). Safety Net Clinics are also able to immediately enroll individuals at point of service through the Presumptive Eligibility program and receive payment for services. These changes provide an opportunity to reduce the administratively complex reconciliation process with the MCOs for retroactive eligibility periods.

Other policies related to retroactive eligibility period:

- Expansion adults with household income above 100% of the FPL who are subject to a premium will have prospective coverage only (after remittance of premium) and will not have retrospective coverage;
- The retroactive period reduction does not include retroactive status changes processed by the Social Security Administration; and
- Native American members and nursing facility residents would be exempt from the new policy and continue to have access to coverage for a three-month retroactive period, providing eligibility requirements are met.

Administration Simplification through Eligibility Refinements Proposal #2: Implement a streamlined NF LOC approval with specific criteria for members whose condition is not expected to change

This proposed change would result in reducing annual assessments for certain members who meet a NF LOC, increasing administrative simplification and possibly achieve cost savings. Under this approach MCOs would still be required to complete an annual CNA and develop an annual CCP. Individuals must meet all financial eligibility criteria to qualify for ongoing coverage. This policy change is particularly relevant for members with certain conditions such as dementia, quadriplegia, etc.

Administration Simplification through Eligibility Refinements Proposal #3: Waive the Transitional Medical Assistance (TMA) requirements for Parents/Caretakers since most are transitioned to the adult expansion category of eligibility when their earnings increase above the income threshold for the Parent/Caretaker category

HSD is requesting to waive the Transitional Medical Assistance program requirements for individuals in the Parent/Caretaker category that require up to an additional 12 months of Medicaid when these individuals have increased earnings that result in loss of eligibility for the Parent/Caretaker category. With the availability of other no-cost or low-cost coverage options, TMA is no longer necessary to maintain health coverage.

As an expansion state, New Mexico has an option available to individuals in the Parent/Caretaker category when their earnings increase that it did not have prior to the passage of the Affordable Care Act (ACA):

- TMA is a concept that predates the ACA and was intended to provide coverage to Parent/Caretaker adults whose income increases above the eligibility standard for full coverage. Most of these individuals are transitioned to the adult expansion category, which has resulted in diminishing enrollment in TMA;
- In 2013, 26,000 individuals were enrolled in the TMA category; today, fewer than 2,000 individuals are enrolled; and
- Parent/Caretakers that have increased earnings above the income threshold for the adult expansion category (138% of the FPL) are eligible to receive subsidies to purchase coverage through the federal Marketplace.

Administration Simplification through Eligibility Refinements Proposal #4: Incorporate eligibility requirements of the Family Planning program

Currently, the Family Planning Category, under the state plan, serves as a catchall for individuals who apply for Medicaid, but do not meet the financial eligibility standards to qualify for full coverage. This has resulted in approximately 72,000 individuals enrolled in the program, including many who have other insurance coverage (such as an Exchange plan), or who are outside of the average Family Planning age standards. Based on an analysis of this population, only approximately six (6) percent use Family Planning and related services covered by the program. This is because the benefit package is limited to reproductive health care, contraceptives and related services, and most individuals find that it does not meet their overall health care needs. In addition, the program is administratively burdensome for HSD because all covered individuals must have their eligibility renewed yearly, at a rate of approximately 6,000 renewals per month.

HSD proposes to better target the program to those individuals who are using it by designing it specifically for men and women through the age of 50 who do not have other health insurance coverage, with certain exceptions, including those individuals under age 65 who have only Medicare coverage that does not include family planning. Streamlining the Family Planning program to apply to the appropriate population will preserve the program for those who need it while saving administrative dollars and resources that are being allocated to renewal processes.

Administration Simplification through Eligibility Refinements Proposal #5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

Under the waiver, HSD proposes to cover former foster care individuals up to age 26 who aged out of foster care in another state. While New Mexico formerly had State Plan authority for this population, CMS recently finalized a regulation retracting states' authority to receive federal Medicaid matching funds to cover this population without a waiver. New Mexico is required to cover this population under state law.

Administration Simplification through Eligibility Refinements Proposal #6: Continue to provide access to Community Interveners

The current 1115 Centennial Care Waiver provides for expenditure authority allowing certain individuals enrolled in Centennial Care who are deaf and blind to access the benefit of Community Interveners.

A Community Intervener is a trained professional who meets the criteria as determined by the state. The Intervener works one-on-one with deaf-blind individuals who are five years and older to provide critical connections to other people and the environment. The Intervener opens channels of communication between the individual and others, provides access to information, and facilitates the development and maintenance of self-directed independent living. Services for Community Interveners are covered and will continue to be covered by Centennial Care MCOs and the costs associated with the Community Interveners may be included in capitation payments from HSD to the Centennial Care MCOs.

SECTION 3: WAIVER LIST

The following waivers are requested to enable New Mexico to implement the New Mexico Centennial Care 2.0 section 1115 waiver.

A. Title XIX Waiver Requests

1.	Reasonable Promptness	Section 1902(a)(8)
Consistent with existing Home- and Community-Based Services (HCBS) waiver authority (Section 1915(c) of the Social Security Act), to the extent necessary to enable HSD to establish enrollment targets for certain HCBS for those who are not otherwise eligible for Medicaid. HSD will take into account current demand and utilization rates and will look to increase such enrollment targets in order to appropriately meet the long term care needs of the community. To the extent necessary to enable HSD to begin benefit coverage on the first day of the first month following receipt of the required premium by the premium due date for individuals in a Medicaid category of eligibility that requires premiums. To the extent necessary to enable HSD to prohibit reenrollment for 3 months for individuals who fail to pay required premiums.		
2.	Amount, Duration and Scope of Services	Section 1902(a)(10)(B)
To the extent necessary to enable HSD to permit managed care plans to offer different value added services or cost-effective alternative benefits to enrollees in Centennial Care. To the extent necessary to enable HSD to offer certain HCBS and care coordination services to individuals who are Medicaid eligible and who meet nursing facility level of care. To the extent necessary to allow HSD to place expenditure boundaries on HCBS and personal care options. To permit HSD to serve adults in the Parent/Caretaker category under the same benefit package as Expansion adults using Secretary-approved ABP coverage.		
3.	Recipient Rewards	Section 1902(a)(10)(C)(i)
To the extent necessary to enable HSD to exclude funds provided through recipient reward programs from income and resource tests established under State and federal law for purposes of establishing Medicaid eligibility.		

4.	Freedom of Choice	Section 1902(a)(23)(A) 42 CFR 431.51
To enable HSD to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care. Moreover, all services will be provided through managed care including behavioral health, HCBS and institutional services, except for services received under the existing Developmental Disabilities 1915(c) waiver, Medically Fragile 1915(c) waiver, and the accompanying Mi Via Self-Directed 1915(c) waiver, individuals in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and individuals in the Program of All-Inclusive Care for the Elderly (PACE). Consistent with the current demonstration, mandatory enrollment of American Indians/Alaska Natives is only permitted for receipt of LTSS.		
5.	Cost Sharing	Sections 1902(a)(14), 1916, 1916A, and 1916(f) 42 CFR 445.15; 447.51-447.56
To permit HSD to impose co-payments for non-emergency use of the emergency room and non-preferred prescription drugs for most categories and income levels above the federal limitation. Co-payments will not be imposed on individuals for whom Indian health care providers, as specified in section 1932(h) of the SSA, have the responsibility to treat. Remove the requirement for HSD to track cost-sharing, since the only co-payments are for unnecessary use of services based on member choice for the unnecessary use of services through member choice. To permit Centennial Care providers to impose missed appointment fees on members..		
6.	Self-Direction of Care	Section 1902(a)(32)(A)
To permit persons receiving certain services to self-direct their care for such services.		
7.	Retroactive Eligibility	Section 1902(a)(34) 42 CFR 435.915
To enable HSD, beginning on January 1, 2019, to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for Medicaid for some eligibility groups.		
8.	Transitional Medical Assistance (TMA)	Section 1902(e)
To permit HSD to waive participation in the TMA program for individuals who lose eligibility due to increased earnings.		

10.	EPSDT for Adults (19-20 years old)	Section 1902(a)(43)
To permit HSD to waive the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for adults in the Expansion Adult and Parent/Caretaker categories who are 19–20 years-old.		
11.	Premiums	Section 1902(a)(14), 1916, 1916A 42 CFR 447.55, 42 CFR 447.56(f)
To permit HSD to impose premiums on certain populations. Remove requirement for HSD to track member premiums since premiums are set at 1-2% of income and well below the 5% out-of-pocket aggregate maximum.		
12.	Nursing Facility Level of Care Redeterminations	Section 1902(a)(10)(A)(ii)(IV), 42 CFR 441.302(c)(2)
To enable HSD to grant Members that meet specified criteria ongoing NF LOC determination.		
13.	Provision of Medical Assistance	Section 1902(a)(8) and 1902(a)(10)
To the extent necessary to permit HSD to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A))(ii)(XX) of the SSA and the State plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), and who were enrolled in Medicaid on that date.		

B. Expenditure Authority Requests

Under the authority of SSA section 1115(a)(2), expenditures made by HSD for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, be regarded as expenditures under the Medicaid State Plan but are further limited by the special terms and conditions for the section 1115 demonstration.

1. Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the SSA specified below. Managed care plans participating in the demonstration will have to meet all the requirements of Section 1903(m), except the following:

    a) Section 1903(m)(2)(H) and federal regulations at 42 CFR 438.56(g), but only insofar as to allow HSD to automatically reenroll an individual who loses Medicaid eligibility for a period of 90-days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditures made under contracts that do not meet the requirements of 1903(m)(2)(A)(iii) and implementing regulations at 42 CFR 438.4 but only insofar as to

allow HSD to include in calculating MCO capitation rates the provision of beneficiary rewards program incentives for health-related items or services.

3. Expenditures for direct payments made by HSD to the Safety Net Care Pool (SNCP), where hospitals receive payments out of a pool.

4. Expenditures to permit HSD to provide enhanced administrative funding for LARC to certain Medicaid providers.

5. Expenditures under contracts with managed care entities where either HSD or the managed care entity will provide for payment for Indian health care providers as specified in Section 1932(h) of the SSA for covered services furnished to Centennial Care managed care plan recipients at the Office of Management and Budget (OMB) rates.

6. Expenditures for Centennial Care recipients who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the SSA and 42 CFR §435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the SSA, if the services they receive under Centennial Care were provided under an Home and Community-Based Services (HCBS) waiver granted to HSD under SSA Section 1915(c) as of the initial approval date of this demonstration. This includes the application of spousal impoverishment eligibility rules.

7. Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid.

8. Expenditures for otherwise covered services furnished to otherwise eligible individuals under managed care and FFS delivery systems who are primarily receiving treatment for psychiatric and SUD who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD).

9. Expenditures for peer-delivered pre-tenancy and tenancy supportive housing services for individuals with Serious Mental Illness (SMI).

10. Expenditures for dental and/or vision benefits for adults receiving such services through a premium assistance/buy-in program rather than as an optional benefit under the State plan.

11. Expenditures to develop and support the total cost of up to ten workforce residency training programs.

SECTION 4: COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

New Mexico is compliant with the requirements of the approved Centennial Care waiver. For example, the state has ensured that:

- All qualified populations have access to a wide array of benefits, including CB services, through a comprehensive managed care delivery system;
- CB services are available to all beneficiaries assessed to meet a nursing facility level of care in provider settings that meet all applicable federal requirements;
- Native Americans continue receiving protections under the program;
- Through the Beneficiary Rewards programs, points are available to redeem for goods and services for all members who participate in defined healthy behaviors;
- Comprehensive care coordination occurs at a level appropriate to each beneficiary's needs and risk stratification is available for all beneficiaries;
- Audits of nursing facility level of care determinations are conducted as required; and
- Supplemental payments are made to defined safety care net providers.

Compliance with all requirements is demonstrated in the Interim Evaluation Report which is included as Appendix B of the renewal application. The State also maintains comprehensive administrative rules, policies and MCO contracts that are regularly updated to reflect the most current program operational requirements.

As a result of the realities of implementation, the following program requirements were modified in order to facilitate greater program efficiencies and to ensure the health and welfare of beneficiaries.

Medically Fragile Waiver
The initial intent was to phase in the Medically Fragile waiver by July 1, 2015. The Medically Fragile waiver is a 1915(c) waiver that provides HCBS to individuals that: 1) have a developmental disability (according to the New Mexico state definition; 2) meet ICF/IID level of care; 3) have a medically fragile condition that meets the definition below; and 4) meet financial eligibility.

This population has very specific health care needs that have been sufficiently addressed to date under the current system. Any disruption in their service delivery could adversely impact their continuity of care. The current Centennial Care MCOs do not have the experience to support this population at the current level or to conduct an ICF/IID level of care. Therefore, for the time being, the Medically Fragile waiver will remain a free standing 1915(c) waiver similar to the Developmental Disability waiver. HSD has continuously updated CMS on the status of this issue.

Post Capitation Reconciliation Process (STC 98)
HSD evaluated MCO encounter data and capitation payments for members assigned to CB settings and, through the Medicaid Management Information System, adjusted capitation payments to the MCOs. In addition, prospective capitation rates reflect the appropriate utilization of CB services by Centennial Care members, which is at a lower rate than previously used by members in the predecessor program, Coordination of Long Term Services and Supports.

New Mexico has successfully completed all required deliverables under the Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements. All deliverables (Independent Consumer Support Program plan, Central registry plan, quarterly reports, quarterly financial reports, annual reports, EQRO reports, draft evaluation plan, and quality strategy) have been delivered timely to CMS.

SECTION 5: APPROACH TO BUDGET NEUTRALITY

1. Budget Neutrality Overview

This section presents the HSD's approach for budget neutrality including the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver request.

Federal policy requires that section 1115 Demonstration applications be budget neutral to the federal government. This means that an 1115 Demonstration cannot cost the federal government more than what would have otherwise been spent absent the 1115 Demonstration. The particulars of budget neutrality, including methodologies, are subject to negotiation between HSD and CMS.

HSD proposes a per capita budget neutrality model for the populations covered under the Demonstration and outline the per capita limit by Medicaid Eligibility Group (MEG) and proposes an aggregate cap, trended annually for uncompensated care and HQII expenditures.

The five-year renewal is proposed to begin January 1, 2019 and end December 31, 2023, each demonstration year (DY) is outlined in Table 10 below.

Table 10 – Centennial Care 2.0 Demonstration Period

Demonstration Year	DY6	DY7	DY8	DY9	DY10
Time Period	1/1/2019 – 12/31/2019	1/1/2020 – 12/31/2020	1/1/2021 – 12/31/2021	1/1/2022 – 12/31/2022	1/1/2023 – 12/31/2023

2. Current Demonstration Period

The current 1115 demonstration covers the period between January 1, 2014 and December 31, 2019 and is identified as DY1 through DY5. Budget Neutrality Exhibit 1at the end of this section illustrates the current budget neutrality per member per month (PMPM) limits, actual member months and expenditures, and the difference between the waiver limits and actual expenditures. Actual member months and expenditures are included for DY1 through DY3. Projections are used for DY4 and DY5 because the data is not complete at the time of this application submission.

The actual member months and PMPM for DY4 and DY5 are projected based on the experience between DY1 and DY3 and consider future anticipated member months and PMPM changes. The trends used to project the actual member months and expenditures for DY4 and DY5 are outlined in Table 11.

Table 11 – Actual DY4 and DY5 Projection

	Member Months		PMPM	
MEG and Description	DY3 to DY4	DY4 to DY5	DY3 to DY4	DY4 to DY5
MEG 1 - TANF and Related	3.8%	3.8%	3.5%	3.5%
MEG 2 - SSI Medicaid Only	1.2%	1.2%	3.9%	3.9%
MEG 3 - SSI Dual	2.9%	2.9%	3.8%	3.8%
MEG 4 - 217-Like Medicaid	3.3%	3.3%	3.1%	3.1%
MEG 5 - 2017-Like group Dual	3.9%	3.9%	4.3%	4.3%
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	2.5%	5.1%	5.1%

3. Renewal Demonstration Period

Projections for DY6-DY10 use the member months and PMPM cost from the DY5 and are adjusted for the items discussed in the following sections noting that certain adjustments may apply to Without Waiver or With Waiver or both.

Without Waiver Adjustments between DY5 and DY6
The DY5 period used to project DY6 through DY10 includes adjustments to remove the following from the Without Waiver expenditures for the renewal period. These adjustments are provided in Table [X] in the column titled "Adjustments to DY5":

- Graduate medical expense / indirect medical expense;
- Budget neutral shift of expenditures between MEG 3 "SSI Dual" and MEG 5 "217-like dual" to reflect appropriate classification of the populations expenditures; and
- Medically fragile home and community based waiver service expenditures that were not implemented under managed care in DY2 of the current demonstration.

DY6 through DY10 Without and With Waiver cost and caseload projections and include the proposed changes in this application as well as the addition of the proposed family planning only population member months and PMPM costs into MEG 1.

Without Waiver DY6 – D10
The DY6-DY10 member months and PMPMs are projected using the adjusted DY5 PMPM, as previously discussed and use the trends outlined in Table 12. The trend factors for DY6 through DY10 use the lesser of the current without waiver budget neutrality agreement trends or the President's budget trends.

- The "217-Like" (MEGs 4 and 5) and the adult expansion population (MEG 6) continues to be treated as hypothetical or "pass-through" populations;

- UC and HQII pool expenditures are aggregated and trended using the aggregate PMPM trend and adjusted each demonstration year to change their proportion of the total as outlined in payment reform proposal #3. The proportion between UC and HQII are adjusted each demonstration year increasing the proportion allocated to HQII; and

- The variance, the difference between the actual and waiver limits, achieved in the current demonstration is carried over into the renewal waiver period. Savings projected

for DY6 through DY10 are reduced in accordance with recent CMS guidance.

Exhibit 2 presents Without Waiver member months, PMPM and expenditures for DY6-DY10.

Table 12 – Without Waiver Annual PMPM Trends

MEG	DY5 to DY6	DY6-DY10
MEG 1 - TANF and Related	3.9%	3.9%
MEG 2 - SSI Medicaid Only	4.4%	4.4%
MEG 3 - SSI Dual	4.3%	4.3%
MEG 4 - 217-Like Medicaid	3.1%	3.1%
MEG 5 - 2017-Like group Dual	4.3%	4.3%
MEG 6 - VIII Group (Medicaid Expansion)	5.1%	5.1%
UC/HQII Pool	4.5%	4.5%

DY6 – DY10 With Waiver Projections
DY6 through DY10 are projected similar to Without Waiver and use DY5 as the starting point. The With Waiver projections use the same trend as the Without Waiver projections but also reflect adjustments for the proposals included in this application. For the hypothetical MEGs the Without and With Waiver are equal.

Exhibit 2 presents With Waiver member months, PMPM and expenditures for DY6-DY10.

CHIP Allotment Neutrality
At the time of this renewal application submission CHIP has not been reauthorized therefore allotment neutrality worksheets are not include. If CHIP is reauthorized HSD will complete the CHIP allotment neutrality worksheet.

4. Budget Neutrality Summary

The federal share of the combined Medicaid expenditures for the populations included in this demonstration, excluding those covered under the Title XXI Allotment Neutrality will not exceed the federal share of Medicaid expenditures would have been without the demonstration. The savings attributable to this waiver will occur through improvement in the quality of care, implementation of pilot projects including expansion of services as well as elimination of certain program costs. Table 13 presents the total Without Waiver, With Waiver and Variance or savings between each period.

HSD makes the following assumptions with regard to budget neutrality

- HSD proposes a per capita budget neutrality model for the populations covered under the Demonstration and outline the per capita limit by Medicaid Eligibility Group (MEG) and proposes an aggregate cap, trended annually for uncompensated care and HQII expenditures;
- State Administrative costs are not subject to the budget neutrality calculations;
- The projected savings is the difference between the without and with waiver projections;
- The State is assuming the implementation of an additional Section 2703 Health Home option within this demonstration proposal. The State plan amendment is estimated to

be submitted during early 2018;
- Nothing in this demonstration application precludes HSD from applying for enhanced Medicaid funding as CMS issues new opportunities or policies; and
- The budget neutrality agreement is in terms of total computable so that HSD is adversely affected by future changes to FMAP rate on services.

Table 13 – DY6-DY10 Summary of Without Waiver and With Waiver Projected Medicaid Expenditures (Total Computable)

Waiver Period Description	Total Computable
Current Waiver Variance (DY1-DY5)	$3,334,307,025
Renewal Waiver (DY6-DY10)	
Without Waiver	$41,688,381,099
With Waiver	$36,843,196,084
Savings (Without Less With Waiver)	$4,845,185,015
Savings after phasedown of savings	$3,303,068,396
Savings with D1-DY5 Carryover and DY6-DY10 Phase-down	$6,637,375,421

Budget Neutrality Exhibit 1 – Current Period PMPM limits, actual member months and expenditures (Total Computable)

Without Waiver	New Mexico Budget Neutrality Status By Calendar Year					
	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 ***Projected	DY5 - 2018 ***Projected	5-Year Total DY1-DY5
Member Months - Actual						
MEG 1 - TANF and Related	4,517,149	4,454,290	4,621,656	4,795,311	4,975,490	**23,363,896**
MEG 2 - SSI Medicaid Only	497,958	494,529	493,577	499,456	505,405	**2,490,925**
MEG 3 - SSI Dual	428,025	435,140	447,801	460,830	474,239	**2,246,035**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	2,799	2,382	2,987	3,086	3,188	**14,441**
MEG 5 - 2017-Like group Dual	26,895	27,063	31,866	33,110	34,402	**153,336**
MEG 6 - VIII Group (Medicaid Expansion)	1,887,728	2,748,632	3,078,074	3,154,814	3,233,466	**14,102,714**
Total Member Months	**7,360,554**	**8,162,036**	**8,675,961**	**8,946,606**	**9,226,190**	**42,371,348**
Without Waiver PMPMs						
MEG 1 - TANF and Related	$ 385.80	$ 400.77	$ 416.32	$ 432.47	$ 449.25	**$ 417.78**
MEG 2 - SSI Medicaid Only	$ 1,763.90	$ 1,842.83	$ 1,925.21	$ 2,008.00	$ 2,094.34	**$ 1,927.52**
MEG 3 - SSI Dual	$ 1,780.77	$ 1,857.34	$ 1,937.21	$ 2,020.51	$ 2,107.39	**$ 1,944.95**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 4,936.92	$ 5,090.46	$ 5,248.77	$ 5,412.01	$ 5,580.32	**$ 5,270.28**
MEG 5 - 2017-Like group Dual	$ 1,776.90	$ 1,853.31	$ 1,933.00	$ 2,016.12	$ 2,102.81	**$ 1,947.60**
MEG 6 - VIII Group (Medicaid Expansion)	$ 577.87	$ 607.34	$ 638.31	$ 670.87	$ 705.08	**$ 646.78**
Total PMPM	**$ 616.22**	**$ 641.55**	**$ 666.65**	**$ 693.87**	**$ 722.20**	**$ 670.90**
Without Waiver Expenditures						
MEG 1 - TANF and Related	$ 1,742,724,978	$ 1,785,150,637	$ 1,924,092,463	$ 2,073,848,407	$ 2,235,260,155	**$ 9,761,076,640**
MEG 2 - SSI Medicaid Only	$ 878,350,269	$ 911,332,022	$ 950,239,887	$ 1,002,905,497	$ 1,058,490,020	**$ 4,801,317,695**
MEG 3 - SSI Dual	$ 762,214,336	$ 808,204,553	$ 867,484,358	$ 931,112,191	$ 999,406,968	**$ 4,368,422,406**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 13,818,444	$ 12,125,476	$ 15,678,086	$ 16,699,751	$ 17,787,992	**$ 76,109,748**
MEG 5 - 2017-Like group Dual	$ 47,789,749	$ 50,156,064	$ 61,596,973	$ 66,753,128	$ 72,340,894	**$ 298,636,809**
MEG 6 - VIII Group (Medicaid Expansion)	$ 1,090,856,222	$ 1,669,350,032	$ 1,964,773,916	$ 2,116,459,453	$ 2,279,855,500	**$ 9,121,295,123**
Safety Net Care Pool						
Uncompensated Care	$ 68,889,323	$ 68,825,102	$ 67,448,851	$ 68,913,183	$ 68,901,002	**$ 342,977,460**
HQII	$ -	$ 2,888,684	$ 7,205,199	$ 8,801,684	$ 12,000,174	**$ 30,895,741**
Total Expenditures	**$ 4,604,643,320**	**$ 5,308,032,569**	**$ 5,858,519,734**	**$ 6,285,493,295**	**$ 6,744,042,704**	**$ 28,800,731,623**

With Waiver	New Mexico Budget Neutrality Status By Calendar Year					
	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 ***Projected	DY5 - 2018 ***Projected	5-Year Total DY 01-DY 05
With Waiver PMPMs						
MEG 1 - TANF and Related	$ 329.59	$ 344.65	$ 338.90	$ 350.64	$ 362.78	**$ 345.69**
MEG 2 - SSI Medicaid Only	$ 1,656.06	$ 1,784.29	$ 1,753.27	$ 1,821.80	$ 1,893.02	**$ 1,782.09**
MEG 3 - SSI Dual	$ 1,333.13	$ 1,342.54	$ 1,340.21	$ 1,391.10	$ 1,443.92	**$ 1,371.65**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 2,380.17	$ 2,331.82	$ 2,542.57	$ 2,621.68	$ 2,703.26	**$ 2,528.70**
MEG 5 - 2017-Like group Dual	$ 3,226.87	$ 3,143.68	$ 2,875.95	$ 2,999.73	$ 3,128.84	**$ 3,068.22**
MEG 6 - VIII Group (Medicaid Expansion)	$ 454.03	$ 477.37	$ 436.18	$ 458.43	$ 481.81	**$ 462.04**
Total PMPM	**$ 520.97**	**$ 539.63**	**$ 515.64**	**$ 534.96**	**$ 555.01**	**$ 533.84**
With Waiver Expenditures						
MEG 1 - TANF and Related	$ 1,488,814,587	$ 1,535,178,128	$ 1,566,271,938	$ 1,681,404,900	$ 1,805,001,015	**$ 8,076,670,568**
MEG 2 - SSI Medicaid Only	$ 824,649,869	$ 882,383,773	$ 865,373,176	$ 909,910,513	$ 956,740,011	**$ 4,439,057,342**
MEG 3 - SSI Dual	$ 570,613,857	$ 584,193,761	$ 600,149,274	$ 641,061,723	$ 684,763,191	**$ 3,080,781,806**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 6,662,084	$ 5,554,385	$ 7,594,642	$ 8,089,674	$ 8,616,973	**$ 36,517,758**
MEG 5 - 2017-Like group Dual	$ 86,786,741	$ 85,077,407	$ 91,645,036	$ 99,320,247	$ 107,638,252	**$ 470,467,682**
MEG 6 - VIII Group (Medicaid Expansion)	$ 857,078,655	$ 1,312,125,315	$ 1,342,604,551	$ 1,446,257,033	$ 1,557,911,750	**$ 6,515,977,303**
Safety Net Care Pool						
Uncompensated Care	$ 68,889,323	$ 67,294,973	$ 68,889,323	$ 68,913,183	$ 68,901,002	**$ 342,887,803**
HQII	$ -	$ 2,824,462	$ 7,359,077	$ 8,801,684	$ 12,000,174	**$ 30,985,397**
Total Expenditures	**$ 3,903,495,116**	**$ 4,474,632,204**	**$ 4,549,887,017**	**$ 4,863,758,956**	**$ 5,201,572,368**	**$ 22,993,345,661**

Budget Neutrality Variance	New Mexico Budget Neutrality Status By Calendar Year					
	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 ***Projected	DY5 - 2018 ***Projected	5-Year Total DY 01-DY 05
Without Less With Waiver Expenditures	**$ 499,211,269**	**$ 502,931,550**	**$ 710,022,321**	**$ 775,488,960**	**$ 846,652,925**	**$ 3,334,307,025**
Cumulative Variance	**$ 499,211,269**	**$ 1,002,142,819**	**$ 1,712,165,140**	**$ 2,487,654,100**	**$ 3,334,307,025**	**$ 3,334,307,025**

** Variance excludes Hypothetical Groups and Safety Net Care Pool Expenditures*

Budget Neutrality Exhibit 2 – Renewal Period PMPM limits, member months and expenditures (Total Computable)

Without Waiver	Annualized Trend	Adjustments to DY5	DY6 - 2019 Projected	DY7 - 2020 Projected	DY8 - 2021 Projected	DY9 - 2022 Projected	DY10 - 2023 Projected	5-Year Total DY6-DY10
			New Mexico Budget Neutrality Status By Calendar Year					
Member Months								
MEG 1 - TANF and Related	3.0%	-	6,585,691	6,779,665	6,980,928	7,189,753	7,406,424	**34,942,461**
MEG 2 - SSI Medicaid Only	1.2%	-	511,425	517,517	523,681	529,919	536,231	**2,618,774**
MEG 3 - SSI Dual	2.9%	-	488,038	502,238	516,851	531,889	547,366	**2,586,381**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.3%	-	3,293	3,402	3,514	3,630	3,750	**17,589**
MEG 5 - 2017-Like group Dual	3.9%	-	35,745	37,140	38,589	40,095	41,660	**193,230**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,314,080	3,396,704	3,481,387	3,568,182	3,657,140	**17,417,493**
Total Member Months	**2.8%**	**-**	**10,938,272**	**11,236,665**	**11,544,951**	**11,863,469**	**12,192,571**	**57,775,928**
Without Waiver PMPM								
MEG 1 - TANF and Related	4.7%	$ (5.88)	$ 361.26	$ 378.22	$ 395.89	$ 414.29	$ 433.46	**$ 397.68**
MEG 2 - SSI Medicaid Only	4.4%	$ (117.62)	$ 2,063.42	$ 2,153.93	$ 2,248.40	$ 2,347.02	$ 2,449.97	**$ 2,254.84**
MEG 3 - SSI Dual	4.3%	$ (21.44)	$ 2,175.65	$ 2,269.20	$ 2,366.78	$ 2,468.55	$ 2,574.70	**$ 2,376.70**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ (7.92)	$ 5,745.71	$ 5,924.40	$ 6,108.65	$ 6,298.63	$ 6,494.52	**$ 6,126.55**
MEG 5 - 2017-Like group Dual	4.3%	$ 1,720.73	$ 3,987.96	$ 4,159.44	$ 4,338.29	$ 4,524.84	$ 4,719.41	**$ 4,359.99**
MEG 6 - VIII Group (Medicaid Expansion)	5.1%	$ -	$ 741.04	$ 778.83	$ 818.55	$ 860.30	$ 904.18	**$ 822.59**
Total PMPM	**4.5%**	**$ (4.30)**	**$ 650.34**	**$ 679.80**	**$ 710.52**	**$ 742.56**	**$ 775.97**	**$ 713.54**
Without Waiver Expenditure								
MEG 1 - TANF and Related		$ (29,231,764)	$ 2,379,136,247	$ 2,564,199,546	$ 2,763,666,689	$ 2,978,658,757	$ 3,210,384,085	**$ 13,896,045,323**
MEG 2 - SSI Medicaid Only		$ (59,444,427)	$ 1,055,287,367	$ 1,114,695,300	$ 1,177,447,632	$ 1,243,732,639	$ 1,313,749,193	**$ 5,904,912,130**
MEG 3 - SSI Dual		$ (10,166,391)	$ 1,061,798,927	$ 1,139,679,253	$ 1,223,271,908	$ 1,312,995,878	$ 1,409,300,879	**$ 6,147,046,845**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ (25,230)	$ 18,920,275	$ 20,153,218	$ 21,466,505	$ 22,865,373	$ 24,355,399	**$ 107,760,770**
MEG 5 - 2017-Like group Dual		$ 59,196,558	$ 142,548,179	$ 154,480,591	$ 167,411,841	$ 181,425,539	$ 196,612,294	**$ 842,478,444**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,455,866,135	$ 2,645,465,239	$ 2,849,701,876	$ 3,069,706,100	$ 3,306,695,208	**$ 14,327,434,559**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 50,732,131	$ 44,185,409	$ 44,333,002	$ 44,403,863	$ 43,381,883	**$ 227,036,288**
HQII		$ -	$ 33,821,421	$ 44,185,409	$ 48,027,418	$ 52,126,274	$ 57,506,217	**$ 235,666,739**
Total Expenditures		**$ (39,671,254)**	**$ 7,198,110,683**	**$ 7,727,043,966**	**$ 8,295,326,871**	**$ 8,905,914,421**	**$ 9,561,985,157**	**$ 41,688,381,099**

With Waiver	Annualized Trend	Adjustments to DY5	DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
			New Mexico Budget Neutrality Status By Calendar Year					
Member Months								
MEG 1 - TANF and Related	3.0%	-	6,513,691	6,704,748	6,905,901	7,114,612	7,331,165	**34,570,118**
MEG 2 - SSI Medicaid Only	1.2%	-	511,425	517,274	523,436	529,670	535,979	**2,617,785**
MEG 3 - SSI Dual	2.9%	-	488,038	501,463	516,053	531,069	546,521	**2,583,143**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.3%	-	3,293	3,402	3,514	3,630	3,750	**17,589**
MEG 5 - 2017-Like group Dual	3.9%	-	35,745	37,140	38,589	40,095	41,660	**193,230**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,314,080	3,396,704	3,481,387	3,568,182	3,657,140	**17,417,493**
Total Member Months	**2.8%**	**-**	**10,866,272**	**11,160,730**	**11,468,881**	**11,787,259**	**12,116,217**	**57,399,358**
With Waiver PMPMs								
MEG 1 - TANF and Related	4.2%	$ -	$ 299.06	$ 311.62	$ 324.76	$ 338.40	$ 352.53	**$ 326.06**
MEG 2 - SSI Medicaid Only	3.9%	$ -	$ 1,980.72	$ 2,057.70	$ 2,138.13	$ 2,221.71	$ 2,308.56	**$ 2,143.29**
MEG 3 - SSI Dual	3.8%	$ -	$ 1,510.78	$ 1,568.50	$ 1,628.05	$ 1,689.87	$ 1,754.03	**$ 1,633.69**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ -	$ 5,745.71	$ 5,924.40	$ 6,108.65	$ 6,298.63	$ 6,494.52	**$ 6,126.55**
MEG 5 - 2017-Like group Dual	4.3%	$ -	$ 3,987.96	$ 4,159.44	$ 4,338.29	$ 4,524.84	$ 4,719.41	**$ 4,359.99**
MEG 6 - VIII Group (Medicaid Expansion)	5.1%	$ -	$ 741.04	$ 778.83	$ 818.55	$ 860.30	$ 904.18	**$ 822.59**
Total PMPM	**4.2%**	**$ -**	**$ 581.22**	**$ 605.73**	**$ 631.34**	**$ 657.98**	**$ 685.70**	**$ 633.81**
With Waiver Expenditures								
MEG 1 - TANF and Related		$ -	$ 1,948,005,737	$ 2,089,313,674	$ 2,242,790,888	$ 2,407,549,849	$ 2,584,419,855	**$ 11,272,080,003**
MEG 2 - SSI Medicaid Only		$ -	$ 1,012,991,286	$ 1,064,394,378	$ 1,119,174,550	$ 1,176,774,041	$ 1,237,337,950	**$ 5,610,672,205**
MEG 3 - SSI Dual		$ -	$ 737,316,063	$ 786,541,859	$ 840,160,775	$ 897,434,917	$ 958,613,462	**$ 4,220,067,076**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ -	$ 18,920,275	$ 20,153,218	$ 21,466,505	$ 22,865,373	$ 24,355,399	**$ 107,760,770**
MEG 5 - 2017-Like group Dual		$ -	$ 142,548,179	$ 154,480,591	$ 167,411,841	$ 181,425,539	$ 196,612,294	**$ 842,478,444**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,455,866,135	$ 2,645,465,239	$ 2,849,701,876	$ 3,069,706,100	$ 3,306,695,208	**$ 14,327,434,559**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 50,732,131	$ 44,185,409	$ 44,333,002	$ 44,403,863	$ 43,381,883	**$ 227,036,288**
HQII		$ -	$ 33,821,421	$ 44,185,409	$ 48,027,418	$ 52,126,274	$ 57,506,217	**$ 235,666,739**
Total Expenditures		**$ -**	**$ 6,400,201,228**	**$ 6,848,719,779**	**$ 7,333,066,855**	**$ 7,852,285,955**	**$ 8,408,922,267**	**$ 36,843,196,084**

Budget Neutrality Variance	DY1 - DY5 Savings	Adjustments to DY5	New Mexico Budget Neutrality Status By Calendar Year DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
Expenditure Variance By Waiver Group								
MEG 1 - TANF and Related			$ 431,130,510	$ 474,885,871	$ 520,875,801	$ 571,108,907	$ 625,964,230	**$ 2,623,965,321**
MEG 2 - SSI Medicaid Only			$ 42,296,080	$ 50,300,922	$ 58,273,082	$ 66,958,598	$ 76,411,243	**$ 294,239,925**
MEG 3 - SSI Dual			$ 324,482,864	$ 353,137,394	$ 383,111,133	$ 415,560,961	$ 450,687,416	**$ 1,926,979,769**
Hypothetical Group								
MEG 4 - 217-Like Medicaid			$ -	$ -	$ -	$ -	$ -	**$ -**
MEG 5 - 2017-Like group Dual			$ -	$ -	$ -	$ -	$ -	**$ -**
MEG 6 - VIII Group (Medicaid Expansion)			$ -	$ -	$ -	$ -	$ -	**$ -**
Safety Net Care Pool								
Uncompensated Care Pool			$ -	$ -	$ -	$ -	$ -	**$ -**
HQII			$ -	$ -	$ -	$ -	$ -	**$ -**
Total Variance			**$ 797,909,455**	**$ 878,324,187**	**$ 962,260,017**	**$ 1,053,628,466**	**$ 1,153,062,890**	**$ 4,845,185,015**
Expenditure Variance, Carry-over and Phase Down								
DY1 - DY5 Variance Carry-over	**$3,334,307,025**							
DY6 - DY10 Variance								
Savings by DY			$ 797,909,455	$ 878,324,187	$ 962,260,017	$ 1,053,628,466	$ 1,153,062,890	
Phase Down %			90.0%	80.0%	70.0%	60.0%	50.0%	
Savings after phase-down			$ 718,118,509.64	$ 702,659,350	$ 673,582,012	$ 632,177,080	$ 576,531,445	**$ 3,303,068,396**
Cumulative Savings			**$ 4,052,425,535**	**$ 4,755,084,884**	**$ 5,428,666,896**	**$ 6,060,843,976**	**$ 6,637,375,421**	**$ 6,637,375,421**

SECTION 6: EVALUATION DESIGN AND QUALITY STRATEGY

Details regarding evaluation of Centennial Care are found in the Interim Evaluation Report (Appendix B). During Centennial Care 2.0, HSD will maintain the original hypotheses and evaluation design plan but will add new metrics in order to evaluate the impact of proposed policies and programs presented within this waiver renewal application. Table 14 describes these hypotheses and how HSD will evaluate the impact:

Table 14 – Quality Goals and Evaluation

	Hypothesis	Methodology	Data Sources
Goal 1: Improve Member outcomes with refinements to care coordination			
1.1	Enhancements to care coordination will result in decreases for avoidable emergency room visits and hospital readmissions.	Track and trend member utilization of avoidable emergency room visits and hospital readmissions and monitor MCO adherence to common chronic disease management and other social support services requirements for care coordination.	Claims data HEDIS reports MCO reporting
1.2	Birthing outcomes will improve with pregnant women participating in the home visiting pilot.	Track and trend low birthweight, pre-term birth, prenatal/post-partum visits and well child visits for members in pilot.	Claims data HEDIS reports MCO reporting
Goal 2: Increase Behavioral Health Integration			
2.1	Member's utilization of Health Homes will increase.	Track and trend the number of members participating in Health Homes.	Claims data MCO reporting
2.2	Treatment outcomes of members participating in Health Homes will improve.	Track and trend Health Homes' treatment outcomes of common behavioral/physical health conditions and care coordination outcomes such as avoidable emergency	Claims data HEDIS reports MCO reporting

	Hypothesis	Methodology	Data Sources
		room visits, hospital readmissions and follow up after hospitalization for mental illness.	
Goal 3: Expand member access to Long Term Services and Supports			
3.1	Allowing all Medicaid-eligible members who meet a nursing facility level of care to access CB services will maintain New Mexico's accomplishments in rebalancing efforts.	Track and trend members accessing CB services.	Claims data
3.2	Increasing caregiver respite hours will improve member outcomes and utilization.	Track and trend member utilization and member outcomes.	Claims data HEDIS reports
3.3	Automatic Nursing Facility Level of Care (NFLOC) approvals will achieve administrative simplification for HSD, the MCOs and members.	Track and trend automatic NFLOC approvals.	MCO reporting
Goal 4: Increase quality of care with Value Based Payment (VBP) arrangements.			
4.1	Healthcare outcomes will improve for members served by providers that have VBP arrangements for the full delegation of care coordination.	Track and trend member utilization and common chronic disease management outcomes of providers with VBP arrangements that include full delegation of care coordination.	Claims data HEDIS reports MCO reporting
4.2	Implementing incremental minimum VBP requirements will support bending the cost curve of Medicaid program costs through	Track and trend program expenditure.	Claims data HEDIS reports MCO reporting

	Hypothesis	Methodology	Data Sources
	alignment with Centennial Care 2.0 program goals of improving care coordination, focus on transitions of care.		
Goal 5: Promoting Member Engagement and Responsibility			
5.1	Members participating in the Centennial Rewards program will continue to have improved healthcare outcomes with decreases in higher-cost services, such as inpatient stays.	Track and trend member utilization of preventive services and rewards credits.	Claims data HEDIS reports MCO/Reward Program Contractor reporting
5.2	Copayments for certain services will drive more appropriate use of services, such as reducing non-emergent use of the emergency department.	Track and trend member utilization of avoidable emergency room visits	Claims data MCO reporting
5.3	Premiums will ensure member engagement and smooth the cost-sharing "cliff" between Medicaid and the commercial market.	Track and trend enrollment rates and rate of churn between Medicaid and commercial/private coverage	Enrollment data Premium collections data
Goal 6: Improve administrative effectiveness and simplicity.			
6.1	Engaging justice-involved members prior to release will improve their health outcomes and begin to reduce recidivism in time.	Track and trend health outcomes and recidivism rates for justice-involved members who are actively participating in the care coordination program.	Claims data MCO reporting HEDIS reports
6.2	Members will have increased access to inpatient services at	Track and trend member utilization of IMDs.	Claims data

	Hypothesis	Methodology	Data Sources
	an Institution for Mental Disease (IMD).		
Goal 7: Improve Delivery System and Access to Services			
7.1	Members will have increased access to CHWs and CHRs.	Track and trend member utilization.	MCO reporting
7.2	Members will have increased access to telehealth.	Track and trend member utilization.	Claims data
7.2	Members will have increased access to Patient Centers Medical Homes.	Track and trend member utilization.	MCO reporting

SECTION 7: STATE PUBLIC NOTICE

The following are highlights of HSD's stakeholder engagement process for renewal of the Centennial Care waiver.

Medicaid Advisory Committee (MAC) Subcommittee for 1115 Waiver Renewal Design
HSD sought stakeholder input and recommendations for Centennial Care 2.0 beginning in October 2016. HSD convened a subcommittee of the MAC between October 2016 and February 2017. The subcommittee of the MAC was comprised of 21 members representing members, advocates, providers, tribal liaisons, other State agencies and was also open to and attended by the public. In addition to facilitated discussions during each meeting, individual subcommittee members and the public were asked to submit their recommendations to HSD in writing.

Native American/Tribal Meetings for 1115 Waiver Renewal Design
During the same time that HSD was meeting with the subcommittee of the MAC, it held monthly NATAC meetings to present the same materials and concepts provided at the MAC subcommittee meetings and to facilitate discussion and obtain feedback about the waiver renewal, specifically related to the needs of the Native American population in Centennial Care. The meetings provided an opportunity for HSD to present concepts and solicit feedback on the key design features for renewal, both verbally and in writing, from the Tribal and IHS representatives. In addition, HSD held formal Tribal Consultations on June 23, 2017 in Albuquerque and on October 20, 2017 in Santa Fe.

Additional Public Meetings
HSD's goal is to provide for a transparent Centennial Care waiver renewal process and to clearly convey expectations. Statewide stakeholder meetings about the concept paper occurred throughout the month of June 2017. Additional NATAC and MAC meetings were also held in June to solicit comment and feedback on the concept paper. Comments received from the MAC Subcommittee, NATAC, Tribal consultation and statewide public meetings about the concept paper informed the development of the renewal application.

Draft Waiver Renewal Application
This waiver renewal application and all related documents can be found at HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. The website also provides information about scheduled public input sessions including meeting dates, times and locations.

HSD published the draft waiver renewal application on September 5, 2017, and published a revised draft waiver application on October 6, 2017. HSD then held four public hearings and a Native American Tribal consultation. The Albuquerque public hearing on October 30, 2017 included a call-in number with capacity for up to 300 callers to participate in the hearing. Twenty-nine callers participated. Table 15 outlines HSD's comprehensive activities and timeline for stakeholder engagement for the waiver renewal.

Refer to Appendix D.1 for comments received on the draft waiver application and HSD's responses and Appendix D.2 for comprehensive comments received by HSD on the draft waiver application.

Table 15 – Renewal Timeline

Event	Dates
Planning and Design Meetings: Subcommittee of the MAC • Santa Fe • Albuquerque • Santa Fe • Albuquerque • Santa Fe	 October 14, 2016 November 18, 2016 December 16, 2016 January 13, 2017 February 10, 2017
NATAC Meetings • Albuquerque • Albuquerque • Santa Fe • Albuquerque	 December 5, 2016 January 20, 2017 February 10, 2017 April 10, 2017
MAC Meetings (All meetings held in Santa Fe)	November 14, 2016 April 3, 2017
Publish Date - Concept Paper	May 19, 2017
Gather Feedback - Concept Paper Statewide Public Input Sessions • Albuquerque • Silver City • Farmington • Roswell	 June 14, 2017 June 19, 2017 June 21, 2017 June 26, 2017
NATAC Meeting (Albuquerque)	July 10, 2017
MAC Meeting (Santa Fe)	July 24, 2017
Formal Tribal Consultation (Albuquerque)	June 23, 2017
Notice Period - 60-day advanced notification to Native American / Tribal stakeholders regarding 1115 waiver renewal application	August 31, 2017
Publish Date – Draft 1115 Waiver Application	September 5, 2017
Publish Date – Revised Draft 1115 Waiver Application	October 6, 2017
Gather Feedback - Draft Waiver Application Public Hearings & Tribal Consultation Meeting sites: • Public meeting: Las Cruces • Public meeting: Santa Fe (MAC meeting) • Public meeting: Las Vegas • Tribal consultation: Santa Fe • Public meeting: Albuquerque	 October 12, 2017 October 16, 2017 October 18, 2017 October 20, 2017 October 30, 2017
Final Waiver Application Submission to CMS	December 5, 2017

SECTION 8: APPENDICES

Appendix A: Glossary

Acronym	Term
ABCB	Agency-Based Community Benefit
ADL	Activities of Daily Living
ASAM	The American Society of Addition Medicine
CARF	Commission on Accreditation of Rehabilitation Facilities
CB	Community Benefit
CCP	Comprehensive Care Plan
CCSS	Comprehensive Community Support Services
CHIP	Children's Health Insurance Program
CHWs	Community Health Workers
CNA	Comprehensive Needs Assessment
COD	Co-Occurring Disorder
COE	Category of Eligibility
CoLTS	Coordination of Long Term Services
CMS	Centers for Medicare & Medicaid Services
CSA	Core Service Agencies
CY	Calendar Year
CYFD	Children, Youth and Families Department
DOH	Department of Health
DY	Demonstration Year
EDIE	Emergency Department Information Exchange
EPSDT	Early Periodic Screening, Diagnostic and Treatment
FFS	Fee-for-Service
FMAP	federal Matching Assistance Program
FPL	federal Poverty Level
FQHC	federally Qualified Health Centers
HCBS	Home and Community-Based Services
HRA	Health Risk Assessment
HQII	Hospital Quality Improvement Incentive
HSD	New Mexico's Human Services Department
IADL	Instrumental Activities of Daily Living
I/T/U	Indian Health Service, Tribal health provider, and Urban Indian providers
IHS	Indian Health Service
IMD	Institution for Mental Disease
IOP	Intensive Outpatient services
LARC	Long-Acting Reversible Contraception
LOC	Level of Care
LPN	Licensed Practical Nurse
LTSS	Long Term Services and Supports
MAC	Medicaid Advisory Committee
MAT	Medication Assisted Treatment
MCO	Managed Care Organization

Acronym	Term
MEG	Medicaid Eligibility Group
MH/SA	Mental Health / Substance Abuse
MMIS	Medicaid Management Information System
NAAB	Native American Advisory Board
NATAC	Native American Technical Advisory Committee
NF	Nursing Facility
NFLOC	Nursing Facility Level of Care
NM	New Mexico
NMICSS	New Mexico Independent Consumer Support System
OMB	Office of Management and Budget
OSAP	New Mexico Office of Substance Abuse Prevention
OTP	Opioid Treatment Programs
OUD	Opioid Use Disorder
PACE	Program for All-Inclusive Care for the Elderly
PCMH	Patient-Centered Medical Homes
PCS	Personal Care Services
RHC	Rural Health Clinic
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHC	School-Based Health Center
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDCB	Self-Directed Community Benefit
SNCP	Safety Net Care Pool
SMI	Serious Mental Illness
SSA	Social Security Act
SSI	Supplemental Security Income
STC	Standard Terms and Conditions
STR	State Targeted Response
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TMA	Transitional Medical Assistance program
UC	Uncompensated Care
VBP	Value-Based Purchasing
WDI	Working Disabled Individuals

Appendix B: Interim Evaluation Report

The interim evaluation report is available on HSD's website at:
http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20B%20-%20Interim%20Evaluation%20Report.pdf

Appendix C: State Public Notices

Attached are copies of the following documents demonstrating HSD's adherence to the public notice requirements set forth under 42 CFR Part 431.408.

Stakeholder Engagement Process Leading to Development of Concept Paper

1. MAC 1115 Waiver Renewal Subcommittee - October 14, 2016
    a. Agenda
    b. Minutes
    c. Presentation
    d. Care coordination brief
2. MAC 1115 Waiver Renewal Subcommittee - November 18, 2016
    a. Agenda
    b. Minutes
    c. Presentation
    d. Supportive housing information brief
    e. Population health services table
3. MAC 1115 Waiver Renewal Subcommittee - December 16, 2016
    a. Agenda
    b. Minutes
    c. Presentation
    d. Long-term care brief
    e. Behavioral health integration brief
4. MAC 1115 Waiver Renewal Subcommittee - January 13, 2017
    a. Agenda
    b. Minutes
    c. Presentation
    d. Value-based purchasing brief
    e. Member engagement brief
5. NATAC - January 20, 2017
    a. Agenda
    b. Presentation
6. NATAC - February 10, 2017
    a. Agenda
    b. Presentation
7. MAC 1115 Waiver Renewal Subcommittee - February 10, 2017
    a. Agenda
    b. Minutes
    c. Presentation
    d. Other meeting documents, Alternative Plan Benefit
8. New Mexico Association of Home and Hospice Care and the New Mexico Association for Home Care - March 2, 2017
    a. Presentation
9. Tribal Consultation - Albuquerque, June 23, 2017
    a. Correspondence for tribal consultation
    b. Individual tribal invitation letters, May 19, 2017
    c. Agenda
    d. Presentation, 1115 Waiver Renewal

Public Notice

1. 30-day state public notice and comment period on the Centennial Care 2.0 waiver renewal providing a comprehensive program description, September 5, 2017 and on the revised draft of the 1115 Centennial Care waiver application, October 6, 2017
   a. HSD website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx
2. Public notice (abbreviated notice) in the state's newspaper with the widest circulation
   a. Las Cruces Sun-News, September 5, 2017, re: public meetings in Las Cruces, Santa Fe and Last Vegas
   b. The Albuquerque Journal, September 6, 2017, re: public meetings in Las Cruces, Santa Fe and Las Vegas
   c. Las Vegas Optics, September 8, 2017, re: public meetings in Las Cruces, Santa Fe and Las Vegas and access to telephonic participation
   d. Las Cruces Sun-News, September 24, 2017, re: public meetings in Las Cruces, Santa Fe and Last Vegas
   e. The Albuquerque Journal, September 27, 2017, re: public meetings in Las Cruces and Santa Fe
   f. The Albuquerque Journal, October 22, 2017, re: public meeting in Albuquerque and access to telephonic participation
   g. The Santa Fe New Mexican, October 22, 2017, re: public meeting in Albuquerque and access to telephonic participation
   h. Las Vegas Optics, October 25 and 29, 2017

3. Proposal posting (abbreviated notice) via HSD's electronic mail lists
   a. Letter and email distribution, September 7, 2017, re: public hearings, website posting and public comment submission
   b. Letter and email distribution, October 6, 2017; re: website posting and public comment period
   c. Letter and email distribution, October 19, 2017, re: public hearing in Albuquerque and access to telephonic participation

Public Hearings on the 1115 Waiver Application

1. Public meetings in Las Cruces, October 12, 2017; Santa Fe, October 16, 2017; Las Vegas, October 18, 2017; Albuquerque, October 30, 2017
   a. Presentation, Centennial Care 2.0, 1115 Demonstration Waiver Renewal Application – Public Hearing
2. MAC Meeting - Santa Fe, October 16, 2017
   a. Agenda
   b. Presentation, Centennial Care 2.0, 1115 Demonstration Waiver Renewal Application – Public Hearing
   c. April 2015-March 2017 Statewide Dashboards
   d. FY17 Lag Model with Centennial Care & Medicaid Expansion with Actual Data Thru June 2017
   e. FY18 Trend Model with Centennial Care & Medicaid Expansion
   f. FY19 Trend Model with Centennial Care & Medicaid Expansion
3. Tribal consultation - Santa Fe, October 20, 2017
   a. Save the date notices, August 28 – October 6, 2017
   b. Individual tribal invitation letters, September 5, 2017

c. Agenda
d. Presentation, Centennial Care 2.0: 1115 Demonstration Waiver Renewal Application

Presentation to State Legislative Committees

1. Presentation to the Legislative Finance Committee, June 7, 2017 - Presentation, Behavioral Health Collaborative Strategic Plan, SFY2015-SFY2017 -
2. Presentation to the Legislative Health and Human Services Committee- June 16, 2017 - Update on Medicaid and Centennial Care 2.0
3. Presentation to the Legislative Finance Committee - August 16, 2017 - Medicaid Reform, Controlling Costs and Improving Quality
4. Presentation to the Legislative Health and Human Services Committee - September 20, 2017 - Centennial Care 2.0 Update

All documents related to the above public notices and input is available on HSD's website at: http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20C%20-%20State%20Public%20Notices.pdf

Appendix D: Summary of Stakeholder Feedback (including Feedback from federally Recognized Tribal Nations) and State Response

HSD has tracked comments received since the release of the Centennial Care 2.0 concept paper in May 2017 but is only summarizing comments received in direct response to the draft 1115 waiver renewal application released on September 5, 2017, and revised and re-released on October 6, 2017. Attached are the following documents demonstrating the feedback received on the Centennial Care 2.0 proposals and HSD's response to the feedback received on the draft waiver application.

1. Summary of comments received and HSD's response to the Centennial Care 2.0 Draft Waiver Renewal Application: September 2017 – November 2017 is available on HSD's website at: http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20D_1%20-%20Public%20Comments%20Summary%20and%20Responses.pdf

2. Comprehensive public comments on the Draft 1115 Waiver Renewal Application is available on HSD's website at: http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20D_2%20-%20Comprehensive%20Comments.pdf

Appendix E: Documents Demonstrating Quality

Attached are the following documents that provide strong evidence of HSD commitment to quality currently and ongoing:

1. Quality Strategy is available on HSD's website at: http://www.hsd.state.nm.us/providers/2017-nm-quality-strategy-final.pdf

2. EQRO Summary Reports are available on HSD's website at: http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20E_2%20-%20EQRO%20Summary%20Report.pdf

Appendix F: Current Centennial Care Eligibility Groups

Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived and as described in the current 1115 Waiver Standard Terms and Conditions.

- Table 16 describes the mandatory State Plan populations included in Centennial Care;
- Table 17 describes the optional State Plan populations included in Centennial Care; and
- Table 18 below, describes the beneficiary eligibility groups who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e. the 217-like group).

Table Column Descriptions:

- Column A describes the consolidated Medicaid eligibility group for the population in accordance with the Medicaid eligibility regulations that take effect January 1, 2014;
- Column B describes the specific statutory/ regulatory citation of any specific Medicaid eligibility groups that are included in the consolidated group described in column A;
- Column C describes the current income and resource standards and methodologies for each Medicaid eligibility group described in the state plan;
- Column D describes whether there are any limits on inclusion in Centennial Care for each Medicaid eligibility group; and
- Column E describes the budget neutrality Medicaid Eligibility Group (MEG) under which expenditures for the population are reported.

Table 16 – Mandatory State Plan Populations

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Parents/ Caretaker Relatives 42 CFR 435.110	Low Income Families (1931) 42 CFR 435.110	Income Test: TANF standards and methods Resource test: No	No	TANF and Related
	Transitional Medical Assistance (12-month extension due to earnings or 4 month extension due to increased child support/ spousal support) • 408(a)(11)(A) and (B) • 1931(c)(1) and (2) • 1925 • 1902(a)(52)	Income test: No Resource test: No	No	TANF and Related
Consolidated group for pregnant women 42 CFR 435.116	Low Income Families (1931) 42 CFR 435.110	Income Test: TANF standards and methods Resource test: No	No	TANF and Related
	Qualified pregnant women • 1902(a)(10)(A)(i)(III) • 1905(n)(1)	Income test: AFDC payment standard Resource test: AFDC	No	TANF and Related
	Mandatory poverty-level related pregnant women section • 1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	Income test: Up to 133% FPL Resource Test: No	No	TANF and Related
	Poverty level pregnant women optional eligible 1902(a)(10)(A)(ii)(IX) 1902(l)(1)(A)	Income test: 133% to 235% FPL Resource Test: No	No	TANF and Related

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Consolidated group for children under age 19 435.118	Low Income Families (1931) 42 CFR 435.110	Income Test: TANF standards and methods Resource test: No	No	TANF and Related
	Poverty level related infants • 1902(a)(10)(A)(i)(IV) • 1902(l)(1)(B)	Income Test: Up to 133% FPL Resource Test: No	No	TANF and Related
	Poverty level related children under ages 1-5 • 1902(a)(10)(A)(i)(VI) • 1902(l)(1)(C)	Income Test: Up to 185% FPL Resource Test: No	No	TANF and Related
	Poverty level related children age 6-18 • 1902(a)(10)(A)(i)(VII) • 1902(l)(1)(D)	Income Test: Up to 185% FPL Resource Test: No	No	TANF and Related
	Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay • 1902(e)(7)	Income Test: Up to 185% FPL Resource Test: No	No	TANF and Related
	Newborns deemed eligible for one year 1902(e)(4) 42 CFR 435.117	Income test: No Resource Test: No	No	TANF and Related
Adoption Assistance and foster care children	Children receiving IV-E foster care payments or with IV-E adoption assistance agreements • 1902(a)(10)(i)(I) 473(b)(3) 42 CFR 435.145	Income test: No Resource Test: No	No	TANF and Related
	Former foster care children 1902(a)(10)(A)(i)(IX)	Income test: No Resource Test: No	No	TANF and Related

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Individuals Age 19 Through 64	Adult group 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119[1]	Income test: Up to 133% MAGI Resource test: No	No	VIII Group
Refugee Medical Assistance	Refugee Medical Assistance 45 CFR 400.94(d) 45 CFR 400.100-102 45 CFR 400.104	Income test: AFDC income standard Resource test: No	No	TANF and Related
Aged, Blind, and Disabled	Individuals receiving SSI cash benefits--§1902(a)(10)(A)(i)(II) Disabled children no longer eligible for SSI benefits because of a change in the definition of disability— §1901(a) (10)(A)(i)(II)(aa)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals under age 21 eligible for Medicaid in the month they apply for SSI— 1902(a)(10(A)(i)(II)(cc)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individual whose earning exceed SSI substantial gainful activity level— 1902(a)(10)(A)(i)(II)§1619(a)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

[1] Note: Although this group is included in Section 1902(a)(10)(A)(i) of the Social Security Act, the state has the authority to decide whether to include this group.

A. Mandatory Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Aged, Blind, and Disabled (continued)	Individuals receiving mandatory state supplements SSI 42 CFR 435.130	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Institutionalized individuals continuously eligible for SSI in December 1973 42 CFR 435.132 Blind and disabled individuals eligible for SSI in December 1973 42 CFR 435.133	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who would be eligible for SSI except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals ineligible for SSI because of requirements prohibited by Medicaid 42 CFR 435.122	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Aged, Blind, and Disabled (continued)	Disabled widows and widowers 1634(b) Early widows/widowers 1634(b) 42 CFR 435.138	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who become ineligible for SSI as a result of OASDI cost-of- living increases received after April 1977 42 CFR 435.135	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	1939(a)(5)(E) Disabled adult children 1634(c)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Disabled individuals whose earnings are too high to receive SSI cash §1619(b)	Earned income is less than the threshold amount as defined by Social Security Unearned income is the SSI amount Resource standard is SSI	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard 1902(a)(10)(A)(ii)(V) 42 CFR 435.236 1905(a)	Income test: 300% of federal Benefit Rate with Nursing Facility Level of Care (NF LOC) or PACE / ICFMR eligible Resource test: $2,000	NF LOC: Included PACE: Excluded ICFMR: Excluded	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 17 – Optional State Plan Populations

A. Optional Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Infants and children under age 19	Poverty level infants not mandatorily eligible • 1902(a)(10)(A)(ii)(IX) • 1902(l)(2)	Income test: 133% up to 185% FPL Resource Test: No	No	TANF and Related
	Optional Targeted Low income children under 19 • 1902(a)(10)(a)(ii)(XIV) Note: If sufficient Title XXI allotment is available as described under STC 99, uninsured individuals in this eligibility group are funded through the Title XXI allotment. Insured individuals in this eligibility group are funded through Title XIX, and if Title XXI funds are exhausted as described in STC 100, then all individuals in this eligibility group are funded through Title XIX.	Income test: 185% up to 235% FPL Resource test: No	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children
Adoption assistance and foster care children	Independent foster care adolescents under age 21 who were in foster care on their 18th birthday • 1902(a)(10)(A)(ii)(XVII)	Income test: No Resource Test: No	No	TANF and Related
Aged, Blind, and Disabled	Working disabled Individuals §1902(A)(10)(A)(ii)(XIII)	Income test: 250% FPL, meet SSI non-income standards Utilize SSI Methodologies Resource test: The state uses 1902(r)(2) disregards in determining eligibility for this group.	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Optional Medicaid Eligibility Group in State Plan	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Aged, Blind, and Disabled (continued)	Individuals who would be eligible for SSI cash if not in an institution 42 CFR 435.211 1902(a)(10)(A)(ii)(IV) 1905(a)	Income test: SSI standards and methodologies	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Breast and Cervical Cancer Program	Individuals under 65 screened for breast or cervical cancer 1902(a)(10)(A)(ii)(XVIII)	Screened by NM Department Of Health/CDC provider	No	TANF and Related
Home and Community Based 1915(c) Waivers that are continuing outside the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the State's 1915(c) Developmentally Disabled waiver	Income test: 300% of federal Benefit Rate with an ICF/MR Level of Care determination. Resource test: $2,000	Only in Centennial Care for Acute Care	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the State's 1915(c) Medically Fragile waiver	Income test: 300% of federal Benefit Rate with an ICF/MR Level of Care determination. Resource test: $2,000	Only in Centennial Care for Acute Care	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 18 – Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Statutory/Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care?	E. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	Income test: 300% of federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Appendix G: Centennial Care Current Benefits

Table 19 describes the current non-CB services, including services available under the Alternative Benefit Plan (ABP). Table 20 lists the CB services. Table 21 lists the services available only through Centennial Care including the three new BH services

Table 19 – Centennial Care Non-Community Benefit Services

Service	Medicaid State Plan	ABP Services
Accredited Residential Treatment Center Services	X	X Age limited
Applied Behavior Analysis (ABA)	X	X Age Limited
Adult Psychological Rehabilitation Services	X	X
Ambulatory Surgical Center Services	X	X
Anesthesia Services	X	X
Assertive Community Treatment Services	X	X
Bariatric Surgery	X	X Lifetime limit
Behavior Management Skills Development Services	X	X Age Limited
Behavioral Health Professional Services: outpatient behavioral health and substance abuse services	X	X
Cancer Clinical Trials	X	X
Case Management	X	
Comprehensive Community Support Services	X	X
Day Treatment Services	X	X Age limited
Dental Services	X	X
Diagnostic Imaging and Therapeutic Radiology Services	X	X
Dialysis Services	X	X
Durable Medical Equipment and Supplies	X	X Limits apply
Emergency Services (including emergency department visits, psychiatric ER, and ground/air ambulance services)	X	X
Experimental or Investigational Procedures, Technology or Non-Drug Therapies[2]	X	X
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	X	X Age Limited
EPSDT Personal Care Services	X	X Age Limited
EPSDT Private Duty Nursing	X	X Age Limited
EPSDT Rehabilitation Services	X	X Age Limited

[2] Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.

Service	Medicaid State Plan	ABP Services
Family Planning	X	X
federally Qualified Health Center Services	X	X
Hearing Aids and Related Evaluations	X	
Home Health Services	X	X Limits apply
Hospice Services	X	X
Hospital Inpatient (including Detoxification services and medical/surgical care)	X	X
Hospital Outpatient	X	X
Inpatient Hospitalization in Freestanding Psychiatric Hospitals	X	X
Inpatient Rehabilitative Facilities	X	X Skilled nursing or acute rehab facility only
Intensive Outpatient Program Services	X	X
Immunizations	X	X
IV Outpatient Services	X	X
Diagnostic Labs, X-Ray and Pathology	X	X
Labor/Delivery and Inpatient Maternity Services	X	X
Medication Assisted Treatment for Opioid Dependence	X	X
Midwife Services	X	X
Multi-Systemic Therapy Services	X	
Non-Accredited Residential Treatment Centers and Group Homes	X	X Age limited
Nursing Facility Services	X	X
Nutritional Services	X	
Occupational Therapy Services	X	X Limits apply
Outpatient Hospital based Psychiatric Services and Partial Hospitalization	X	X
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital	X	X
Outpatient Health Care Professional Services	X	X
Outpatient Surgery	X	X
Prescription Drugs	X	X
Primary Care Services	X	X
Physical Therapy	X	X Limits apply
Physician Visits	X	X
Podiatry Services	X	X Limits apply
Pre- and Post-Natal Care	X	X

Service	Medicaid State Plan	ABP Services
Pregnancy Termination Procedures	X State-funded	X State-funded
Preventive Services	X	X
Prosthetics and Orthotics	X	X Limits apply
Psychosocial Rehabilitation Services	X	X
Radiation Therapy and Chemotherapy	X	X
Radiology Facilities	X	X
Rehabilitation Option Services (Psycho social rehab)	X	X Limits apply
Rehabilitation Services Providers	X	X Limits apply
Reproductive Health Services	X	X
Rural Health Clinics Services	X	X
School-Based Health Center Services	X	X
Smoking Cessation Services	X	X
Specialist Visits	X	X
Speech and Language Therapy	X	X Limits apply
Swing Bed Hospital Services	X	X
Telemedicine Services	X	X
Tot-to-Teen Health Checks	X	X Age Limited
Organ and Tissue Transplant Services	X	X Lifetime limit
Transportation Services (medical)	X	X
Treatment Foster Care	X	X Age Limited
Treatment Foster Care II	X	X Age Limited
Treatment of Diabetes	X	X
Urgent Care Services/Facilities	X	X
Vision Care Services	X	X Only for eye injury or disease; routine vision care not covered

Table 20 – Centennial Care Current Community Benefit Services

Service Description	ABCB	SDCB
Adult Day Health	X	
Assisted Living	X	
Behavioral Support Consultation	X	X
Community Transition *(community reintegration members only)*	X	
Customized Community Supports		X
Emergency Response	X	X
Employment Supports	X	X
Environmental Modifications *($5,000 every 5 years)*	X	X
Home Health Aide	X	X
Homemaker		X
Nutritional Counseling		X
Personal Care Services *(Consumer Directed and Consumer Delegated)*	X	X
Private Duty Nursing Services for Adults (RN or LPN)	X	X
Related Goods *(phone, internet, printer etc...)*		X
Respite	X	X
Skilled Maintenance Therapy Services *(occupational, physical and speech therapy)*	X	X
Specialized Therapies *(acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, Hippotherapy, massage therapy, Naprapathy, Native American Healers)*		X
Non-Medical Transportation		X

Table 21 – Services Available to Centennial Care Members Only

Service Description
Family Support
Behavioral Health Respite
Recovery Services
Community Interveners for the Deaf and Blind

Appendix H: Proposed Community Benefit Definitions and Limits
The following is a list of proposed Community Benefit services for Centennial Care 2.0, including service definitions and limits.

I. Adult Day Health (ABCB)

Adult Day Health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of members by the care plans incorporated into the care plan.

Adult Day Health Services are provided by a licensed adult day-care, community-based facility that offers health and social services to assist members to achieve optimal functioning. Private Duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided within the Adult Day Health setting and in conjunction with the Adult Day Health services but would be reimbursed separately from reimbursement for Adult Day Health services.

II. Assisted Living (ABCB)

Assisted Living is a residential service that provides a homelike environment which may be in a group setting, with individualized services designed to respond to the individual needs as identified by and incorporated in the care plan.

Core services provide assistance to the recipient in meeting a broad range of activities of daily living including; personal support services (homemaker, chore, attendant services, meal preparation), and companion services; medication oversight (to the extent permitted under State law), 24-hour, on-site response capability to meet scheduled or unpredictable member's needs and to provide supervision, safety, and security. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral to, the provision of assisted living services. Services provided by third parties must be coordinated with the assisted living provider.

Limits or Exclusions: The following services will not be provided to recipients in Assisted Living facilities: Personal Care, Respite, Environmental Modifications, Emergency Response or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.

III. Behavior Support Consultation (ABCB and SDCB)

Behavior Support Consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, parents, family enrollees and/or primary caregivers with coping skills which promote maintaining the member in a home environment.

Behavior Support Consultation: 1) informs and guides the member's providers with the services and supports as they relate to the member's behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary

therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

IV. Community Transition Services (ABCB)

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement (excluding assisted living facilities) to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual's health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy; and
- Moving expenses.

Limits or Exclusions: Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services are limited to $3,500 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a nursing facility stay of at least 90 days prior to transition to the community.

V. Customized Community Supports (SDCB)

Customized Community Supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized Community Supports may include day support models. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

VI. Emergency Response (ABCB and SDCB)

Emergency Response services provide an electronic device that enables a member to secure help in an emergency at home and avoid institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: installing, testing and maintaining equipment; training members, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and reporting member

emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response and emergency response high need.

VII. Employment Supports (ABCB and SDCB)

Employment Supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that a member may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational and/or vocational assessments and profiles; education of the member and co-workers on rights and responsibilities; and benefits counseling. The service must be tied to a specific goal specified in the member's care plan.

Job development is a service provided to members by skilled staff. The service has five components: 1) job identification and development activities; 2) employer negotiations; 3) job restructuring; 4) job sampling; and 5) job placement.

Employment Supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Limits or Exclusions: Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program. federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.

VIII. Environmental Modifications (ABCB and SDCB)

Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance his/her level of independence. Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

All services shall be provided in accordance with applicable federal, State, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility

and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family enrollees, providers and contractors concerning environmental modification projects to the member's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

Limits or Exclusions: Environmental Modification services are limited to five thousand dollars ($5,000) every five (5) years. Additional services may be requested if a member's health and safety needs exceed the specified limit.

IX. Home Health Aide (ABCB and SDCB)

Home Health Aide services provide total care or assist a member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The Home Health Aide services assist the member in a manner that promotes an improved quality of life and a safe environment for the member. Home Health Aide services can be provided outside the member's home. State Plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, Home Health Aide services are provided hourly, for members who need this service on a more long term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records. Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff. Must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether goals are being met.

X. Non-Medical Transportation (SDCB)

Non-Medical Transportation services enable SDCB members to travel to and from community services, activities and resources as specified in the SDCB care plan.

Limits or Exclusions: Limited to 75 miles radius of the member's home. Non-Medical Transportation is limited to $1,000 per year. Not a covered service for minors.

XI. Nutritional Counseling (ABCB and SDCB)

Nutritional Counseling services include assessment of the member's nutritional needs, development and/or revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

XII. Personal Care Services (ABCB and SDCB)

Personal Care Services (PCS) provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). There are three PCs delivery models.

Under Agency-Based Community Benefit:

1. Consumer delegated PCS allows the member to select the PCS agency to perform all PCS employer related tasks. The agency is responsible for ensuring PCS is delivered to the member in accordance with the care plan.
2. Consumer directed PCS allows the member to oversee his or her own PCS delivery, and requires the member to work with his or her PCS agency who then acts as a fiscal intermediary agency.

Under the Self-Directed Community Benefit:

1. The member has employer authority and directly hires PCS caregivers or contracts with an agency.

XIII. Private Duty Nursing for Adults (ABCB and SDCB)

Private Duty Nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for recipients who are twenty-one (21) years of age or older with intermittent or extended direct nursing care in the recipients home. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

Limits or Exclusions*:* All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse or a Licensed Practical Nurse under written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing.

XIV. Related Goods (SDCB)

Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit. The member receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the member's individual budget.

Limits or Exclusions: Experimental or prohibited treatments and goods are excluded. Related goods are limited to $2,000 per person per care plan year.

XV. Respite (ABCB and SDCB)

Respite services are provided to recipients unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or nursing facility or an ICF/MR meeting the qualifications for provider certification. When respite care services are provided to a member by an institution, that individual will not be considered a resident of the institution for purposes of waiver eligibility. Respite care services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder car; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and case manager, ensuring the health and safety of the member at all times.

Limits or Exclusions: Respite services are limited to a maximum of 300 hours annually per care plan year.

XVI. Skilled Maintenance Therapy Services (ABCB and SDCB)

Skilled maintenance therapy services include Physical Therapy (PT), Occupational Therapy (OT) or Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that are provided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships.
Services in this category include:

Physical Therapy

Physical Therapy services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding PT activities, use of equipment and technologies or any other aspect of the individual's physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the care plan goals and objectives; and consulting or collaborating with other service providers or family enrollees, as directed by the member.

Occupational Therapy Services
OT services promote fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the member.

Speech Language Therapy
SLT services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the member's environment to meet his/her needs; training regarding SLT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the member.

Limits or Exclusions: A signed therapy referral for treatment must be obtained from the recipient's primary care physician. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered.

XVII. Specialized Therapies (SDCB)
Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his/her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid State Plan benefit are excluded.

Services in this category include:

Acupuncture
Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits.

Biofeedback
Biofeedback uses visual, auditory or other monitors to feed back to members' physiological information of which they are normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Chiropractic
Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health.

Cognitive Rehabilitation Therapy
Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems.

Hippotherapy
Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for members with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. Members with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production.

Massage Therapy
Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or

hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member's ability to be more independent in the performance of ADL living; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

Naprapathy
Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function.

Native American Healers
There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support members in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects. This form of therapy may be provided by community-recognized medicine men and women and others as healers, mentors and advisors to members, and provides opportunities for members to remain connected with their communities. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some Tribes, Nations and Pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties.

Limits and Exclusions: Specialized therapies are limited to $2,000 annually.

Appendix I: SUD Continuum of Care

I. ASAM Level 0.5 Early Intervention

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – New Mexico was part of the first cohort of states selected to receive SBIRT funding. In August 2013, SAMHSA awarded NM with a new five year, $10 million grant to implement SBIRT at selected locations. SBIRT services integrate BH within primary care and community health care settings. Each medical partner site universally screens adult patients 18 years old or over at least annually to identify those at-risk of or those having a substance use disorder and offers brief intervention, brief treatment, and appropriate referral as needed. The following are the seven NM SBIRT medical partner sites and locations: White Sands Family Medical Practice, Alamogordo; Aspen Medical Center, Santa Fe; Christus St. Vincent Entrada Contenta, Santa Fe; Christus St. Vincent Family Medicine Center, Santa Fe; First Nations Community Health Source Zuni Clinic, Albuquerque; Santa Fe Indian Hospital, Santa Fe; University of New Mexico Hospital, Albuquerque. As of September 2017, 37,536 screens were conducted with 34,092 individuals screened. Grant funding ends July 30, 2018.

II. ASAM Level 1 Outpatient

This is a covered Medicaid benefit, covering a wide range of services including assessment, treatment plan development, individual and group therapy, crisis intervention, pharmacological management, suboxone induction, and methadone maintenance.

III. ASAM Level 2.1 Intensive Outpatient

This is a covered Medicaid benefit. Intensive outpatient (IOP) services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MH providers. The intent is to not exclude consumers with co-occurring disorders. IOP is available for adults with SUD or Co-Occurring Disorder (COD) that meet ASAM patient placement criteria for Level II Intensive Outpatient Treatment.

IV. ASAM Level 2.5 Partial Hospitalization Services

Defined in the ASAM criteria as 20 or more hours of clinically intensive programming per week for multidimensional instability not requiring 24-hour care. This is currently a covered benefit for MH but not SUD. HSD is currently revising the rule on partial hospitalization to include SUD as a covered benefit.

V. ASAM Level 3 Adult Residential Treatment

This is currently not a covered Medicaid benefit. SUD services at 11 adult residential treatment centers (RTCs) are state-funded. $7.2 million was spent in CY16, with a projection of close to $8 million for CY17. A recent survey of eleven RTC providers showed 199 beds, with 126 for men and 73 for women, far less than what is needed. Nine of ten responding providers use ASAM admission criteria. Only two of ten are Commission on Accreditation of Rehabilitation Facilities (CARF) accredited, but others are in process. The planned State Plan Amendment to include adult RTCs in the Medicaid program would enable important transitions of care within the SUD continuum to produce better outcomes for Medicaid members.

VI. Educational and Prevention Efforts

Naloxone Pharmacy Technical Assistance -New Mexico's Office of Substance Abuse Prevention (OSAP) has contracted with the Southwest CARE Center under the Opioid State Targeted Resource (STR) grant to provide technical assistance to NM pharmacies reimbursed by Medicaid to dispense naloxone for 100 pharmacy trainings over the two-year grant period, to be completed by September 2018.

Opioid treatment training – the Opioid STR grant supports training on MAT, including buprenorphine, to increase the availability of qualified staff and programs to address the needs of peoples with OUD and improve access to services.

Prescription drug monitoring – New Mexico's OSAP received SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF Rx), which provides $371,616 award per year for five years beginning September 1, 2016. The purpose of the grant is to raise awareness about the dangers of sharing medications, and promote collaboration between states, pharmaceutical and medical communities to understand the risks of over-prescribing to youth and adults; bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and users in a targeted community of high need; and promote increased incorporation of Prescription Monitoring Program (PMP) data into state and community level needs assessments and strategic plans.

Training on Medical Detoxification – Medically managed inpatient detoxification is a Medicaid reimbursable service if provided in general hospital settings. Standardized evidence-based protocols are available to systematically guide medically managed detoxification, but too often this has not been part of regular practice among general hospitalists and nurses in NM. To improve capacity, through CBHTR, New Mexico's Human Services Department supports training in evidence-based, medically-managed detoxification in community hospitals throughout the state.

Underage Drinking and Prescription Drug Abuse - New Mexico's Office of Substance Abuse Prevention (OSAP) was awarded a SAMHSA grant of $1.68 annually for 5 years ($8 million total) beginning October 2015 to address underage drinking and youth prescription drug abuse through targeted strategic planning for selected New Mexico communities. Implementation of evidence based strategies began August 2017.

PAX Good Behavior Game – PAX is an evidence-based practice that teaches students self-regulation, self-control, and self-management. Long-term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, and initiation of sexual activity; and increases in high school graduation rates and college attendance. The Human Services Department, Behavioral Health Services Division, funded a pilot project in 2016 to train 172 teachers in PAX, reaching 3,329 students. A 2017 request for application is expected to extend the reach to an additional 139 elementary school teachers. The STR will build on SGF efforts to expand PAX to 12 tribal schools.

VII. Opioid Treatment Services

Defined as daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. OTS is a Medicaid funded service. New Mexico's Human Services Department approves licensing of Opioid Treatment Programs (OTPs). Currently there are 19 Opioid Treatment Programs, serving approximately 5,800 patients. There is a high concentration of OTPs in Albuquerque, NM's largest population center; thus, the Opioid STR grant (above) is providing training to expand OTC capacity throughout the state.

VIII. Utilization of Buprenorphine

State direction to MCOs to cover buprenorphine in any formulation for the treatment of OUD without requiring a prior authorization.

IX. Behavioral Health Investment Zones

HSD has developed and funded two Investment Zones in counties with high rates of OUD: Rio Arriba County has implemented county-wide Pathways care coordination system; McKinley County has renovated the Gallup Detox center, converted an old hospital into a SUD RTC.

X. Programs for Justice-Involved Individuals

Through state general funds, New Mexico supports a range of programs for adult substance abuse offenders and their families, from jail diversion to treatment to reentry, aftercare and recovery planning. Funding supports district courts, county alternative sentencing programs, and other community providers of services for justice-involved individuals.

XI. Recovery Support Services

New Mexico's Office of Peer Recovery and Engagement (OPRE) is developing and delivering trainings with a special focus on OUD for certified peer support specialists who can work in regional hubs to provide recovery services. One of our peer-run recovery agencies will have dedicated staff trained to support local agencies and providers in implementing MAT for OUD. In addition, Medicaid covers the following recovery services: Comprehensive Community Support Services, Behavioral Management Skills Development, Adaptive Skills Building, Psychosocial Rehab, Family Support Services, Recovery Services, and BH Respite Services.

XII. Supportive Housing

NM has a number of supportive housing programs (Crisis Housing, Move-in Assistance and Eviction Prevention, Oxford House, Linkages Permanent Supportive Housing, Special Needs Housing, SAMHSA Permanent Supportive Housing Grant) that provide a continuum of support for individuals with behavioral health issues (SUD, SMI, and COD), from Crisis Housing to Transitional Housing to Permanent Supportive Housing. Some programs allow a primary SUD diagnosis, while others require primary SMI diagnosis. A combination of state funds and federal grants supports these housing programs. Medicaid covers certain supportive housing services through CCSS.

XIII. Collaborative Efforts

HSD continues to have strong collaboration and partnership with Counties & Municipalities to provide better coordinated behavioral health services: The January 2017 New Mexico Association of Counties (NMAC) Conference showcased BH innovations in the counties of

McKinley, Rio Arriba, Bernalillo, and Dona Ana; June 2017 conference: Opioid crisis & increased access to naloxone in detention centers; 2018: Crisis triage and Emergency Department Information Exchange (EDIE). In addition, Bernalillo County approved 1/8 GRT ($16 million) to fund behavioral health services in Albuquerque and Bernalillo County.

Deloitte.

Centennial Care:

Evaluation Interim Report

Demonstration Years 1 – 2 and Preliminary Demonstration Year 3:

January 2014 – December 2016

October 2017

Table of Contents

Executive Summary

New Mexico's Section 1115 Demonstration Waiver program, known as Centennial Care, is largely progressing with the major designated goals, including efforts to improve access to care, coordinated care, quality of care, and the member experience while reducing the growth trend in program expenditures.

When reading the contents of this report in detail, it is important to understand that total Centennial Care member months increased from DY1 to DY3 by about 1,306,000, or 17.8%[1]. The vast majority of this increase was driven by Medicaid Eligibility Group (MEG) 6, (named "VIII Group"), which is the Medicaid adult expansion group. Enrollment in VIII Group grew by 63.3% from DY1 to DY3. Members eligible under this MEG are individuals at or below 133% federal poverty level (FPL) who are between ages 19 and 64 and who do not qualify for Medicaid under a previously implemented MEG (e.g. not disabled and not pregnant women).

The increase in members served by Centennial Care under this MEG may have significant impacts on the results of various measures as the members participating in Centennial Care in DY2 and DY3 may not have participated in Centennial Care in DY1. When making longitudinal comparisons, readers should keep this context in mind as results are presented. Given the high-level nature of the data used to support this report, the impact of this membership increase was not directly quantifiable at the measure level. However, the discussion section of each measure indicates where this membership change may have had a relatively significant impact on the results.

Highlights from the interim waiver evaluation, based on data through calendar year (CY) 2015 and preliminary CY2016 data, include:

- **Improving Access to Care –** The 1115 Waiver Evaluation noted mixed progress in timely access to care related to several measures as compared to the baseline[2] of the Centennial Care program. Improvements were found in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans opting into Centennial Care, the ratio of providers to members, increased access to telemedicine, the percentage of members utilizing newly available BH services (BH respite, family support, and recovery services), and the rate of flu vaccinations.

  Conversely, declines were found in the percentage of members who had an annual dental visit (although the rates across the cohorts are higher than the national averages), the number of adult members accessing preventive/ambulatory services, the percentage of members who had a PCP visit, the percentage of PCPs with open panels (though the overall percentage of open panels remained above 90%), breast cancer screening rates, cervical cancer screening rates, childhood and adolescent immunization rates, and prenatal and postpartum care, and the percentage of members utilizing mental health services (as indicated by their principal diagnosis)[3]. These declines represent potential areas for improvement in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the continued influx of these members.

  It should be noted that a significant transition within the behavioral health provider network took place during 2015 (DY2). There was a concerted effort to rebuild the network which included supporting Federally Qualified Health Centers (FQHCs) with the expansion of their

[1] Based on member month figures according to the budget neutrality tables for DY1, DY2, and DY3.
[2] The baseline period is typically considered calendar year 2013, but may be SFY2013 or calendar year 2014 (DY1) depending on the measure and data availability from CY2013.
[3] This HEDIS measure is based on the Mental Health Value Set, which does not include diagnoses or services related to Substance Use Disorders.

service offerings to cover behavioral health services through support of obtaining additional required certifications to offer these specialized services. While some gaps in the network existed for a time resulting in service delays, the efforts by New Mexico and other stakeholders helped to quickly resolve these issues and reduce the concern of future service delays or access limitations.

- **Improving Care Coordination and Integration –** The Evaluation indicated general progress in both care coordination and integration activities. Improvements were noted in the percentage of members the managed care organizations (MCOs) were able to engage, the percentage of members for whom Health Risk Assessments (HRAs) were completed, the percentage of Level 2 members who received telephonic and in-person outreach, the percentage of members who had a BH service and also received outpatient ambulatory visits, and the Emergency Room (ER) visit rates among members with BH needs.

  There has been an increase in the number of unique members receiving Home and Community-Based services (HCBS), and an overall increase in HCBS provided. New Mexico continues to be successful in its rebalancing efforts with 84.6% of long-term care members receiving long-term services in their homes and 13.6% of members residing in nursing facilities.

  Conversely, a higher percentage of LTSS members had ER visits, a lower percentage of members with schizophrenia or bipolar disorder received diabetes screening, a lower percentage of members with schizophrenia and diabetes received tests for diabetes monitoring.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care. There were improvements in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening ratios; increases in monitoring rates of Body Mass Index (BMI) for adults, children and adolescents; and increases in asthma medication management. Hospital admission rates also decreased across all five ambulatory care sensitive (ACS) measures. Finally, there was a decline in the percentage of ER visits that were potentially avoidable.

- **Reducing Expenditures and Shifting to Less Costly Services –** The Evaluation found that the program continued to demonstrate significant savings in comparison to the waiver budget neutrality threshold through DY3. Total program expenditures for DY3 alone were 21.8% below the budget-neutral limits as defined by the Special Terms and Conditions (STCs), which includes per member per month (PMPM) cost caps by MEG, uncompensated care costs, and Hospital Quality Improvement Incentive (HQII) pool amounts. The total cost of Centennial Care for DY1, DY2, and DY3 combined is below the budget neutrality limits as defined in the STCs[4] by about $2.5 billion, or 15.8%.

  In addition, inpatient claims exceeding $50,000 as a percentage of healthcare costs were slightly lower. There were also decreases in hospital readmission rates, positive increases in the use of substance abuse services and use of HCBS, positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and positive shifts from higher level of care (LOC) Nursing Facility (NF) utilization to lower LOC NF utilization.

- **Increased Member Engagement** – There was a significant increase in the number of members enrolled in the Centennial Rewards program and performing various wellness-related activities designed to earn rewards under the program; at the end of DY1, approximately

[4] STCs 102, 104, and 111 define budget neutrality for the demonstration.

47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered for the program. There are over 40 activities members can perform to earn rewards from adhering to refilling monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased through DY2.

Note that the Centennial Rewards program was a brand new program that required introductory member outreach for making members aware of the program and how to participate. It began April 1, 2014 and thus there were fewer months in DY1 in which members were able to register and participate in the program.

Increased Member Satisfaction – The Evaluation found that member satisfaction results largely improved from the baseline to DY2. Measures that exhibited improvements included the percentage of expedited appeals resolved on time and the percentage of appeals upheld. Improvement was also noted in the number of appeals partially overturned and overturned, marked by decreases through DY2. Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY2.

Program Background

Managed care has been the primary service delivery system for Medicaid in the State of New Mexico (State) for more than a decade. The State began its managed care program for physical health, known as the Salud! program, in 1997, its managed care program for behavioral health began in 2005, and its Coordination of Long Term Services (CoLTS) program began in 2008. Prior to Centennial Care, New Mexico managed a variety of federal waivers that were administered through six (6) different managed care organizations (MCOs) and one Behavioral Health Statewide Entity (BHSE). New Mexico continues to offer a fee-for-service system for certain short-term eligibility groups and services, home and community-based services for Individuals with Intellectual Disabilities (IID) and Medically Fragile conditions, the Program of All Inclusive Care for the Elderly, Intermediate Care Facilities for Individuals with IID, and Native Americans who choose not to "opt in" to managed care.

In January 2014, New Mexico implemented Centennial Care, a Section 1115 demonstration waiver approved by the Centers for Medicare and Medicaid Services (CMS). Centennial Care offers Medicaid members an integrated model of care including physical health, behavioral health and long term services and supports. The State contracted with four MCOs to administer the Centennial Care program:

- Blue Cross Blue Shield (BCBS)
- Molina Healthcare (MHC)
- Presbyterian Health Plan (PHP)
- United Healthcare (UHC)

The CMS approved Special Terms and Conditions (STCs) outline the following goals:

1. Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, cost effectively in the right setting;

2. Ensure that the expenditures for care and services being provided are measured in terms of its quality and not solely by its quantity;

3. Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility or reducing provider rates; and

4. Streamline and modernize the Medicaid program in the State.

This report satisfies the requirements under Centennial Care STCs[5]. The Interim Report offers a more in-depth update to assess ongoing status of the Centennial Care waiver implementation. The Evaluation methodologies and results presented should be considered an ongoing analysis and are subject to change as the program matures and more information and data become available.

[5] STC 122: Interim Evaluation Report.

Evaluation Plan Design

Consistent with the STCs from CMS, Deloitte Consulting LLP (Deloitte) conducted this Evaluation to study HSD's performance operating the waiver program following the approved Evaluation Plan Design. This Interim Report covers program operations from January 1, 2014 through December 31, 2015 (DY2), with additional program data through December 31, 2016 (DY3) when available.

Program Goals and Hypotheses

The Evaluation Plan for Centennial Care set out four goals for the waiver, each with its own hypothesis and related research questions. Each research question had multiple performance measures to be assessed to determine the extent to which the waiver is achieving its goals. The goals and their corresponding hypotheses outlined in the Evaluation Plan are shown below:

Goal 1: Assure that Medicaid beneficiaries in the demonstration receive the right amount of care, delivered at the right time, in the right setting. The design of the program seeks to eliminate programmatic silos through the consolidation of several waiver programs.

> **Hypothesis 1:** Centennial Care's managed care design will deliver greater access in an appropriate and timely fashion.

Goal 2: Ensure that expenditures for care and services being provided are measured in terms of quality and not solely by quantity. This goal is guided by the principle that health care services improve health status most efficiently through coordinated, efficacious care. Centennial Care seeks to provide high quality services and reduce preventable adverse events.

> **Hypothesis 2:** Increased provision of care coordination will lead to improved health care outcomes and a reduction in adverse events.

Goal 3: Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility, or reducing provider rates. Measuring Centennial Care's progress toward this goal requires monitoring the impact of the expansion in Medicaid eligibility authorized under the Affordable Care Act (ACA). This goal seeks to examine whether improved care coordination results in a shift in spending towards more comprehensive services for individuals with chronic conditions and/or behavioral health needs and away from unnecessary and often costly service utilization by populations with lesser needs. Centennial Care's success in slowing cost growth by rewarding members who achieve certain health care goals will also need to be monitored.

> **Hypothesis 3:** The rate of growth in program expenditures under Centennial Care will trend lower over the course of the waiver through lower utilization and/or substitution of less costly services.

Goal 4: Streamline and modernize the Medicaid program in the State. The consolidation of multiple waivers, benefits, and services into the Centennial Care program by itself will streamline New Mexico's Medicaid program. The hypothesis and research questions addressing this goal test whether this consolidation has substantive implications for the State's health care delivery system providers, enrollees, and the administration.

> **Hypothesis 4:** Streamlining through Centennial Care will result in improved health care experiences for beneficiaries, improved claims processing for providers, and efficiencies in program administration for the State.

Approach

HSD engaged Deloitte to conduct the Evaluation of Centennial Care's impact on service delivery and integration through tracking and analysis of performance measures that address access to care, enrollment trends, care coordination, and changes in utilization and cost. The objective of the Centennial Care Evaluation Design Plan is to track performance of each Centennial Care evaluation measure over time against a baseline value.

For this Interim Report and for all Centennial Care demonstration reports going forward, each of these performance measures will be tracked against a baseline value measured either over calendar year 2013 prior to Centennial Care or over calendar year 2014 if pre-Centennial Care data was not available to establish a baseline value from calendar year 2013. In addition, the performance measures will be compared to other meaningful points of reference, including but not limited to:

- Measure values for prior demonstration years, such as progress in DY3 compared to DY2 and DY2 compared to DY1, to evaluate the progress of access to care, quality, and/or cost over time;
- PMPM budget neutrality limits as defined by the STCs from CMS, Section XIV: Monitoring budget neutrality for the Demonstration; and
- National average rates for health compliance, screening, and/or monitoring, such as average rates for standard Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures as published annually by the National Committee for Quality Assurance (NCQA) or as available from other sources[6].

This Interim Report includes detailed quantitative analysis of each performance measure under the Evaluation Plan Design. In the context of this report, discussions of changes in measure values between periods are based on the percent change (increase/decrease) which is calculated as [Current period measure value] / [Prior period measure value] – 1. Additional information related to measure definition and calculation methodology are provided in Appendix A.

For certain measures, hypothesis testing was performed using a two-proportion z-test to determine if a statistically significant change can be inferred. For additional information on the statistical test performed, see Appendix C.

Data Utilized

Consistent with HSD's approved Evaluation Design Plan, Deloitte conducted its Evaluation using a combination of State-provided reports including MCO reports, External Quality Review Organization (EQRO) reports, HSD reports, CMS-64 expenditures/computable cost reports, and special ad-hoc reports extracted from the Medicaid Management Information System (MMIS) and MCO ad-hoc reports. Additional detail on the data utilized for each measure has been provided in Appendix B.

[6] National benchmarks for CAHPS measures obtained through NCQA's Quality Compass (QC) tool referenced in this report uses data captured in calendar year 2014 for all qualified providers nationwide. In instances where QC benchmarks are not available, national benchmarks developed by Symphony Performance Health (SPH), a CMS-approved CAHPS survey vendor for a few MCOs, are provided as a point of reference. SPH benchmarks are based on data captured in calendar year 2015 for a subset of qualified providers nationwide.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Evaluation Limitations

Consistent with HSD's approved Evaluation Plan, Deloitte conducted its Evaluation using State-provided reports, including MCO reports, EQRO reports, HSD reports, and special ad-hoc reports from the MMIS and the MCOs.

Prior to January 1, 2014, HSD did systematically collect and analyze access to care, quality of care, and cost and utilization information for the legacy programs. However, in some cases, the legacy reports were not comparable to Centennial Care's reporting requirements. In other cases, Centennial Care's integration of services and changes in participating providers required changes in reporting. As an example, the level of detail required in reporting utilization by category of service changed dramatically between the legacy reports and Centennial Care. For some performance measures, this lack of consistency between the legacy programs and the new Centennial Care program impeded Deloitte's ability to create baseline metrics to directly compare improvements in access to care, quality of care, and cost and utilization attained by the new waiver program. In such cases, baselines were developed based on the best information available at the time, or Deloitte worked with HSD to revise the measure to accommodate the data available. Note that the details relevant to baseline development for each impacted measure are described in greater detail within Appendix A.

Additional limitations include:

- Certain measures do not include the Native American population that opted out of managed care as this information was not available in the data sources provided to support those measures.
- Due to the aggregate nature of collected data, various adjustment factors could not be applied. These factors include lag time in reporting (e.g. IBNR or data completion), fee schedule changes and/or benefit changes, demographic shifts (age/gender changes, category of eligibility enrollment changes), and changes in provider networks and MCO sub-capitated arrangements.
- Measures that track use of certain services may not accurately capture the use of these services for all possible sites of service. For example, immunizations or vaccines could be received in a walk-up clinic without charge that is outside the managed care network. We expect the impact to be relatively stable year to year with respect to the under reported utilization as the prevalence of alternate site type administration does not seem to fluctuate significantly.
- Where appropriate (e.g. utilization by category of service), measures were calculated on a per 1,000 basis using member month data to adjust for changes in population size. However, these data were not available for all measures nor for all baseline and demonstration year data to be adjusted consistently. Going forward, Deloitte will work with HSD to verify if additional data is available to allow for consistent application of this methodology across all appropriate measures.
- Similar to the above data limitation, analysis was not performed to quantify the impact of seasonality on certain measures where a partial year's data was used to establish the baseline.

- For the measure reporting the percentage of PCPs with open panels, the data submitted by MCOs does not include the number of additional patient slots available across the open panels. Such data would more precisely indicate available capacity in the system.
- To calculate HEDIS measures, plans may use two primary sources of data. Claims/encounter data is always used as a data source, but plans may also perform reviews of medical records to supplement their data for certain measures. When plans use solely claims/encounter data, it is referred to as an "administrative" method of calculating the numerator and denominator. When plans use both administrative data, as well as medical records, it is referred to as a "hybrid" method of data collection. Plans report their method of collection for each measure on its audited HEDIS report as "A" for administrative and "H" for hybrid. When calculating aggregate measure results (e.g. across all MCOs participating in Centennial Care) for HEDIS-based measures, the reporting methodology of the MCOs needed to be consistent. Therefore, there are measures where the aggregate results were calculated only with MCOs using the same HEDIS reporting methodology for that measure during a particular period, which are footnoted in the detailed measure results. This exclusion may skew results in certain periods.
- Due to the aggregate nature of some reports provided by the State, it was not always possible to determine the underlying cause of observed changes in measure values over time nor to test changes for statistical significance.
- For certain measures, data was not received from all four MCOs in all demonstration years. The aggregate results could potentially be skewed for these measures.
- DY1 data for the Centennial Care Rewards Program was limited and only available for a partial year due to an April 1 go-live date.
- Reports provided by participating MCOs had occasional data errors that were identified throughout the Evaluation process. Deloitte has worked with HSD to identify the errors and suggested requesting updated reports for future reporting cycles.

Evaluation Analysis Results

For listings of detailed definitions and evaluation methodologies for all measures, please refer to Appendix A.

Hypothesis 1

Centennial Care's managed care design will deliver greater access in an appropriate and timely fashion.

Centennial Care seeks to ensure that access to preventive care and services is assured for children, adolescents, and adults and that the use of preventive services increases over time, as preventive services may help to lower the utilization of more costly services incurred by members in the future as a result of chronic disease. Another goal is to assess members' health needs and risks in a timely manner, provide care planning and care coordination for members found to require support and access to care in order to prevent decline, crisis and unnecessary admissions. Hypothesis 1 assumes that the Centennial Care's managed care design will deliver greater access to care, in an appropriate and timely fashion.

The Evaluation found that access to care generally improved, while the timeliness with which services were delivered varied compared to the baseline. Overall, the MCOs care coordination activities have generally increased as plans were able to engage more members, and fewer refused care coordination services.

Research Question 1.A

Has access to care for all populations and services covered under the waiver, including physical health, behavioral health, and LTSS, improved under Centennial Care?

The Centennial Care waiver combines PH, BH, and LTSS within a single, consolidated waiver that establishes an integrated model of care. Prior to the waiver's implementation in 2014, these services were fragmented in separate waiver programs, with six different managed care contractors and one Behavioral Health Statewide Entity (BHSE).

The Evaluation is reviewing Centennial Care's impact on service delivery and integration through the analysis of 11 measures designed to address enrollment trends, access to care, and care settings. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY2 of the Centennial Care program, programmatic performance generally showed improved access to care. There were positive performance results when compared to the baseline in 7 out of 12 measures.

While a higher percentage of state population are enrolling in Centennial Care, and a greater percentage of Native Americans are participating in the program, New Mexico saw increases from the baseline to DY2 in members' access to key services in an appropriate care setting, including increased access to telemedicine and the utilization of new BH support services (which were not fully operational during DY1 and DY2). A higher percentage of members with a NF level of care (LOC) designation received care through the community, and a lower percentage of those members received care in NFs. Finally, a larger number of providers participated in Centennial Care in DY2 compared to DY1 and the provider-to-member ratio experienced a favorable decrease.

There was a decline in 5 out of 12 measures from the baseline to DY2. These results included a lower percentage of children and young adults received dental visits (although the rates across cohorts are higher than the national averages), a lower percentage of adult enrollees that utilized preventive or ambulatory services, a lower percentage of members had at least one visit to a Primary Care Provider (PCP), and a lower percentage of PCPs reported open panels in their practices (though the overall

percentage of open panels remained above 90%), and a lower percentage of members utilized overall mental health services (as indicated by their principal diagnosis). It should be noted that in 2015 (DY2), there was a significant transition with the NM behavioral health provider network with some gaps in the network existed for a time resulting in service delays.

Emerging trends for measures that have DY3 data available indicate a continuation of baseline to DY2 trends, including continued increases in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans participating in Centennial Care, and utilization of new BH support services. Available DY3 data also indicates stable percentages of members with NF LOC designation receiving care through HCBS and NFs compared to DY2. However, emerging DY3 information shows a continued decrease in the percentage of members having at least one visit to a PCP. DY3 data for these measures is through at least Q2, though some of the measures have full DY3 data.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 1 – Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups.

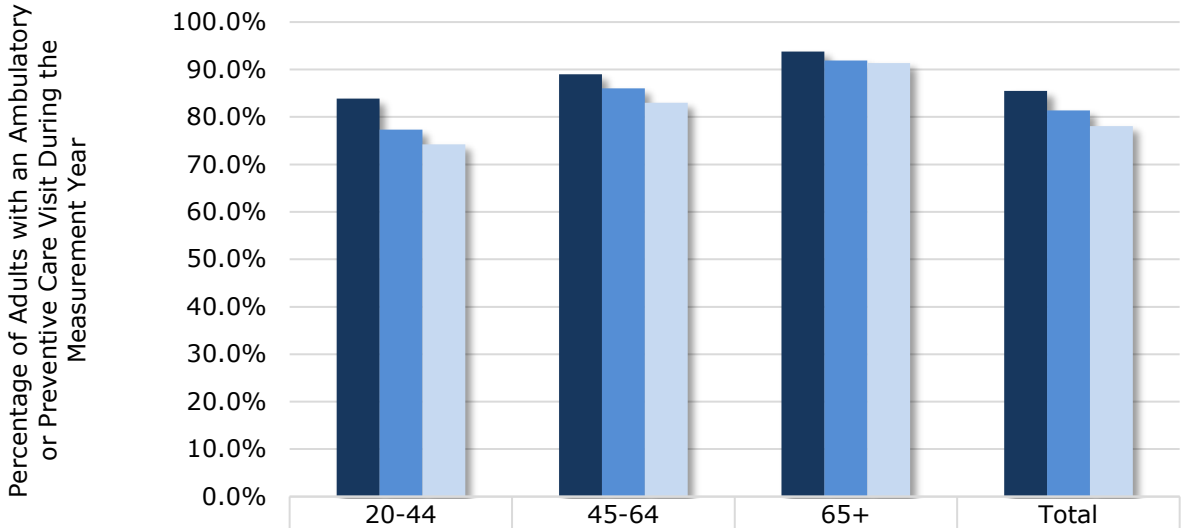
Exhibit 1 presents rates for the 2013 baseline, DY1, and DY2 for the measure Access to Ambulatory/Preventive Care. As illustrated, the rates for each of the three age cohorts as well as the aggregate rate experienced a decrease from DY1 to DY2. The largest decrease among the age cohorts was experienced in the 20-44 years of age cohort which decreased from 77.3% in DY1 to 74.2% in DY2 (a 4.0% change). This change was statistically significant at the 95% confidence level. All decreases apart from the decrease experienced in the 65+ years of age cohort were statistically significant, including the aggregate decrease of 4.1%.

Upon review of the individual MCO performance, PHP experienced the largest change in the aggregate rate (-5.1%) from DY1 to DY2 compared to BCBS, MHC, and UHC, which had changes of -0.3%, -4.3%, and -4.3% respectively.

The rates for each of the three age cohorts as well as the aggregate rate declined from the baseline to DY2. The aggregate rate declined 8.7%, which was statistically significant at the 95% confidence level. An 11.5% decrease in the 20-44 years of age cohort and a 6.8% decrease in the 45-64 years of age cohort were also statistically significant, while the decline in the 65+ years of age cohort was not statistically significant. All four MCOs experienced statistically significant decreases from the baseline to DY2 in their aggregate rate, the greatest of which was UHCs 15.0% decrease.

A national comparison rate could not be identified for this measure.

Exhibit 1 – Access to Preventive/Ambulatory Health Services among Centennial Care Enrollees in Aggregate and in Subgroups[7]



	20-44	45-64	65+	Total
2013 Baseline	83.9%	89.0%	93.8%	85.5%
DY1 Centennial Care	77.3%	86.1%	91.9%	81.4%
DY2 Centennial Care	74.2%	83.0%	91.4%	78.1%

[7] Source: MCO annual HEDIS reports for 2013 – 2015.

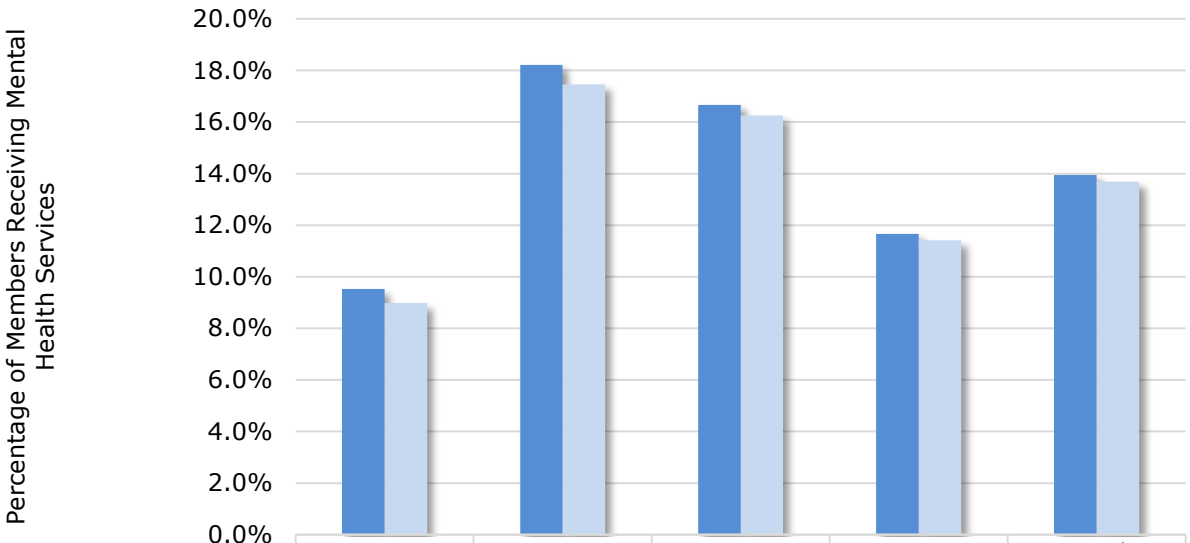
Measure 2 – Mental health services utilization (Members receiving any mental health service with mental health as the principal diagnosis).

Exhibit 2 presents rates for DY1 and DY2 for mental health services utilization. As illustrated, the rates for each of the four age cohorts as well as the aggregate rate experienced a decrease from DY1 to DY2. The largest decrease among the age cohort subcomponents was experienced in the 0-12 years of age cohort which decreased from 18.2% in DY1 to 17.5% in DY2 (a 5.7% change). This change was statistically significant at the 95% confidence level. All decreases apart from the decrease experienced in the 65+ years of age cohort were statistically significant, including the aggregate decrease of 1.8%.

The most significant decline in the aggregate rate from DY1 to DY2 among individual MCOs was experienced by BCBS (-12.3%), a decline that was statistically significant at the 95% confidence level. This was relatively larger than the changes experienced by MHC, PHP, and UHC, which were 2.8%, -1.2%, and -4.5%, respectively.

A national comparison rate could not be identified for this measure.

Exhibit 2 – Mental Health Services Utilization Aggregate[8]



	0-12	13-17	18-64	65+	Total
DY1 Centennial Care	9.5%	18.2%	16.7%	11.7%	13.9%
DY2 Centennial Care	9.0%	17.5%	16.3%	11.4%	13.7%

[8] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 3 – Telemedicine utilization (Number of telemedicine providers and telemedicine utilization).

Exhibit 3 presents results for the 2013 baseline, DY1, and DY2 for the measure Number of Telemedicine Providers and Telemedicine Utilization. As illustrated, utilization of telemedicine increased in both PH and BH subcomponents, as well as in aggregate. From DY1 to DY2, PH utilization experienced a 432.3% increase while BH experienced a 27.7% increase. Aggregate utilization increased by 47.5% from DY1 to DY2.

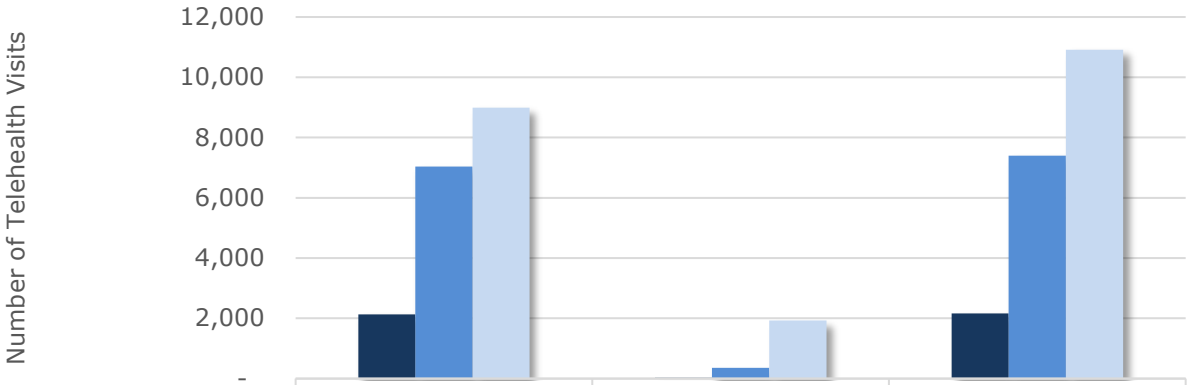
Aggregate utilization (both PH and BH) increased across all MCOs. UHC experienced the greatest increase (81.2%), while BCBS, MHC, and PHP increased by 72.5%, 48.7%, and 25.2%, respectively.

From the baseline to DY2, the aggregate utilization of telehealth services increased 405.3%. The PH utilization subcomponent increased by 6,544.8% while the BH utilization subcomponent increased by 321.7%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 3 – Telemedicine Utilization[9]



	Behavioral health	Physical health	Total
2013 Baseline	2,131	29	2,160
DY1 Centennial Care	7,039	362	7,401
DY2 Centennial Care	8,987	1,927	10,914

[9] Source: Ad hoc MCO reports 2013 - 2015.

Measure 4 and 5 – Number and percentage of people meeting nursing facility level of care who are in nursing facilities or are receiving HCBS.

With the implementation of Centennial Care, eligibility for HCBS does not require a waiver allocation ("slot") to access HCBS services if the member is eligible for full Medicaid and meets a NF LOC. Also, the personal care service (PCS) benefit was changed from being a state plan service to a component of the CB service package. Under the former Coordination of Long-Term Services (CoLTS) program, individuals who were Medicaid eligible could receive PCS under the state plan, and were required to wait for a waiver allocation in order to have access to the full array of CoLTS HCBS. Under Centennial Care, Medicaid members have access to all CB services that they are assessed to need, without an allocation, upon meeting the NF LOC criteria. Individuals who do not meet full Medicaid financial eligibility requirements will be allocated to a waiver "slot".

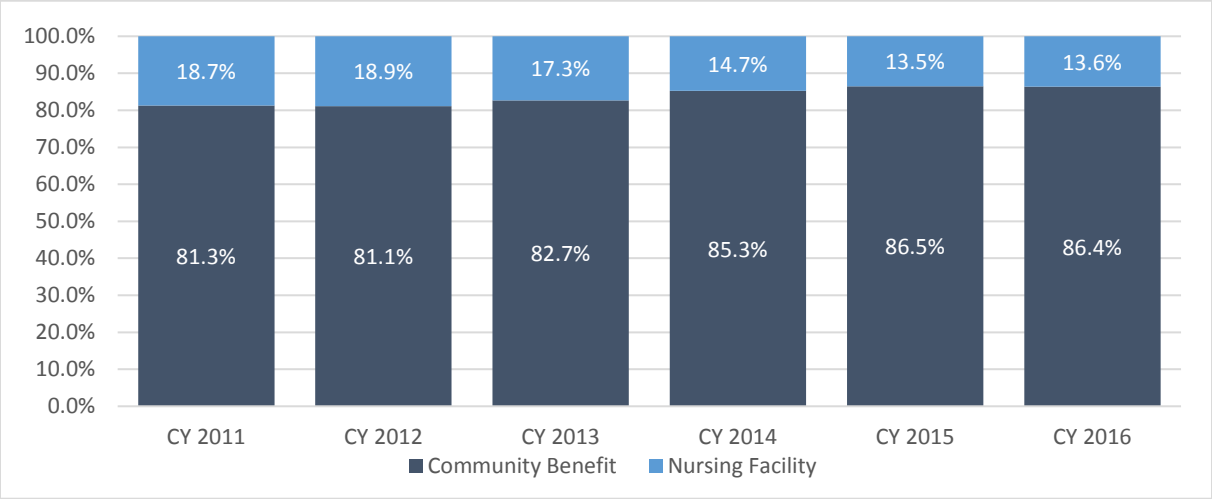
The number of unique members receiving HCBS increased from 24,015 to 29,799 (a 24.1% increase) from DY1 to DY3[10].

In overall performance of its LTSS program, New Mexico ranks in the second best quartile in the 2014 National State Long-Term Care Scorecard published by the AARP and the Commonwealth Fund. New Mexico's LTC system is especially strong in terms of:

- Affordability and access (top quartile)
- Choice of setting and provider (top quartile)
- Effective transitions across settings of care (second quartile)
- Community Reintegration/Rebalancing

Under Centennial Care, NM has continued to reintegrate members from nursing facilities into the community, with 86.4% of members in the long-term care program being served in the community in 2016, which is relatively consistent results with 2015 results.

Exhibit 4.a/5.a – Long Term Services and Supports Enrollment - Dual and Medicaid Only NF LOC Enrollment Proportion[11]

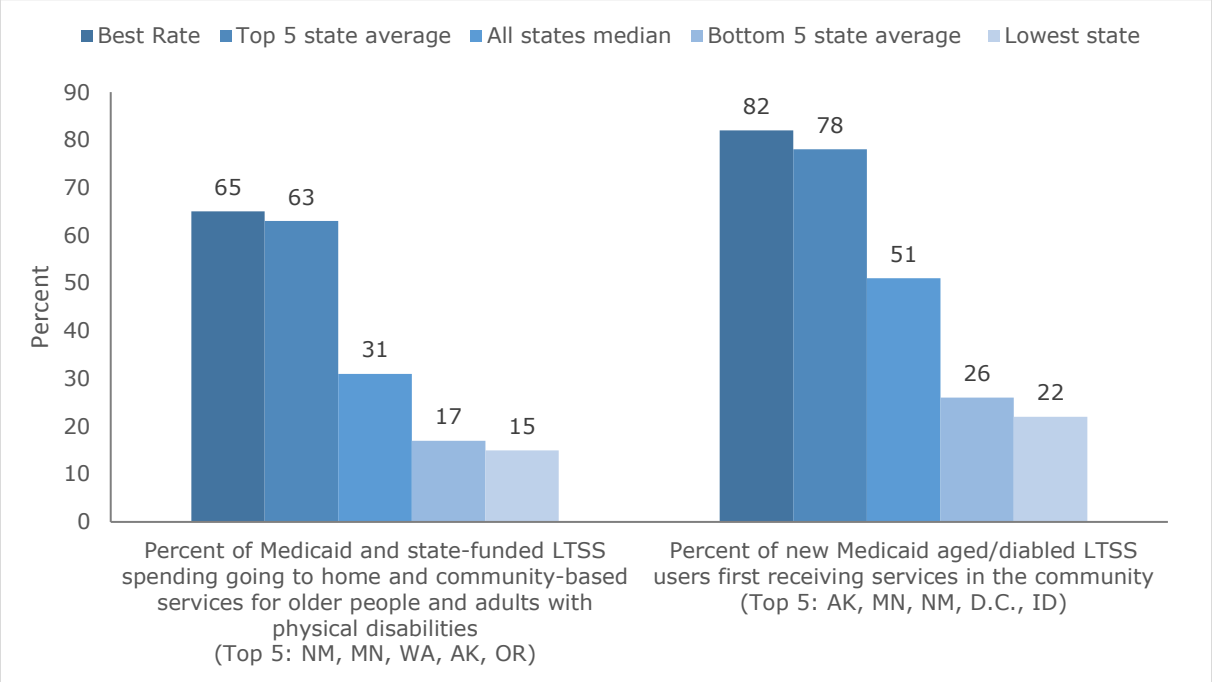


In the AARP's annual report for 2014, *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, New Mexico ranks first in the nation for

[10] Source: Mercer calculation based on MCO encounter data.
[11] Source: Ad hoc report developed by Mercer that analyzes distribution of member months for NF vs. community benefit. Note that Deloitte did not review the underlying data report that supports this exhibit.

spending more than 65 percent of its long-term care dollars on home and community-based services, as seen in Exhibit 4.b/5.b below.

Exhibit 4.b/5.b – National Ranking of New Mexico's HCBS Spending as a Percentage of LTSS Spending and Percentage of New Medicaid Users First Receiving Services in the Community



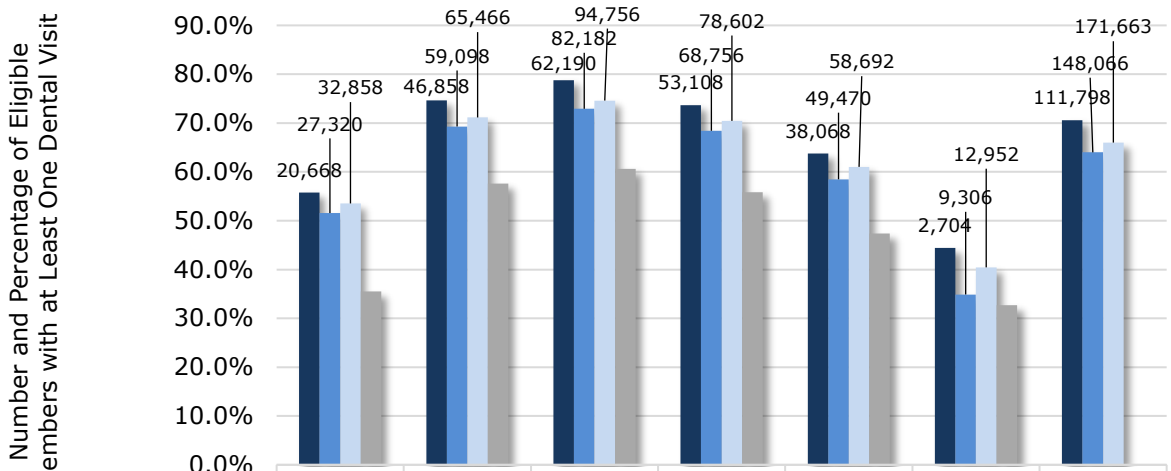
Measure 6 – Number and percentage of people with annual dental visit.

Exhibit 6 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the Number and Percentage of Members with an Annual Dental Visit. As illustrated, the aggregate rate has declined from 70.6% in the baseline to 66.0% in DY2 (a 6.5% change) which was statistically significant at the 95% confidence level. However, the most recent year-over-year change for the Centennial Care program resulted in a 3.1% increase from DY1 to DY2, which also was statistically significant at the 95% confidence level.

The largest change from DY1 to DY2 among the age cohorts was a 15.9% increase experienced by the adult cohort, ages 19-21. The adult cohort also experienced the greatest change from the baseline to DY2 (-9.0%). All cohort and aggregate changes from both the baseline to DY2 and from DY1 to DY2 were statistically significant at the 95% confidence level.

It should be noted that while the rates across the cohorts have decreased from the baseline to DY2, the DY2 rates across all age cohorts were higher than the national averages.

Exhibit 6 – Number and Percentage of Participants with Annual Dental Visits by Age Group[12]



	2-3	4-6	7-10	11-14	15-18	19-21	Total
2013 Baseline	55.7%	74.6%	78.7%	73.6%	63.8%	44.4%	70.6%
DY1 Centennial Care	51.6%	69.3%	72.9%	68.4%	58.5%	34.9%	64.0%
DY2 Centennial Care	53.5%	71.1%	74.6%	70.4%	61.0%	40.4%	66.0%
2015 National Avg	35.5%	57.6%	60.6%	55.8%	47.4%	32.7%	48.3%

[12] Source: MCO annual HEDIS reports for 2013 – 2015.

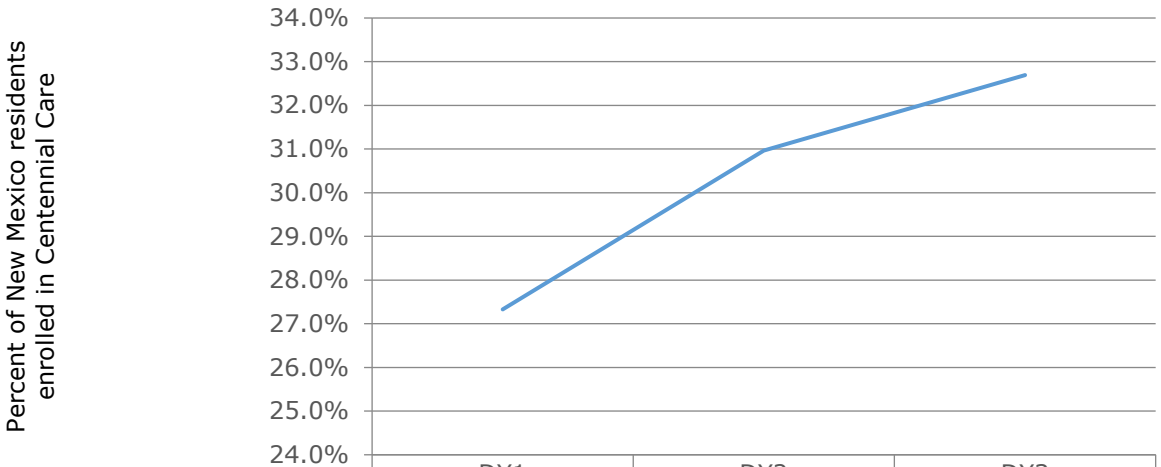
Measure 7 – Enrollment in Centennial Care as a percentage of state population.

Exhibit 7 presents rates for DY1, DY2, and DY3 for the percentage of the population enrolled in Centennial Care.

As illustrated, the percentage of New Mexicans enrolled in Centennial Care has increased from DY2 to DY3 by 5.6%. This year-over-year increase is consistent with trends since the program's inception, and the total program-to-date increase from DY1 to DY3 was 19.6% which was a statistically significant change.

A national comparison rate could not be identified for this measure.

Exhibit 7 – Percentage of State Population Enrolled in Centennial Care[13]



	DY1	DY2	DY3
Percentage of the population enrolled	27.3%	31.0%	32.7%

[13] Source: Mercer Dashboard reports for Centennial Care enrollment and United States Census Bureau annual state level population estimates.

Measure 8 – Number of Native Americans opting-in and opting-out of Centennial Care.

Exhibit 8 presents rates for DY1, DY2, and DY3 for the Number of Native Americans that Opt-out of Centennial Care.

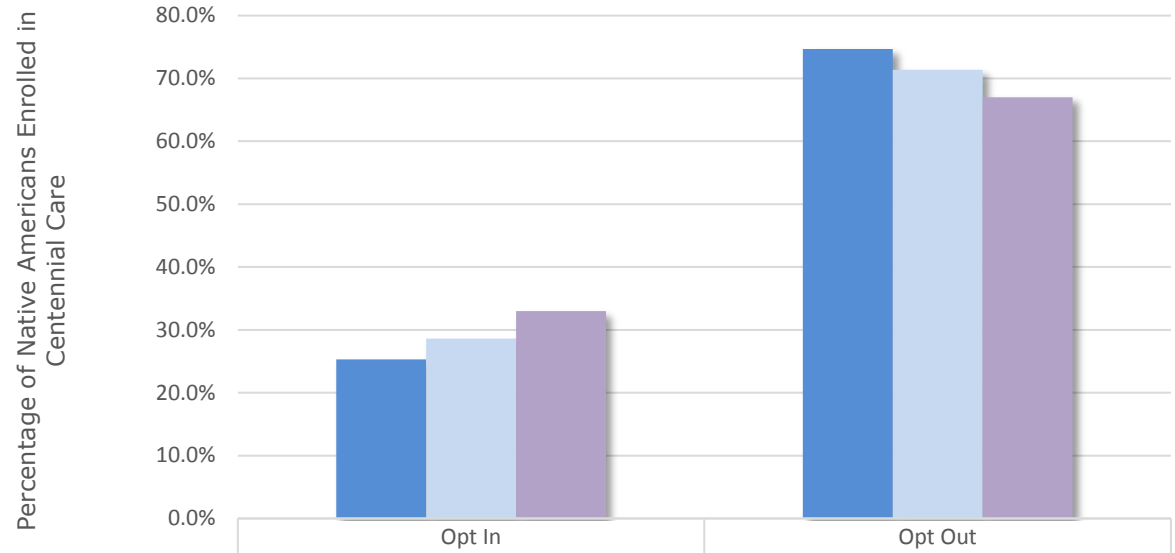
As illustrated, Native Americans' preference for Centennial Care grew as the opt-out rate declined from 71.4% to 67.0%, while the rate at which Native Americans opted-in increased from 28.6% to 33.0% from DY2 to DY3.

The change since Centennial Care's inception demonstrates a consistent story, as the rate at which Native Americans opted-in increased from 25.3% to 33.0% from DY1 to DY3. The opt-out rate dropped from 74.7% to 67.0% over the same period.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

A national comparison rate could not be identified for this measure.

Exhibit 8 – Percentage of Native Americans Opting-In and Opting-Out of Centennial Care[14]



	Opt In	Opt Out
DY1 Centennial Care	25.3%	74.7%
DY2 Centennial Care	28.6%	71.4%
DY3 Centennial Care	33.0%	67.0%

[14] Source: Native American Opt In reports for 2014 – 2016.

Measure 10 – Number and percentage of participants with BH conditions who accessed any of the three new BH services (BH respite, family support, and recovery).

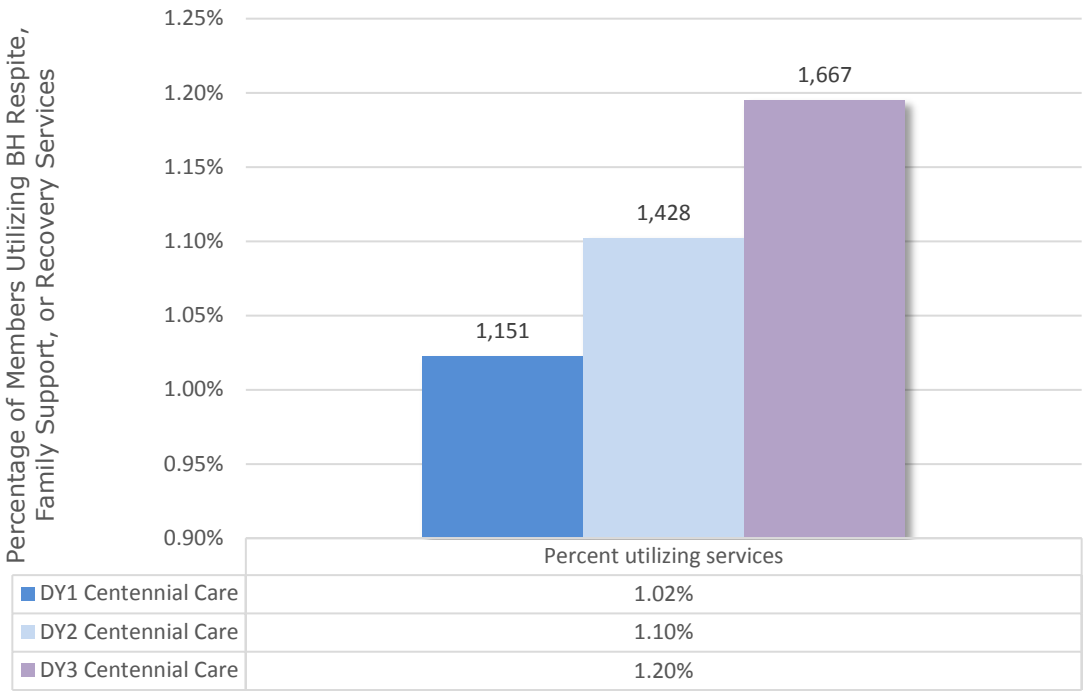
Exhibit 10 presents rates for DY1, DY2, and DY3 for the utilization of new BH services. The three new services were not fully operational in DY1 and DY2 and there are several considerations with respect to the results:

- The Family Support Services were not launched during this review period as the Family Certification program was being built to train qualified staff. In DY4, the certification will begin in January 2018 for families of children and for families of adults. The existing Certified Peer Support Worker certification will include a specialty training on providing this service.
- BH respite care is only available for parents of youth and there were instances of miscommunication among providers about existing respite services within the Community Benefit program compared to the new behavioral health respite.
- The Recovery Services were launched in 2014 in the group setting only and providers did not find it useful. In DY4, these services will be available individually for adults.

As illustrated, utilization of the new services increased from 1.10% in DY2 to 1.20% in DY3 (a change of 8.43%), which was not statistically significant. Year-over-year increases in the utilization of these services has been a consistent trend since the inception of Centennial Care, and the program-to-date increase from 1.02% in DY1 to 1.20% in DY3 (a 16.90% change), which was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 10 – Members Utilizing BH Respite, Family Support, and Recovery Services[15]



[15] Source: BH Clients with Respite, Family Support, Recovery Services MMIS reports for 2014 – 2016.

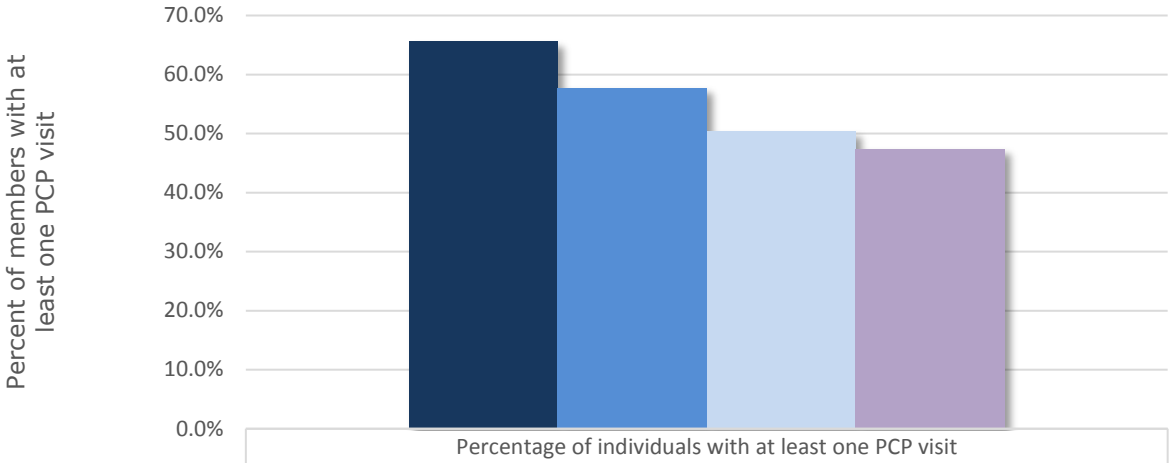
Measure 11 – Number and percentage of unduplicated participants with at least one PCP visit.

Exhibit 11 presents rates for DY1, DY2, and DY3 for the Access to PCP measure.

As illustrated, the percentage of members with at least one PCP visit declined from 50.4% in DY2 to 47.4% in DY3 (a 5.8% change), which was not statistically significant. This measure has demonstrated consistent decline for each year measured, and the total decline from 65.5% in the baseline to 47.4% in DY3, a 27.7% change. This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 11 – Percentage of Members with at Least One PCP Visit[16]



	Percentage of individuals with at least one PCP visit
2013 Baseline	65.5%
DY1 Centennial Care	57.6%
DY2 Centennial Care	50.4%
DY3 Centennial Care	47.4%

[16] Source: PCP Visits MMIS reports for 2014 – 2016.

Measure 12 – Number/ratio of participating providers to enrollees.

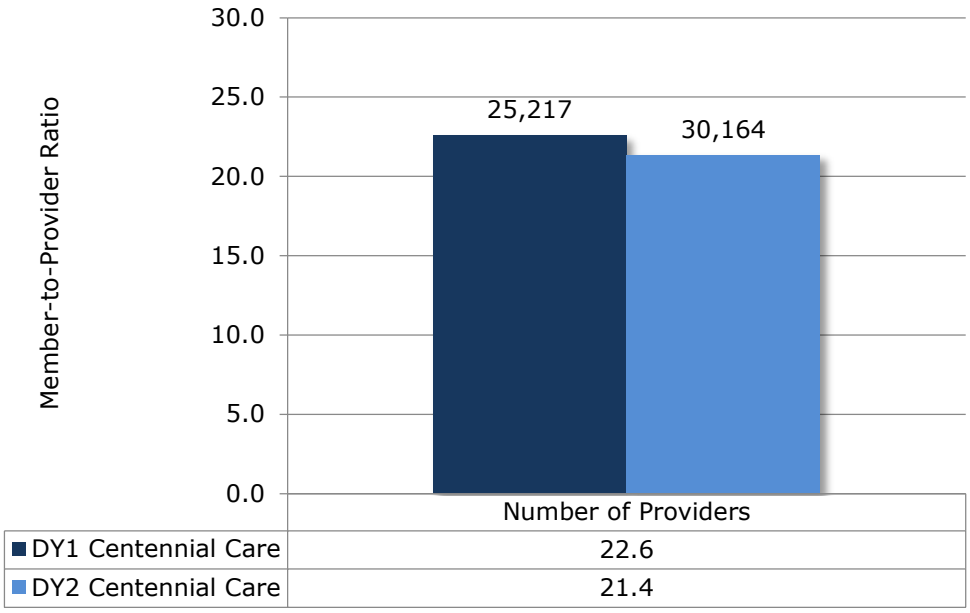
Exhibit 12 presents results for DY1 and DY2 for the number and ratio of providers to members. This measure was not reported previously due to the data source and reporting methodology undergoing refinements.

As illustrated, the ratio of providers to members experienced a favorable decrease from 22.6 in DY1 to 21.4 in DY2 (a 5.4% change). This decrease in the ratio was driven by a 19.6% increase in the number of providers participating in Centennial Care, which increased from approximately 25K in DY1 to approximately 30K in DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the timing that the data was made available for analysis.

Exhibit 12 – Number/Ratio of Participating Provider to Members



Measure 13 – Percentage of primary care providers with open panels.

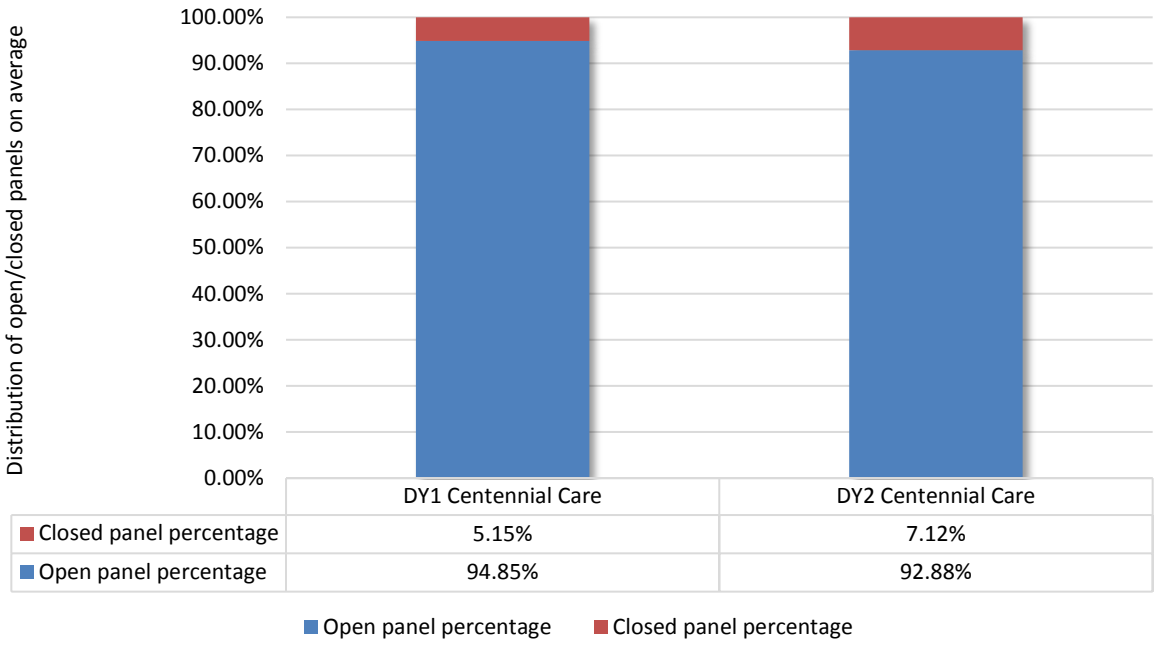
Exhibit 13 presents rates for DY1 and DY2 for PCPs with Open Panels. As illustrated, the percentage of open panels declined by 2.1% from DY1 to DY2. Conversely, the number of closed panels increased by 38.1% in this same interval. Despite these changes, the overall percentage of open panels remained above 90.0% and the percentage of closed panels remained below 10.0% for both years.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests relatively consistent results for both subcomponents as seen in DY1 and DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 13 – Percent of PCPs by Open/Closed Panel Status[17]



[17] Source: MCO reports for 2014 – 2015 (HSD 3).

Research Question 1.B

Is access to care timely under Centennial Care?

The Evaluation is reviewing Centennial Care's impact on timely access to care through the analysis of 14 performance measures that specifically address geographic access to PCPs, adult, child, and adolescent preventive health/wellness services, prenatal and postpartum care, and follow-up after BH and Residential Treatment Center (RTC) services. For each measure, performance is tracked over time against a baseline value as well as on an annual basis. Overall through DY2 of Centennial Care, programmatic performance varied across performance measures.

Although the MCO geographic-based data showed very high percentage of members with access to PCPs in all county types (urban, rural and frontier), the member to PCP ratios increased from DY1 to DY2 especially in the rural and frontier counties. It is important to note that the large increase in the percentage of the state population enrolled in Centennial Care may have contributed to the increase in member to PCP ratio; and may have contributed to the lower percentage of members with at least one PCP visit and rates of other screenings and immunizations that are generally checked and provided during an annual PCP visit.

The only measure that demonstrated clear improvement was flu vaccination rates for adults, and emerging DY3 experience suggests consistent performance results as DY2.

Plan by plan comparisons were examined in place of aggregate rates for the measure Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life due to differences in data reporting methodologies across MCOs. Performance trends varied by MCOs for this measure. Additionally, the measures Initiation and Engagement of Alcohol and Other Drug Dependence Treatment showed mixed results as certain subcomponents improved while others declined.

Ten of the 14 measures showed decline in performance. Rates decreased for timely follow-up after leaving an RTC, timely follow-up after hospitalization for mental illness, childhood immunization, immunization for adolescents, adolescent well care visits (three of the four MCOs), timely prenatal and postpartum care, breast cancer screening for women, and cervical cancer screening for women. In addition, there were observed shifts from the highest frequency to lower frequencies of visits for Well-Child Visits in First Month of Life and Frequency of Ongoing Prenatal Care, which also indicate decline in performance.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 14 – Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC).

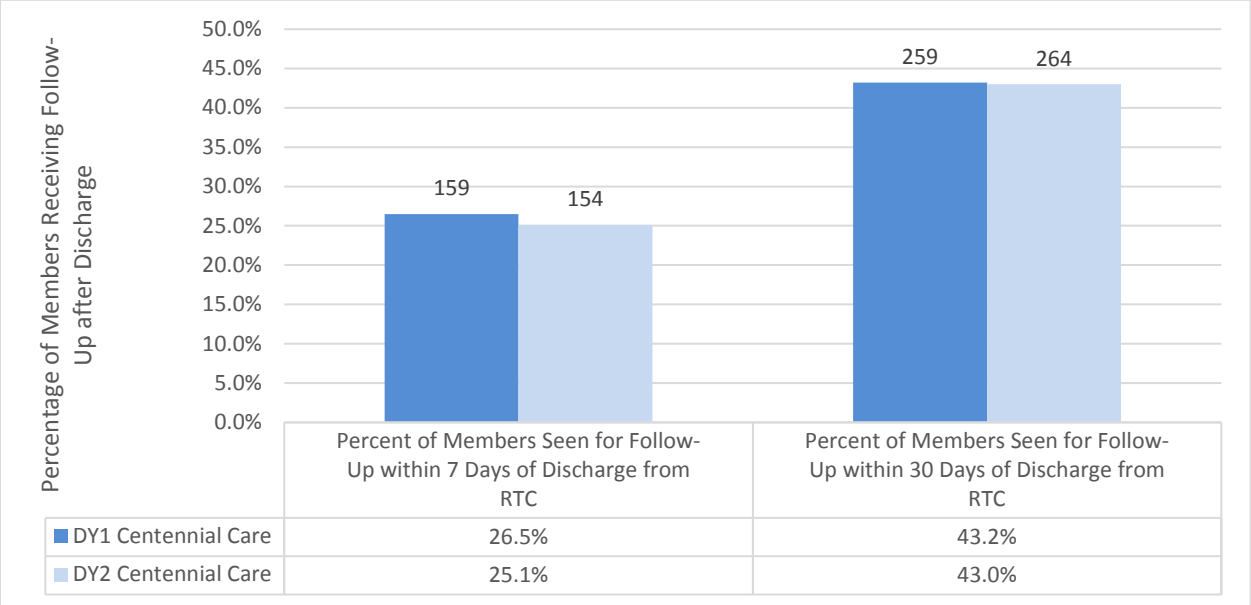
Exhibit 14 presents results for DY1 and DY2 for the Number and Percentage of Substance Use Disorder Participants with Follow-up 7 and 30 Days after leaving a RTC. RTCs serve the youth population under age 21 who are enrolled in Centennial Care.

As illustrated, the percentage of members with follow-up care after an RTC visit declined slightly for both the 7-day and 30-day subcomponents from DY1 to DY2. The 7-day follow-up percentage declined from 26.5% in DY1 to 25.1% in DY2 (a 5.2% change), and the 30-day follow-up rate declined from 43.2% in DY1 to 43.0% in DY2 (a 0.3% change). Neither of these changes were statistically significant.

Upon review of individual MCO performance of the 7-day follow-up subcomponent during the same period, MHC experienced the largest increase (82.8%) followed by UHC (40.3%), BCBS (-15.8%), and PHP (-37.0%). For the 30-day follow-up subcomponent, MHC experienced the largest increase (86.3%), followed by UHC (2.5%), BCBS (-11.7%), and PHP (-26.3%).

A national comparison could not be identified for this measure.

Exhibit 14 – Number and Percentage of Centennial Care Members Seen for a Follow-up with 7 and 30 Days after Discharge from an RTC[18]



	Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC
DY1 Centennial Care	26.5%	43.2%
DY2 Centennial Care	25.1%	43.0%

[18] Source: MCO reports for 2014 – 2015 (HSD 5).

Measure 15 – Number and percentage of BH participants with follow-up after hospitalization for mental illness.

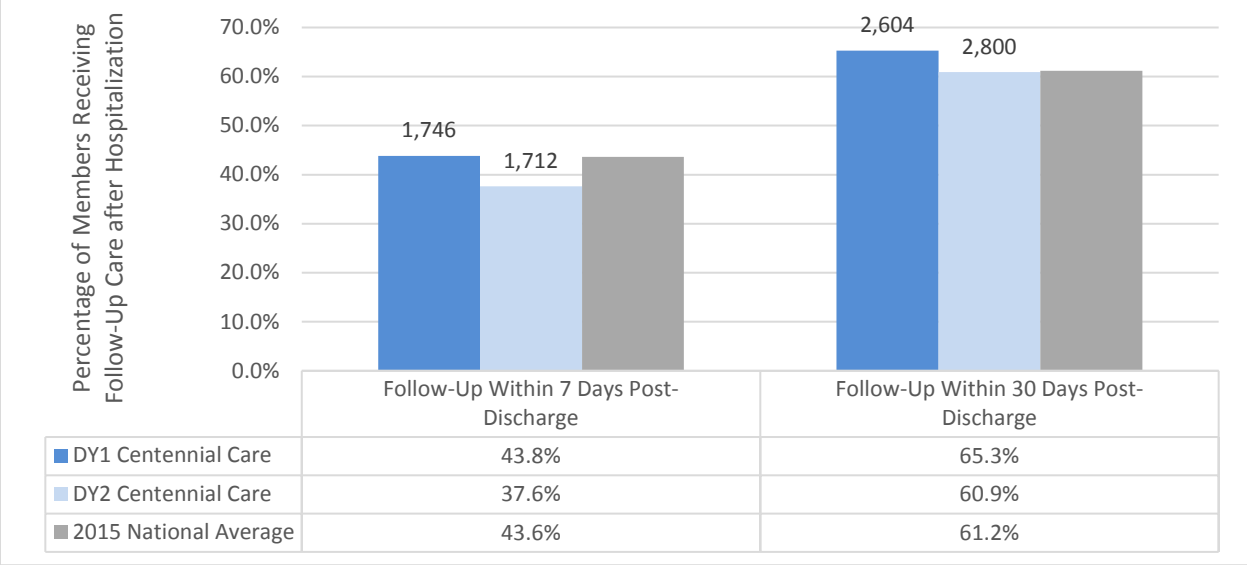
Exhibit 15 presents results for the percentage of members who were discharged after a hospitalization for mental illness and seen for follow-up care within 7 days and 30 days for DY1, DY2, and 2015 HEDIS Medicaid national averages.

As illustrated, the percentage of adults and children that had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days and 30 days after their discharge declined (-14.2% and -6.9%, respectively) from DY1 to DY2. Both declines were statistically significant at the 95% confidence level. It is worth noting that the DY2 rate for a follow-up within 30 days subcomponent is within 0.3% of the 2015 national average rate.

The declines can largely be attributed to gaps in network coverage that occurred throughout DY2 with the closure of 7 BH provider locations in March, which impacted 2,357 members being served, and an additional closure of 12 BH provider locations in May, which impacted 3,567 members being served.

After the exit of these providers, HSD worked with the MCOs to close the network gap and rebuild the program services. Many members were moved to FQHCs which required additional certifications to administer the specialized BH services, and this delay may be a driver of the decreases that occurred from DY1 to DY2.

Exhibit 15 – Number and Percentage of Participants with Follow-up after Hospitalization for Mental Illness[19]



	Follow-Up Within 7 Days Post-Discharge	Follow-Up Within 30 Days Post-Discharge
DY1 Centennial Care	43.8%	65.3%
DY2 Centennial Care	37.6%	60.9%
2015 National Average	43.6%	61.2%

[19] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 16 – Childhood immunization status.

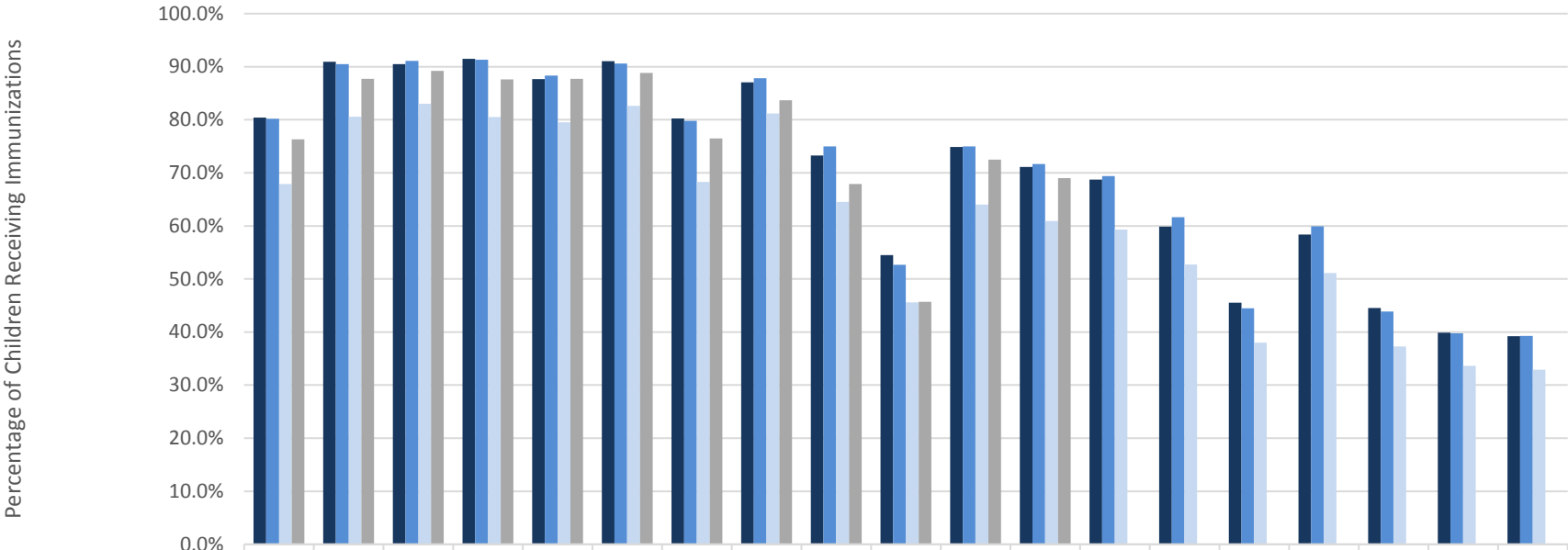
Exhibit 16 presents rates for the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national averages for the 19 subcomponent rates and the aggregate rate for the Childhood Immunization Status measure. The evaluation provides results for 10 vaccines and 9 separate combination rates for three out of the four plans in the baseline and all four plans in DY1 and DY2.[20]

As the exhibit illustrates, rates for all 19 subcomponents declined from DY1 to DY2. The rate of decline across all subcomponents ranged from 7.5% to 16.1% and all declines in the rates were statistically significant at the 95% confidence level. Similarly, the rates for all 19 subcomponents declined from the baseline to DY2. The rate of decline ranged from 6.7% to 16.5% and all declines were statistically significant at the 95% confidence level. Additionally, all subcomponent rates for DY2 were below the corresponding 2015 national averages.

MHC experienced drops in all measures from the baseline to DY2, while other plans experienced varied results. However, not all changes from the baseline to DY2 for the individual plans (increases and declines) were statistically significant at the 95% confidence level. See Appendix C for more details regarding statistical significance for this measure.

[20] UHC reported "Not Reportable" (NR) in the baseline.

Exhibit 16 – Childhood Immunization Status[21]



	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	Rotavirus	Influenza	Combo 2	Combo 3	Combo 4	Combo 5	Combo 6	Combo 7	Combo 8	Combo 9	Combo 10
2013 Baseline	80.4%	90.9%	90.5%	91.5%	87.6%	91.0%	80.2%	87.1%	73.3%	54.5%	74.9%	71.1%	68.7%	59.9%	45.5%	58.4%	44.5%	39.9%	39.2%
DY1 Centennial Care	80.2%	90.5%	91.1%	91.3%	88.4%	90.6%	79.8%	87.9%	75.0%	52.7%	75.0%	71.7%	69.4%	61.6%	44.5%	59.9%	43.9%	39.8%	39.3%
DY2 Centennial Care	67.9%	80.6%	83.0%	80.5%	79.5%	82.6%	68.3%	81.2%	64.5%	45.6%	64.0%	60.9%	59.3%	52.7%	38.0%	51.1%	37.3%	33.6%	32.9%
2015 National Average	76.3%	87.7%	89.2%	87.6%	87.7%	88.8%	76.5%	83.7%	67.9%	45.7%	72.5%	69.0%							

[21] Source: MCO annual HEDIS reports for 2013-2015.

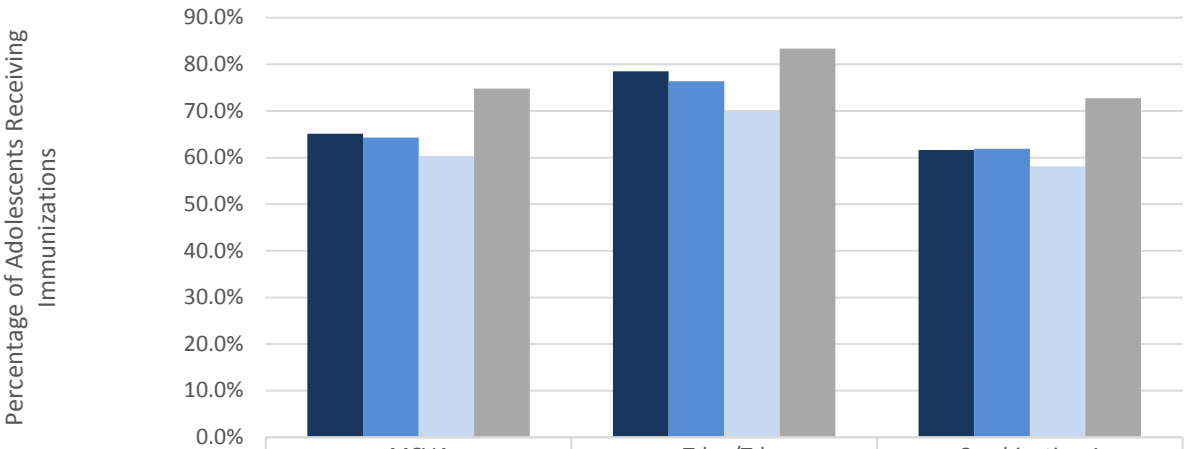
Measure 17 – Immunizations for Adolescents.

Exhibit 17.a presents rates for Immunizations for Adolescents for three plans the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national averages. The rates declined from DY1 to DY2 for meningococcal (MCV4), Tdap/Td, and the combined vaccine (Combination 1) by 6.3%, 8.6%, and 6.2% respectively. Only the 8.6% decline for Tdap/Td was statistically significant at the 95% confidence level.

Statistically significant drops in immunization rates for meningococcal (MCV4) vaccine (-7.3%) and Tdap/Td vaccines (-11.1%) occurred from the baseline to DY2. Combination 1 vaccination rates also declined from the baseline to DY2, but the change was not statistically significant.

The DY2 rates for all three subcomponents of immunizations were below the 2015 national average rates as depicted by Exhibit 17.a.

Exhibit 17.a – Immunizations for Adolescents (Three-Plan Aggregate)[22]

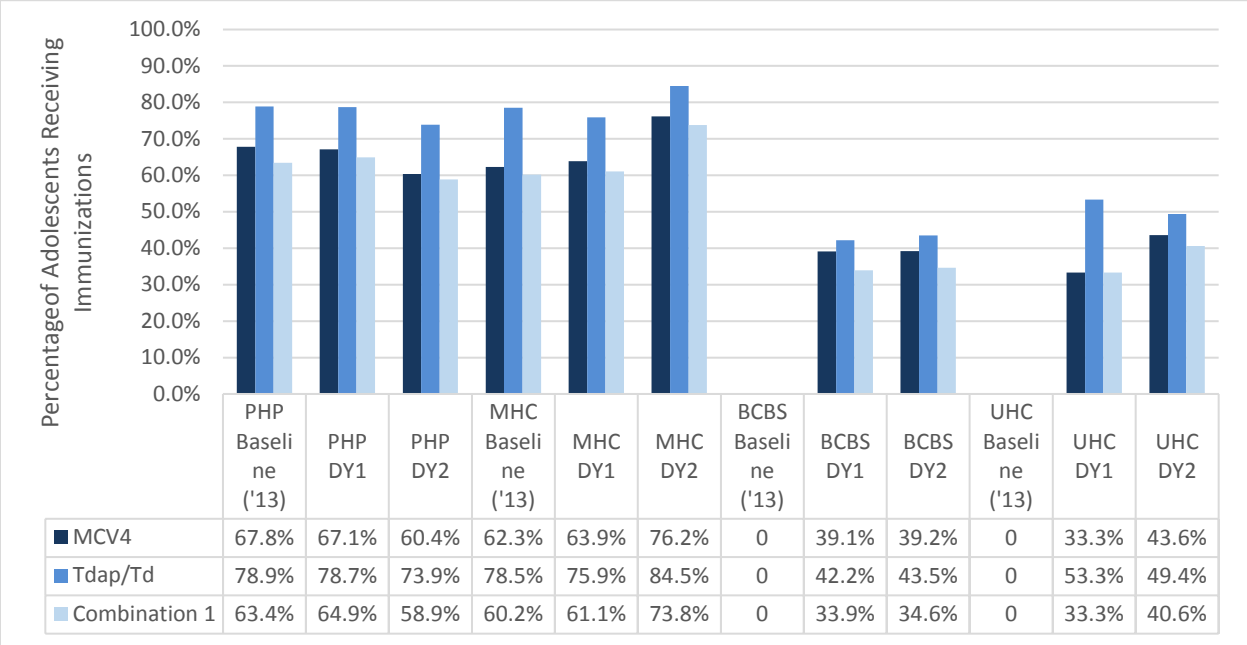


	MCV4	Tdap/Td	Combination 1
2013 Baseline	65.1%	78.5%	61.6%
DY1 Centennial Care	64.3%	76.4%	61.9%
DY2 Centennial Care	60.3%	69.8%	58.1%
2015 National Average	74.8%	83.4%	72.7%

Because of the inability to provide a four-plan aggregate rate, the evaluation also considered individual performance by each MCO across the three subcomponents of Immunizations for Adolescents. As illustrated in Exhibit 17.b, MHC experienced statistically significant increases in rates from the baseline to DY2 for MCV4 (22.3%), Tdap/Td (0.9%), and Combination 1 (22.7%), while PHP experienced slight drops in all subcomponents, although only the decline for MCV4 (-10.9%) was statistically significant at the 95% confidence level. Because UHC and BCBS did not report rates in the baseline, longitudinal comparison from the baseline to DY2 was not evaluated.

[22] Source: MCO annual HEDIS reports for 2013 – 2015. BCBS reported using the administrative method of data collection for all years while the other plans used the hybrid method. Therefore, BCBS was excluded from the aggregate results in all years. UHC did not report individually in the baseline due to a low denominator but their numerator and denominator results were included in the aggregate display.

Exhibit 17.b – Immunizations for Adolescents (Plan by Plan Rate)[23]



	PHP Baseline ('13)	PHP DY1	PHP DY2	MHC Baseline ('13)	MHC DY1	MHC DY2	BCBS Baseline ('13)	BCBS DY1	BCBS DY2	UHC Baseline ('13)	UHC DY1	UHC DY2
MCV4	67.8%	67.1%	60.4%	62.3%	63.9%	76.2%	0	39.1%	39.2%	0	33.3%	43.6%
Tdap/Td	78.9%	78.7%	73.9%	78.5%	75.9%	84.5%	0	42.2%	43.5%	0	53.3%	49.4%
Combination 1	63.4%	64.9%	58.9%	60.2%	61.1%	73.8%	0	33.9%	34.6%	0	33.3%	40.6%

[23] Source: MCO annual HEDIS reports for 2013 – 2015.

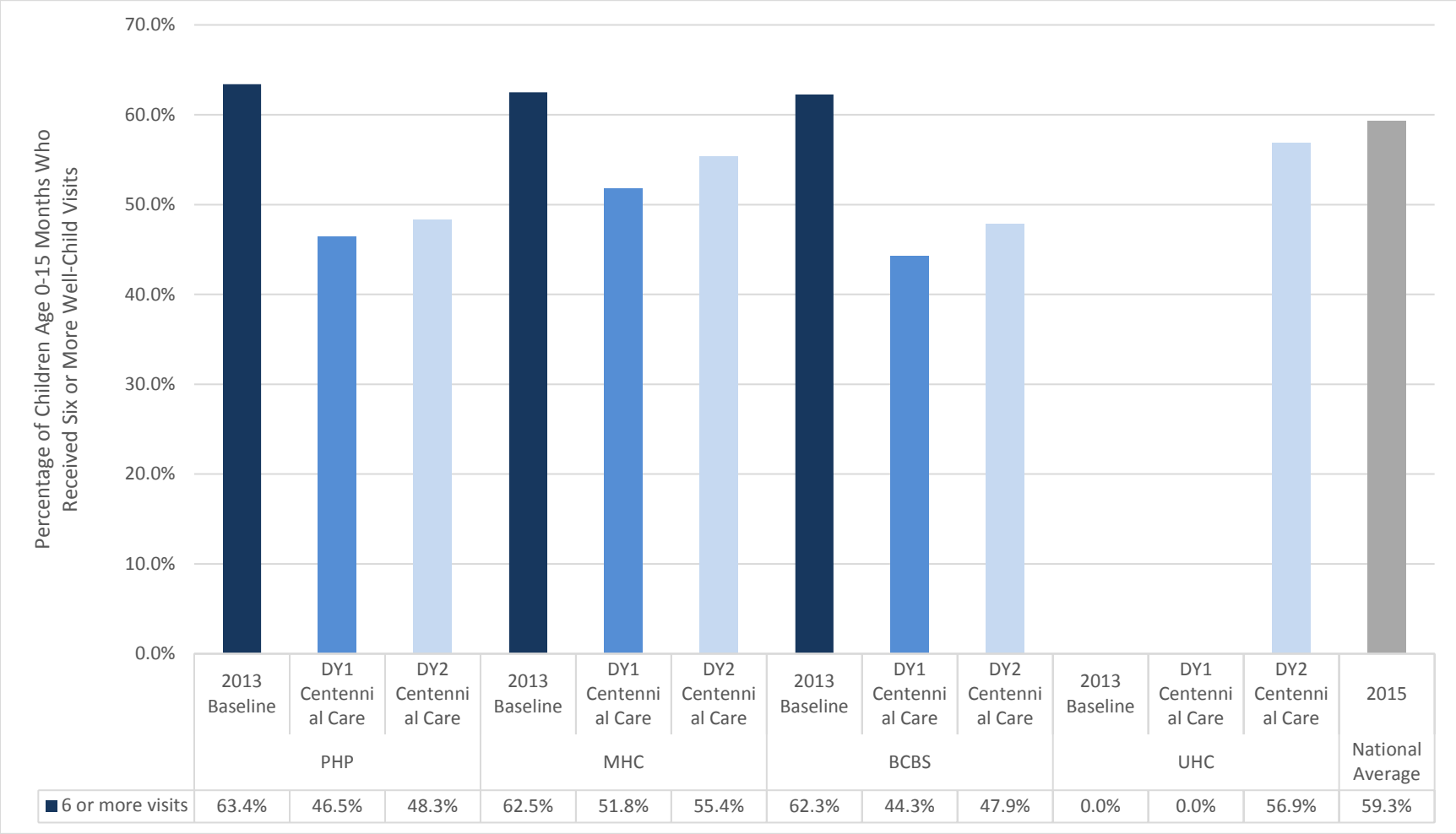
Measure 18 – Well-Child visits in first 15 months of life.

Exhibit 18 presents rates of six or more Well-Child Visits in First 15 Months of Life on seven subcomponents reporting the frequency of visits received by children 15 months and younger during the measurement year, from zero visits to six or more. The Evaluation considered rates for the four MCOs on an individual basis; because of the varied methodologies plans used to report rates, an aggregate rate was not assessed. The 2015 HEDIS Medicaid national average[24] for six or more visits was also included in Exhibit 18 for comparison purposes.

When evaluating plan-by-plan performance, all Centennial Care MCOs that reported experienced an improvement in the rate of six or more well-child visits from DY1 to DY2. However, all MCOs that reported experienced statistically significant declines from the baseline to DY1 and DY2.

[24] NCQA Quality Compass National Average for all lines of business provided by HSD

Exhibit 18 – Well-Child Visits in First 15 Months of Life (Plan-by-Plan Rates)[25]



	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2015 National Average
	PHP			MHC			BCBS			UHC			
6 or more visits	63.4%	46.5%	48.3%	62.5%	51.8%	55.4%	62.3%	44.3%	47.9%	0.0%	0.0%	56.9%	59.3%

[25] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in the baseline and DY1; PHP and BCBS reported rates under the Administrative methodology, while MHC report rates under the Hybrid methodology in DY1 and DY2. UHC reported under the Hybrid methodology in DY2. An aggregate rate was not calculated due to the different reporting methodologies.

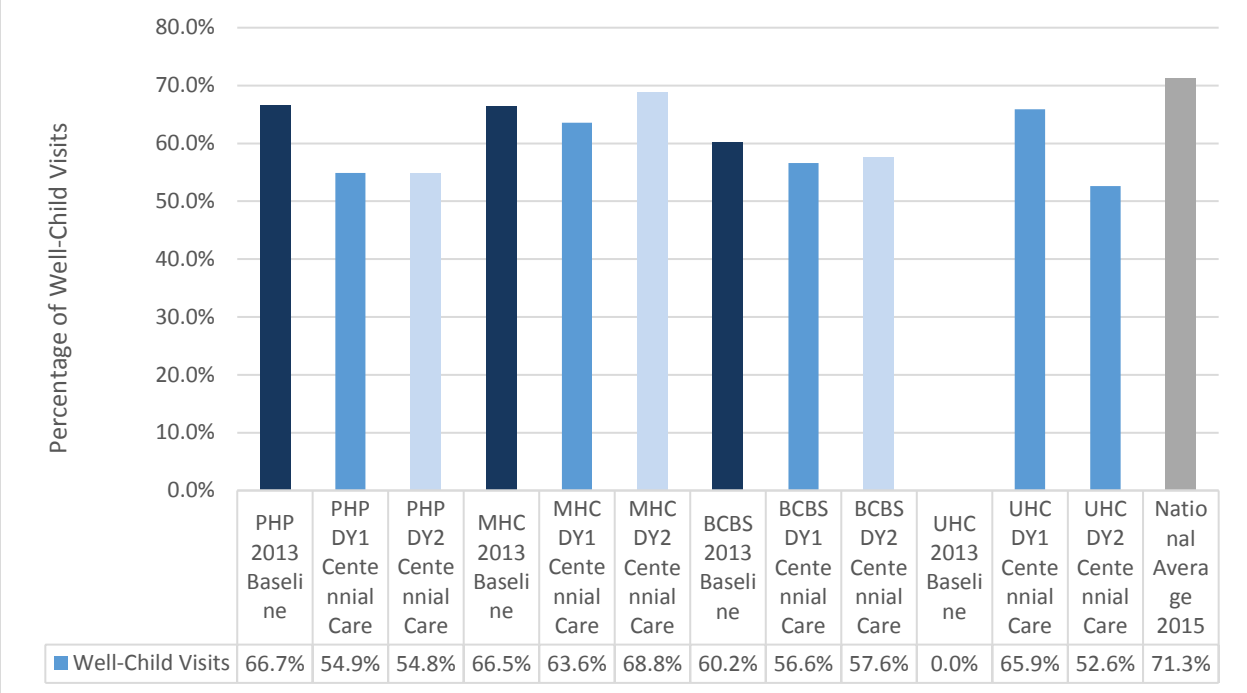
Measure 19 – Well-Child visits in third, fourth, fifth and sixth years of life.

Exhibit 19 presents rates for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life for the four Centennial Care MCOs from the baseline to DY2 as well as the 2015 HEDIS Medicaid national average. The Evaluation considered rates for the four MCOs on an individual basis; because of the varied methodologies plans used to report rates, an aggregate rate was not assessed.

As the exhibit below shows, MCO performance over time varied. For example, the three plans that reported baseline rates experienced declines from the baseline to DY1 ranging from 4.4% to 17.6% (only the 17.6% decline was statistically significant at the 95% confidence level). In DY2, two of the four plans experienced increases in the rate of visits from DY1. MHC experienced an 8.2% increase and BCBS a 1.7% increase; however, PHP and UHC both experienced declines of 0.2% and 20.3%, respectively. The UHC rate of change was statistically significant at the 95% confidence level. All MCOs fell below the 2015 national average of 71.3% in DY2.

Only PHP experienced a change in the rate of visits from the baseline to DY2 that was statistically significant at the 95% confidence level (-17.8%). The slight increase by MHC and decrease by BCBS during the same period were not statistically significant.

Exhibit 19 – Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life (Plan-by-Plan Rates)[26]



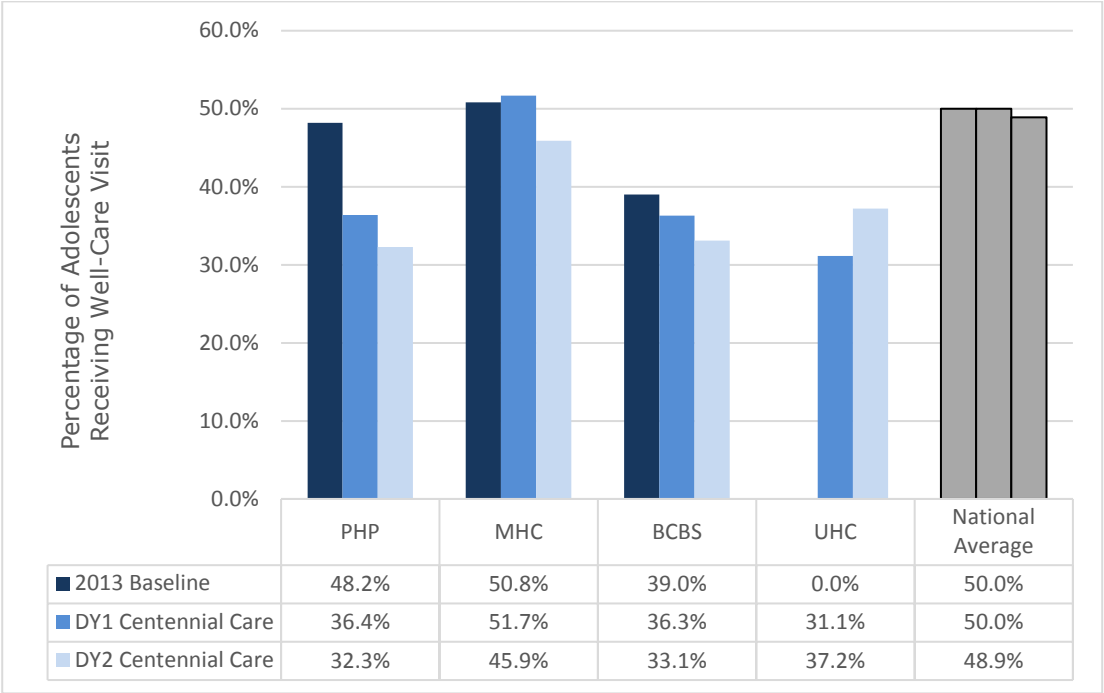
[26] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in the baseline. PHP and BCBS reported rates under the Administrative methodology in DY1 and DY2, while MHC report rates under the Hybrid methodology in DY1 and DY2. UHC reported under the Hybrid methodology in DY2. An aggregate rate was not calculated due to the different reporting methodologies.

Measure 20 – Adolescent well care visits.

Exhibit 20 presents rates for adolescents receiving at least one well care visits with a primary care practitioner or an OB/GYN practitioner during the measurement year for the 2013 baseline, DY1, DY2. The Evaluation considered rates for the four MCOs on an individual basis; an aggregate rate was not assessed because of the varied methodologies plans used to report rates. The HEDIS Medicaid national averages for 2013, 2014, and 2015 were also included in Exhibit 20 for comparison purposes.

The performance of the Centennial Care MCOs on adolescent well care visits has been historically below the Medicaid national average, which hovers around 50.0%. The 2015 national average of 48.9% is depicted in the graph below. PHP and BCBS experienced consistent declines in adolescent well care visits from the baseline to DY1 and again from DY1 to DY2, both of which were statistically significant at the 95% confidence level. This resulted in a 33.0% decline from the baseline to DY2 for PHP and a 15.2% decline for BCBS. MHC had a slight increase from the baseline to DY1 and then experienced an 11.1% decline from DY1 to DY2, but neither was statistically significant. UHC did not report a rate in the baseline, but experienced a 19.5% increase in well care visits from DY1 to DY2, although it was not statistically significant.

Exhibit 20 – Adolescent Well Care Visits[27]



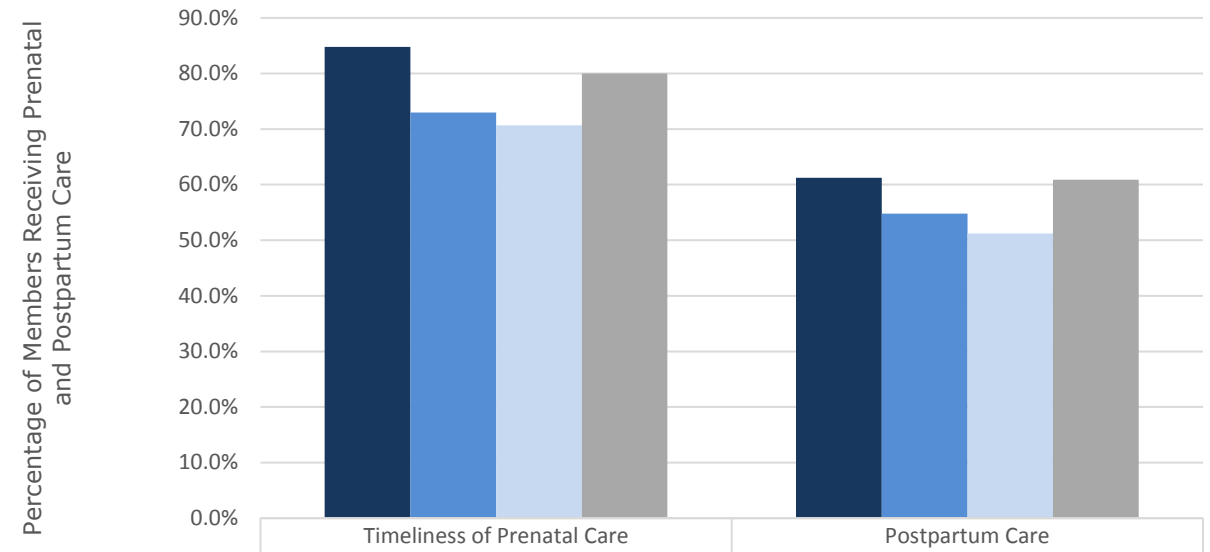
	PHP	MHC	BCBS	UHC	National Average
2013 Baseline	48.2%	50.8%	39.0%	0.0%	50.0%
DY1 Centennial Care	36.4%	51.7%	36.3%	31.1%	50.0%
DY2 Centennial Care	32.3%	45.9%	33.1%	37.2%	48.9%

[27] Source: MCO annual HEDIS reports for 2013 – 2015. UHCs' baseline denominator was less than 30, thus the rate is not included in the representation of individual MCO performance above. The non-reported rate (NR) is reflected as 0% in the graph above. PHP reported rates under the Administrative methodology in DY1 and DY2, BCBS reported under the Administrative methodology in DY1 – DY, while MHC and UHC reported under the Hybrid methodology. An aggregate rate was not calculated due to the different reporting methodologies.

Measure 21 – Prenatal and postpartum care.

Exhibit 21 presents rates of the timeliness of prenatal care and completion of postpartum care for the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national averages. As illustrated, the rates have declined year-over-year for the last three years. The most significant year-over-year decline occurred between the baseline and DY1 for both timeliness of prenatal care (-13.9%) and postpartum care (-10.5%). While rates continued to drop from DY1 to DY2, the declines were less drastic at 3.2% for timeliness of prenatal care and 6.7% for postpartum care. Overall from the baseline to DY2, timeliness of prenatal care (-16.6%) and postpartum care (-16.5%) both decreased. Each year-over-year change was statistically significant at the 95% confidence level apart from the DY1 to DY2 change for timeliness of prenatal care.

Exhibit 21 – Prenatal and Postpartum Care[28]



	Timeliness of Prenatal Care	Postpartum Care
2013 Baseline	84.8%	61.3%
DY1 Centennial Care	73.0%	54.8%
DY2 Centennial Care	70.7%	51.2%
2015 National Average	80.0%	60.9%

[28] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 22 – Frequency of ongoing prenatal care.

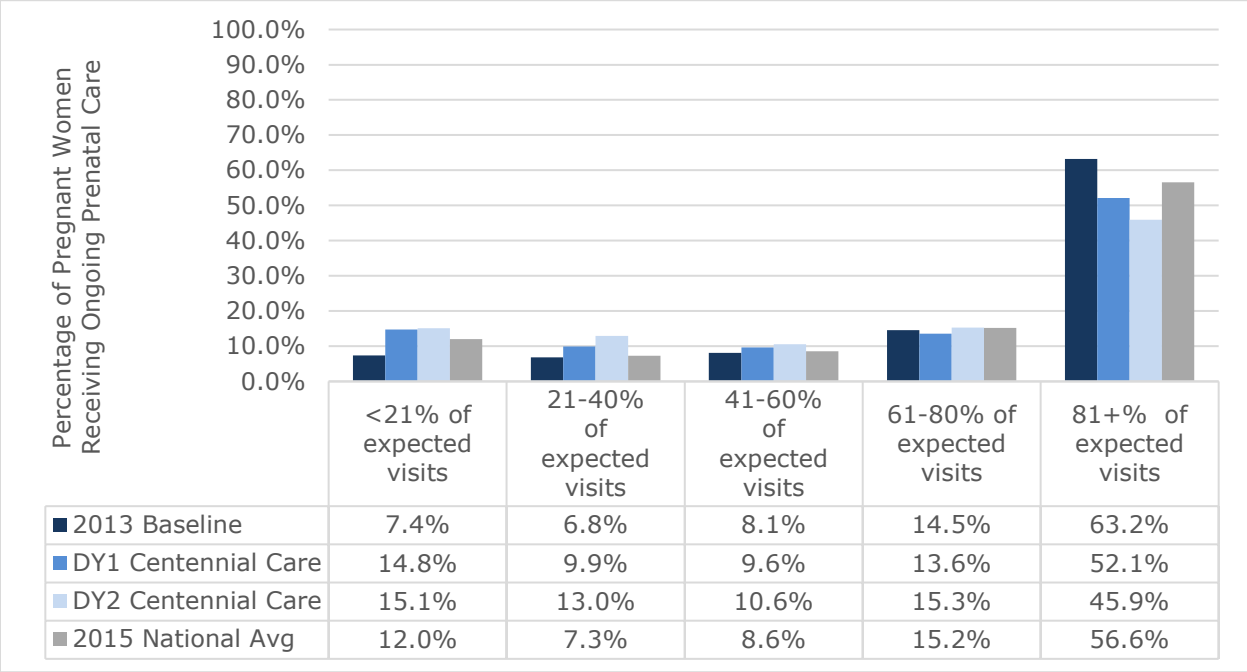
Exhibit 22 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the Frequency of Ongoing Prenatal Care measure. This measure parses the number of expected prenatal care visits into a distribution, represented by the different subcomponents. The number of expected visits are based on the recommendation that a woman with an uncomplicated pregnancy be examined every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation and weekly thereafter. Rates for members that received <21% of expected visits; 21–40% of expected visits; 41–60% of expected visits; 61–80% of expected visits; and ≥81% of expected visits were evaluated.

Three subcomponents had statistically significant rates of change from the baseline to DY1. The percentage of deliveries that received ≤21% of expected visits increased 100.1% indicating significant growth in deliveries that received less than adequate prenatal care. Deliveries that received 21-40% expected visits increased 45.2% and those received over 81% of expected prenatal visits decreased 17.6% demonstrating a shift towards less compliance with the measure from the baseline to DY1.

Performance from DY1 to DY2 showed a similar pattern toward an increase of deliveries receiving less than 80% of expected visits. The percentage of deliveries that received 21 – 40% expected visits increased 30.5%, and the percentage of deliveries that received over 81% of expected prenatal visits decreased 11.8%, both of which were statistically significant. Three subcomponents experienced increase in rates but were not statistically significant: deliveries that received under 21% (2.4%), deliveries receiving between 41 – 60% (10.5%), and deliveries receiving between 61 – 80% expected visits (12.9%).

When reviewing the experience from the baseline to DY2 holistically, there is an observed shift from the highest compliance, ≥81% of expected visits, to lower compliance rates, as members receiving <21%, 21–40%, 41-60%, and 61-80% of expected visits have increased from DY1 to DY2. The aggregate reported rate increased from the baseline to DY2 for four of the five subcomponents (excluding the ≥81% of expected visits subcomponent) and ranging from 5.7% to 104.9%. All increases apart from the 61–80% of expected visits subcomponent were statistically significant at the 95% confidence level. A statistically significant decrease of 27.3% was experienced for the subcomponent measuring ≥81% of expected visits.

Exhibit 22 – Frequency of Ongoing Prenatal Care[29]



	<21% of expected visits	21-40% of expected visits	41-60% of expected visits	61-80% of expected visits	81+% of expected visits
2013 Baseline	7.4%	6.8%	8.1%	14.5%	63.2%
DY1 Centennial Care	14.8%	9.9%	9.6%	13.6%	52.1%
DY2 Centennial Care	15.1%	13.0%	10.6%	15.3%	45.9%
2015 National Avg	12.0%	7.3%	8.6%	15.2%	56.6%

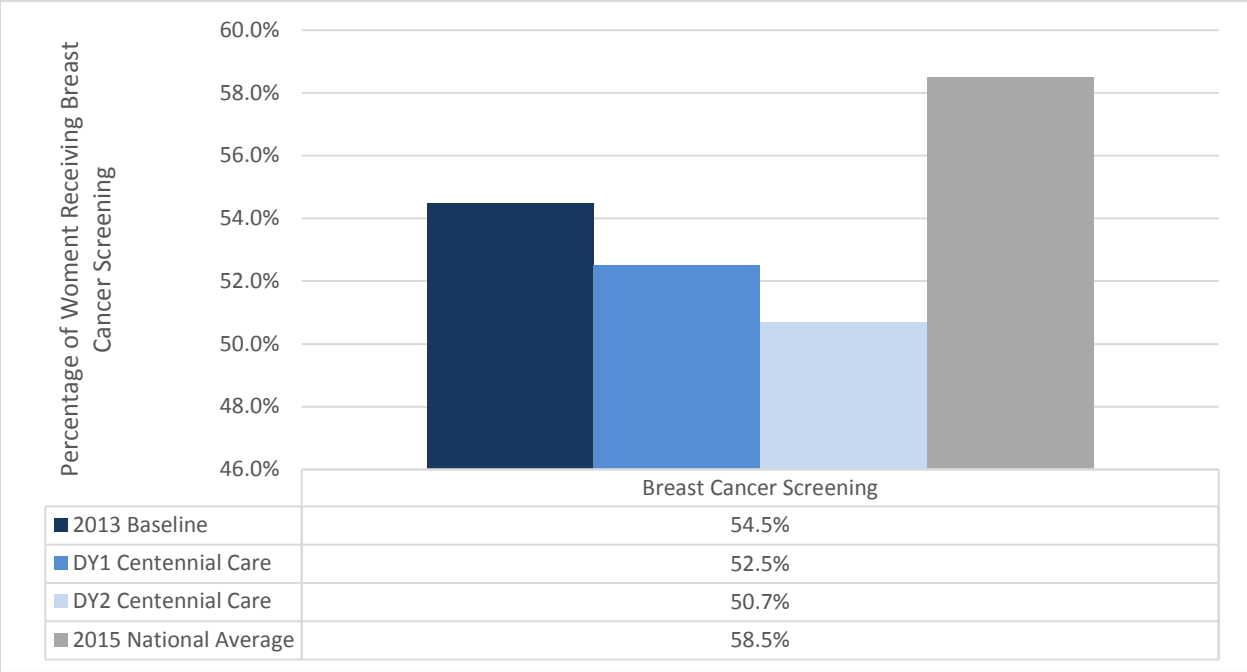
[29] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 23 – Breast cancer screening for women.

Exhibit 23 presents rates for Breast Cancer Screening for Women for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. As illustrated, there was a decline in the aggregate calculated rate from DY1 to DY2 (-3.3%) and a decline from the baseline to DY2 (-6.9%) that were statistically significant at the 95% confidence level. The DY2 rate was nearly eight percentage points below the national average.

PHP and UHC experienced sharp declines of 9.0% and 17.3%, respectively, from the baseline to DY1, which brought down the aggregate DY1 average. The DY2 aggregate average was brought down by declines in the PHP rate (-10.7%) and the MHC rate (-11.1%). These year-over-year changes were statistically significant at the 95% confidence level.

Exhibit 23 – Breast Cancer Screening for Women[30]



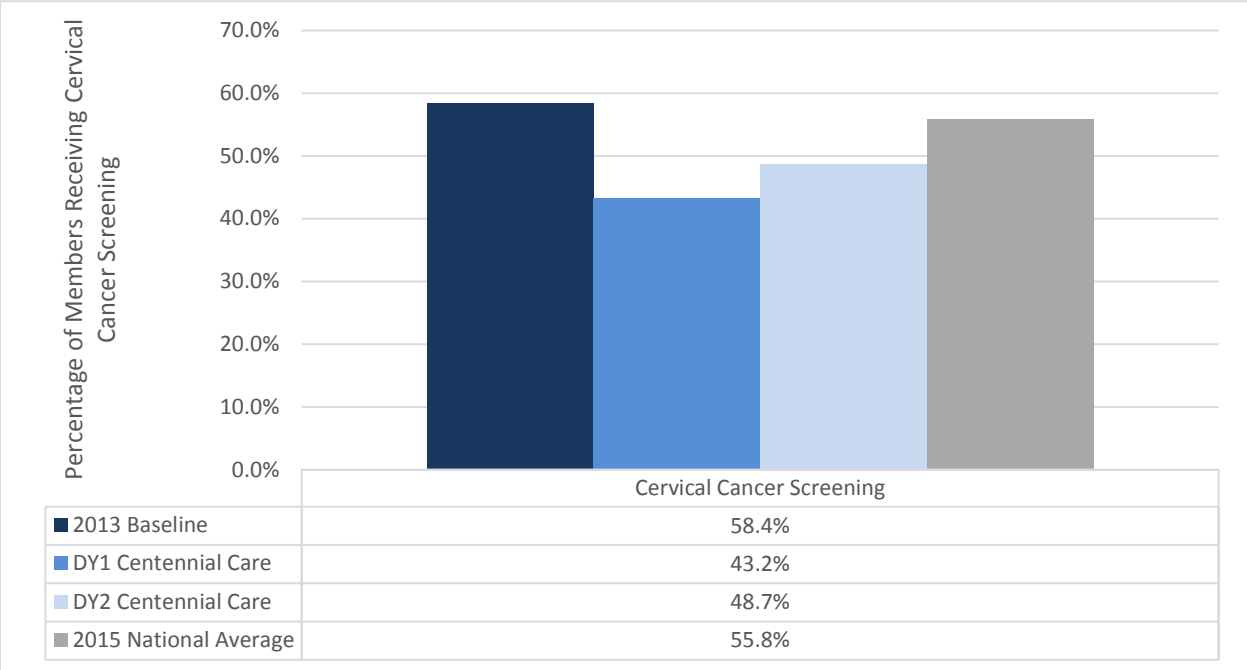
	Breast Cancer Screening
2013 Baseline	54.5%
DY1 Centennial Care	52.5%
DY2 Centennial Care	50.7%
2015 National Average	58.5%

[30] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 24 – Cervical cancer screening for women.

Exhibit 24 presents rates for Cervical Cancer Screening for Women for the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national average. As illustrated, the performance on the rate of screenings has declined from the baseline to DY2 by 16.6%, which was a statistically significant change at the 95% confidence level. It is important to note that the rate improved from DY1 to DY2 by 12.7%, which was also statistically significant and may indicate an upward trend in performance in future demonstration years.

Exhibit 24 – Cervical Cancer Screening for Women[31]



	Cervical Cancer Screening
2013 Baseline	58.4%
DY1 Centennial Care	43.2%
DY2 Centennial Care	48.7%
2015 National Average	55.8%

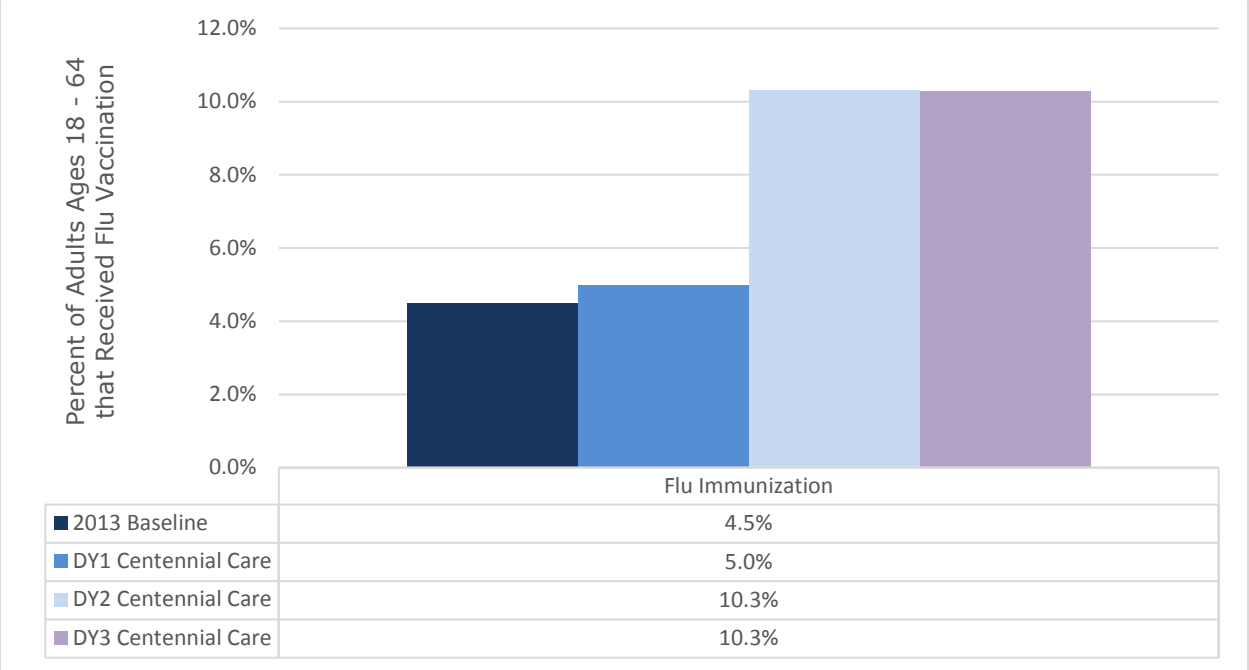
[31] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 25 – Flu vaccinations for adults.

Exhibit 25 presents results for the 2013 baseline, DY1, DY2, and DY3 of the Flu Vaccinations for Adults measure. As illustrated, the rate of immunizations was consistent from DY2 to DY3, but has increased substantially from 4.5% in the baseline to 10.3% in DY3 (a 128.7% change) which was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 25 – Flu Vaccinations for Adults[32]



	Flu Immunization
2013 Baseline	4.5%
DY1 Centennial Care	5.0%
DY2 Centennial Care	10.3%
DY3 Centennial Care	10.3%

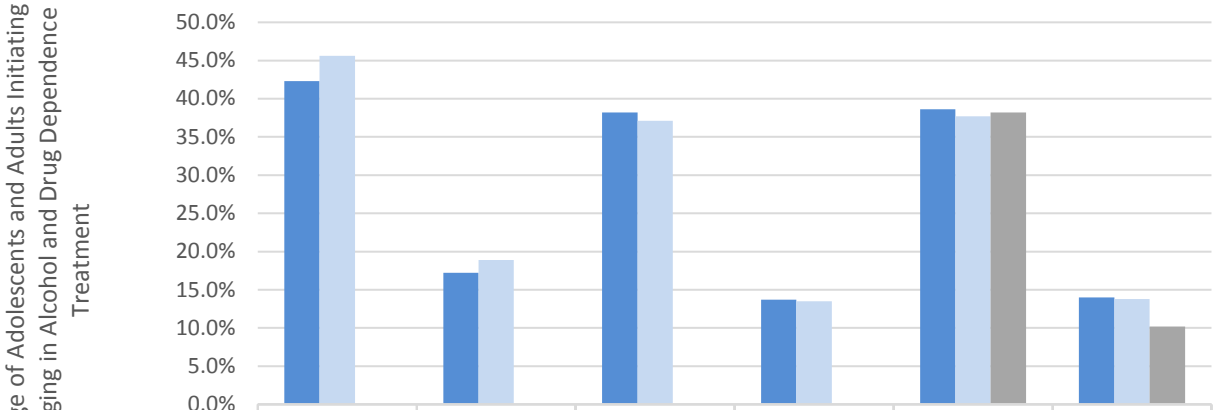
[32] Source: Flu vaccination MMIS reports for 2013 – 2016.

Measure 26 – Initiation and engagement of alcohol and other drug (AOD) dependence treatment.

Exhibit 26.a presents rates of Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment for DY1, DY2, and 2015 HEDIS Medicaid national averages for two age cohorts and the total population for three of the four MCOs.

MCO performance for members 13-17 years of age cohort on both initiation and engagement of AOD increased from DY1 to DY2 by 7.7% and 9.8%, respectively. Rates for members 18+ years of age cohort and the all-age cohort declined from DY1 to DY2 for both initiation (-2.9% and -2.4% respectively) and engagement (-1.6% and -1.2% respectively), although the DY2 results for engagement was higher than the 2015 national average. Only the 2.9% decline in initiation rate for members 18+ years of age cohort was statistically significant at the 95% confidence level.

Exhibit 26.a – Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment[33]

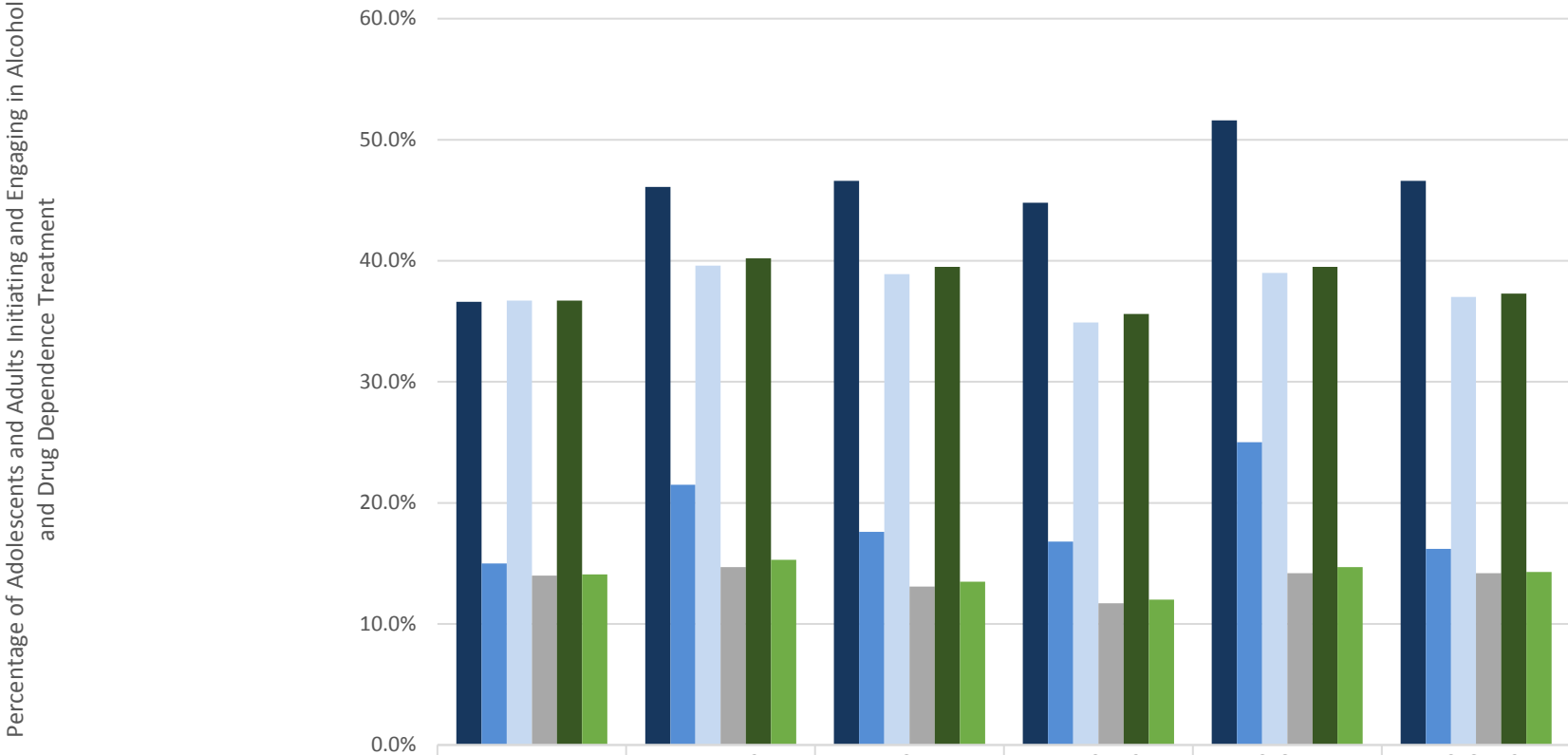


	13-17 years		18+ years		Total	
	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment
DY1 Centennial Care	42.3%	17.2%	38.2%	13.7%	38.6%	14.0%
DY2 Centennial Care	45.6%	18.9%	37.1%	13.5%	37.7%	13.8%
2015 National Average					38.2%	10.2%

Exhibit 26.b below demonstrates individual MCO performance on the Initiation and Engagement of AOD. PHP was the only MCO to have positive increases from DY1 to DY2 for all subcomponents. PHP experienced double-digit increases in both initiation and engagement of AOD for adolescents aged 13-17 (25.9% and 43.2%, respectively), both of which were statistically significant at the 95% confidence level. Conversely, MHC and BCBS experienced statistically significant declines from DY1 to DY2. MHC's rate of initiation of AOD treatment in adults aged 18 and older decreased 10.2% and the rate of engagement decreased by 10.7% from DY1 to DY2. BCBS's rate of engagement in AOD treatment in adolescents declined by 35.3%.

[33] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in DY1 and DY2.

Exhibit 26.b. – Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (Plan by Plan Rates)[34]



	PHP DY1	PHP DY2	MHC DY1	MHC DY2	BCBS DY1	BCBS DY2
13-17 years Initiation of AOD Treatment	36.6%	46.1%	46.6%	44.8%	51.6%	46.6%
13-17 years Engagement of AOD Treatment	15.0%	21.5%	17.6%	16.8%	25.0%	16.2%
18+ years Initiation of AOD Treatment	36.7%	39.6%	38.9%	34.9%	39.0%	37.0%
18+ years Engagement of AOD Treatment	14.0%	14.7%	13.1%	11.7%	14.2%	14.2%
Total Initiation of AOD Treatment	36.7%	40.2%	39.5%	35.6%	39.5%	37.3%
Total Engagement of AOD Treatment	14.1%	15.3%	13.5%	12.0%	14.7%	14.3%

[34] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in DY1 and DY2.

Measure 27 – Geographic access measures.

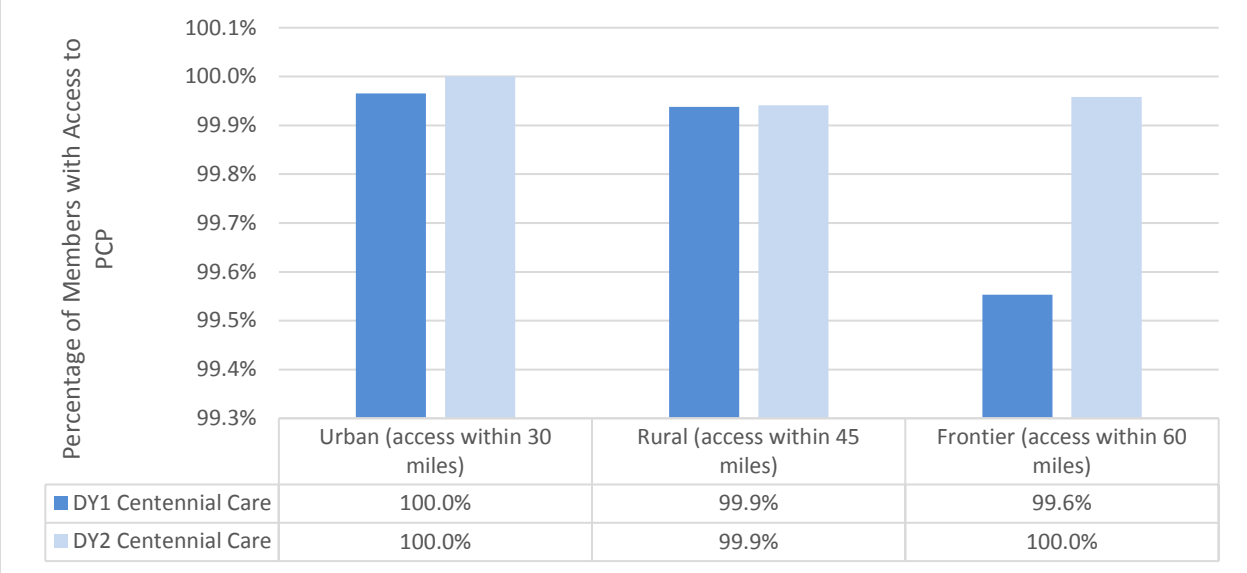
Geographic Access Measures is a general measure developed by HSD as a way to evaluate access to primary and specialty care for Centennial Care members across the State of New Mexico. Monitoring the networks of providers contracted by HSD assures its Medicaid beneficiaries are within a reasonable driving distance of providers and that there is an adequate number of providers to deliver care for Medicaid members.

HSD has developed standards for measuring geographic-based access to care which MCOs reported by quarter based on three county types:

- Urban Counties = 90% of members have access to a PCP within 30 miles
- Rural Counties = 90% of members have access to a PCP within 45 miles
- Frontier Counties = 90% of members have access to a PCP within 60 miles

Exhibit 27.a demonstrates the percentage of members with access to PCPs in each county type. As illustrated, all MCOs met the requirement for accessibility across counties in both performance years. Accessibility of PCPs in urban and rural counties remained steady while accessibility in frontier counties increased to 100.0% from DY1 to DY2.

Exhibit 27.a – Percentage of Members with Access to PCPs[35]

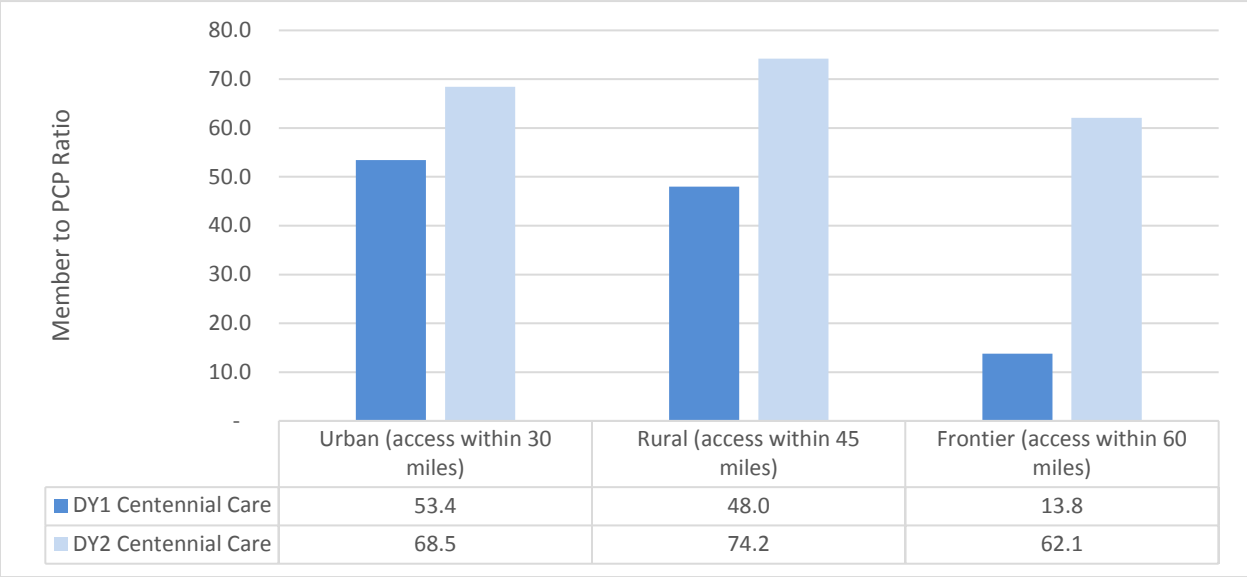


	Urban (access within 30 miles)	Rural (access within 45 miles)	Frontier (access within 60 miles)
DY1 Centennial Care	100.0%	99.9%	99.6%
DY2 Centennial Care	100.0%	99.9%	100.0%

[35] Source: MCO reports for 2014 – 2015 (HSD 55).

Exhibit 27.b presents results for DY1 and DY2 of member to PCP ratios by county type. While HSD defines requirements for mileage access to PCPs, it does not have requirements for the ratio of members to providers by county type. As illustrated, member to PCP ratios increased in all county types from DY1 to DY2, the increases were 28.1%, 54.6%, and 350.4% for urban, rural, and frontier, respectively. These increases are not desired as a smaller member to provider ratio usually indicates better accessibility.

Exhibit 27.b – Members to PCP Ratio[36]



	Urban (access within 30 miles)	Rural (access within 45 miles)	Frontier (access within 60 miles)
DY1 Centennial Care	53.4	48.0	13.8
DY2 Centennial Care	68.5	74.2	62.1

[36] Source: MCO reports for 2014 – 2015 (HSD 55).

Research Question 1.C

Are care coordination activities meeting the goals of the right amount of care delivered at the right time in the right setting?

The Centennial Care waiver aims to integrate management of PH, BH, and LTSS benefits and services with the assumption that aligned benefits and incentives to coordinate care and services will produce improved outcomes. MCOs are responsible for assessing their members' health risks and service needs, determining care coordination levels, developing comprehensive care plans, and providing outreach and service coordination based on that level.

The Evaluation is reviewing Centennial Care's impact on care coordination through the analysis of nine performance measures that assess MCO activities to increase member engagement in the program, understand member health risks, stratify members into care coordination levels, and perform member outreach via telephone or in-person visits. In addition, Research Question 1.C attempts to understand the success of care coordination activities provided to HCBS beneficiaries.

Overall through DY3 of the Centennial Care program, the rate of care coordination activities has generally increased among MCOs, plans were able to engage a greater percentage of members, and fewer members refused care coordination services.

Five of nine measures saw improvement in the rate of activities performed for members from the baseline to DY2 despite a trend of increasing participants in Care Coordination Levels 2 and 3; those included completing HRAs, performing outreach to members in care coordination Level 2 and Level 3, engaging members for care coordination, and reducing instances of members refusing care coordination services.

Performance on one measure declined since the baseline including the percentage of members who transitioned from a NF into the community.

Three measures showed mixed results where each measure contains two subcomponents measuring performance for transition members and new members. For these measures, one subcomponent showed improvement while the other declined. These measures include members who were assigned care coordination Level 2 and Level 3 that had a Comprehensive Needs Assessment (CNA), and providing Care Coordination level assignment packages within contract timeframes.

It should be noted that in DY2 and DY3, PHP did not report data on several subcomponents related to activities provided to transition members (HRAs, CNAs, CCPs); these members were not considered in the numerator or the denominator of rates. Therefore, it is not expected to have impacted aggregate results.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 28 – Number and percentage of members with Health Risk Assessments (HRAs) completed within contract timeframes.

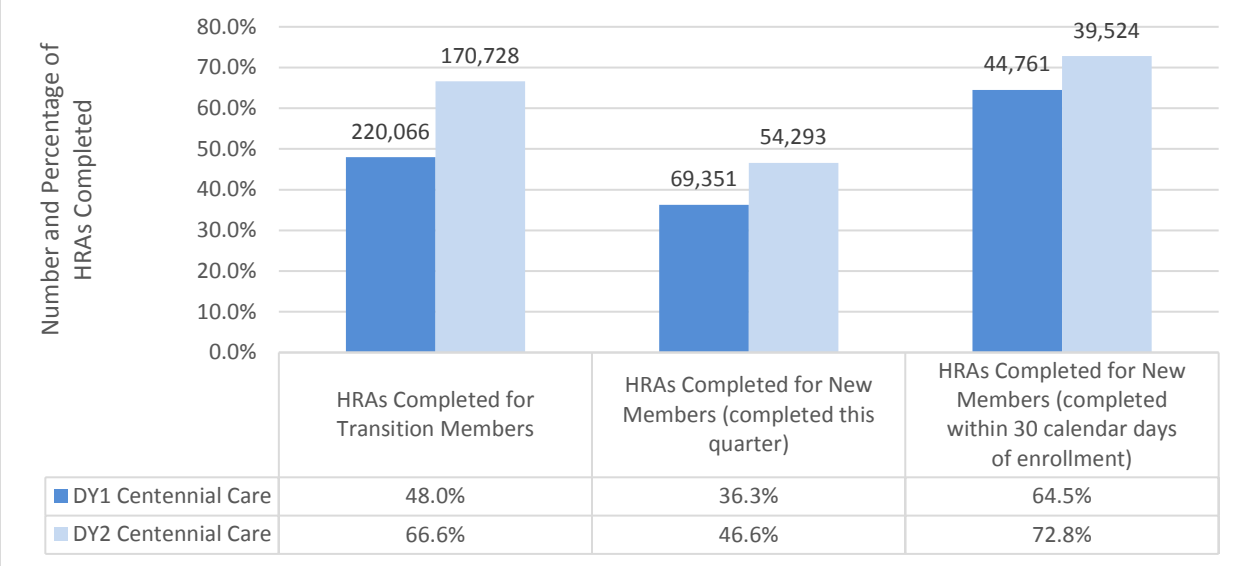
Exhibit 28 presents the results for DY1 and DY2 for the three subcomponents reflecting completed HRAs for transition and new members. Results of the number and percentage of HRAs completed within contract timeframes for transition and new members, as well as HRAs completed within 30 days of enrollment for new members are described below. From DY1 to DY2 the percentage of HRAs completed for transition members increased from 48.0% to 66.6% (a 38.8% increase) and the percentage of HRAs completed for new members increased from 36.3% to 46.6% (a 28.5% increase). Similarly, HRAs completed within 30 days of enrollment for new members increased from 64.5% to 72.8% (a 12.8% increase) from DY1 to DY2.

Upon review of the individual MCO performance over the same time period, BCBS experienced a 52.6% improvement in their individual rates of HRAs completed for transition members from DY1 to DY2, while UHC and MHC experienced increases of 27.6% and 22.3% respectively.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 28 – Number and Percentage of Members with HRAs Completed within Contract Timeframes[37]



	HRAs Completed for Transition Members	HRAs Completed for New Members (completed this quarter)	HRAs Completed for New Members (completed within 30 calendar days of enrollment)
DY1 Centennial Care	48.0%	36.3%	64.5%
DY2 Centennial Care	66.6%	46.6%	72.8%

[37] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 29 – Number and percentage of those provided care coordination level assignment within 10 calendar days of HRA (participants who received a care coordination designation and assignment of care coordinator within contract timeframes).

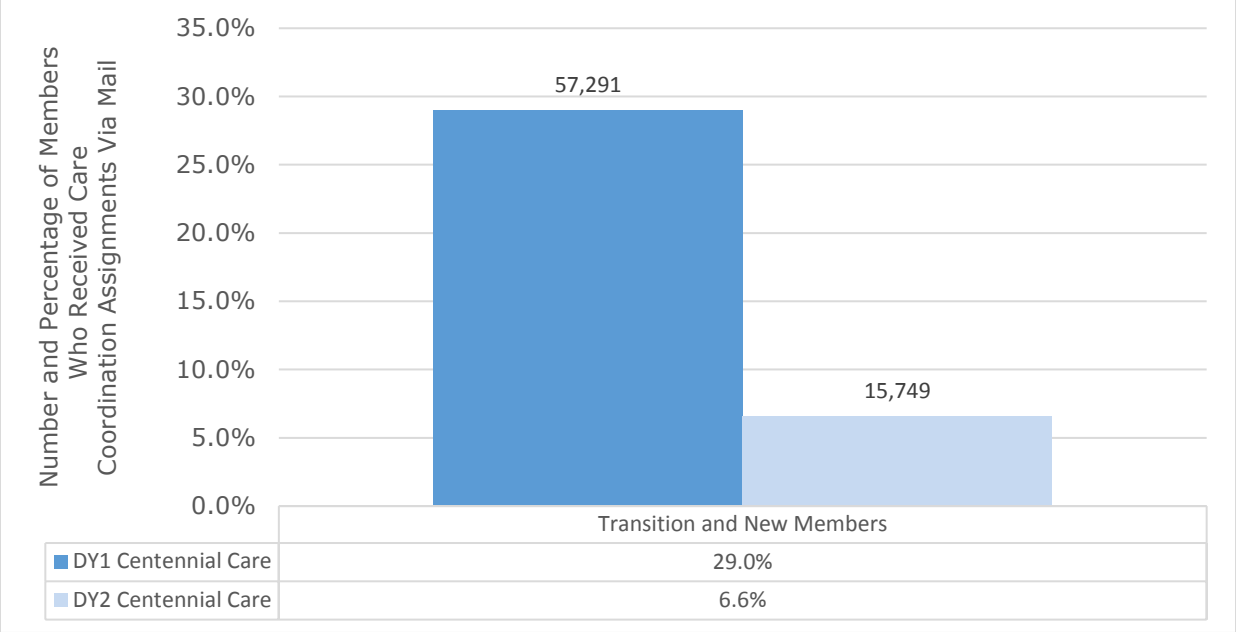
Exhibit 29 below presents results for DY1 and DY2 for the Number of Medicaid Members who were Provided Care Coordination Level Assignments within 10 Calendar Days of an HRA. This definition is being used by HSD as an alternative for "the number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes" since HSD Report 6 does not contain those specific data points. Furthermore, it should be noted that HSD Report 6 only captures data on the number of CCL assignments that MCOs sent to members via mail and does not include the sharing of CCL information verbally which MCOs are allowed to do. Appendix A provides more detail on the definition and methodology used to calculate this measure.

As illustrated, the percentage of members provided care coordination level assignments via mail trended downward from DY1 to DY2. This is somewhat expected, as CCL assignment information was sent via mail most frequently to members transitioning into Centennial Care from the legacy programs and those transitions occurred early in DY1 .

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 29 – Number and Percentage of those Provided Care Coordination Level Assignment Via Mail within 10 Calendar Days of HRA[38]



[38] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 30 – Number and percentage of participants in care coordination Level 2 based on the Comprehensive Needs Assessment (number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes).

Exhibit 30 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 2 based on the Comprehensive Needs Assessment. The data elements required to measure the activity reflected in the Evaluation Plan (number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes) were not included in the HSD Report 6. Therefore, an alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Report 6, and the measure name was updated to "Number and Percentage of Level 2 Assignments Based on the CNA."

Results for both transition and new members are calculated using the number of Level 2 assignments made based on CNA answers, as a percentage of CNAs completed. The measure does not reflect performance of the Centennial Care MCOs, but instead reflects the needs of the population and resulting stratification into one of two higher care levels (Level 2 and Level 3)[39].

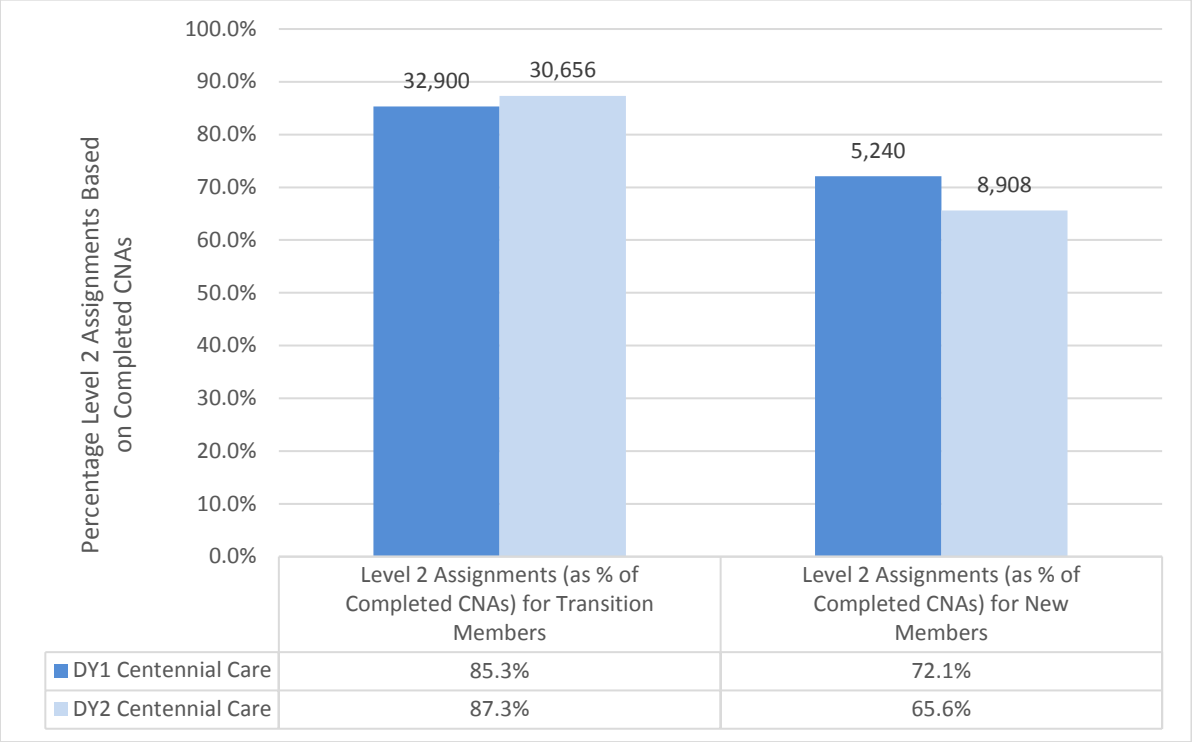
As Exhibit 30 illustrates, the percentage of transition members reported by three of the four MCOs that were assigned to Level 2 from DY1 to DY2 remained relatively consistent, staying between 85.3% and 87.3%. By comparison, a lower percentage of new Medicaid members were assigned to Level 2 and the percentage of Level 2 assignments decreased from 72.1% to 65.6% (a 9.0% decline) from DY1 to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

[39] In DY3, HSD indicated that members will only be stratified into two levels. Level 1 is no longer considered a Care Coordination Level that is measured.

Exhibit 30 – Number and Percentage of Participants in Care Coordination Level 2 Based on the Comprehensive Needs Assessment [40]



	Level 2 Assignments (as % of Completed CNAs) for Transition Members	Level 2 Assignments (as % of Completed CNAs) for New Members
DY1 Centennial Care	85.3%	72.1%
DY2 Centennial Care	87.3%	65.6%

[40] Source: MCO reports for 2014 – 2016 (HSD 6). PHP did not report on transition members in DY2.

Measure 31 –Number and percentage of participants in care coordination Level 3 based on the Comprehensive Needs Assessment (number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes).

Exhibit 31 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 3 based on the Comprehensive Needs Assessment. The data elements required to measure the activity reflected in the Evaluation Plan (number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes) were not included in the HSD Report 6 report. Therefore, an alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Report 6, and the measure name was updated to "Number and Percentage of Level 3 Assignments Based on the CNA."

Results for both transition and new members are calculated using the number of Level 3 assignments made based on CNA answers, as a percentage of CNAs completed. The measure does not reflect performance of the Centennial Care MCOs, but instead reflects the needs of the population and resulting stratification into one of two levels (Level 2 and Level 3 are possible)[41].

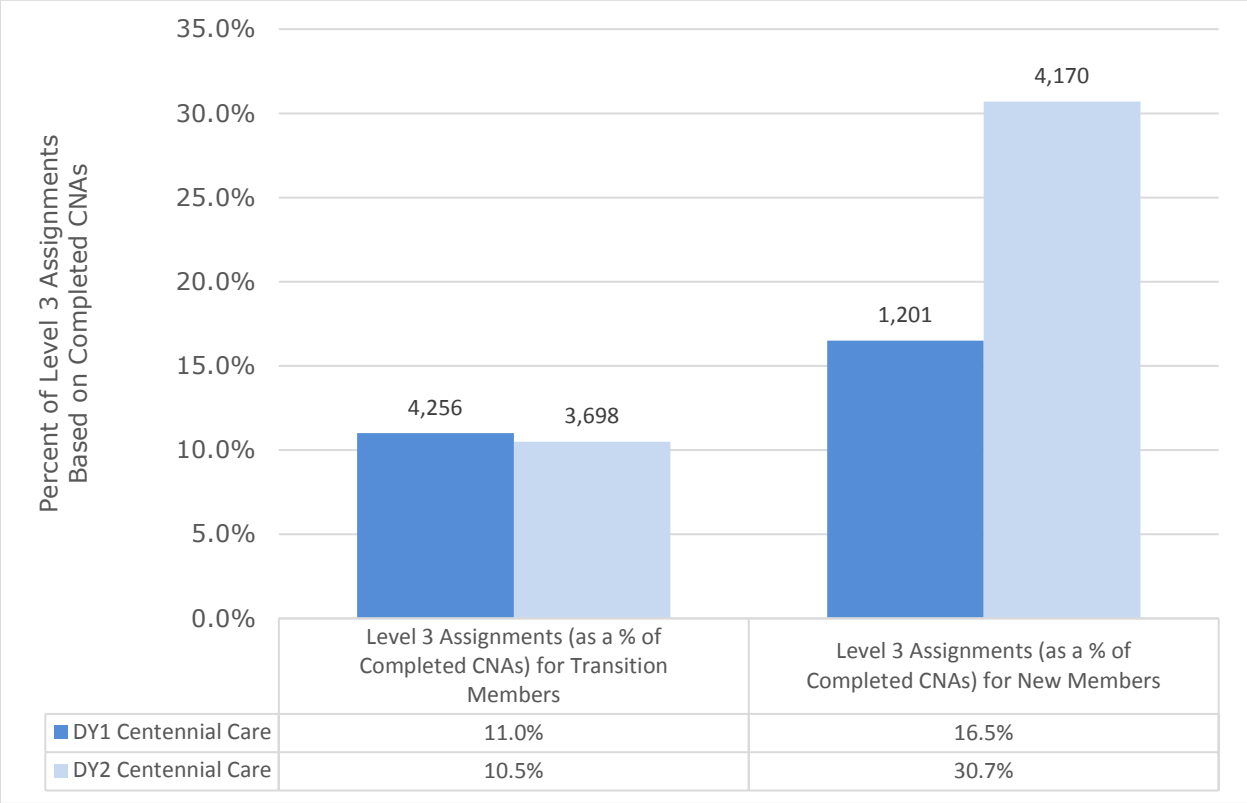
As Exhibit 31 illustrates, the percentage of new members who were assigned to Level 3 was greater than the percentage of transition members assigned to Level 3. The percentage of transition members assigned to Level 3 remained fairly level from DY1 to DY2 (11.0% and 10.5% respectively). Conversely, the percentage of new members assigned to Level 3 grew significantly year-over-year, increasing from 16.5% in DY1 to 30.7% in DY2 (a 85.9% change).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

[41] In DY3, HSD indicated that members will only be stratified into two levels. Level 1 is no longer a Care Coordination Level.

Exhibit 31 – Number and Percentage of Participants in Care Coordination Level 3 Based on the Comprehensive Needs Assessment[42]



	Level 3 Assignments (as a % of Completed CNAs) for Transition Members	Level 3 Assignments (as a % of Completed CNAs) for New Members
DY1 Centennial Care	11.0%	16.5%
DY2 Centennial Care	10.5%	30.7%

[42] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 32 – Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes.

Exhibit 32 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 2 who received in-person visits at least twice a year (semi-annual) and telephone contact during the quarter.

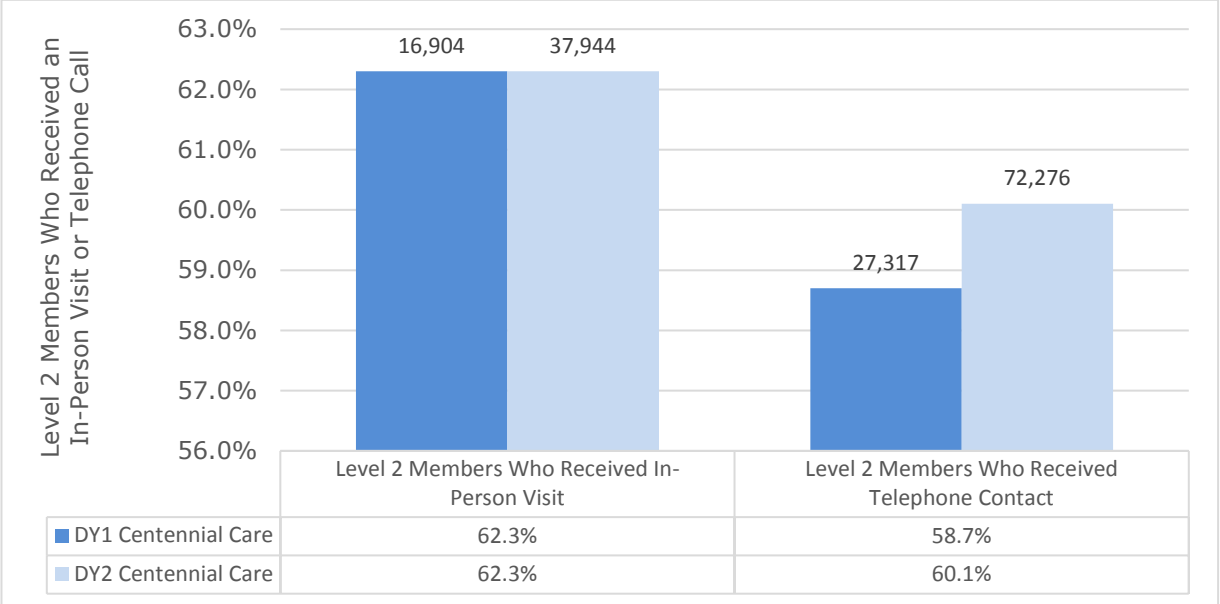
As illustrated, the percentage of Level 2 members who received in-person visits remained steady from DY1 to DY2. Members who received quarterly phone contact increased slightly year-over-year between DY1 and DY2.

Upon review of the individual MCOs, performance in both activities provided to Level 2 members demonstrated relatively consistent patterns of over time, with the exception of BCBS. BCBSs performance declined for both activities from DY1 to DY2 (-30.7% for in-person, -13.2% for telephone).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 32 – Number and Percentage of Participants in Care Coordination Level 2 Who Received In-Person Visits and Telephone Contact [43]



[43] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 33 – Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes.

Exhibit 33 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 3 who received a quarterly in-person visit and those who received monthly telephone contact.

As illustrated, the percentage of Level 3 members who received quarterly in-person visits remained relatively consistent from DY1 to DY2. The percentage of Level 3 members who received monthly phone contact increased from 54.3% to 61.7% (a 13.6% change).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 33 – Number and Percentage of Participants in Care Coordination Level 3 who Received In-Person Visits and Telephone Contact within Contract Timeframes[44]

[44] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 34 – Number and percentage of participants the MCO is unable to engage for care coordination (number and percentage of participants the MCO is unable to locate for care coordination).

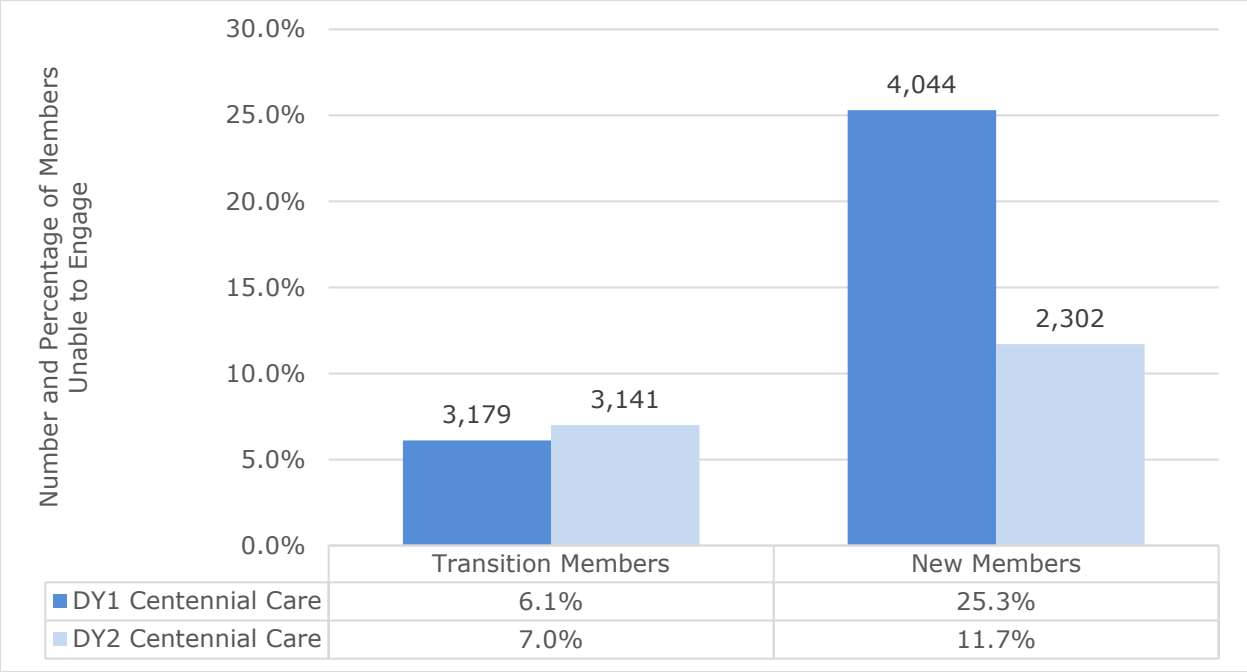
Exhibit 34 below presents results for DY1 and DY2 for the number and percentage of participants for whom a CNA is required, but the MCO is unable to engage the member. The data element specifically citing "unable to locate for care coordination" was not included in HSD Report 6, therefore, the number of transition and new Medicaid members for whom a CNA was required but the MCO was "unable to engage" is used. A reduction in the percentage of members for whom the MCOs were unable to engage indicates a positive trend in the ability of MCOs to find and contact members.

As illustrated, the percentage of transition members MCOs were unable to engage in care coordination was relatively consistent from DY1 to DY2. The percentage of new members the MCOs were unable to engage experienced a favorable decline from 25.3% to 11.7% (a 53.9% change) from DY1 to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 34 – Number and Percentage of Participants the MCO is Unable to Engage for Care Coordination[45]



[45] Source: MCO reports for 2014 – 2016 (HSD 6). PHP did not report information on transition members in DY2.

Measure 35 - Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS).

Exhibit 35 presents rates for DY1 and DY2 of the number and percentage of members who have transitioned between NF LOC and the community to use HCBS. There are two subcomponents reported: those members who left a NF and moved to the community to use HCBS and those who were in the community, but were readmitted into a NF.

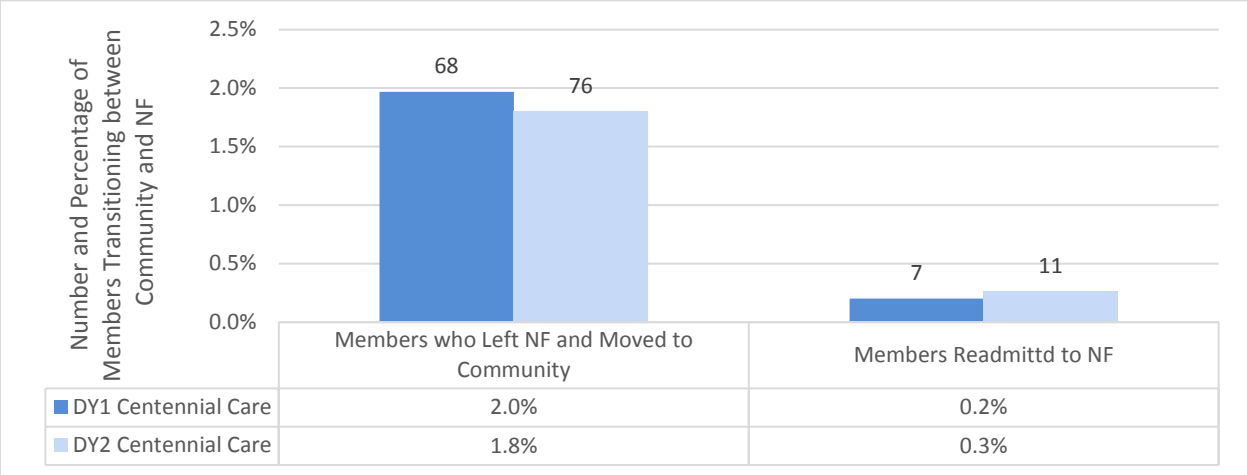
As illustrated, the rate of members moving from a NF into the community declined from 2.0% to 1.8% (an 8.5% change) from DY1 to DY2. The percentage of members who were readmitted into a NF increased from 0.2% to 0.3% (a 28.6% change) over the same period. It must be noted that the overall percentages of members transitioning between care settings is quite small, and a slightly higher percentage are transitioning from NF to the community as opposed to from the community to a NF. None of these changes were statistically significant.

Individual plan performance on this measure was varied. For example, PHP improved the percentage of members who transferred from a NF to the community from 2.5% in DY1 to 4.8% in DY2 (a 93.4% change) and experienced only a slight increase (from 0.0% to 0.3%) in the percentage of NF readmissions. MHC and UHC both experienced decreases in the percentage of members leaving a NF for community care; MHC decreased from 4.8% in DY1 and 3.5% in DY2 (a 27.2% change) and UHC decreased from 1.1% in DY1 to 0.9% in DY2 (a 19.9% change). None of these changes were statistically significant.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests that the percentage of members readmitted to a NF will remain relatively consistent and the percentage of members leaving NF for community care may increase slightly.

A national comparison rate could not be identified for this measure.

Exhibit 35 – Number and Percentage of Participants in Nursing Facility (NF) Transitioning to Community (HCBS)[46]



[46] Source: MCO reports for 2014 – 2015 (HSD 7).

Measure 36 – Number and percentage of participants who refused care coordination.

Exhibit 36 below presents rates for DY1 and DY2 for the number and percentage of participants who refused care coordination. The specific data element required to measure this activity was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members who "refused a CNA," based on the assumption that if the member refused the process to screen for care coordination, then they would also refuse to participate in care coordination. A declining percentage of members who refused care coordination indicates a positive trend in the ability for MCOs to engage members in specialized programs.

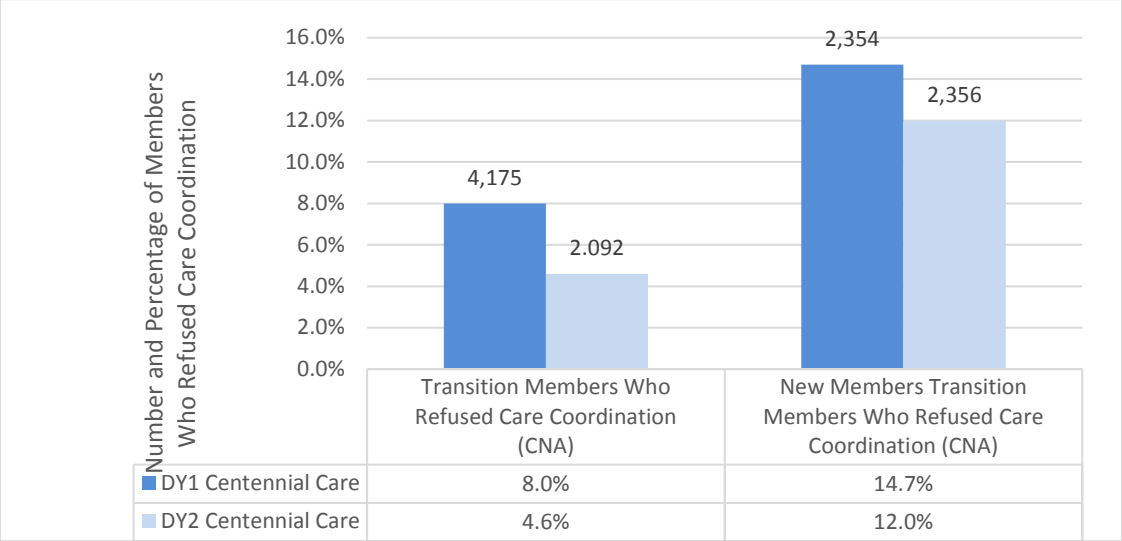
As illustrated, the percentage of both transition and new members who refused a CNA, thereby refusing care coordination services, declined from DY1 to DY2. Overall, the percentage of transition members who refused care coordination declined from 8.0% in DY1 to 4.6% in DY2 (a 42.2% change) and a decline in the percentage of new members refusing care coordination from 14.7% in DY1 to 12.0% in DY2 (a 19.0% change), meaning a greater percentage of members are accepting care coordination over time.

BCBS, one of the three plans that reported transition member activities in DY2, experienced a decline from 15.0% to 12.1% (a 19.5% change) in the percentage of refusals from DY1 to DY2. PHP, MHC, and BCBS experienced declining percentages of refusals for new members over the same period, indicating improved performance.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 36 – Number and Percentage of Participants who Refused Care Coordination[47]



	Transition Members Who Refused Care Coordination (CNA)	New Members Transition Members Who Refused Care Coordination (CNA)
DY1 Centennial Care	8.0%	14.7%
DY2 Centennial Care	4.6%	12.0%

[47] Source: MCO reports for 2014 – 2016 (HSD 6).

Hypothesis 2

Increased provision of care coordination will lead to improved care outcomes and a reduction in adverse events.

One of Centennial Care's goals is to ensure that expenditures for care and services being provided are measured in terms of quality and not solely by quantity. This goal is guided by the principle that health care services improve health status most efficiently through coordinated, efficacious care. Centennial Care seeks to provide high quality services and reduce preventable adverse events.

The Evaluation found that enhanced care coordination under Centennial Care is resulting in improved care outcomes for needed services and is generally meeting waiver goals to improve quality.

Research Question 2.A

To what extent has quality of care improved due to the implementation of the Centennial Care program for Medicaid/CHIP beneficiaries in New Mexico?

The Centennial Care waiver provides some new and enhanced benefits, in addition to traditional Medicaid State Plan benefits, including care coordination, a comprehensive community benefit that includes personal care and HCBS, new BH services integrated with traditional PH services, and a member rewards program intended to incentivize individuals to participate in state-defined activities that promote healthy behaviors. Prior to the waiver's implementation in 2014, these services were fragmented into multiple waiver programs, with six managed care contractors and one BHSE.

The Evaluation is reviewing Centennial Care's impact on quality of care through analysis of 17 measures that address adult, child and adolescent screenings, ACS conditions, avoidable ER visits, adverse events (i.e., critical incidents, fall risk management), BH inpatient admissions and nursing facility acuity transitions. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY2 of the Centennial Care program, the MCOs continue to improve quality of care as noted in the findings for the assigned performance measures. There were positive performance results across measures and within various subcomponents of measures, with rates improving in 10 out of 17 measures.

New Mexico saw improvement from the baseline[48] to DY2 in several subcomponents of EPSDT screening ratios; slight increases in monitoring rates of BMI for adults, children and adolescents; increases in asthma medication management among most cohorts; increases in antidepressant medication management; a positive shift from higher NF acuity to lower NF acuity; and increased fall risk intervention.

There were also improvements in hospital admission rates and ER visit rates. There were reductions in hospital admission rates across most ACS measures (i.e., short and long term diabetes, asthma in younger adults and Chronic Obstructive Pulmonary Disease (COPD) or asthma in older adults, and hypertension) across both time periods (i.e., DY1 to DY2 and the baseline to DY2). Finally, there was a decline in the percentage of ER visits that were potentially avoidable from DY1 to DY2. Downward trends for these measures are considered desirable.

On the other hand, there was a decline in performance across measures and within various subcomponents of measures in 5 out of 17 measures compared to the baseline. These measures include asthma medication ratios, smoking and tobacco use cessation rates, annual patient monitoring

[48] The baseline period is typically considered calendar year 2013, but may be SFY2013 or calendar year 2014 (DY1) depending on the measure and data availability from CY2013.

for persistent medications, inpatient admissions to psychiatric hospitals and RTCs, and a slight unfavorable increase in pediatric asthma admissions.

Two measures experienced mixed results with data through DY2; for critical incident reporting, there were decreases in half of the critical incidents categories but increases in the other categories across the three cohorts. For comprehensive diabetes care, there were improvements in 3 of 6 subcomponents from the baseline to DY2.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

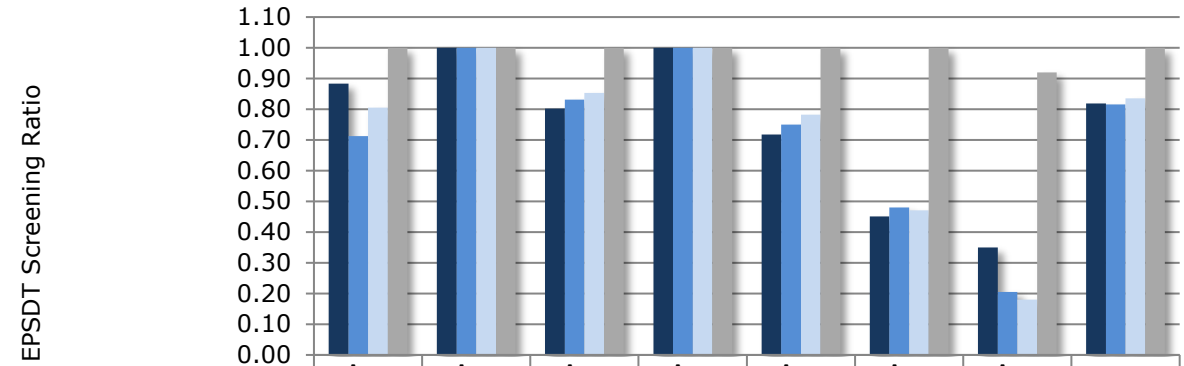
Measure 37 – EPSDT screening ratio.

Exhibit 37 presents results for the FFY 2013 baseline, FFY 2014, FFY 2015, and the EPSDT FFY 2015 national average[49] for the seven age cohorts and the aggregate rate for the measure EPSDT Screening Ratio. As illustrated, the screening ratios improved from FFY 2014 to FFY 2015 for the <1 age cohort (13.0%), 3-5 age cohort (2.6%), 10-14 age cohort (4.3%), and the aggregate (2.4%). The ratios declined for members in the 15-18 age cohort (-1.8%) and the 19-20 age cohort (-12.2%). The ratios stayed the same for the 1-2 age cohort and the 6-9 age cohort.

Screening ratios improved from the FFY 2013 baseline to FFY 2015 for the 3-5 age cohort (6.3%), the 10-14 age cohort (8.9%), the 15-18 age cohort (4.5%), and in the aggregate (2.0%). Two age cohorts declined from the FFY 2013 baseline to FFY 2015: <1 (-8.8%) and 19-20 (-48.5%). During this same time period, there was no change in the 1-2 age cohort and the 6-9 age cohort.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 37 – EPSDT Screening Ratio[50]



	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20	Total
FFY 2013 Baseline	0.88	1.00	0.80	1.00	0.72	0.45	0.35	0.82
FFY 2014	0.71	1.00	0.83	1.00	0.75	0.48	0.21	0.82
FFY 2015	0.81	1.00	0.85	1.00	0.78	0.47	0.18	0.84
FFY 2015 National Avg	1.00	1.00	1.00	1.00	1.00	1.00	0.92	1.00

[49] Source: CMS-416 Annual EPSDT Participation Report (National) Federal Fiscal Year 2016.
[50] Source: CMS-416 Reports for Federal Fiscal Years 2013 – 2015.

Measure 38 – Annual monitoring for patients on persistent medication.

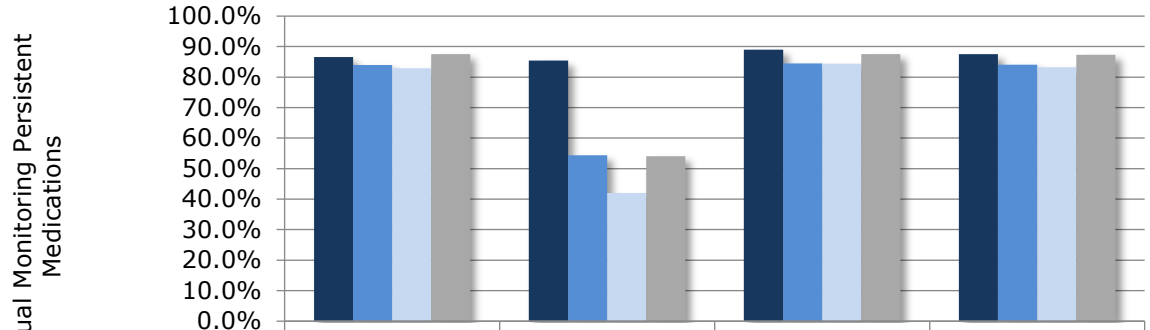
Exhibit 38 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the three subcomponent rates and the aggregate rate for the measure Annual Monitoring for Patients on Persistent Medication.

All three subcomponents and the aggregate rate declined from DY1 to DY2. The declines in angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (-1.2%) and the aggregate rate (-0.9%) were statistically significant at the 95% confidence level. The largest decline was in the digoxin rate (-22.8%), although this change was not statistically significant at the 95% confidence level.

Upon review of the individual MCO performance for the ACE inhibitors or ARBs subcomponent, BCBS experienced the steepest decline (-2.8%) from DY1 to DY2 compared to MHC, PHP, and UHC, which had declines of 0.6%, 0.5%, and 1.9% respectively. Similarly, for the aggregate rate, BCBS had the steepest decline (-2.5%) from DY1 to DY2 compared to MHC and UHC, which had declines of 0.3% and 2.1% respectively. PHP experienced a 0.1% increase in the aggregate rate from DY1 to DY2.

Across all four MCOs, all three subcomponents and the aggregate rate declined from the baseline to DY2. The digoxin subcomponent experienced the steepest decline (-50.9%), while the ACE inhibitors (or ARBs) and diuretics had declines of 4.2% and 5.3% respectively. The aggregate rate declined by 4.9%. All declines were statistically significant at the 95% confidence level.

Exhibit 38 – Annual Monitoring for Patients on Persistent Medications[51]



	ACE Inhibitors or ARBs	Digoxin	Diuretics	Total
2013 Baseline	86.6%	85.4%	89.0%	87.5%
DY1 Centennial Care	83.9%	54.3%	84.5%	84.0%
DY2 Centennial Care	82.9%	42.0%	84.3%	83.3%
2015 National Avg	87.5%	54.1%	87.5%	87.3%

[51] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 39 – Medication management for people with asthma (50% compliance).

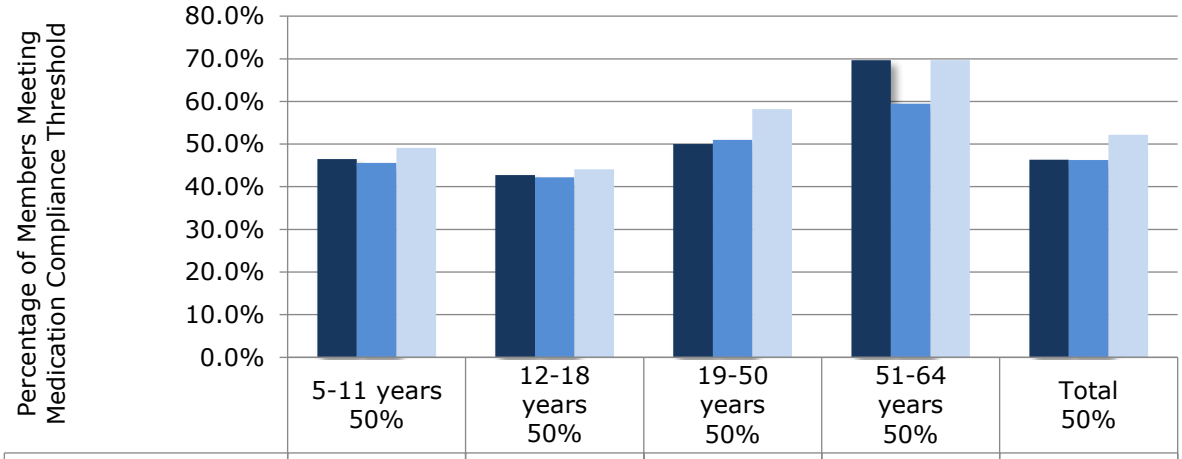
Exhibit 39 presents rates for the 2013 baseline, DY1, and DY2 for the four age cohorts and the aggregate rate for the measure Medication Management for People with Asthma. As illustrated, rates increased in all four age cohorts and in the aggregate from DY1 to DY2. The largest increases at the cohort level were among members 51-64 years of age cohort (17.2%), followed by members 19-50 years of age cohort (14.1%). The aggregate rate increased by 12.8%. These changes were statistically significant at the 95% confidence level.

Upon review of the individual MCO performance from DY1 to DY2 for the 5-11 years of age cohort, PHPs increase (17.4%) was statistically significant at the 95% confidence level, while BCBSs increase (2.8%) and MHCs change (0.0%) were not. During this same period, two plans had a decline for the 12-18 year of age cohort: BCBS (-25.8%) and MHC (-6.1%) while one plan reported an increase: PHP (20.4%). PHPs increase was statistically significant at the 95% confidence level. UHC did not have sufficient data to report. As it relates to the 19-50 years of age cohort, three plans had sufficient data to calculate rates and the rates all increased: MHC (17.3%), PHP (16.8%), and BCBS (7.8%). The MHC and PHP increases were statistically significant at the 95% confidence level. For the 51-64 years of age cohort, MHCs increase (25.6%) was statistically significant at the 95% confidence level while the other two plans that reported on this age cohort was not: PHP (27.7%) and UHC (6.9%). For the aggregate rates, no changes were statistically significant at the 95% confidence level.

Three of the four age cohorts and the aggregate increased from the baseline to DY2. The largest improvements at the cohort level were among members 19-50 years of age (16.3%) followed by members 5-11 years of age (5.6%) and members 12-18 years of age (3.2%). The aggregate rate increased by 12.7%. The changes in the 19-50 years of age cohort and the aggregate rate were statistically significant at the 95% confidence level. Upon review of the individual MCO performance from the baseline to DY2, PHP had increases in the 5-11, 12-18, and 19-50 years of age cohort that were statistically significant at the 95% confidence level. No changes were statistically significant at the 95% confidence level for the 51-64 years of age cohort or the aggregate rate.

A national comparison rate could not be identified for this measure.

Exhibit 39 – Medication Management for People with Asthma[52]



	5-11 years 50%	12-18 years 50%	19-50 years 50%	51-64 years 50%	Total 50%
2013 Baseline	46.5%	42.7%	50.0%	69.7%	46.3%
DY1 Centennial Care	45.6%	42.2%	51.0%	59.4%	46.3%
DY2 Centennial Care	49.1%	44.1%	58.2%	69.6%	52.2%

[52] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 40 – Asthma medication ratio.

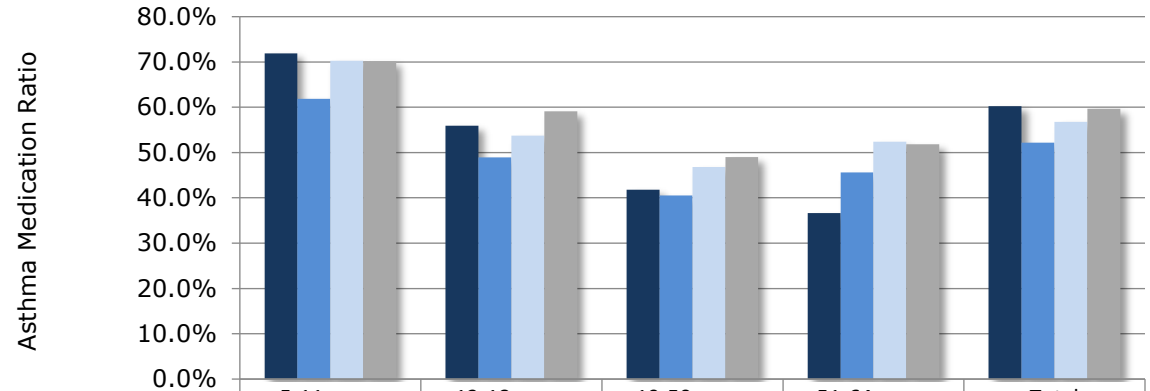
Exhibit 40 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the four age cohorts and the aggregate rate for the measure Asthma Medication Ratio. As illustrated, all age cohorts and the aggregate rate increased from DY1 to DY2. The largest improvement was among members 19-50 years of age (15.4%), followed by increases in the 5-11 age cohort (13.5%), and the 12-18 cohort (9.9%), all of which were statistically significant at the 95% confidence level. The change in the aggregate rate (8.7%) was also statistically significant. The increase in the 51-54 age cohort (14.8%) was not statistically significant.

Upon review of the individual MCO performance from DY1 to DY2 for the 5-11 age cohort, MHC experienced the largest increase (22.5%) followed by PHP (8.1%) and BCBS (6.1%). Both MHC and PHPs rates were statistically significant at the 95% confidence level. UHC did not have sufficient data to report. Similarly, for the 19-50 age cohort, PHP had a statistically significant increase (27.8%) from DY1 to DY2 compared to BCBS, MHC, and UHC, which had changes of -9.8%, 12.4%, and -9.2%, respectively. As it relates to the 51-64 age cohort, three plans had sufficient data to calculate rates. MHC had a statistically significant increase (45.4%) compared to MHC and UHC, which had changes of 3.6% and -6.0%. For the aggregate rate, MHC had a statistically significant increase (15.5%) compared to BCBS, PHP, and UHC, which had changes of 3.3%, 5.24%, and -3.5%.

Two of the four age cohorts experienced increases in rates from the baseline to DY2: 19-50 (11.9%) and 51-64 (43.0%). The increases were statistically significant at the 95% confidence level. The remaining two age cohorts (5-11 and 12-18) declined slightly from the baseline to DY2, though the changes were not statistically significant. The aggregate decline was 5.7%, which was statistically significant at the 95% confidence level.

Upon review of the individual MCO performance from the baseline to DY2 for the 5-11 age cohort, both BCBS and PHP had statistically significant declines (-22.5% and -6.1%) while MHC had a statistically significant increase (7.9%). UHC did not have sufficient data to report. For the 19-50 age cohort, PHP had a statistically significant increase (19.9%) compared to the increases for MHC (14.5%) and UHC (15.5%). On the other hand, BCBS had a statistically significant decline (-28.6%). As it relates to the 51-64 age cohort, three plans had sufficient data to calculate rates. Both MHC and PHP had statistically significant increases (66.2% and 46.6%) while UHC did not (13.6%). BCBS and PHP experienced statistically significant declines in the aggregate rate, decreasing 24.0% and 8.6% respectively. Both MHC and UHC experienced increases though the changes were not statistically significant at the 95% confidence level.

Exhibit 40 – Asthma Medication Ratio[53]



	5-11 years	12-18 years	19-50 years	51-64 years	Total
2013 Baseline	71.9%	55.9%	41.8%	36.6%	60.2%
DY1 Centennial Care	61.9%	48.9%	40.6%	45.6%	52.2%
DY2 Centennial Care	70.2%	53.8%	46.8%	52.4%	56.8%
2015 National Avg	70.1%	59.1%	49.0%	51.8%	59.7%

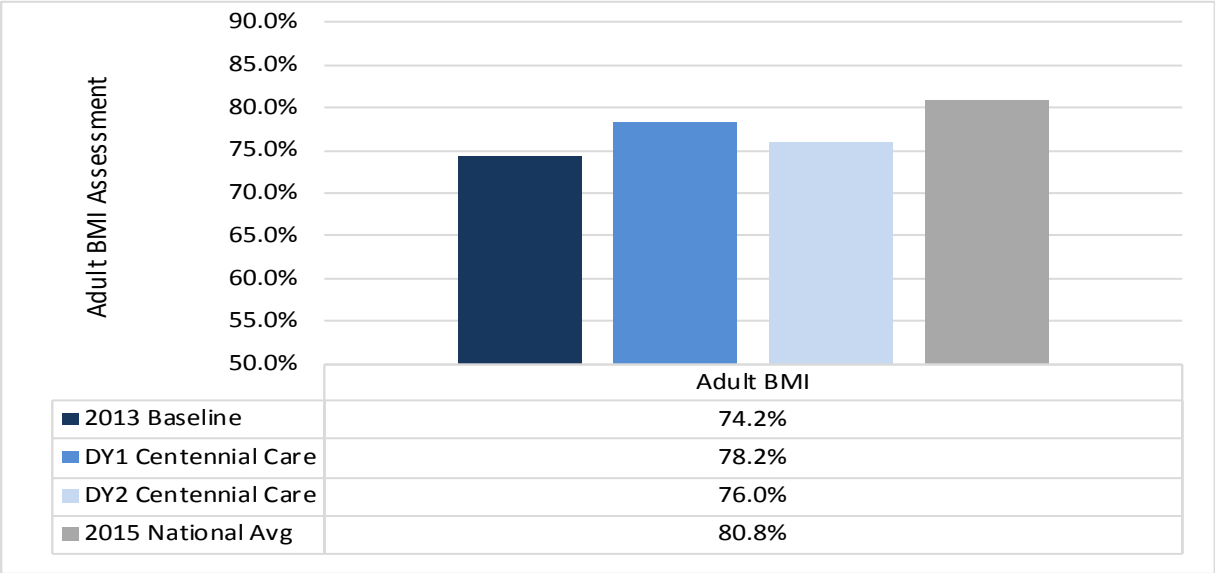
[53] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 41 – Adult BMI assessment and weight assessment for children/adolescents.

Exhibit 41.a presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the measure Adult BMI Assessment. As illustrated, the rate decreased modestly from DY1 to DY2 (2.8%), but it was not statistically significant at the 95% confidence level. Upon review of the individual MCO performance, MHC's rate increased (7.0%) while the other MCO rates declined: BCBS (-9.0%), PHP (-0.5%), and UHC (-3.8%). Only BCBS's decline was statistically significant at the 95% confidence level.

The rate increased from the baseline to DY2 (2.4%) but this was not statistically significant at the 95% confidence level. Upon review of the individual MCO performance, the largest increase from the baseline to DY2 among MCOs was PHP (14.4%), which was statistically significant at the 95% confidence level, compared to changes for BCBS (0.6%), MHC (-1.7%), and UHC (0.2%).

Exhibit 41.a – Adult BMI Assessment[54]



	Adult BMI
2013 Baseline	74.2%
DY1 Centennial Care	78.2%
DY2 Centennial Care	76.0%
2015 National Avg	80.8%

Exhibit 41.b presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the three subcomponents included in the measure Weight Assessment for Children/Adolescents. As illustrated, BMI percentile had a positive increase from DY1 to DY2 of 21.0%, which was statistically significant at the 95% confidence level. The other two rates declined from DY1 to DY2: counseling for nutrition (-5.1%) and counseling for physical activity (-1.4%). The declines were not statistically significant.

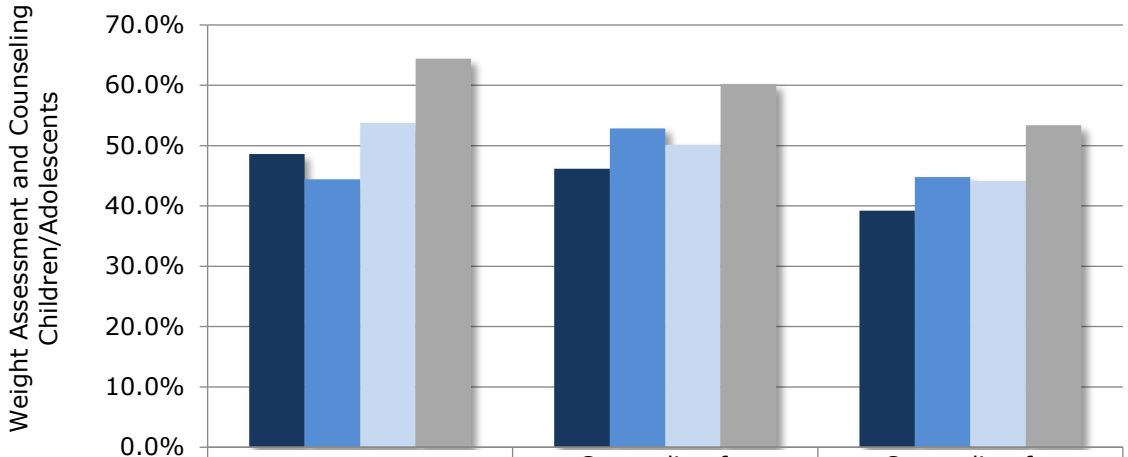
Upon review of the individual MCO performance for the BMI percentile from DY1 to DY2, MHC experienced the largest increase (51.6%), followed by PHP (45.1%). These improvements were statistically significant at the 95% confidence level. During this same period, BCBS exhibited the largest decline in rate for counseling for nutrition (-22.8%), which was statistically significant at the 95% confidence level. As it relates to counseling for physical activity, UHC had a large increase during this same time period (30.5%), which was statistically significant at the 95% confidence level.

There were improvements in all three subcomponents from the baseline to DY2. The largest improvement was in the rate for counseling for physical activity (12.5%), followed by BMI percentile (10.5%), and then counseling for nutrition (8.6%). The increases in all three rates were statistically

[54] Source: MCO annual HEDIS reports for 2013 – 2015.

significant at the 95% confidence level. Upon review of the individual MCO performance, the largest increase from the baseline to DY2 among MCOs was in PHP's BMI assessment rate (70.5%), which was statistically significant at the 95% confidence level.

Exhibit 41.b – Weight Assessment for Children/Adolescents[55]



	BMI Percentile	Counseling for Nutrition	Counseling for Physical Activity
2013 Baseline	48.6%	46.2%	39.2%
DY1 Centennial Care	44.4%	52.9%	44.8%
DY2 Centennial Care	53.7%	50.1%	44.1%
2015 National Avg	64.4%	60.2%	53.4%

[55] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 42 – Comprehensive diabetes care.

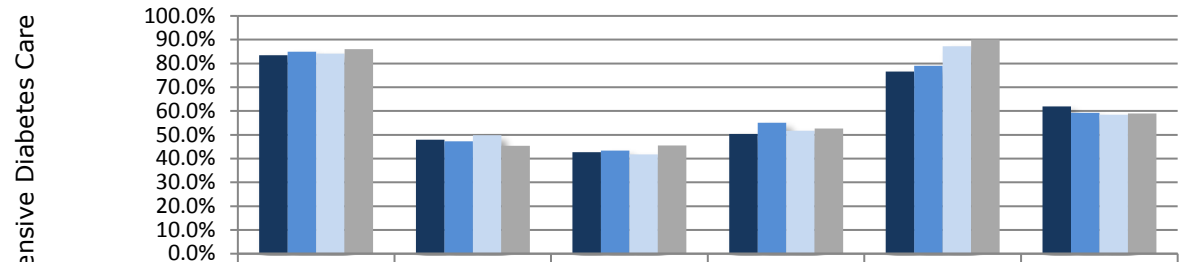
Exhibit 42 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the six subcomponents included in Comprehensive Diabetes Care. As illustrated, one of six rates had a positive increase from DY1 to DY2: medical attention for nephropathy (10.4%). The change in the rate for medical attention for nephropathy was statistically significant at the 95% confidence level.

Four subcomponents (HbA1c testing, HbA1c poor control >9.0%, eye exam, and blood pressure control) declined from DY1 to DY2 but only one decrease (eye exam) was statistically significant at the 95% confidence level. Upon review of individual MCO performance for the eye exam measure, BCBS experienced the steepest decline (-11.9%) from DY1 to DY2 compared to MHC, PHP, and UHC, which had declines of 3.5%, 3.5%, and 4.1% respectively.

The last subcomponent (HbA1c poor control >9.0%) had an unfavorable increase from DY1 to DY2.

Three of six of the subcomponents (HbA1c testing, eye exam, and medical attention for nephropathy) improved from the baseline to DY2. The largest improvement was in the rate for medical attention for nephropathy, increasing by 14.0%, which was statistically significant at the 95% confidence level. Two subcomponents declined from the baseline to DY2 (HbA1c poor control <8.0% and blood pressure control) but only blood pressure control was statistically significant at the 95% confidence level. One of the six subcomponents (HbA1c poor control >9.0%) had an unfavorable increase from the baseline to DY2.

Exhibit 42 – Comprehensive Diabetes Care[56]



	HbA1c Testing	HbA1c Poor Control (>9.0%)	HbA1c Control (<8.0%)	Eye Exam	Medical Attention for Nephropathy	Blood Pressure Controlled <140/90 mm Hg
2013 Baseline	83.5%	47.9%	42.7%	50.4%	76.6%	62.0%
DY1 Centennial Care	85.0%	47.2%	43.4%	55.0%	79.1%	59.3%
DY2 Centennial Care	84.1%	49.8%	41.8%	51.8%	87.3%	58.4%
2015 National Avg	86.0%	45.4%	45.5%	52.7%	90.0%	59.0%

[56] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 43.a – Ambulatory care sensitive diabetes long-term complications admission rates.

Exhibit 43.a presents results for the baseline, DY1, and DY2 for Ambulatory Care Sensitive Diabetes Long Term Complications Admission Rates. As illustrated, there was an improvement in performance resulting in a 14.1% decrease in the rate per 100,000 with admissions due to long term complications from diabetes from DY1 to DY2.

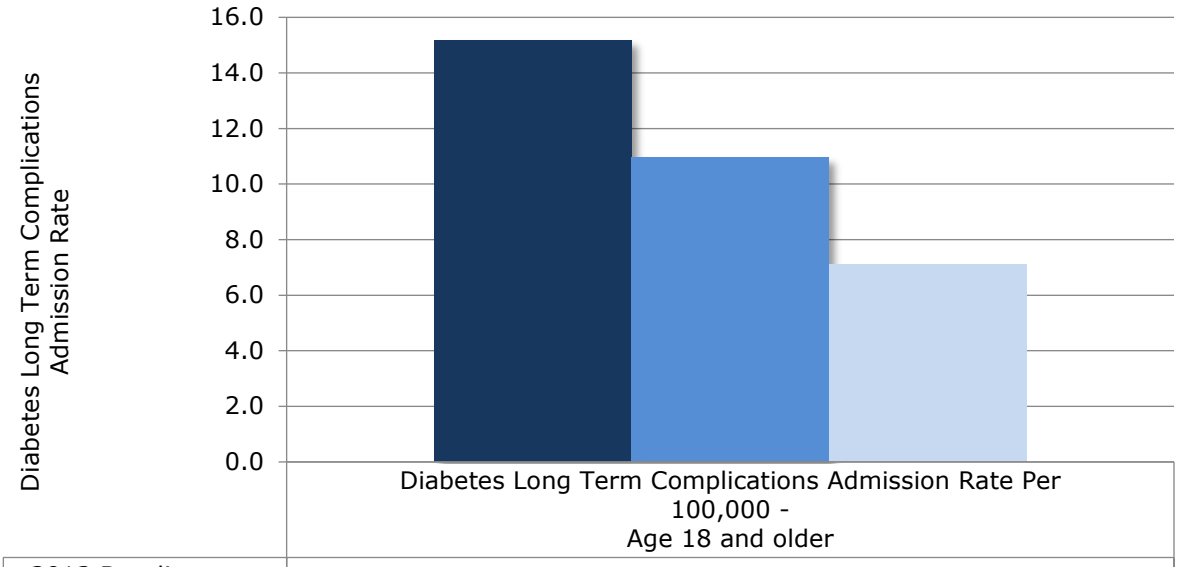
Upon review of the individual MCO performance during the same time period, there was improvement in performance, resulting in a decrease in the rate per 100,000 for admissions due to long term complications from diabetes, for all MCOs: BCBS (-22.7%), MHC (-0.4%), PHP (-10.6%), and UHC (-19.1%).

There was also an improvement in performance resulting in a 38.0% decrease in the rate per 100,000 with admissions due to long term complications from diabetes from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 43.a – Diabetes Long Term Complications Admissions Rate[57]



	Diabetes Long Term Complications Admission Rate Per 100,000 - Age 18 and older
2013 Baseline	15.2
DY1 Centennial Care	10.9
DY2 Centennial Care	7.1

[57] Source: ACS MMIS reports.

Measure 43.b – Ambulatory care sensitive diabetes short-term complications admission rates.

Exhibit 43.b presents results for DY1 and DY2 for Ambulatory Care Sensitive Diabetes Short Term Complications Admission Rates. As illustrated, there was an improvement in performance resulting in a 22.0% decrease in the rate per 100,000 for members 18-64 years of age with admissions due to short term complications from diabetes from DY1 to DY2. For members 65 years of age and older, the performance decreased resulting in an 8.6% increase in the rate per 100,000.

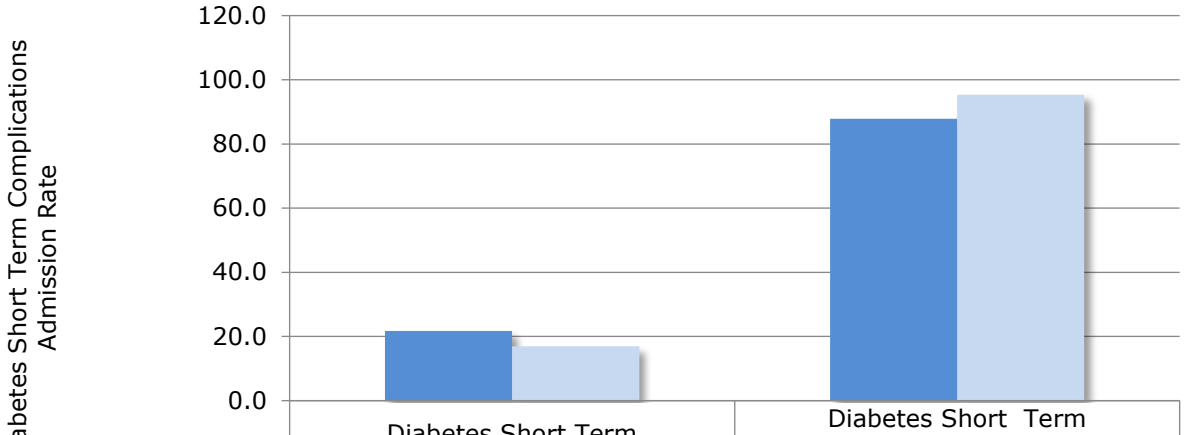
There was an improvement in individual MCO performance over the same time period for three MCOs, resulting in a decrease in rate per 100,000 for admissions of 18-64 year olds due to short term complications from diabetes: BCBS (-15.3%), MHC (-30.2%), and UHC (-39.6%). PHP experienced a 4.1% increase in rate per 100,000, which was a decline in performance. For members 65 years of age and older, performance improved for UHC (-0.1%) and declined for BCBS, MHC, and PHP who experienced increases in rates of 76.1%, 825.9%, and 1,204.8%, respectively.

Although BCBS, MHC, and PHP experienced increases in their rates, it should be noted that their admission rate per 100,000 were in the range of 8–40, while UHC's rate per 100,000 was nearly 250 in DY2 and significantly pulled up the average in both DY1 and DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 43.b – Diabetes Short Term Complications Admissions Rate[58]



	Diabetes Short Term Complications Admission Rate 18-64 years	Diabetes Short Term Complications Admission Rate 65+ years
DY1 Centennial Care	21.7	87.8
DY2 Centennial Care	17.0	95.3

[58] Source: Centennial Care Diabetes Inpatient Encounters (PQI) reports and MMIS reports.

Measure 44 – ACS admission rates for COPD or asthma in older adults; asthma in younger adults.

Exhibit 44.a presents results for the 2013 baseline, DY1, and DY2 for ACS Admission Rates for Asthma in Younger Adults. As illustrated, there was improvement in performance resulting in a 23.8% decrease in the asthma admission rate per 100,000 for members 18-39 years of age from DY1 to DY2.

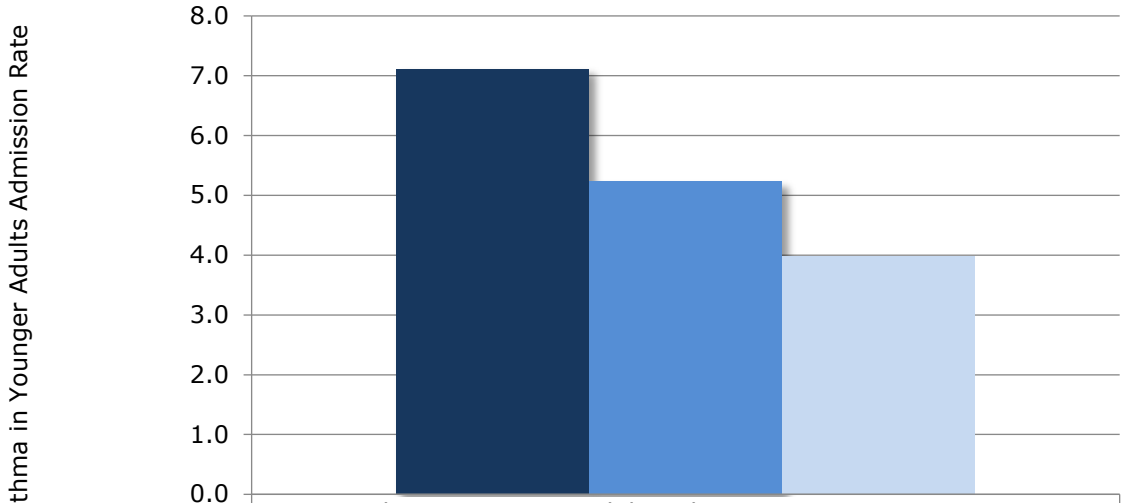
Upon review of the individual MCO performance over the same time period, there were no outliers noted.

There were similar results analyzing changes from the baseline to DY2, where there was an improvement in performance resulting in a 44.0% decline in the rate per 100,000.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 44.a – Asthma in Younger Adults Admission Rate[59]



	Asthma in Younger Adults Admission Rate Per 100,000 - Ages 18 to 39
Baseline	7.1
DY1 Centennial Care	5.2
DY2 Centennial Care	4.0

Exhibit 44.b presents results for the 2013 baseline, DY1, and DY2 for ACS Admission Rates for COPD or Asthma in Older Adults. As illustrated, there was an improvement in performance resulting in a 38.4% decline in the COPD or asthma admission rate per 100,000 for members 40-64 years of age from DY1 to DY2. Similarly, there was an improvement in performance resulting in a 19.6% decline in the COPD or asthma admission rate per 100,000 for members aged 65+ over the same time period.

Upon review of the individual MCO performance over the same time period, there were no outliers noted in the admission rates for members 40-64 years of age. Conversely, for members age 65+,

[59] Source: ACS MMIS reports.

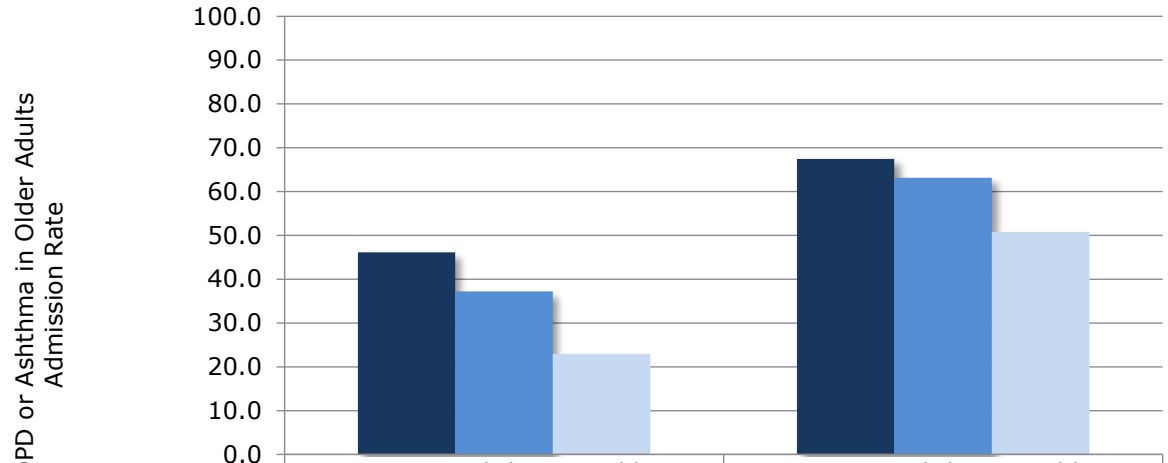
COPD or asthma admission rates declined for MHC (-12.9%), PHP (-56.7%), and UHC (-33.7%) while the rate increased for BCBS (621.4%).

There was an improvement in performance in the COPD or asthma admission rates per 100,000 for members 40-64 years of age (-50.2%) and for members aged 65+ (-24.7%) from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 44.b – COPD or Asthma in Older Adults Admission Rate[60]



	COPD or Ashthma in Older Adults Admission Rate Per 100,000 - Ages 40-64	COPD or Ashthma in Older Adults Admission Rate Per 100,000 - Age 65+
Baseline	46.1	67.5
DY1 Centennial Care	37.2	63.2
DY2 Centennial Care	23.0	50.8

[60] Source: ACS MMIS reports.

Measure 45 – Ambulatory care sensitive admission rates for hypertension.

Exhibit 45 presents results for the 2013 baseline, DY1, and DY2 for Ambulatory Care Sensitive Admission Rates for Hypertension. As illustrated, there was an improvement in performance resulting in a 0.6% decrease in the rate per 100,000 for members with admissions due to hypertension from DY1 to DY2.

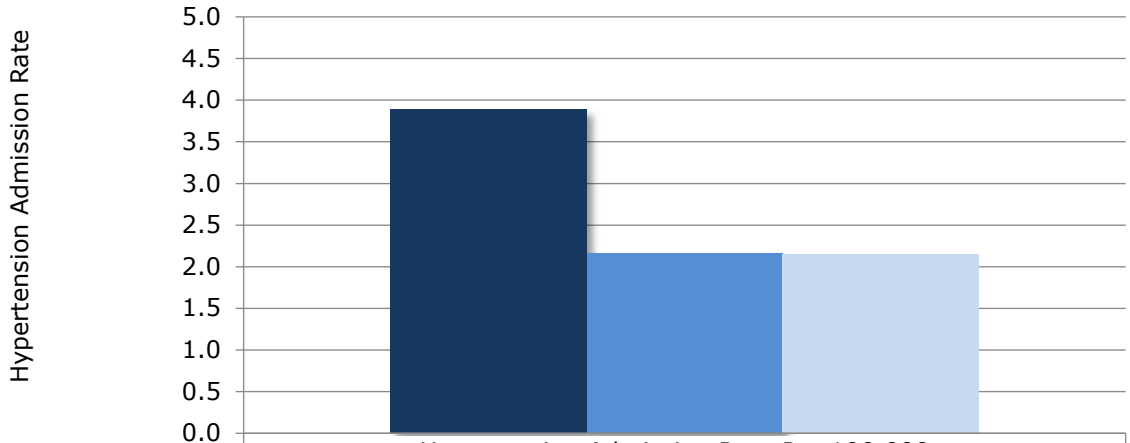
There was an improvement in individual MCO performance over the same time period for two of the MCOs, resulting in a decrease in rate per 100,000 for members with admissions due hypertension: MHC (-28.5%) and UHC (-31.4%). BCBS experienced a 31.2% increase and PHP experienced a 93.3% increase in the rate per 100,000, which was a decline in performance.

From the baseline to DY2, there was an improvement in performance resulting in a 44.6% decrease in the rate per 100,000 with admissions due to hypertension.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 45 – Hypertension Admissions Rate[61]



	Hypertension Admission Rate Per 100,000 - Ages 18 and Older
Baseline	3.9
DY1 Centennial Care	2.2
DY2 Centennial Care	2.2

[61] Source: ACS MMIS reports.

Measure 46 – ACS admission rates for pediatric asthma.

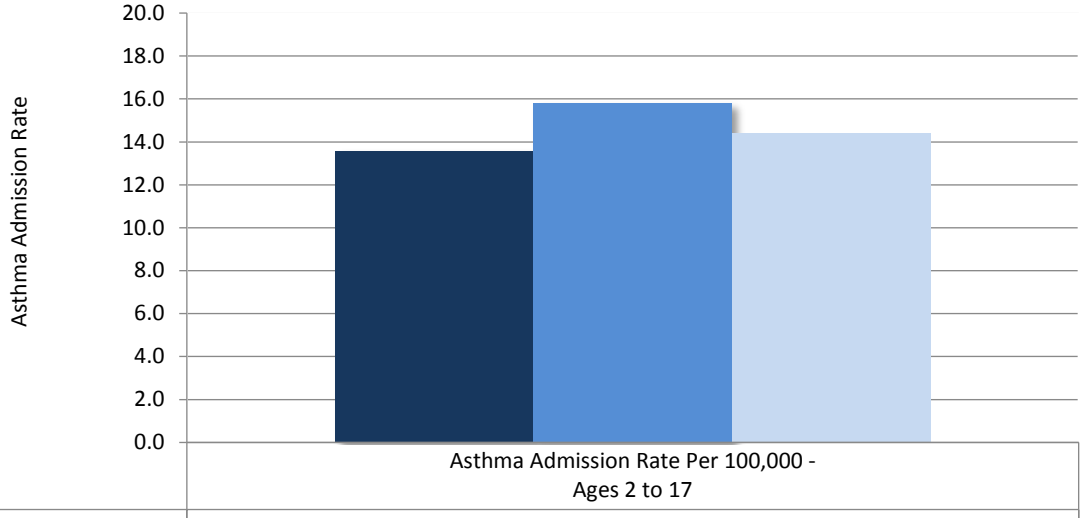
Exhibit 46 presents rates for the 2013 baseline, DY1, and DY2 for the ACS Pediatric Asthma Admission measure for members 2 through 17 years of age. Similar to other admission rate measures, this is an inverse measure where a decreasing rate represents an improvement in performance. As illustrated, there was an improvement in performance resulting in an 8.8% decrease in the in the rate per 100,000 with admissions for pediatric asthma from DY1 to DY2.

There was a decline in performance resulting in a 6.3% increase from the baseline to DY2. Upon review of individual MCO performance during this same time period, MHC experienced the steepest decline at 31.0% compared to UHC's decline of 12.9%. Both BCBS and PHP experienced increases over this same time period.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 46 – ACS Admissions Rate for Pediatric Asthma Aggregate[62]



	Asthma Admission Rate Per 100,000 - Ages 2 to 17
2013 Baseline	13.6
DY1 Centennial Care	15.8
DY2 Centennial Care	14.4

[62] A downward trend for this measure is considered an improvement as an annual reduction in admission rates is desirable. Source: ACS MMIS reports.

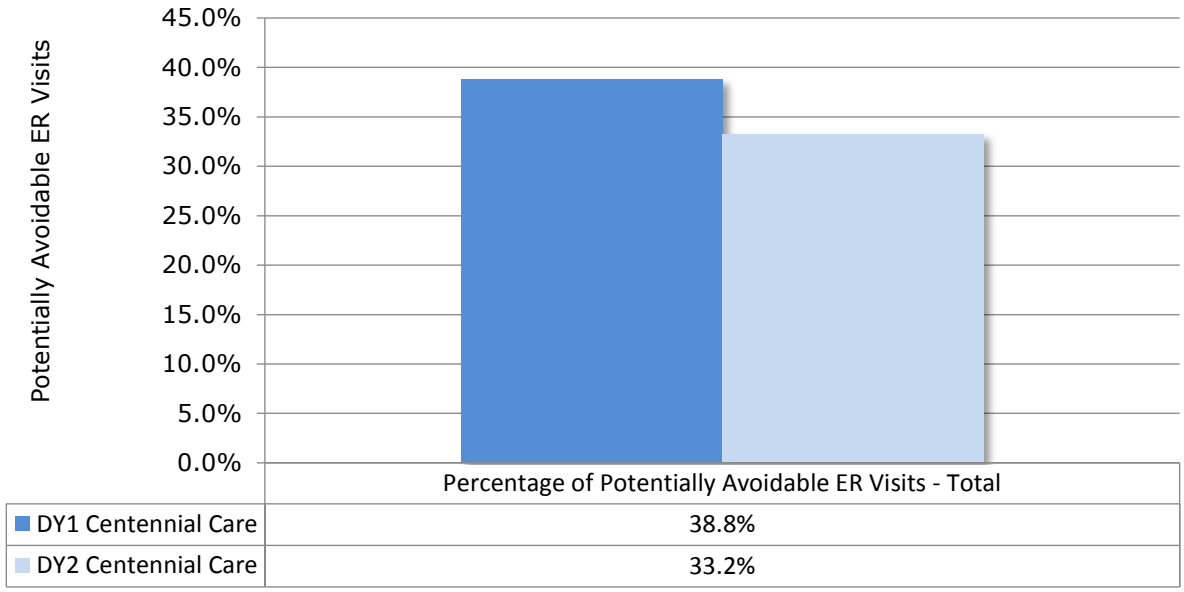
Measure 47 – Number and percentage of potentially avoidable ER visits.

Exhibit 47.a presents results for DY1 and DY2 for the Percentage of Unduplicated Members with a Potentially Avoidable ER Visits. As illustrated, there was a 14.4% decline in the percentage of unduplicated members with a potentially avoidable ER visit out of the total number of ER visits from DY1 to DY2. This is an improvement despite the total ER usage increased between DY1 and DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 47.a – Percentage of Members with Potentially Avoidable ER Visits[63]



	Percentage of Potentially Avoidable ER Visits - Total
DY1 Centennial Care	38.8%
DY2 Centennial Care	33.2%

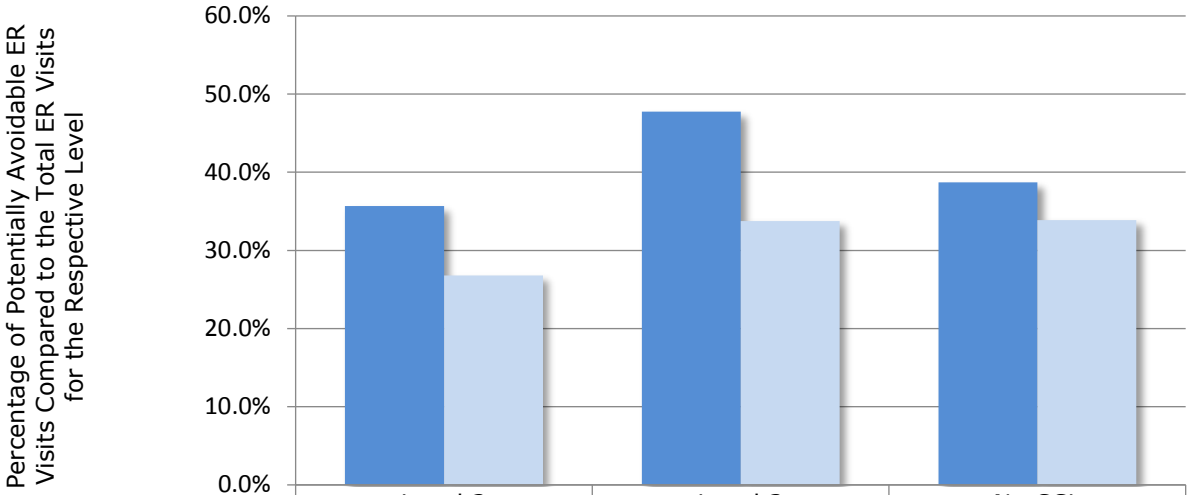
[63] Source: MCO reports for 2014 – 2015 (HSD 40).

Exhibit 47.b presents results for DY1 and DY2 for the Percentage of Unduplicated Members with Non-Emergent ER Visits by Care Coordination Level Out of the Total Number of ER Visits by Level. As illustrated, there were reductions in non-emergent ER visits in Care Coordination Level 2 (-24.9%), Level 3 (-29.4%), and members with no care coordination level (-12.4%) from DY1 to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 47.b – Percentage of Members with Potentially Avoidable ER Visits Out of the Total Number of ER Visits by Care Coordination Level[64]

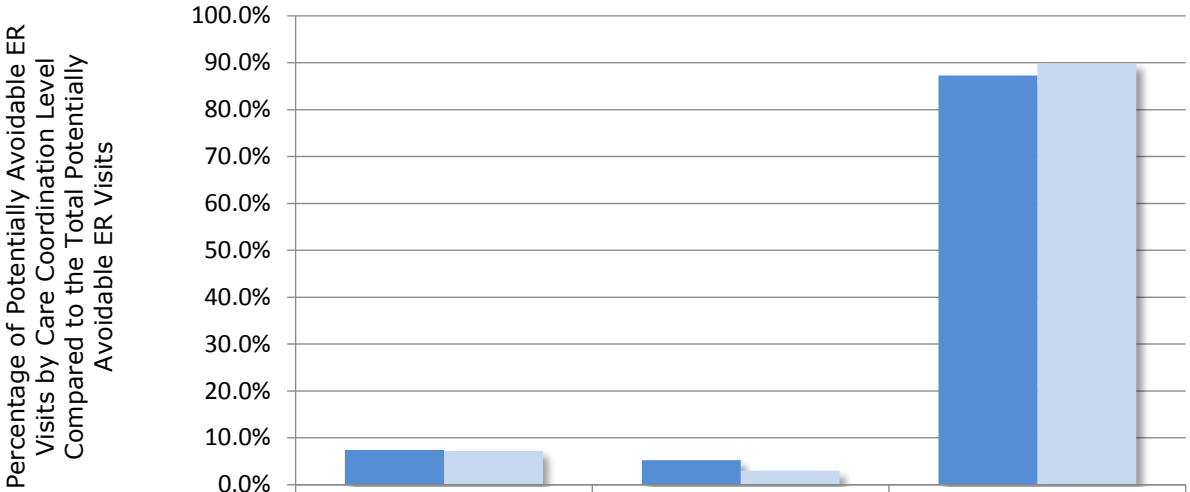


	Level 2	Level 3	No CCL
DY1 Centennial Care	35.7%	47.8%	38.7%
DY2 Centennial Care	26.8%	33.7%	33.9%

[64] Source: MCO reports for 2014 – 2015 (HSD 40).

Exhibit 47.c presents results for DY1 and DY2 for Potentially Avoidable ER Visits by Care Coordination Level. As illustrated, there were reductions in potentially avoidable ER visits in Care Coordination Level 2 (-2.4%) and Level 3 (-42.3%). The percentage for members with no Care Coordination Level increased by 2.8%.

Exhibit 47.c – Percentage of Members with Potentially Avoidable ER Visits by Care Coordination Level Out of the Total Number of Non-Emergent ER Visits[65]



	Level 2	Level 3	No CCL
DY1 Centennial Care	7.4%	5.3%	87.3%
DY2 Centennial Care	7.3%	3.0%	89.7%

[65] Source: MCO reports for 2014 – 2015 (HSD 40).

Measure 48 – Medical assistance with smoking and tobacco use cessation.

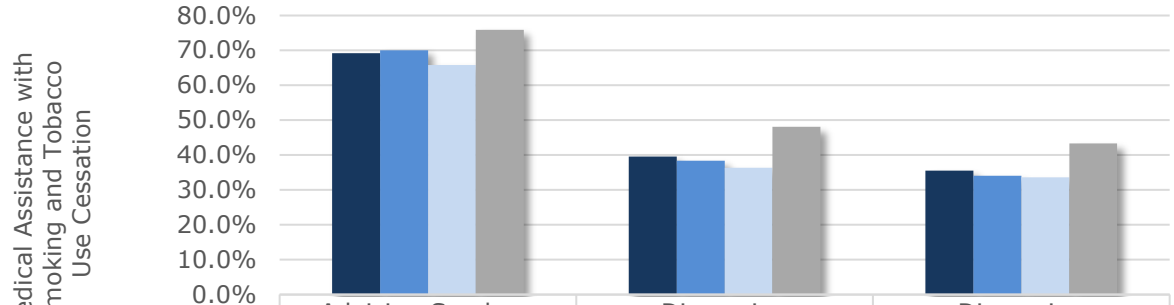
Exhibit 48 presents results for the baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the three subcomponents for the Medical Assistance with Tobacco Use Cessation measure. As illustrated, the rate of members who received advice to quit declined by 6.1% from DY1 and DY2. There was a 5.2% decline in the rate of members who discussed or were recommended cessation medications and a 1.3% decline in the rate of members who discussed cessation strategies during the same time period. Upon review of the individual MCO performance, there was a large improvement in the discussion of cessation strategies subcomponent from DY1 to DY2 for PHP (9.5%) compared to declines for BCBS (-1.0%), MHC (-2.4%), and UHC (-7.8%), though these three MCOs maintained higher rates in DY2 compared to PHP. There were no significant outliers across any of the MCOs for the advising smokers and tobaccos users to quit subcomponent and the discussing cessation medications subcomponent.

The rates for all three subcomponents fell from the baseline to DY2. The largest decline was in the rate of members who discussed or were recommended cessation medications (-8.2%) followed by the rate of members who discussed cessation strategies (-5.5%) and the rate of members who received advice to quit (-4.9%).

Upon review of the individual MCO performance, MHC had improvements in the advising smokers and tobaccos users to quit subcomponent from the baseline to DY2 for MHC (10.8%) though there were declines across all other MCOs: BCBS (-15.5%), PHP (-5.7%), and UHC (-8.2%). Similarly, there was improvement in the discussing of cessation medications subcomponent from the baseline to DY2 for MHC (12.7%) though there were declines across all other MCOs: BCBS (-14.6%), PHP (-12.8%), and UHC (-15.9%). MHC's rate also improved for the discussing cessation medications subcomponent (16.8%) compared to the declines across the other MCOs from the baseline to DY2: BCBS (-15.4%), PHP (-3.15%), and UHC (-16.9%).

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 48 – Medical Assistance with Smoking and Tobacco Use Cessation[66]



	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
2013 Baseline	69.2%	39.6%	35.5%
DY1 Centennial Care	70.0%	38.4%	34.0%
DY2 Centennial Care	65.8%	36.4%	33.6%
2015 National Avg	75.9%	48.1%	43.3%

[66] Source: MCO CAHPS reports for 2013 – 2015.

Measure 49.a – Number of critical incidents by reporting category – Centennial Care.

Exhibit 49.a presents results for DY1 and DY2 for the Number of Critical Incidents by Reporting Category for Centennial Care. As illustrated, in four categories there were increases in percentage of critical incidents reported from DY1 to DY2: Emergency Services (2.9%), Death (8.5%), Neglect (13.9%), and Missing/Elopement (37.4%). During the same time period, there were declines in the percentage of critical incident reports for Abuse (-26.8%), Exploitation (-23.6%), Law Enforcement (-8.7%), and Environmental Hazard (-6.8%).

Upon review of the individual MCO performance from DY1 and DY2, UHC experienced declines in four reporting categories: Abuse (-26.7%), Environmental Hazard (-6.3%), Exploitation (-29.1%), and Law Enforcement (-20.6%), and PHP had declines in two reporting categories: Abuse (-12.6%) and Neglect (-31.3%). BCBS had one reporting category, Law Enforcement, which remained constant. All other rates for the MCOs increased from DY1 to DY2.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests that Emergency Services, Death, and Neglect will continue to be the most frequently reported incident categories.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the dependent nature of the data.

Exhibit 49.a – Critical Incidents by Reporting Category: Centennial Care Total[67]

Critical Incident Type	Centennial Care - DY1		Centennial Care - DY2		DY1 - DY2 % Change
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	
Abuse	958	9.8%	875	7.2%	-26.8%
Death	1,058	10.8%	1,432	11.8%	8.5%
Natural/Expected	886	83.7%	1,246	87.0%	3.9%
Unexpected	164	15.5%	169	11.8%	-23.9%
Homicide	5	0.5%	5	0.3%	-26.1%
Suicide	3	0.3%	13	0.9%	220.2%
Emergency Services	5,710	58.5%	7,326	60.2%	2.9%
Environmental Hazard	179	1.8%	208	1.7%	-6.8%
Exploitation	463	4.7%	441	3.6%	-23.6%
Law Enforcement	448	4.6%	510	4.2%	-8.7%
Missing/Elopement	94	1.0%	161	1.3%	37.4%
Neglect	853	8.7%	1,211	9.9%	13.9%
Total Number of Critical Incidents	**9,763**		**12,164**		

Measure 49.b – Number of critical incidents by reporting category – behavioral health.

[67] Source: MCO Critical Incident Reports.

Exhibit 49.b presents results for DY1 and DY2 for the Number of Critical Incidents by Reporting Category for the Behavioral Health subcomponent. As illustrated, there were declines in four of the eight reporting categories: Abuse, which was the category with the second largest number of reported incidents (-36.3%), Environmental Hazard (-100.0%), Law Enforcement (-8.1%), and Missing/Elopement (-33.5%). The remaining four categories had increases in percentage of critical incident reports: Emergency Services, the category with the largest number of reports (38.9%), Death (46.5%), Exploitation (73.6%), and Neglect (0.03%).

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend appears consistent with the results from DY1 to DY2. The categories of Abuse, Law Enforcement, Missing/Elopement, and Neglect declined while the remaining four categories (Death, Emergency Services, Environmental Hazard, and Exploitation) continue to trend upward.

A plan by plan comparison on BH sub category was not performed as this data was only available in the aggregate.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the dependent nature of the data.

Exhibit 49.b – Critical Incident Reports for Centennial Care: Behavioral Health [68]

Critical Incident Type	Behavioral Health - DY1		Behavioral Health - DY2		DY1 - DY2 % Change
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	
Abuse	304	33.3%	223	21.2%	-36.3%
Death	32	3.5%	54	5.1%	46.5%
Natural/Expected	20	62.5%	30	55.6%	-11.1%
Unexpected	10	31.3%	21	38.9%	24.4%
Homicide	1	3.1%	1	1.9%	-40.7%
Suicide	1	3.1%	2	3.7%	18.5%
Emergency Services	310	34.0%	496	47.1%	38.9%
Environmental Hazard	6	0.7%	0	0.0%	-100.0%
Exploitation	7	0.8%	14	1.3%	73.6%
Law Enforcement	135	14.8%	143	13.6%	-8.1%
Missing/Elopement	60	6.6%	46	4.4%	-33.5%
Neglect	59	6.5%	68	6.5%	0.0%
Total Number of Critical Incidents	**913**		**1,044**		

Measure 49.c – Number of critical incidents by reporting category – self-direction.

Exhibit 49.c presents results for DY1 and DY2 for the Number of Critical Incidents by Reporting Category for the Self-Direction subcomponent. As illustrated, four of the eight reporting

[68] Source: MCO Critical Incident Reports.

categories declined in the percentage of critical incident reports: Abuse (-2.5%), Death (-20.5%), Exploitation (-7.8%), and Neglect (-54.6%). The reporting category with the largest number of critical incident reports, Emergency Services, increased by 6.9% from DY1 to DY2. The remaining three categories had increases in the percentage of critical incident reports: Environmental Hazards (4.9%), Law Enforcement (34.8%), and Missing/Elopement increased from 0.4% to 1.3%, a 267.0% change.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests a decrease in the percentage of critical incident reports for Death, Environmental Hazard, Exploitation, Law Enforcement, and Missing/Elopement. Data suggests that Emergency Services may continue as the category with the most critical incident reports.

A plan by plan comparison on the self-directed sub category was not performed as this data was only available in the aggregate.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the dependent nature of the data.

Exhibit 49.c – Critical Incident Reports for Centennial Care: Self-Direction[69]

Measure	Self-Direction - DY1		Self-Direction - DY2		
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	DY1 - DY2 % Change
Abuse	71	8.5%	44	8.2%	-2.5%
Death	95	11.3%	48	9.0%	-20.5%
Natural/Expected	81	85.3%	43	89.6%	5.1%
Unexpected	13	13.7%	4	8.3%	-39.1%
Homicide	0	0.0%	0	0.0%	0.0%
Suicide	1	1.1%	1	2.1%	97.9%
Emergency Services	521	62.0%	354	66.3%	6.9%
Environmental Hazard	12	1.4%	8	1.5%	4.9%
Exploitation	58	6.9%	34	6.4%	-7.8%
Law Enforcement	28	3.3%	24	4.5%	34.8%
Missing/Elopement	3	0.4%	7	1.3%	267.0%
Neglect	52	6.2%	15	2.8%	-54.6%
Total Number of Critical Incidents	**840**		**534**		

[69] Source: MCO Critical Incident Reports.

Measure 50 – Antidepressant medication management.

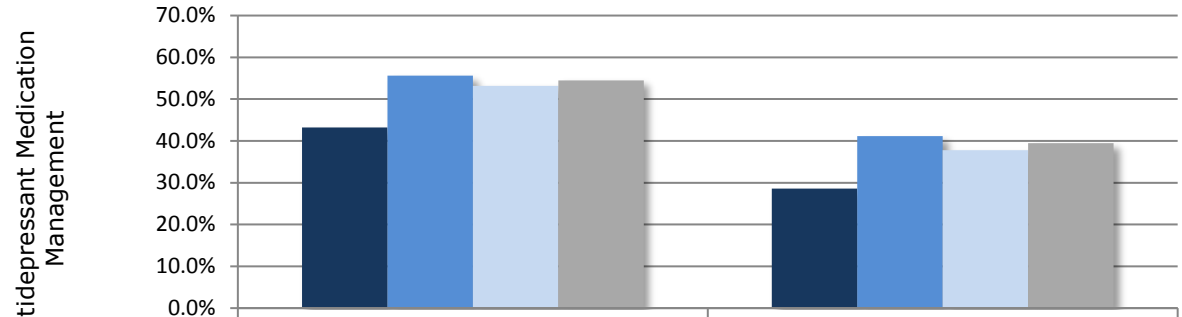
Exhibit 50 presents results for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for Antidepressant Medication Management. As illustrated, there was a decline in the effective acute phase treatment rate (-4.4%) and a decline in the effective continuation phase treatment rate (-8.1%) from DY1 to DY2. Both declines were statistically significant at the 95% confidence level.

Upon review of the individual MCO performance during the same time period, there were declines across all MCOs for the effective acute phase treatment rate: BCBS (-8.6%), MHC (-7.4%), PHP (-1.1%), and UHC (-9.4%). Of these, only the PHP decline was not statistically significant at the 95% confidence level. There were also declines across all MCOs for the effective continuation phase treatment rate: BCBS (-17.5%), MHC (-10.2%), PHP (-7.0%), and UHC (-11.3%). Of these, only the PHP decline was not statistically significant at the 95% confidence level.

The effective acute phase treatment rate increased substantially from the baseline to DY2 (22.9%), which was statistically significant at the 95% confidence level. Similarly, the effective continuation phase treatment rate increased substantially from the baseline to DY2 (32.2%), which was statistically significant at the 95% confidence level.

Upon review of the individual MCO performance from the baseline to DY2, BCBS had the largest increase for the effective acute phase treatment rate (28.1%), followed by MHC (21.5%), and UHC (11.0%). Both the BCBS and MHC rates were statistically significant at the 95% confidence level. Likewise, BCBS had the largest increase for the effective continuation phase treatment rate (31.8%), followed by MHC (38.4%) and UHC (15.7%). Both the BCBS and MHC rates were statistically significant at the 95% confidence level.

Exhibit 50 – Antidepressant Medication Management[70]



	Effective Acute Phase Treatment	Effective Continuation Phase Treatment
2013 Baseline	43.2%	28.6%
DY1 Centennial Care	55.6%	41.1%
DY2 Centennial Care	53.1%	37.8%
2015 National Avg	54.5%	39.5%

[70] Source: MCO annual HEDIS reports for 2013 – 2015. The 2013 baseline rate was adjusted in this report compared to the DY1 report due to corrected data.

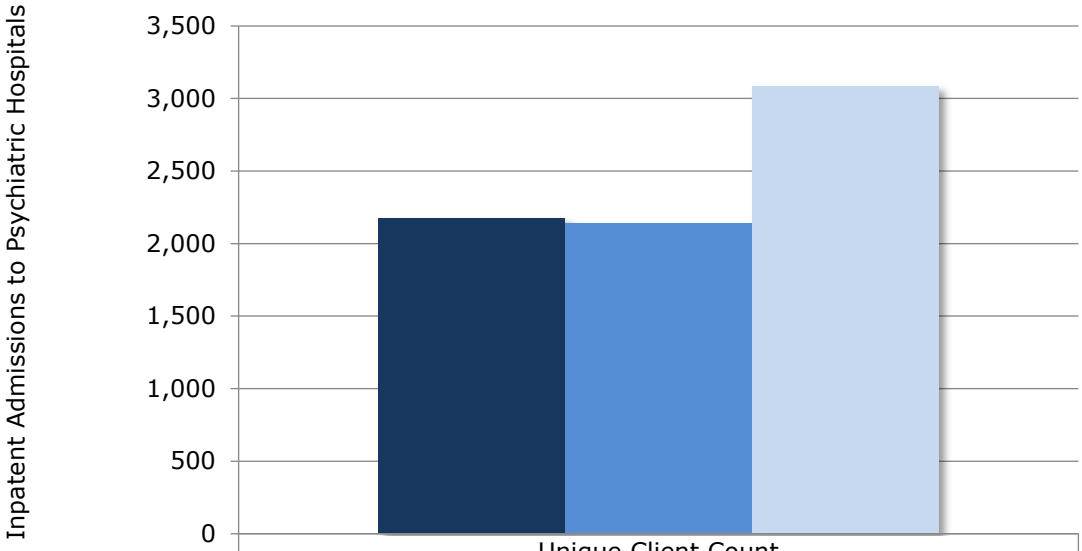
Measure 51 – Inpatient admissions to psychiatric hospitals and residential treatment centers.

Exhibit 51.a presents results for the 2013 baseline, DY1, and DY2 for the Inpatient Admissions to Psychiatric Hospitals measure in aggregate. As illustrated, the count increased 44.1% from DY1 to DY2. Similarly, the count increased by 41.8% from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 51.a – Inpatient Admissions to Psychiatric Hospitals[71]



	Unique Client Count
Baseline	2,177
DY1 Centennial Care	2,141
DY2 Centennial Care	3,086

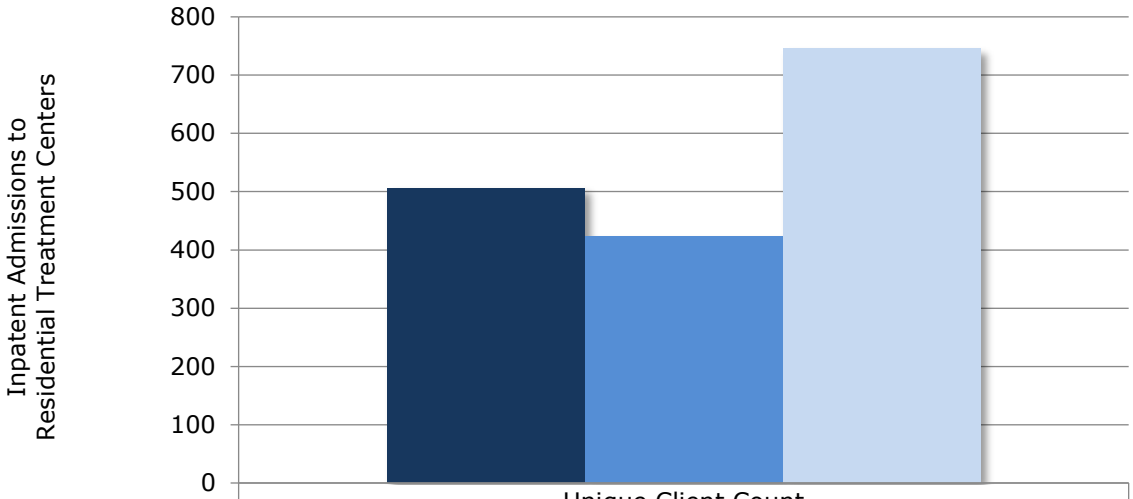
Exhibit 51.b presents counts for Admissions to Residential Treatment Centers (RTCs) in the 2013 baseline, DY1, and DY2. Note that RTCs treat Centennial Care's youth population through age 21. As illustrated, the number of inpatient admissions to RTCs increased 76.1% from DY1 to DY2. Similarly, the count increased by 47.2% from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

[71] Source: Admissions for Inpatient Psychiatric Hospitals (Claims type A and I) and RTCs MMIS reports.

Exhibit 51.b – Inpatient Admissions to Residential Treatment Centers[72]



	Unique Client Count
2013 Baseline	506
DY1 Centennial Care	423
DY2 Centennial Care	745

[72] Source: Admissions for Inpatient Psychiatric Hospitals (Claims type A and I) and RTCs MMIS reports.

Measure 52 – Percentage of nursing facility members who transitioned from a low nursing facility (NF) to a high nursing facility (NF).

Exhibit 52 presents results for DY1, DY2, and DY3 for the Percentage of Nursing Facility Members Who Transitioned from a Low Nursing Facility to a High Nursing Facility. As illustrated, there was an increase in the percentage of members who met low nursing facility LOC (6.9%) and a decline in the percentage of members who met high nursing facility LOC (-55.1%) from DY2 to DY3. These changes were not statistically significant.

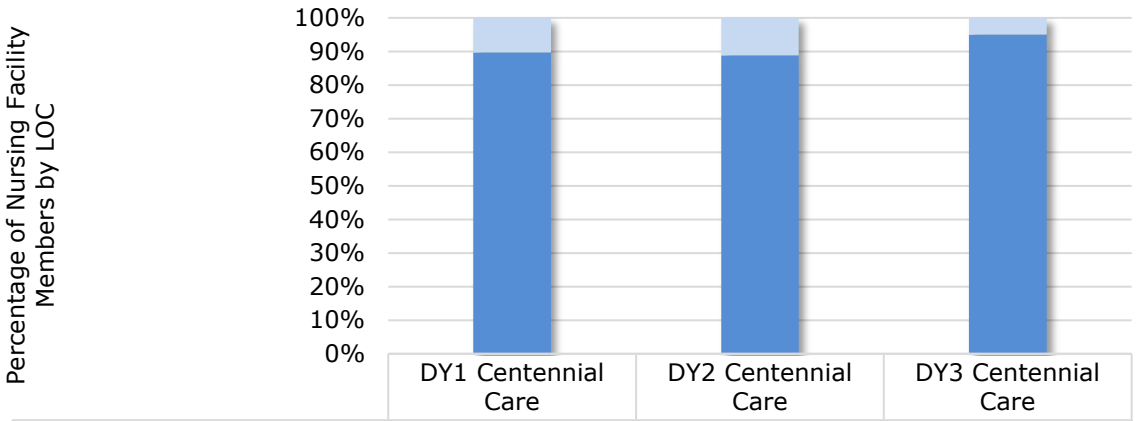
Upon review of the individual MCO performance during the same time period, the percentage of members who met low nursing facility LOC increased for BCBS (2.1%), MHC (28.2%), PHP (13.6%), and UHC (1.2%). Conversely, the percentage of members who met high nursing facility LOC declined across all MCOs: BCBS (-19.4%), MHC (-70.7%), PHP (-66.9%), and UHC (-36.7%). None of these changes were statistically significant.

The percentage of members who met low nursing facility LOC increased 5.9% while the percentage of members who met high nursing facility LOC decreased 51.4% from DY1 to DY3. These changes were not statistically significant.

Upon review of the individual MCO performance during the same time period, the percentage of members in low nursing facilities increased for BCBS (4.7%), MHC (16.3%), PHP (14.5%), and UHC (1.5%) and the percentage of members who met high nursing facility declined for all MCOs: BCBS (-34.7%), MHC (-60.6%), PHP (-68.2%), and UHC (-42.1%). None of these changes were statistically significant.

A national comparison rate could not be identified for this measure.

Exhibit 52 – Percent of NF Residents by LOC[73]



	DY1 Centennial Care	DY2 Centennial Care	DY3 Centennial Care
Percentage of Members who Meet High Nursing Facility Acuity	10.3%	11.2%	5.0%
Percentage of Members who Meet Low Nursing Facility Acuity	89.7%	88.8%	95.0%

[73] Source: MCO reports for 2014 – 2016 (HSD 8).

Measure 53 – Fall risk intervention.

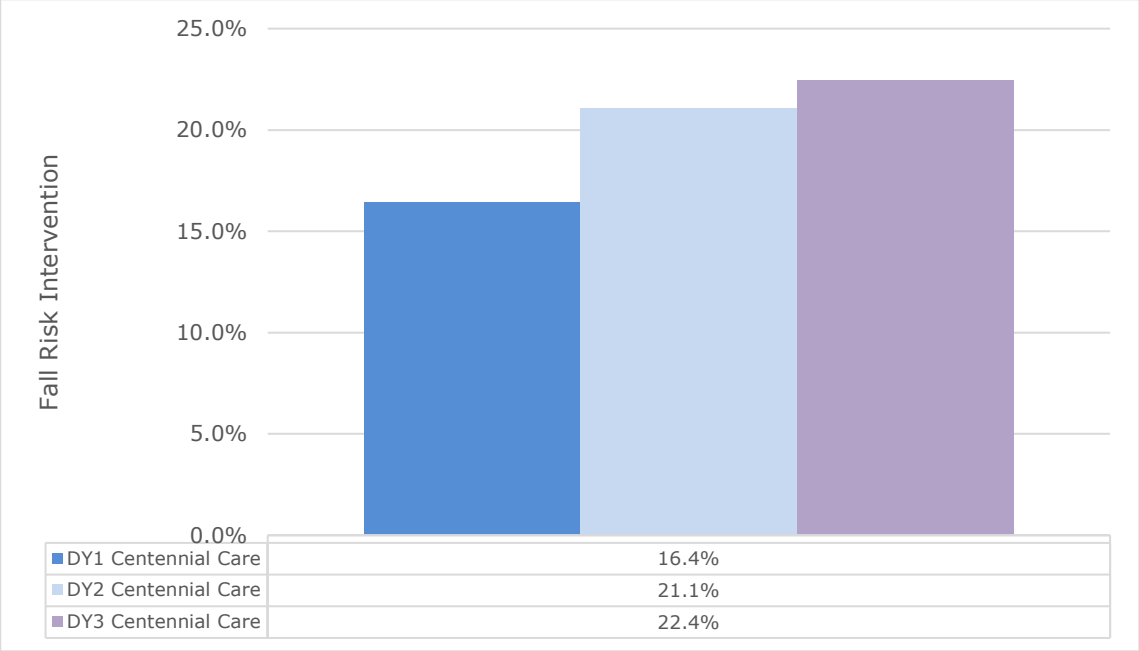
Exhibit 53 presents rates for DY1, DY2, and DY3 for Fall Risk Intervention, which measures members 65 years of age and older who have had a fall or problem with balance in the 12 months and who were seen by a provider and who received a fall risk intervention. It should be noted that the data source for this measure was revised and therefore the DY1 baseline has been modified to reflect the new data source.

As illustrated, the percentage of members that received a fall risk intervention increased from 21.1% in DY2 to 22.4% in DY3 (a 6.6% change).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data.

Exhibit 53 – Fall Risk Intervention[74]



[74] Source: NM HEDIS rates calculated by Mercer for 2014 – 2015.

Research Question 2.B

Is care integration effective under Centennial Care?

The Centennial Care waiver consolidates services within a single program and seeks to improve care delivery through an integrated model of care that includes PH, BH, and LTSS and provides a care coordination benefit to all members.

The Evaluation is reviewing Centennial Care's impact on care integration through analysis of 11 measures that address utilization of PCP, BH, LTSS, ER and ambulatory health services, nursing facility transition and HCBS, movement between care coordination levels, and HEDIS measures for co-occurring PH and BH conditions. For each measure, performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, the MCOs' care integration efforts show mixed results with respect to managing member acuity and improving the utilization of outpatient services.

Rates improved in 4 out of 11 measures from the baseline to DY2. New Mexico saw increases in the percentage of members who had a BH service and also received an LTSS service, and increases in the percentage of members who had a BH service and also received an outpatient ambulatory visit in the same year. There were also improvements across subcomponents for the care coordination level transitions and favorable declines in the percentage of members with BH needs who had an ER visit.

The percentage of members accessing a LTSS service and a PCP visit and the percentage of members who had a BH service and also accessed HCBS in the same year remained relatively consistent from the baseline to DY2.

Potential opportunities for improvement were identified for 4 out of 11 measures. The percentage of members accessing both a BH service and a PCP visit in the same year declined, as did diabetes screening and monitoring rates (diabetes screening for members with schizophrenia or bipolar disorder; diabetes monitoring for members with diabetes and schizophrenia). There was also an unfavorable increase in the percentage of members with LTSS needs who had an ER visit.

There was also a decrease in the percentage of member at risk for NF placement who remained in the community, but this measure is expected to be retired as members are no longer required to enter a NF as the only means to being allocated NF LOC services, and thus the measure is no longer valid.

Emerging trends for measures that have DY3 data available indicate a continuation of baseline to DY2 trend, including continuing improvements for the percentage of members who had a BH service and also received an LTSS service, the percentage of members who had a BH service and also accessed HCBS, and improvements across subcomponents for the care coordination level transitions.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 54 – Percentage of population accessing a behavioral health service that received a PCP visit in the same year.

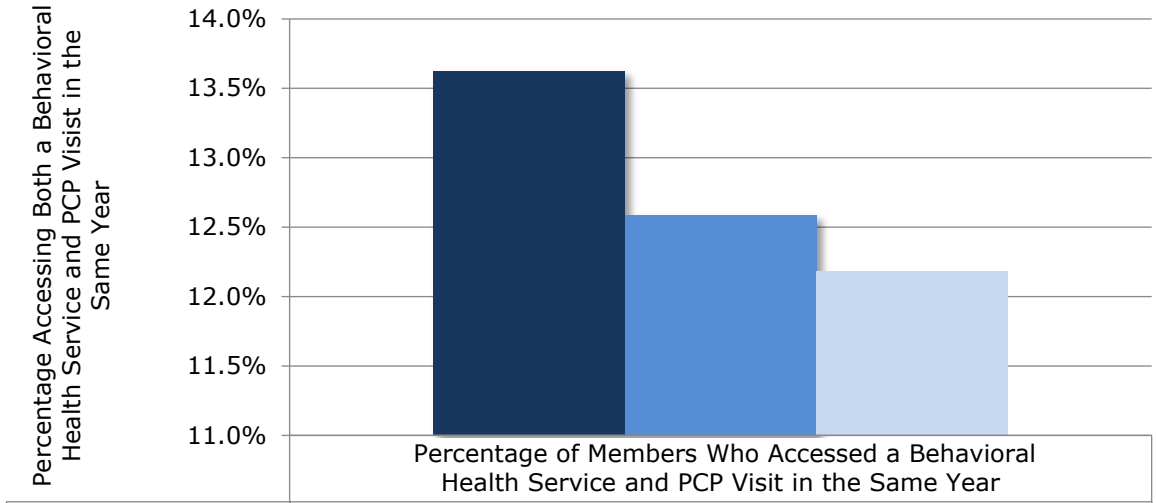
Exhibit 54 presents results for the 2013 baseline, DY1, and DY2 for the Percentage of the Population Accessing a Behavioral Health Service and a PCP Visit in the Same Year. As illustrated, there was a 3.2% decline in the percentage of members that accessed both a BH service and PCP visit in the same year from DY1 to DY2. This change was statistically significant at the 95% confidence level. As mentioned in discussion of measure 15, there were significant changes in the number of BH providers participating in DY2 which had an impact on members' ability to access BH services during certain periods of DY2.

Upon review of the individual MCO performance over the same time period, PHP experienced a larger decline (-10.5%) than MHC (-4.8%), and UHC (-2.2%). BCBS experienced an 8.8% increase from DY1 to DY2.

There was a 10.6% decline in the percentage of members utilizing both a BH service and PCP visit in the same year from baseline to DY2. This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 54 – Percentage of the Population Accessing a Behavioral Health Service and a PCP Visit in the Same Year[75]



	Percentage of Members Who Accessed a Behavioral Health Service and PCP Visit in the Same Year
Baseline	13.6%
DY1 Centennial Care	12.6%
DY2 Centennial Care	12.2%

[75] Source: BH and PCP Visits MMIS reports.

Measure 55 – Percentage of the LTSS population that received a PCP visit in the year (Percentage of population accessing an LTSS service that received a PCP visit in the same year).

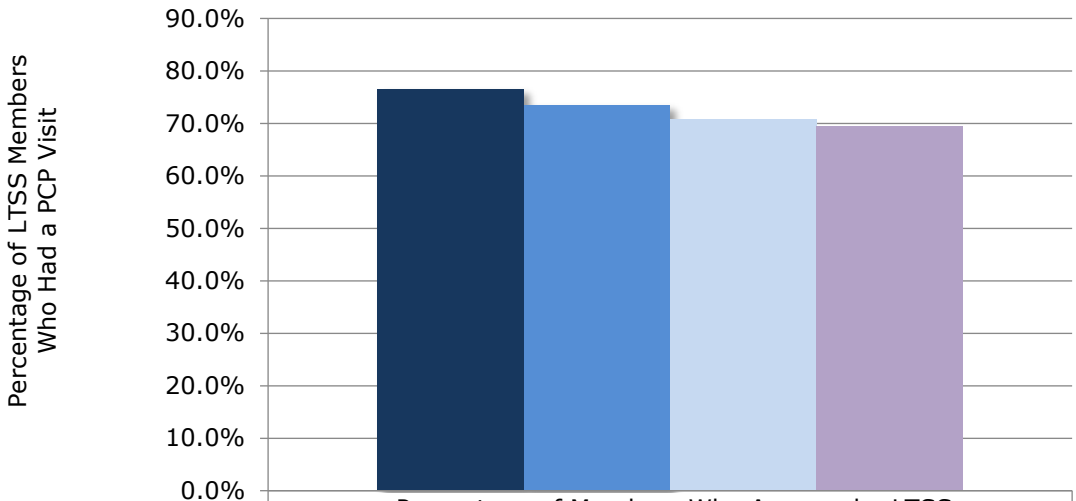
Exhibit 55 presents results for the 2013 baseline, DY1, DY2, and DY3 for the Percentage of the LTSS Population that Received a PCP Visit in the Same Year. This measure has been modified to isolate the LTSS population as the eligible population, or denominator. Previously this measure used the entire Centennial Care population as the denominator and then isolated those that received both LTSS services and a PCP visit within the reporting year. We believe this change more accurately captures the purpose of the measure, namely to measure what percent of the LTSS population, which is a higher needs, higher cost population, received a PCP visit.

As illustrated, the percentage changed from 70.7% in DY2 to 69.4% in DY3 (a -1.9% change) for the members utilizing both an LTSS service and PCP visit in the same year. This change was not statistically significant.

When analyzing changes from the baseline to DY3, there was a 9.3% decrease in percentage of members accessing an LTSS service that received a PCP visit in the same year. This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 55 – Percentage of Members Who Accessed an LTSS Service and PCP Visit in the Same Year[76]



	Percentage of Members Who Accessed a LTSS Service and PCP Visit in the Same Year
Baseline	76.5%
DY1 Centennial Care	73.5%
DY2 Centennial Care	70.7%
DY3 Centennial Care	69.4%

[76] Source: LTSS and PCP Visits MMIS reports.

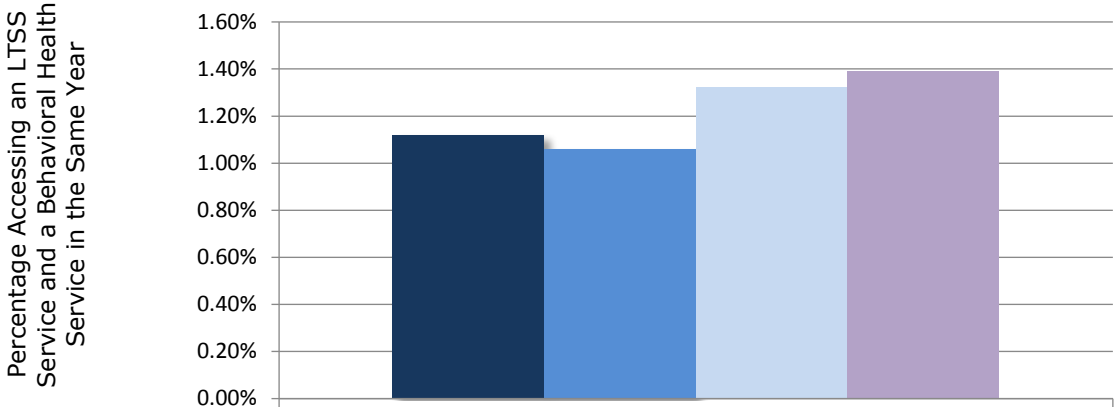
Measure 56 – Percentage of the population accessing an LTSS service and a behavioral health visit in the same year.

Exhibit 56 below presents results for the 2013 baseline, DY1, DY2 and DY3 for the measure Percentage of Participants Who Accessed an LTSS Service and a Behavioral Health Visit in the Same Year. As illustrated, there was an increase in the percentage of members accessing both LTSS and a BH service from 1.32% in DY2 to 1.39% in DY3 (a 4.89% change), and the percentage has been increasing each year since the implementation of Centennial Care. This change was not statistically significant.

Similarly, the percentage of participants accessing both an LTSS service and BH service in the same year has increased from 1.12% for the baseline to 1.39% in DY3 (a 24.20% change). This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 56 – Percentage of the Population Accessing an LTSS Service and a Behavioral Health Visit in the Same Year [77]



	Percentage of Participants Who Accessed an LTSS Service and a Behavioral Health Service in the Same Year
2013 Baseline	1.12%
DY1 Centennial Care	1.06%
DY2 Centennial Care	1.32%
DY3 Centennial Care	1.39%

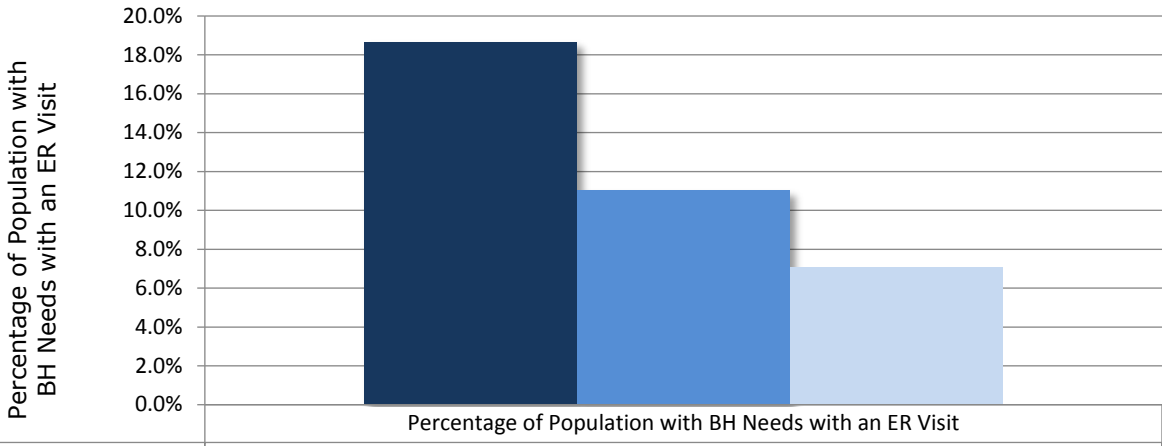
[77] Source: LTSS and BH MMIS reports.

Measure 57 – Percentage of population with behavioral health needs with an ER visit by type of ER visit.

Exhibit 57.a presents results for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with Behavioral Health Needs with an ER Visit. As illustrated, there was a favorable decline in the total percentage of members from 11.0% in DY1 to 7.1% in DY2 (a 36.5% change), and a favorable decline in the percentage from 18.7% in the baseline to 7.1% in DY2 (a 62.5% change). These changes were statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 57.a – Percentage of the Population with Behavioral Health Needs with an ER Visit[78]



	Percentage of Population with BH Needs with an ER Visit
2013 Baseline	18.7%
DY1 Centennial Care	11.0%
DY2 Centennial Care	7.1%

[78] Source: BH population with ED visits MMIS reports.

Exhibit 57.b presents results for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with BH Needs with an ER Visit by Type of ER Visit. As illustrated, there were favorable declines in four (EMTALA, Moderate, Life threatening, and Admitted through the ER) of the eight ER visit types from DY1 to DY2 with a range from 7.48% to 82.76%.

There were unfavorable increases in three (Limited or Minor, Low to Moderate, and High Severity) of the eight ER visit types from DY1 to DY2 with a range from 12.59% and 23.54%.

All changes from DY1 to DY2 were statistically significant at the 95% confidence level except for EMTALA and Urgent Care ER visit changes.

There were favorable declines in all rates from the baseline to DY2. The largest decline was in urgent care visits (-95.53% change). The smallest decline was in limited to minor type ER visits (-36.91% change). All changes from the baseline to DY2 were statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 57.b – Percentage of the Population with Behavioral Health Needs with an ER Visit by Type of ER Visit[79]

ER Visit Type	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care
EMTALA	0.23%	0.09%	0.08%
Urgent Care	0.02%	0.00%	0.00%
Limited or Minor	0.59%	0.32%	0.37%
Low to Moderate	1.77%	0.59%	0.73%
Moderate	6.41%	2.49%	2.21%
High Severity	7.00%	2.24%	2.52%
Life Threatening	5.39%	2.47%	2.29%
Admitted through the ER	3.57%	5.14%	0.89%

[79] Source: BH population with ED visits MMIS reports.

Measure 58 – Percentage of population with LTSS needs with an ER visit by type of ER visit.

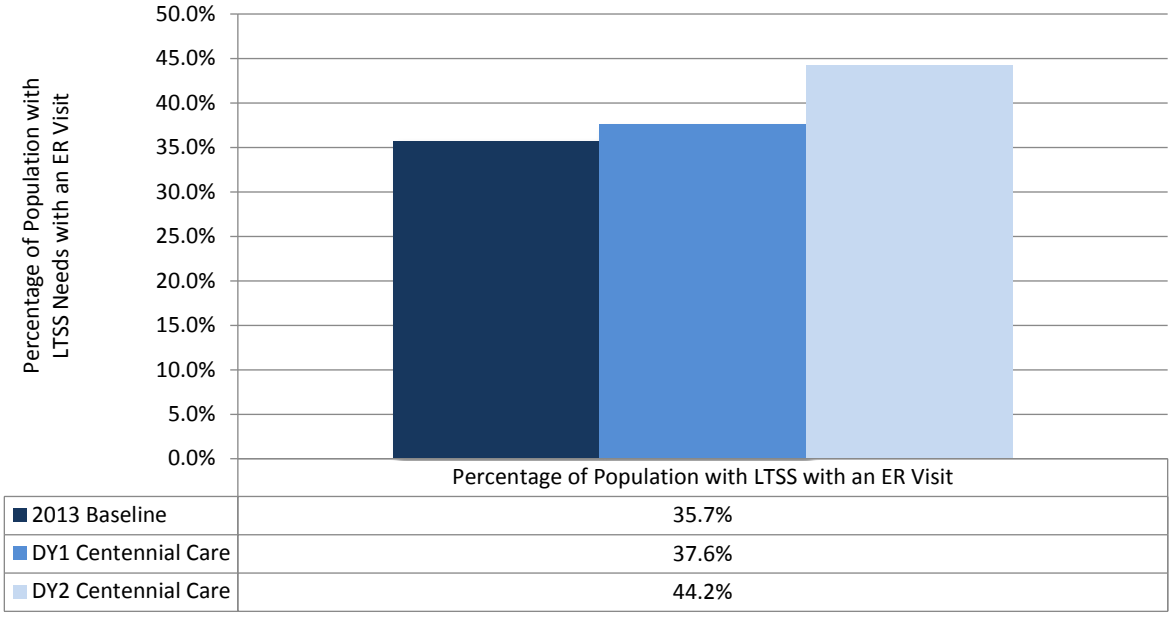
Exhibit 58.a below presents rates for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with LTSS Needs with an ER Visit. As illustrated, there was an unfavorable increase in the total rate from 37.6% in DY1 to 44.2% in DY2 (a 17.7% change).

Similarly, there was an unfavorable increase in the total rate from 35.7% in the baseline to 44.2% in DY2 (a 23.8% change).

These changes were statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 58.a – Percentage of the Population with LTSS Needs with an ER Visit[80]



	Percentage of Population with LTSS with an ER Visit
2013 Baseline	35.7%
DY1 Centennial Care	37.6%
DY2 Centennial Care	44.2%

[80] Source: LTSS Population with ED visits MMIS reports.

Exhibit 58.b presents rates for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with LTSS Needs with an ER Visit by Type of ER Visit. As illustrated, there was a favorable decrease in the reported rate for once (Urgent Care) of the eight ER visit types from DY1 to DY2 with a decrease from 0.02% to 0.01%.

There was an unfavorable increase in the reported rate for seven (EMTALA, Admitted through ER, Limited or Minor, Life Threatening, Low to Moderate, Moderate, and High Severity) of the eight ER visit types from DY1 to DY2 with a range of changes from 13.16% to 52.12%. There were favorable declines in two rates from the baseline to DY2: EMTALA (1.82% change) and Urgent Care (43.27% change).

All changes were statistically significant at the 95% confidence level except the changes for EMTALA and Urgent Care type ER visits.

A national comparison rate could not be identified for this measure.

Exhibit 58.b – Percentage of the Population with LTSS Needs with an ER Visit by Type of ER Visit[81]

ER Visit Type	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care
EMTALA	0.30%	0.25%	0.29%
Urgent Care	0.02%	0.02%	0.01%
Limited or Minor	1.50%	1.76%	2.68%
Low to Moderate	3.91%	3.73%	4.88%
Moderate	13.33%	13.78%	16.06%
High Severity	15.18%	15.46%	19.67%
Life Threatening	13.19%	14.07%	17.22%
Admitted through the ER	8.66%	12.78%	14.47%

[81] Source: LTSS Population with ED visits MMIS reports.

Measure 59 – Number at risk for nursing facility placement who remain in the community (Percentage of the population at risk for nursing facility placement who remain in the community).

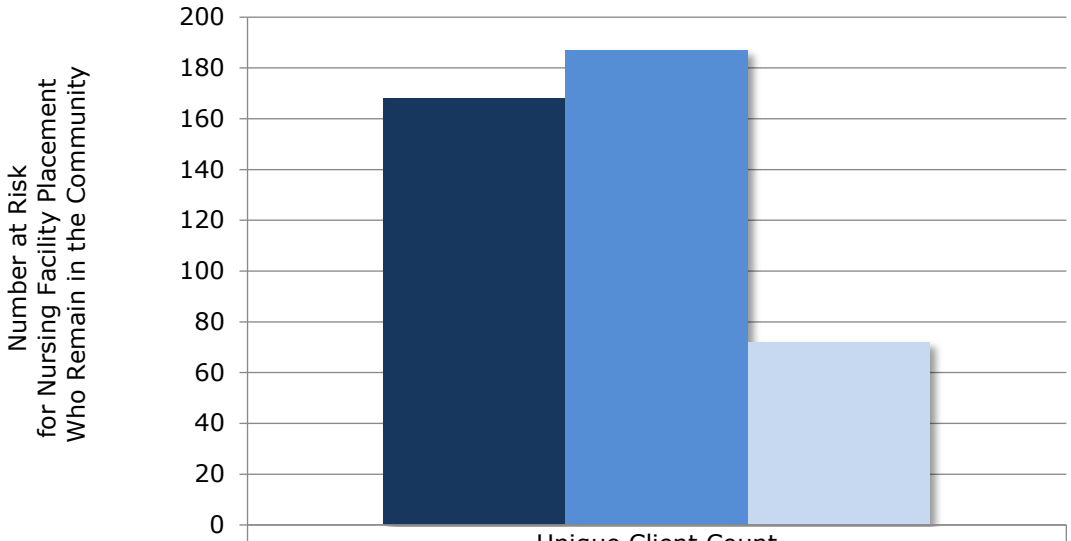
Exhibit 59 presents results for the 2013 baseline, DY1, and DY2 for the Number at Risk for Nursing Facility Placement Who Remain in the Community. As illustrated, the number of members that transitioned from NFs into the community declined 61.5% from DY1 to DY2. Similarly, the rate also declined (57.1%) from the baseline to DY2.

Although there has been a decrease in the number of members transitioning from NFs into the community, more people are accessing community benefits under Centennial Care. With the implementation of Centennial Care, members are no longer required to enter a NF as the only means to being allocated NF LOC services. As a result, this measure is no longer valid and HSD has requested that CMS retire this measure.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data.

Exhibit 59 – Number at Risk for Nursing Facility Placement Who Remain in the Community[82]



	Unique Client Count
SFY 2013 Baseline	168
SFY 2014 Centennial Care	187
SFY 2015 Centennial Care	72

[82] Source: NM Medical Assistance Division (MAD) reports.

Measure 60 – Number and percentage of members who accessed a behavioral health service that also accessed HCBS in the same year.

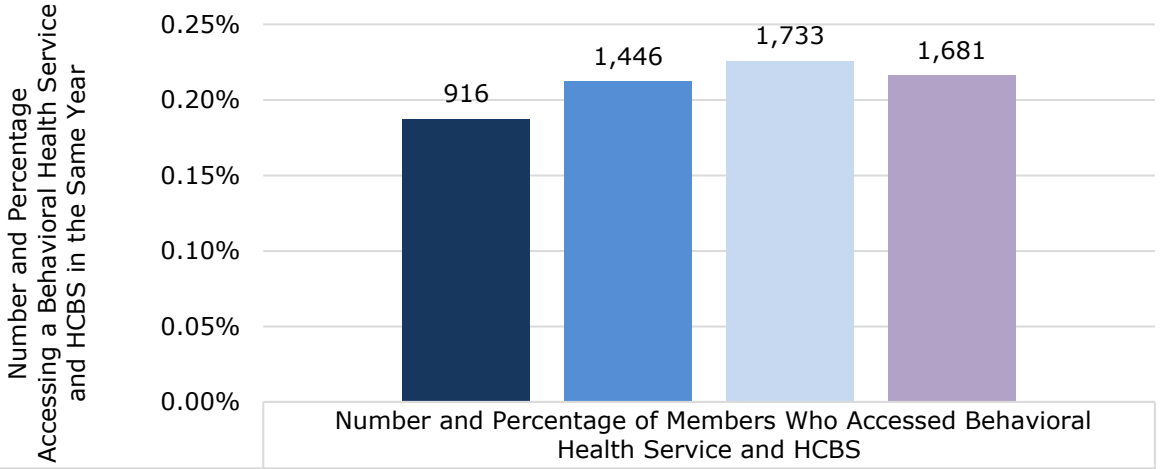
Exhibit 60 below presents results for the 2013 baseline, DY1, DY2, and DY3 for the Number and Percentage of Members who Accessed a Behavioral Health Service that also Accessed HCBS in the Same Year. As illustrated, there was a slight decrease in the percentage of members accessing both BH and HCBS services from 0.23% in DY2 to 0.22% in DY3 (a 7.53% change) which was not a statistically significant change.

Overall, results for DY3 were relatively consistent with the results from DY1 and DY2, and all three years have shown a slight increase over the baseline. As illustrated, there was an increase from 0.19% in the baseline to 0.22% in DY3 (a change of 15.37%). This change was statistically significant at the 95% confidence level.

A plan by plan analysis was performed but the results did not yield any significant outliers across any of the MCOs.

A national comparison rate could not be identified for this measure.

Exhibit 60 – Number and Percentage of Members Who Accessed a Behavioral Health Service and That Also Accessed HCBS in the Same Year[83]



2013 Baseline	0.19%
DY1 Centennial Care	0.21%
DY2 Centennial Care	0.23%
DY3 Centennial Care	0.22%

[83] Source: BH Population with HCBS MMIS reports.

Measure 61 – Number and percentage of members that maintained their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level.

Exhibit 61 presents results for DY1, DY2, and DY3 for the Number and Percentage of Members That Maintained Their Care Coordination Level, Moved to a Lower Care Coordination Level, or Moved to a Higher Care Coordination Level. As illustrated, there was a 6.9% increase in the average number of members that maintained their care coordination from DY2 to DY3. The percentage of members that maintained their care coordination level with respect to the average total number of members receiving care coordination increased by 0.4% over the same period.

There was a 7.5% increase in the average number of members that moved to a lower care coordination level from DY2 to DY3. The percentage of members that moved to a lower care coordination level with respect to the average total number of members receiving care coordination increased by 0.9% over the same period.

There was a 9.1% decrease in the average number of members that moved to a higher care coordination level from DY2 to DY3. The percentage of members that moved to a higher care coordination level with respect to the average total number of members receiving care coordination decreased by 14.6%.

Upon review of the individual MCO performance over the same period, there were slight increases in the percentage of members that maintained their care coordination level for PHP (0.8%), MHC (0.8%), BCBS (0.6%), and UHC (0.3%), and all MCOs had a DY3 rate of over 93.0% for this subcomponent. Similarly, three MCOs experienced slight increases for the percentage of members that moved to a lower level of care coordination: PHP (5.6%), MHC (3.5%), BCBS (17.6%), while UHC experienced a decline (-35.9%). The percentage of members that moved to a higher care coordination level declined across all four MCOs: PHP (-18.6%), MHC (-22.0%), BCBS (-19.2%), and UHC (-14.5%). It should be noted that the membership in this subcomponent relative to total members receiving care coordination tends to be low and for DY3 all rates were below 5.0%, therefore even a small difference in the rate year-over-year results in a relatively larger calculated percent change.

When analyzing DY1 to DY3, there was a 69.8% increase in the average number of members that maintained their care coordination, and the percentage of members that maintained their care coordination level with respect to the average total number of members receiving care coordination increased by 4.2%.

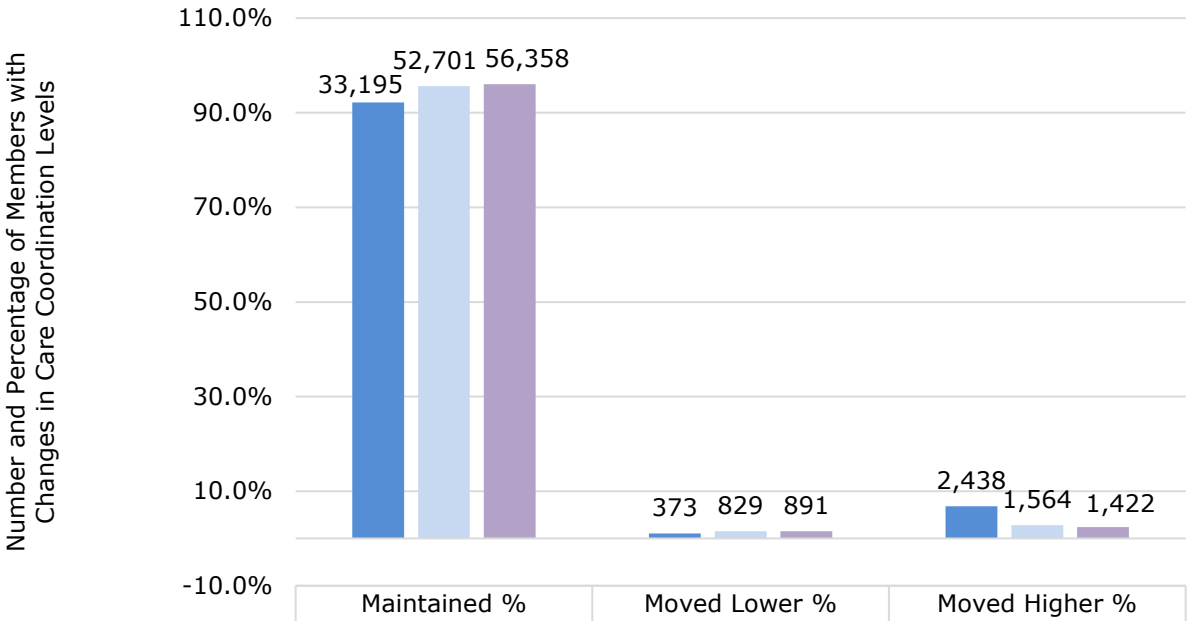
The average number of members that moved to a lower care coordination level increased 138.9% and the percentage of members that moved to a lower care coordination level with respect to the average total number of members receiving care coordination increased by 46.6% over the same period.

There was a 41.7% decrease in the average number of members that moved to a higher care coordination level from DY1 to DY3, and the percentage of members that moved to a higher care coordination level with respect to the average total number of members receiving care coordination declined by 64.2%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 61 – Number and Percentage of Members Who Maintained or Changed Care Coordination Levels[84]



	Maintained %	Moved Lower %	Moved Higher %
DY1 Centennial Care	92.2%	1.0%	6.8%
DY2 Centennial Care	95.7%	1.5%	2.8%
DY3 Centennial Care	96.1%	1.5%	2.4%

[84] Source: MCO ad hoc care coordination reports for 2014 – 2016.

Measure 62 – Percentage of population accessing a behavioral health service that received an outpatient ambulatory visit in the same year.

Exhibit 62 presents results for the 2013 baseline, DY1, and DY2 for the Percentage of the Population Accessing a Behavioral Health Service that Received an Outpatient Ambulatory Visit in the Same Year. As illustrated, the percentage of members utilizing both a BH service and outpatient ambulatory visit in the same year increased from 13.9% in DY1 to 15.6% in DY2 (a 12.7% change). This change was statistically significant at the 95% confidence level.

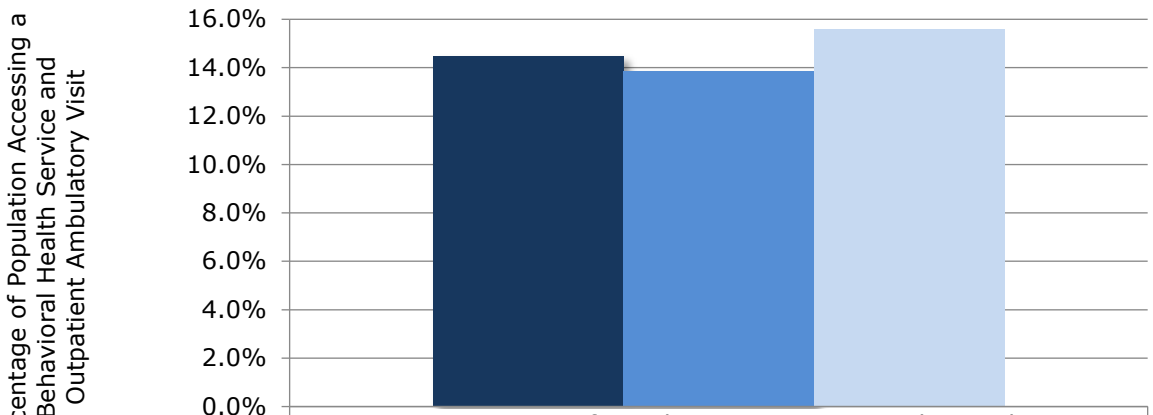
Upon review of the individual MCO performance over the same time period, there were increases in the percentage of members accessing a BH service that received an outpatient ambulatory visit in the same year for BCBS (25.9%), MHC (9.8%), PHP (3.6%), and UHC (19.2%).

When analyzing the baseline to DY2 performance trend, the percentage of members utilizing both a BH service and outpatient ambulatory visit in the same year increased from 14.5% to 15.6% (a 7.7% change). This change was statistically significant at the 95% confidence level.

A plan by plan analysis was not performed for baseline to DY2 because there was not a direct comparison based on the plans that participated during the baseline measurement period.

A national comparison rate could not be identified for this measure.

Exhibit 62 – Percentage of Population Who Accessed a Behavioral Health Service and Outpatient Ambulatory Visit in the Same Year[85]



	Percentage of Population Accessing a Behavioral HealthService that Received an Outpatient Ambulatory Visit in the Same Year
Baseline	14.5%
DY1 Centennial Care	13.9%
DY2 Centennial Care	15.6%

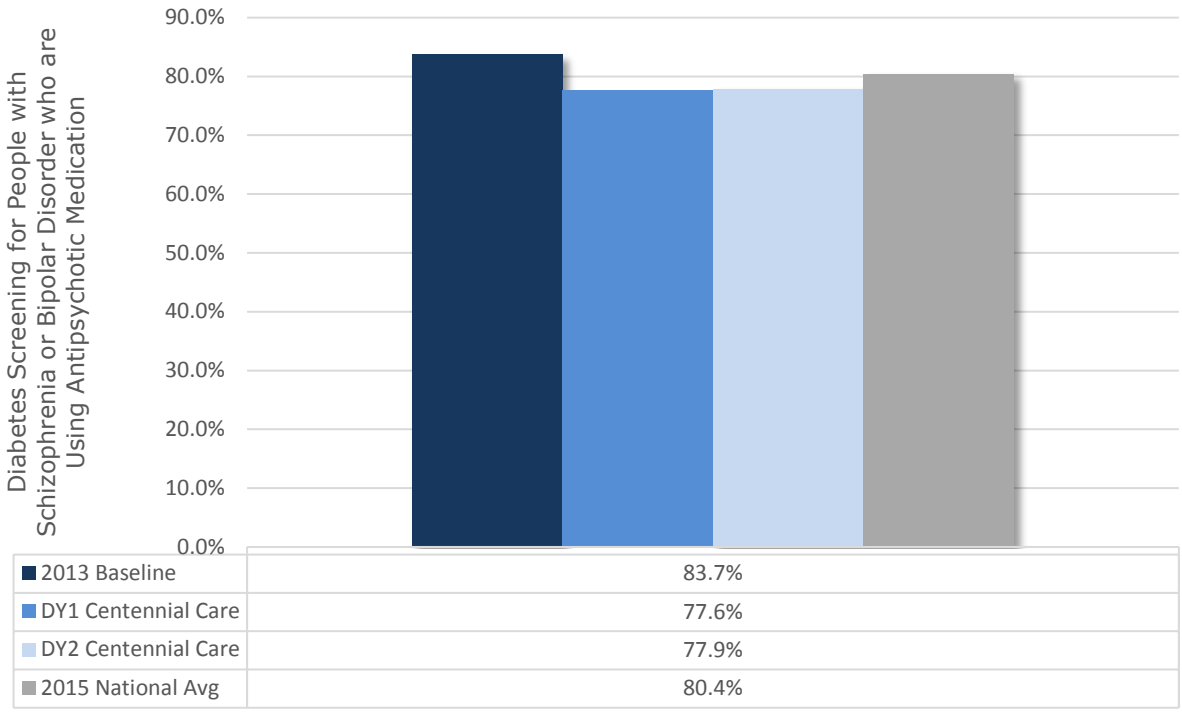
[85] Source: BH Clients with Outpatient Ambulatory Visits MMIS reports.

Measure 63 – Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications.

Exhibit 63 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the measure Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications. As illustrated, there was a modest increase (0.3%) in the rate from DY1 to DY2, but the change was not statistically significant at the 95% confidence level.

The rate declined from the baseline to DY2 (-7.0%), which was statistically significant at the 95% confidence level. Upon review of the individual MCO performance during the same time period, there were no changes that were statistically significant at the 95% confidence level.

Exhibit 63 – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication[86]



2013 Baseline	83.7%
DY1 Centennial Care	77.6%
DY2 Centennial Care	77.9%
2015 National Avg	80.4%

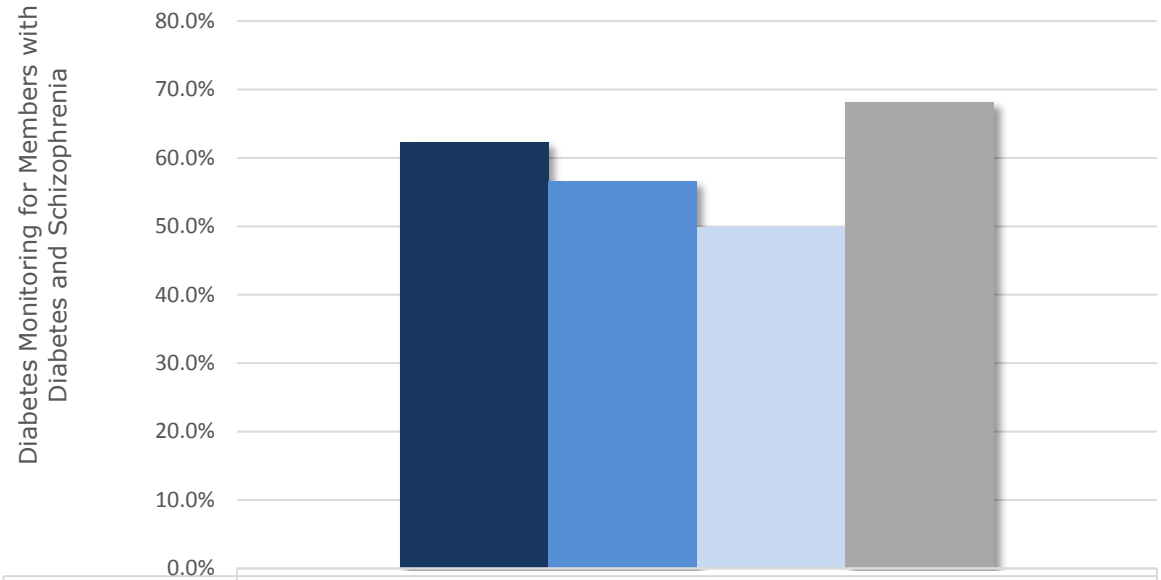
[86] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 64 – Diabetes monitoring for people with diabetes and schizophrenia.

Exhibit 64 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the measure Diabetes Monitoring for People with Diabetes and Schizophrenia. As illustrated, there was a decline in the rate from DY1 to DY2 (-11.8%), which was statistically significant at the 95% confidence level. Upon review of the individual MCO performance during the same time period, PHP was the only MCO that experienced a statistically significant decline, with a decline of 26.8%.

The rate declined more drastically from the baseline to DY2 (-20.0%). This decline was also statistically significant at a 95% confidence level. Of the two plans for which there was sufficient data to calculate rates for both time periods, PHP's decline (-28.4%) was statistically significant at the 95% confidence level, while UHC's decline (-15.0%) was not.

Exhibit 64 – Diabetes Monitoring for Member with Diabetes and Schizophrenia[87]



2013 Baseline	62.4%
DY1 Centennial Care	56.6%
DY2 Centennial Care	49.9%
2015 National Avg	68.2%

[87] Source: MCO annual HEDIS reports for 2013 – 2015.

Hypothesis 3

The rate of growth in program expenditures under Centennial Care will trend lower over the course of the waiver through lower utilization and/or substitution of less costly services.

Hypothesis 3 asks whether the rate of growth in program expenditures under Centennial Care will trend lower over the course of the waiver through lower utilization and/or substitution of less costly services. The Evaluation found that the State's managed care program is achieving cost savings based on budget neutrality expectations and is generally seeing a shift from what are typically more costly services to less costly services.

The information illustrated in some of the tables was compiled from Centennial Care MCO reported utilization data. The information presented is aggregated for all Medicaid populations for the Physical Health and Behavioral Health groupings. The data presented has not been adjusted to account for changes in the enrollment between populations (physical health and Other Adult Group) or the changes in the proportion enrollment (age / gender) that occurred between periods.

The Other Adult Group population experienced significant growth between DY1 and DY3, and based on discussions with the State, more acute and higher cost individuals enrolled in DY1 and less acute enrolled later (DY2 and DY3). These enrollment changes likely influenced the per 1,000 statistics reported for each year and may cause significant variation in the percentage change reported.

In addition, the State has indicated that some Centennial Care MCOs changed their provider networks which resulted in either expanding or eliminating certain sub-capitated arrangements between the years presented. Since the data presented is non-capitated utilization, these changes may have affected the results in the utilization for services like non-emergency transportation which is often covered through a sub-capitated arrangement.

It should also be noted that the data has not been adjusted for impacts associated with fee schedule and benefit changes implemented by HSD during DY2 and DY3. The changes include:

- Increases to private nursing facilities low bed day reimbursement (July 1, 2015)
- Reductions to dental services provided in outpatient facilities (December 1, 2015)
- Reductions to professional dental reimbursement (July 1, 2016)
- Reductions to community benefit reimbursement (July 1, 2016)
- Reductions to outpatient hospital reimbursement, excluding outpatient dental (July 1, 2016)
- Reductions to inpatient hospital reimbursement (July 1, 2016)
- Reductions to professional fee schedule (August 1, 2016)
- Patient loss on Ability (April 2015 - impacts behavioral health pharmacy cost)
- Added autism spectrum disorder service coverage (May 2015)

Research Question 3.A

To what extent did service utilization and costs increase or decrease due to the implementation of the Centennial Care program for Medicaid/CHIP beneficiaries in New Mexico?

As previously mentioned under Research Questions 1.A – 1.C, the Centennial Care waiver seeks to manage medical service utilization through care coordination for the Medicaid managed care population and to control cost by consolidating covered services within an integrated health care delivery system.

The Evaluation is reviewing Centennial Care's Budget Neutrality as stipulated in the STCs and utilization management through analysis of 15 performance measures that track total costs and cost per member for specific eligibility groups as well as utilization trends for various categories of service. Service categories tracked include ER use, HCBS, hospital costs, mental health and substance abuse services, and use of pharmaceuticals, among others. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY3 of the program, costs continue to be budget neutral and utilization is shifting away from more costly services. There were clear improvements in 9 of 15 performance measures and their subcomponents, with five other measures showing both positive and negative results depending on the subcomponent and two showing a decline.

New Mexico saw improvement from the baseline to DY3 for total program expenditures, costs per member, and costs per user for five out of six MEGs for each of the three measures. There were also increases in most subcomponents for the use of mental health services, increases in the use of substance abuse services and use of HCBS, and positive shifts for pharmacy utilization where usage of generic drugs is more prevalent than brand drugs. Inpatient services exceeding $50,000 and all cause readmission rates have also seen favorable declines.

There were mixed results for 3 out of 15 measures, particularly measures with multiple subcomponents. These include utilization by category of service, where there were favorable decreases in average length of stay for acute and specialty hospitals and favorable decreases in higher LOC NF use while lower LOC NF use increased, a positive utilization shift to less costly services. Other categories such as non-emergency transportation had unfavorable increases in utilization from the baseline to DY3. The use of institutional care experienced increases in days per thousand but decreases in admits per thousand. Use of inpatient and mental health/substance abuse services also saw increases in services in the RTC setting though the psychiatric hospital setting remained fairly consistent.

There was a decline in performance from the baseline to DY3 for diagnostic imaging costs, hospital costs, and for ED use, all of which experienced unfavorable increases. However it is important to note that diagnostic imaging costs remain very immaterial and ED utilization has trended down year-over-year from DY1 to DY3.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 65 – Total program expenditures.

Exhibit 65.a and Exhibit 65.b presents total costs by MEG for DY1, DY2, and DY3 compared to the baseline projected program expenditures. In Exhibit 65.a and Exhibit 65.b, "DYX STC" indicates the projected dollar cost for a particular MEG by multiplying the PMPM for a particular demonstration year by the actual member months for the same demonstration year. The goal of the Centennial Care Waiver is to meet budget neutrality requirements, which is to say that the total "with waiver" costs do not exceed the total "without" waiver costs. As illustrated, total costs by MEG for DY1, DY2, and DY3 were below cost projections for all MEGs apart from the NF LOC Dual group[88]. Total DY3 costs as of March 6, 2017 were 21.8% below the STC cost projections for DY3.

The Group VIII (Medicaid-expansion eligible adults) and TANF groups experienced the greatest dollar difference between projected costs and actual costs in DY3. The SSI-Dual group also experienced material differences between projected and actual costs in DY3, where actual costs were 30.7% below projected costs and made up the third largest dollar difference.

The significant difference in comparing baseline projected costs to actual expenditures for the NF LOC group is partially attributable to the large PMPM cost cap that was estimated for this group. Under STC 107 that cost cap is $4,936.92 PMPM for DY1, and will increase by 3.1% per year through the end of DY5. The reportable data from CMS-64 Schedule C and the HSD Budget Neutrality tables submitted to CMS indicate relatively lower costs for the NF LOC population. In addition, with less than 3,000 member months attributed to this MEG, the variance between actual costs from costs estimated from STC 107 is greater than the variance between actual and estimated costs under MEGs with a larger population base.

In regards to the NF LOC Dual group, HSD determined that the estimated PMPM for budget neutrality included a population of healthy duals. Healthy duals have a very low cost PMPM which, when weighted across the whole NF LOC Dual population, pushed the estimated PMPM down. The final CMS approved population attributed to NF LOC Dual for the waiver demonstration did not include the aforementioned healthy duals, yet their costs were included in the estimated PMPM under STC 107. With the waiver demonstration population for NF LOC Dual not including healthy duals, the PMPM cost increased relative to the original estimates and NF LOC Dual exceeds the budget neutrality "test one" limit.

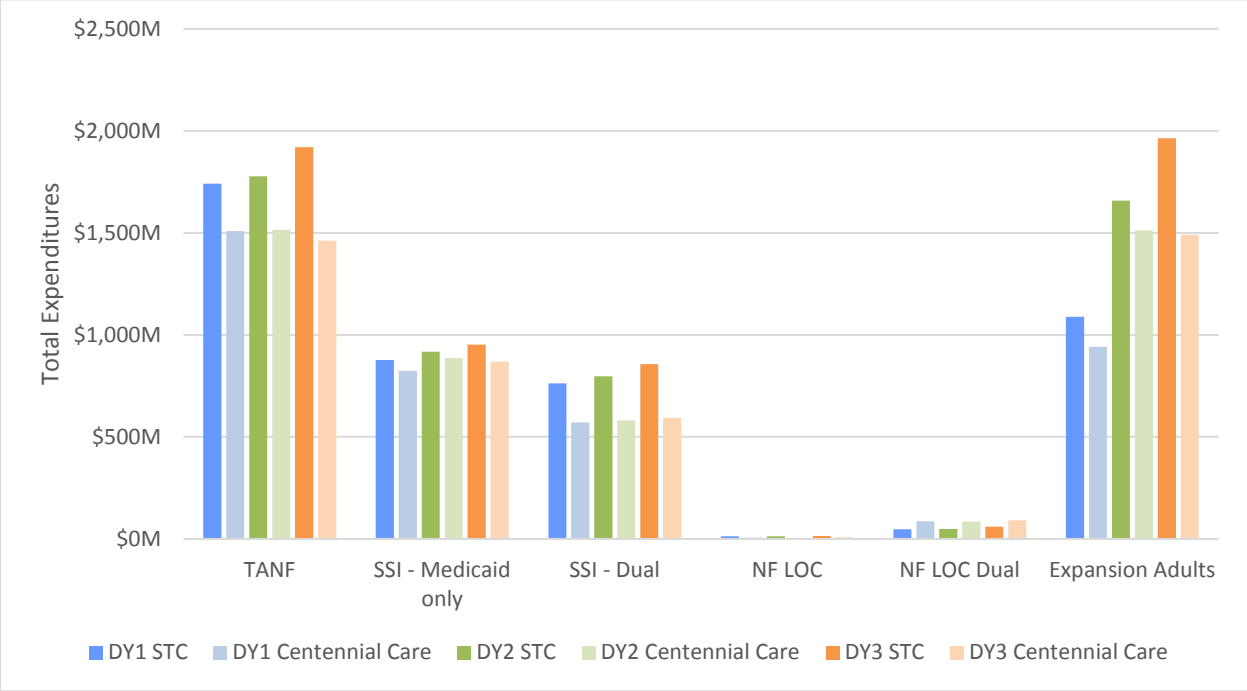
The footnote of Exhibit 65.b below specifies that the cost comparison for TANF members does not include the costs and member months for children living in families with incomes between 133% and 185% of the federal poverty level as those costs and member months were reported under CHIP. Expenses reported in CHIP are not subject to budget neutrality, except when the State has exhausted its CHIP allotment (STCs 99 to 101). The impact of excluding the costs and member months of these children in TANF is that the reportable costs and member months for TANF were understated relative to the baseline.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

[88] The MEGs "NF LOC" and "NF LOC Dual" are equivalent to the MEGs "217-like Medicaid" and "217-like Group Dual" respectively as defined by STC 18.

Exhibit 65.a – DY1 to DY3 Total Program Expenditures by MEG[89]



[89] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016.

Exhibit 65.b – DY1 to DY3 Total Program Expenditures by MEG[90]

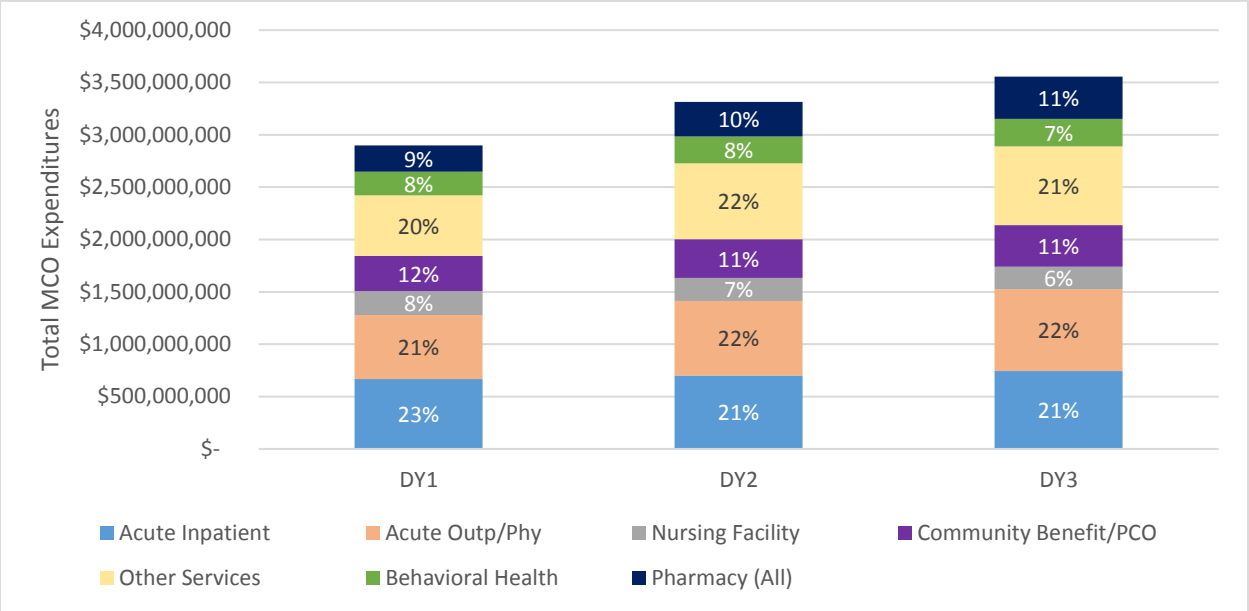
Year and Measure		TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults	Uncompensated Care	HQII	Total
2014	STC	$1,741,829,516	$877,545,542	$762,650,368	$13,403,738	$47,908,778	$1,088,709,391	$68,889,322	$0	**$4,600,936,654**
	Centennial Care	$1,508,687,841	$824,511,459	$570,589,894	$6,662,907	$86,784,521	$941,763,087	$68,889,323	$0	**$4,007,889,032**
	Measured Over/ (Under) Baseline	($233,141,675)	($53,034,083)	($192,060,474)	($6,740,831)	$38,875,743	($146,946,304)	$1	$0	**($593,047,622)**
	% Measured Over / (Under) Baseline	-13.4%	-6.0%	-25.2%	-50.3%	81.1%	-13.5%	0.0%	0.0%	**-12.9%**
2015	STC	$1,777,899,080	$917,996,550	$796,997,595	$12,369,818	$49,614,962	$1,657,978,073	$68,889,322	$2,824,462	**$5,284,569,863**
	Centennial Care	$1,515,008,918	$886,963,101	$581,487,225	$5,631,972	$84,975,937	$1,511,725,079	$68,889,323	$2,824,462	**$4,657,506,017**
	Measured Over/ (Under) Baseline	($262,890,162)	($31,033,449)	($215,510,370)	($6,737,846)	$35,360,975	($146,252,994)	$1	$0	**($627,063,846)**
	% Measured Over / (Under) Baseline	-14.8%	-3.4%	-27.0%	-54.5%	71.3%	-8.8%	0.0%	0.0%	**-11.9%**
2016	STC	$1,920,328,873	$952,799,905	$856,853,167	$14,827,775	$60,473,905	$1,963,790,716	$68,889,322	$5,764,727	**$5,843,728,390**
	Centennial Care	$1,462,319,710	$868,969,133	$593,582,822	$7,962,326	$90,826,284	$1,490,021,951	$51,667,000	$5,764,727	**$4,571,113,953**
	Measured Over/ (Under) Baseline	($458,009,163)	($83,830,772)	($263,270,345)	($6,865,449)	$30,352,379	($473,768,765)	($17,222,322)	$0	**($1,272,614,437)**
	% Measured Over / (Under) Baseline	-23.9%	-8.8%	-30.7%	-46.3%	50.2%	-24.1%	-25.0%	0.0%	**-21.8%**

[1]The expenses and member months of the optional children who qualified for Medicaid under Sections 1902(a)(10)(A)(u)(IX) and 1902(l)(2) were included in MEG1 – TANF and Related for the calculation of the PMPM cost "without waiver", but the actual expenses and member months of this group of children were reported under the CHIP program, which is not subject to budget neutrality testing.

The Evaluation also examined data summarized by Mercer which demonstrates the distribution of total program expenditures by service category in DY1, DY2, and DY3. As Exhibit 65.b illustrates, the distribution of program expenditure has been relatively stable throughout DY1 to DY3. Notable trends from DY1 to DY3 include the steady increase in expenditures for pharmacy. There has also been a steady decrease in expenditures for NF, which aligns to program goals for moving members to the community care setting when able. Overall, acute inpatient, acute outpatient/physician, and other services remain as the largest spending categories. In particular, acute inpatient and acute outpatient/physician services together make up over 40% of total program expenditures in each year. Meanwhile NF has been the least expensive service category, costing less than 10% of program expenditures in each year.

[90] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016. The 2016 uncompensated care payment consists of three quarters of payments; one quarter of payments have not been made and reported as of December 31, 2016

Exhibit 65.b – DY1 to DY3 Total Program Expenditure Distribution by Service Category[91]



Measure 66 – Costs per member.

Exhibit 66.a presents the annual cost per member for DY1, DY2, and DY3 compared to the baseline PMPM costs. In the exhibit, "DYX STC" is the PMPM caps by MEG for that particular demonstration year. The budget neutrality goal of the Centennial Care Waiver is to ensure that the "with waiver" PMPM costs for each MEG do not exceed the "without waiver" PMPM costs for each MEG. Furthermore, the State is not at risk for total expenditures as a result of increases in membership. As illustrated, and consistent with measure 65, the costs for all MEGs stayed below the MEG PMPM cap throughout DY1 to DY3 apart from the NF LOC Dual group.

In addition, the PMPM costs for all MEGs experienced decreases in the range of 1.0% to 12.5% from DY2 to DY3, apart from the NF LOC group. The PMPM reduction is particularly noteworthy for the Expansion Adults population, which is population that had not previously had access to these benefits and has continued to experience tremendous enrollment growth since DY1. The PMPM costs for this group in particular decreased 12.5% from DY2 to DY3 and decreased 3.1% from DY1 to DY3.

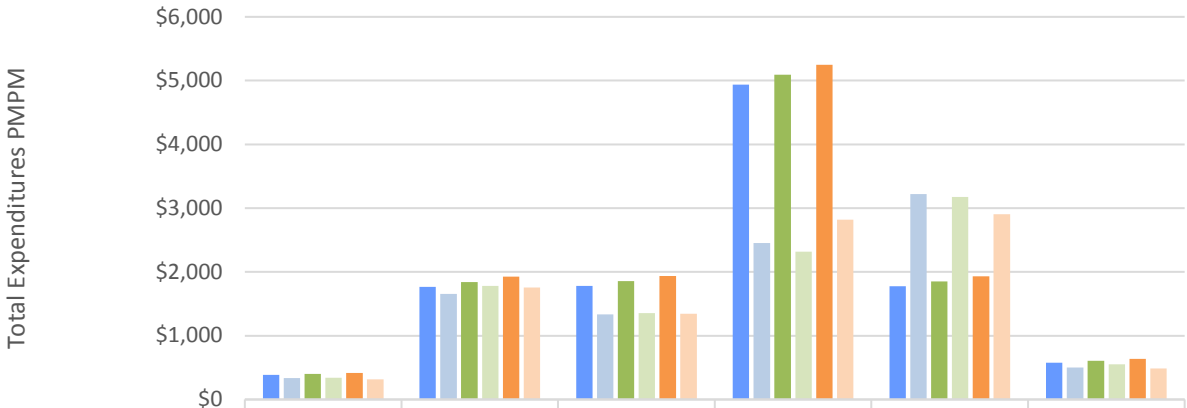
The aggregate program PMPM decreased 7.6% from DY2 to DY3 and decreased 2.6% from DY1 to DY3. These decreases in PMPM by MEG demonstrates that the Centennial Care program is experiencing success with respect to cost containment, a principal goal of the program.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

[91] Source: Data summarized by Mercer based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures, though cost distribution across categories of service would generally align.

Exhibit 66.a – DY1 to DY3 PMPM Expenditures by MEG[92]

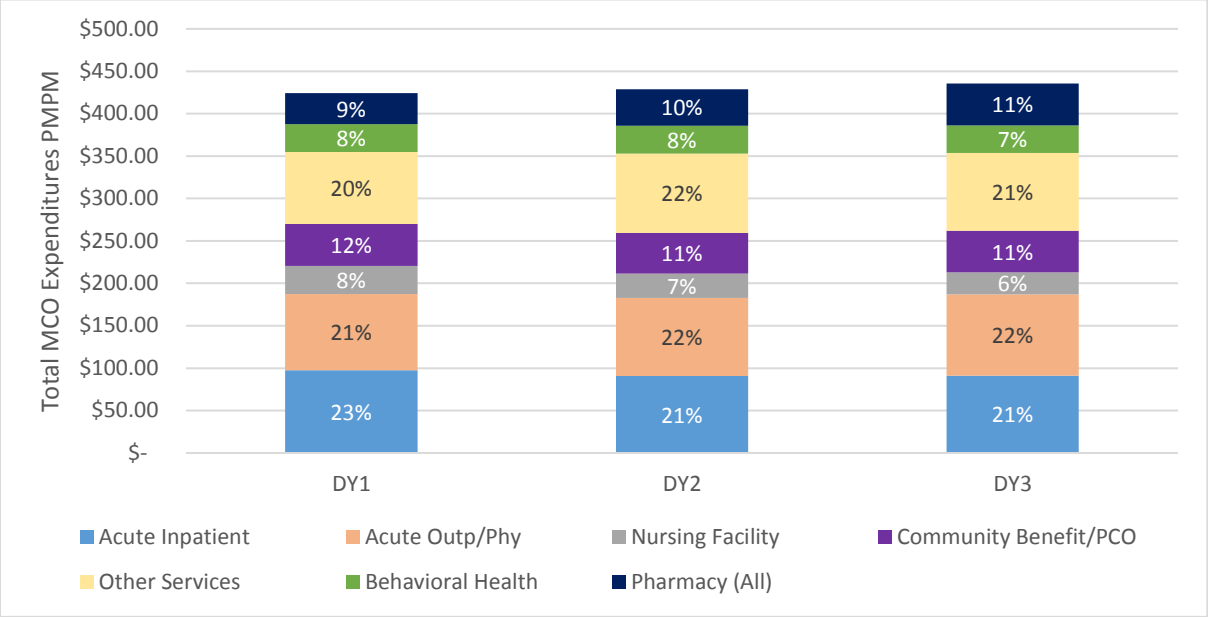


	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$385.80	$1,763.90	$1,780.77	$4,936.92	$1,776.90	$577.87
DY1 Centennial Care	$334.16	$1,657.30	$1,332.31	$2,454.11	$3,218.77	$499.87
DY2 STC	$400.77	$1,842.83	$1,857.34	$5,090.46	$1,853.31	$607.34
DY2 Centennial Care	$341.51	$1,780.53	$1,355.11	$2,317.68	$3,174.18	$553.77
DY3 STC	$416.32	$1,925.21	$1,937.21	$5,248.77	$1,933.00	$638.31
DY3 Centennial Care	$317.03	$1,755.82	$1,342.00	$2,818.52	$2,903.19	$484.32

The Evaluation also examined data summarized by Mercer which shows the distribution of PMPM program expenditures by service category in DY1, DY2, and DY3. As Exhibit 66.b illustrates, and consistent with measure 65 above, the distribution of PMPM expenditure has been relatively stable throughout DY1 to DY3. Notable trends from DY1 to DY3 include the steadily increasing PMPM expenditures for pharmacy and steadily decreasing PMPM expenditures for NF. Overall, acute inpatient, acute outpatient/physician, and other services remain as the largest spending categories PMPM. In particular, acute inpatient and acute outpatient/physician services together make up over 40% of total PMPM expenditure in each year. Meanwhile nursing facility has been the least expensive service category, making up less than 10% of total PMPM expenditures in each year.

[92] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016.

Exhibit 66.b – DY1 to DY3 PMPM Expenditure Distribution by Service Category[93]



[93] Source: Data summarized by Mercer based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures, though cost distribution across categories of service would generally align.

Measure 67 – Costs per user of services.

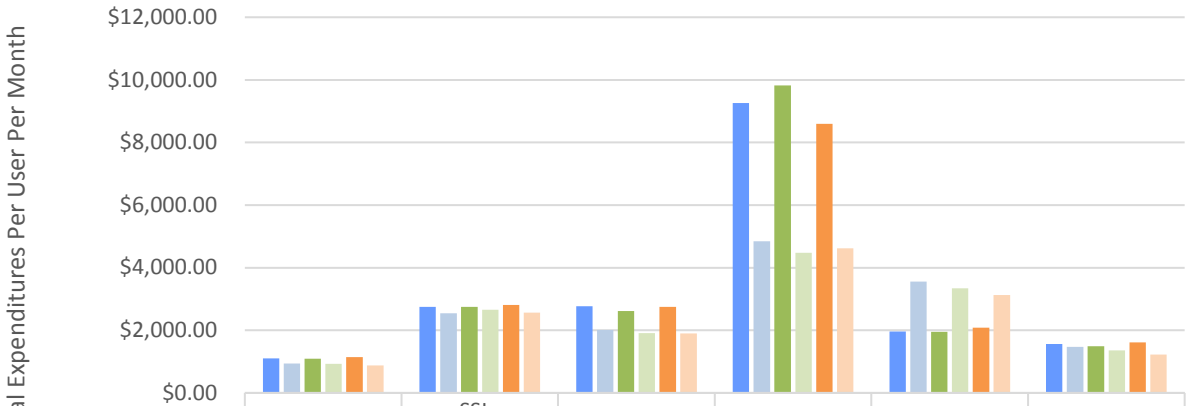
Exhibit 67 presents the calculated costs per user by MEG for DY1, DY2, and DY3 compared to the baseline costs. In the exhibit, "DYX STC" is the cost-per-user caps by MEG. As the exhibit illustrates, and consistent with the measure 65, the costs for all MEGs, apart from NF LOC Dual, remained below the MEG cost-per-user cap throughout DY1 to DY3.

Consistent with results from the PMPM costs measure, the Per User Per Month (PUPM) costs for all MEGs experienced decreases from DY2 to DY3, apart from the NF LOC group. These decreases in costs, which ranged from 0.3% to 10.0%, demonstrate that the Centennial Care program is experiencing success with respect to cost containment.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 67 – Cost per User of Services[94]



	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$1,099.95	$2,747.08	$2,770.82	$9,263.12	$1,963.64	$1,560.03
DY1 Centennial Care	$939.42	$2,540.92	$2,017.46	$4,848.78	$3,555.20	$1,474.95
DY2 STC	$1,090.73	$2,747.84	$2,617.08	$9,825.11	$1,952.04	$1,487.91
DY2 Centennial Care	$929.44	$2,654.95	$1,909.41	$4,473.37	$3,343.27	$1,356.66
DY3 STC	$1,148.13	$2,809.02	$2,746.76	$8,595.81	$2,082.65	$1,609.30
DY3 Centennial Care	$874.29	$2,561.87	$1,902.81	$4,615.84	$3,127.95	$1,221.05

[94] CMS-64 Schedule C , Quarter End December 2016; Cost Per User of Service MMIS reports.

Measure 68 – Utilization by category of service.

Exhibit 68 presents the utilization of various service categories across PH and LTSS for the Q1 2014 baseline, DY1, DY2, and DY3.

For inpatient PH services for specialty hospitals, the trend of decreasing average length of stay has continued throughout the baseline to DY3. There were smaller increases in days per 1,000 and larger increases in admits per 1,000 from DY2 to DY3 as well as from the baseline to DY3, resulting in decreases in the average length of stay in both periods. For acute hospitals, the average length of stay increased slightly in DY3 compared to DY2, but overall both the days per 1,000 and admits per 1,000 have decreased substantially from the baseline.

For other PH services, there were minor decreases in visits per 1,000 for outpatient surgeries and outpatient hospital visits to urgent care from DY2 to DY3. However, both subcomponents experienced increases in utilization from the baseline to DY3 (17.5% for outpatient surgeries and 59.7% for urgent care). There was also a significant increase (282.1%) in non-emergent transportation trips from DY2 to DY3.

Inpatient LTSS services (including acute hospitals, specialty hospitals, and hospital swing bed) showed mixed performance results across time periods. From DY2 to DY3, utilization of both acute and specialty hospital services generally experienced increases in days per 1,000, admits per 1,000, and average length of stay, although the average length of stay in specialty hospitals experienced a slight decrease. However, overall from the baseline to DY3, utilization of both acute and specialty hospital services experienced substantial decreases in the same measures; only average length of stay in specialty hospitals experienced a significant increase. Utilization of hospital swing bed appears to experience decreases in performance from the baseline to DY3, but there is limited data to draw sound conclusions.

Overall from the baseline to DY3, NF care for high levels of care experienced decreases in utilization, while low levels of care experienced increases in utilization. This trend is desirable as shifting utilization from higher levels of care to lower levels of care should result in a net decrease in healthcare costs.

Other LTSS services that experienced increases in utilization from the baseline to DY3 include the use of personal care services (73.6% for T1019, 207.5% for 99509), outpatient urgent care (128.1%), and non-emergent transportation (15,563.2%). Outpatient surgery visits experienced a slight decrease (-9.5%) from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 68 – Utilization by Category of Service[95]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
UTILIZATION BY CATEGORY OF SERVICE										
PHYSICAL HEALTH										
Inpatient Hospital - Acute	Days per 1,000	2,152.6	2,086.0	-3.1%	1,634.6	-21.6%	-24.1%	1,392.6	-14.8%	-35.3%
Inpatient Hospital - Acute	Admits per 1,000	281.0	281.5	0.2%	275.6	-2.1%	-1.9%	220.5	-20.0%	-21.5%
Inpatient Hospital - Acute	Average Length of Stay	7.7	7.4	-3.2%	5.9	-20.0%	-22.6%	6.3	6.5%	-17.6%
Inpatient - Specialty Hospital	Days per 1,000	19.0	16.2	-14.5%	21.2	30.4%	11.6%	25.5	20.3%	34.2%
Inpatient - Specialty Hospital	Admits per 1,000	1.1	0.9	-13.9%	1.3	46.1%	25.8%	2.1	58.8%	99.7%
Inpatient - Specialty Hospital	Average Length of Stay	17.8	17.7	-0.7%	15.8	-10.7%	-11.3%	12.0	-24.2%	-32.8%
Ambulatory Surgery Centers - Outpatient Surgeries	Vists per 1,000	14.3	17.4	21.2%	18.0	3.5%	25.5%	16.8	-6.4%	17.5%
Outpatient Hospital - Urgent Care	Vists per 1,000	31.3	44.6	42.5%	50.2	12.6%	60.4%	50.0	-0.5%	59.7%
Non-Emergent Transportation - Non-Capitated	Trips per 1,000	0.0	0.0	N/A	73.6	N/A	N/A	281.1	282.1%	N/A
LTSS										
Nursing Facility State Owned - High Level of Care	Days per 1,000	328.4	171.9	-47.7%	164.5	-4.3%	-49.9%	159.7	-2.9%	-51.4%
Nursing Facility State Owned - Low Level of Care	Days per 1,000	1,849.5	1,881.6	1.7%	1,923.9	2.2%	4.0%	2,054.5	6.8%	11.1%
Nursing Facility Private - High Level of Care	Days per 1,000	6,436.2	3,564.5	-44.6%	1,631.5	-54.2%	-74.7%	2,408.3	47.6%	-62.6%
Nursing Facility Private - Low Level of Care	Days per 1,000	19,719.3	21,622.5	9.7%	22,997.1	6.4%	16.6%	21,081.8	-8.3%	6.9%
Hospital Swing Bed - High Level of Care	Days per 1,000	2.3	2.7	15.7%	0.0	-100.0%	-100.0%	0.2	N/A	-93.0%
Hospital Swing Bed - Low Level of Care	Days per 1,000	0.9	3.1	247.5%	2.1	-33.2%	132.2%	0.0	-100.0%	-100.0%
Personal Care Option - T1019	15 Minute Intervals per 1,000	447,638.9	495,883.9	10.8%	705,853.0	42.3%	57.7%	777,046.9	10.1%	73.6%
Personal Care Option - 99509	1 Hour Intervals per 1,000	39,516.6	54,837.6	38.8%	161,393.9	194.3%	308.4%	121,531.8	-24.7%	207.5%
Inpatient Hospital - Acute	Days per 1,000	2,429.4	2,748.6	13.1%	1,308.4	-52.4%	-46.1%	1,552.0	18.6%	-36.1%
Inpatient Hospital - Acute	Admits per 1,000	292.4	309.9	6.0%	209.2	-32.5%	-28.5%	211.7	1.2%	-27.6%
Inpatient Hospital - Acute	Average Length of Stay	8.3	8.9	6.8%	6.3	-29.5%	-24.7%	7.3	17.2%	-11.7%
Inpatient - Specialty Hospital	Days per 1,000	377.1	361.4	-4.1%	106.0	-70.7%	-71.9%	132.2	24.7%	-64.9%
Inpatient - Specialty Hospital	Admits per 1,000	54.1	52.8	-2.5%	5.5	-89.6%	-89.9%	7.3	33.2%	-86.5%
Inpatient - Specialty Hospital	Average Length of Stay	7.0	6.9	-1.7%	19.4	183.0%	178.2%	18.1	-6.4%	160.4%
Ambulatory Surgery Centers - Outpatient Surgeries	Vists per 1,000	65.5	69.4	5.9%	61.7	-11.1%	-5.9%	59.3	-3.8%	-9.5%
Outpatient Hospital - Urgent Care	Vists per 1,000	10.4	15.8	52.2%	18.3	16.2%	76.9%	23.6	29.0%	128.1%
Non-Emergent Transportation - Non-Capitated	Trips per 1,000	31.7	30.0	-5.3%	1,658.7	5,425.9%	5,135.3%	4,962.6	199.2%	15,563.2%

[95] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

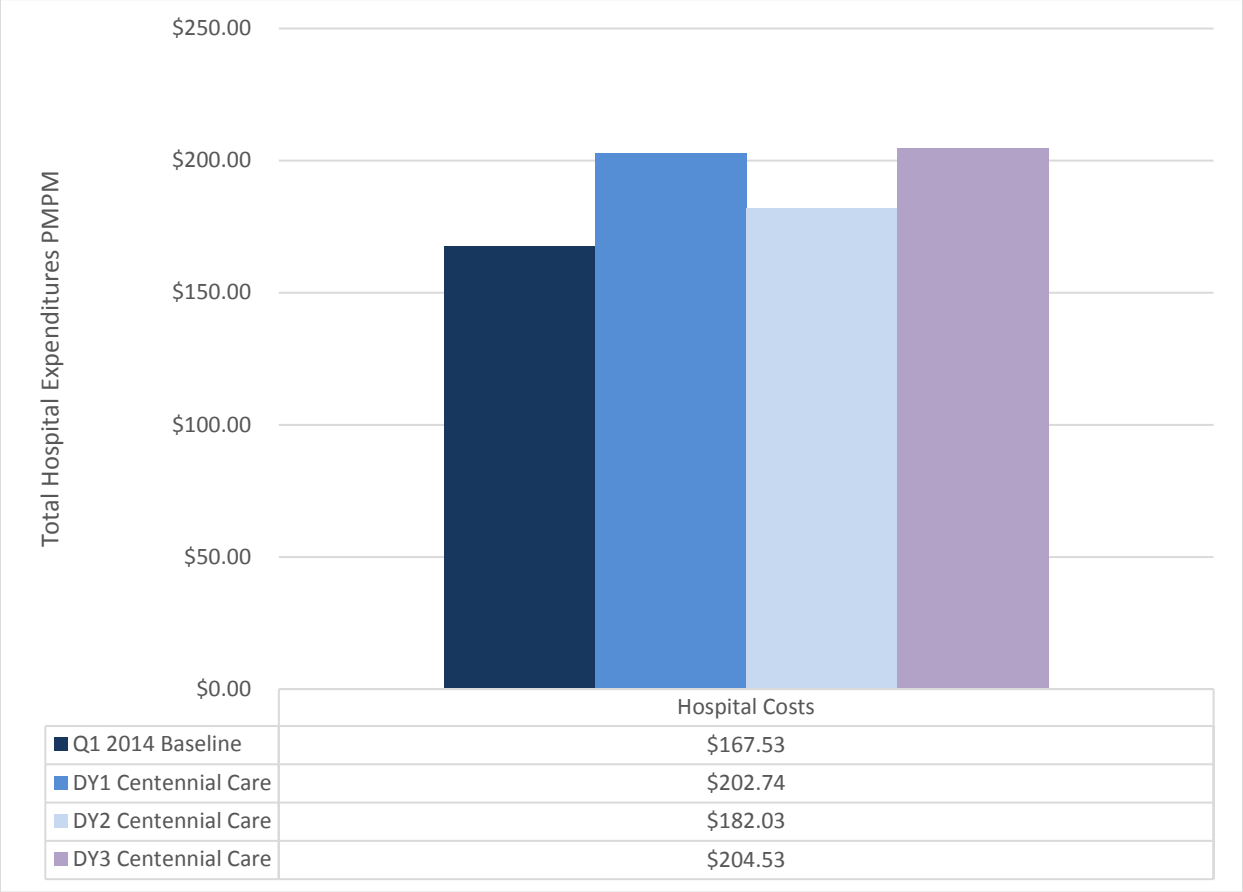
Measure 69 – Hospital costs.

Exhibit 69 presents the PMPM cost for services that are associated with hospital, clinic, and facility visits for DY1, DY2, and DY3 compared to the baseline PMPM. Refer to Appendix A for a complete listing of all services included in this measure. As illustrated, the average PMPM across all hospital services experienced a 10.2% year-over-year decrease in DY2 followed by a 12.4% year-over year increase in DY3, and actual PMPM cost exceed the baseline PMPM in each year.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 69 – Hospital Cost PMPM[96]



	Hospital Costs
Q1 2014 Baseline	$167.53
DY1 Centennial Care	$202.74
DY2 Centennial Care	$182.03
DY3 Centennial Care	$204.53

[96] Source: Revenue and expense reports (Report 1) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 70 – Use of HCBS.

Essential to the Centennial Care program is the Community Benefit (CB) home and community-based services (HCBS) program for members who require LTSS to remain in the family residence, in their own home, or in community residences. The CB is a less costly alternative to placement in a Nursing Facility (NF) and is available to members who meet Nursing Facility Level of Care (NF LOC). CB services supplement a member's natural supports but do not provide 24-hour care.

Exhibit 70 presents the annualized utilization for various HCBS services for the Q1 2014 baseline, DY1, DY2, and DY3. From DY2 to DY3, the use of adult day health and assisted living benefits have increased 43.2% and 36.6% respectively, while the use of respite, environmental modifications, and private duty nursing benefits all decreased between 15.7% to 61.5% percent.

Overall from the baseline to DY3, the use of HCBS benefits has increased significantly, with increases in subcategories ranging from 109.4% to 7,929.1%. These HCBS increases are in line with Centennial Care's goal with respect to enhancing services with more effective coordination of care. In addition, the influx of members through the expansion of eligibility may also have had an impact on the calculated increase in utilization. Despite the general trend of increasing utilization, the private duty nursing subcomponent has been consistently experiencing decreases year-over-year, and has decreased 87.4% from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 70 – Use of HCBS[97]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
USE OF HOME AND COMMUNITY BASED SERVICES (HCBS)									
Community Benefit - Respite	15 Minute Intervals per 1,000	3,355.9	6,172.0	83.9%	10,955.2	77.5%	7,027.1	-35.9%	109.4%
Community Benefit - Adult Day Health	Days per 1,000	366.3	1,225.1	234.4%	3,233.4	163.9%	4,630.1	43.2%	1,163.9%
Community Benefit - Assisted Living	Days per 1,000	500.9	573.4	14.5%	779.4	35.9%	1,064.7	36.6%	112.6%
Community Benefit - Environmental Modifications	Modifications per 1,000	6.9	20.7	198.7%	660.2	3,089.3%	556.5	-15.7%	7,929.1%
Community Benefit - Private Duty Nursing	15 Minute Intervals per 1,000	853.0	372.9	-56.3%	279.3	-25.1%	107.4	-61.5%	-87.4%

[97] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 71 – Use of institutional care (skilled nursing facilities).

Exhibit 71 presents the annualized utilization for services related to institutional care for the Q1 2014 baseline, DY1, DY2, and DY3. The days per 1,000 subcomponent increased (105.4%) while the admits per 1,000 subcomponent decreased (-69.7%), resulting in a 578.1% increase in the average length of stay from the baseline to DY3. These increases were consistent with DY2 to DY3 trends for this measure.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 71 – Use of Institutional Care (Skilled Nursing Facilities)[98]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF INSTITUTIONAL CARE (SKILLED NURSING FACILITY)										
Non-Acute LTC/SNF/Respite	Days per 1,000	76.0	117.4	54.3%	121.9	3.8%	60.3%	156.2	28.1%	105.4%
Non-Acute LTC/SNF/Respite	Admits per 1,000	20.7	29.9	44.3%	6.6	-77.8%	-67.9%	6.3	-5.7%	-69.7%
Non-Acute LTC/SNF/Respite	Average Length of Stay	3.7	3.9	6.9%	18.3	366.8%	399.2%	24.9	35.8%	578.1%

[98] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 72 – Use of mental health services.

Exhibit 72 presents the annualized utilization for services related to mental health services in the Q1 2014 baseline, DY1, DY2, and DY3. From DY2 to DY3, the utilization of RTCs (-7.9%) and average length of stay for psychiatric hospitalization service (-0.6%) decreased while utilization for foster care therapeutic (47.0%) and Federally Qualified Health Centers (FQHCs) (21.1%) increased. Similar to DY2 to DY3 trends in performance change, the utilization of RTCs (-9.3%) and average length of stay for psychiatric hospitalization service (-12.2%) decreased while utilization for foster care therapeutic (24.4%) and FQHCs (65.8%) increased from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 72 – Use of Mental Health Services[99]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF MENTAL HEALTH SERVICES										
Residential Treatment Center, ARTC and Group Homes < 21	Days per 1,000	217.1	209.5	-3.5%	213.8	2.1%	-1.5%	197.0	-7.9%	-9.3%
Foster Care Therapeutic (TFC I & II) < 21	Days per 1,000	127.9	129.3	1.1%	108.2	-16.3%	-15.4%	159.1	47.0%	24.4%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Days per 1,000	56.6	61.9	9.3%	68.8	11.1%	21.4%	103.1	50.0%	82.1%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Admits per 1,000	6.7	7.5	10.9%	9.3	24.0%	37.5%	14.0	50.9%	107.5%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Average Length of Stay	8.4	8.3	-1.4%	7.4	-10.4%	-11.7%	7.4	-0.6%	-12.2%
Federally Qualified Health Centers (FQHC's)	Vists per 1,000	147.8	150.1	1.5%	202.3	34.8%	36.8%	245.0	21.1%	65.8%

[99] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 73 – Use of substance abuse services.

Exhibit 73 presents the annualized utilization for services related to substance abuse in the Q1 2014 baseline, DY1, DY2, and DY3. In the MCO financial reports, methadone treatment was the only category of service determined to be specifically characterized as a substance abuse service, which saw an increase in visits per 1,000 of 35.9% from DY2 to DY3, and a total increase from the baseline to DY3 of 316.8%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 73 – Use of Substance Abuse Services[100]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
USE OF SUBSTANCE ABUSE SERVICES									
Methadone Treatment	Vists per 1,000	44.9	65.9	46.8%	137.7	108.9%	187.1	35.9%	316.8%

[100] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 74 – Use of pharmacy services.

Exhibit 74 presents the annualized utilization for services related to pharmacy in the Q1 2014 baseline, DY1, DY2, and DY3. Generally there were decreases in the number of scripts per 1,000 for brand, generic, and other drugs in the PH, BH, and LTSS care settings from DY2 to DY3, with decreases in the range of 2.8% to 97.6%. The only increases in drug utilization was seen in generic drugs for the PH setting (4.1%) and BH setting (0.9%).

Similar to the DY2 to DY3 timeframe, most drug utilization decreased across BH and LTSS care settings from the baseline to DY3, with decreases in the range of 9.8% to 98.3%. The only increases in scripts per 1,000 were for brand (8.5%) and generic drugs (16.9%) in the PH setting, generic (2.1%) in the BH setting, and other drugs (20.8%) in the LTSS setting.

One item of particular interest was the sharp decrease in the use of "other" type drugs in DY3. We are working with the State to investigate this decrease and determine the reason or identify any potential reporting issue.

When comparing the baseline results to other years, it is important to note that seasonality (the regular and predictable changes which recur every calendar year) may account for some of the difference since the baseline is only the first quarter of 2014. Additionally, although lowering utilization is generally considered a positive outcome, under this measure, higher utilization of generic drugs is desirable as shifting utilization from brand name drugs to generic drugs generally results in a decrease in overall drug costs.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

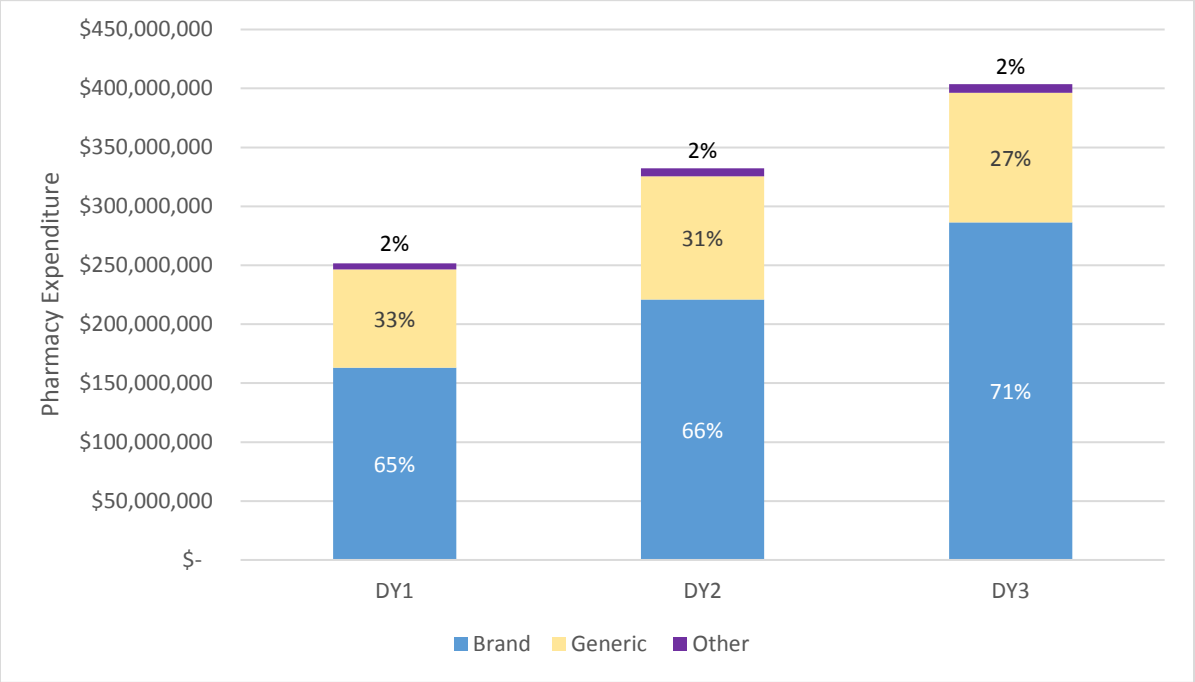
Exhibit 74 – Use of Pharmacy Services[101]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF PHARMACY										
PHYSICAL HEALTH										
Prescribed Drugs - Brand Name	Scripts per 1,000	842.1	890.8	5.8%	939.4	5.5%	11.6%	913.5	-2.8%	8.5%
Prescribed Drugs - Generic	Scripts per 1,000	5,489.7	5,875.4	7.0%	6,270.9	6.7%	14.2%	6,418.4	2.4%	16.9%
Prescribed Drugs - Other	Scripts per 1,000	180.0	174.2	-3.2%	162.1	-7.0%	-9.9%	24.3	-85.0%	-86.5%
BEHAVIORAL HEALTH										
BH Pharmaceuticals - Brand Name	Scripts per 1,000	183.3	166.9	-9.0%	149.3	-10.5%	-18.6%	141.6	-5.2%	-22.8%
BH Pharmaceuticals - Generic	Scripts per 1,000	1,713.8	1,742.1	1.7%	1,733.5	-0.5%	1.2%	1,749.8	0.9%	2.1%
BH Pharmaceuticals - Other	Scripts per 1,000	71.9	57.0	-20.7%	50.8	-10.9%	-29.4%	1.2	-97.6%	-98.3%
LTSS										
Prescribed Drugs - Brand Name	Scripts per 1,000	1,676.7	1,677.9	0.1%	1,505.5	-10.3%	-10.2%	1,398.3	-7.1%	-16.6%
Prescribed Drugs - Generic	Scripts per 1,000	9,609.5	9,625.5	0.2%	9,237.2	-4.0%	-3.9%	8,666.3	-6.2%	-9.8%
Prescribed Drugs - Other	Scripts per 1,000	358.3	378.0	5.5%	385.2	1.9%	7.5%	432.9	12.4%	20.8%

[101] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

The Evaluation also examined data summarized by Mercer which shows the distribution of pharmacy expenditure in DY1, DY2, and DY3. As illustrated in Exhibit 74, total drug expenditure has been increasing throughout DY1 to DY2, with a 21.4% increase from DY2 to DY3. In addition, pharmacy expenditure has been shifting from generic drugs to brand name drugs from DY1 to DY3. Possible explanations for this shift may include effective but expensive brand name drugs entering the market (such as newly-developed, brand name drugs for Hepatitis C treatment that were utilized mainly by the Medicaid adult expansion group), increases in prices of existing brand name drugs, etc. In DY3, brand name drug expenditure made up 71% of total drug cost, while generic drugs accounted for 27%.

Exhibit 74 – Distribution of Pharmacy Expenditures by Brand, Generic, and Other Drugs[102]



[102] Source: Data summarized by Mercer based on financial statements submitted by MCOs.

Measure 75 – Inpatient services exceeding $50,000.

Exhibit 75 presents the inpatient services exceeding $50,000 as a percentage of total healthcare related expenditures as reported by the MCOs for DY1, DY2, and DY3. The percentage of high cost inpatient service expenditure continues to drop each year from DY1 to DY3, with high cost inpatient claims representing only 1.3% of total healthcare related expenditures in DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 75 – Inpatient Services Exceeding $50,000 as % of Total Healthcare Expenditures[103]

	DY1	DY2	DY3
Baseline	4.1%	4.1%	4.1%
Measured Total	4.1%	2.5%	1.3%
Difference Measured Over/(Under) Baseline	0.0%	-1.7%	-2.8%

[103] Source: Revenue and expense reports and high cost claims reports (Report 1 and Report 7) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 76 – Diagnostic imaging costs.

Exhibit 76 presents the PMPM cost for services related to diagnostic imaging for the Q1 2014 baseline, DY1, DY2, and DY3. Although the PMPM cost of diagnostic imaging service dropped below the baseline in DY2, it increased substantially in DY3 and exceeded the baseline by 21.7%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 76 – Diagnostic Imaging Cost PMPM[104]

	Q1 2014	DY1	DY2	DY3
Baseline	$0.67	$0.67	$0.67	$0.67
Measured Total	$0.67	$0.71	$0.49	$0.82
Measured Over/(Under) Baseline	$0.00	$0.04	-$0.19	$0.15
% Measured Over/(Under) Baseline	0.0%	5.5%	-28.0%	21.7%

[104] Source: Expense reports (Report 2) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 77 – Emergency department use.

Exhibit 77 presents ER utilization for the Q1 2014 baseline, DY1, DY2, and DY3. As the exhibit illustrates, utilization for ER services increased in both PH and LTSS care settings from the baseline to DY3, which is an undesirable trend given that ER services are high cost in nature. However, it is important to note that ER utilization has been experiencing annual decreases from DY1 to DY3 in the PH care setting, which serves a population base that is more than twelve times larger than the population served in the LTSS care setting.

It is likely that the membership change in the adult expansion group had an impact on the results for this measure since this measure is inclusive of all populations and not limited to a specific population subset or MEG.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 77 – Emergency Department Use[105]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
EMERGENCY DEPARTMENT USE										
PHYSICAL HEALTH										
Outpatient Hospital - Emergency Room	Vists per 1,000	552.5	579.0	4.8%	557.8	-3.7%	1.0%	556.2	-0.3%	0.7%
LTSS										
Outpatient Hospital - Emergency Room	Vists per 1,000	552.6	599.8	8.5%	690.8	15.2%	25.0%	734.9	6.4%	33.0%

[105] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports. In 2016, the "Ambulance – Ground" category of service was removed from PH and Other Adult Group – Physical Health (OAGPH) reports, therefore analysis for this measure no longer includes ambulance services.

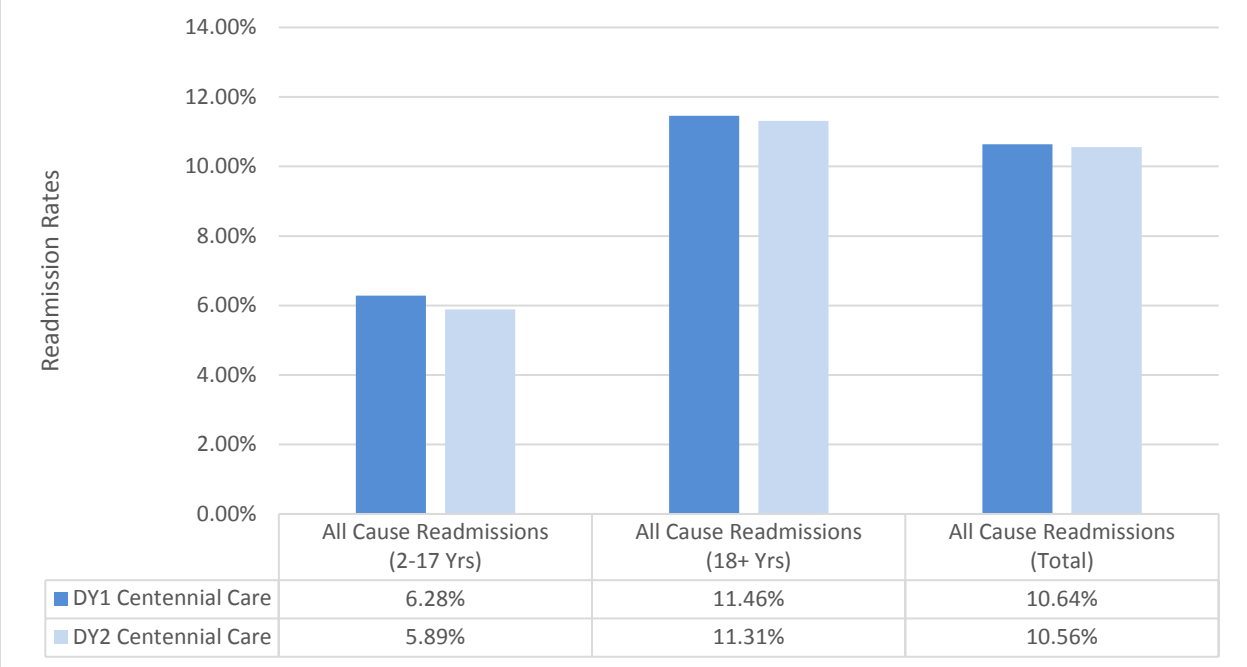
Measure 78 – All cause readmissions.

Exhibit 78 presents readmission rates for the 2-17 years of age cohort, 18+ years of age cohort, and the weighted average of both cohorts in DY1 and DY2. As illustrated, all cause readmission rates decreased for both the 2-17 years of age cohort (-6.2%) and the 18+ years of age cohort (-1.3%), which resulted in a 0.8% decrease in the weighted average readmission rate from DY1 to DY2. It should be noted that since the 18+ years of age cohort is roughly ten times larger than the 2-17 years of age cohort, the aggregate readmission rate is weighted more heavily toward the rate of the 18+ years of age cohort.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 78 – All Cause Readmission Rate[106]



	All Cause Readmissions (2-17 Yrs)	All Cause Readmissions (18+ Yrs)	All Cause Readmissions (Total)
DY1 Centennial Care	6.28%	11.46%	10.64%
DY2 Centennial Care	5.89%	11.31%	10.56%

[106] Source: Data provided by Mercer. HSD indicated a data source change for this measure in DY2 to replace MMIS data with Mercer summary data. Due to the change in available fields in the new reports, there is a change in the subcomponents analyzed for this measure compared to the DY1 Annual Report.

Measure 79 – Inpatient mental health/substance use services.

Exhibit 79 presents the utilization for services related to inpatient mental health and substance abuse for the Q1 2014 baseline, DY1, and DY2. The utilization of psychiatric hospitals stayed relatively consistent throughout the baseline to DY2, at around 1.3 encounters per client. There was a slight decrease (-28.0%) in utilization of RTCs from DY1 to DY2, but an overall significant increase (683.6%) from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 79 – Inpatient Mental Health/Substance Use[107]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline
INPATIENT MENTAL HEALTH/SUBSTANCE ABUSE SERVICES							
Psychiatric Hospital	Encounters per Client	1.28	1.27	-1.4%	1.30	2.5%	1.1%
Residential Treatment Center	Encounters per Client	1.04	11.33	987.9%	8.16	-28.0%	683.6%

[107] Source: Inpatient mental health and substance use MMIS reports.

Research Question 3.B

Has the member rewards program encouraged members to better manage their care?

The Centennial Rewards program is an incentive program that went live on April 1, 2014 as part of Centennial Care and is designed to motivate members to better manage their own health. For example, members can earn rewards for adhering to medication regiments and routine exams for various chronic illnesses or behavioral conditions such as refilling prescriptions for asthma, schizophrenia, bipolar and taking medical exams for diabetes. To increase program awareness and engagement, MCOs have been actively involved in outreach, communication, and marketing, including distributing program materials and reaching out to members through the call center. There is also a public portal that allows individuals not registered for the program to learn more about Centennial Rewards.

The Evaluation is reviewing the impact of the Centennial Rewards program on member behavior through analysis of nine measures designed to monitor members' compliance with various treatment protocols or use of annual preventive services. Currently, performance measures are not reported for Centennial Rewards enrollees by specific cohorts. For the purposes of this report, the reward-earning and redemption rates associated with the health compliance activities were examined in detail for the population as a whole.

Overall through DY2 of the Centennial Care program, all measures experienced significant increases in members earning rewards and redemption rates. This includes increases in members earning and redeeming rewards for managing chronic conditions such as asthma, schizophrenia, bipolar disorder, and diabetes. There were also increases in members earning and redeeming rewards for engaging in preventive services such as receiving an annual bone density test for those at risk for osteoporosis, pregnant women enrolling in prenatal programs, and child and adult members receiving an annual dental visit.

These results indicate that the Centennial Rewards program has encouraged members to engage in the program and better manage their own health and wellness.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

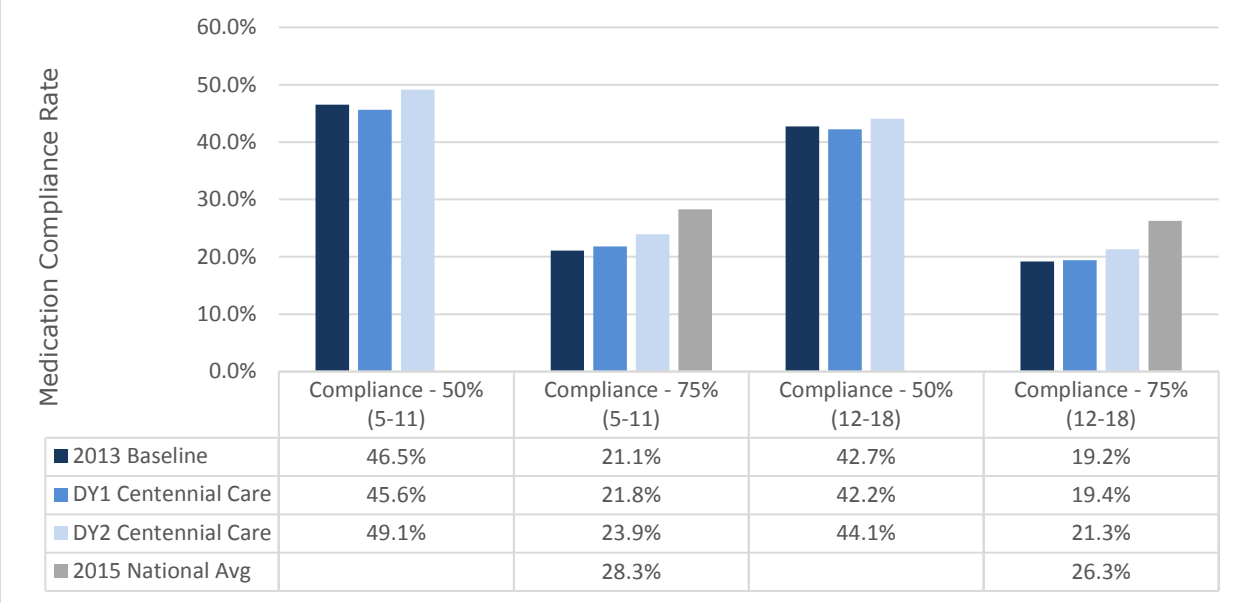
Measure 80 – Asthma controller medication compliance (children).

Exhibit 80.a demonstrates asthma medication compliance for children at various compliance levels and age cohorts. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Aggregate compliance rates increased from DY1 to DY2 for all compliance thresholds and age cohorts, but the only statistically significant change was the 7.7% increase of the 50% compliance rate for the 5-11 years of age cohort. Upon review of individual MCO performance, PHP was the only MCO that experienced statistically significant changes from DY1 to DY2, with 17.4% to 34.8% increases across all age cohorts.

Aggregate compliance rates increased from the baseline to DY2 for all thresholds and cohorts, but the only statistically significant rate of change was a 13.6% increase of the 75% compliance rate for the 5-11 years of age cohort. The compliance rates at the 75% threshold show slight positive trends year-over-year but remained below the 2015 national average. PHP was the only MCO that experienced statistically significant changes from the baseline to DY2, with increases ranging between 11.5% and 30.2% across all subcomponents.

Exhibit 80.a – Asthma Medication Compliance for Children[108]



	Compliance - 50% (5-11)	Compliance - 75% (5-11)	Compliance - 50% (12-18)	Compliance - 75% (12-18)
2013 Baseline	46.5%	21.1%	42.7%	19.2%
DY1 Centennial Care	45.6%	21.8%	42.2%	19.4%
DY2 Centennial Care	49.1%	23.9%	44.1%	21.3%
2015 National Avg		28.3%		26.3%

[108] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 80.b summarizes activity of members earning and redeeming Centennial Rewards points for activities to manage their children's asthma condition. As indicated in the exhibit, the number of members earning rewards and the percentage of members that are redeeming their rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 80.b Centennial Rewards for Activities Related to Asthma in Children, DY1 – DY2[109]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Asthma	1st Asthma	6,274	9.1%	11,152	29.1%	77.7%	218.9%
Asthma	3rd Asthma	4,771	8.6%	8,198	30.4%	71.8%	252.6%
Asthma	6th Asthma	2,510	7.5%	4,139	33.1%	64.9%	340.2%
Asthma	9th Asthma	1,246	5.9%	2,260	33.8%	81.4%	476.3%
Asthma	12th Asthma	663	5.7%	1,252	35.3%	88.8%	516.0%

[109] Source: Finity 2015 member rewards data.

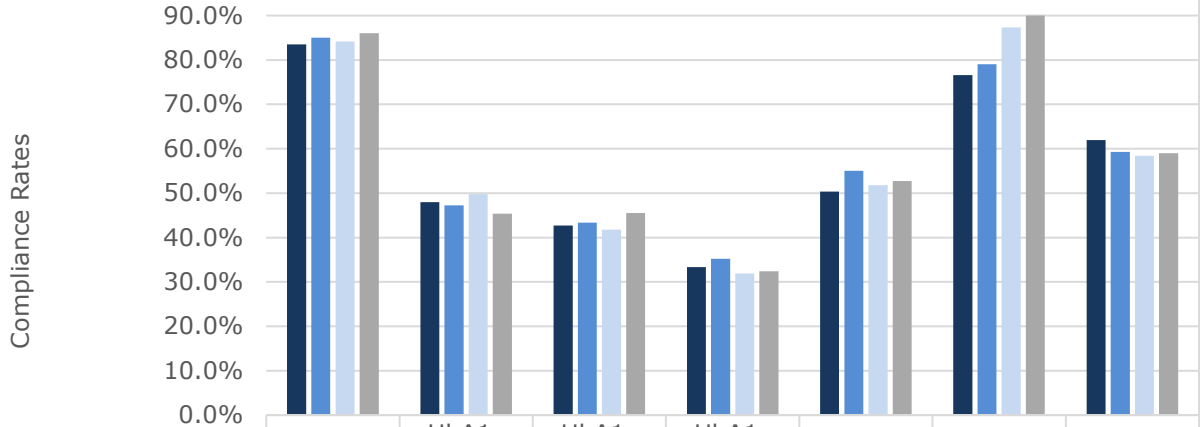
Measure 81 – Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam.

Exhibit 81.a demonstrates compliance rates for various preventive services associated with diabetes care and monitoring. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Nephropathy was the only subcomponent that showed increased compliance (10.4% increase) from DY1 to DY2, which was statistically significant at the 95% confidence level. Of the subcomponents that showed decreases, eye exam was the only statistically significant change with a decrease of 5.9%. Note that while the rate for HbA1c poor control subcomponent increased from DY1 to DY2, it is an inverse measure, meaning a decrease in the rate indicates improved compliance and vice versa.

The baseline to DY2 rate of change for nephropathy was 14.0% and the baseline to DY2 rate of change for blood pressure control was -5.7%, which were the only statistically significant rates of change between the baseline and DY2. Of the non-statistically significant rates of change, HbA1C testing and eye exams rates increased, while HbA1c control (<8.0% and <7.0%) rates decreased, and HbA1c poor control experienced an unfavorable increase from the baseline to DY2.

Exhibit 81.a – Comprehensive Diabetes Care[110]



	HbA1c Testing	HbA1c Poor Control	HbA1c Control (<8.0%)	HbA1c Control (<7.0%)	Eye Exam	Nephropathy	Blood Pressure
2013 Baseline	83.5%	47.9%	42.7%	33.3%	50.4%	76.6%	62.0%
DY1 Centennial Care	85.0%	47.2%	43.4%	35.2%	55.0%	79.1%	59.3%
DY2 Centennial Care	84.1%	49.8%	41.8%	31.9%	51.8%	87.3%	58.4%
2015 National Avg	86.0%	45.4%	45.5%	32.4%	52.7%	90.0%	59.0%

[110] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 81.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to manage their diabetes. As seen in the table, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 81.b Centennial Rewards for Activities Related to Diabetes, DY1 – DY2[111]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Diabetes	Eye Exam	9,874	8.0%	21,951	24.1%	122.3%	203.5%
Diabetes	HbA1c Test	18,135	9.2%	28,723	25.9%	58.4%	180.9%
Diabetes	LDL Test	13,569	9.2%	23,617	26.7%	74.1%	190.8%
Diabetes	Nephropathy Exam	14,944	9.0%	28,072	24.2%	87.8%	168.2%

[111] Source: Finity 2015 member rewards data.

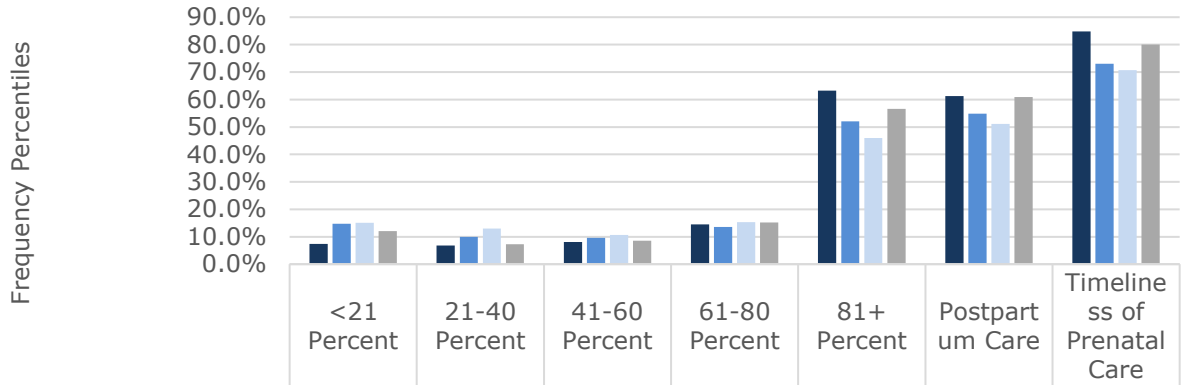
Measure 82 – Prenatal program.

Exhibit 82.a demonstrates compliance rates of frequency for ongoing prenatal care, postpartum care, and timeliness of prenatal care. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Three subcomponents had statistically significant rates of change from DY1 to DY2. The percentage of deliveries that received 21-40% of expected visits increased 30.5%, and the percentage of deliveries that received over 81% of expected prenatal visits decreased 11.8%. The percentage of deliveries that received postpartum care decreased 6.7%. Three subcomponents experienced increase in rates but are not statistically significant: deliveries that received under 21%, between 41-60%, and between 61-80% expected visits. Timeliness of prenatal care rates decreased from DY1 to DY2 although not statistically significant.

From the baseline to DY2, lower frequencies of prenatal visits increased across compliance categories (deliveries receiving under 21% expected visits increased 104.9%, deliveries receiving 21-40% expected visits increased 89.5%, deliveries receiving 41-60% expected visits increased 32.2%, deliveries receiving 61-80% expected visits increased 5.7%), while the percentage of deliveries that received over 81% of expected prenatal visits decreased 27.3%. The percentage of deliveries that received postpartum care decreased 16.5%, and the timeliness of prenatal care decreased 16.6% from the baseline to DY2. All changes from the baseline to DY2 were statistically significant at the 95% confidence level except for rates of deliveries receiving 61-80% expected prenatal visits. Most subcomponents of the prenatal program measure underperformed compared to the 2015 national average rates in DY2.

Exhibit 82.a – Prenatal Program[112]



	<21 Percent	21-40 Percent	41-60 Percent	61-80 Percent	81+ Percent	Postpartum Care	Timeliness of Prenatal Care
2013 Baseline	7.4%	6.8%	8.1%	14.5%	63.2%	61.3%	84.8%
DY1 Centennial Care	14.8%	9.9%	9.6%	13.6%	52.1%	54.8%	73.0%
DY2 Centennial Care	15.1%	13.0%	10.6%	15.3%	45.9%	51.2%	70.7%
2015 National Avg	12.0%	7.3%	8.6%	15.2%	56.6%	60.9%	80.0%

[112] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 82.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to enroll in the prenatal program. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 82.b – Centennial Rewards for Activities Related to Prenatal Program, DY1 – DY2[113]

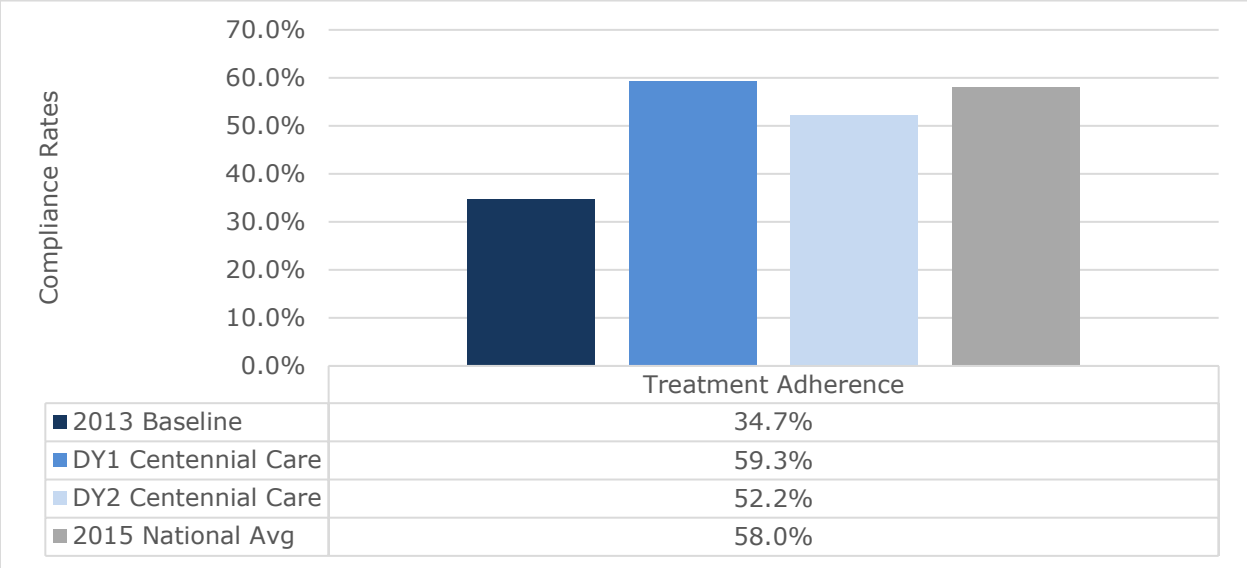
		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Pregnancy	Prenatal Enrollment	3,441	10.8%	7,386	24.0%	114.6%	122.4%

[113] Source: Finity 2015 member rewards data.

Measure 83 – Treatment adherence – schizophrenia.

Exhibit 83.a presents the schizophrenia treatment adherence rate for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. Although the treatment adherence rate experienced a statistically significant decline of 12.0% from DY1 to DY2, the aggregate change from the baseline to DY2 was a statistically significant increase of 50.3%. This increase from the baseline to DY2 was mainly driven by PHP's increase of 135.4%, which was the only statistically significant change among all MCOs. The DY2 performance was below the national average rate for 2015.

Exhibit 83.a – Treatment Adherence – Schizophrenia[114]



	Treatment Adherence
2013 Baseline	34.7%
DY1 Centennial Care	59.3%
DY2 Centennial Care	52.2%
2015 National Avg	58.0%

[114] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 83.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to manage schizophrenia. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program encourages greater treatment adherence for the subset of Centennial Care members that are registered for the Centennial Rewards program compared to the broader Centennial Care population.

Exhibit 83.b – Centennial Rewards for Activities Related to Schizophrenia, DY1 – DY2[115]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Schizophrenia	1st Schizophrenia	3,083	6.8%	4,718	19.9%	53.0%	190.8%
Schizophrenia	3rd Schizophrenia	2,515	6.7%	3,888	21.0%	54.6%	213.8%
Schizophrenia	6th Schizophrenia	1,944	6.0%	3,038	22.0%	56.3%	268.5%
Schizophrenia	9th Schizophrenia	1,570	5.2%	2,460	22.4%	56.7%	328.8%
Schizophrenia	12th Schizophrenia	1,100	5.2%	1,885	22.2%	71.4%	327.9%

[115] Source: Finity 2015 member rewards data.

Measure 85 – Osteoporosis management in elderly women - females aged 65+ years.

Exhibit 85.a presents data on osteoporosis management in elderly women for the 2013 baseline, DY1, DY2, and DY3. The number of unique clients and unique encounters both increased significantly from the baseline to DY3. However, the more relevant subcomponent is the number of unique encounters per client, which decreased by 2.0% from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 85.a – Osteoporosis Management in Elderly Women – Females Age 65+ Years[116]

Program Measure	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
Unique Count of Clients	106	159	50.0%	227	42.8%	253	11.5%	138.7%
Unique Count of Encounter Claims	127	195	53.5%	271	39.0%	297	9.6%	133.9%
Unique Count of Encounter Per Client	1.20	1.23	2.4%	1.19	-2.7%	1.17	-1.7%	-2.0%

Exhibit 85.b summarizes activity on members earning and redeeming Centennial Rewards points for bone density testing. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 85.b – Centennial Rewards for Bone Density Testing, DY1 – DY2[117]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Bone Density	Bone Density Test	374	5.1%	749	20.3%	100.3%	299.5%

[116] Source: Osteoporosis MMIS Report.
[117] Source: Finity 2015 member rewards data.

Measure 86 – Annual dental visit – adult.

Exhibit 86.a illustrates frequency of dental visits among members 19-21 years of age for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. The percentage of young adults receiving at least one dental visit annually had an increase of 15.9% from DY1 to DY2, although there has been a decrease of 9.0% from the baseline to DY2. Both rates of change are statistically significant. It is important to note that DY2 performance exceeded the HEDIS Medicaid national average.

Exhibit 86.a – Annual Dental Visit – Adult[118]

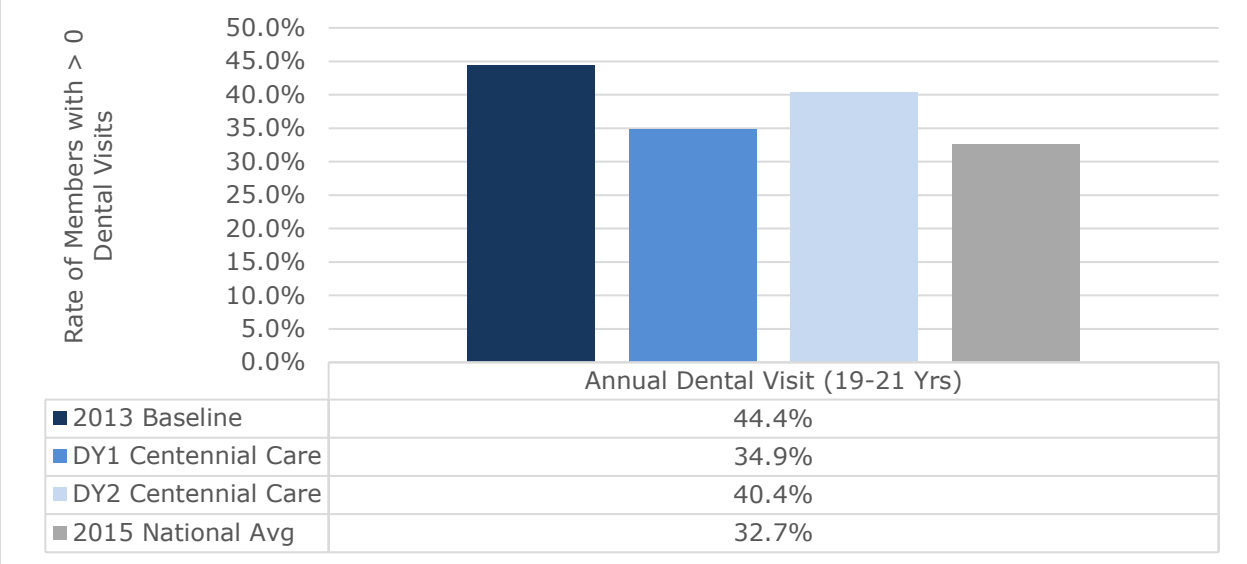


Exhibit 86.b summarizes activity on members earning and redeeming Centennial Rewards points for having their annual dental visit. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2, which may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 86.b – Centennial Rewards for Adult Annual Dental Visits, DY1 – DY2[119]

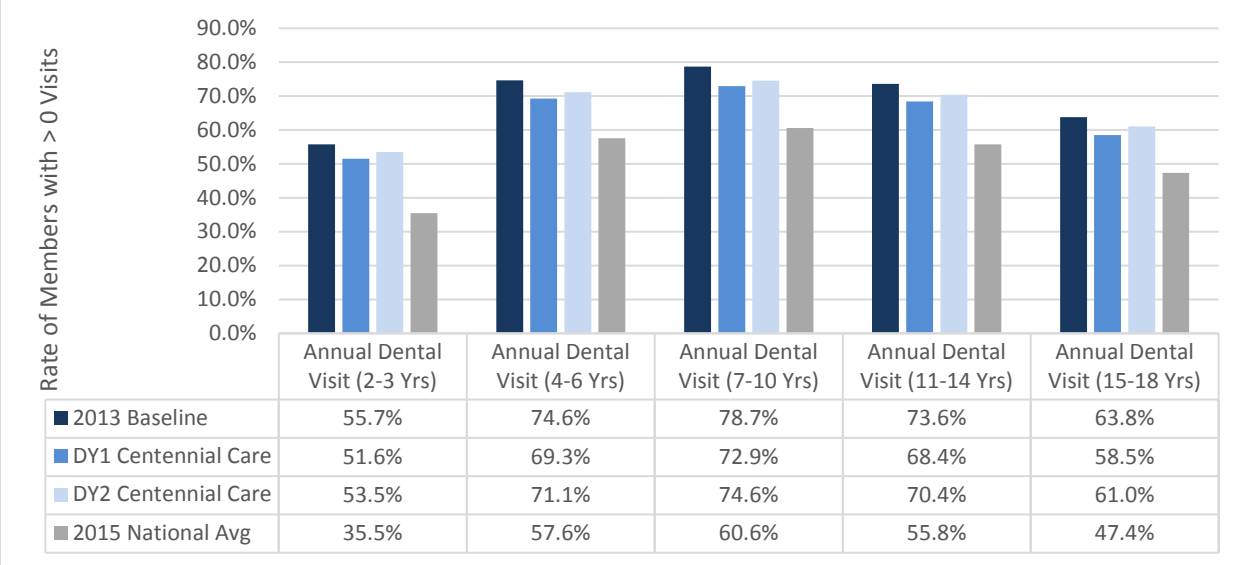
		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Adult Dental Visit	82,646	7.4%	152,833	19.7%	84.9%	164.4%

[118] Source: MCO annual HEDIS reports for 2013 – 2015.
[119] Source: Finity 2015 member rewards data.

Measure 87 – Annual dental visit – child.

Exhibit 87.a illustrates frequency of dental visits among children up to age 18 for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. The percentage of children receiving at least one dental visit annually increased in the range of 2.3% to 4.4% across all age cohorts from DY1 to DY2, although the rates decreased in the range of 4.0% to 5.2% across all age cohorts from the baseline to DY2. All rates of change are statistically significant at the 95% confidence level. It is important to note that DY2 performance exceeded the HEDIS Medicaid national average across all age cohorts.

Exhibit 87.a – Annual Dental Visit – Child[120]



	Annual Dental Visit (2-3 Yrs)	Annual Dental Visit (4-6 Yrs)	Annual Dental Visit (7-10 Yrs)	Annual Dental Visit (11-14 Yrs)	Annual Dental Visit (15-18 Yrs)
2013 Baseline	55.7%	74.6%	78.7%	73.6%	63.8%
DY1 Centennial Care	51.6%	69.3%	72.9%	68.4%	58.5%
DY2 Centennial Care	53.5%	71.1%	74.6%	70.4%	61.0%
2015 National Avg	35.5%	57.6%	60.6%	55.8%	47.4%

Exhibit 87.b summarizes members earning and redeeming Centennial Rewards points for activities performed to manage their children's dental health. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 87.b – Centennial Rewards for Child Annual Dental Visits, DY1 – DY2[121]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Child Dental Visit	157,152	8.9%	214,036	25.7%	36.2%	188.5%

[120] Source: MCO annual HEDIS reports for 2013 – 2015.
[121] Source: Finity 2015 member rewards data.

Measure 88 – Number of members spending credits.

Exhibit 88 summarizes the number of members spending credits in DY1 and DY2. As illustrated in the exhibit, the number of members registered, earning, and redeeming rewards all increased significantly from DY1 to DY2. More importantly, a larger percentage of members that are earning rewards are redeeming rewards in DY2 (20.0%) compared to DY1 (8.4%).

Exhibit 88 – Number of Members Spending Credits[122]

Measure	DY1	DY2
Number of Members Registered in the Rewards Program	46,537	155,764
Number of Members Earning Rewards	263,336	502,448
Number of Members Redeeming Rewards	22,150	100,579
Percentage of Members Redeeming Rewards	8.4%	20.0%

[122] Source: Finity 2015 member rewards data.

Hypothesis 4

Streamlining through Centennial Care will result in improved health care experiences for beneficiaries, improved claims processing for providers, and efficiencies in program administration for the state.

Centennial Care supports improved healthcare delivery and emphasizes greater access to primary care services. Access to primary care is important for preventive care and management of existing conditions because primary care may allow for members to increase use of preventive services and care management for existing conditions. Centennial Care seeks to enhance the access and availability of primary care to address existing care needs and prevent more serious conditions.

The Evaluation found that results of the Centennial Care program have been mixed, producing some improved outcomes and some that have declined since the implementation of the program. These outcomes vary among populations surveyed for individuals measured.

Research Question 4.A

Are enrollees satisfied with their providers and the services they receive?

The Centennial Care waiver consolidates services within a single program and defines performance standards for contracted MCOs related to timely adjudication of member grievances and appeals, access to providers, and responsive customer service. These performance standards are intended, in part, to improve the member experience and increase satisfaction with the program.

The Evaluation is reviewing Centennial Care's impact on member satisfaction through the analysis of 12 measures that address grievance and appeal resolution timeliness and components of member satisfaction. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY2 of the Centennial Care program, programmatic performance was generally positive from the member's perspective. Member satisfaction rates and grievances/appeals performance metrics reported showed improvement in 7 out of 12 measures. Improved performance was experienced in the percentage of expedited appeals resolved on time; and the percentage of appeals upheld, partially overturned, and overturned. There were also improvements across all three cohorts for the number and percentage of members satisfied with their care coordination, slight improvements for two of three subcomponents for the rating of personal doctors, and improvements across all three cohorts for customer service.

Measure performance remained relatively consistent through DY2 for the percentage of grievances resolved within 30 days and the number and percentage of calls answered within 30 seconds, both of which maintained high rates each year.

Opportunities for continued improvement were identified for the remaining three measures: rating of health care, which experienced slight decreases in two of three cohorts; rating for how well doctors communicate, which also experienced decreases in two of three cohorts; and the rating for the specialist seen most often, which decreased for two of three cohorts.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 88 – Percentage of expedited appeals resolved within three business days.

Exhibit 88 presents the rate at which expedited appeals were resolved within their allowed timeframes for DY1 and DY2. The overall resolution rate increased by 0.6% from DY1 to DY2.

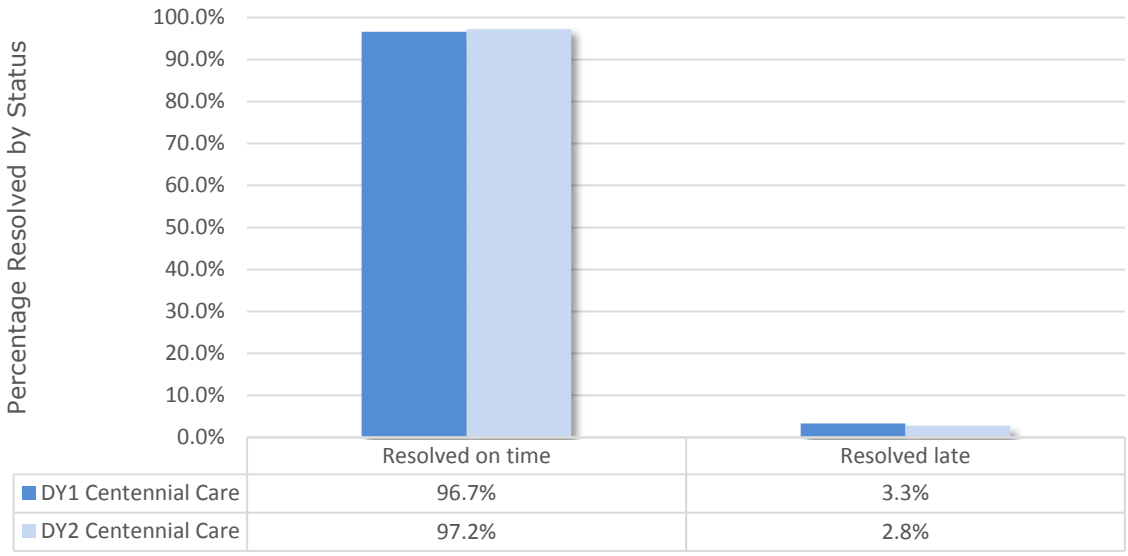
When analyzing changes from DY1 to DY2 among individual MCOs, PHP experienced the greatest increase (4.3%) followed by UHC (2.1%), while BCBS (-4.4%) and MHC (-0.9%) both experienced declines.

Emerging data through November of DY3 suggests that the rate at which expedited appeals were resolved within their allowed timeframe may decline slightly from DY2 to DY3, however it should be noted that the overall resolution rates across all three demonstration years are very high.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 88 – Percent of Expedited Appeals Resolved on Time[123]



	Resolved on time	Resolved late
DY1 Centennial Care	96.7%	3.3%
DY2 Centennial Care	97.2%	2.8%

[123] Source: MCO reports for 2014 – 2015 (HSD 37).

Measure 89 – Percentage of grievances resolved within 30 days.

Exhibit 89 presents the rate at which grievances were resolved within 30 days for DY1 and DY2. The overall resolution rate increased slightly by 0.1% from DY1 to DY2.

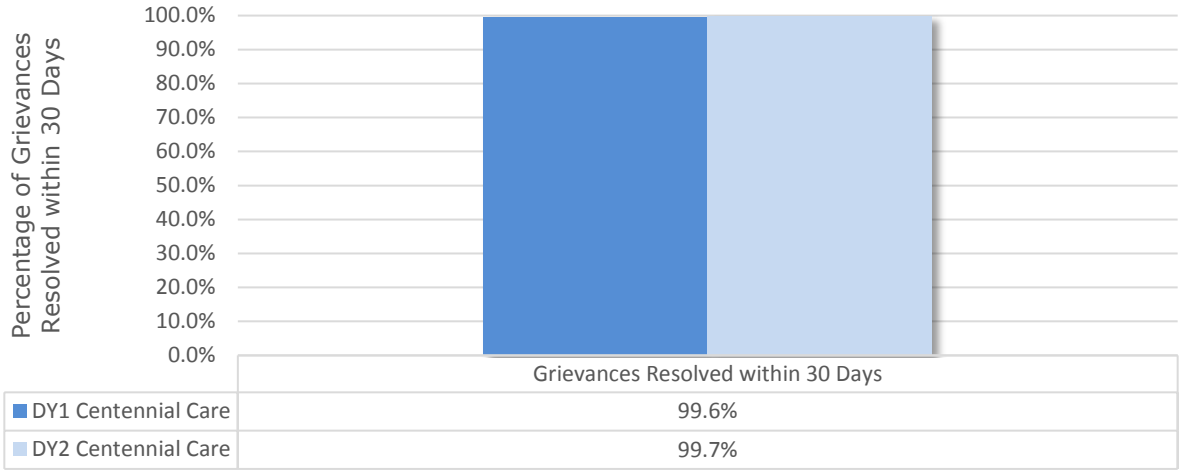
Among individual MCOs, BCBS experienced a 1.2% increase, and PHP's rate did not change from DY1 to DY2; MHC and UHC experienced declines in their rates over the same period of 0.1% and 0.4% respectively.

Emerging data through November of DY3 suggests that the rate at which grievances were resolved within 30 days may decline slightly from DY2 to DY3, however it should be noted that the overall resolution rates across all three demonstration years are very high.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 89 – Percentage of Grievances Resolved on Time[124]



	Grievances Resolved within 30 Days
DY1 Centennial Care	99.6%
DY2 Centennial Care	99.7%

[124] Source: MCO reports for 2014 – 2015 (HSD 37).

Measures 90, 91, and 92 – Percentage of appeals by adjudication (upheld, partially overturned, and overturned).

Exhibit 90 presents the rate at which appeals were upheld, partially overturned, or overturned. The rate at which appeals were upheld declined 6.4% from DY1 to DY2, while the rate at which appeals were partially overturned and fully overturned decreased over the same period by 45.4% and 11.0%, respectively.

Three of four MCOs experienced an increase in upheld appeals, a development that reflects positively on the adjudication of appeals under Centennial Care. The largest relative increase among MCOs was a 25.7% increase experienced by UHC. The other changes among BCBS, MHC, and PHP were -3.8%, 2.6%, and 3.4%, respectively.

BCBS, PHP, and UHC experienced decreases in the percentage of appeals that were partially overturned, which is also considered a positive development. MHC's rate did not change from DY1 to DY2.

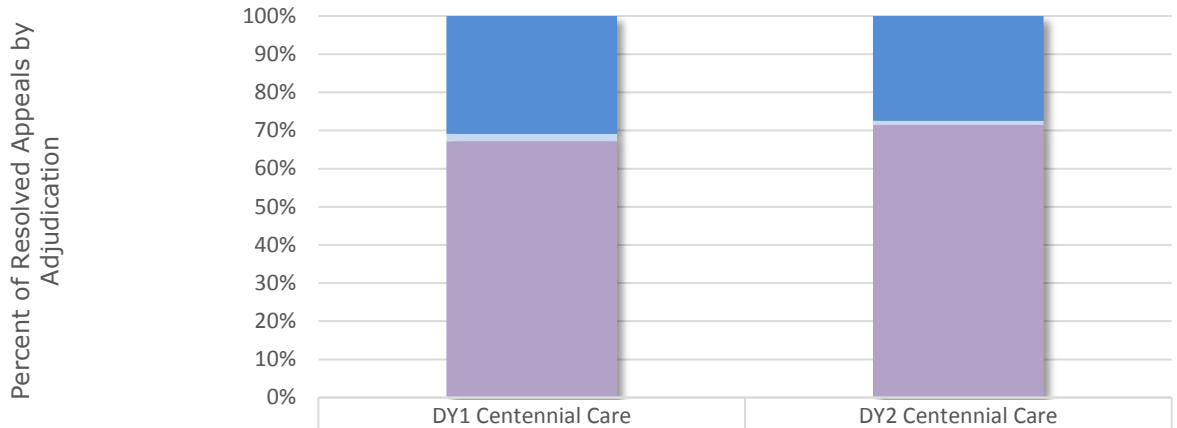
For the percentage of appeals fully overturned, MHC, PHP, and UHC each experienced a decline in the rate from DY1 to DY2, which is a positive development. BCBS experienced a slight increase over the same period.

Emerging data through November of DY3 suggests that Centennial Care may see a slight decline from DY2 to DY3 in appeals upheld and appeals partially overturned, and an increase in the percentage of appeals fully overturned.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 90 – Appeals by Adjudication[125]



	DY1 Centennial Care	DY2 Centennial Care
Appeals overturned	30.9%	27.5%
Appeals partially overturned	1.9%	1.0%
Appeals upheld	67.2%	71.5%

[125] Source: MCO reports for 2014 – 2015 (HSD 37).

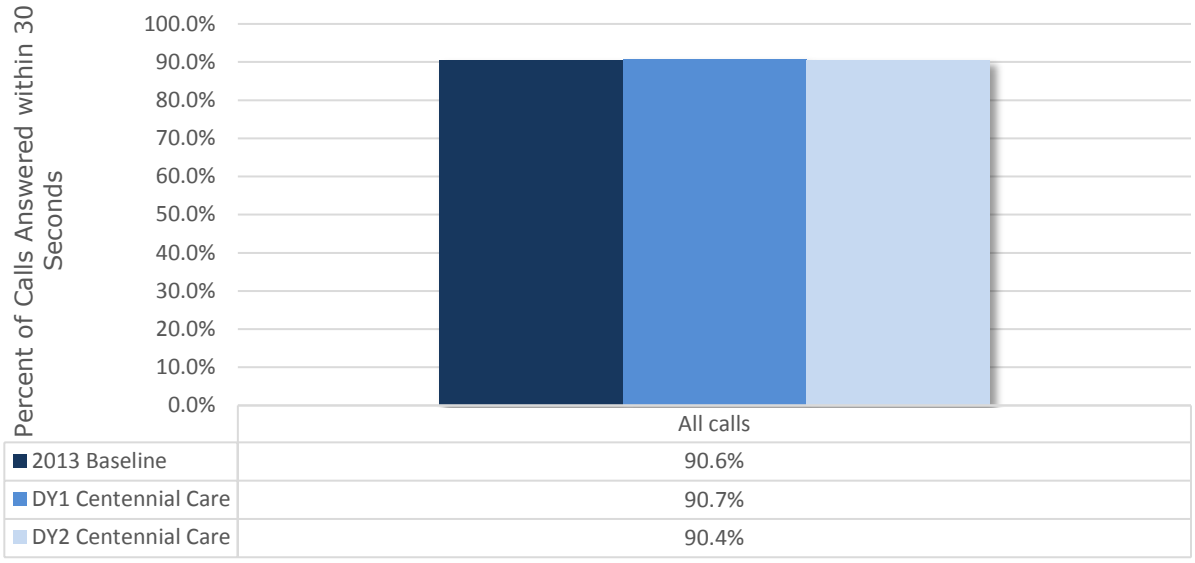
Measure 93 – Number and percentage of calls answered within 30 seconds.

Exhibit 93 presents rates for the 2013 baseline, DY1, and DY2 for the percentage of calls answered within 30 seconds. The percentage of calls answered within 30 seconds declined slightly from DY1 to DY2 by 0.3%, a change that was not statistically significant at a 95% confidence level. Overall, the rate declined slightly from the baseline to DY2 by 0.2%, which was not statistically significant at the 95% confidence level.

Only two MCOs, PHP and UHC, had a reportable rate in DY2, compared to all four having a reportable rate in DY1. Both rates improved from DY1 to DY2. UHC's increase (2.4%) was relatively larger than PHP's increase (0.3%), and both increases were statistically significant at the 95% confidence level. Both plans' increases from the baseline to DY2 were also statistically significant, and UHC's increase (1.9%) was greater than that of PHP (1.4%).

A national comparison rate could not be identified for this measure.

Exhibit 93 –Percentage of Calls Answered within 30 Seconds[126]



[126] Source: MCO Annual HEDIS Reports for 2013 – 2015.

Measure 94 – Number and percentage of participants satisfied with care coordination.

Exhibit 94 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average comparison rate for the percentage of participants satisfied with their care coordination. This information is based on CAHPS surveys that are sent out to random samples of eligible members covered under each MCO. Results of the survey are segmented into three population subgroups, the adult group, the child group ("child general population"), and children with chronic conditions (CCC).

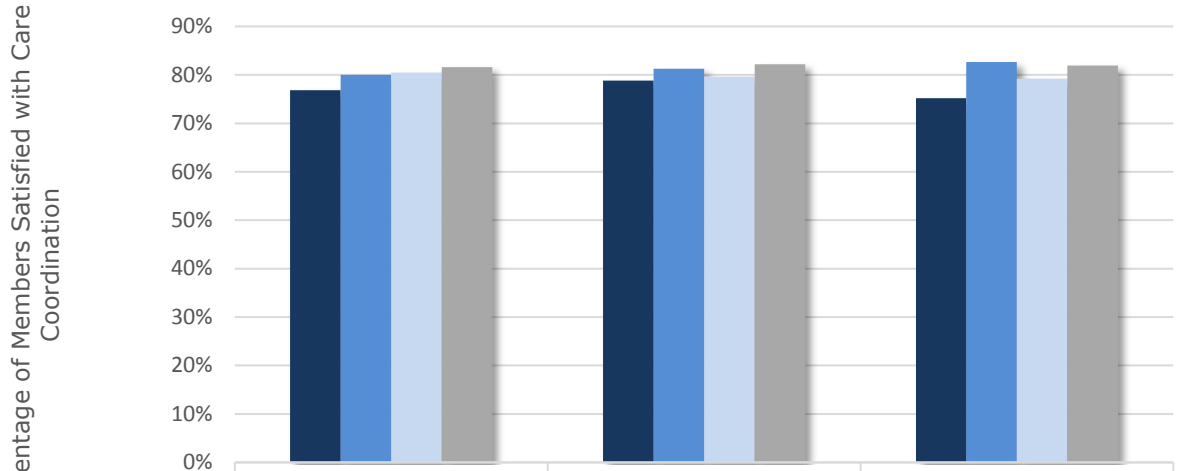
As illustrated, the percentage for the adult population in increased between DY1 and DY2 (1%), though declines were experienced among children with chronic conditions (-2%) and the child general population (-4%) during the same period.

All three population subgroups have experienced increases from the baseline to DY2 in the percentage of members that expressed satisfaction with their care coordination. The adult population has increased 5%, children with chronic conditions has increased 1%, and the child general population has increased 5% from the baseline to DY2.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark rate as the SPH Analytics benchmark was not available.

Exhibit 94 –Percentage of Participants Satisfied with Care Coordination[127]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	77%	79%	75%
DY1 Centennial Care	80%	81%	83%
DY2 Centennial Care	81%	80%	79%
2015 National Avg	82%	82%	82%

[127] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 95 – Rating of personal doctor.

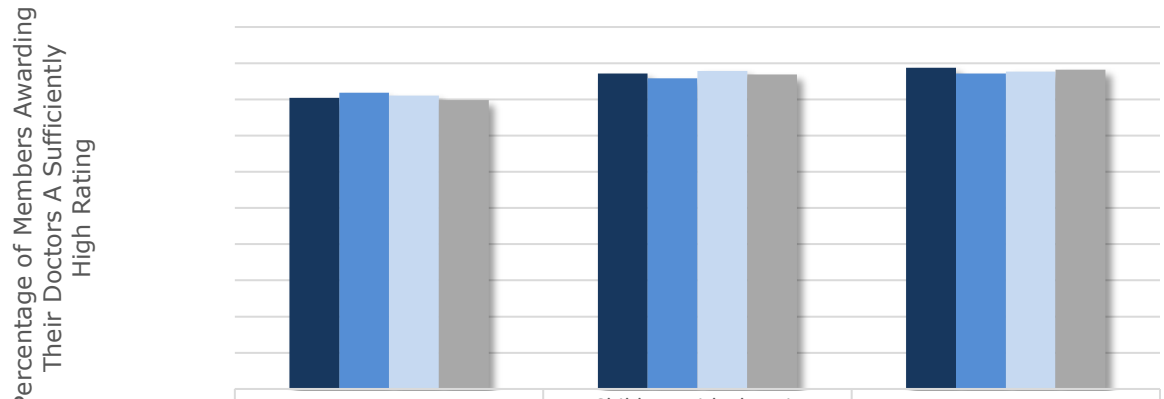
Exhibit 95 presents percentages for the 2013 baseline, DY1, DY2 and an appropriate national average for the percentage of participants satisfied with their personal doctor. As illustrated, the satisfaction percentage increased for two of three populations between DY1 and DY2, namely the child general population (1%) and children with chronic conditions (2%). The adult population's satisfaction with their personal doctor declined (-1%) over the same period.

When analyzing the baseline to DY2 performance trends, the percentage of adults satisfied with their personal doctor increased (1%) as did the percentage of children with chronic conditions (1%). The satisfaction of the child general population declined 1% from the baseline to DY2.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 95 –Percentage of Participants Satisfied with Personal Doctor[128]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	80%	87%	89%
DY1 Centennial Care	82%	86%	87%
DY2 Centennial Care	81%	88%	88%
2015 National Avg	80%	87%	88%

[128] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 96 – Rating of health care.

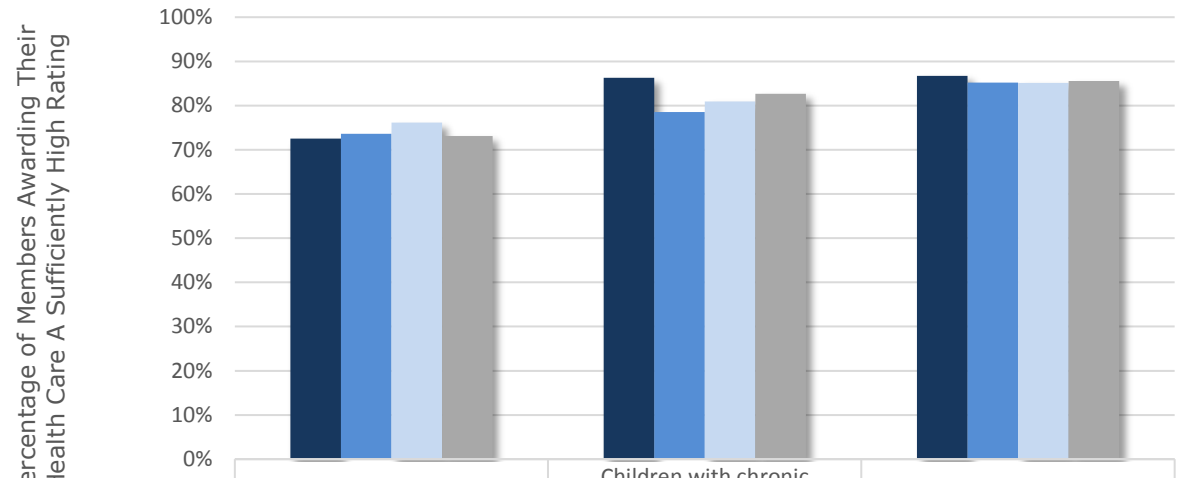
Exhibit 96 presents percentage for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members satisfied with their health care. As illustrated, the satisfaction percentage increased for two of three subcomponents between DY1 and DY2, namely the children with chronic conditions population (3%) and the adult population (3%). The child general population's high percentage of satisfaction with their personal doctor remained stable over the same period.

When analyzing the baseline to DY2 performance trends, the percentage of children with chronic condition satisfied with their health care declined (-6%) as did the percentage of the child general population (-2%). The satisfaction of the adult population increased by 5% from the baseline to DY2.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 96 – Percentage of Participants Satisfied with Health Care[129]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	73%	86%	87%
DY1 Centennial Care	74%	79%	85%
DY2 Centennial Care	76%	81%	85%
2015 National Avg	73%	83%	86%

[129] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 97 – Percentage of participants satisfied with how well their doctors communicate.

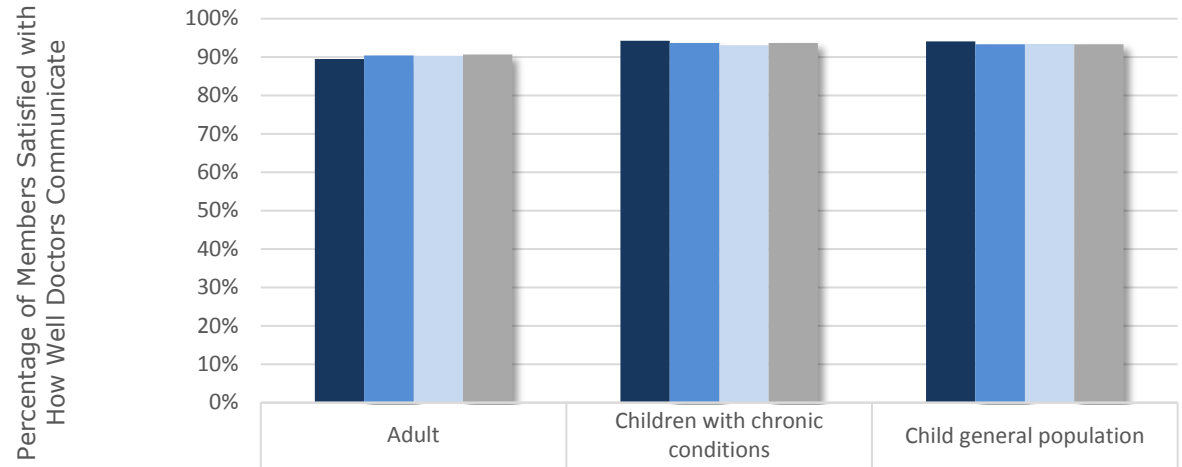
Exhibit 97 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of participants satisfied with how well their doctors communicate. As illustrated, the satisfaction percentage remained level for the child general population and the adult population from DY1 and DY2. There was a slight decline for the children with chronic conditions population (-1%) over this period.

When analyzing the baseline to DY2 performance trends, the percentage of adults satisfied with how well their doctors communicate increased (1%) while the satisfaction for the child general population and the children with chronic condition population both declined (-1%). The satisfaction percentage for DY2 were all within 1% of national averages.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 97 – Percentage of Participants Satisfied with How Well Their Doctors Communicate[130]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	90%	94%	94%
DY1 Centennial Care	90%	94%	93%
DY2 Centennial Care	90%	93%	93%
2015 National Average	91%	94%	93%

[130] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 98 – Customer service satisfaction.

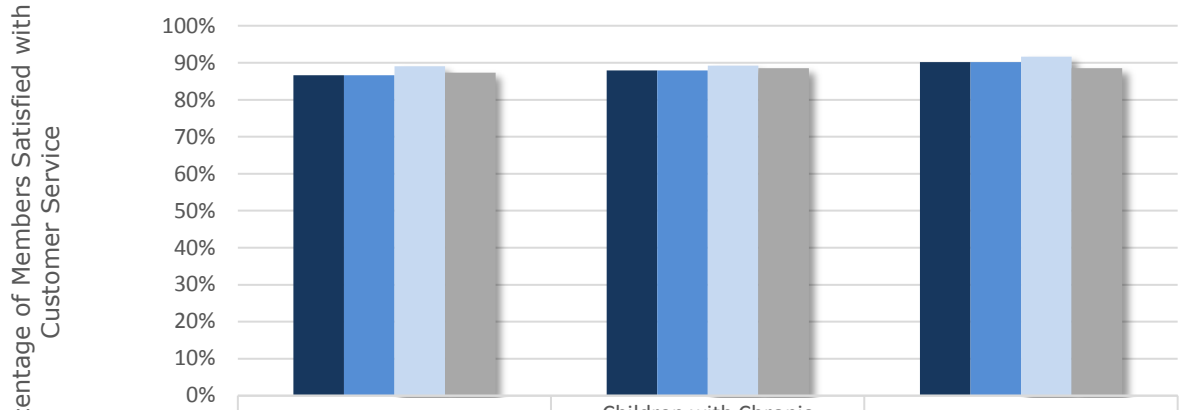
Exhibit 98 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members who were satisfied with customer service. As illustrated, customer service satisfaction percentages increased across all three populations: adult satisfaction increased by 3%, satisfaction for children with chronic conditions increased by 1%, and the child general population satisfaction increased by 2% between DY1 and DY2.

When comparing the baseline to DY2 performance trends, all three populations experienced increases in the satisfaction rates by the same percentages as the DY1 to DY2 increases.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark rate for the adult and general child populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark rate as the SPH Analytics benchmark was not available.

Exhibit 98 – Customer Service Satisfaction[131]



	Adult	Children with Chronic Conditions	Child general population
2013 Baseline	87%	88%	90%
DY1 Centennial Care	87%	88%	90%
DY2 Centennial Care	89%	89%	92%
2015 National Avg	87%	89%	89%

[131] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 99 – Rating of specialist seen most often.

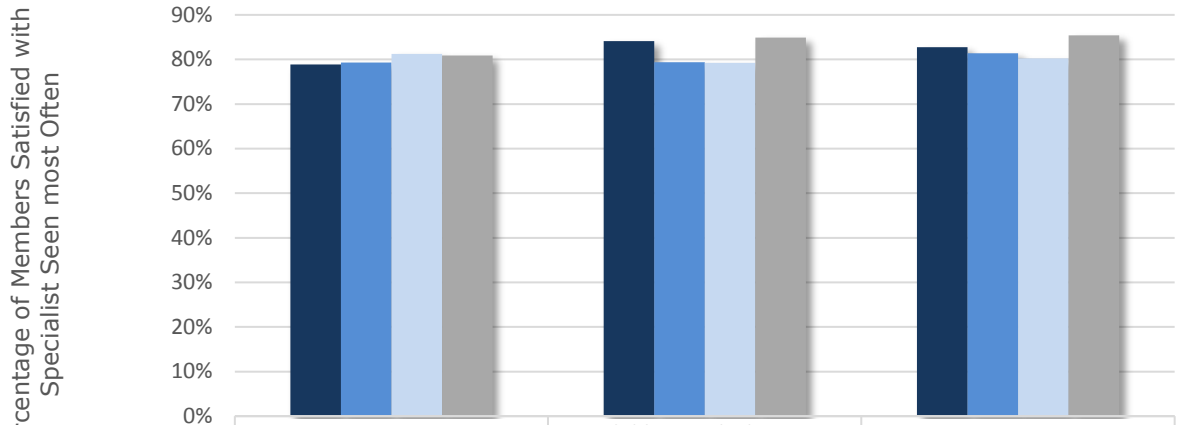
Exhibit 99 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members who were satisfied with the specialist seen most often. As illustrated, satisfaction increased among the adult population (2%) and decreased among the child general population (-1%) from DY1 to DY2. The percentage for the children with chronic conditions population did not change over this period.

When comparing the baseline to DY2 performance trends, the adult satisfaction with specialists increased (3%) while satisfaction declined for both children with chronic conditions (-6%) and child general population (-3%).

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 99 – Rating of Specialist Seen Most Often[132]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	79%	84%	83%
DY1 Centennial Care	79%	79%	81%
DY2 Centennial Care	81%	79%	80%
2015 National Avg	81%	85%	85%

[132] Source: MCO annual CAHPS reports for 2013 – 2015.

Research Question 4.B

Are provider claims paid accurately and on time?

The Centennial Care program requires contracted MCOs to adjudicate and pay claims accurately and in accordance with prescribed timeliness standards. The program also includes a provider grievance and appeals process with uniform resolution timeliness standards. Centennial Care's streamlined processes are intended to improve the provider experience and increase provider satisfaction with the program. This, in turn, should encourage provider participation and facilitate member access to care.

The Evaluation is reviewing Centennial Care's impact on these processes through the analysis of five measures that address components of claim adjudication, processing, and payment from the health pan to the providers. For each measure, performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, the MCOs continue to demonstrate high compliance rates across the measures. There was a favorable decrease in the percentage of claims denied, and the percentage of provider grievances and provider appeals both remained relatively consistent with rates over 99% for both.

Results were mixed across subcomponents for the percentage of clean claims adjudicated; the 30 and 90 day adjudication rates declined slightly, though the 30 day rate was greater than HSD standards of 90%; for claims subject to the 15/30 day standard, the 15-day subcomponent increased slightly while the 30 day component decreased slightly. For each of the four subcomponents, the adjudication rates exceeded 96% in DY2.

The dollar accuracy rate also showed mixed results, as 5 of 10 subcomponents experienced slight decreases in accuracy rates while the others showed slight increases. The crossover claim type subcomponent demonstrated the greatest increase since program inception and is worth noting, as crossover claims are often complex to adjudicate due to the presence of Medicare as an additional payer. All accuracy rate subcomponents exceeded 93% in DY2.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 100 – Percentage of clean claims adjudicated within 30/90 days.

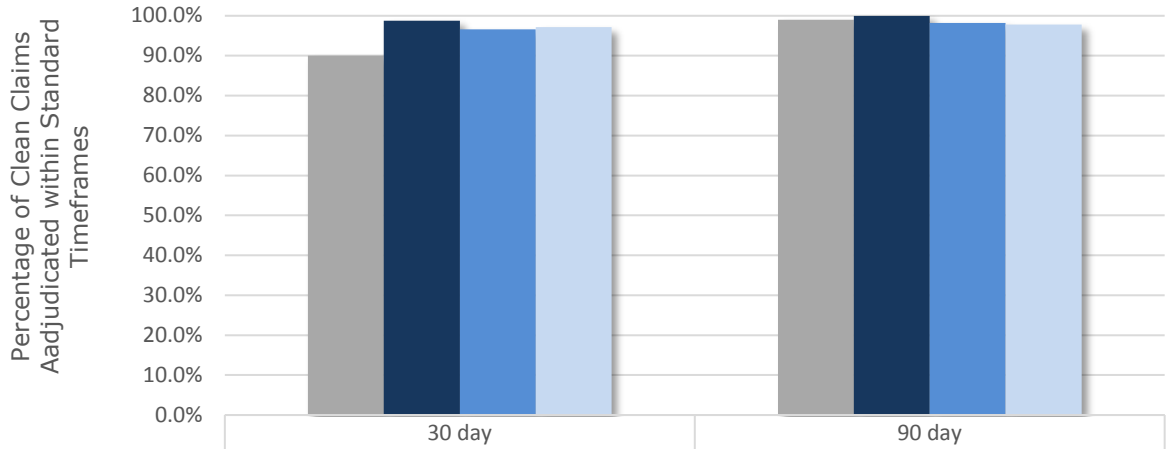
Exhibit 100.a presents the results for SFY 2013, DY1, and DY2 of the rate at which claims with a 30/90 day adjudication standard were resolved within 30 days. As illustrated, the rate increased from DY1 to DY2 by 0.6%. The rate at which these same claims were resolved within the 90 day interval declined slightly by 0.4%.

The rate at which claims with a 30/90 day adjudication standard were resolved within 30 days fell by 1.6% from SFY 2013 to DY2. The rate at which these same claims were resolved within the 90 day standard fell by 2.1% over the same period.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 100.a – Clean Claims Adjudicated within 30/90 Day Standard[133]



	30 day	90 day
HSD Standard	90.0%	99.0%
SFY 2013	98.8%	99.9%
DY1 Centennial Care	96.6%	98.2%
DY2 Centennial Care	97.2%	97.8%

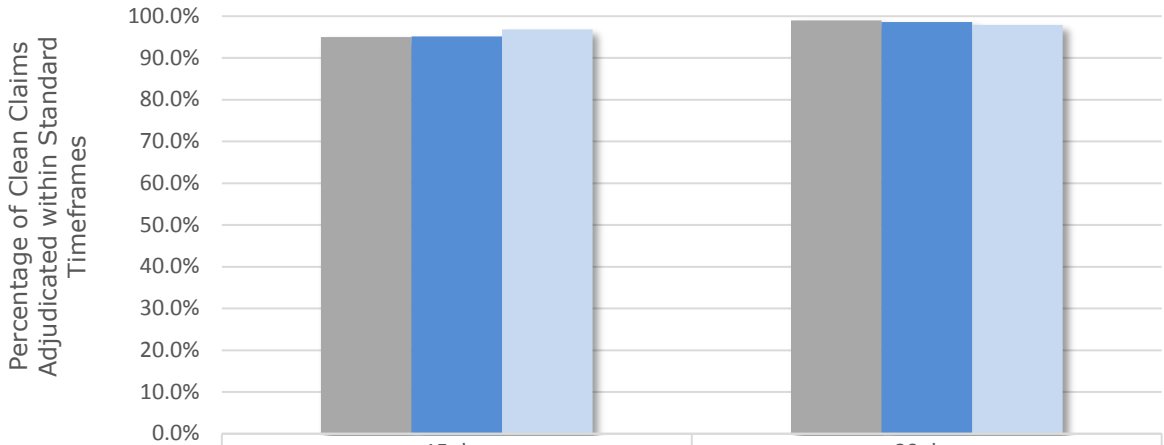
[133] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

Exhibit 100.b presents the results for DY1 and DY2 of the rate at which claims with a 15/30 day adjudication standard were adjudicated within 15 days. As illustrated, the rate increased by 1.7% from DY1 to DY2. The rate at which these same claims were adjudicated within the 30 day standard during this same interval declined by 0.7%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 100.b – Clean Claims Adjudicated within 15/30 Day Standard[134]



	15 day	30 day
HSD Standard	95.0%	99.0%
DY1 Centennial Care	95.2%	98.6%
DY2 Centennial Care	96.8%	97.9%

[134] Source: MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

Measure 101 – Percentage of claims denied.

Exhibit 101 presents the results for SFY 2013, DY1, and DY2 of the rate at which claims were denied. As illustrated, the percentage decreased 17.0% from DY1 to DY2. From SFY 2013 to DY2, the rate at which claims were denied fell by 25.2%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 101 – Percent of Claims Denied[135]

	Aggregate Denial Rate
SFY 2013	11.9%
DY1 Centennial Care	10.7%
DY2 Centennial Care	8.9%

[135] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

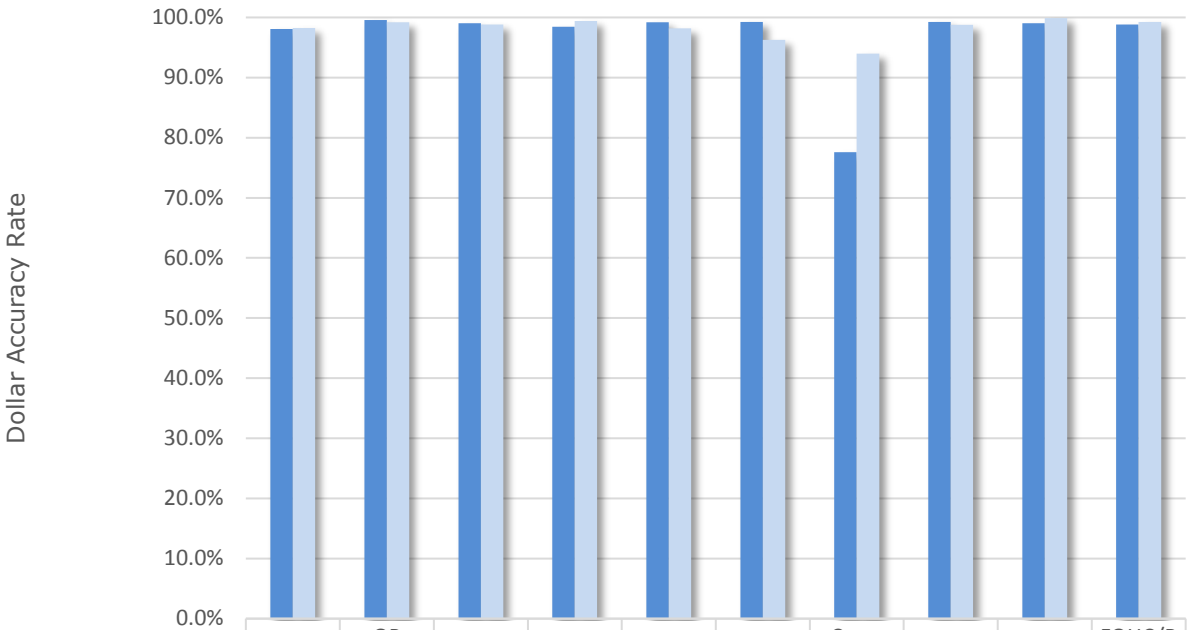
Measure 102 – Dollar accuracy rate.

Exhibit 102 presents results for dollar accuracy rates in DY1 and DY2. For the 10 types of claims reported, 5 showed increases in accuracy rates from DY1 to DY2, a positive development. The claim types that showed increases were inpatient hospital (0.1%), BH (1.0%), cross over (21.1%), dental (0.9%), and FQHC/RHC (0.5%). The claim types that experienced declines in dollar accuracy rates were outpatient hospital (-0.4%), professional (-0.2%), NF (-1.0%), I/T/U (-3.0%), and HCBS (-0.5%) type claims. These changes, whether increases or decreases, were relatively minor as accuracy rates remained high overall.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 102 – Dollar Accuracy Rate[136]



	IP Hosp	OP Hosp	Prof	BH	NF	I/T/U	Cross over	HCBS	Dental	FQHC/RHC
DY1 Centennial Care	98.1%	99.6%	99.1%	98.5%	99.2%	99.3%	77.6%	99.3%	99.0%	98.8%
DY2 Centennial Care	98.2%	99.2%	98.8%	99.4%	98.2%	96.3%	94.0%	98.8%	99.9%	99.2%

[136] Source: MCO reports for 2014 (HSD 46); ad hoc claims payment and activity reports for 2015. For DY2, Deloitte was unable to calculate an aggregate dollar accuracy rate due to data limitations; a dollar accuracy rate for each individual claim type was provided instead.

Measure 103 – Percent of grievances resolved on time.

Exhibit 103 presents rates for DY1 and DY2 of the percentage of provider grievances resolved on time. As illustrated, the rates for timely resolution remained high and were stable from DY1 to DY2, with a 0.0% change.

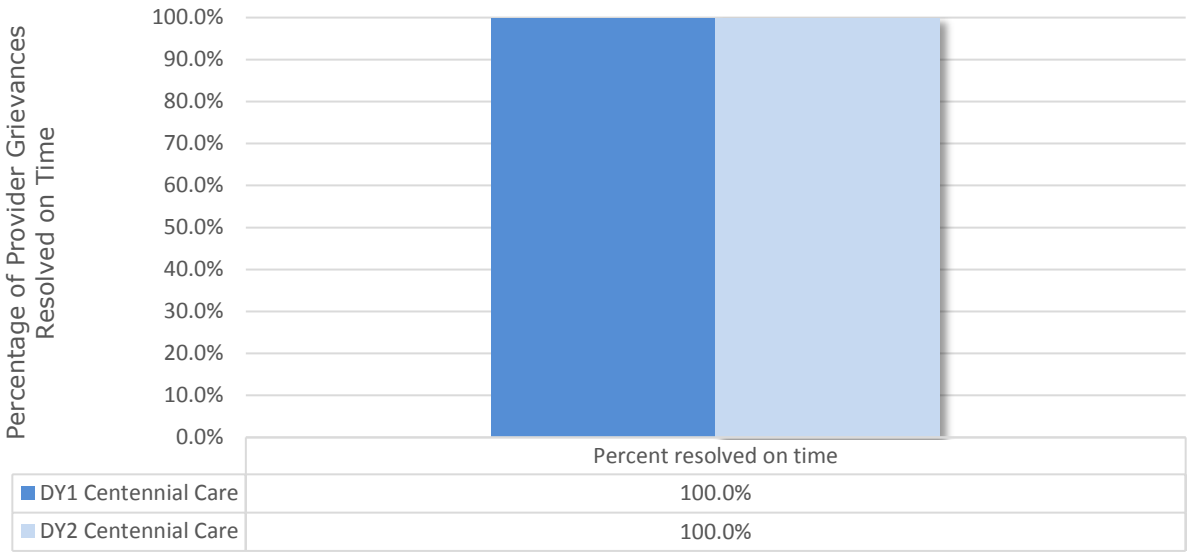
Individual MCO results were consistent with the calculated aggregate, where each MCO experienced 100% timely resolution in DY1 and DY2 with the exception of UHC, who did not produce data for this measure in DY1.

Provisional data is available through November of DY3, which suggests that DY3 rates will likely remain stable from DY2 at 100% timely resolution.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 103 – Percent of Provider Grievances Resolved on Time[137]



[137] Source: MCO reports for 2014 – 2015 (HSD 37).

Measure 104 – Percentage of provider appeals resolved on time.

Exhibit 104 presents rates for DY1 and DY2 of the percentage of provider appeals resolved on time. As illustrated, the rate for timely resolution experienced a marginal increase from DY1 to DY2 by 0.2%.

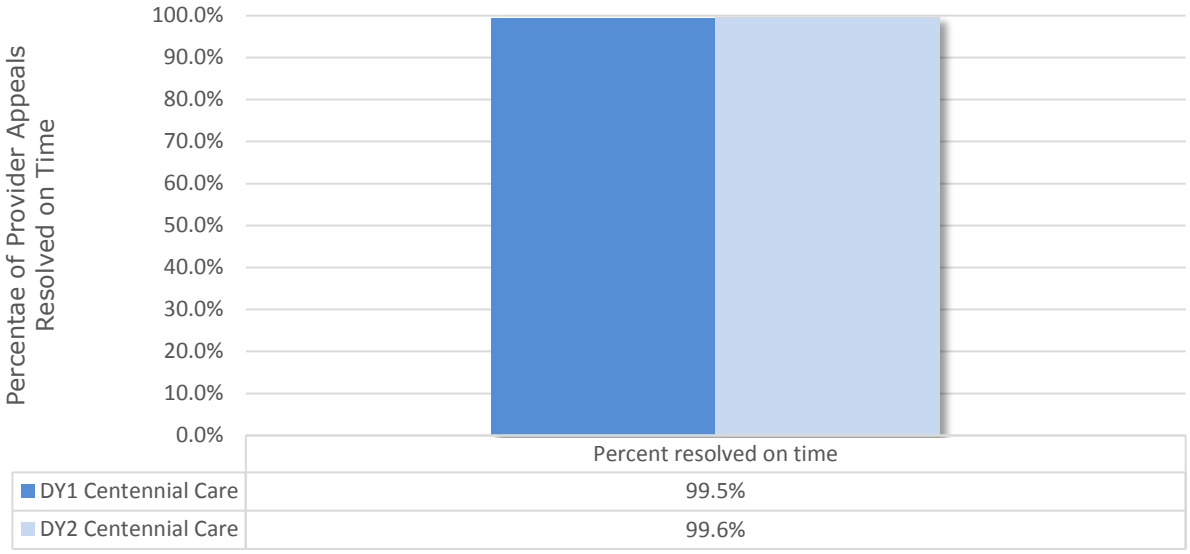
From DY1 to DY2, individual MCO results were also stable, with no MCO experiencing a change of more than 1.0%.

Provisional data is available through November of DY3, which suggests that DY3 rates will likely remain stable from DY2, with timely resolution rates at or above 99.0%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 104 – Percent of Provider Appeals Resolved on Time[138]



[138] Source: MCO reports for 2014 – 2015 (HSD 37).

Research Question 4.C

Has the state successfully implemented new processes and technologies for program management, reporting, and delivery system reform?

The Centennial Care waiver seeks to improve the efficiency and effectiveness of health care delivery through adoption of new processes and technology.

The Evaluation assesses the impact of program consolidation and adoption of new processes and technologies through analysis of three measures that address use of electronic tools for patient management, implementation of care delivery and payment reforms, claims payment accuracy and program reporting activities. One of these measures evaluates payments made for providers who demonstrate "meaningful use" of electronic health record (EHR) technology, which involves meeting a set of standards and specifications defined by CMS for how the technology is used to improve healthcare. For each measure performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, progress continues to be made across all three measures. The number of eligible providers receiving EHR incentive payments has remained steady for hospitals and initial payments continue to increase slightly for professionals. Follow-up payments have declined in recent years however it must be noted that both hospitals and professionals are limited to a specific number of payments within the program, so the decreasing follow-up payments may reflect "aging out" of the incentive program.

In addition, the percentage of claims paid accurately increased across all ten claim-type subcomponents, and PCMH member attribution and hospital/ER utilization (use and outcomes of payment reforms) has shown increases in members attributed to a PCMH and favorable decreases in hospital readmissions, however there were unfavorable increases in ER visits.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 106 – Number of eligible providers receiving Electronic Health Record (EHR) incentive payments.

Exhibit 106.a presents rates for 2011 through 2016 of the number of hospitals that received EHR payments.

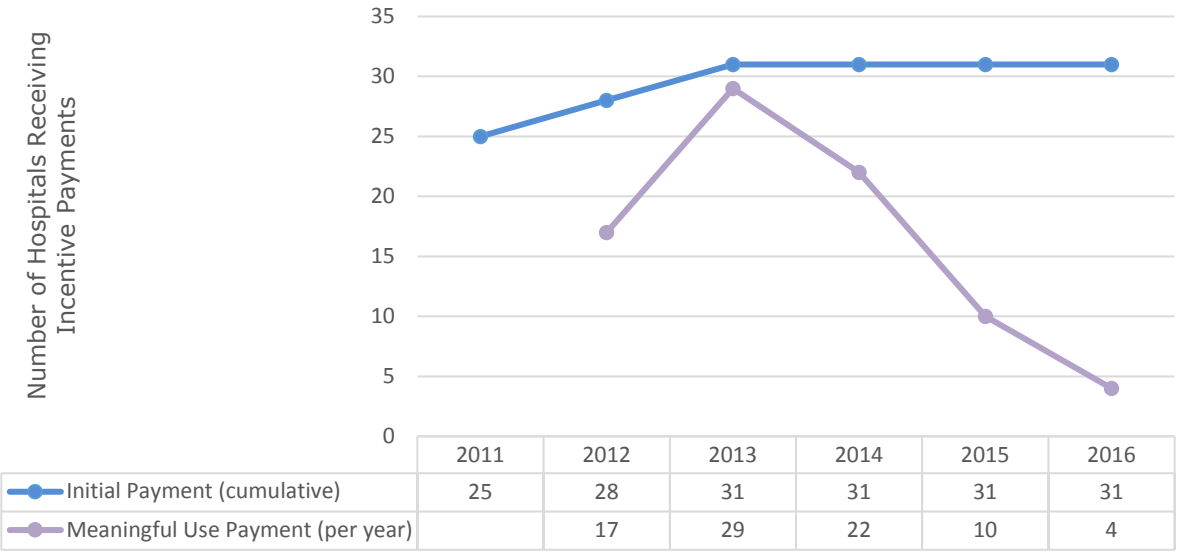
The number of initial hospital payments did not increase from 2015 to 2016. These payments are only available to new participants in their first year of the program and may not be received more than once. This year-to-year stability in the cumulative payments suggests that all hospitals interested in participating in the EHR incentive program and receiving payments have already been engaged. The majority of these hospitals (80.6%) were engaged in 2011 alone.

The number of meaningful use payments showed a 60.0% decrease from 2015 to 2016. This is not necessarily a negative development, as hospitals may only receive EHR payments for three years before they are no longer eligible. Over 88% of the meaningful use payments that could possibly be made, based on the number of providers in the program, have already been made.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 106.a – Number of Hospitals Receiving EHR Incentive Payments[139]



	2011	2012	2013	2014	2015	2016
Initial Payment (cumulative)	25	28	31	31	31	31
Meaningful Use Payment (per year)		17	29	22	10	4

Exhibit 106.b presents the number of professional providers that received incentive payments from 2011 to 2016.

The incremental increase in the number of initial payments made to eligible professionals decreased by 47.1% from 2015 to 2016, but this decline is not necessarily negative. Similar to the hospital payments, there are limitations on the EHR payments. Each provider may receive an initial payment once, so a decrease in the number of providers receiving those payments may be reflective of the relatively smaller number of professional providers yet to be involved in the program. In addition, the University of New Mexico Medical Group came back into the EHR program in 2015, with associated eligible professionals receiving initial payments and meaningful use payments. This event greatly

[139] Source: HSD ad hoc reports for 2014 – 2016.

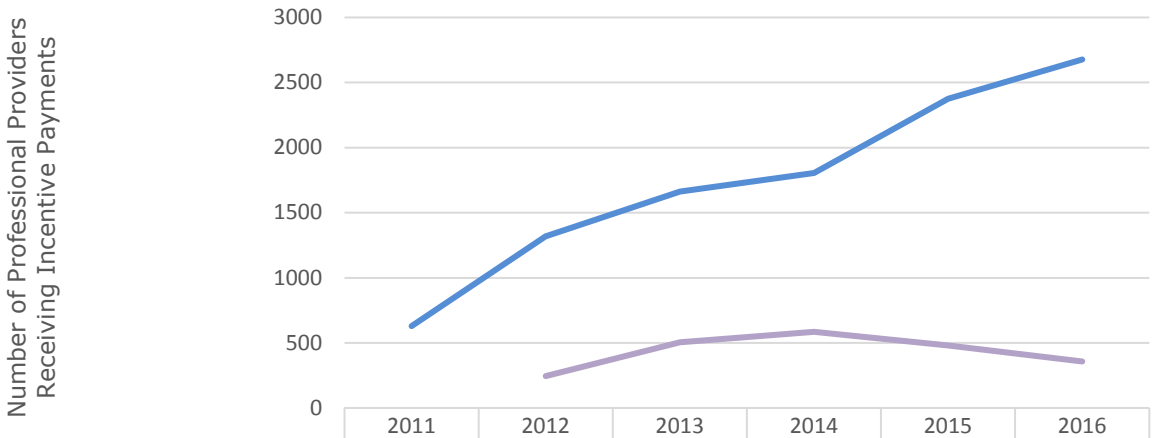
increased the number of initial EHR payments in 2015, and therefore a subsequent drop in the number of initial payments in 2016 was to be expected.

The number of meaningful use payments dropped from 2015 to 2016 by 25.6%. As with the hospital meaningful use payments, there is a six-payment limit for any one eligible professional, so a decline may be reflective of a smaller number of professionals still eligible and an overall effective program. In addition, the 2016 meaningful use count is affected by a problem encountered by the University of New Mexico Medical Group, a source of many of the eligible providers within the state. Providers of this group were unable to successfully attest and this likely affected the 2016 payment count.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 106.b – Number of Eligible Professionals Receiving EHR Incentive Payments[140]



	2011	2012	2013	2014	2015	2016
Initial Payment (cumulative)	629	1319	1662	1804	2375	2677
Meaningful Use Payment (per year)		245	504	585	480	357

[140] Source: HSD ad hoc reports for 2014 – 2016.

Measure 108 – Percentage of claims paid accurately.

Exhibit 108 presents results for DY1 and DY2 of the percentage of claims paid accurately. For each of the ten types of claims reported, accuracy rates increased from DY1 to DY2.

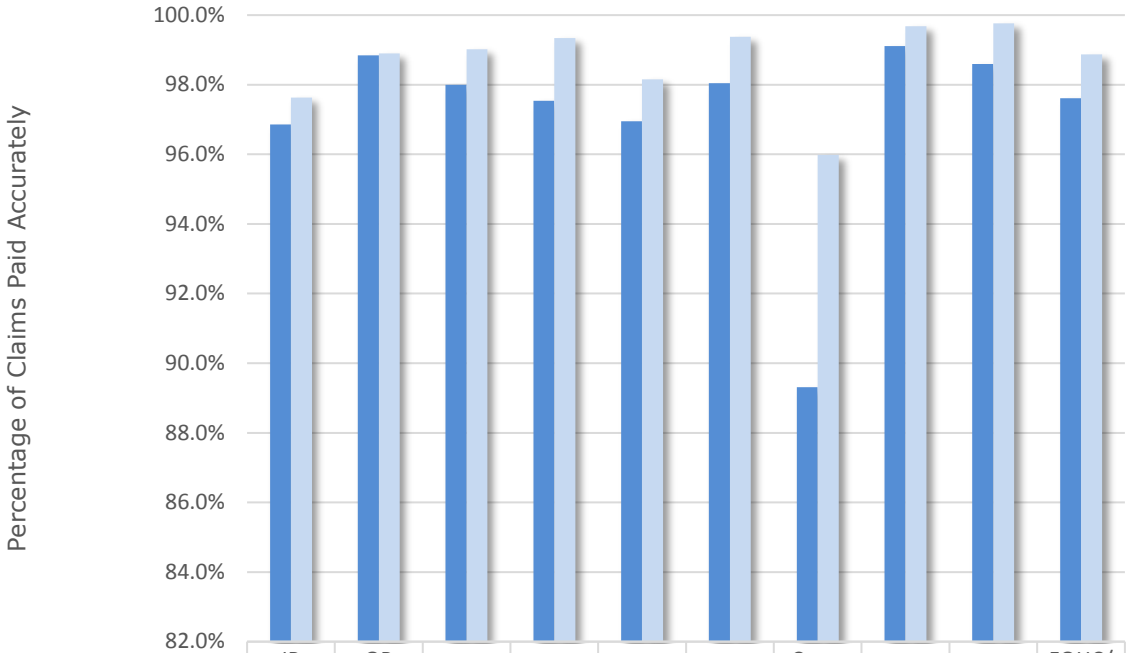
The increases were 0.8% for inpatient hospital, 0.1% for outpatient hospital, 1.0% for professional, 1.9% for BH, 1.2% for NF, 1.4% for I/T/U, 7.5% for cross over, 0.6% for HCBS, 1.2% for dental, and 1.3% for FQHC/RHC.

DY3 results were developing as this narrative was being drafted, but not in sufficient detail to merit being provisionally included in this analysis.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 108 – Percentage of Claims Paid Accurately[141]



	IP Hosp	OP Hosp	Prof	BH	NF	I/T/U	Cross over	HCBS	Dental	FQHC/ RHC
DY1 Centennial Care	96.9%	98.8%	98.0%	97.5%	97.0%	98.0%	89.3%	99.1%	98.6%	97.6%
DY2 Centennial Care	97.6%	98.9%	99.0%	99.3%	98.2%	99.4%	96.0%	99.7%	99.8%	98.9%

[141] Source: MCO reports for 2014 (HSD 46); ad hoc claims payment and activity reports for 2015. For DY2, Deloitte was unable to calculate an aggregate payment accuracy rate due to data limitations; a payment accuracy rate for each individual claim type was provided instead.

Measure 109 –PCMH member attribution and hospital/ER utilization (use and outcomes of payment reforms).

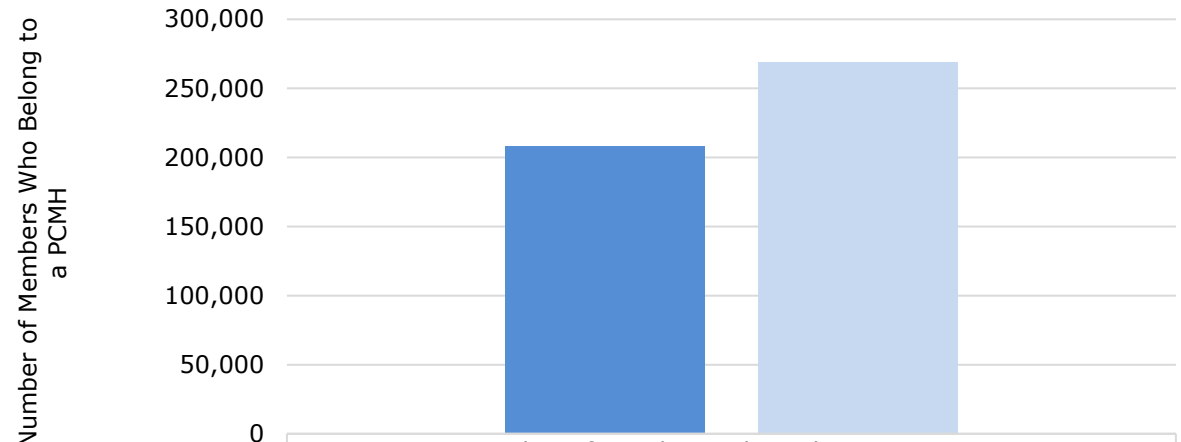
Exhibits 109.a and 109.b presents results for DY1 and DY2 for PCMH membership attribution and the Hospital/ER Utilization impact for members attributed to a PCMH. This definition is being used as an alternative for "use and outcomes of payment reforms" since the data source for this measure focuses on PCMHs and impact on member readmissions as opposed to all payment reform projects (ACOs, gainsharing, etc.).

As illustrated, the number of members who belong to PCMH increased by 29.1% from DY1 to DY2. There were declines in the percentage of PCMH members with a hospital readmission within 30 days of a pervious hospital admission (-34.5%) and in the percentage of PCMH members with one ED visit during the year (-6.3%). There were also increases in the percentage of members with a PCMH visit seven days after an ED visit (2.9%), the percentage of members with two or three ED visits (48.3%), and the percentage of members with four or more ED visits (130.9%), though the percentage with four or more visits was below 3.0%.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

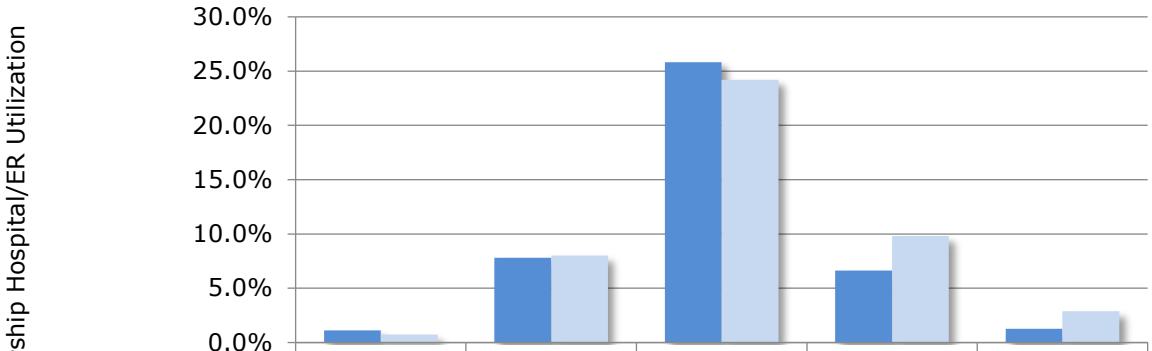
No national benchmark rate could be identified for this measure.

Exhibit 109.a – Number of Members who Belong to a PCMH[142]



[142] Source: MCO reports for 2014 – 2015 (HSD 48).

Exhibit 109.b – PCMH Membership Hospital/ER Utilization[143]



	Percent PCMH members readmitted to a hospital within 30 days of a previous hospital admission	Percent PCMH members seen at the PCMH site within 7 days following a hospital admission or emergency departme…	Percent PCMH members who visited the emergency departmen t 1 time during the reporting period	Percent PCMH members who visited the emergency departmen t 2-3 times during the reporting period	Percent PCMH members who visited the emergency departmen t 4 or more times during the reporting period
DY1 Centennial Care	1.1%	7.8%	25.8%	6.6%	1.3%
DY2 Centennial Care	0.7%	8.0%	24.2%	9.8%	2.9%

[143] Source: MCO reports for 2014 – 2015 (HSD 48).

Conclusion

The Centennial Care 1115 Waiver program is largely progressing on the major designated goals to date. One significant change to the program was that total Centennial Care member months increased by about 1,306,000, or 17.8%, from DY1 to DY3. The vast majority of this increase was driven by the Medicaid expansion group, which grew by 63.3%.

Major Centennial Care program goals include commitments to improving care access, enhancing care coordination and integration, improving the quality of care, reducing the growth trend in program expenditures, increasing member engagement and satisfaction, and implementing new processes and technologies:

- **Improving Access to Care –** The 1115 Waiver Evaluation found mixed results in timely access to care as compared to the baseline of the Centennial Care program. Improvements were found in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans opting into Centennial Care, the ratio of providers to members, increased access to telemedicine, the percentage of members utilizing newly available BH services (BH respite, family support, and recovery services), and the rate of flu vaccinations.

  The Evaluation found declines in various performance measures as well. The declines were found in the number of adult members accessing preventive/ambulatory services, the percentage of members utilizing mental health services (as indicated by their principal diagnosis), the percentage of members who had an annual dental visit (although the rates across the cohorts are higher than the national averages), the percentage of members who had a PCP visit, the percentage of PCPs with open panels, breast cancer screening rates, cervical cancer screening rates, childhood and adolescent immunization rates, and prenatal and postpartum care. These declines represent potential areas for improvement in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the continued influx of these members.

- **Improving Care Coordination** – The Evaluation generally noted improvements in care coordination activities. Improvements were observed in the percentage of members the MCOs were able to engage, the percentage of members for whom HRAs were completed, and the percentage of Level 2 and level 3 members who received telephonic and in-person outreach.

  There has been an increase in the number of unique members receiving Home and Community-Based services (HCBS), and an overall increase in HCBS provided. New Mexico continues to be successful in its rebalancing efforts with 84.6% of long-term care members receiving long-term services in their homes and 13.6% of members residing in nursing facilities.

- **Improving Care Integration** – The Evaluation noted mixed progress in care integration activities. Improvements were noted in the increased percentage of members who had a BH service and also received outpatient ambulatory visits and a favorable decline in the ER visit rates among members with BH needs. Rates also increased for members with LTSS who accessed BH services, and members who accessed a BH service who also accessed HCBS.

  Conversely, performance declined for ER visit rates for LTSS members, diabetes screening for members with schizophrenia or bipolar disorder, diabetes monitoring for members with diabetes and schizophrenia, and the percentage of members accessing both BH services and PCP Visits.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care as noted in the findings for the assigned performance measures. There were

improvements in the EPSDT screening ratios; increases in monitoring rates of BMI for adults, children and adolescents; and increases in asthma medication management. Hospital admission rates also decreased across nearly all ACS measures. Finally, there was a decline in the percentage of ER visits that were potentially avoidable and fall risk intervention.

Conversely, performance declined for asthma medication ratios, smoking and tobacco use cessation, annual patient monitoring for persistent medications, and inpatient admissions to psychiatric hospitals and RTCs.

- **Reducing Expenditures and Shifting to Less Costly Services** – The Evaluation found that the program continued to demonstrate significant savings in comparison to the waiver budget neutrality threshold through DY3. Total program expenditures for DY3 alone were 21.8% below the budget-neutral limits as defined by the Special Terms and Conditions (STCs), which includes per member per month (PMPM) cost caps by MEG, uncompensated care costs, and HQII pool amounts. The total cost of Centennial Care since inception through DY3 combined is below the budget neutrality limits as defined by the STCs by about $2.5 billion, or 15.8%.

  In addition, inpatient claims exceeding $50,000 as a percentage of healthcare costs were slightly lower. There were also improvements in most subcomponents for the use of mental health services, desirable decreases in hospital readmission rates, positive increases in the use of substance abuse services and use of HCBS, positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and positive shifts from higher LOC NF utilization to lower LOC NF utilization.

  The Evaluation also found negative changes in utilization for certain measures. There was a decline in performance from the baseline to DY3 for diagnostic imaging costs, hospital costs, and ED utilization, all of which experienced unfavorable increases.

- **Increased Member Engagement** – There was a significant increase in the number of members becoming enrolled in the Centennial Rewards program and performing various wellness-related activities designed to earn rewards under the program; at the end of DY1, approximately 47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered for the program. There are over 40 activities members can perform to earn rewards from adhering to monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased through DY2.

- **Increased Member Satisfaction** – The Evaluation found that member satisfaction results largely improved through DY2. Measures that exhibited improvements included the percentage of expedited appeals resolved on time and the percentage of appeals upheld. Improvement was also noted in the number of appeals partially overturned and overturned, marked by decreases through DY2. Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY2.

  Note that the Centennial Rewards program was a brand new program that required introductory member outreach for making members aware of the program and how to participate. It began April 1, 2014 and thus there were fewer months in DY1 in which members were able to register and participate in the program.

- **Implementing New Processes and Technologies** – The three measures for which there are sufficient data showed mixed results through DY2. There were improvements in the percentage of claims paid accurately increased across all claim types and the number of members attributed to a PCMH under a payment reform program. Conversely, incentive payments for EHR use either increased, decreased, or experienced little change depending on the type of provider and type of payment made.

In conclusion, the Centennial Care waiver demonstration has yielded many promising results and progress made aligning with the four hypotheses set forth in the Evaluation Design Plan. Certain areas were identified for improvement in future years, and while many aspects of the program are demonstrating positive results, the Evaluation would expect continued progress as the program matures, and as HSD continues to work with the MCOs to continue to enhance the program.

Appendix

A. Measure Definition and Evaluation Methodology

Measure	Measure Name	Definition	Evaluation Methodology	
1	Access to preventive/ambulatory services among Centennial Care members in aggregate and within subgroups	"Access to Preventive/Ambulatory Health Services" is a Healthcare Effectiveness Data and Information Set (HEDIS) measure that reports the percentage of adults ages 20 and older who had an ambulatory or preventive care visit during the measurement year. It provides important information about the accessibility of primary/preventive services for adult Centennial Care enrollees. To be counted under this measure, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
2	Mental health services utilization	"Mental Health Utilization" is a HEDIS measure that reports the number and percentage of enrolled members receiving any mental health service during the measurement year with mental health as the principal diagnosis based on the HEDIS mental health diagnosis value set. It provides important information about the availability of mental health services to Centennial Care enrollees.	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, CY 2014 Centennial Care data will be utilized as the baseline. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for

Measure	Measure Name	Definition	Evaluation Methodology	
		The measure applies to members of all ages. The service types counted in the measure include: • Inpatient care at either a hospital or a treatment facility (including residential care and rehabilitation facilities) with mental health as the principal diagnosis • Intensive outpatient and partial hospitalization encounters in conjunction with a principal mental health diagnosis, whether treated by a physician or non-physician • Outpatient and ED encounters in conjunction with a principal mental health diagnosis, whether treated by a physician or non-physician.		comparison purposes only; it is not an audited HEDIS rate.
3	Number of telemedicine providers and telemedicine utilization	"Number of Telemedicine Providers and Telemedicine Utilization" is a measure that reports the number of units of service rendered via telemedicine during the measurement year. As a rural state, New Mexico has the potential to improve access to care through greater use of technology such as telemedicine/telehealth. In Amendment Number 3 to the Centennial Care Agreement, HSD defined the following Telehealth Delivery Service Improvement Target: *"A minimum of a fifteen percent (15%) increase in telehealth "office" visits with specialists, including behavioral health providers, for members in rural and*	Baseline	For the 2013 baseline rate, HSD furnished Deloitte with telemedicine visit data obtained through ad hoc reports filed by the four Centennial Care MCOs. The MCOs followed a consistent methodology in terms of services included and excluded from the data. For example, services in urban areas and services associated with Project ECHO were not counted as telemedicine visits. However, behavioral health services in 2013 were provided by a separate behavioral health organization and one of the four MCOs reported that it did not include BHO telemedicine activity for its members in its 2013 data. Therefore, 2013 behavioral health visit count provided appears to understate total activity for the year.

Measure	Measure Name	Definition	Evaluation Methodology	
		frontier areas. At least five percent (5%) of the increase must be visits with behavioral health providers." Each of the Centennial Care Managed Care Organizations (MCOs) has undertaken steps to increase the use of telemedicine around the state. For example, one MCO recently launched an initiative to provide urgent behavioral health care through its telehealth platform. Another has begun providing tele-dermatology consultations to primary care physicians and tele-pulmonology services for clinically fragile members in rural and frontier areas. The measure examines the number of telemedicine professional services (visits) occurring each year in rural/frontier New Mexico, with behavioral and physical health visits separately reported.		For the DY1 and DY2 counts, HSD again furnished telemedicine visit data obtained through ad hoc reports filed by the four Centennial Care MCOs.
4 and 5	Number and percentage of people meeting nursing facility level of care who are in a nursing facility/receive home-and community-based services	Centennial Care members who meet financial and clinical eligibility criteria for nursing facility level of care may receive long term care services either in a nursing facility or in their home or another community setting. Members have the right to receive long term care in a community-based setting when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into	Baseline to DY3	For both NF and HCBS rates for all years, Deloitte was provided with rates by HSD with no additional data regarding numerators, denominators, or overall counts. The data is driven by membership in INF and community benefit cohorts (consisting of ADB, ANW, SDB, and SNW) and the analysis of encounter data was performed by Mercer.

Measure	Measure Name	Definition	Evaluation Methodology	
		account the resources available to the public entity and the needs of others who are receiving services from the entity. Although nursing facilities remain an essential care setting, HCBS settings are often preferred by members and are, on average, less costly than nursing facilities. One of the objectives of Centennial Care is to gradually "re-balance" where members are served, from institutional to HCBS settings. This combined measure identifies the portion of the population at the nursing facility level of care that resides in a nursing facility and the portion residing at home or in the community and receiving HCBS. (Measures 1.4.A and 5 have been combined to avoid redundancy.)		
6	Number and percentage of people with annual dental visit	"Annual Dental Visit" is a HEDIS measure defined as the percentage of members 2–21 years of age who had at least one dental visit during the measurement year. It provides important information about the accessibility of dental services for younger Centennial Care members. To be counted under this measure, members must fall into the range of 2–21 years of age on December 31 of the measurement year and must have had no more than one gap in coverage of up to 45 days.	Baseline to DY2	For the Baseline calculation, HSD furnished Deloitte with audited HEDIS data for three of the four plans contracted under the Salud! program and one of the two plans contracted under the CoLTS program. The total enrollment in 2013 of the four plans provided represented 75% of total combined Salud!/CoLTS membership. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for

Measure	Measure Name	Definition	Evaluation Methodology	
				comparison purposes only; it is not an audited HEDIS rate. For the national comparison rate, a 2015 National Medicaid HMO rate as reported by the National Committee for Quality Assurance (NCQA) was used. For this rate, neither numerator nor denominator was provided. Instead, individual rates were provided for each age group (2 – 3 years; 4 – 6 years; 7 – 10 years; 11 – 14 years; 15 – 18 years; and 19 – 21 years). Each rate was weighted based on the number of years the rate measured (two, three, four, four, four, and three, respectively) and took the average using the total number of years accounted for in the measurement (twenty). This methodology assumes that the program has approximately an even distribution of members across ages two to twenty-one. If this is not the case, the average rate reported could be either lower or higher.
7	Enrollment in Centennial Care as a percentage of state population	"Enrollment in Centennial Care" is a measure that reports the percentage of New Mexico residents who were enrolled in Centennial Care during the measurement year. New Mexico is one of 31 states and the District of Columbia to expand eligibility for Medicaid under the terms of the Affordable Care Act. Centennial Care's potential for improving the health of New Mexicans is dependent on the state's success in enrolling and recertifying timely persons eligible for the program. To be counted under this measure, members had to be included in enrollment reported by MCOs. State	DY1	HSD furnished Deloitte with statewide analyses developed by Mercer that included member months for the Centennial Care population. This count was divided by 12 to estimate an average annual membership over the calendar year and served as the numerator for this measure in each respective year. For the denominator, Deloitte used publicly available population estimates from the United States Census Bureau. Annual state population estimates are made on July 1 of the measurement year.

Measure	Measure Name	Definition	Evaluation Methodology	
		population estimates are from the U.S. Census Bureau.		
8	Native American members opting-in and opting-out of Centennial Care	Enrollment in managed care is only mandatory for Native Americans who are nursing facility level of care eligible; other Native Americans have the right to opt-out of managed care and to receive care through the fee-for-service system. The opt-out rate is a useful proxy for assessing the managed care program's perceived value among Native Americans who have a choice of systems for their care. Centennial Care plans provide monthly data to HSD on the number and percentage of Native Americans opting-in and out of the program. Note that this measure does not control for changes in size of the Centennial Care-eligible Native American population. Deloitte did not use Q1 2014 data to construct a baseline as it did in some other measures because Native American enrollment may have been significantly different under predecessor programs, a distinction which a baseline constructed from 2014 data would have been unable to capture. Using the count from an individual month (December) was appropriate because this measure reflects a distribution of potential	DY1 to DY3	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. HSD furnished Deloitte with the monthly reports submitted by the four Centennial Care plans in DY1, DY2, and DY3. Therefore, we used the December reports for each year, which captured the opt-in/opt-out rate at the end of the calendar year. (The rate varied only slightly from month-to-month.) For the opt-in figure, the numerator was the number of Native Americans electing to be a part of the Centennial Care program, while the opt-out number was the number of Native Americans who chose not to be included. The denominator was the sum of the opt-in and opt-out counts across the four plans.

Measure	Measure Name	Definition	Evaluation Methodology	
		members at a point in time. December was the most appropriate month because it is furthest in time from the commencement of services.		
10	Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support, and recovery)	The Centennial Care program expanded behavioral health coverage by adding three services intended to support the program's person-and family-centered care model. The services are respite, family support, and recovery. HSD requires Centennial Care plans to submit encounter data on service activity. The data can be used to profile service utilization, by service type, at the member level.	DY1 to DY3	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with a count of members who received both BH services and the enumerated specialty services as well as a count of total managed care population in each year. Deloitte calculated resulting percentages by dividing the former by the latter.
11	Number and percentage of unduplicated participants with at least one PCP visit	Regular visits with a PCP is a central feature of delivering coordinated care. PCPs fill many important roles in the care coordination process, including ensuring continuity of care, identifying health problems early, delivering preventive care, and referring members to appropriate specialists. Centennial Care encourages members to visit their PCP at least once annually.	Baseline to DY3	HSD furnished Deloitte with MMIS reports that included a count of the entire managed care population and a count of members that had at least one PCP visit during the measurement year. The visit count was divided by the population count for an overall rate for each year.
12	Number/ratio of participating providers to enrollees	The number of available providers relative to members is an important ratio that provides insight into whether the provider network is growing or shrinking relative to membership. A lower member-to-provider ratio indicates a greater available capacity in	DY1 to DY2	HSD furnished Deloitte with quarterly HSD 3 reports for the four Centennial Care MCOs. Deloitte calculated an average number of providers based on unique provider names/IDs across the MCOs in each quarter (to avoid double-counting providers that operate in multiple MCO networks). The unique quarterly providers were summed and divided by

Measure	Measure Name	Definition	Evaluation Methodology	
		the provider network to provide services.		four to arrive at an average annual number of providers as the denominator. The numerator was member months from the Mercer dashboard data that supports Measure 7, divided by twelve to arrive at the average annual members.
13	Percentage of primary care providers with open panels	The ease with which Centennial Care members are able to access primary care is partly dependent on the percentage of PCPs who have open panels and are able to accept new patients into their practices. If a large percentage of panels are closed, members may find it difficult to locate a PCP near where they live or work, reducing their ease of access to preventive care and increasing the risk that they will go to an emergency room for a non-emergent problem. HSD requires Centennial Care plans to report quarterly on the number of PCPs with open and closed panels.	DY1 to DY2	HSD furnished Deloitte with quarterly HSD 3 reports for the four Centennial Care MCOs. Deloitte calculated an average number of open and closed panels based on quarterly count data. The denominator for the measure was the sum of the open and closed panel counts.
14	Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC)	"Number and Percentage of Substance Use Disorder Participants with follow-up 7 and 30 days after Leaving Residential Treatment Center (RTC)" is a HSD measure that reports the number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC. These are reported as two separate rates and closely resemble the HEDIS measure that reports "Follow-up after hospitalization of mental illness."	DY1 to DY2	HSD furnished Deloitte with HSD5 reports containing the count of RTC discharges as well as follow-up visits within 7 and 30 days of discharge in each year.

Measure	Measure Name	Definition	Evaluation Methodology	
15	Number and percentage of BH participants with follow-up after hospitalization of mental illness	"Number and Percentage of BH Participants with Follow-up after Hospitalization of Mental Illness" is a HEDIS measure that assesses adults and children six years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days of discharge and within 30 days of discharge.	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, CY 2014 Centennial Care data will be utilized as the baseline. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
16	Childhood immunization status	"Childhood Immunization Status" is a HEDIS measure that reports the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (UHC did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
17	Immunizations for adolescents	"Immunizations for Adolescents" is a HEDIS measure that reports the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (BCBS did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for four MCOs. Deloitte only combined the numerator and denominator values of three plans that used the same reporting methodology to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
18	Well-child visits in first 15 months of life	"Well-Child Visits in First 15 Months of Life" is a HEDIS measure that reports the percentage of child members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits • One well-child visits • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in 2013 and 2014, and four MCOs in 2015. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2015.

Measure	Measure Name	Definition	Evaluation Methodology	
19	Well-child visits in third, fourth, fifth and sixth years of life	"Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life" is a HEDIS measure that reports the percentage of members 3 – 6 years of age who received one or more well-child visits with a PCP during the measurement year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in 2013, and four MCOs in 2014 and 2015. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2014 and 2015.
20	Adolescent well care visits	"Adolescent Well Care Visits" is a HEDIS measure that reports the percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an Obstetrician/Gynecologist (OB/GYN) practitioner during the measurement year. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for four MCOs in each year. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2014 and 2015.

Measure	Measure Name	Definition	Evaluation Methodology	
21	Prenatal and postpartum care	"Prenatal and Postpartum Care" is a HEDIS measure that reports the percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an Obstetrician/Gynecologist (OB/GYN) practitioner during the measurement year. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
22	Frequency of ongoing Prenatal care	"Frequency of Ongoing Prenatal Care" is a HEDIS measure that reports the percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • ≥81 percent of expected visits This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
23	Breast cancer screening	"Breast Cancer Screening" is a HEDIS measure that reports the percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
24	Cervical cancer screening for women	"Cervical Cancer Screening for Women" is a HEDIS measure that reports the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21 to 64 who had cervical cytology performed every 3 years; or • Women age 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY1	HSD furnished Deloitte with audited HEDIS data for four MCOs. Deloitte only combined the numerator and denominator values of three plans that used the same reporting methodology to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
25	Flu vaccinations for adults	"Flu Vaccinations for Adults" is a HEDIS-based measure that assesses the percentage of adults 18–64 years of age who report receiving an influenza vaccination. To be counted under this measure, members must be adults age 18-64 as of December 31 of the measurement year.	Baseline to DY3	HSD furnished Deloitte with MMIS reports containing counts of the total managed care adult population and unique members who had a flu vaccination.
26	Initiation and engagement of alcohol and other drug (AOD) dependence treatment	"Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment" is a HEDIS measure that assesses the percentage of adolescents and adults with a new episode of AOD dependence who received the following care: • Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The measure reports two age stratifications (13–17 years and 18+ years) for both initiation and engagement of AOD treatment, as well as a total rate. It is meant to provide important information about the	DY1 to DY2	No MCO reported on this measure in 2013, and thus 2014 data is used as the baseline. HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in each year. Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		timeliness of substance abuse treatment services for Centennial Care members.		

Measure	Measure Name	Definition	Evaluation Methodology	
27	Geographic Access Measures	"Geographic Access Measures" is a measure developed by HSD as a way to evaluate access to primary care for Centennial Care enrollees across the State of New Mexico. HSD has developed standards for measuring geographic-based access to care which MCOs reported by quarter in quarterly geographic access reports (Report 55): • Urban Counties = 90% of members have access to a PCP within 30 miles • Rural Counties = 90% of members have access to a PCP within 45 miles • Frontier Counties = 90% of members have access to a PCP within 60 miles	DY1 to DY2	HSD furnished Deloitte with HSD 55 quarterly reports containing member counts, percentage of members with access to PCPs, and PCP counts by county type. Deloitte combined quarterly counts of total members, members with access to PCPs, and PCP counts across MCOs to produce aggregate annual results of percentage of members with access to PCPs and member to PCP ratios by county type.

Measure	Measure Name	Definition	Evaluation Methodology	
28	Number and percentage of participants with health risk assessments (HRA) completed within contract timeframes	"Number and Percentage of Members with HRAs Completed within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. It calculates the percentages based on: • A Q4 cumulative total of HRAs completed compared to the number of HRAs required for transition members • The number of HRAs completed during the quarter compared to the number of HRAs required for new members • The number of HRAs completed within 30 days of enrollment compared to those completed during the quarter for new members • HSD agreed to use the timeline of "during the quarter" and "within 30 calendar days of enrollment" reported by the MCOs as surrogates for "within contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing counts of HRAs required and completed for transition and new Medicaid members in each year. For the percentage of required HRAs completed for transition members within the quarter, Deloitte summed the fourth quarter cumulative counts of HRAs completed by transition members as well as the fourth quarter cumulative counts of HRAs required for transition members across MCOs then divided the former by the latter for each year. For the percentage of required HRAs completed for new members during the quarter, Deloitte summed quarterly counts of HRAs completed for new members as well as quarterly counts of HRAs required for new members across MCOs then divided the former by the latter for each year. For the percentage of required HRAs completed within 30 days of enrollment for new members, Deloitte summed quarterly counts of HRAs completed within 30 days of enrollment for new members across MCOs then divided that by the sum of the number of HRAs completed for new members previously calculated. PHP did not report a rate for HRAs completed for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
29	Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes.	"Number and Percentage of those Provided Care Coordination Level Assignment Package within 10 Calendar Days of HRA" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to members covered under Centennial Care. The data elements required for this measure are not included in the HSD Care Coordination reports, therefore, HSD agreed to use the metric "Number of Medicaid Members who were Provided Care Coordination Level Assignment Package within 10 Calendar Days of HRA" as an alternative definition based on the assumption that if a member receives a care coordination packet, then the MCO would have also designated the member to care coordination and assigned a care coordinator.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received care coordination level assignment packages within 10 days of HRA. Numerators and denominators were developed by summing the quarterly counts across MCOs.
30	Number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 2 Based on the Comprehensive Needs Assessment" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. However, the data elements required to measure this activity were not included in HSD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Care	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of Level 2 assignments given and CNAs completed for both transition and new members during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
		Coordination Report 6: The "Number and Percentage of Level 2 Assignments Based on the CNA." Measure calculated using "Level 2 Assignments based on the CNA as a percentage of the CNAs completed for both transition and new members.		
31	Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 3 Based on the Comprehensive Needs Assessment" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. However, the data elements required to measure this activity were not included in HSD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Care Coordination Report 6: The "Number and Percentage of Level 3 Assignments Based on the CNA." Measure calculated using "Level 3 Assignments based on the CNA as a percentage of the CNAs completed for both transition and new members.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of Level 3 assignments given and CNAs completed for both transition and new members during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
32	Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 2 Who Received In-Person Visits and Telephone Contact within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. This measure is calculated using: • Number of Level 2 members who completed semi-annual in person visit this quarter compared to the number of Level 2 members who required semi-annual in person visit this quarter • Number of Level 2 members who completed quarterly telephone contacts this quarter compared to the number of Level 2 members who required quarterly telephone contacts this quarter HSD agreed to use required "semiannual visits" and "quarterly telephone contact" listed in HSD Report 6 as the timelines that fulfill "contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received in-person visits and telephone contact as well as the number of in-person visits and telephone contacts required for the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
33	Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 3 Who Received In-Person Visits and Telephone Contact within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees This measure is calculated using: • Number of Level 3 members who completed quarterly in person visit during the quarter compared to the number of Level 3 members who required quarterly in person visits during the quarter • Number of Level 3 members who completed monthly telephone contacts during the quarter compared to the number of Level 3 members who required monthly telephone contacts during the quarter HSD agreed to use required "quarterly visits" and "monthly telephone contact" listed in HSD Report 6 as the timelines that fulfill "contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received in-person visits and telephone contact as well as the number of in-person visits and telephone contacts required for the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
34	Number and percentage of participants the MCO is unable to locate for care coordination	"Number and Percentage of Participants the MCO is Unable to Engage for Care Coordination" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees. The data element specifically citing "unable to locate for care coordination" was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members for whom a CNA was required but the MCO was "unable to engage." This differs from those members who refused a CNA which is reflected in measure 36. To calculate this measure, a four-quarter cumulative total for transition members and an annual total for new members was calculated.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that the MCO was unable to engage during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.
35	Number and percentage of members transitioning from HCBS to a NF; number and percentage of participants in NF transitioning to community (HCBS)	"Number and Percentage of Participants in Nursing Facility (NF) Transitioning to Community (HCBS)" is a measure developed by HSD as a way to evaluate efforts to appropriately avoid nursing home admissions. The specific data elements required to measure this activity were not included in MCO reports; instead, MCOs reported the number of members who left a nursing facility and moved to the community and the number of members readmitted to a nursing facility during the quarter. Therefore, an alternative definition was developed to align the	DY1 to DY3	HSD furnished Deloitte with HSD 7 reports containing quarterly counts of unique members in NF, members that left NF and moved to community, and members readmitted to NF during the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
		intent of the Evaluation Plan with the information available in HSD Care Coordination Report 7. The data contained in the plans' reporting of these data points under the assumption that moving to the community from a NF means members will require HCBS. HSD also agreed to use NF readmissions (as a percentage of members transitioned to the community) as an alternative for "members transitioning from HCBS to a NF".		
36	Number and percentage of participants who refuse care coordination	"Number and Percentage of Participants who Refused Care Coordination" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees. The specific data element required to measure this activity was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members who "refused a CNA," based on the assumption that if the member refused the process to screen for care coordination, then they would also refuse to participate in care coordination. To calculate this measure, a four-quarter cumulative total for transition members and an annual total for new members was calculated as a percentage of the number of CNAs required for Medicaid members.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that the MCO was unable to engage during the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
37	EPSDT screening ratio	"EPSDT Screening Ratio" measures the actual number of screenings children under the age of 21 were provided with against the number of screenings that all children enrolled in Medicaid should have received. Each state that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. The actual number of screenings is based on the number of initial and periodic screening services required by the state's periodicity schedule and prorated by the proportion of the year for which they were EPSDT eligible. The information is used to assess the effectiveness of state EPSDT programs in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services. To be counted under this measure, members must have been enrolled for at least 90 continuous days during the reporting period. The EPSDT Screening Ratio is one of several measures required to be included in the federally required Annual EPSDT Participation Report (Form CMS-416). The CMS-416 Report provides basic information on participation in the Medicaid child health program.	FFY 2013 Baseline to FFY 2015	HSD furnished Deloitte with CMS-416 reports for each FFY that contained a combined EPSDT screening ratio for the four MCOs participating in Centennial Care. For the national comparison rate, the CMS-416 Annual EPSDT Participation Report for FFY 2015 was used.

Measure	Measure Name	Definition	Evaluation Methodology	
38	Annual monitoring for patients on persistent medications	"Annual Monitoring for Patients on Persistent Medications" is a HEDIS measure that reports the percentage of members 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year, and received at least one therapeutic monitoring event for the therapeutic agent in the measurement year: • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) • Annual monitoring for members on digoxin • Annual monitoring for members on diuretics • Total rate (sum of the three numerators divided by the sum of the three denominators) To be counted towards this measure, members may not have more than one gap in enrollment of up to 45 days during the measurement year. In addition, members must have had at least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. For the digoxin measure, members must have had at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year. Adverse	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		drug events contribute to patient injury and increased health care costs. For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events. This HEDIS measure evaluates whether adult members receiving medication therapy were monitored while on the medication.		
39	Medication management for people with asthma	"Medication Management for People with Asthma" is a HEDIS measure that reports the percentage of adults and children 5 – 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed an asthma controller medication that they remained on for at least 50% of their treatment period. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions and missed days of work or school.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the national comparison rate, Deloitte used the 2016 National Medicaid MCO rate as reported by NCQA in "The State of Health Quality – 2016." The 2016 national rate represents activity in 2015.
40	Asthma medication ratio	"Asthma Medication Ratio" is a HEDIS measure that reports the percentage of adults and children 5 – 64 years of age who were identified as having persistent asthma and who had a ratio of controller medications to total asthma medications of 0.50 or greater during	Baseline – DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting

Measure	Measure Name	Definition	Evaluation Methodology	
		the measurement year. The NCQA reports an overall ratio, as well as a separate ratio for children age 5 – 11, children age 12 – 18, adults age 19 – 50, and adults age 51 – 64. The Asthma Medication Ratio evaluates whether people diagnosed with persistent asthma were adequately using controller medications.		the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
41	Adult BMI assessment and weight assessment for children/adolescents	"Adult BMI Assessment" is a HEDIS measure that reports the percentage of adults 18 – 74 years of age who had an outpatient visit and whose BMI was documented in the past two years. "Weight Assessment for Children/Adolescents" is a HEDIS measure that reports the percentage of children and adolescents 3 – 17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and who had evidence of: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity "Obesity" is defined as an amount of body fat higher than what is considered healthy for an individual's weight. Obesity contributes to nearly one in five deaths in the United States. Obesity ranges are determined by using a commonly used weight-for-height screening tool called the "BMI", which	Baseline to DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		correlates with the amount of body fat. BMI provides the most useful population-level measure of overweight and obesity. The Adult BMI Assessment rate is based on the assumption that careful monitoring of BMI will help health care providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight. The Weight Assessment for Children/Adolescents measure recognizes that obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents under the age of 18 and provide guidance for maintaining a healthy weight and lifestyle.		
42	Comprehensive diabetes care	"Comprehensive Diabetes Care" is a HEDIS measure defined as the percentage of adults 18 – 75 years of age with diabetes (Type One or Type Two) who had each of the following: • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm Hg) A separate rate is reported for each of the six factors included in the above	Baseline to DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		measure definition. One additional rate associated with this measure, HbA1c Control (<7.0%) for a Selected Population, was not reported by any of the MCOs in either any reported data year.		
43	Ambulatory Care Sensitive admission rates: diabetes short and long term complications, uncontrolled admission rates	The "ACS Diabetes Short-Term Complications Admission Rate (PQI-01)" is defined as the number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid enrollees ages 18 years and older. The "ACS Diabetes Long-Term Complications Admission Rate (PQI-03)" is defined as the number of admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 Medicaid enrollees 18 years and older. Both measures are PQI measures sponsored by the AHRQ. The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early	Baseline	For the baseline calculation, HSD furnished Deloitte with two MMIS reports (Diabetes Short Term and Long Term Complications) containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated. Separate short-term diabetes complication admission rates were calculated for members 18 – 64 years of age and members age 65 and over. Long-term diabetes complication admission rates were aggregated for all members 18 years and older.

Measure	Measure Name	Definition	Evaluation Methodology	
		intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. With high-quality, community based primary care, hospitalization for these illnesses often can be avoided. The PQIs provide a good starting point for assessing quality of health services in the community. To be counted in the numerator for the ACS Diabetes Short-Term Complications Admission Rate, members must be 18 years and older and have had an admission during measurement year for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma). To be counted in the numerator for the ACS Diabetes Long-Term Complications Admission Rate, members must be 18 years and older and have had an admission during the measurement year for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified). For both measures, the denominator consists of all members 18 years and older. The measure is reported as a rate per 100,000.	DY1 to DY2	HSD furnished Deloitte with two reports based on encounters (i.e., PQI report for Diabetes Short Term and MMIS ad hoc report for Long Term Complications) containing combined numerator and denominator counts for the four MCOs contracted under Centennial Care. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated. Separate short-term diabetes complication admission rates were calculated for members 18 – 64 years of age and members age 65 and over. Long-term diabetes complication admission rates were aggregated for all members 18 years and older.

Measure	Measure Name	Definition	Evaluation Methodology	
44	Ambulatory care sensitive admission rates for COPD or asthma in older adults; asthma in younger adults	The "Asthma in Younger Adults Admission Rate (PQI-15)" is defined as the number of inpatient hospital admissions for asthma per 100,000 enrollee months for Medicaid enrollees 18 – 39 years of age. The "COPD or Asthma in Older Adults Admission Rate (PQI-05)" is defined as the number of inpatient hospital admissions for COPD or asthma per 100,000 enrollee months for Medicaid enrollees 40 years and older. Both measures are PQI measures. To be counted in the "Asthma in Younger Adults Admission Rate" measure, members must be 18 – 39 years of age and have had an admission during the measurement year for a principal diagnosis of asthma, excluding admissions with an indication of cystic	Baseline	HSD furnished Deloitte with two MMIS reports (i.e., Asthma in Younger Adults and COPD or Asthma in Older Adults) containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.

Measure	Measure Name	Definition	Evaluation Methodology	
		fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. To be counted in the "COPD or Asthma in Older Adults Admission Rate" measure, members must be 40 years and older and have had an admission with a principal diagnosis of COPD or asthma, excluding obstetric admissions and transfers from other institutions. To be included in the denominator, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	DY1 to DY2	HSD furnished Deloitte with two MMIS reports (i.e., Asthma in Younger Adults and COPD or Asthma in Older Adults) containing combined numerator and denominator counts for the four MCOs contracted under the Centennial Care program for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.
45	Ambulatory care sensitive admission rates for hypertension	The "ACS Admission Rate for Hypertension (PQI-7)" is defined as the number of inpatient hospital admissions with a principal diagnosis of hypertension per 100,000 enrollee months for Medicaid enrollees 18 years and older. The measure excludes kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, obstetric admissions, and transfers from other	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. The numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.

Measure	Measure Name	Definition	Evaluation Methodology	
		institutions. The measure is a PQI measure. To be counted under this measure, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	DY1 to DY2	For DY1 to DY2, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care. The numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.
46	ACS admission rates for pediatric asthma	Evaluates the number of inpatient hospital admissions per 100,000 member months with a principal diagnosis of asthma in children 2 – 17 years of age. The measure excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	Baseline to DY2	The unique managed care encounter claim count is summed across MCOs and divided by the member month count (also summed across MCOs) as a denominator.
47	Number and percentage of potentially avoidable ER visits	The "Number and Percentage of Potentially Avoidable ER Visits" examines the number and percentage of unduplicated members with an ER visit for a non-emergent condition relative to the number of unduplicated members with an ER visit for any reason. This measure applies to any member who presents at an ER, has a claim is submitted and for which the condition is non-emergent. Per the Centennial Care contract, an emergency medical condition means a medical or behavioral health condition manifesting itself through acute	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with MCO reports (HSD 40: Over-Under Utilization Report) submitted by three of the four MCOs (MHC did not have reportable data in 2014 or 2015). The reports covered the four quarters of their respective calendar years (DY1 and DY2) and contained the total number of unduplicated members by care coordination levels one through seven. To calculate the percent of potentially avoidable ER visits in each year, Deloitte combined the three plans' total number of unduplicated members with

Measure	Measure Name	Definition	Evaluation Methodology	
		symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the members' health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) serious disfigurement to the member. Conditions that do not meet the criteria of an emergency medical condition are considered to be potentially avoidable ER visits. This measure examines potentially avoidable ER visits per care coordination level and in total. MCOs are also required to identify the 10 most frequent ICD codes for members with non-emergent ER visits during the quarterly reporting period.		an ER visit for non-emergent conditions and divided this by the total number of unduplicated members with an ER visit for any condition.
48	Medical assistance with smoking and tobacco use cessation	"Medical Assistance with Smoking and Tobacco Use Cessation" is a HEDIS measure that uses survey data to assess the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit smoking during the measurement year. This measure is one component of a three-part CAHPS survey measure that assesses different facets of providing medical assistance	Baseline	HSD furnished Deloitte with CY 2013 CAHPS data for three of the four MCOs contracted under the Salud program and one of the two MCOs contracted under the CoLTS program. The total enrollment in 2013 of the four plans represented 75% of total combined Salud/CoLTS membership. Deloitte took an unweighted average of each plan's summary rate (which is a two-year rolling average for smoking cessation measures) for each subcomponent.

Measure	Measure Name	Definition	Evaluation Methodology	
		with smoking and tobacco cessation. The three components include: • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies.	DY1 to DY2	HSD furnished Deloitte with CY 2014 and CY 2015 CAHPS data for the four Centennial Care MCOs. Deloitte took an unweighted average of each plan's summary rate (again, a two-year rolling average) to compute the aggregate rate for each subcomponent.
49	Number of critical incidents by reporting category	The "Number of Critical Incidents by Reporting Category" measure determines the number and percentage of critical incidents reported in the following categories: • Abuse; • Neglect; • Exploitation; • Environmental hazard; • Emergency services; • Law enforcement; • Elopement/missing; and • Death (Natural/expected; Unexpected; Homicide; and Suicide). The standard definition of a "critical incident" is "an occurrence that represents actual or potential serious harm to the well-being of a member or to others by members." A reportable incident for the behavioral health provider community is defined as "any known, alleged or suspected event of abuse, neglect, exploitation, injuries of	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 data will be utilized as the baseline. HSD furnished Deloitte with critical incident reports submitted for the four MCOs. The reports covered the 12 months of each year. The results are aggregated across MCOs by incident category for the purposes of reporting. Results are presented separately for Centennial Care total, Behavioral Health, and Self-directed.

Measure	Measure Name	Definition	Evaluation Methodology	
		unknown origin, death, environmental hazard, which involve some level of reporting or intervention with other state or service entities including law enforcement, crisis or emergency services, and present actual or potential serious harm to the well-being of a consumer or to others by the consumer. MCOs are required to submit critical incident reports on a quarterly basis. Each contracted MCO has access to the web-based Critical Incident Reporting System. MCO access to the website includes access to all critical incident reports submitted by the MCO. It also includes all critical incidents submitted by providers of authorized services for the members of that MCO.		
50	Antidepressant medication management	"Antidepressant Medication Management" is a HEDIS measure defined as the percentage of adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on an antidepressant medication treatment. Two rates are reported: • Effective Acute Phase Treatment; and • Effective Continuation Phase Treatment. This measure recognizes that effective medication treatment of major depression can improve a person's daily	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well. To be included in the numerator for the two measures, members must have received: • Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114 -day period following the Index Prescription Start Date. • Effective Continuous Phase Treatment: At least 180 days (six months) of continuous treatment with antidepressant medication during the 231 day period following the Index Prescription Start Date. To be counted in the denominator, members must be 18 years of age and older as of April 30 of the measurement year, have a negative medication history, have a diagnosis of major depression during the intake period, and have been treated with antidepressant medication. Members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment.		

Measure	Measure Name	Definition	Evaluation Methodology	
51	Inpatient admissions to psychiatric hospitals and RTCs	The "Inpatient Admissions to Psychiatric Hospitals and RTCs" measure provides separate counts for the number of members admitted to either a psychiatric hospital or RTC. The counts may be duplicated when a member has multiple claims during the report period with different billing providers. This measure is based on the premise that effective care management should reduce the number of admissions through the use of appropriate early interventions. To be counted for the psychiatric hospital measure, members must have a paid claim type A or I for the measurement year for admission to a hospital, psychiatric unit within an acute care hospital, or a psychiatric hospital. To be counted for the RTC measure, members must have a paid encounter for admission to an RTC during the measurement year.	Baseline	For the baseline calculation, HSD furnished Deloitte with the Inpatient Admissions to Psychiatric Hospitals (Claims Type A and I) and Residential Treatment Centers Report for CY 2013, which was derived from MMIS data. The report contained data for the four MCOs contracted under the Salud program and two MCOs contracted under the CoLTS program. The total number of Paid Psychiatric Hospital encounters with a date of service in CY 2013 was reported. The total number of Paid Residential Treatment Center encounters with a date of service in CY 2013 was reported.
			DY1 to DY2	For DY1 to DY2, HSD furnished Deloitte with the Inpatient Admissions to Psychiatric Hospitals (Claims Type A and I) and Residential Treatment Centers Report, which was derived from claims data. The report data contained data submitted by the four MCOs.
52	Percentage of NF members who transitioned from a low NF to a high NF	The "Percentage of Nursing Facility Members Who Transitioned from a Low Nursing Facility to a High Nursing Facility" is intended to determine to what extent care management assists members in remaining in the least restrictive setting that meets their needs. This measure counts all Centennial Care members who were receiving either	DY1 to DY3	The MCOs did not report on this measure in 2013. Therefore, 2014 data is utilized as the baseline. HSD furnished Deloitte with HSD8 reports containing monthly data for the four Centennial Care plans in each year. Deloitte took the sum of all 12 months of data of members in high and low nursing facilities and combined this number into a denominator. The counts of high and low nursing facility enrollees were divided by this denominator to get a rate for each MCO. These numerators were

Measure	Measure Name	Definition	Evaluation Methodology	
		high or low nursing facility services during one or more months of calendar year 2014.		summed and divided by the denominators for an aggregate rate in each calendar year.
53	Fall risk intervention	The percentage of members 65 years of age and older who have had a fall or problem with balance in the 12 months prior to the measurement date, who were seen by a practitioner during that same time period, and who received a fall risk intervention. This HEDIS measure is collected using the Medicare Health Outcome Survey (HOS). The two components of this survey measure assess different facets of fall risk management: discussing fall risk and managing fall risk.	DY1 to DY2	HSD furnished Deloitte with ad hoc reports containing the FRM rates and denominators for each year.
54	Percentage of the population accessing both a behavioral health service and a PCP visit in the same year	The "Percentage of the Population Accessing both a Behavioral Health Service and a PCP Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service (defined by provider types and/or services on the claim) and at least one PCP visit during the measurement year. To be counted under this measure, members must have been enrolled on the last day of the measurement year. This measure examines the percentage of unduplicated members with at least one PCP visit. The numerator is the number of members (any age) that accessed both a behavioral health service and at least on PCP visit in the same year. The denominator is the entire managed care population.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for the baseline.
			DY1 to DY2	For DY1 and DY2, HSD furnished Deloitte with MMIS reports containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.

Measure	Measure Name	Definition	Evaluation Methodology	
55	Percentage of population accessing an LTSS service that received a PCP visit in the same year	The "Percentage of the Population Accessing an LTSS Service and a PCP Visit in the Same Year" is defined as the percentage of the LTSS population that received at least one PCP visit during the measurement year. To be counted under this measure, members must have been enrolled on the last day of the measurement year. This measure examines the percentage of unduplicated members with at least one PCP visit. The numerator is the number of members (any age) that accessed at least one PCP visit in the year. The denominator is the LTSS population as defined by LTSS services received during the year.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for the baseline.
			DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with MMIS reports containing combined numerator and denominator counts of unique individuals that accessed the specified services for the four MCOs participating in Centennial Care.
56	Percentage of participants who accessed an LTSS service and a behavioral health visit in the same year	The "Percentage of the Population Accessing an LTSS Service and a Behavioral Health Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both an LTSS service and a behavioral health visit during the measurement year. The population accessing LTSS is defined as: members who are nursing facility level of care; members who are dually eligible for Medicare and Medicaid; members are developmentally disabled or medically fragile and who	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for 2013.

Measure	Measure Name	Definition	Evaluation Methodology	
		are in the Mi Via Self-Directed Waiver; members with HIV/AIDs; and members who are in the physically disabled or frail elderly category. To be counted under this measure, members must have been enrolled on the last day of the measurement year. The numerator is the number of members (any age) that accessed an LTSS service and a behavioral health service in the same year. The denominator is the entire managed care population.	DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
57	Percentage of population with behavioral health needs with an ER visit by type of ER visit	The percentage of the Centennial Care population with behavioral health needs that has any type of ER visit with a behavioral health diagnosis during the measurement year, which is broken down by the following types of ER visits: • Emergency Medical Treatment and Labor Act (EMTALA) • Urgent care • Limited to minor • Low to moderate • Moderate • High severity • Life threatening • Admitted through the ER	Baseline to DY2	HSD furnished Deloitte with MMIS reports containing a count of the behavioral health needs and all emergency department visits for each type of ER visit. This count is then divided by the total behavioral health needs population for a rate for each type of visit.

Measure	Measure Name	Definition	Evaluation Methodology	
58	Percentage of the population with LTSS needs with an ER visit by type of ER visit	The percentage of the Centennial Care population with LTSS needs that has any type of ER visit during the measurement year, which is broken down by the following types of ER visits: • EMTALA • Urgent care • Limited to minor • Low to moderate • Moderate • High severity • Life threatening • Admitted through the ER	Baseline to DY2	HSD furnished Deloitte with MMIS reports containing a count of the LTSS needs and all emergency department visits for each type of ER visit. This count is then divided by the total LTSS needs population for a rate for each type of visit.
59	Percentage of the population at risk for nursing facility placement who remain in the community	The "Percentage of the Population at Risk for Nursing Facility Placement Who Remain in the Community" is defined as the number of consumers who transition from nursing facilities and who are served and maintained with community-based services for six months. This measure is intended, for future years, to determine whether there are trends identified in the number of members who transition from nursing facilities and who are served in the community. Members with LTSS needs who receive care coordination services should be able to remain safely in their homes as an alternative to nursing home care. This outcome is desirable both from a quality-of-life perspective for members	Baseline	For the baseline calculation, HSD furnished Deloitte with the HSD Medical Assistance Division (MAD) Fourth Quarter SFY 14 HSD Performance Measures Report. The MAD report contained the quarterly and annual numbers of members who transition from nursing facilities and who are served and maintained with community-based services. The reports covered the 12 months of SFY 2013 for the two MCOs contracted under the CoLTS program. The report was derived from quarterly MMIS reports containing the number and service longevity of members who transitioned from a nursing facility into a community-based service. The MMIS reports are run 30 days after the end of each quarter. The total number of members who transitioned into community services is current with the last month of each quarter when reported, but the number maintained for six months has a nine month reporting lag.

Measure	Measure Name	Definition	Evaluation Methodology	
		and also from a cost-effectiveness perspective for the state. The numerator for this measure is the number of members who receive community-based services for six or more months without a readmission to a nursing facility.	DY1 to DY2	For DY1 and DY2, HSD furnished Deloitte with the HSD Medical Assistance Division (MAD) Fourth Quarter SFY 15 HSD Performance Measures Report. The reports covered the 12 months of SFY 2014 and SFY 15, which included six months of data for the four MCOs participating in Centennial Care.
60	Number and percentage of participants who accessed a behavioral health service that also accessed HCBS	The "Number and percentage of Members Who Accessed a Behavioral Health Service That Also Accessed HCBS in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service and HCBS during the measurement year. The population accessing HCBS is defined as all members who are enrolled in managed care who accessed both a behavioral health and HCBS service.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013.

Measure	Measure Name	Definition	Evaluation Methodology	
		Under Centennial Care, these members include individuals who are enrolled in the Developmentally Disabled waiver or the Medically Fragile waiver. To be counted under this measure, members must have been enrolled on the last day of the measurement year. The numerator is the number of members (any age) that accessed a behavioral health service and HCBS in the same year. The denominator is the entire managed care population.	DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
61	Number and percentage of members that maintained their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level	The "Number and Percentage of Members Who Maintain Their Care Coordination Level or Move to a Different Level" measure determines the number and percentage of members receiving care coordination services who: • Remain at their current level - The number of unduplicated active members who are receiving Care Coordination as of the last day of the reporting period and are assigned the same Care Coordination Level (CCL2 or CCL3) as of the last day of the prior reporting period; • Move to a lower level - the number of unduplicated active members who, as a result of a CNA, are determined to no longer meet the requirements for CCL3 but still meet the requirements of CCL2 during the month reporting period; plus the number of unduplicated active members who, as a result of a CNA, are determined to no longer	DY1 to DY3	HSD furnished Deloitte with ad hoc care coordination reports for the four MCOs for each year. The membership counts are reported by month, and Deloitte averaged the monthly count for each MCO and combined the four plans' numerator and denominator values to calculate an average aggregate rate for each year. The counts presented in the exhibit are the average member months, or an estimate for unduplicated member counts over the measurement year.

Measure	Measure Name	Definition	Evaluation Methodology	
		meet the requirements for CCL2 during the monthly reporting period but were receiving CCL2 as of the last day of the prior monthly reporting period on the last day of the reporting period, the members is no longer receiving Care Coordination; and • Move to a higher level - The number of unduplicated active members who, as a result of a CNA, are determined to meet the requirements for CCL2 during the monthly reporting period. On the last day of the prior reporting period the member was enrolled but not receiving Care Coordination; plus, the number of unduplicated active members who, as a result of a CNA, were determined to meet the requirements for CCL3 during the monthly reporting period. On the last day of the prior reporting period, the member was enrolled, but either receiving CCL2 or was not receiving Care Coordination.		

Measure	Measure Name	Definition	Evaluation Methodology	
62	Percentage of population accessing a behavioral health service that received an outpatient ambulatory visit in the same year	The "Percentage of the Population Accessing a Behavioral Health Service That Received an Outpatient Ambulatory Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service and an outpatient ambulatory visit during the measurement year, based on a review of provider IDs and procedure codes found on the claims. To be counted under this measure, members must have been enrolled during the measurement year. The numerator is the number of members (any age) that accessed both a behavioral health service and an outpatient ambulatory visit in the same year. The denominator is the entire managed care population.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program.
			DY1 to DY2	For DY1 through DY2, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
63	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications	"Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications" is a HEDIS measure defined as the percentage of members 18 – 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. To be counted under this measure, members must have been continuously enrolled during the measurement year and must not have had more than one gap in enrollment of up to 45 days	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage. The denominator for this measure includes members 18 – 64 years of age by December 31 of the measurement year who have schizophrenia or bipolar disorder who were dispensed an antipsychotic medication. The numerator consists of members who had a glucose test or an HbA1c test performed during the measurement year.		
64	Diabetes monitoring for members with diabetes and schizophrenia	"Diabetes Monitoring for Members with Diabetes and Schizophrenia" is a HEDIS measure defined as the percentage of members 18 – 64 years of age with diabetes and schizophrenia who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the measurement year. To be counted under this measure, members must have been continuously enrolled during the measurement year and must not have had more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one month gap in coverage.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		The denominator for this measure includes members 18 – 64 years of age as of December 31 of the measurement year with schizophrenia and diabetes. The numerator consists of members who had an HbA1c test and an LDL-C test performed during the measurement year.		
65	Total program expenditures	"Total Program Expenditures" is intended to summarize all costs of providing services to eligible Medicaid beneficiaries enrolled in the Centennial Care program, including: • Total computable costs of providing Medical Assistance Program services to the populations covered under Centennial Care, • Tracked and recorded uncompensated care costs of approximately $68.9 million, and • Fee-for-service, managed care, and other associated costs for the covered Native American Indian population.	Baseline	HSD furnished Deloitte with the quarterly CMS-64 Schedule C expenditure reports as well as the quarterly Centennial Care reports submitted to CMS which summarize member months by MEG each quarter. Deloitte calculated a baseline program cost for each MEG using the respective member months from the quarterly reports HSD submitted to CMS and the estimated per-member per-month (PMPM) costs without waiver thresholds set under STCs 106 – 108. Per STCs 106 – 108, these cost thresholds were defined for each of the six MEGs covered under Centennial Care and vary annually for the five years of the waiver demonstration. The member months from HSD's quarterly reports were used to convert the PMPM cost thresholds from STCs 106 – 108 into total program expenditures.
			DY1 to DY3	The total program costs for each year as provided in the CMS-64 Schedule C reports.

Measure	Measure Name	Definition	Evaluation Methodology	
66	Costs per member	The "Costs per Member" measure is the per-member per-month cost calculated as the total expenditure of each MEG divided by the corresponding total member months of that MEG.	Baseline	The baseline PMPMs were taken directly from STCs 106 – 108 for each MEG.
			DY1 to DY3	The PMPM cost for each MEG were calculated by using the total program costs for each year as tracked in measure 65 divided by the member months provided in each of the quarterly Centennial Care submissions to CMS.
67	Costs per user of services	The "Costs per User of Services" measure is a per-user per-month representation of the total expenditures reported from Measure 65.	Baseline	Deloitte received an MMIS data extraction from HSD which calculated the number of Centennial Care members with paid capitation and a service encounter in the same month, for each month. The user PMPM without waiver is calculated by multiplying the estimated PMPM by MEG from the STCs by the given member months divided by their corresponding user member months.

Measure	Measure Name	Definition	Evaluation Methodology	
			DY1 to DY3	The PMPM cost for each MEG were calculated by using the total program costs for each year as tracked in measure 65 divided by the number of users by MEG provided in the MMIS data extraction described above.

Measure	Measure Name	Definition	Evaluation Methodology	
68	Utilization by category of service	"Utilization by Category of Service" tracks the utilization of selected services for physical health, behavioral health, and long term services and supports.	Baseline	The utilization across various service categories were reported in quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The reported utilization units were divided by annualized member months found in the same quarterly submissions to report the sub-measures on a "units per 1,000" basis. For certain measures where applicable, the average length of stay was calculated as days per admit. The baseline utilization measures are based on the first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of DY1, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized utilization rates in each year was calculated by summing the utilization units for the year and dividing by the total member months for the year. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.
69	Hospital costs	The "Hospital Costs" measure tracks the PMPM program expenditures of categories that are associated with	Baseline	The costs across various categories related to hospitals, clinics, and facilities, as well as member months, were reported in quarterly MCO financial

Measure	Measure Name	Definition	Evaluation Methodology	
		hospital, clinic, and facility visits. The categories of service included in hospital costs by program are: • PH: Inpatient Hospital – Acute, Inpatient - Specialty Hospital, Outpatient Hospital - Emergency Room, Outpatient Hospital - Urgent Care, Outpatient Facility – Other, Rural Health Clinics, FQHCs, Freestanding Clinics • BH: Outpatient Hospital (Evaluations, Therapies, and BH Physical Evaluations), Hospital Outpatient Facility (BH Treatment Services), Hospital Inpatient Facility (Psychiatric Hospitalization Services), Rural Health Clinics, FQHCs • LTSS: Nursing Facility State Owned - High Level of Care, Nursing Facility State Owned - Low Level of Care, Nursing Facility Private - High Level of Care, Nursing Facility Private - Low Level of Care, Nursing Facility Professional Charges, Other Nursing Facility Payments, Hospital Swing Bed - High Level of Care, Hospital Swing Bed - Low Level of Care, Inpatient Hospital – Acute, Inpatient - Specialty Hospital, Outpatient Hospital - Emergency Room, Outpatient Hospital - Urgent Care, Outpatient Facility – Other, Rural Health Clinics, FQHC's, Freestanding Clinics		submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. Reported costs from these files were aggregated on categories of service determined to be related to hospital services. For the baseline calculation, the hospital costs measure utilizes the sum of the costs for the hospital services reported in the first quarter of 2014 divided by the total member months in the same timeframe.
			DY1 to DY3	The annual PMPM for each demonstration year was calculated by summing the costs for the hospital services for the year and dividing by the total member months in the year.

Measure	Measure Name	Definition	Evaluation Methodology	
70	Use of HCBS	"Use of HCBS" tracks the utilization for Home and Community-Based Services (HCBS).	Baseline	The utilization for HCBS was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. For the baseline calculation, the use of HCBS measure utilizes the sum of the costs for the HCBS reported in the first quarter of 2014 divided by the total member months in the same timeframe, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
71	Use of institutional care (skilled nursing facilities)	The "Use of Institutional Care (Skilled Nursing Facilities)" measure tracks the utilization for non-acute long term care and skilled nursing services.	Baseline	The utilization for skilled nursing was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
72	Use of mental health services	The "Use of Mental Health Services" measure tracks the utilization for behavioral health services and related facility visits.	Baseline	The utilization for mental health services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
73	Use of substance abuse services	"Use of Substance Abuse Services" tracks the utilization for methadone treatment.	Baseline	The utilization for substance abuse services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
74	Use of pharmacy services	This measure tracks the number of scripts per 1,000 for brand name, generic, and other drugs.	Baseline	The utilization for drug prescriptions services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
75	Inpatient services exceeding $50,000	"Inpatient Services Exceeding $50,000" tracks the annual cost of inpatient services exceeding $50,000 in a given calendar year. The measure is calculated in two ways; first, as the inpatient cost on a PMPM basis, and second, as a percentage of total health-related expenditures.	DY1 to DY3	High claims were reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. To calculate the inpatient claims cost PMPM, the sum of the inpatient high cost claims were divided by the total member months as reported in the MCO quarterly submissions. To calculate the cost as a percentage of health-related expenditures, the sum of the claims was divided by total healthcare costs, not inclusive of administrative expenses. The baseline was determined using full DY1 experience since costs associated with inpatient services were tracked and reported on an aggregate, cumulative basis in the legacy programs (Salud!, CoLTS, and Behavioral Health).
76	Diagnostic Imaging Costs	The "Diagnostic Imaging Costs" measure tracks the PMPM costs associated with diagnostic imaging procedures. It was amended from its original measure, "Use of Diagnostic Imaging", as utilization data on diagnostic imaging was not available for DY1 for the purposes of tracking in this report. Deloitte will continue working with HSD to explore ways for diagnostic imaging utilization to be reported.	Baseline	The PMPM costs for diagnostic imaging were reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO

Measure	Measure Name	Definition	Evaluation Methodology	
				submissions, divided by the member months as of the first quarter of 2014.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months.

Measure	Measure Name	Definition	Evaluation Methodology	
77	Emergency department use	"Emergency Department (ED) Use" tracks the utilization for ED visits for the physical health and LTSS services covered under the Centennial Care program.	Baseline	ED use was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
78	All cause readmissions	The "All Cause Readmissions" measure reports the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of readmission. To be counted under this measure, acute inpatient discharges within 30 days of previous acute inpatient discharges are tracked during the measurement year.	Baseline to DY2	HSD furnished Deloitte with MMIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate 2014 rate.
79	Inpatient mental health/substance use services	The "Inpatient Mental Health/Substance Use" measure tracks the utilization for mental health and substance abuse services rendered in an inpatient setting.	Baseline to DY2	HSD furnished Deloitte with MMIS data where encounters and claims were summarized for psychiatric hospitals and residential treatment centers. The number of encounters are divided by the number of clients for the entire calendar year to arrive at the final rate in each demonstration year.
80	Asthma controller medication compliance (children)	"Asthma Controller Medication Compliance" is a HEDIS measure that reports the percentage of children with persistent asthma and who were dispensed appropriate medications that they remained on for the treatment period. Two rates of medication compliance are reported; those that remained on their medication for 50% of the treatment period, and those that	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (PHP did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		remained on their medication for 75% of the treatment period. To be counted under this measure, members must be identified as having persistent asthma in the measurement year or the year prior to the measurement year through claim encounter data and/or pharmacy data in either the current year or the prior year. The frequency of Centennial Care members earning and redeeming points for activities performed to manage their child's asthma is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $75 (750 points) per calendar year for refilling their child's asthma as prescribed.	DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
81	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	"Comprehensive Diabetes Care" is a HEDIS measure that reports the percentage of members ages 18 – 75 with Type 1 or Type 2 diabetes who had the applicable tests performed and whose health indicators aligned with the indicator category being tracked. To be counted under this measure, members must have been identified as having diabetes in the measurement year or the year prior to the measurement year via claim encounter data or pharmacy data. The frequency of Centennial Care members earning and redeeming points for activities to manage diabetes is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $80 (800 points) for taking steps to manage their diabetes.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
82	Prenatal program	The "Prenatal Program" measure was based on a collection of HEDIS measures on the frequency of ongoing prenatal care and postpartum care. The measures report on the percentage of deliveries that received various ranges of expected percentages of visits, the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery, and the percentage of deliveries that received a prenatal visit during the first trimester. To be counted under this measure, female members must be identified as having a live birth between November 6 of the prior year and November 5 of the measurement year. The frequency of Centennial Care members earning and redeeming points for activities to manage prenatal care is also tracked under this measure. According to the Centennial Rewards website, members who are pregnant may earn up to $100 (1,000 points) for joining the prenatal program sponsored by its health plan.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
83	Treatment adherence - schizophrenia	"Treatment Adherence – Schizophrenia" is a HEDIS measure that reports the percentage of members diagnosed with schizophrenia that remain on their medication for at least 80% of the treatment period. To be counted under this measure, members ages 19 – 64 must be diagnosed with schizophrenia by having at least one acute inpatient claim with the diagnosis of schizophrenia or must have at least two outpatient, partial hospitalization, ED, or non-acute claims on different dates of service with the diagnosis of schizophrenia. The frequency of Centennial Care members earning and redeeming points for activities to manage their schizophrenia is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $75 (750 points) for taking steps to manage their schizophrenia.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
84	Treatment adherence - bipolar	The "Treatment Adherence – Bipolar" measure was intended to track treatment adherence for bipolar disorders. However, there are no known HEDIS measures related to the tracking of health status for bipolar individuals and MCOs were not required to track this activity. Therefore, this measure has been modified to track the frequency of Centennial Care members earning and redeeming points for activities to manage bipolar disorder. According to the Centennial Rewards website, members may earn up to $75 (750 points) per calendar year for taking steps to manage their bipolar condition. If, in the future, appropriate data and reporting become available, Deloitte will reassess this measures at that time.	DY1 to DY2	HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
85	Osteoporosis management in elderly women - females aged 65+ years	"Osteoporosis Management In Elderly Women – Females Age 65 and Over" is a measure that tracks the number of unique members and unique encounters related to osteoporosis over the course of the measurement year. The frequency of Centennial Care members earning and redeeming points for testing bone density, a test commonly performed to prescreen for osteoporosis, is also tracked under this measure. According to the Centennial Rewards website, members may earn up a one-time reward of $35 (350 points) by getting a bone density test.	Baseline to DY2	HSD provided an MMIS data extract for calendar years 2013 through 2015 to track the number of unique members and unique encounters related to osteoporosis in elderly women. This information was used to calculate an encounter rate by dividing encounters over clients. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
86	Annual dental visit - adult	The "Annual Dental Visits – Adults" measure tracks the percentage of adult members that had at least one dental visit during the measurement year. The annual dental visit HEDIS measure was used to track this rate and was reported specifically for the 19 – 21 age range. The frequency of Centennial Care adult members earning and redeeming points for having their annual dental visit is also tracked under this measure. According to the Centennial Rewards website, the Healthy Smiles program rewards members up to $25 (250 points) per calendar year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
87	Annual dental visit - child	The "Annual Dental Visits – Child" measure tracks the percentage of child members that had at least one dental visit during the measurement year. The annual dental visit HEDIS measure was used to track this rate and was reported specifically for the following age groups: 2-3 years, 4-6 years, 7-10 years, 11-14 years, and 15-18 years. The frequency of Centennial Care child members earning and redeeming points for having their annual dental visit is also tracked under this measure. According to the Centennial Rewards website, the Healthy Smiles program rewards members up to $25 (250 points) per calendar year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
88	Number of members spending credits	The "Number of Members Spending Credits" measure tracks the number of members redeeming and spending credits, or points, earned in the Centennial Rewards program relative to the number of people registered in the Centennial Rewards program. In previous measures described in this report, this information was also provided for specific points-earning activities that were applicable to the health condition under discussion. Here, this measure reports the total number of members earning or redeeming credits in the Centennial Rewards program, regardless of points-generating activity.	DY1 to DY2	HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
88	Percentage of expedited appeals resolved within three business days	HSD requires MCOs to establish and maintain an expedited review process for appeals and adhere to the allowed timeframe. Specifically: *"The contractor shall establish and maintain an expedited process for Appeals in accordance with 42 C.F.R. § 438.410. The contractor shall ensure that the expedited review process is convenient and efficient for the Member. The contractor shall resolve the expedited Appeal in accordance 42 C.F.R. § 438.408(b)(3) and (d)(2)…"*[144][145] The New Mexico Human Services Department (HSD) requires MCOs to track and	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with the Grievances and Appeals reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of expedited appeals resolved, as well as the number and percent resolved within the three day standard. Deloitte combined the four plans' total resolved expedited appeals to establish a denominator for each year. Deloitte then combined the count of expedited appeals resolved within three days to establish a numerator for each year.

[144] Contractors may request an extension from HSD in accordance with 42CFR Section 438.408(c).
[145] Centennial Care Contract, Section 4.16.3 – Expedited Resolution of Appeals.

Measure	Measure Name	Definition	Evaluation Methodology	
		report on appeals and grievance activity on a monthly basis. This includes the number of new appeals filed and the number resolved timely or untimely that month. The acceptable time period for resolution is seventy-two hours after the receipt of the appeal. Timely resolution of expedited appeals is essential for ensuring members do not experience a delay in receiving urgently needed care (in situations where the initial denial is overturned). The measure examines the percentage of expedited appeals resolved within three days of receipt by the MCO.		
89	Percentage of grievances resolved within 30 days	HSD requires MCOs to adhere to timeliness standards for resolution of grievances, whether filed by members or providers. Grievances were defined in the Centennial Care managed care contract as follows: *"Grievance means an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor action."*[146]	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of grievances resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish a denominator for each year. Deloitte then combined the count of grievances resolved

[146] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.

Measure	Measure Name	Definition	Evaluation Methodology	
		HSD also defines the allowable time period for resolution of grievances. Specifically: *"The contractor shall complete the investigation and final resolution process for grievances within 30 calendar days of the date the grievance is received by the contractor or as expeditiously as the member's health condition requires…"*[147][148] HSD requires MCOs to track and report grievance activity on a monthly basis. This includes the number of new grievances filed, the number carried over from the previous month, the number resolved timely or untimely that month, and the number still pending (for carry over to the next month's report). MCOs report member grievance activity as a distinct category. Failure to resolve member grievances timely could contribute to dissatisfaction with the program and have a negative impact on member access to care. The measure examines the percentage of grievances		within 30 days to establish a numerator for each year.

[147] Contractors may request an extension from HSD in accordance with 42 CFR § 438.408(c).
[148] Centennial Care Contract, Section 4.16.2 – Grievances, page 137.

Measure	Measure Name	Definition	Evaluation Methodology	
		resolved within 30 days of receipt by the MCO.		
90 91 92	Percentage of appeals upheld, partially overturned, and overturned	In conformance with federal regulations, HSD requires Centennial Care MCOs to adhere to the following procedures with respect to notices of action and appeals: *"The contractor shall mail a notice of action to the member or provider in accordance with the procedures and timeframes of 42 C.F.R. §438.404 and 431.200 unless such timeframe is prescribed in this section 4.16.2… The contractor may mail a notice of action no later than the date of the action for the following:* • *The contractor has factual information confirming the death of a member;* • *The contractor receives a signed written member statement requesting service termination or giving information requiring termination of covered services (where the member understands*	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with Grievances and Appeal reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of appeals resolved and the disposition of the appeals. Appeals that were listed as "pending" at the time the report was compiled were not included in the calculations of this measure.

Measure	Measure Name	Definition	Evaluation Methodology	
		that this must be the result of supplying that information); • *The member has been admitted to an institution where he or she is ineligible for further services;* • *The member's address is unknown and mail directed to him or her has no forwarding address;* • *The member has been accepted for Medicaid services in another state or US territory;* • *The member's physician prescribes a change in the level of medical care;* • *An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions; and* • *In accordance with 42 CFR Section 483.12(a)(5)(ii)*[149]*.* *A member may file an appeal of a contractor action either orally or in writing within (90) calendar days of receiving the contractor's notice of action. The representative or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member."* [150] Appeals may be upheld (affirming the original determination), partially overturned, or overturned in full. HSD requires MCOs to track and report		

[149] Section relates to transfers and discharges from long term care facilities.
[150] Centennial Care Contract, Section 4.16.3 –Appeals, pages 147 – 148.

Measure	Measure Name	Definition	Evaluation Methodology	
		appeal activity, including the nature of the resolution. A high rate of overturned denials could indicate that MCOs' are applying too stringent a standard when making initial determinations. (Measures 90, 91, and 92 have been combined to eliminate redundancy in reporting results.) The measure examines the percentage of appeals that were upheld, partially overturned, and overturned in full upon review.		
93	Number and percentage of calls answered within 30 seconds	"Call answer timeliness" is a HEDIS measure that reports the frequency with which calls are answered within the NCQA standard of 30 seconds. HSD requires that the participating MCOs operate a toll-free Member Services Call Center. HSD also defines performance standards for the call centers: *"The contractor shall adequately staff the Member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within 30 seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed two (2) minutes."*	Baseline to DY1	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY2	HSD furnished Deloitte with audited HEDIS data for two of the four MCOs (MHC and BCBS did not report on this measure in 2015). Deloitte combined the two plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the two MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		The call centers are an important resource for members in understanding program benefits and accessing services. If members have difficulty getting through to the call center, their overall satisfaction with the plan is likely to be affected. HSD requires contracting MCOs to report call center performance as a component of their annual HEDIS submissions.		
94	Number and percentage participants satisfied with care coordination	Many Centennial Care members have complex health care needs for which they receive care from multiple physicians. "How often personal doctor informed about care from other doctors" is a CAHPS measure that rates member satisfaction with how well his or her personal doctor is kept informed by other doctors. Although care coordination encompasses more than communication between physicians, it is an important component of the process and one that is visible to the member. If a member finds his or her personal doctor is not well-informed about the member's interaction with specialists, it is likely to negatively affect the member's satisfaction with his or her doctor and plan. The CAHPS survey asks members to rate how often their personal doctor is informed about care from other doctors using a scale of one to four, where one	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results. Deloitte used the 2016 SPH Analytics Benchmark rate for the adult and general child populations. For the children with chronic conditions population Deloitte used the 2015 Quality Compass All Plans benchmark rate, as the 2016 SPH Analytics Benchmark rate could not be identified for this population.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		is "never," two is "sometimes," three is "usually" and four is "always." There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and children with chronic conditions (CCC). (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses could produce materially different results.		

Measure	Measure Name	Definition	Evaluation Methodology	
95	Rating of personal doctor	"Rating of Personal Doctor" is a CAHPS measure that evaluates member satisfaction with their PCP. The PCP is a central figure in the member's care; the member's rating of his or her doctor can be expected to influence the member's overall perception of plan quality. The CAHPS survey asks members to rate their personal doctor on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering eight, nine, or ten. Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
96	Rating of health care	"Rating of Health Care" is a CAHPS measure that evaluates overall member satisfaction with their care. The CAHPS survey asks members to rate their health care on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and (CCC). (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering eight, nine or ten. Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
97	How well doctors communicate	"How Well Doctors Communicate" is a CAHPS composite measure that combines data from responses to four survey items: • Doctors explained things in a way that was easy to understand • Doctors listened carefully • Doctors showed respect for what you had to say • Doctors spent enough time with you. The CAHPS survey asks members to rate their doctors on each item using a scale of one to four, where one is "never," two is "sometimes," three is "usually," and four is "always." In the CAHPS report the answers to these questions are combined and used to	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		calculate an overall satisfaction rate with doctor communication. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
98	Customer service satisfaction	"Customer Service Satisfaction" is a CAHPS composite measure that combines data from responses to four survey items: • Found needed information in written materials and on the internet • Health plan forms were easy to fill out • Received needed information from the health plan's customer service • Customer service staff treated you with courtesy and respect. The CAHPS survey asks members to rate their customer service experience on each item using a scale of one to four, where one is "never," two is "sometimes," three is "usually," and four is "always." In the CAHPS report the answers to these questions are combined and used to calculate an	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		overall satisfaction rate with doctor communication. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses would produce materially different results.	DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
99	Rating of specialist seen most often	"Rating of Specialist Seen Most Often" evaluates member satisfaction with the provider most critical to the member's care, in addition to the member's PCP. The CAHPS survey asks members to rate their specialist on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
100	Percentage of clean claims adjudicated in 30/90 days	HSD requires MCOs to adhere to timeliness standards for adjudication of clean claims. The standards also apply to any capitated subcontractors responsible for processing provider claims. Clean claims are defined in the Centennial Care contract as follows: "Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity." HSD defined two sets of timeliness standards, the first of which applies to Indian Health Service/Tribal/Urban Indian (I/T/U) and long term care providers, and the second of which applies to all other providers. Specifically: "For claims from I/T/Us, day activity providers, assisted living providers, nursing facilities and home care agencies, including community benefit providers, ninety-five percent (95%) of clean claims must be adjudicated within a time period of no greater than fifteen (15) calendar days of receipt and ninety-nine percent (99%) or more of clean claims must be adjudicated within	SFY 2013	For the baseline calculation, HSD furnished Deloitte with monthly standardized claims timeliness reports submitted by the four MCOs contracted under the Salud! program, the two MCOs contracted under the CoLTS program and the Behavioral Health Organization (BHO) contracted to provider behavioral health benefits to both Salud! and CoLTS members. The reports covered the 12 months of SFY 2013 and contained counts of the total number of clean claims processed, as well as the number and percent adjudicated within 30 and 90 calendar days. Deloitte combined the seven plans' total clean claim counts for SFY 2013 to establish a denominator. Deloitte then combined the 30 and 90 day adjudication counts to establish numerators for calculation of 30 and 90 day rates.
			DY1	For the DY1 rate, HSD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of calendar year 2014 and contained counts of the total number of clean claims processed, as well as the number and percent adjudicated within program timeliness standards. The MCOs provided separate data for providers falling under the 15/30 day standard and providers falling under the 30/90 day standard. Deloitte combined the four plans' total clean claim counts for CY 2014 to establish a denominator. Deloitte then combined the 30 and 90 day adjudication counts to establish numerators for calculation of 30 and 90 day rates. Deloitte was able to compare SFY 2013 and DY1 performance with respect to the 30/90 day standard, which was captured in both sets of

Measure	Measure Name	Definition	Evaluation Methodology	
		a time period of no greater than thirty (30) calendar days of receipt; *"For all other claims, ninety percent (90%) of all clean claims must be adjudicated within thirty (30) calendar days of receipt, and ninety-nine percent (99%) of all clean claims must be adjudicated within ninety (90) calendar days of receipt."* [151] The measure examines claims that have been adjudicated (i.e., paid in full), paid in part and denied in part, or denied in full.		reports. Data for the 15/30 day standard was reported only in 2014 and will serve as a baseline for longitudinal analysis.
			DY2	For DY2 HSD supplied Deloitte with rates from each MCO for several types of rendering providers (BH providers, PH providers, BH and PH providers, I/T/Us, specialty-pay providers, and an aggregate rate of all providers). These rates did not come with numerators and denominators, so for DY2 the rates could not be weighted in their aggregate. Deloitte produced the DY2 30/90 day standard rate by calculating the straight average for the three categories of providers whose claims are adjudicated under the 30/90 day standard. For the DY2 15/30 day standard rate, Deloitte calculated the straight average of the two types of claims that adjudicated under that standard. The variations in calculation methodologies should be noted year-to-year when comparing results.

[151] Centennial Care contract, Section 4.19 – Claims Management, page 168.

Measure	Measure Name	Definition	Evaluation Methodology	
101	Percentage of claims denied	HSD requires MCOs to track and report the percentage of clean claims denied for payment. A high denial rate can be an indication of confusion among providers regarding coverage guidelines, prior authorization requirements and/or proper billing procedures. Clean claims are defined in the Centennial Care contract as follows: *"Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity."*[152] The measure examines clean claims that have been adjudicated and denied.	SFY 2013	For the Baseline calculation, HSD furnished Deloitte with monthly standardized claims timeliness reports submitted by the four MCOs contracted under the Salud! program, the two MCOs contracted under the CoLTS program and the BHO contracted to provider behavioral health benefits to both Salud! and CoLTS members. The reports covered the 12 months of SFY 2013 and contained counts of the total number of clean claims processed, as well as the number and percent denied upon adjudication. Deloitte combined the seven plans' total clean claim counts for SFY 2013 to establish a denominator. Deloitte then combined the denial counts to establish a numerator.
			DY1	For the DY1 rate, HSD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of calendar year 2014 and contained counts of the total number of clean claims processed, as well as the number and percent denied upon adjudication. Deloitte combined the four plans' total clean claim counts for CY2014 to establish a denominator. Deloitte then combined the denial counts to establish a numerator.

[152] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 9.

Measure	Measure Name	Definition	Evaluation Methodology	
			DY2	For DY2 HSD supplied Deloitte with rates from each MCO for several types of rendering providers (BH providers, PH providers, BH and PH providers, I/T/Us, specialty-pay providers, and an aggregate rate of all providers). These rates did not come with numerators and denominators, so for DY2, Deloitte calculated the straight average of each MCO's aggregate claim denial rate. The variations in calculation methodologies should be noted year-to-year when comparing results.
102	Dollar accuracy rate	HSD requires MCOs to track and report the dollar accuracy of paid claims, based on a quarterly MCO audit of a random sample of claims. A high inaccurate percentage can be an indication of claims management issues, including but not limited to: incorrect pricing of claims, payment of duplicate claims, and/or payment for non-covered charges. HSD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. For the baseline calculation, HSD furnished Deloitte with quarterly audit reports submitted by the four MCOs. The reports covered the 12 months of CY2014[153]. Deloitte combined the four plans' total paid amounts, by claim type, to establish claim type-specific denominators. Deloitte then combined the dollar error amounts, by claim type, and subtracted these amounts from the totals to establish claim type-specific numerators. Deloitte performed the same exercise across all claim types to establish an aggregate denominator and numerator.

[153] Deloitte received all four quarterly reports for three of the four Centennial Care MCOs and three of the quarterly reports for the fourth MCO. Deloitte does not believe that the absence of one quarterly report is of material importance in calculating a percentage accuracy rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		• Outpatient hospital • Professional • Behavioral health • Nursing Facility • I/T/U • Medicare crossover • Home- and Community-Based Services (HCBS) • Dental • Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) MCOs select at least one hundred paid claims, by claim type, on a quarterly basis. The claims are audited both for dollar accuracy and procedural accuracy. Dollar errors are classified either as overpayments or underpayments. MCOs report the total dollars paid and the total amount of overpayments and underpayments. The overpayment and underpayment amounts are combined to establish a total inaccurate dollar amount by claim type and for all audited claims in aggregate. The measure examines percentage of total dollars paid correctly (no overpayment or underpayment) out of the total paid dollars for audited claims.	DY2	For DY2 HSD supplied Deloitte with dollar accuracy rates from each MCO by claim type. These rates did not include underlying dollar amounts, so the DY2 aggregate rate was calculated as a straight average of MCO rates instead of a weighted average. No aggregate accuracy rate for all types of claims was available. The variations in calculation methodologies should be noted year-to-year when comparing results.

Measure	Measure Name	Definition	Evaluation Methodology	
103	Percentage of grievances resolved on time	HSD requires MCOs to adhere to timeliness standards for resolution of grievances, whether filed by members or providers. Grievances are defined in the Centennial Care contract as follows: *"Grievance means an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor action."* [154][155] HSD also defines the allowable time period for resolution of grievances. Specifically: *"The contractor shall complete the investigation and final resolution process for grievances within thirty (30) calendar days of the date the grievance is received by the contractor or as expeditiously as the member's health condition requires…"*[156][157] HSD requires MCOs to track and report grievance activity on a monthly basis. This includes the number of new grievances filed, the number carried over from the previous month, the number resolved timely or untimely that month, and the number still pending (for carry over to the next month's report).	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of grievances resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish respective denominators for each year. Deloitte then combined the count of grievances resolved within 30 days to establish a numerator for each year.

[154] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.
[155] Actions refer to service reductions or denials and are addressed through the appeals, rather than grievance, process.
[156] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 146.
[157] Contractors may request an extension from HSD in accordance with 42CFR Section 438.408(c).

Measure	Measure Name	Definition	Evaluation Methodology	
		MCOs report provider grievance activity as a distinct category. Failure to resolve provider grievances timely could contribute to dissatisfaction with the program and have a negative impact on provider participation and member access to care. The measure examines the percentage of grievances resolved within 30 days of receipt by the MCO.		
104	Percentage of provider appeals resolved on time	In conformance with federal regulations, HSD requires Centennial Care MCOs (contractors) to adhere to the following procedures with respect to notices of action and appeals: *"The contractor shall mail a notice of action no later than the date of the action for the following:* • *The contractor has factual information confirming the death of a member;* • *The contractor receives a signed written member statement requesting service termination or giving information requiring termination of covered services (where the member understands that this must be the result of supplying that information);* • *The member has been admitted to an institution where he or she is ineligible for further services;*	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered the 12 months of each year and contained counts of the total number of appeals resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish respective denominators for each year. Deloitte then combined the count of grievances resolved within 30 days to establish a numerator for each year.

Measure	Measure Name	Definition	Evaluation Methodology	
		• *The member's address is unknown and mail directed to him or her has no forwarding address;* • *The member has been accepted for Medicaid services in another state or US territory;* • *The member's physician prescribes a change in the level of medical care;* • *An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions; and* • *In accordance with 42 CFR Section 483.12(a)(5)(ii)*[158]*.* *A member may file an appeal of a contractor action either orally or in writing within (90) calendar days of receiving the contractor's notice of action. The representative or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member."*[159] HSD requires MCOs to adhere to timeliness standards for resolution of standard and expedited appeals. Specifically: *Standard appeals - "The contractor has thirty (30) calendar days from the date the initial oral or written appeal is*		

[158] Section relates to transfers and discharges from long term care facilities.
[159] Centennial Care contract, Section 4.16 – Grievances and Appeals, pp 147-148 (emphasis added).

Measure	Measure Name	Definition	Evaluation Methodology	
		received by the contractor to resolve the appeal."[160] *Expedited appeals – "The contractor shall resolve the expedited appeal in accordance with 42 CFR Section 438.408(b)(3) and (d)(2)."*[161] The CFR section cited in the Centennial Care contract includes the following language: *"For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than three working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section."* Paragraph (c) permits the MCO to extend the timeframe by up to fourteen calendar days if the enrollee requests the extension or the MCO shows (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. HSD requires MCOs to track and report appeal activity, including the date the appeal was filed and the date of resolution. MCOs report appeals filed by providers on behalf of members as a distinct category. Failure to resolve		

[160] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 148.
[161] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 149.

Measure	Measure Name	Definition	Evaluation Methodology	
		these appeals timely could contribute to dissatisfaction with the program and have a negative impact on provider participation and member access to care. The measure examines the percentage of standard appeals resolved timely by the MCO.		
106	Number of eligible providers receiving EHR incentive payments	The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act of 2009, committed the federal government to supporting the development, adoption and meaningful use of EHRs. The EHR offers the potential to improve care coordination and achieve cost savings through consolidation and real time sharing of clinical data across providers and care settings, while also facilitating a patient's access to his or her personal health data. The federal Centers for Medicare and Medicaid Services (CMS) has undertaken a multi-stage EHR incentive payment methodology to encourage adoption and meaningful use of EHRs by Medicare providers. Each state Medicaid program, including New Mexico's, has established a corresponding incentive	2011 to 2016	HSD generated a report with counts of the number of eligible hospitals and professional providers that qualified for an initial incentive payment in 2013 or for a meaningful use incentive payment. Deloitte added the initial payment count to the cumulative count for 2011 – 2012, to arrive at a baseline number for this portion of the measure. (Meaningful use counts are unique to each year and not cumulative.) Deloitte replied on the same reports generated by HSD in DY1 through DY3.

Measure	Measure Name	Definition	Evaluation Methodology	
		methodology for Medicaid providers in accordance with federal regulations. HSD included a definition of EHRs in the Centennial Care MCO contract. Specifically: *"Electronic Health Record (EHR) means a record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information."*[162] HSD also required MCOs to partner with the Department in facilitating adoption of EHRs by New Mexico providers. Specifically: *"The contractor shall participate in, and, as may be directed, implement any Health Information Exchange or Electronic Health Record initiatives undertaken by HSD or other entities."*[163] Under the federally-established rules for EHR incentive payments, Medicaid providers can receive up to six incentive payments. The payments are made on an annual basis and can be earned over non-consecutive years. The eligible		

[162] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, pp 11-12.
[163] Centennial Care contract, Section 4.20 – Information Systems, page 176.

Measure	Measure Name	Definition	Evaluation Methodology	
		provider types include hospitals and professionals (physicians, dentists, nurse practitioners, certified nurse midwives and physician assistants). Providers qualify for an initial payment upon attesting that they have adopted, implemented or upgraded federally-certified EHR technology. (The federal government has raised the standards for the minimally allowable technology over time). Providers qualify for up to five additional annual payments by attesting that they have met the meaningful use standard in effect for that year. Incentive payment rules differ by provider type. For example, hospitals can receive both Medicare and Medicaid incentive payments in the same year but professionals cannot. Hospitals must meet a 10% Medicaid patient volume threshold; the corresponding threshold for professionals is 30%. There are additional restrictions for individual provider types. For example, physician assistants can qualify for an incentive payment only if they practice at an FQHC. HSD has tracked the number of eligible and participating providers, by provider type, since the program opened to Medicaid providers in 2011. In 2011, 628 eligible professionals and 25 eligible hospitals attested to adopting, implementing or upgrading a certified		

Measure	Measure Name	Definition	Evaluation Methodology	
		EHR and qualified for an initial incentive payment. In 2012, an additional 5 hospitals and 690 professionals made this attestation. At the same time, 5 of the original attesting hospitals from 2011, and 245 of the original attesting professionals met the meaningful use standard and qualified for a second incentive payment. The measure examines the cumulative number and percentage of eligible providers (hospitals and professionals) who have qualified for an initial incentive payment through adoption, implementation or upgrading of certified EHR technology. The measure also examines the number and percentage who have qualified for a meaningful use incentive payment in a calendar year.		
108	Percentage of claims paid accurately	HSD requires MCOs to track and report the percentage of provider claims paid accurately, based on a quarterly MCO audit of a random sample of claims. A high inaccurate percentage can be an indication of claims management issues, including but not limited to: incorrect pricing of claims, payment of duplicate claims and/or payment for non-covered charges. HSD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. For the baseline calculation, HSD furnished Deloitte with quarterly audit reports submitted by the four MCOs. The reports covered the 12 months of CY 2014. Deloitte combined the four plans' total paid claim counts, by claim type, to establish claim type-specific denominators. Deloitte then combined the claims without errors, by claim type, to establish claim type-specific numerators. Deloitte performed the same exercise across all claim types to establish an aggregate denominator and numerator.

Measure	Measure Name	Definition	Evaluation Methodology	
		• Outpatient hospital • Professional • Behavioral health • Nursing Facility • Indian Health Service/Tribal/Urban Indian (I/T/U) • Medicare crossover • Home- and Community-Based Services (HCBS) • Dental • Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) MCOs select at least one hundred paid claims, by claim type, on a quarterly basis. The claims are audited both for dollar accuracy and procedural accuracy. Dollar errors are classified either as overpayments or underpayments. MCOs report the total dollars paid and the total amount of overpayments and underpayments. The overpayment and underpayment amounts are combined to establish a total inaccurate dollar amount by claim type and for all audited claims in aggregate[164]. The measure examines percentage of provider claims paid correctly (no overpayment or underpayment) out of the total audited claims.	DY2	For DY2 HSD supplied Deloitte with claim accuracy rates from each MCO by claim type. These rates did not include underlying claim counts, so the DY2 aggregate rate was calculated as a straight average of MCO rates instead of a weighted average. No aggregate accuracy rate for all types of claims was available. The variations in calculation methodologies should be noted year-to-year when comparing results.

[164] Both values are treated as positive numbers. For example, an underpayment of $100 on a first claim and an overpayment of $50 on a second claim should be combined and reported as a $150 total error amount.

Measure	Measure Name	Definition	Evaluation Methodology	
109	PCMH Membership and Hospital/ER Utilization (Use and Outcomes of Payment Reforms)	The PCMH Membership and Hospital/ER Utilization measure provides key metrics pertaining to members attributed to a PCMH as well as the impact on key member outcome metrics. This information serves as a proxy for payment reform initiatives as the PCMH model undergoes various levels of credentialing by the NCQA.	DY1 to DY2	HSD provided Deloitte with MCO reports containing membership attributed to a PCMH as well as key ER and hospital admission utilization metrics. The calendar year totals were summed across MCOs and the ER and hospital admission metrics were compared to PCMH membership in each respective year.

B. Data Sources

The following table identifies the data sources used to support measure development and analysis. The table is structured by measure, but some measures were supported by information found in the same data source. Measures with gray shading were retired due to insufficient data.

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
1	Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups	MCO HEDIS reports	2013	N/A
2	Mental health services utilization	MCO HEDIS reports	2014	N/A
3	Number of telemedicine providers and telemedicine utilization	Ad hoc MCO report	2013	N/A
4	Number and percentage of people meeting nursing facility level of care (NF LOC) who are in a nursing facility	Ad hoc data provided via email from HSD	2013	N/A
5	Number and percentage who are receiving home- and community-based services (HCBS)	Ad hoc data provided via email from HSD	2013	N/A
6	Number and percentage of people with annual dental visit	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
7	Enrollment in Centennial Care as a percentage of state population	Mercer Data Dashboard and US Census Bureau residency estimates	2014	N/A
8	Number of Native Americans opting-in and opting-out of Centennial Care	Native American Opt In reports	2014	N/A
10	Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support, and recovery)	BH Clients with Respite, Familty Support, Recovery Services MMIS reports	2014	N/A
11	Number and percentage of unduplicated participants with at least one PCP visit	PCP Visits MMIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
12	Number/ratio of enrollees to participating providers	MCO reports (HSD 3)	2014	N/A
13	Percentage of primary care provider with open panels	MCO reports (HSD 3)	2014	N/A
14	Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC)	MCO reports (HSD 5)	2014	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
15	Number and percentage of Behavioral Health (BH) participants with follow-up after hospitalization of mental illness	MCO HEDIS reports	2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
16	Childhood Immunization Status	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
17	Immunization for Adolescents	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
18	Well-Child Visits in First Months of Life	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
19	Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
20	Adolescent Well Care Visits	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
21	Prenatal and Postpartum Care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
22	Frequency of Ongoing Prenatal Care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
23	Breast Cancer Screening for Women	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
24	Cervical Cancer Screening for Women	MCO HEDIS reports	2013	N/A
25	Flu Vaccinations for Adults	Flu Vaccination MMIS reports	2013	N/A
26	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	MCO HEDIS reports	2014	The NQCA State of Health Quality 2016

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
				Report (for CY 2015)
27	Geographic Access Measures	MCO reports (HSD 55)	2014	N/A
28	Number and percentage of participants with health risk assessments (HRA) completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
29	Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes	MCO reports (HSD 6)	2014	N/A
30	Number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
31	Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
32	Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes	MCO reports (HSD 6)	2014	N/A
33	Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes	MCO reports (HSD 6)	2014	N/A
34	Number and percentage of participants the MCO is unable to locate for care coordination	MCO reports (HSD 6)	2014	N/A
35	Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS)	MCO reports (HSD 7)	2014	N/A
36	Number and percentage of participants who refuse care coordination	MCO reports (HSD 6)	2014	N/A
37	EPSDT screening ratio	Centers for Medicare & Medicaid (CMS) 416 Report	2013	Federal Fiscal Year (FFY) 2015 National CMS-416 Annual EPSDT Participation Report

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
38	Annual monitoring for patients on persistent medications	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
39	Medication management for people with asthma	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
40	Asthma medication ratio	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
41	Adult BMI assessment and weight assessment for children/adolescents	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
42	Comprehensive diabetes care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
43	Ambulatory Care Sensitive (ACS) admission rates: diabetes short and long term complications, uncontrolled admission rates	Centennial Care Diabetes inpatient encounters (PQI) report and MMIS report	2013 (LT diabetes) 2014 (ST diabetes)	N/A
44	ACS admission rates for COPD or asthma in older adults; asthma in younger adults	ACS MMIS reports	2013	N/A
45	ACS admission rates for hypertension	ACS MMIS reports	2013	N/A
46	ACS admission rates for pediatric asthma	ACS MMIS reports	2013	N/A
47	Number and percentage of potentially avoidable ER visits	MCO reports (HSD 40)	2014	N/A
48	Medical assistance with smoking and tobacco use cessation	MCO CAHPS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
49	Number of critical incidents by reporting category	MCO Quarterly Reports (critical incident report)	2014	N/A
50	Antidepressant medication management	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
51	Inpatient admissions to psychiatric hospitals and RTCs	Admissions for Inpatient Psychiatric Hospitals (Claims type A and I) and RTCs MMIS reports	2013	N/A
52	Percentage of nursing facility residents who transitioned from a low nursing facility to a high nursing facility	MCO reports (HSD 8)	2014	N/A
53	Fall risk intervention	HEDIS rates calculated by Mercer	2014 (updated to reflect new data reporting)	N/A
54	Percentage of the population accessing both a behavioral health service and a PCP visit in the same year	BH-PCP Visits MMIS reports	2013	N/A
55	Percentage of population accessing an LTSS service that received a PCP visit in the same year	LTSS-PCP Visits MMIS reports	2013	N/A
56	Percentage of the population accessing an LTSS service and a behavioral health visit in the same year	LTSS and BH MMIS reports	2013	N/A
57	Percentage of the population with behavioral health needs with an ER Visit by type of ER visit	BH Population with ED Visits MMIS reports	2013	N/A
58	Percentage of the population with LTSS needs with an ER visit by type of ER visit	LTSS Population with ED Visits MMIS reports	2013	N/A
59	Percentage of the population at risk for nursing facility placement who remain in the community	MAD SFY Reports	SFY 2013	N/A
60	Number and percentage of members who accessed a behavioral health service that also accessed HCBS in the same year	BH Population with HCBS MMIS reports	2013	N/A
61	Number and percentage of members who maintain their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level	MCO ad hoc care coordination reports	2014	N/A
62	Percentage of the population accessing a behavioral health service that also received an	BH Clients with Outpatient	2013	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
	outpatient ambulatory visit in the same year	Ambulatory Visits MMIS reports		
63	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
64	Diabetes monitoring for members with diabetes and schizophrenia	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
65	Total program expenditures	CMS-64 Schedule C	STC	N/A
66	Costs per member	CMS-64 Schedule C (Cost and Member Months)	STC	N/A
67	Costs per user of services	CMS-64 Schedule C (Cost and Member Months); Cost per user of service MMIS reports	STC	N/A
68	Utilization by category of service	FIN Reports	2014	N/A
69	Hospital costs	FIN Reports	2014	N/A
70	Use of HCBS	FIN Reports	2014	N/A
71	Use of institutional care (skilled nursing facilities)	FIN Reports	2014	N/A
72	Use of mental health services	FIN Reports	2014	N/A
73	Use of substance abuse services	FIN Reports	2014	N/A
74	Use of pharmacy services	FIN Reports	2014	N/A
75	Inpatient services exceeding $50,000	FIN Reports	2014	N/A
76	Diagnostic imaging costs	FIN Reports	2014	N/A
77	Emergency department use	FIN Reports	2014	N/A
78	All cause readmissions	MMIS reports	2013	N/A
79	Inpatient mental health/substance use services	MMIS reports	2013	N/A
80	Asthma controller medication compliance (children)	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
81	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
82	Prenatal program	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
83	Treatment adherence - schizophrenia	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
84	Treatment adherence - bipolar	Finity member rewards data	2014	N/A
85	Osteoporosis management in elderly women - females aged 65+ years	Osteoporosis MMIS reports; Finity member rewards data	2013/2014	N/A
86	Annual dental visit - adult	MCO HEDIS reports; Finity member rewards data	2014/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
87	Annual dental visit - child	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
88	Number of members spending credits	Finity member rewards data	2014	N/A
88	Percentage of expedited appeals resolved within three business days	MCO reports (HSD 37)	2014	N/A
89	Percentage of grievances resolved within 30 days	MCO reports (HSD 37)	2014	N/A
90	Percentage of appeals by adjudication (upheld)	MCO reports (HSD 37)	2014	N/A
91	Percentage of appeals by adjudication (partially overturned)	MCO reports (HSD 37)	2014	N/A
92	Percentage of appeals by adjudication (overturned in full)	MCO reports (HSD 37)	2014	N/A
93	Number and percentage of calls answered within 30 seconds	MCO HEDIS reports	2013	N/A
94	Number and percentage of participants satisfied with care coordination	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
95	Rating of personal doctor	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
96	Rating of health care	MCO CAHPS reports	2013	SPH and Quality

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
				Compass benchmarks
97	How well doctors communicate	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
98	Customer service satisfaction	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
99	Rating of specialist seen most often	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
100	Percentage of clean claims adjudicated in 30/90 days	Provider Payment Timeliness Report; MCO reports (HSD 47); ad hoc MCO claims payment and activity reports	SFY 2013	N/A
101	Percentage of claims denied	Provider Payment Timeliness Report; MCO reports (HSD 47); ad hoc MCO claims payment and activity reports	SFY 2013	N/A
102	Dollar accuracy rate	MCO reports (HSD 46); ad hoc MCO claims payment and activity reports	2014	N/A
103	Percentage of grievances resolved on time	MCO reports (HSD 37)	2014	N/A
104	Percentage of provider appeals resolved on time	MCO reports (HSD 37)	2014	N/A
105	Provider satisfaction survey results	N/A	2014	N/A
106	Number of eligible providers receiving Electronic Health Record (EHR) incentive payments	Ad hoc EHR program report	2013	N/A
107	Use of different care delivery models, such as number of Health Home participants	N/A	N/A	N/A
108	Percentage of claims paid accurately	MCO reports (HSD 46); ad hoc MCO claims payment and activity reports	2014	N/A
109	PCMH Membership and Hospital/ER Utilization (Use and Outcomes of Payment Reforms)	MCO reports (HSD 48)	2014	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
110	Number and percentage of visits in compliance with Electronic Visit Verification (EVV) system requirement	N/A	N/A	N/A
111	Adoption of electronic case management/care coordination system	N/A	2014	N/A

C. Statistical Significance and Hypothesis Testing

As part of the Evaluation process, hypothesis testing was performed on measures where available data was deemed adequate and appropriate for such testing. Hypothesis tests are employed to help indicate if an observed change over time was statistically significant. These tests are often applied to HEDIS data when analyzing changes in rates over time, but can be employed on other data sets as appropriate. Although statistical significance does not prove "meaningful improvement," it does help to indicate whether improvement occurred. Furthermore, tests for statistical significance help to indicate how likely it is that intervention caused the improvement as opposed to chance.

For measures that are rates or proportions, a two-sided, pooled proportion z-test was performed to determine whether the hypothesized difference between rates is significantly different from observed sample differences. A significance level of .05 was used in these tests.

The null hypothesis in a given test was that the rate in one year was equal to the rate in the comparison year, and the null hypothesis was rejected when the calculated test statistic was less than .05.

To perform these tests, an implicit assumption was made that the rates derived from the sample populations were independent between years. In addition for HEDIS measures, rates are only aggregated across MCOs if they were reported under the same methodology (Administrative vs. Hybrid) for statistical significance testing. Refer to Appendix A for detailed calculation methodology for each measure.

Note: Cells with blue font in the below tables indicate a statistically significant change using a two-sided pooled proportion z-test

Access to Preventive/Ambulatory Health Services among Centennial Care Enrollees in Aggregate and in Subgroups (Measure 1)

	Baseline	DY1		DY2		Baseline to DY2
Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Access to preventive/ambulatory health services (20-44 Yrs)	84.5%	79.9%	-5.5%	75.8%	-5.2%	-10.4%
Access to preventive/ambulatory health services (45-64 Yrs)	87.3%	85.8%	-1.7%	81.2%	-5.4%	-7.0%
Access to preventive/ambulatory health services (65+ Yrs)	90.0%	88.4%	-1.8%	87.4%	-1.1%	-2.8%
Access to preventive/ambulatory health services (Total)	85.3%	81.9%	-3.9%	77.7%	-5.1%	-8.8%
Molina Healthcare of New Mexico, Inc.						
Access to preventive/ambulatory health services (20-44 Yrs)	82.2%	76.3%	-7.2%	73.6%	-3.5%	-10.4%
Access to preventive/ambulatory health services (45-64 Yrs)	86.4%	84.8%	-1.9%	81.9%	-3.4%	-5.2%
Access to preventive/ambulatory health services (65+ Yrs)	91.4%	86.8%	-5.0%	39.8%	-54.1%	-56.4%
Access to preventive/ambulatory health services (Total)	83.5%	79.5%	-4.8%	76.1%	-4.3%	-8.8%
Blue Cross and Blue Shield of New Mexico						
Access to preventive/ambulatory health services (20-44 Yrs)	81.0%	71.9%	-11.3%	72.4%	0.6%	-10.7%
Access to preventive/ambulatory health services (45-64 Yrs)	86.1%	82.2%	-4.5%	81.6%	-0.7%	-5.2%
Access to preventive/ambulatory health services (65+ Yrs)	NR	85.9%	N/A	89.6%	4.4%	N/A
Access to preventive/ambulatory health services (Total)	82.5%	76.6%	-7.1%	76.4%	-0.3%	-7.4%
United Healthcare of New Mexico, Inc.						
Access to preventive/ambulatory health services (20-44 Yrs)	96.2%	78.7%	-18.1%	75.3%	-4.3%	-21.7%
Access to preventive/ambulatory health services (45-64 Yrs)	99.1%	90.8%	-8.3%	88.0%	-3.1%	-11.1%
Access to preventive/ambulatory health services (65+ Yrs)	97.2%	96.3%	-0.9%	96.9%	0.6%	-0.3%
Access to preventive/ambulatory health services (Total)	98.2%	87.2%	-11.2%	83.5%	-4.3%	-15.0%
Total						
Access to preventive/ambulatory health services (20-44 Yrs)	83.9%	77.3%	-7.8%	74.2%	-4.0%	-11.5%
Access to preventive/ambulatory health services (45-64 Yrs)	89.0%	86.1%	-3.3%	83.0%	-3.6%	-6.8%
Access to preventive/ambulatory health services (65+ Yrs)	93.8%	91.9%	-2.0%	91.4%	-0.6%	-2.6%
Access to preventive/ambulatory health services (Total)	85.5%	81.4%	-4.8%	78.1%	-4.1%	-8.7%

Mental Health Services Utilization (Measure 2)

	DY1	DY2	
Mental health services utilization	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan			
Mental Health Utilization (0-12 Yrs, Male)	12.2%	11.6%	-4.4%
Mental Health Utilization (0-12 Yrs, Female)	8.9%	8.7%	-2.1%
Mental Health Utilization (0-12 Yrs, Total)	10.6%	10.2%	-3.4%
Mental Health Utilization (13-17 Yrs, Male)	18.0%	17.1%	-5.0%
Mental Health Utilization (13-17 Yrs, Female)	19.4%	19.1%	-1.4%
Mental Health Utilization (13-17 Yrs, Total)	18.7%	18.1%	-3.2%
Mental Health Utilization (18-64 Yrs, Male)	16.0%	14.4%	-9.9%
Mental Health Utilization (18-64 Yrs, Female)	16.5%	16.9%	2.0%
Mental Health Utilization (18-64 Yrs, Total)	16.3%	15.9%	-2.5%
Mental Health Utilization (65+ Yrs, Male)	7.9%	8.6%	8.9%
Mental Health Utilization (65+ Yrs, Female)	10.2%	12.0%	17.7%
Mental Health Utilization (65+ Yrs, Total)	9.4%	10.8%	15.0%
Mental Health Utilization (Total, Male)	14.3%	13.5%	-5.4%
Mental Health Utilization (Total, Female)	13.8%	14.1%	2.3%
Mental Health Utilization (Grand Total)	14.0%	13.8%	-1.2%
Molina Healthcare of New Mexico, Inc.			
Mental Health Utilization (0-12 Yrs, Male)	9.9%	9.7%	-2.9%
Mental Health Utilization (0-12 Yrs, Female)	7.3%	7.4%	1.6%
Mental Health Utilization (0-12 Yrs, Total)	8.7%	8.6%	-1.0%
Mental Health Utilization (13-17 Yrs, Male)	16.5%	16.5%	0.4%
Mental Health Utilization (13-17 Yrs, Female)	18.1%	17.9%	-1.3%
Mental Health Utilization (13-17 Yrs, Total)	17.3%	17.2%	-0.5%
Mental Health Utilization (18-64 Yrs, Male)	14.6%	14.2%	-3.0%
Mental Health Utilization (18-64 Yrs, Female)	15.1%	16.2%	7.4%
Mental Health Utilization (18-64 Yrs, Total)	14.9%	15.4%	3.1%
Mental Health Utilization (65+ Yrs, Male)	8.8%	8.9%	0.9%
Mental Health Utilization (65+ Yrs, Female)	11.3%	10.1%	-10.5%
Mental Health Utilization (65+ Yrs, Total)	10.4%	9.6%	-7.1%
Mental Health Utilization (Total, Male)	12.5%	12.5%	-0.6%
Mental Health Utilization (Total, Female)	12.4%	13.1%	5.7%
Mental Health Utilization (Grand Total)	12.5%	12.8%	2.8%
Blue Cross and Blue Shield of New Mexico			
Mental Health Utilization (0-12 Yrs, Male)	10.9%	8.9%	-18.3%
Mental Health Utilization (0-12 Yrs, Female)	7.8%	6.6%	-15.7%
Mental Health Utilization (0-12 Yrs, Total)	9.4%	7.8%	-17.2%
Mental Health Utilization (13-17 Yrs, Male)	18.2%	15.5%	-15.2%
Mental Health Utilization (13-17 Yrs, Female)	20.9%	17.6%	-16.0%
Mental Health Utilization (13-17 Yrs, Total)	19.5%	16.5%	-15.5%
Mental Health Utilization (18-64 Yrs, Male)	18.1%	15.4%	-14.9%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	17.5%	-9.2%
Mental Health Utilization (18-64 Yrs, Total)	18.7%	16.5%	-11.9%
Mental Health Utilization (65+ Yrs, Male)	15.3%	12.8%	-16.2%
Mental Health Utilization (65+ Yrs, Female)	18.4%	15.4%	-16.3%
Mental Health Utilization (65+ Yrs, Total)	17.2%	14.4%	-16.2%
Mental Health Utilization (Total, Male)	15.6%	13.3%	-14.6%
Mental Health Utilization (Total, Female)	16.0%	14.4%	-10.1%
Mental Health Utilization (Grand Total)	15.8%	13.9%	-12.3%

Mental Health Services Utilization (Continued)

Mental health services utilization	DY1 Rate, p_1	DY2 Rate, p_2	DY2 Change (p_2/p_1-1)
United Healthcare of New Mexico, Inc.			
Mental Health Utilization (0-12 Yrs, Male)	9.6%	8.2%	-14.1%
Mental Health Utilization (0-12 Yrs, Female)	6.9%	5.6%	-17.8%
Mental Health Utilization (0-12 Yrs, Total)	8.3%	7.0%	-15.4%
Mental Health Utilization (13-17 Yrs, Male)	17.6%	15.6%	-11.7%
Mental Health Utilization (13-17 Yrs, Female)	18.4%	17.0%	-7.5%
Mental Health Utilization (13-17 Yrs, Total)	18.0%	16.3%	-9.5%
Mental Health Utilization (18-64 Yrs, Male)	17.5%	16.8%	-3.8%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	19.1%	-1.0%
Mental Health Utilization (18-64 Yrs, Total)	18.5%	18.0%	-2.5%
Mental Health Utilization (65+ Yrs, Male)	10.3%	9.4%	-9.1%
Mental Health Utilization (65+ Yrs, Female)	11.6%	11.0%	-5.0%
Mental Health Utilization (65+ Yrs, Total)	11.2%	10.5%	-6.2%
Mental Health Utilization (Total, Male)	15.6%	14.7%	-5.8%
Mental Health Utilization (Total, Female)	16.4%	15.9%	-3.2%
Mental Health Utilization (Grand Total)	16.0%	15.3%	-4.5%

Total			
Mental Health Utilization (0-12 Yrs, Male)	11.0%	10.2%	-6.9%
Mental Health Utilization (0-12 Yrs, Female)	8.0%	7.7%	-4.1%
Mental Health Utilization (0-12 Yrs, Total)	9.5%	9.0%	-5.7%
Mental Health Utilization (13-17 Yrs, Male)	17.4%	16.6%	-4.8%
Mental Health Utilization (13-17 Yrs, Female)	19.0%	18.3%	-3.6%
Mental Health Utilization (13-17 Yrs, Total)	18.2%	17.5%	-4.1%
Mental Health Utilization (18-64 Yrs, Male)	16.3%	15.1%	-7.5%
Mental Health Utilization (18-64 Yrs, Female)	16.9%	17.2%	1.4%
Mental Health Utilization (18-64 Yrs, Total)	16.7%	16.3%	-2.4%
Mental Health Utilization (65+ Yrs, Male)	10.4%	10.0%	-3.6%
Mental Health Utilization (65+ Yrs, Female)	12.3%	12.1%	-1.5%
Mental Health Utilization (65+ Yrs, Total)	11.7%	11.4%	-2.1%
Mental Health Utilization (Total, Male)	14.0%	13.3%	-5.2%
Mental Health Utilization (Total, Female)	13.9%	14.1%	1.1%
Mental Health Utilization (Grand Total)	13.9%	13.7%	-1.8%

Number and percentage of people with an annual dental visit (Measure 6)[165]

	Baseline	DY1		DY2		Baseline to DY2
Annual dental visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	-4.8%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	-4.5%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	-5.3%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	-4.8%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	-4.3%
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	-6.9%
Annual Dental Visit (Total)	71.0%	68.1%	-4.1%	66.4%	-2.5%	-6.5%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	4.1%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	0.7%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	-0.8%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	0.6%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	1.7%
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	-5.2%
Annual Dental Visit (Total)	70.9%	62.7%	-11.5%	70.1%	11.7%	-1.2%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	-13.6%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	-11.1%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	-9.8%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	-6.8%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	-6.6%
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	-9.7%
Annual Dental Visit (Total)	66.8%	57.5%	-14.0%	59.6%	3.8%	-10.7%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	N/A
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	N/A
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	N/A
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	N/A
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	N/A
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	N/A
Annual Dental Visit (Total)	51.5%	41.5%	-19.4%	49.9%	20.1%	-3.2%
Total						
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	-4.0%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	-4.7%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	-5.2%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	-4.3%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	-4.3%
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	-9.0%
Annual Dental Visit (Total)	70.6%	64.0%	-9.3%	66.0%	3.1%	-6.5%

Enrollment in Centennial Care as a Percentage of State Population (Measure 7)

	DY1	DY2		DY3		DY1 to DY3
Enrollment in Centennial Care as a Percentage of State Population	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Enrollment in Centennial Care as a Percentage of State Population	27.3%	31.0%	13.3%	32.7%	5.6%	19.6%

[165] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Number and percentage of participants with BH conditions who accessed any of the three new BH services (BH respite, family support and recovery) (Measure 10)

	DY1		DY2		DY1 to DY3
Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support and recovery)	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_3/p_1-1)**
Total					
Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support and recovery)	1.02%	N/A	1.10%	7.82%	16.90%

Number and percentage of Unduplicated Participants with at Least One PCP Visit (Measure 11)

	Baseline	DY1		DY2		DY3		Baseline to DY3
Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Change (p_2/p_0-1)**
Total								
Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups	65.5%	57.6%	-12.1%	50.4%	-12.6%	47.4%	-5.8%	-27.7%

Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC (Measure 14)

	DY1		DY2	
Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	43.0%	N/A	27.1%	-37.0%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	64.7%	N/A	47.7%	-26.3%
Molina Healthcare of New Mexico, Inc.				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	13.6%	N/A	24.9%	82.8%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	22.0%	N/A	41.0%	86.3%
Blue Cross and Blue Shield of New Mexico				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	13.8%	N/A	11.5%	-16.7%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	30.3%	N/A	28.7%	-5.3%
United Healthcare of New Mexico, Inc.				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	NR	N/A	58.1%	N/A
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	NR	N/A	74.2%	N/A
Total				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	26.5%	N/A	25.7%	-3.1%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	43.2%	N/A	44.0%	1.9%

Follow-up after Hospitalization of Mental Illness (Measure 15)[166]

	DY1	DY2	
Number and percentage of BH participants with follow-up after hospitalization of mental illness	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan			
Follow-Up After Hospitalization for Mental Illness (30-day)	67.9%	59.7%	-12.0%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.1%	32.6%	-24.5%
Molina Healthcare of New Mexico, Inc.			
Follow-Up After Hospitalization for Mental Illness (30-day)	64.8%	59.8%	-7.8%
Follow-Up After Hospitalization for Mental Illness (7-day)	41.8%	34.6%	-17.1%
Blue Cross and Blue Shield of New Mexico			
Follow-Up After Hospitalization for Mental Illness (30-day)	58.5%	55.1%	-5.8%
Follow-Up After Hospitalization for Mental Illness (7-day)	39.0%	34.3%	-12.1%
United Healthcare of New Mexico, Inc.			
Follow-Up After Hospitalization for Mental Illness (30-day)	71.0%	73.1%	2.9%
Follow-Up After Hospitalization for Mental Illness (7-day)	55.2%	55.0%	-0.4%
Total			
Follow-Up After Hospitalization for Mental Illness (30-day)	65.3%	60.9%	-6.9%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.8%	37.6%	-14.2%

[166] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Childhood Immunization Status (Measure 16)

	Baseline	DY1		DY2		Baseline to DY2
Childhood Immunization Status	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Childhood Immunization Status (DTaP)	77.3%	79.2%	2.4%	75.9%	-4.1%	-1.8%
Childhood Immunization Status (IPV)	88.0%	88.0%	0.0%	87.3%	-0.8%	-0.8%
Childhood Immunization Status (MMR)	87.5%	91.2%	4.2%	85.2%	-6.6%	-2.6%
Childhood Immunization Status (HiB)	90.0%	90.3%	0.3%	87.3%	-3.3%	-3.1%
Childhood Immunization Status (Hepatitis B)	79.2%	81.3%	2.6%	83.8%	3.1%	5.8%
Childhood Immunization Status (VZV)	88.0%	90.5%	2.9%	85.0%	-6.1%	-3.4%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.6%	78.0%	-3.2%	76.4%	-2.1%	-5.2%
Childhood Immunization Status (Hepatitis A)	86.1%	87.3%	1.3%	84.5%	-3.2%	-1.9%
Childhood Immunization Status (Rotavirus)	73.1%	75.5%	3.2%	75.9%	0.6%	3.8%
Childhood Immunization Status (Influenza)	57.2%	53.9%	-5.7%	52.1%	-3.4%	-8.9%
Childhood Immunization Status (Combination 2)	67.4%	69.4%	3.1%	69.7%	0.3%	3.4%
Childhood Immunization Status (Combination 3)	66.0%	64.6%	-2.1%	66.4%	2.9%	0.7%
Childhood Immunization Status (Combination 4)	63.0%	61.8%	-1.8%	65.0%	5.2%	3.3%
Childhood Immunization Status (Combination 5)	57.6%	56.5%	-2.0%	59.7%	5.7%	3.6%
Childhood Immunization Status (Combination 6)	44.4%	39.1%	-12.0%	44.0%	12.4%	-1.0%
Childhood Immunization Status (Combination 7)	55.8%	54.4%	-2.5%	58.3%	7.2%	4.6%
Childhood Immunization Status (Combination 8)	43.1%	38.2%	-11.3%	43.5%	13.9%	1.1%
Childhood Immunization Status (Combination 9)	39.4%	35.2%	-10.6%	39.4%	11.8%	0.0%
Childhood Immunization Status (Combination 10)	38.7%	34.5%	-10.8%	38.9%	12.8%	0.6%
Molina Healthcare of New Mexico, Inc.						
Childhood Immunization Status (DTaP)	81.9%	83.0%	1.3%	70.6%	-14.9%	-13.7%
Childhood Immunization Status (IPV)	92.5%	93.2%	0.7%	84.8%	-9.0%	-8.4%
Childhood Immunization Status (MMR)	92.1%	93.4%	1.4%	87.2%	-6.6%	-5.3%
Childhood Immunization Status (HiB)	92.3%	93.2%	1.0%	83.9%	-10.0%	-9.1%
Childhood Immunization Status (Hepatitis B)	92.1%	92.9%	1.0%	84.8%	-8.8%	-7.9%
Childhood Immunization Status (VZV)	92.3%	92.9%	0.7%	86.3%	-7.1%	-6.5%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.1%	82.6%	3.0%	71.5%	-13.4%	-10.7%
Childhood Immunization Status (Hepatitis A)	87.9%	89.6%	2.0%	83.4%	-6.9%	-5.0%
Childhood Immunization Status (Rotavirus)	72.6%	76.4%	5.2%	67.8%	-11.3%	-6.7%
Childhood Immunization Status (Influenza)	53.6%	54.5%	1.6%	41.9%	-23.1%	-21.8%
Childhood Immunization Status (Combination 2)	78.6%	80.8%	2.8%	67.1%	-16.9%	-14.6%
Childhood Immunization Status (Combination 3)	73.3%	77.7%	6.0%	64.7%	-16.8%	-11.7%
Childhood Immunization Status (Combination 4)	71.1%	75.1%	5.6%	62.0%	-17.4%	-12.7%
Childhood Immunization Status (Combination 5)	59.6%	66.4%	11.5%	57.8%	-13.0%	-3.0%
Childhood Immunization Status (Combination 6)	46.1%	50.3%	9.1%	35.3%	-29.8%	-23.4%
Childhood Immunization Status (Combination 7)	57.8%	64.2%	11.1%	55.4%	-13.7%	-4.2%
Childhood Immunization Status (Combination 8)	45.5%	49.4%	8.7%	34.7%	-29.9%	-23.8%
Childhood Immunization Status (Combination 9)	40.4%	45.7%	13.1%	32.7%	-28.5%	-19.1%
Childhood Immunization Status (Combination 10)	39.7%	44.8%	12.8%	32.0%	-28.6%	-19.4%

Childhood Immunization Status (Continued)

	Baseline	DY1		DY2		Baseline to DY2
Childhood Immunization Status	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Blue Cross and Blue Shield of New Mexico						
Childhood Immunization Status (DTaP)	81.8%	80.6%	-1.5%	72.6%	-9.9%	-11.2%
Childhood Immunization Status (IPV)	92.2%	92.7%	0.5%	86.3%	-6.9%	-6.4%
Childhood Immunization Status (MMR)	91.8%	90.5%	-1.4%	87.0%	-3.9%	-5.3%
Childhood Immunization Status (HiB)	92.0%	92.9%	1.0%	85.0%	-8.6%	-7.6%
Childhood Immunization Status (Hepatitis B)	91.4%	92.7%	1.5%	87.2%	-6.0%	-4.5%
Childhood Immunization Status (VZV)	92.7%	90.1%	-2.8%	87.0%	-3.4%	-6.2%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.0%	80.8%	0.9%	74.0%	-8.5%	-7.6%
Childhood Immunization Status (Hepatitis A)	87.1%	88.5%	1.6%	83.9%	-5.2%	-3.7%
Childhood Immunization Status (Rotavirus)	74.1%	74.8%	1.0%	68.7%	-8.3%	-7.3%
Childhood Immunization Status (Influenza)	52.8%	51.4%	-2.5%	52.8%	2.6%	0.0%
Childhood Immunization Status (Combination 2)	78.3%	76.8%	-1.9%	70.9%	-7.8%	-9.5%
Childhood Immunization Status (Combination 3)	73.8%	74.4%	0.8%	67.8%	-8.9%	-8.2%
Childhood Immunization Status (Combination 4)	71.8%	73.1%	1.7%	65.8%	-10.0%	-8.4%
Childhood Immunization Status (Combination 5)	62.3%	63.4%	1.7%	57.4%	-9.4%	-7.9%
Childhood Immunization Status (Combination 6)	45.9%	45.7%	-0.4%	45.9%	0.5%	0.0%
Childhood Immunization Status (Combination 7)	61.4%	62.7%	2.1%	55.6%	-11.3%	-9.4%
Childhood Immunization Status (Combination 8)	45.0%	45.7%	1.5%	44.4%	-2.9%	-1.4%
Childhood Immunization Status (Combination 9)	39.9%	40.4%	1.2%	39.1%	-3.3%	-2.1%
Childhood Immunization Status (Combination 10)	39.2%	40.4%	2.9%	37.7%	-6.6%	-3.8%
United Healthcare of New Mexico, Inc.						
Childhood Immunization Status (DTaP)	NR	65.7%	N/A	51.3%	-21.9%	N/A
Childhood Immunization Status (IPV)	NR	74.3%	N/A	62.5%	-15.8%	N/A
Childhood Immunization Status (MMR)	NR	80.0%	N/A	71.8%	-10.3%	N/A
Childhood Immunization Status (HiB)	NR	75.7%	N/A	64.7%	-14.5%	N/A
Childhood Immunization Status (Hepatitis B)	NR	74.3%	N/A	60.8%	-18.1%	N/A
Childhood Immunization Status (VZV)	NR	80.0%	N/A	71.3%	-10.9%	N/A
Childhood Immunization Status (Pneumo- coccal Conjugate)	NR	67.1%	N/A	50.1%	-25.4%	N/A
Childhood Immunization Status (Hepatitis A)	NR	75.7%	N/A	72.5%	-4.2%	N/A
Childhood Immunization Status (Rotavirus)	NR	64.3%	N/A	44.3%	-31.1%	N/A
Childhood Immunization Status (Influenza)	NR	41.4%	N/A	34.8%	-16.0%	N/A
Childhood Immunization Status (Combination 2)	NR	60.0%	N/A	47.0%	-21.7%	N/A
Childhood Immunization Status (Combination 3)	NR	58.6%	N/A	43.6%	-25.6%	N/A
Childhood Immunization Status (Combination 4)	NR	55.7%	N/A	43.1%	-22.7%	N/A
Childhood Immunization Status (Combination 5)	NR	51.4%	N/A	34.3%	-33.3%	N/A
Childhood Immunization Status (Combination 6)	NR	31.4%	N/A	26.0%	-17.2%	N/A
Childhood Immunization Status (Combination 7)	NR	48.6%	N/A	33.8%	-30.4%	N/A
Childhood Immunization Status (Combination 8)	NR	31.4%	N/A	26.0%	-17.2%	N/A
Childhood Immunization Status (Combination 9)	NR	25.7%	N/A	22.4%	-12.9%	N/A
Childhood Immunization Status (Combination 10)	NR	25.7%	N/A	22.4%	-12.9%	N/A

Childhood Immunization Status (Continued)

Childhood Immunization Status	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Total						
Childhood Immunization Status (DTaP)	80.4%	80.2%	-0.3%	67.9%	-15.3%	-15.5%
Childhood Immunization Status (IPV)	90.9%	90.5%	-0.5%	80.6%	-11.0%	-11.4%
Childhood Immunization Status (MMR)	90.5%	91.1%	0.7%	83.0%	-8.9%	-8.3%
Childhood Immunization Status (HiB)	91.5%	91.3%	-0.1%	80.5%	-11.9%	-12.0%
Childhood Immunization Status (Hepatitis B)	87.6%	88.4%	0.8%	79.5%	-10.0%	-9.3%
Childhood Immunization Status (VZV)	91.0%	90.6%	-0.4%	82.6%	-8.8%	-9.2%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.2%	79.8%	-0.5%	68.3%	-14.4%	-14.8%
Childhood Immunization Status (Hepatitis A)	87.1%	87.9%	0.9%	81.2%	-7.5%	-6.7%
Childhood Immunization Status (Rotavirus)	73.3%	75.0%	2.3%	64.5%	-14.0%	-12.0%
Childhood Immunization Status (Influenza)	54.5%	52.7%	-3.3%	45.6%	-13.5%	-16.4%
Childhood Immunization Status (Combination 2)	74.9%	75.0%	0.2%	64.0%	-14.7%	-14.5%
Childhood Immunization Status (Combination 3)	71.1%	71.7%	0.8%	60.9%	-14.9%	-14.3%
Childhood Immunization Status (Combination 4)	68.7%	69.4%	1.0%	59.3%	-14.6%	-13.7%
Childhood Immunization Status (Combination 5)	59.9%	61.6%	3.0%	52.7%	-14.6%	-12.1%
Childhood Immunization Status (Combination 6)	45.5%	44.5%	-2.3%	38.0%	-14.5%	-16.5%
Childhood Immunization Status (Combination 7)	58.4%	59.9%	2.7%	51.1%	-14.7%	-12.4%
Childhood Immunization Status (Combination 8)	44.5%	43.9%	-1.4%	37.3%	-14.9%	-16.2%
Childhood Immunization Status (Combination 9)	39.9%	39.8%	-0.3%	33.6%	-15.6%	-15.9%
Childhood Immunization Status (Combination 10)	39.2%	39.3%	0.1%	32.9%	-16.1%	-16.0%

Immunizations for Adolescents (Measure 17)[167]

Immunizations for Adolescents	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Immunizations for Adolescents (Meningococcal)	67.8%	67.1%	-1.1%	60.4%	-10.0%	-10.9%
Immunizations for Adolescents (Tdap/Td)	78.9%	78.7%	-0.3%	73.9%	-6.1%	-6.3%
Immunizations for Adolescents (Combination 1)	63.4%	64.9%	2.2%	58.9%	-9.2%	-7.1%
Molina Healthcare of New Mexico, Inc.						
Immunizations for Adolescents (Meningococcal)	62.3%	63.9%	2.6%	76.2%	19.2%	22.3%
Immunizations for Adolescents (Tdap/Td)	78.5%	75.9%	-3.3%	85.4%	12.6%	8.9%
Immunizations for Adolescents (Combination 1)	60.2%	61.1%	1.6%	73.8%	20.8%	22.7%
Blue Cross and Blue Shield of New Mexico						
Immunizations for Adolescents (Meningococcal)	NR	39.1%	N/A	39.2%	0.2%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	42.2%	N/A	43.5%	3.2%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.9%	N/A	34.6%	2.0%	N/A
United Healthcare of New Mexico, Inc.						
Immunizations for Adolescents (Meningococcal)	NR	33.3%	N/A	43.6%	30.7%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	53.3%	N/A	49.4%	-7.4%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.3%	N/A	40.6%	21.9%	N/A
Total						
Immunizations for Adolescents (Meningococcal)	65.1%	64.3%	-1.2%	60.3%	-6.3%	-7.3%
Immunizations for Adolescents (Tdap/Td)	78.5%	76.4%	-2.7%	69.8%	-8.6%	-11.1%
Immunizations for Adolescents (Combination 1)	61.6%	61.9%	0.5%	58.1%	-6.2%	-5.8%

[167] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Well-Child Visits in the First 15 Months of Life (Measure 18)[168]

	Baseline	DY1		DY2		Baseline to DY2
Well-child visits in first 15 months of life	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	63.4%	46.5%	-26.6%	48.3%	3.7%	-23.9%
Molina Healthcare of New Mexico, Inc.						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.5%	51.8%	-17.2%	55.4%	7.1%	-11.3%
Blue Cross and Blue Shield of New Mexico						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.3%	44.3%	-28.8%	47.9%	8.0%	-23.0%
United Healthcare of New Mexico, Inc.						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	NR	NR	N/A	56.9%	N/A	N/A
Total						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.7%	46.1%	-26.5%	56.1%	21.7%	-10.5%

[168] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life (Measure 19)[169]

	Baseline	DY1		DY2		Baseline to DY2
Well-child visits in third, fourth, fifth and sixth years of life	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Well-child visits in third, fourth, fifth and sixth years of life	66.7%	54.9%	-17.6%	54.8%	-0.2%	-17.8%
Molina Healthcare of New Mexico, Inc.						
Well-child visits in third, fourth, fifth and sixth years of life	66.5%	63.6%	-4.4%	68.8%	8.2%	3.5%
Blue Cross and Blue Shield of New Mexico						
Well-child visits in third, fourth, fifth and sixth years of life	60.2%	56.6%	-5.9%	57.6%	1.7%	-4.3%
United Healthcare of New Mexico, Inc.						
Well-child visits in third, fourth, fifth and sixth years of life	NR	65.9%	N/A	52.6%	-20.3%	N/A
Total						
Well-child visits in third, fourth, fifth and sixth years of life	64.3%	64.8%	0.7%	60.8%	-6.1%	-5.5%

Adolescent Well Care Visits (Measure 20)[170]

	Baseline	DY1		DY2		Baseline to DY2
Adolescent well care visits	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Adolescent well care visits	48.1%	36.4%	-24.5%	32.3%	-11.3%	-33.0%
Molina Healthcare of New Mexico, Inc.						
Adolescent well care visits	50.8%	51.7%	1.7%	45.9%	-11.1%	-9.6%
Blue Cross and Blue Shield of New Mexico						
Adolescent well care visits	39.0%	36.3%	-6.8%	33.1%	-8.9%	-15.2%
United Healthcare of New Mexico, Inc.						
Adolescent well care visits	NR	31.1%	N/A	37.2%	19.5%	N/A
Total						
Adolescent well care visits	49.7%	41.9%	-15.6%	41.8%	-0.3%	-15.9%

[169] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[170] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Prenatal and Postpartum Care (Measure 21)[171]

	Baseline	DY1		DY2		Baseline to DY2
Prenatal and Postpartum Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Postpartum Care	57.9%	61.9%	6.9%	53.1%	-14.1%	-8.2%
Timeliness of Prenatal Care	80.0%	77.9%	-2.7%	66.4%	-14.8%	-17.1%
Molina Healthcare of New Mexico, Inc.						
Postpartum Care	62.9%	54.5%	-13.4%	51.5%	-5.5%	-18.1%
Timeliness of Prenatal Care	89.2%	76.8%	-13.9%	76.0%	-1.1%	-14.8%
Blue Cross and Blue Shield of New Mexico						
Postpartum Care	63.1%	54.5%	-13.5%	57.9%	6.2%	-8.2%
Timeliness of Prenatal Care	86.1%	73.1%	-15.1%	72.6%	-0.6%	-15.6%
United Healthcare of New Mexico, Inc.						
Postpartum Care	NR	48.2%	N/A	41.4%	-14.1%	N/A
Timeliness of Prenatal Care	NR	63.7%	N/A	67.4%	5.7%	N/A
Total						
Postpartum Care	61.3%	54.8%	-10.5%	51.2%	-6.7%	-16.5%
Timeliness of Prenatal Care	84.8%	73.0%	-13.9%	70.7%	-3.2%	-16.6%

[171] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Frequency of Ongoing Prenatal Care (Measure 22)[172]

	Baseline	DY1		DY2		Baseline to DY2
Frequency of Prenatal Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Frequency of Ongoing Prenatal Care (<21%)	9.3%	13.6%	47.4%	21.3%	56.4%	130.5%
Frequency of Ongoing Prenatal Care (21-40%)	10.6%	12.5%	17.1%	10.9%	-12.6%	2.4%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	12.7%	37.2%	10.7%	-16.0%	15.3%
Frequency of Ongoing Prenatal Care (61-80%)	13.9%	12.5%	-10.2%	14.2%	13.5%	1.9%
Frequency of Ongoing Prenatal Care (>= 81%)	56.9%	48.7%	-14.5%	42.9%	-11.9%	-24.6%
Molina Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	4.0%	9.0%	124.2%	7.6%	-16.2%	87.9%
Frequency of Ongoing Prenatal Care (21-40%)	3.5%	7.7%	115.9%	7.8%	1.6%	119.4%
Frequency of Ongoing Prenatal Care (41-60%)	5.7%	8.3%	46.9%	10.3%	23.6%	81.5%
Frequency of Ongoing Prenatal Care (61-80%)	13.5%	14.0%	3.6%	19.0%	36.0%	40.9%
Frequency of Ongoing Prenatal Care (>= 81%)	73.3%	61.0%	-16.7%	55.4%	-9.3%	-24.4%
Blue Cross and Blue Shield of New Mexico						
Frequency of Ongoing Prenatal Care (<21%)	7.7%	16.1%	107.4%	11.6%	-27.9%	49.6%
Frequency of Ongoing Prenatal Care (21-40%)	6.0%	7.7%	28.8%	10.7%	39.0%	79.0%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	6.6%	-29.4%	11.1%	69.7%	19.8%
Frequency of Ongoing Prenatal Care (61-80%)	16.2%	14.5%	-10.3%	16.0%	10.7%	-0.7%
Frequency of Ongoing Prenatal Care (>= 81%)	60.8%	55.2%	-9.3%	50.6%	-8.4%	-16.9%
United Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	NR	20.7%	N/A	20.4%	-1.2%	N/A
Frequency of Ongoing Prenatal Care (21-40%)	NR	12.2%	N/A	23.1%	90.0%	N/A
Frequency of Ongoing Prenatal Care (41-60%)	NR	11.2%	N/A	10.5%	-6.5%	N/A
Frequency of Ongoing Prenatal Care (61-80%)	NR	13.4%	N/A	11.9%	-10.9%	N/A
Frequency of Ongoing Prenatal Care (>= 81%)	NR	42.6%	N/A	34.1%	-20.0%	N/A
Total						
Frequency of Ongoing Prenatal Care (<21%)	7.4%	14.8%	100.1%	15.1%	2.4%	104.9%
Frequency of Ongoing Prenatal Care (21-40%)	6.8%	9.9%	45.2%	13.0%	30.5%	89.5%
Frequency of Ongoing Prenatal Care (41-60%)	8.1%	9.6%	19.7%	10.6%	10.5%	32.2%
Frequency of Ongoing Prenatal Care (61-80%)	14.5%	13.6%	-6.4%	15.3%	12.9%	5.7%
Frequency of Ongoing Prenatal Care (>= 81%)	63.2%	52.1%	-17.6%	45.9%	-11.8%	-27.3%

[172] UHC baseline numerators and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Breast Cancer Screening for Women (Measure 23)[173]

	Baseline	DY1		DY2		Baseline to DY2
Breast cancer screening for women	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Breast cancer screening	54.6%	49.7%	-9.0%	44.4%	-10.7%	-18.7%
Molina Healthcare of New Mexico, Inc.						
Breast cancer screening	67.0%	71.4%	6.6%	63.5%	-11.1%	-5.2%
Blue Cross and Blue Shield of New Mexico						
Breast cancer screening	51.4%	51.2%	-0.4%	54.6%	6.5%	6.1%
United Healthcare of New Mexico, Inc.						
Breast cancer screening	44.4%	36.7%	-17.3%	38.9%	6.0%	-12.4%
Total						
Breast cancer screening	54.5%	52.5%	-3.7%	50.7%	-3.3%	-6.9%

Cervical Cancer Screening for Women (Measure 24)[174]

	Baseline	DY1		DY2		Baseline to DY2
Cervical cancer screening for women	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Cervical cancer screening	65.0%	57.3%	-12.0%	56.4%	-1.5%	-13.3%
Molina Healthcare of New Mexico, Inc.						
Cervical cancer screening	66.7%	45.8%	-31.3%	52.7%	15.1%	-20.9%
Blue Cross and Blue Shield of New Mexico						
Cervical cancer screening	48.0%	28.4%	-41.0%	45.8%	61.5%	-4.7%
United Healthcare of New Mexico, Inc.						
Cervical cancer screening	43.1%	27.3%	-36.7%	39.7%	45.5%	-7.9%
Total						
Cervical cancer screening	58.4%	43.2%	-26.0%	48.7%	12.7%	-16.6%

Flu Vaccinations for Adults (Measure 25)

	Baseline	DY1		DY2		DY3		Baseline to DY3
Flu Vaccinations for Adults	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Change (p_3/p_0-1)**
Total								
Flu Vaccinations for Adults	4.5%	5.0%	10.7%	10.3%	106.2%	10.3%	0.2%	128.7%

[173] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[174] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Measure 26)

	DY1	DY2	
Initiation and engagement of alcohol and other drug dependence treatment	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Initiation of AOD Treatment (13-17 Yrs)	36.6%	46.1%	25.9%
Initiation of AOD Treatment (18+ Yrs)	36.7%	39.6%	8.0%
Initiation of AOD Treatment (Total)	36.7%	40.2%	9.7%
Engagement of AOD Treatment (13-17 Yrs)	15.0%	21.5%	43.2%
Engagement of AOD Treatment (18+ Yrs)	14.0%	14.7%	5.0%
Engagement of AOD Treatment (Total)	14.1%	15.3%	8.5%
Molina Healthcare of New Mexico, Inc.			
Initiation of AOD Treatment (13-17 Yrs)	46.6%	44.8%	-3.9%
Initiation of AOD Treatment (18+ Yrs)	38.9%	34.9%	-10.2%
Initiation of AOD Treatment (Total)	39.5%	35.6%	-9.9%
Engagement of AOD Treatment (13-17 Yrs)	17.6%	16.8%	-4.6%
Engagement of AOD Treatment (18+ Yrs)	13.1%	11.7%	-10.7%
Engagement of AOD Treatment (Total)	13.5%	12.0%	-10.5%
Blue Cross and Blue Shield of New Mexico			
Initiation of AOD Treatment (13-17 Yrs)	51.6%	46.6%	-9.7%
Initiation of AOD Treatment (18+ Yrs)	39.0%	37.0%	-4.9%
Initiation of AOD Treatment (Total)	39.5%	37.3%	-5.4%
Engagement of AOD Treatment (13-17 Yrs)	25.0%	16.2%	-35.3%
Engagement of AOD Treatment (18+ Yrs)	14.2%	14.2%	0.0%
Engagement of AOD Treatment (Total)	14.7%	14.3%	-2.4%
United Healthcare of New Mexico, Inc.			
Initiation of AOD Treatment (13-17 Yrs)	NR	NR	N/A
Initiation of AOD Treatment (18+ Yrs)	NR	NR	N/A
Initiation of AOD Treatment (Total)	NR	NR	N/A
Engagement of AOD Treatment (13-17 Yrs)	NR	NR	N/A
Engagement of AOD Treatment (18+ Yrs)	NR	NR	N/A
Engagement of AOD Treatment (Total)	NR	NR	N/A
Total			
Initiation of AOD Treatment (13-17 Yrs)	42.3%	45.6%	7.7%
Initiation of AOD Treatment (18+ Yrs)	38.2%	37.1%	-2.9%
Initiation of AOD Treatment (Total)	38.6%	37.7%	-2.4%
Engagement of AOD Treatment (13-17 Yrs)	17.2%	18.9%	9.8%
Engagement of AOD Treatment (18+ Yrs)	13.7%	13.5%	-1.6%
Engagement of AOD Treatment (Total)	14.0%	13.8%	-1.2%

Annual Monitoring Persistent Medications (Measure 38)[175]

	Baseline	DY1		DY2		Baseline to DY2
Annual monitoring for patients on persistent medications	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Annual monitoring for patients on ACE Inhibitors or ARBs	84.7%	83.9%	-0.9%	83.5%	-0.5%	-1.4%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	87.8%	84.8%	-3.4%	85.8%	1.2%	-2.3%
Annual monitoring for patients: Total	85.9%	84.0%	-2.2%	84.1%	0.1%	-2.1%
Molina Healthcare of New Mexico, Inc.						
Annual monitoring for patients on ACE Inhibitors or ARBs	87.2%	83.1%	-4.7%	82.7%	-0.6%	-5.2%
Annual monitoring for patients on persistent Digoxin	NR	60.0%	N/A	42.9%	-28.6%	N/A
Annual monitoring for patients on Diuretics	88.9%	83.2%	-6.4%	83.5%	0.3%	-6.1%
Annual monitoring for patients: Total	87.8%	83.1%	-5.4%	82.8%	-0.3%	-5.7%
Blue Cross and Blue Shield of New Mexico						
Annual monitoring for patients on ACE Inhibitors or ARBs	89.7%	85.1%	-5.2%	82.7%	-2.8%	-7.8%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	89.8%	85.2%	-5.1%	83.3%	-2.2%	-7.2%
Annual monitoring for patients: Total	89.6%	85.0%	-5.2%	82.8%	-2.5%	-7.6%
United Healthcare of New Mexico, Inc.						
Annual monitoring for patients on ACE Inhibitors or ARBs	88.6%	84.7%	-4.4%	83.0%	-1.9%	-6.3%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	91.5%	86.4%	-5.5%	84.9%	-1.8%	-7.2%
Annual monitoring for patients: Total	89.9%	85.3%	-5.1%	83.5%	-2.1%	-7.1%
Total						
Annual monitoring for patients on ACE Inhibitors or ARBs	86.6%	83.9%	-3.0%	82.9%	-1.2%	-4.2%
Annual monitoring for patients on persistent Digoxin	85.4%	54.3%	-36.4%	42.0%	-22.8%	-50.9%
Annual monitoring for patients on Diuretics	89.0%	84.5%	-5.1%	84.3%	-0.2%	-5.3%
Annual monitoring for patients: Total	87.5%	84.0%	-4.0%	83.3%	-0.9%	-4.9%

[175] All MCOs Digoxin subcomponent numerators and denominators were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Medication Management for People with Asthma (Measure 39)[176]

	Baseline	DY1		DY2		Baseline to DY2
Medication Management for People With Asthma	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
5-11 Years - Medication Compliance 50%	47.9%	45.5%	-5.0%	53.4%	17.4%	11.5%
12-18 Years - Medication Compliance 50%	42.7%	40.6%	-4.9%	48.9%	20.4%	14.5%
19-50 Years - Medication Compliance 50%	47.4%	51.2%	8.1%	59.8%	16.8%	26.3%
51-64 Years - Medication Compliance 50%	71.4%	56.8%	-20.5%	72.5%	27.7%	1.5%
Total - Medication Compliance 50%	46.4%	44.7%	-3.6%	54.6%	22.0%	17.6%
Molina Healthcare of New Mexico, Inc.						
5-11 Years - Medication Compliance 50%	44.1%	46.2%	4.8%	46.2%	0.0%	4.8%
12-18 Years - Medication Compliance 50%	42.7%	44.2%	3.7%	41.5%	-6.1%	-2.7%
19-50 Years - Medication Compliance 50%	48.5%	47.9%	-1.3%	56.2%	17.3%	15.8%
51-64 Years - Medication Compliance 50%	NR	56.6%	N/A	71.0%	25.6%	N/A
Total - Medication Compliance 50%	44.8%	47.0%	5.0%	49.4%	5.0%	10.3%
Blue Cross and Blue Shield of New Mexico						
5-11 Years - Medication Compliance 50%	43.6%	43.9%	0.6%	45.1%	2.8%	3.5%
12-18 Years - Medication Compliance 50%	43.3%	48.2%	11.3%	35.8%	-25.8%	-17.5%
19-50 Years - Medication Compliance 50%	62.5%	55.3%	-11.6%	59.6%	7.8%	-4.7%
51-64 Years - Medication Compliance 50%	NR	NR	N/A	66.7%	N/A	N/A
Total - Medication Compliance 50%	48.5%	49.5%	2.1%	51.1%	3.2%	5.3%
United Healthcare of New Mexico, Inc.						
5-11 Years - Medication Compliance 50%	NR	NR	N/A	31.6%	N/A	N/A
12-18 Years - Medication Compliance 50%	NR	NR	N/A	36.7%	N/A	N/A
19-50 Years - Medication Compliance 50%	NR	NR	N/A	56.7%	N/A	N/A
51-64 Years - Medication Compliance 50%	NR	63.3%	N/A	67.7%	6.9%	N/A
Total - Medication Compliance 50%	64.9%	67.2%	3.7%	56.3%	-16.3%	-13.2%
Total						
5-11 Years - Medication Compliance 50%	46.5%	45.6%	-2.0%	49.1%	7.7%	5.6%
12-18 Years - Medication Compliance 50%	42.7%	42.2%	-1.1%	44.1%	4.4%	3.2%
19-50 Years - Medication Compliance 50%	50.0%	51.0%	2.0%	58.2%	14.1%	16.3%
51-64 Years - Medication Compliance 50%	69.7%	59.4%	-14.7%	69.6%	17.2%	0.0%
Total - Medication Compliance 50%	46.3%	46.3%	-0.1%	52.2%	12.8%	12.7%

[176] BCBS and UHC baseline and DY1 numerators and denominators (except for UHCs 5-11 years of age cohort) were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Asthma Medication Ratio (Measure 40)[177]

	Baseline	DY1		DY2		Baseline to DY2
Asthma Medication Ratio	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Asthma Medication Ratio (5-11)	71.7%	62.3%	-13.1%	67.3%	8.1%	-6.1%
Asthma Medication Ratio (12-18)	54.0%	47.7%	-11.6%	50.9%	6.7%	-5.7%
Asthma Medication Ratio (19-50)	36.4%	34.1%	-6.2%	43.6%	27.8%	19.9%
Asthma Medication Ratio (51-64)	34.5%	34.8%	0.9%	50.6%	45.4%	46.6%
Asthma Medication Ratio: Total	59.3%	51.5%	-13.2%	54.2%	5.2%	-8.6%
Molina Healthcare of New Mexico, Inc.						
Asthma Medication Ratio (5-11)	69.2%	60.9%	-12.0%	74.7%	22.5%	7.9%
Asthma Medication Ratio (12-18)	58.5%	51.7%	-11.7%	57.1%	10.5%	-2.4%
Asthma Medication Ratio (19-50)	43.6%	44.4%	1.8%	49.9%	12.4%	14.5%
Asthma Medication Ratio (51-64)	31.0%	49.6%	60.4%	51.4%	3.6%	66.2%
Asthma Medication Ratio: Total	60.1%	53.0%	-11.8%	61.2%	15.5%	1.8%
Blue Cross and Blue Shield of New Mexico						
Asthma Medication Ratio (5-11)	85.6%	62.5%	-27.0%	66.3%	6.1%	-22.5%
Asthma Medication Ratio (12-18)	65.2%	47.0%	-28.0%	53.6%	14.1%	-17.8%
Asthma Medication Ratio (19-50)	70.2%	55.6%	-20.9%	50.1%	-9.8%	-28.6%
Asthma Medication Ratio (51-64)	NR	NR	N/A	60.5%	N/A	N/A
Asthma Medication Ratio: Total	74.8%	55.0%	-26.4%	56.8%	3.3%	-24.0%
United Healthcare of New Mexico, Inc.						
Asthma Medication Ratio (5-11)	NR	NR	N/A	70.0%	N/A	N/A
Asthma Medication Ratio (12-18)	NR	NR	N/A	55.9%	N/A	N/A
Asthma Medication Ratio (19-50)	36.7%	46.7%	27.3%	42.4%	-9.2%	15.6%
Asthma Medication Ratio (51-64)	42.4%	51.2%	20.7%	48.2%	-6.0%	13.5%
Asthma Medication Ratio: Total	40.0%	49.4%	23.6%	47.7%	-3.5%	19.2%
Total						
Asthma Medication Ratio (5-11)	71.9%	61.9%	-13.9%	70.2%	13.5%	-2.3%
Asthma Medication Ratio (12-18)	55.9%	48.9%	-12.5%	53.8%	9.9%	-3.8%
Asthma Medication Ratio (19-50)	41.8%	40.6%	-3.0%	46.8%	15.4%	11.9%
Asthma Medication Ratio (51-64)	36.6%	45.6%	24.6%	52.4%	14.8%	43.0%
Asthma Medication Ratio: Total	60.2%	52.2%	-13.3%	56.8%	8.7%	-5.7%

[177] BCBS and UHC baseline and DY1 numerators and denominators (except for UHCs 5-11 years of age cohort) were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Adult BMI Assessment and Weight Assessment for Children/Adolescents (Measure 41)[178]

	Baseline	DY1		DY2		Baseline to DY2
Adult Body Mass Index (BMI) assessment; weight assessment for children/adolescents	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Adult BMI assessment	73.4%	84.3%	14.9%	83.9%	-0.5%	14.4%
BMI Percentile (3-11 Yrs)	34.6%	44.7%	29.3%	61.7%	38.0%	78.5%
BMI Percentile (12-17 Yrs)	40.6%	40.8%	0.3%	64.8%	59.0%	59.6%
BMI Percentile (Total)	36.8%	43.3%	17.5%	62.8%	45.1%	70.5%
Counseling for Nutrition (3-11 Yrs)	48.9%	55.7%	13.9%	51.8%	-6.9%	6.0%
Counseling for Nutrition (12-17 Yrs)	43.1%	47.8%	10.8%	50.3%	5.4%	16.7%
Counseling for Nutrition (Total)	46.8%	52.8%	12.9%	51.3%	-2.8%	9.7%
Counseling for Physical Activity (3-11 Yrs)	38.2%	44.7%	16.9%	37.2%	-16.7%	-2.6%
Counseling for Physical Activity (12-17 Yrs)	40.0%	42.0%	5.1%	51.7%	23.0%	29.3%
Counseling for Physical Activity (Total)	38.9%	43.7%	12.4%	42.2%	-3.4%	8.6%
Molina Healthcare of New Mexico, Inc.						
Adult BMI assessment	81.0%	74.5%	-8.1%	79.7%	7.0%	-1.7%
BMI Percentile (3-11 Yrs)	57.8%	32.3%	-44.1%	53.7%	66.1%	-7.2%
BMI Percentile (12-17 Yrs)	56.4%	40.0%	-29.1%	51.6%	29.1%	-8.5%
BMI Percentile (Total)	57.4%	35.0%	-39.1%	53.0%	51.6%	-7.7%
Counseling for Nutrition (3-11 Yrs)	51.1%	55.2%	8.0%	54.0%	-2.2%	5.7%
Counseling for Nutrition (12-17 Yrs)	49.3%	49.7%	0.8%	50.3%	1.3%	2.1%
Counseling for Nutrition (Total)	50.6%	53.3%	5.5%	52.8%	-1.0%	4.4%
Counseling for Physical Activity (3-11 Yrs)	41.5%	50.2%	20.8%	49.3%	-1.7%	18.8%
Counseling for Physical Activity (12-17 Yrs)	45.7%	47.7%	4.4%	49.7%	4.0%	8.7%
Counseling for Physical Activity (Total)	42.8%	49.3%	15.2%	49.4%	0.2%	15.5%
Blue Cross and Blue Shield of New Mexico						
Adult BMI assessment	71.7%	79.2%	10.6%	72.1%	-9.0%	0.6%
BMI Percentile (3-11 Yrs)	52.9%	55.2%	4.3%	52.7%	-4.5%	-0.4%
BMI Percentile (12-17 Yrs)	46.2%	55.8%	20.9%	53.2%	-4.7%	15.2%
BMI Percentile (Total)	51.0%	55.4%	8.7%	52.9%	-4.6%	3.7%
Counseling for Nutrition (3-11 Yrs)	41.5%	57.1%	37.7%	43.4%	-24.0%	4.6%
Counseling for Nutrition (12-17 Yrs)	36.2%	52.2%	44.3%	41.8%	-19.8%	15.7%
Counseling for Nutrition (Total)	40.0%	55.6%	39.2%	42.9%	-22.8%	7.4%
Counseling for Physical Activity (3-11 Yrs)	34.4%	48.9%	42.3%	38.6%	-21.1%	12.3%
Counseling for Physical Activity (12-17 Yrs)	37.7%	52.9%	40.3%	40.4%	-23.6%	7.3%
Counseling for Physical Activity (Total)	35.3%	50.1%	41.9%	39.2%	-21.9%	10.9%
United Healthcare of New Mexico, Inc.						
Adult BMI assessment	71.5%	74.5%	4.1%	71.7%	-3.8%	0.2%
BMI Percentile (3-11 Yrs)	NR	43.8%	N/A	48.1%	9.9%	N/A
BMI Percentile (12-17 Yrs)	NR	43.8%	N/A	42.6%	-2.7%	N/A
BMI Percentile (Total)	NR	43.8%	N/A	46.2%	5.6%	N/A
Counseling for Nutrition (3-11 Yrs)	NR	53.4%	N/A	54.8%	2.7%	N/A
Counseling for Nutrition (12-17 Yrs)	NR	43.1%	N/A	52.5%	21.7%	N/A
Counseling for Nutrition (Total)	NR	49.4%	N/A	54.0%	9.4%	N/A
Counseling for Physical Activity (3-11 Yrs)	NR	31.5%	N/A	43.3%	37.7%	N/A
Counseling for Physical Activity (12-17 Yrs)	NR	40.6%	N/A	50.4%	23.9%	N/A
Counseling for Physical Activity (Total)	NR	35.0%	N/A	45.7%	30.6%	N/A
Total						
Adult BMI assessment	74.2%	78.2%	5.4%	76.0%	-2.8%	2.4%
BMI Percentile (3-11 Yrs)	49.2%	44.2%	-10.1%	54.0%	22.3%	9.9%
BMI Percentile (12-17 Yrs)	47.4%	44.8%	-5.5%	53.1%	18.7%	12.1%
BMI Percentile (Total)	48.6%	44.4%	-8.7%	53.7%	21.0%	10.5%
Counseling for Nutrition (3-11 Yrs)	47.4%	55.5%	16.9%	50.8%	-8.4%	7.1%
Counseling for Nutrition (12-17 Yrs)	43.5%	48.0%	10.4%	48.8%	1.6%	12.1%
Counseling for Nutrition (Total)	46.2%	52.9%	14.5%	50.1%	-5.1%	8.6%
Counseling for Physical Activity (3-11 Yrs)	38.3%	44.4%	15.9%	42.2%	-5.0%	10.1%
Counseling for Physical Activity (12-17 Yrs)	41.2%	45.6%	10.5%	48.1%	5.6%	16.7%
Counseling for Physical Activity (Total)	39.2%	44.8%	14.2%	44.1%	-1.4%	12.5%

[178] UHC baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Annual Rate Data for Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam (Measure 42 & 81)[179]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
HbA1c Testing	81.4%	86.5%	6.3%	84.6%	-2.2%	3.9%
HbA1c Poor Control (>9.0%)	47.9%	43.9%	-8.3%	48.3%	10.1%	0.9%
HbA1c Control (<8.0%)	42.8%	47.9%	12.0%	44.9%	-6.4%	4.8%
HbA1c Control (<7.0%) for a Selected Population	33.3%	35.2%	5.7%	31.9%	-9.5%	-4.4%
Eye Exam	48.3%	47.8%	-1.0%	46.1%	-3.5%	-4.5%
Medical Attention for Nephropathy	71.6%	79.5%	11.0%	86.9%	9.3%	21.3%
Blood Pressure Controlled <140/90 mm Hg	63.7%	64.2%	0.9%	62.7%	-2.5%	-1.6%
Molina Healthcare of New Mexico, Inc.						
HbA1c Testing	85.1%	85.7%	0.6%	88.1%	2.8%	3.5%
HbA1c Poor Control (>9.0%)	41.8%	49.9%	19.5%	45.0%	-9.7%	7.8%
HbA1c Control (<8.0%)	48.5%	37.7%	-22.2%	45.0%	19.3%	-7.2%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	58.2%	56.5%	-3.0%	54.5%	-3.5%	-6.4%
Medical Attention for Nephropathy	78.1%	74.8%	-4.2%	88.1%	17.7%	12.8%
Blood Pressure Controlled <140/90 mm Hg	64.3%	59.4%	-7.7%	62.0%	4.5%	-3.6%
Blue Cross and Blue Shield of New Mexico						
HbA1c Testing	82.2%	83.4%	1.4%	80.4%	-3.6%	-2.2%
HbA1c Poor Control (>9.0%)	53.6%	47.3%	-11.7%	52.9%	11.9%	-1.2%
HbA1c Control (<8.0%)	36.3%	43.1%	18.7%	39.3%	-8.8%	8.2%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	51.9%	54.2%	4.5%	47.8%	-11.9%	-8.0%
Medical Attention for Nephropathy	75.4%	78.6%	4.2%	85.1%	8.2%	12.8%
Blood Pressure Controlled <140/90 mm Hg	55.7%	57.4%	2.9%	55.9%	-2.6%	0.3%
United Healthcare of New Mexico, Inc.						
HbA1c Testing	85.9%	84.4%	-1.7%	84.4%	0.0%	-1.7%
HbA1c Poor Control (>9.0%)	49.5%	49.1%	-0.8%	52.6%	6.9%	6.1%
HbA1c Control (<8.0%)	41.9%	43.3%	3.4%	37.5%	-13.5%	-10.6%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	44.0%	65.2%	48.3%	62.5%	-4.1%	42.2%
Medical Attention for Nephropathy	82.9%	83.7%	1.0%	90.3%	7.8%	8.9%
Blood Pressure Controlled <140/90 mm Hg	62.5%	54.7%	-12.4%	52.3%	-4.4%	-16.3%
Total						
HbA1c Testing	83.5%	85.0%	1.8%	84.1%	-1.0%	0.7%
HbA1c Poor Control (>9.0%)	47.9%	47.2%	-1.5%	49.8%	5.4%	3.9%
HbA1c Control (<8.0%)	42.7%	43.4%	1.6%	41.8%	-3.7%	-2.1%
HbA1c Control (<7.0%) for a Selected Population	33.3%	35.2%	5.7%	31.9%	-9.5%	-4.4%
Eye Exam	50.4%	55.0%	9.2%	51.8%	-5.9%	2.7%
Medical Attention for Nephropathy	76.6%	79.1%	3.3%	87.3%	10.4%	14.0%
Blood Pressure Controlled <140/90 mm Hg	62.0%	59.3%	-4.4%	58.4%	-1.4%	-5.7%

[179] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Antidepressant Medication Management (Measure 50)

Antidepressant medication management	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Effective Acute Phase Treatment	NR	53.9%	N/A	53.4%	-1.1%	N/A
Effective Continuation Phase Treatment	NR	39.0%	N/A	36.2%	-7.0%	N/A
Molina Healthcare of New Mexico, Inc.						
Effective Acute Phase Treatment	40.8%	53.5%	31.2%	49.5%	-7.4%	21.5%
Effective Continuation Phase Treatment	25.1%	38.6%	54.2%	34.7%	-10.2%	38.4%
Blue Cross and Blue Shield of New Mexico						
Effective Acute Phase Treatment	42.8%	60.0%	40.2%	54.8%	-8.6%	28.1%
Effective Continuation Phase Treatment	29.9%	47.8%	59.8%	39.4%	-17.5%	31.8%
United Healthcare of New Mexico, Inc.						
Effective Acute Phase Treatment	51.0%	62.5%	22.6%	56.6%	-9.4%	11.0%
Effective Continuation Phase Treatment	37.1%	48.3%	30.4%	42.9%	-11.3%	15.7%
Total						
Effective Acute Phase Treatment	43.2%	55.6%	28.6%	53.1%	-4.4%	22.9%
Effective Continuation Phase Treatment	28.6%	41.1%	43.9%	37.8%	-8.1%	32.2%

Percentage of the Population Accessing a Behavioral Health Service that Received a PCP Visit in the Same Year (Measure 54)

Percentage of population accessing a behavioral health service that received a PCP visit in the same year	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Total						
Percentage of population accessing a behavioral health service that received a PCP visit in the same year	13.6%	12.6%	-7.6%	12.2%	-3.2%	-10.6%

Percentage of the Population Accessing an LTSS Service that Received a PCP Visit in the Same Year (Measure 55)

Percentage of LTSS population accessing a PCP visit during the year	Baseline	DY1		DY2		DY3		Baseline to DY3
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Rate, p_3	Change (p_3/p_2-1)	Change (p_3/p_0-1)
Total								
Percentage of LTSS population accessing a PCP visit during the year	76.5%	73.5%	-3.8%	70.7%	-3.8%	69.4%	-1.9%	-9.3%

Percentage of the Population Accessing an LTSS Service that also accessed a BH Service in the Same Year (Measure 56)

Percentage of population accessing an LTSS service that also accessed a BH service in the same year	Baseline	DY1		DY2		DY3		Baseline to DY3
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Rate, p_3	Change (p_3/p_2-1)	Change (p_2/p_0-1)
Total								
Percentage of population accessing an LTSS service that also accessed a BH service in the same year	1.12%	1.06%	-5.38%	1.32%	25.14%	1.39%	4.89%	24.20%

Percentage of the Population with LTSS Needs with an ED Visit by Type of ED Visit (Measure 57)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population with BH needs with an ED visit by type of ED visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
BH Population with ER Visits	18.7%	11.0%	-41.0%	7.0%	-36.49%	-62.51%
BH Population with EMTALA ER Visit Type	0.2%	0.1%	-58.9%	0.1%	-13.01%	-64.27%
BH Population with Urgent Care ER Visit Type	0.0%	0.0%	-100.0%	0.0%	N/A	-95.53%
BH Population with Limited or Minor ER Visit Type	0.6%	0.3%	-45.2%	0.4%	15.09%	-36.91%
BH Population with Low to Moderate ER Visit Type	1.8%	0.6%	-66.7%	0.7%	23.54%	-58.85%
BH Population with Moderate ER Visit Type	6.4%	2.5%	-61.2%	2.2%	-11.30%	-65.59%
BH Population with High Severity ER Visit Type	7.0%	2.2%	-68.0%	2.5%	12.59%	-63.96%
BH Population with Life Threatening ER Visit Type	5.4%	2.5%	-54.1%	2.3%	-7.48%	-57.55%
BH Population with Admitted Through ER Visit Type	3.6%	5.1%	44.1%	0.9%	-82.76%	-75.16%

Percentage of the Population with BH Needs with an ED Visit by Type of ED Visit (Measure 58)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population with LTSS needs with an ED visit by type of ED visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
BH Population with ER Visits	35.71%	37.56%	5.18%	44.22%	17.71%	23.82%
BH Population with EMTALA ER Visit Type	0.30%	0.25%	-14.62%	0.29%	14.99%	-1.82%
BH Population with Urgent Care ER Visit Type	0.02%	0.02%	-15.91%	0.01%	-32.54%	-43.27%
BH Population with Limited or Minor ER Visit Type	1.50%	1.76%	16.96%	2.68%	52.12%	77.92%
BH Population with Low to Moderate ER Visit Type	3.91%	3.73%	-4.59%	4.88%	30.78%	24.78%
BH Population with Moderate ER Visit Type	13.33%	13.78%	3.38%	16.06%	16.60%	20.53%
BH Population with High Severity ER Visit Type	15.18%	15.46%	1.84%	19.67%	27.28%	29.61%
BH Population with Life Threatening ER Visit Type	13.19%	14.07%	6.68%	17.22%	22.39%	30.57%
BH Population with Admitted Through ER Visit Type	8.66%	12.78%	47.62%	14.47%	13.16%	67.05%

Percentage of Participants Who Accessed a BH Service that also Accessed HCBS (Measure 60)

	Baseline	DY1		DY2		Baseline to DY3
Number and percentage of participants who accessed a BH service that also accessed HCBS	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Number and percentage of participants who accessed a BH service that also accessed HCBS	0.19%	0.21%	13.21%	0.23%	10.22%	15.37%

Percentage of the Population Accessing a BH Service that Received an Outpatient Ambulatory Visit in the Same Year (Measure 62)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population accessing a BH service that received an outpatient ambulatory visit in the same year	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Percentage of population accessing a BH service that received an outpatient ambulatory visit in the same year	14.5%	13.9%	-4.4%	15.6%	12.7%	7.7%

Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (Measure 63)[180]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	85.3%	79.8%	-6.4%	79.7%	-0.1%	-6.6%
Molina Healthcare of New Mexico, Inc.						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	79.5%	77.0%	-3.2%	78.5%	1.9%	-1.3%
Blue Cross and Blue Shield of New Mexico						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	NR	79.7%	N/A	76.3%	-4.2%	N/A
United Healthcare of New Mexico, Inc.						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	80.7%	74.2%	-8.0%	76.5%	3.0%	-5.2%
Total						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	83.7%	77.6%	-7.2%	77.9%	0.3%	-7.0%

[180] BCBS baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Diabetes Monitoring for People with Diabetes and Schizophrenia (Measure 64)[181]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes monitoring for people with diabetes and schizophrenia	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Diabetes monitoring for people with diabetes and schizophrenia	76.7%	75.0%	-2.2%	54.9%	-26.8%	-28.4%
Molina Healthcare of New Mexico, Inc.						
Diabetes monitoring for people with diabetes and schizophrenia	NR	57.9%	N/A	55.0%	-4.9%	N/A
Blue Cross and Blue Shield of New Mexico						
Diabetes monitoring for people with diabetes and schizophrenia	NR	44.6%	N/A	44.9%	0.7%	N/A
United Healthcare of New Mexico, Inc.						
Diabetes monitoring for people with diabetes and schizophrenia	55.8%	49.8%	-10.9%	47.4%	-4.7%	-15.0%
Total						
Diabetes monitoring for people with diabetes and schizophrenia	62.4%	56.6%	-9.2%	49.9%	-11.8%	-20.0%

[181] MHC and BCBS baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Statistical Significance Testing of Annual Rate Data for Asthma controller medication compliance (Measure 80)[182]

	Baseline	DY1		DY2		Baseline to DY2
Asthma controller medication compliance (children)	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Medication Compliance - 50% (5-11)	47.9%	45.5%	-5.0%	53.4%	17.4%	11.5%
Medication Compliance - 75% (5-11)	20.9%	21.3%	2.0%	26.5%	24.1%	26.6%
Medication Compliance - 50% (12-18)	42.7%	40.6%	-4.9%	48.9%	20.4%	14.5%
Medication Compliance - 75% (12-18)	19.5%	18.9%	-3.4%	25.4%	34.8%	30.2%
Molina Healthcare of New Mexico, Inc.						
Medication Compliance - 50% (5-11)	44.1%	46.2%	4.8%	46.2%	0.0%	4.8%
Medication Compliance - 75% (5-11)	22.2%	23.1%	4.2%	21.7%	-6.0%	-2.1%
Medication Compliance - 50% (12-18)	42.7%	44.2%	3.7%	41.5%	-6.1%	-2.7%
Medication Compliance - 75% (12-18)	18.8%	19.1%	2.0%	18.9%	-1.2%	0.7%
Blue Cross and Blue Shield of New Mexico						
Medication Compliance - 50% (5-11)	43.6%	43.9%	0.6%	45.1%	2.8%	3.5%
Medication Compliance - 75% (5-11)	18.1%	20.4%	12.8%	22.0%	7.6%	21.4%
Medication Compliance - 50% (12-18)	43.3%	48.2%	11.3%	35.8%	-25.8%	-17.5%
Medication Compliance - 75% (12-18)	16.7%	25.0%	50.0%	15.1%	-39.7%	-9.5%
United Healthcare of New Mexico, Inc.						
Medication Compliance - 50% (5-11)	NR	NR	N/A	31.6%	N/A	N/A
Medication Compliance - 75% (5-11)	NR	NR	N/A	NR	N/A	N/A
Medication Compliance - 50% (12-18)	NR	NR	N/A	36.7%	N/A	N/A
Medication Compliance - 75% (12-18)	NR	NR	N/A	13.3%	N/A	N/A
Total						
Medication Compliance - 50% (5-11)	46.5%	45.6%	-2.0%	49.1%	7.7%	5.6%
Medication Compliance - 75% (5-11)	21.1%	21.8%	3.4%	24.3%	11.5%	15.2%
Medication Compliance - 50% (12-18)	42.7%	42.2%	-1.1%	44.1%	4.4%	3.2%
Medication Compliance - 75% (12-18)	19.2%	19.4%	1.0%	21.3%	9.9%	11.0%

[182] UHC baseline and DY1 numerators and denominators for the 12-18 age cohort were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Prenatal program (Measure 82)[183]

	Baseline	DY1		DY2		Baseline to DY2
Frequency of Prenatal Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Frequency of Ongoing Prenatal Care (<21%)	9.3%	13.6%	47.4%	21.3%	56.4%	130.5%
Frequency of Ongoing Prenatal Care (21-40%)	10.6%	12.5%	17.1%	10.9%	-12.6%	2.4%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	12.7%	37.2%	10.7%	-16.0%	15.3%
Frequency of Ongoing Prenatal Care (61-80%)	13.9%	12.5%	-10.2%	14.2%	13.5%	1.9%
Frequency of Ongoing Prenatal Care (>= 81%)	56.9%	48.7%	-14.5%	42.9%	-11.9%	-24.6%
Molina Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	4.0%	9.0%	124.2%	7.6%	-16.2%	87.9%
Frequency of Ongoing Prenatal Care (21-40%)	3.5%	7.7%	115.9%	7.8%	1.6%	119.4%
Frequency of Ongoing Prenatal Care (41-60%)	5.7%	8.3%	46.9%	10.3%	23.6%	81.5%
Frequency of Ongoing Prenatal Care (61-80%)	13.5%	14.0%	3.6%	19.0%	36.0%	40.9%
Frequency of Ongoing Prenatal Care (>= 81%)	73.3%	61.0%	-16.7%	55.4%	-9.3%	-24.4%
Blue Cross and Blue Shield of New Mexico						
Frequency of Ongoing Prenatal Care (<21%)	7.7%	16.1%	107.4%	11.6%	-27.9%	49.6%
Frequency of Ongoing Prenatal Care (21-40%)	6.0%	7.7%	28.8%	10.7%	39.0%	79.0%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	6.6%	-29.4%	11.1%	69.7%	19.8%
Frequency of Ongoing Prenatal Care (61-80%)	16.2%	14.5%	-10.3%	16.0%	10.7%	-0.7%
Frequency of Ongoing Prenatal Care (>= 81%)	60.8%	55.2%	-9.3%	50.6%	-8.4%	-16.9%
United Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	NR	20.7%	N/A	20.4%	-1.2%	N/A
Frequency of Ongoing Prenatal Care (21-40%)	NR	12.2%	N/A	23.1%	90.0%	N/A
Frequency of Ongoing Prenatal Care (41-60%)	NR	11.2%	N/A	10.5%	-6.5%	N/A
Frequency of Ongoing Prenatal Care (61-80%)	NR	13.4%	N/A	11.9%	-10.9%	N/A
Frequency of Ongoing Prenatal Care (>= 81%)	NR	42.6%	N/A	34.1%	-20.0%	N/A
Total						
Frequency of Ongoing Prenatal Care (<21%)	7.4%	14.8%	100.1%	15.1%	2.4%	104.9%
Frequency of Ongoing Prenatal Care (21-40%)	6.8%	9.9%	45.2%	13.0%	30.5%	89.5%
Frequency of Ongoing Prenatal Care (41-60%)	8.1%	9.6%	19.7%	10.6%	10.5%	32.2%
Frequency of Ongoing Prenatal Care (61-80%)	14.5%	13.6%	-6.4%	15.3%	12.9%	5.7%
Frequency of Ongoing Prenatal Care (>= 81%)	63.2%	52.1%	-17.6%	45.9%	-11.8%	-27.3%

	Baseline	DY1		DY2		Baseline to DY2
Prenatal and Postpartum Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Postpartum Care	57.9%	61.9%	6.9%	53.1%	-14.1%	-8.2%
Timeliness of Prenatal Care	80.0%	77.9%	-2.7%	66.4%	-14.8%	-17.1%
Molina Healthcare of New Mexico, Inc.						
Postpartum Care	62.9%	54.5%	-13.4%	51.5%	-5.5%	-18.1%
Timeliness of Prenatal Care	89.2%	76.8%	-13.9%	76.0%	-1.1%	-14.8%
Blue Cross and Blue Shield of New Mexico						
Postpartum Care	63.1%	54.5%	-13.5%	57.9%	6.2%	-8.2%
Timeliness of Prenatal Care	86.1%	73.1%	-15.1%	72.6%	-0.6%	-15.6%
United Healthcare of New Mexico, Inc.						
Postpartum Care	NR	48.2%	N/A	41.4%	-14.1%	N/A
Timeliness of Prenatal Care	NR	63.7%	N/A	67.4%	5.7%	N/A
Total						
Postpartum Care	61.3%	54.8%	-10.5%	51.2%	-6.7%	-16.5%
Timeliness of Prenatal Care	84.8%	73.0%	-13.9%	70.7%	-3.2%	-16.6%

[183] UHC baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 Prenatal and Postpartum Care rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Treatment adherence – schizophrenia (Measure 83)[184]

Treatment adherence - schizophrenia	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	24.0%	58.1%	141.9%	56.5%	-2.7%	135.4%
Molina Healthcare of New Mexico, Inc.						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	58.7%	N/A	52.8%	-10.0%	N/A
Blue Cross and Blue Shield of New Mexico						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	60.0%	N/A	44.6%	-25.6%	N/A
United Healthcare of New Mexico, Inc.						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	50.0%	61.1%	22.2%	54.6%	-10.6%	9.2%
Total						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	34.7%	59.3%	70.8%	52.2%	-12.0%	50.3%

Annual dental visit – adult (Measure 86)

Annual dental visit – adult	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	-6.9%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	-5.2%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	-9.7%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	N/A
Total						
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	-9.0%

[184] MHC and BCBS baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Annual dental visit – child (Measure 87)[185]

Annual dental visit – child	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	-4.8%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	-4.5%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	-5.3%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	-4.8%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	-4.3%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	4.1%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	0.7%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	-0.8%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	0.6%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	1.7%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	-13.6%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	-11.1%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	-9.8%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	-6.8%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	-6.6%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	N/A
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	N/A
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	N/A
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	N/A
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	N/A
Total						
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	-4.0%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	-4.7%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	-5.2%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	-4.3%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	-4.3%

Calls answered within 30 seconds (Measure 93)

Calls answered within 30 seconds	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Call Answer Timeliness	86.8%	87.8%	1.1%	88.0%	0.3%	1.4%
Molina Healthcare of New Mexico, Inc.						
Call Answer Timeliness	95.6%	93.7%	-2.0%	NR	N/A	N/A
Blue Cross and Blue Shield of New Mexico						
Call Answer Timeliness	NR	89.7%	N/A	NR	N/A	N/A
United Healthcare of New Mexico, Inc.						
Call Answer Timeliness	93.4%	92.9%	-0.5%	95.2%	2.4%	1.9%
Total						
Call Answer Timeliness	90.6%	90.7%	0.1%	90.4%	-0.3%	-0.2%

[185] UHC baseline numerators and denominators for the 11-14 and 15-18 age cohorts were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.

D. Additional DY3 Data for HEDIS Measures

In the below table, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative of the report due to the timing that the data was received, but it is provided here for the reader's consideration.

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
1	Access to preventive/ambulatory health services among CC enrollees in aggregate and within subgroups		85.5%	81.4%	78.1%	76.0%
2	Mental Health Services Utilization		N/A	13.9%	13.7%	14.0%
6	Number and percentage of people with annual dental visit		111,798 (70.6%)	148,066 (64.0%)	171,663 (66.0%)	184,458 (67.6%)
17	Childhood Immunization Status	DTaP	80.4%	80.2%	67.9%	74.1%
		IPV	90.9%	90.5%	80.6%	86.0%
		MMR	90.5%	91.1%	83.0%	87.0%
		HiB	91.5%	91.3%	80.5%	85.3%
		Hepatitis B	87.6%	88.4%	79.5%	84.3%
		VZV	91.0%	90.6%	82.6%	86.6%
		PCV	80.2%	79.8%	68.3%	75.2%
		Hepatitis A	87.1%	87.9%	81.2%	85.0%
		Rotavirus	73.3%	75.0%	64.5%	71.2%
		Influenza	54.5%	52.7%	45.6%	45.3%
		Combo 2	74.9%	75.0%	64.0%	69.4%
		Combo 3	71.1%	71.7%	60.9%	66.7%
		Combo 4	68.7%	69.4%	59.3%	65.4%
		Combo 5	59.9%	61.6%	52.7%	59.0%
		Combo 6	45.5%	44.5%	38.0%	38.4%
		Combo 7	58.4%	59.9%	51.1%	57.9%
		Combo 8	44.5%	43.9%	37.3%	38.1%
		Combo 9	39.9%	39.8%	33.6%	35.0%
		Combo 10	39.2%	39.3%	32.9%	34.9%
18	Immunizations for Adolescents	MCV4	65.1%	64.3%	60.3%	71.1%
		Tdap/TD	78.5%	76.4%	69.8%	84.4%
		Combo 1	61.6%	61.9%	58.1%	69.9%
19	Well-child visits in first 15 months of life	PHP	63.4%	46.5%	48.3%	52.2%
		MHC	62.5%	51.8%	55.4%	59.2%
		BCBS	62.3%	44.3%	47.9%	58.4%
		UHC	0.0%	0.0%	56.9%	68.9%
20	Well-child visits in third, fourth, fifth and sixth years of life	PHP	66.7%	54.9%	54.8%	55.6%
		MHC	66.5%	63.6%	68.8%	64.4%

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
		BCBS	60.2%	56.6%	57.6%	55.8%
		UHC	0.0%	65.9%	52.6%	53.5%
21	Adolescent well care visits	PHP	48.1%	36.4%	32.3%	33.1%
		MHC	50.8%	51.7%	45.9%	47.7%
		BCBS	39.0%	36.3%	33.1%	32.3%
		UHC	N/A	31.1%	37.2%	32.1%
22	Prenatal and Postpartum care: timeliness of prenatal care and percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Prenatal	84.8%	73.0%	70.7%	76.8%
		Postpartum	61.3%	54.8%	51.2%	57.8%
23	Frequency of ongoing prenatal care		63.2%	52.1%	45.9%	55.8%
24	Breast cancer screening for women		54.5%	52.5%	50.7%	47.2%
25	Cervical cancer screening for women		54.8%	43.2%	48.7%	53.5%
27	Initiation and engagement of alcohol and other drug dependence treatment	Initiation of AOD	N/A	38.6%	37.7%	36.8%
		Engagement of AOD	N/A	14.0%	13.8%	13.5%
40	EPSDT screening ratio		0.82	0.82	0.84	N/A
41	Monitoring for patients on persistent medications		87.5%	84.0%	83.3%	83.6%
45	Medication Management for people with asthma		46.3%	46.3%	52.2%	53.5%
47	Asthma medication ratio		60.2%	52.2%	56.8%	57.1%
48	Adult BMI assessment; weight assessment for children/adolescents		74.2%	78.2%	76.0%	78.6%
49	Comprehensive Diabetes care	HbA1c Testing	83.5%	85.0%	84.1%	N/A
		HbA1c Poor Control (>9.0%)	47.9%	47.2%	49.8%	N/A
		HbA1c Control (<8.0%)	42.7%	43.4%	41.8%	N/A
		Eye Exam	50.4%	55.0%	51.8%	N/A
		Medical Attention for Nephropathy	76.6%	79.1%	87.3%	N/A
		Blood Pressure Controlled <140/90 mm Hg	62.0%	59.3%	58.4%	N/A
58	Antidepressant medication management	Effective Acute Phase Treatment	43.2%	55.6%	53.1%	50.4%
		Effective Continuation Phase Treatment	28.6%	41.1%	37.8%	34.9%

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
74	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications		83.7%	77.6%	77.9%	78.1%
75	Diabetes monitoring for people with diabetes and schizophrenia		62.4%	56.6%	49.9%	57.6%
106	Number and percentage of calls answered; answered within 30 seconds; call abandonment rate		90.6%	90.7%	90.4%	NR by MCOs

Stakeholder Engagement Process Leading to Development of Concept Paper

1. MAC 1115 Waiver Renewal Subcommittee, October 14, 2016

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

1474 Rodeo Road, Santa Fe, NM
October 14, 2016
8:30 – 11:30 AM

Topic	Time
Introductions	8:30 – 9:15 am
Role of subcommittee	
Renewal waiver timeline	
Overview of current waiver	
Areas of focus for waiver renewal	9:15 – 10:10 am
Break	10:10 – 10:20 am
Care coordination	10:20 – 11:25 am
Meeting close – next steps	11:25 – 11:30 am

HUMAN SERVICES DEPARTMENT

CENTENNIAL CARE: NEXT PHASE

Kickoff Meeting of the 1115 Waiver Renewal Subcommittee
October 14, 2016

Agenda

- Introductions
- Role of subcommittee
- Subcommittee guidance
- Renewal waiver timeline
- Overview of current waiver
- Key areas for consideration
- Renewal waiver
- Care coordination
- Meeting close/next steps

HUMAN SERVICES DEPARTMENT

Role of Subcommittee

- Provide feedback on key issues for renewal
- Obtain comprehensive and diverse stakeholder input
- Provide input early in the process
- Help to guide development of the concept paper
- Focus on issues relevant for waiver

HUMAN SERVICES DEPARTMENT

Guidance for Discussion

What is waiver vs. non-waiver topics

Waiver

- System Transformation: Items that require waiver authority to implement
- Eligibility changes or expansions
- Benefit packages
- Financing

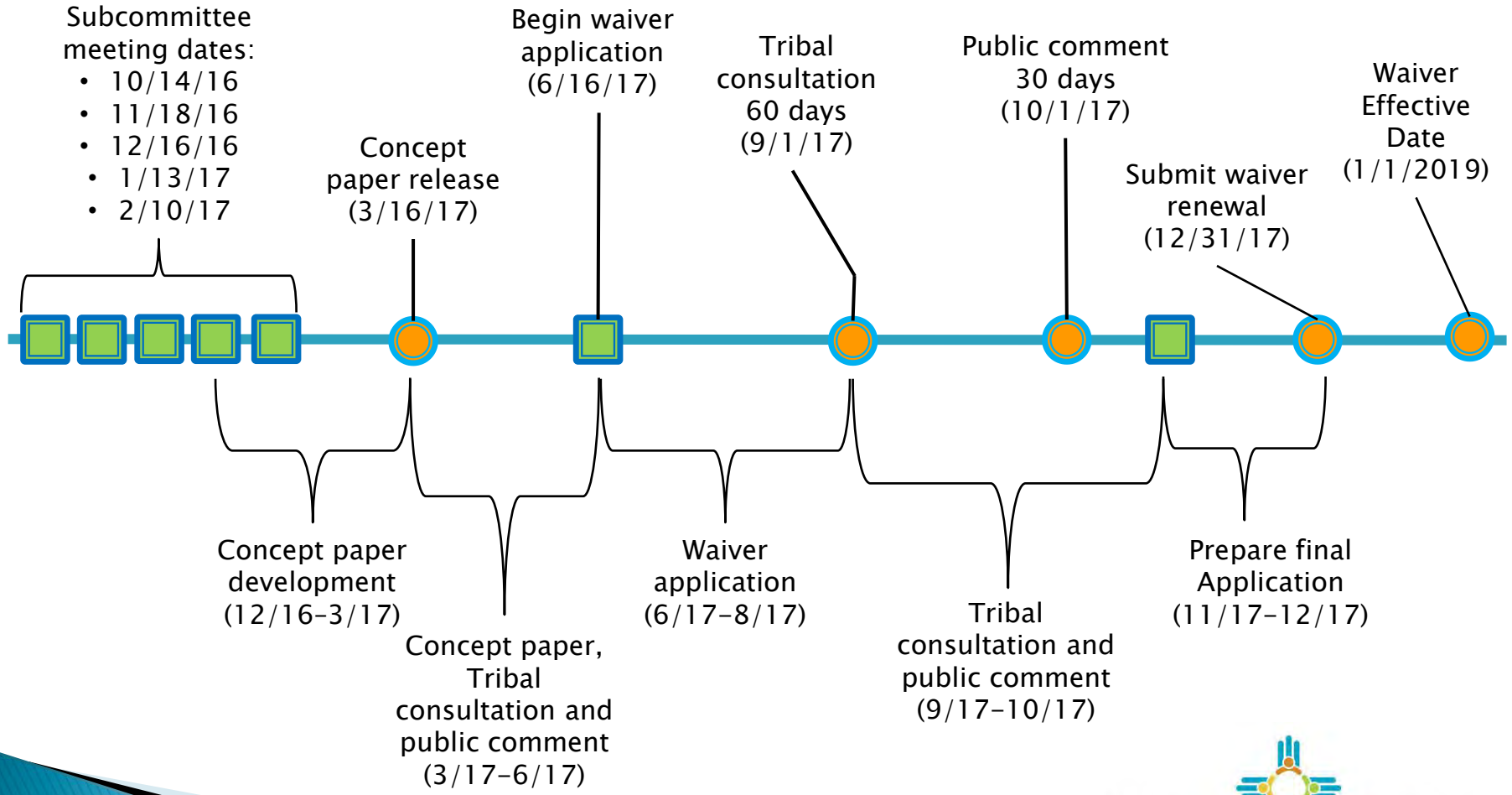
Non-Waiver

- Policy or implementation issues
- New contract terms, process, or tools
- Modification of provider qualifications
- Implementation of quality strategy and monitoring approaches

HUMAN SERVICES DEPARTMENT

1115 Waiver Renewal

Timeframe



HUMAN SERVICES DEPARTMENT

Overview of Current Waiver

Program Goals

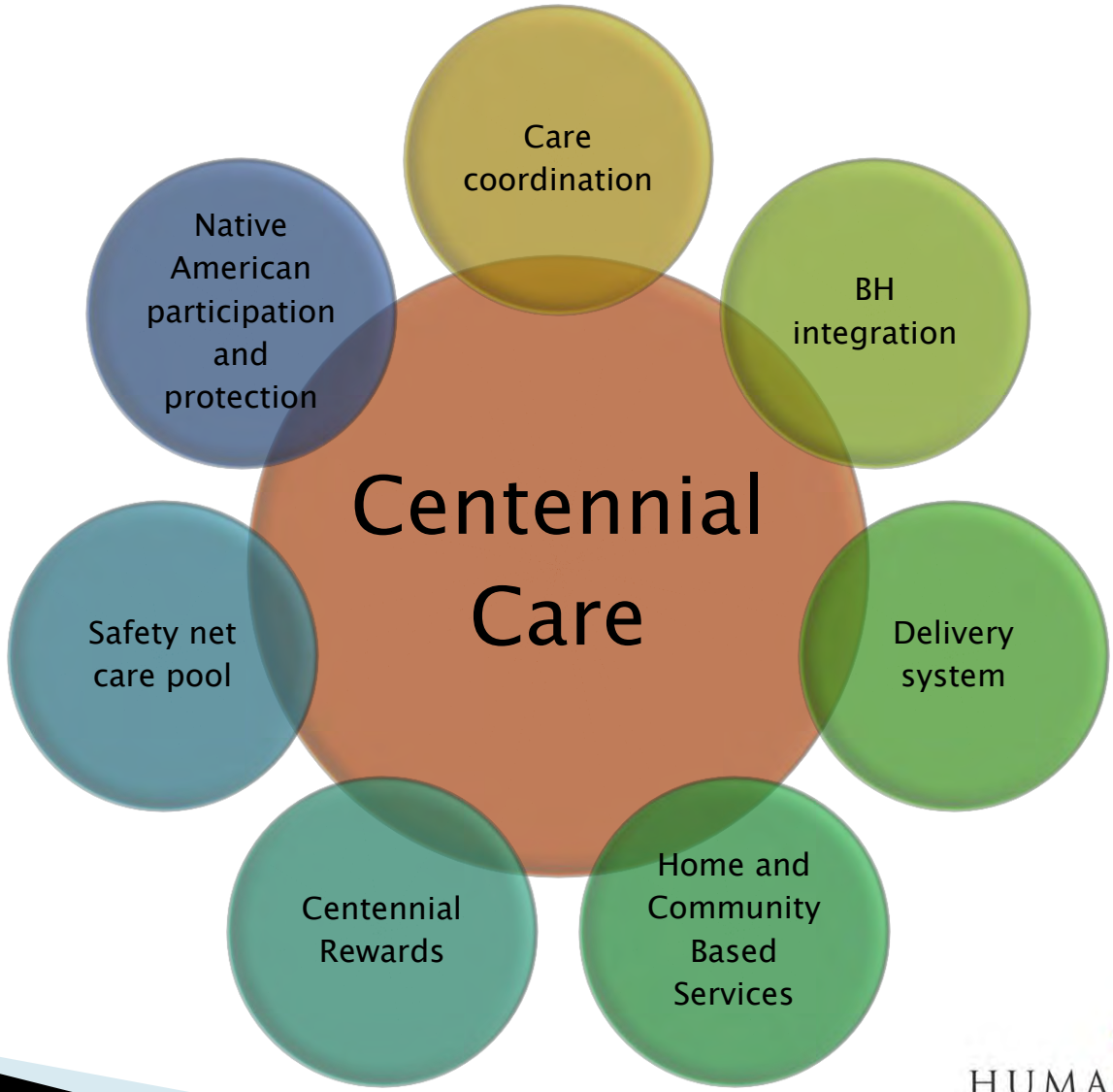
- To assure that enrollees receive the right amount of care at the right time and in the most cost appropriate or "right" settings
- To assure that the care being purchased by the program is measured in terms of quality and not solely quantity
- To bend the cost curve over time
- Streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 individuals beginning January 2014

Guiding Principles

- Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State's Medicaid program
- Encouraging more personal responsibility by members for their own health
- Increasing the emphasis on payment reforms that pay for quality rather than for quantity of services delivered
- Simplifying administration of the program for the state, for providers and for members where possible

HUMAN SERVICES DEPARTMENT

Overview of Centennial Care



HUMAN SERVICES DEPARTMENT

Current Program Successes

Principle 1

Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an integrated, person-centered model of care

- Care coordination
  - 950 care coordinators
  - 60,000 in care coordination L2 and L3
  - Focus on high cost/high need members
- Health risk assessment
  - Standardized HRA across MCOs
  - 610,000 HRAs
- Increased use of community health workers
  - 100+ employed by MCOs
- Increase in members served by PCMH
  - 200k to 250k between 2014 and 2015
- Telemedicine – 45% increase over 2014
- Health Home – Implemented Clovis and San Juan (SMI/SED)
- Expanding HCBS – 85.5% in community and increasing community benefit services
- Electronic visit verification
- Reduction in the use of ED for non-emergent conditions

HUMAN SERVICES DEPARTMENT

Current Program Successes

Principle 2

Encouraging Personal Responsibility

Offer a member rewards program to incentivize members to engage in healthy behaviors

- Centennial Rewards
  - health risk assessments
  - dental visits
  - bone density screenings
  - refilling asthma inhalers
  - diabetic screenings
  - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: $23 million
  - Reduced IP admissions
  - 43% higher asthma controller refill adherence
  - 40% higher HbA1c test compliance
  - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

HUMAN SERVICES DEPARTMENT

Current Program Successes

Principle 3

Increasing Emphasis on Payment Reforms

Create an incentive payment program that rewards providers for performance on quality and outcome measures that improve members health

- July 2015, 10 pilot projects approved
  - ACO-like models
  - Bundled payments
  - Shared savings

- Developed quarterly reporting templates and agreed-upon set of metrics that included process measures and efficiency metrics

- Subcapitated payment for defined population
- Three-tiered reimbursement for PCMHs
- Bundled payments for episodes of care
- PCMH Shared Savings
- Obstetrics gain sharing

- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts

HUMAN SERVICES DEPARTMENT

Current Program Successes

Principle 4

Simplify Administration

Create a coordinated delivery system that focuses on integrated care and improved health outcomes; increases accountability for more limited number of MCOs and reduces administrative burden for both providers and members

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; streamline application and enrollment processes for members; and develop strategies with MCOs to reduce provider administrative burden
- One application for Medicaid and subsidized coverage through the Marketplace
- Streamlined enrollment and re-certifications
- MCO provider billing training around the State for all BH providers and Nursing Facilities
- Standardized the BH prior authorization form for managed care and FFS
- Standardized the BH level of care guidelines
- Standardized the facility/organization credentialing application
- Standardized the single ownership and controlling interest disclosure form for credentialing.
- Created FAQs for credentialing and BH provider billing

HUMAN SERVICES DEPARTMENT

Future Outlook and Opportunities

Outlook

- As Medicaid approaches covering almost half of New Mexico's two million population, immense opportunity to drive value and health outcomes for our State
- Continued Medicaid enrollment growth/spending growth combined with reduced oil and gas revenue and an aging population continue to drive—
  - Innovations for LTSS program and better management of dually-eligible population
  - Advancement of value-based purchasing arrangements
  - Strategies to improve care for high utilizers—5 percent of members who account for 50% of spend

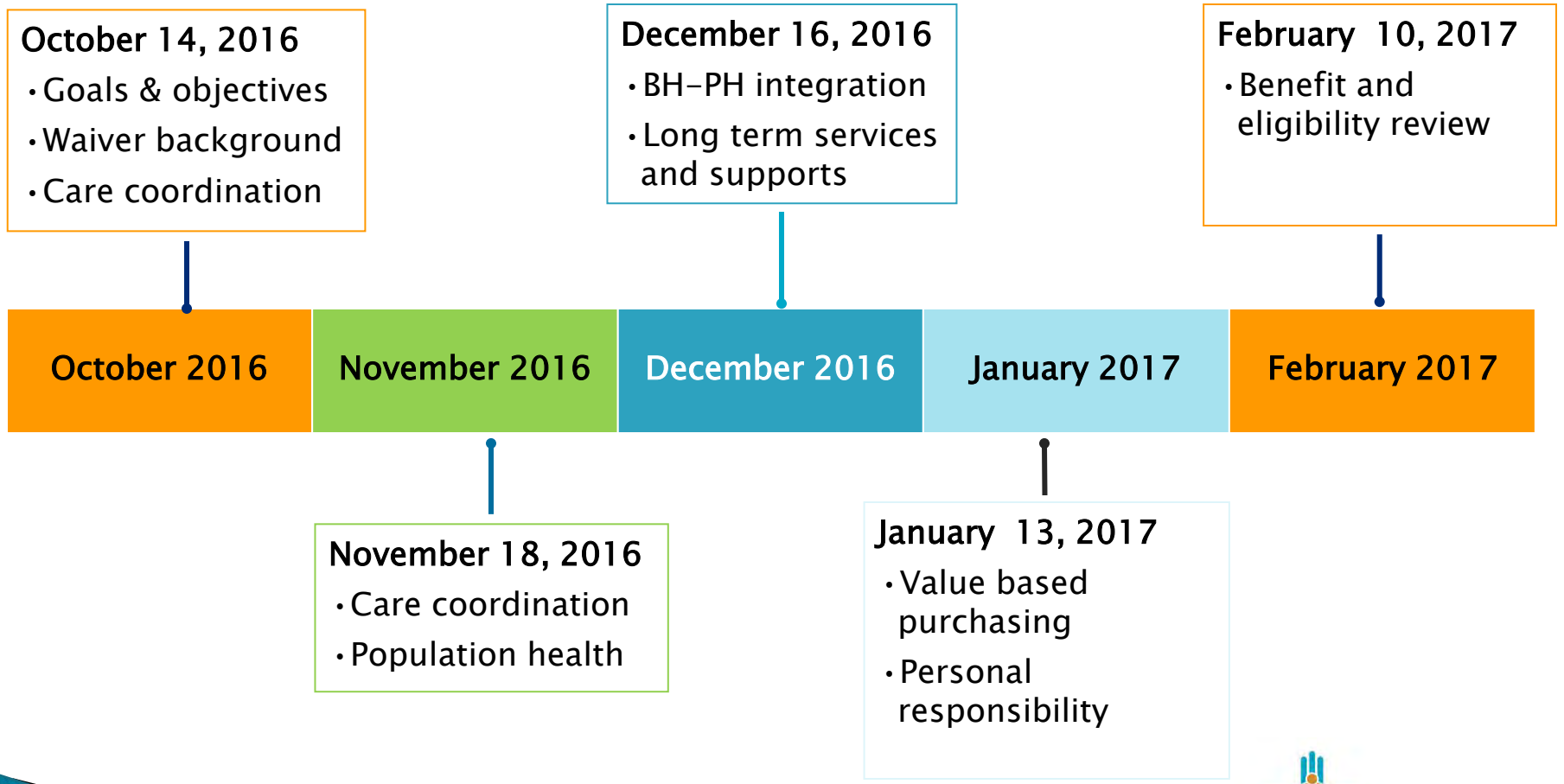
Opportunities

- Continue to build upon existing waiver goals and principles
- Improve engagement for unreachable members
- Appropriate level of care coordination for high need populations
- Performance incentives for MCOs and providers

HUMAN SERVICES DEPARTMENT

Subcommittee Meetings

Timeframe for Discussion



HUMAN SERVICES DEPARTMENT

Renewal Waiver

- Areas of Focus

HUMAN SERVICES DEPARTMENT

Renewal Waiver

Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address population health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

HUMAN SERVICES DEPARTMENT

Care Coordination

Opportunities/Goals

- Improve transitions of care
- Focus on higher need populations
- Provider's role in care coordination

HUMAN SERVICES DEPARTMENT

Care Coordination

Improve Transitions of Care

1. Improve Transitions of Care

- Follow-up after 7 days
- Readmission rates
- Care Coordination chart audits demonstrating opportunities to improve transitions of care
- There is also evidence in Care Coordination audits that suggest a higher-level of care coordination is needed during these critical transitions

Benefit	Challenges	Questions/Feedback
➢ Reduce readmissions ➢ Improve member confidence in their healthcare and providers ➢ Ensure care delivered in the right place	➢ Communication with hospitals/facilities ➢ Engagement of family and other community supports ➢ Member adherence to recommended follow-up	1. What is the value of this initiative to the program overall? 2. What are strategies to improve communication between MCOs and Providers? 3. What are strategies to better engage families? 4. What is the capacity to increase planning and follow-up by care coordinators?

HUMAN SERVICES DEPARTMENT

Care Coordination
Focus on higher need populations

2. Focus on high utilizers, children with special health care needs, difficult to engage members and incarcerated populations

- Use of the Emergency Department (ED) to meet primary care needs
- The largest percentage of high utilizers has a behavioral health diagnosis including mental health and substance abuse.
- Children with special health care needs require unique care coordination interventions due to extent of health needs.
- Incarcerated population requires early interventions prior to release to increase community tenure and recidivism rates.

HUMAN SERVICES DEPARTMENT

Care Coordination

Focus on higher need populations

Benefit	Challenges	Questions / Feedback
➢ Reduced ED use ➢ Reduced hospitalization and re-admission rates ➢ Increase comprehensive holistic care through primary care and specialists ➢ Reduced recidivism ➢ Improved continuity of care	➢ Accessible primary care particularly after-hours ➢ Member understanding/acceptance of appropriate use of the ED ➢ Follow-up care after ED visits ➢ Engaging hard to reach members in care coordination ➢ These populations have high social, economic and resource needs	1. What is the value of this initiative to the program overall? 2. What are other strategies beyond care coordination that may be effective? 3. How can we incentivize participation in care coordination through co-payments (i.e., waive some co-pays for those engaged in care coordination or charge co-payment for non-emergent use of ED)? 4. How can we use Community Health Workers or others as resources for a more intensive touch for these members? 5. What are some interventions to engage hard to reach members?

HUMAN SERVICES DEPARTMENT

Care Coordination

Provider's role in care coordination

3. Increase Access to Care Coordination at Provider Level

- National best practice evidence suggests that provider-based care coordination has the most impact on members who are difficult to engage
- Providers have the most interaction with members and impact on their health
- There are providers in the community who are interested in delivering care coordination and have the capacity and experience to do so
- Additionally providers are increasingly invested in the outcomes for their members as they take on more financial risk through participation in value based purchasing initiatives

HUMAN SERVICES DEPARTMENT

Care Coordination

Provider's role in care coordination

Benefit	Challenges	Questions / Feedback
➢ Efficiency in locating and interacting with members, accessing records and health history ➢ Improve member confidence and trust in their healthcare and providers ➢ Strengthen relationships between members and primary care ➢ Improve preventative care rates ➢ Reduce unnecessary ED utilization	➢ MCO role in quality and provider oversight ➢ Avoiding duplication of efforts ➢ Data sharing and tracking ➢ Reducing confusion for members in transitions ➢ Payment structures ➢ Readiness to deliver all elements of care coordination in the provider community	1. What is the value of this initiative to the program overall? 2. What are challenges we have not already identified? 3. How do we build capacity and readiness in the provider community? 4. Who should be delegated and how does the State encourage delegation (i.e., incentives to MCOs for reaching a percentage of delegation)? 5. Without delegation, what other strategies can we implement to be more inclusive of providers in responsibility for outcomes? 6. What are the minimum staff qualifications to provide care coordination at the provider level?

HUMAN SERVICES DEPARTMENT

Next Steps

- Next subcommittee meeting November 18th
- Subcommittee documents
- Email for follow-up questions/clarifications
  - Email Address: **HSD-PublicComment2016@state.nm.us**
  - Include "Waiver Renewal" in email subject line:
  - Include a background, proposed solution and impact in your correspondence

- **Information Links**
  - Centennial Care (CC) 1115 Waiver Submission Documents:
  - http://www.hsd.state.nm.us/Centennial_Care_Waiver_Documents.aspx

  - Centennial Care 1115 Waiver Approval Documents:
  - http://www.hsd.state.nm.us/approvals.aspx

  - Centennial Care Reports:
  - http://www.hsd.state.nm.us/reports.aspx

HUMAN SERVICES DEPARTMENT

Centennial Care 1115 Waiver Renewal Subcommittee
Care Coordination Brief
October 14, 2016

Background

Launched on January 1, 2014, Centennial Care provides a comprehensive delivery system for Medicaid members that integrates physical, behavioral and long-term care services; ensures cost-effective care; and focuses on quality over quantity.

Fundamental to the program is a robust care coordination system that requires coordination at a level appropriate to each member's needs and risk stratification. The care coordination program creates a person-centered environment in which members receive the care they need in the most efficient and appropriate manner. Care coordination activities include:

- Assessing each member's physical, behavioral, functional and psychosocial needs;
- Identifying the medical, behavioral and long-term care services and other social support services and assistance, such as housing and transportation;
- Ensuring timely access, coordination and monitoring of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and resource assistance needed in order to promote each member's health, safety and welfare.

All Medicaid members receive a health risk assessment (HRA) and are placed in an appropriate level of care coordination 2 or 3. Those in higher levels of care coordination (level 2 or 3) receive a comprehensive needs assessment (CNA) to assess physical, behavioral and long-term care (LTC) needs and receive a person-centered care plan. Members in care coordination level 2 receive semi-annual in-person visits, quarterly telephone contact, and an annual CNA to determine if the level of coordination and care plan are appropriate. Members in care coordination level 3 receive monthly telephone contact, quarterly in-person visits and a semi-annual CNA to determine if the level of coordination and care plan are appropriate.
The following outlines the requirements for care coordination level 2 and 3:

Based on the CNA, care coordination **level 2** will be assigned to a member with **one** of the following:

- Co-morbid health conditions;
- High emergency room used, defined as 3 or more emergency room visits in 30 days;
- A mental health or substance abuse condition causing moderate functional impairment;
- Requiring assistance with 2 or more Activities of Daily Living (ADL) or Instrumental Activities of Daily Living(IADL) living in the community at low risk;
- Mild cognitive deficits requiring prompting or cues; and/or
- Poly-pharmaceutical use, defined as simultaneous use of 6 or more medications from different drug classes and/or simultaneous use of 3 or more medications from the same drug class.

Based on the CNA, care coordination **level 3** will be assigned to a member with **one** of the following:

- Who are medically complex or fragile;
- Excessive emergency room use as defined as 4 or more emergency room visits in a 12 month period;
- A mental health or substance abuse condition causing high functional impairment;
- Untreated substance dependency based on the current DSM or other functional scale determined by the State;
- Requiring assistance with 2 or more ADLs or IADLs living in the community at medium to high risk;
- Significant cognitive deficits; and/or
- Contraindicated pharmaceutical use.

The following outlines the caseload to care coordination ratios:

Care coordination level 2: • Members not residing in a nursing facility 1:75, and • Members residing in a nursing facility 1:125; and • Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit 1:100;
Care coordination level 3: • Members not residing in a nursing facility 1:50; and • Members residing in a nursing facility 1:125; and • Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination 1:75; and
Care coordination for Members who participate in the Self-Directed Community Benefit: • Members under age of twenty-one (21) 1:40

Care Coordination Monitoring

The State conducts a variety of activities to monitor the MCOs' care coordination activities. In 2014 and 2015, the State conducted 1 onsite audit and 2 desk audits of MCO Care Coordination member records. The desk audits have shown:

- Improvement in MCO compliance with Care Coordination contractual requirements
- A need for further development of the MCO care coordinators, including improving member engagement rates and
- A need for improved documentation of member needs.

As a result, the MCOs developed internal action plans to address concerns or deficits found in the audits. Action plans include more information about the MCOs' self-auditing, trend identification, and details related to following-up on expected outcomes. The State conducts ongoing monitoring of the MCOs' internal action plans, provides ongoing technical assistance, and conducts trainings for MCO Care Coordinators on general Care Coordination activities and Care Coordination documentation requirements.

Each year, Medicaid Centennial Care members participate in the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey. In relation to Care Coordination, the survey reported an average of 78% member satisfaction for the 2014 survey. The 2015 survey is due in October 2016. In

addition, the MCOs are required to submit quarterly reports to the State regarding care coordination activities including the number of HRAs, CNAs and Comprehensive Care Plans (CCPs) completed.

Accomplishments Related to Care Coordination

The Centennial Care MCOs have hired approximately 950 care coordinators. The MCOs have conducted 610,000 health risk assessments and have assigned 70,000 members to higher levels of care coordination (levels 2 and 3). These assessments have resulted in more than 250,000 members receiving care in patient-centered medical homes and more than 24,000 members receiving home and community based services. The MCOs have collaborated with the University of New Mexico's ECHO Care program to provide access to an intensivist team for 500 high need/high cost members that included primary care physicians, behavioral health counselors, specialists as needed, and community health workers.

During the period of September 2014 through June 2016, the MCOs launched a campaign to reach those members who were unreachable. Successful strategies included but were not limited to:

- Call campaigns were implemented;
- Contracts with several organization were established to complete HRAs;
- Member advocates were deployed to residential addresses to make in-person visits;
- Specialized care coordination teams were developed to locate members; and
- Offices were set-up specifically for walk-in members who need assistance.

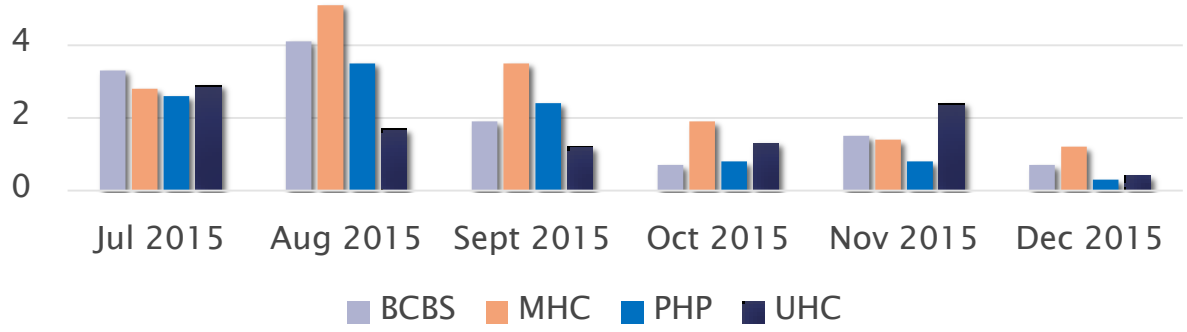
As a result, 248,513 previously unreachable members were successfully reached by the MCOs during this campaign. The percent of unreachable members, as compared to enrollment, decreased to 11.62% and 164,267 HRAs were completed during this period.

In order to develop a solid Care Coordination infrastructure, the State and the MCOs recognized the importance of Community Health Workers (CHWs) in assisting with the engagement of members in their healthcare. CHWs also provide health education, health literacy, and community support linkage. The State included a Delivery System Performance Improvement Target within the MCOs' contracts to increase the utilization of CHWs. To date, the MCOs have:

- Employed more than 100 CHWs directly or through a contractual relationship;
- Utilized CHWs to work with members who are high Emergency Department (ED) utilizers and redirect them to PCPs; and
- Partnered with UNM to expand the role of CHWs

In addition to the use of CHWs in working with members who have high ED utilization, the State implemented the Super Utilizer Project with MCOs to track members with ED use. The goal of the project is to review MCO care coordinator activities with the selected members in an effort to reduce this utilization, as well as share successful activities resulting in reduced utilization with all MCOs. The MCOs have identified that intensive engagement with some members and addressing their medical deficits (i.e., inability to fill medications) their ED utilization decreases. It is important to note

that some members take longer to accept the engagement and some will ultimately refuse. The following graph illustrates progress in ED reduction for the top 10 utilizers with each MCO.



The State provided the MCOs with access to the Predictive Risk Intelligence System (PRISM) to assist with monitoring member utilization. PRISM provides the MCOs with historical member service utilization. The MCOs have collaborated to begin utilization of the Emergency Department Information Exchange (EDIE), to enhance Care Coordination Activity at Emergency Departments. EDIE will provide the MCOs with real time data regarding member utilization of the ED. HSD had defined varying levels of ED utilization (excessive, frequent, and high) for the MCOs to better define the need for care coordination for members.

In 2015, in an effort to streamline care coordination processes, the State and the MCOs collaborated to streamline the Health Risk Assessment (HRA) across all four MCOs. Streamlining of the HRA provided uniformity for MCOs in identifying Medicaid members who need a CNA and potentially a higher level of care coordination.

In 2016, the State and MCOs implemented the Health Home project for members with Severe Mental Illness (SMI) or Severe Emotional Disturbance (SED) in 2 counties (Curry and San Juan) to enhance the integration and coordination of primary, acute, behavioral health and long-term care services. This phase I implementation allows for the delegation of care coordination to the selected provider agencies and allows HSD to monitor impact for potential expansion statewide.

Additional MCO care coordination initiatives include:

- Molina Healthcare working with the Metropolitan Detention Center (MDC) to begin Care Coordination prior to an incarcerated member's release.
- MCOs partnering with community agencies, such as Albuquerque Ambulance and Kitchen Angels, to conduct home visits for super ED utilizers.

Care Coordination Challenges

As Centennial Care continues to grow, there continues to be room for improvement and opportunities to enhance the program through furthering best practices identified. Engaging certain members in the care coordination process continues to be a challenge, particularly those who are classified as "high

utilizers". Communication between care coordinators and various partners (hospitals, nursing homes) needs to be strengthened and incentivized. Thoughtful role definition and collaboration between MCO care coordinators and Department of Health case managers for the Developmentally Disabled and Medically Fragile populations requires continuous review. Finally, HSD continues to work towards further enhancing the seamless integration of physical and behavioral health services.

New Ideas for Care Coordination

HSD has reviewed information from a variety of data sources including claims and utilization trends, HEDIS outcomes, MCO reports, Special Project reports and Care Coordination reviews and file audits. In addition, HSD continually looks to other states for models with positive outcomes. Great strides have been made in the implementation of a comprehensive care coordination model, the training and capacity building of MCO staff and initial outcomes from the investment in care coordinators.

HSD has identified a few areas where an enhancement or shift in the approach to Care Coordination promises to continue to improve health outcomes, lower cost and increase member participation in managing their own care.

While these are not the only ideas HSD is considering, the following are Care Coordination priorities for discussion with this sub-committee as we continue the process of refining our vision:

- Focus on Transitions of Care through targeted care coordination.
- Increase care coordination and competency to manage the unique challenges of special populations such as high utilizers, inmate populations, and members who are difficult to engage in care coordination.
- Increase access to care coordination functions at the provider level when appropriate
- Implement a Coordination First Model - allows for multiple care coordination contacts to complete assessments
- Expansion of the Health Home pilot to allow selected providers to conduct care coordination activities

Stakeholder Engagement Process Leading to Development of Concept Paper

2. MAC 1115 Waiver Renewal Subcommittee, November 18, 2016

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

1115 Waiver Renewal
MAC Subcommittee Meeting

Presbyterian Learning Center Room 13110
Presbyterian Cooper Center
9521 San Mateo Blvd. NE
Albuquerque, NM 87113

November 18, 2016
8:30 – 11:45 AM

Topic	Time
Introductions	8:30 – 8:40 am
Feedback from October meeting	8:40 – 8:45 am
Care coordination discussion	8:45 – 10:00 am
Break	10:00 – 10:10 am
Population health discussion	10:10 – 11:20 am
Public comment	11:20 – 11:35 am
Meeting close	11:35 – 11:45 am

Medicaid 1115 Waiver Renewal Subcommittee Meeting
Meeting Minutes
November 18, 2016 — 8:30am – 11:30am
Presbyterian Cooper Center 9521 San Mateo Blvd. NE, Albuquerque, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department	Jim Jackson, Disability Rights New Mexico
David Roddy, New Mexico Primary Care Association	Linda Sechovec, New Mexico Health Care Association
Dawn Hunter, Department of Health	Sandra Winfrey, Indian Health Service
Jeff Dye, New Mexico Hospital Association	Naomi Sandweiss, Parents Reaching Out (proxy for Lisa Rossignol)
Christine Boerner, Legislative Finance Committee	Dave Panana, Kewa Pueblo Health Corp.
Joie Glenn, New Mexico Association for Home & Hospice Care	Mary Eden, Presbyterian Health Plan
Kristin Jones, CYFD (proxy for Sec. Jacobsen)	Fritzi Hardy (proxy for Doris Husted), The Arc of New Mexico
Carol Luna-Anderson, The Life Link	Rick Madden, New Mexico Medical Society
	Carolyn Montoya, University of New Mexico, School of Nursing
Mary Kay Pera, New Mexico Alliance for School-Based Health Care	Lauren Reichert (proxy for Steve Kopelman), New Mexico Association of Counties

Absent Members:

Steve Kopelman, New Mexico Association of Counties	Patricia Montoya, New Mexico Coalition for Healthcare Value
Kris Hendricks, Dentistry for Kids	Lisa Rossignol, Parents Reaching Out
Monique Jacobsen, Children Youth and Families Department	Doris Husted, The Arc of NM

Staff and Visitors Attending:

Nancy Smith-Leslie, HSD/MAD	Robyn Nardone, HSD/MAD
Angela Medrano, HSD/MAD	Tina Sanchez, HSD/MAD
Wayne Lindstrom, HSD/BHSD	Laine Snow, HSD/BHSD
Karen Meador, HSD/BHSD	Cynthia Melugin, HSD/BHSD
Michael Nelson, HSD	Jared Nason, Mercer
Kari Armijo, HSD/MAD	Jessica Osborne, Mercer
Dan Clavio, HSD/MAD	Cindy Ward, Mercer
Kim Carter, HSD/MAD	Amilya Ellis, UHC

Tallie Tolen, HSD/MAD Theresa Belanger, HSD/MAD Curt Schatz, UHC Liz Lacouture, PHP Jessica Bloom, Consumer advocate Pauline Lucero, Isleta Elder Center Lisa Maury, New Mexico Coalition to End Homelessness Maggie McCowen, New Mexico Behavioral Health Providers Assoc. Elly Rael, UHC Jeanene Kerestes, BCBSNM Shawnna Romero, BCBSNM Mary Kate Nash, HCS/Molina	Patricia Lucero, Isleta Elder Program Teresa Turietta, New Mexico Assoc. Home & Hospice Care Margaret White, HealthInsight New Mexico Debi Peterman, HealthInsight New Mexico Jennifer Crosbie, Senior Link Deanna Talley, Molina Kyra Ochoa, Santa Fe County Rachel Wexler, DOH Sarah Howse, PMS Beth Landon, NMHA

Agenda Item	Details	Discussion
I. Introductions	• Jared Nason from Mercer and Angela Medrano delivered opening comments. • Reviewed options for providing comments and recommendations in addition to the meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal • All are encouraged to use the website to submit additional comments that were not mentioned during the meetings. • All recommendations regarding care coordination (CC) and population health should be submitted by November 30, 2016.
II. Care Coordination – Transitions of Care	• Identify funding to focus on facilities improving discharge planning. • Enhanced care coordination as part of transitions (short-term): – Jail release, inpatient stay, nursing facility to community, children in residential facilities. • Incentives for outcomes of a successful discharge: – Attend follow up PCP visit, no unnecessary ED visit post discharge for 30 days, no preventable readmission post discharge for 30 days, filling medications, completing medication reconciliation (provider). • Incentives for member adherence to recommended follow-up. • Member rewards.	• Carolyn commented that many members do not have a primary care physician (PCP) and cannot get one assigned quickly enough. • Wayne commented that Behavioral Health Services Division (BHSD) will have an emergency department (ED) information exchange tool next year that will help promote real time interventions. • Children, Youth, and Families Department (CYFD) recommended focus on out-of-home placement transitions in addition to residential. • Mary noted that Presbyterian is working on the Emergency Department Information Exchange (EDIE) system Wayne referred to, phase 1 rolls out November. Most hospitals are in final contract phase and will sign and link-in by the end of 2016. • MAD should focus on elements of the system that are least likely to be “thrown-out” under the new Federal administration. • Measure discharge outcomes at 30 and 60 days for released inmates as this is a critical time particularly for those with substance abuse issues. • Managed care organizations (MCOs) need information at discharge as quickly as possible.

Agenda Item	Details	Discussion
		• Dave noted that most Native American Members are in fee-for-service (FFS). There is a practice in place to assign care manager who sees member prior to discharge and provides assistance with PCP follow-up, durable medical equipment and prescription. This is a challenge because the practice is only open Monday through Friday. This could be replicated in other practices. — Many tribes have community health representatives performing care management tasks but are not reimbursed for it. • Jeff Dye commented that hospitals are challenged by unnecessarily long "Awaiting Placement" status during the approval process. Auto authorizations or a supplement payment to hospital would "grease the skids for approval." — Expand readmission measure to look at what caused the readmission. • Linda commented to look at Illinois model for Medicaid billing during discharge planning for incarcerated individuals. — Look at medication reconciliation practices between hospital and receiving facility to identify discharge issues. • Carol noted that transition is complicated by homelessness and is a cost driver. • Joie commented that skilled nursing visits after discharge is underutilized and should be incented. • David requested additional data on the transition issues. Notes that it appears that each MCO would be challenged to cover all hospitals. Recommends considering a consolidated approach and not require four MCOs to

Agenda Item	Details	Discussion
		build care management programs. – Review Colorado's regional approach to care coordination.
III. Care Coordination – Higher Needs Populations	• Improved engagement of family and other community supports: – Family/caregiver role, increase use of community health workers / Certified Peer Support Workers (CPSWs). • Promote creative approaches by MCOs to support unique high needs populations. • Focused education and interventions that are condition or location specific: – Areas with fewer providers, transportation issues and/or specific cultural aspects, areas with high risk pregnancies, with high prevalence of diabetes, chronic obstructive pulmonary disease and other chronic diseases. • Use of Community Health Workers for more intensive "touch" for these members. • Expand health homes. • Use of population health information to develop targeted education and interventions.	• Carolyn noted concern about increasing the family/caregiver role and stated that we rely heavily on parents who best understand a child's complex needs however "we are turning parents into nurses and if we are doing that there needs to be more in terms of respite for these families." • Lauren recommended looking at personal care services (PCS)-like payment for home care for a few hours a week if the family is doing the work anyway. – Consider use of incentives, gift and gas cards when Members achieve certain goals. Expand comprehensive community support (CCS) billing to others outside core services agencies and allow intensive case management (ICM) to bill as well. Allow transportation workers to have the opportunity to engage members and expand their role from "bus driver" to support staff. • CYFD is investing in a wraparound model: child and family teams that has large care coordination components; they have identified support of the family and family child team. – Consider children who are being reunited with their family as a higher need population. Without appropriate services that are timely, the reunification is at-risk. – The intensity of care coordination is higher than people receive in the current model. Caseloads are too high for this population. – Focus on health literacy and developing providers that

Agenda Item	Details	Discussion
		will communicate to members about available resources. Look at strategies that support participation in needed services and activities. • Carol notes that caseloads are too high. 1:200 case load is not a relationship; the relationship is what brings change and builds engagement; and is why peer support workers work- they have a relationship with members. – Mercer asked for Carol to add information on how to prioritize care coordination considering a limited number of available care coordinators and limited funding: where should the State focus for this recommendation. • Mary Kay Pera: School–based health centers should be leveraged better. They are identifying kids at risk for emotional and physical needs including prenatal care. The kids trust the support staff there, and they know these children; mostly school clinicians and other support staff at schools. They are ideal for care coordination of adolescents. • MCOs should collaborate with local community resources and provide compensation to the local resources that provide CC to members; these community service providers are doing CC (MCO and FFS members and not getting reimbursed for this). • Consider concept of Para-Medicine: Emergency medical services contact high users/hard to engage and form relationship in a way that no other health worker really has and results are promising. • Naomi, proxy for Lisa Rossignol: "Members are saying they do not even know about CC" or "my CC keeps changing" and "if I speak Spanish, phone contacts are more challenging, and we would prefer face-to-face

Agenda Item	Details	Discussion
		contacts". • Monique commented about transition for youth aging out of foster care and juvenile justice system; high risk for homelessness and incarceration. – Explore Youth Peer Support Workers. • Fritzi noted that guardians get left out of transition and discharge conversations. – There are too many CCs; parents of kids on Waivers have too many CCs to share their story; provide more services to the parent- do not need all of these CCs (adult children in parent's home). – CCs are not completing tasks requested of them. • Dave commented that MCOs are not held accountable; assessments for Tribal members are not occurring; so shift the money or put stronger requirements on the MCOs; majority of tribes are complaining about the MCO conducting assessment as they (the Tribal members) already know the member and do not see value in the duplication of effort to assess by MCO. • Lauren commented that counties are using cash accounting versus accrual practices; could we get help to switch to accrual to work more effectively with Medicaid.
IV. Care Coordination – Provider Role	• Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination. • MCOs could share dollars with local programs for direct linkages to members. • MCO and Provider Incentives for outcomes. • Value-based payment approaches mean more responsibility for providers to provide	• General comment and discussion: – Focus on a higher level of physical health-behavioral health (PH-BH) integration. – Competencies within CC and with providers are in siloes. Example - anxiety disorders showing up as chest pain; and those with chronic or acute PH conditions show up as having emotional issues; Look for ways to do a better job integrating and educating providers. Note – This is the topic for the December meeting.

Agenda Item	Details	Discussion
	care coordination to meet value based payment goals. • Value-based payment approaches will involve / delegate care coordination to providers.	– Patient-centered medical homes (PCMHs) are doing this: if they are meeting the requirements of the PCMH; it is more than training it is frame of mind to be open to assisting BH comorbidities. – Community Asset Mapping and Hospital Community level data should be built into the CC model. – In Long Term Care (LTC): facilities need a better understanding of where the MCO CC and the hospital CC roles lie and how they work toward the same goals. – Providers need clarification on what information can be shared especially those that provide confidential services. – We are not hearing from everyone who is touching or caring for a member and it builds a holistic view of the member and their needs. – MCOs are getting paid for CC while the community CC is still occurring. They are not getting the financial support and the "addition" of MCO CC is not only a waste of dollars, it further fragments CC for the member. – If we are thinking about moving CC and "flexing" where CC occurs the MCO requirements need to be aligned and accountable for things they can control and report. • Mary Kay -School-based clinics are doing PH-BH integration. – Need flexibility for where CC exists: community needs likely vary and it could vary by individual where the 'best' place for CC may be for that member. • Fritzi mentioned that provider turn-over means that the

Agenda Item	Details	Discussion
		term Medical Home really isn't a home.
V. Population Health	• Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination. • MCOs could share dollars with local programs for direct linkages to members. • MCO and Provider Incentives for outcomes. • Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals. • Value-based payment approaches will involve / delegate care coordination to providers.	• Department Health has robust collection of health data; use existing data that looks at highest disease burden. • Consider the following populations for focus: – Tobacco use – Obesity – All high cost drivers – High teen birth rates – Geography: looking at neighborhoods – Food deserts – High pollution – Seniors age 60 and beyond – High-risk populations coming out of jail. • Secretary Copeland - Support family care givers who support this population through Alzheimer's Association and Savvy Care Giver program to relieve care giver burden. • General comment and discussion: – Consider partnering with Senior Centers and providers to help keep people in their homes. – Support Senate Bill-42 to improve justice reform and divert Medicaid members prior to being incarcerated through diversion programs. – Provide police training for people with identified mental health (MH) issues versus criminal issues. • Naomi commented that adverse childhood experiences and link to health outcomes and incarceration and substance abuse (SA). • CYFD commented to focus on parents who have children at risk for out of home placement.

Agenda Item	Details	Discussion
		– Employment of CYFD youth; need jobs and life skills. • Carol Luna-Anderson: MH and trauma population have shorter life-expectancy and disparities in outcomes. Many are tobacco users and have poorer self-care and the chronicity of disease tends to be high cost toward end of disease. • Fritzi notes that she has heard for years that we need a resource book and if it is created, it is out of date almost immediately or focuses on specific populations such as individuals with developmental disabilities. • Wayne commented that the BH collaborative has an automated portal and contains a resource directory for LTC and Veterans Services. Providers can enter detailed information on the service and within 24 hours, a provider is contacted to verify the information. Information is uploaded to the system after validation occurs. – A service directory will only be good if providers update their information. – The MCOs could require that their providers supply information. – There is a site called New Mexico Network of Care: 3 Different Portals. – CYFD has a site for community resources. – Affordable Housing is a real need: support and supported housing services are desired and can impact outcomes. • MCO: The new Medicaid Management Information System will be a great tool to look at health issues and disparities. • Support services really are keys to improving population health outcomes.

Agenda Item	Details	Discussion
		• Karen commented that some states have added services to support pre-tenancy and staying in housing. – Supports that help keep them in housing and linking to service and health supports. • Department of Health commented that there is a lack of education for providers to identify SA issues and social determinants of health needs. – Not everything that is needed can be solved by Medicaid; and not everything can be "outcomes" based and aging is an example. Outcome measures can drive restriction to care. For example, reducing readmissions rates can be achieved by not admitting them to avoid the penalty. • General comment and discussion: – Language we use in waiver should appeal to new administration and focus on needs of rural areas. – Rural transportation is major New Mexico issue, particularly with seniors. • David-Tribal technical advisory committee for the Centers for Medicare and Medicaid Services and wants HSD to vet decisions with all tribes and not just those who attend meetings; thinks it should be on the agenda to really get input and share 1115 ideas with Tribes.
VI. Public Comments	• Care coordination service is needed at the community level • Keep a broad view of population health statewide and note many contributing factors • Importance of cultural competency	• Need hands-on care coordination services at the community level: – Santa Fe County has identified top give needs: three BH issues, food access, and homelessness. – We need better provider alignment throughout the system and communities. – Santa Fe County would like to partner with HSD/MAD to pilot better care coordination and develop a

Agenda Item	Details	Discussion
		regional health support system. • Utilizing regional and community health councils may be beneficial and progress made with the State Innovation Models grant project should be noted. • Cultural competency and effective use of resources are important. • Requested not using acronyms.
VII. Meeting Close	• Follow-up materials • HSD contact protocol • Next meeting date	• Instructions for how the subcommittee should submit comments. • Request all care coordination and population health recommendations are submitted by November 30, 2016. • Next meeting is on December 16, 2016 in Santa Fe at the Administrative Services Building on Rodeo Road.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACO – Accountable Care Organization
ADL – Activity of Daily Living
ALTSD – NM Aging and Long Term Services Department
BCBSNM – Blue Cross Blue Shield of NM
BH – Behavioral Health
BHSD – Behavioral Health Services Division of the HSD
CB – Community Benefit
CBSQ - Community Benefit Services Questionnaire
CCBHCs - Certified Community Behavioral Health Clinic
CC – Care Coordination
CCP – Comprehensive Care Plan
CCS – Comprehensive Community Support
CHIP – Children's Health Insurance Program
CHR – Community Health Resources
CMS – Centers for Medicaid and Medicaid Services, division of the HHS
CNA – Comprehensive Needs Assessment
CPSW – Certified Peer Support Worker
CSA – Core Service Agency
CYFD – NM Children, Families and Youth Department
DD – Developmental Disability and Developmentally Disabled
D&E – Disabled and Elderly
DOH – NM Department of Health
ED – Emergency Department
EDIE – Emergency Department Information Exchange
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
EVV – Electronic Visit Verification
FAQ – Frequently Asked Questions
FF – Face to Face
FFS – Fee for Service
FQHC – Federally Qualified Health Center
HCBS – Home and Community-Based Services
HH – Health Home
HHS – US Health and Human Service Department
HRA – Health Risk Assessment
HSD – NM Human Services Department
IHS – Indian Health Service
IP – In-patient
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports
MAD – Medical Assistance Division of the HSD
MC – Managed Care
MCO – Managed Care Organization
MH – Mental Health
MMIS – Medicaid Management Information System
MMISR – Medicaid Management Information System Replacement
NF – Nursing Facility
NF LOC – Nursing Facility Level of Care

NMICSS – NM Independent Consumer Support System
PCMH – Patient-Centered Medical Home
PCP – Primary Care Physician
PCS – Personal Care Services
PH – Physical Health
PH-BH – Physical Health – Behavioral Health
PHP – Presbyterian Health Plan
PMS – Presbyterian Medical Services (FQHC)
SA – Substance Abuse
SBHC – School-Based Health Center
SDCB – Self-Directed Community Benefit
SED – Severe Emotional Disturbance
SMI – Serious Mental Illness
SOC – Setting of Care
SUD – Substance Use Disorder
UHC – United Health Care
VBP – Value-Based Purchasing

HUMAN SERVICES DEPARTMENT

CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
November 18, 2016

Agenda

Introductions	8:30 – 8:40
Feedback from October meeting	8:40 – 8:45
Care coordination continued	8:45 – 10:00
Break	10:00 – 10:10
Population health	10:10 – 11:20
Public comment	11:20 – 11:35
Wrap up	11:35 – 11:45

HUMAN SERVICES DEPARTMENT

Renewal Waiver
Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address social determinants of health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

HUMAN SERVICES DEPARTMENT

Care Coordination

HUMAN SERVICES DEPARTMENT

Care Coordination
Opportunities/Goals

- Improve transitions of care: *The movement of a member from one setting of care (examples: inpatient facilities, rehabilitation settings, skilled settings and after incarceration) to another setting or home*[1]
- Focus on higher need populations
- Provider's role in care coordination

[1] Adapted from CMS' definition of terms, Eligible Professional Meaningful Use Menu Set of Measures; Measure 7 of 9; Stage 1 (2014 Definition) updated: May 2014. retrieved: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downl

HUMAN SERVICES DEPARTMENT

Improve Transitions of Care

Feedback	Concepts	Further Discussion

➢ Communication across health providers and managed care is a challenge
➢ Real time information is critical to transitions
➢ Care Coordinator's access in hospitals is challenging
	➢ Identify funding to focus on facilities improving discharge planning
	➢ Enhanced care coordination as part of transitions (short-term):
	  ➢ Jail release
	  ➢ Inpatient stay
	  ➢ Nursing facility to community
	  ➢ Children in residential facilities
	➢ Incentives for outcomes of a successful discharge:
	  ➢ Attend follow up PCP visit
	  ➢ No unnecessary ED visit post discharge for 30-days
	  ➢ No preventable readmission post discharge for 30-days
	  ➢ Filling medications
	  ➢ Completing medication reconciliation (provider)
	➢ Incentives for member adherence to recommended follow-up:
	  ➢ member rewards
		1. Are there ideas here that will have more impact than others?
		2. What are good measures for defining a successful discharge?
		3. Carrot or stick for adherence to discharge plan?
		4. Any other at-risk populations we should address?

HUMAN SERVICES DEPARTMENT

Focus on Higher Needs Populations

Feedback	Concepts	Further Discussion

➢ Improve education to members about use of public health services
➢ Increase member education and use of community supports such as public health services:
  ➢ Community Health Workers / Certified Peer Support Worker (CPSW)
  ➢ School-based health centers
  ➢ Expand Health homes
	➢ Improved engagement of family and other community supports:
	  ➢ Family/caregiver role
	  ➢ Increase use of community health workers / CPSWs
	➢ Promote creative approaches by MCOs to support unique high needs populations.
	➢ Focused education and interventions that are condition or location specific:
	  ➢ Areas with fewer providers, transportation issues and/or specific cultural aspects
	  ➢ Areas with high risk pregnancies, with high prevalence of diabetes, COPD and other chronic diseases
	➢ Use of Community Health Workers for more intensive "touch" for these members
	➢ Expand health homes
	➢ Use of population health information to develop targeted education and interventions
		1. How can we incentivize member participation in care coordination? In their healthcare? In preventative care?
		2. How can we use Community Health Workers and others as resources for a more intensive role for these members?
		3. What are some interventions to engage hard to reach members?
		4. Who are higher need populations we should consider?

HUMAN SERVICES DEPARTMENT

Provider's Role in Care Coordination

Feedback	Concepts	Further Discussion
➢ Information sharing with local providers is key. ➢ Need for further definition of care coordination roles based on where a member is receiving care (FQHC, Senior Center, Jail, ER) ➢ Need to increase consistent use of terms (case management, care coordination, care management) ➢ Increase use of local/community supports to support MCO care coordination. More use of CPSW, peer navigator: ➢ Teen parents, cancer center	➢ Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination ➢ MCOs could share dollars with local programs for direct linkages to members ➢ MCO and Provider Incentives for outcomes ➢ Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals ➢ Value-based payment approaches will involve / delegate care coordination to providers	1. How do we build capacity and readiness in the provider community? 2. Where should care coordination be provided (physical location)? 3. How do you avoid duplication of efforts between MCO care coordination and provider level? 4. How do you promote communication and coordination between the MCO and provider level care coordination?

HUMAN SERVICES DEPARTMENT

Population Health

HUMAN SERVICES DEPARTMENT

Population Health
Key Terms

- Population Health

"A population-based approach to health care and preventative services improves health outcomes for all populations and helps individuals achieve their highest health-related quality of life" [2]

- Social Determinants of Health

Factors that enhance quality of life and can have a significant influence on population health outcomes. Examples include safe and affordable housing, access to education, a safe environment, availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins [3]

[2] Centers for Medicaid and Medicare, CMS Strategy: The Road Forward (2013-2017); retrieved: https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf

[3] Adapted from :Office of Disease Prevention and Health Promotion, Health People 2020; 2020 Topics and Objectives: Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

HUMAN SERVICES DEPARTMENT

Population Health

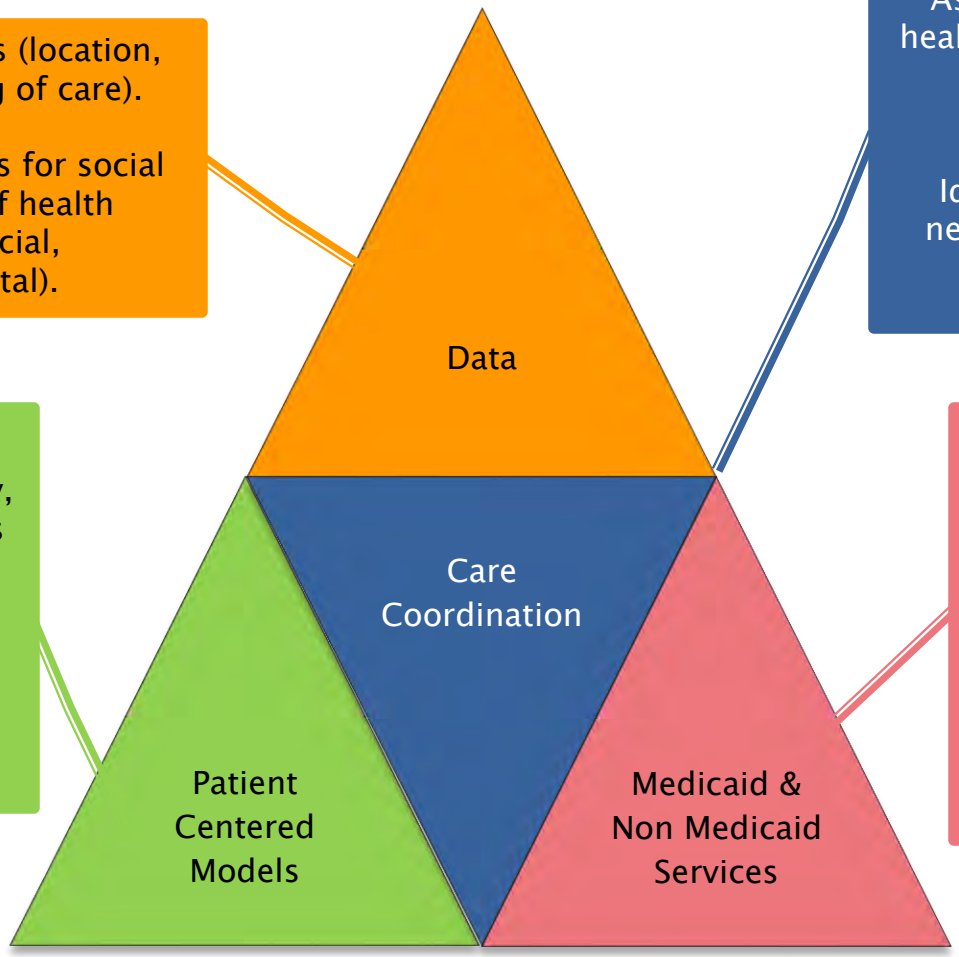
Overview

Define populations (location, condition, setting of care).

Identify data points for social determinants of health (cultural, social, environmental).

Assess physical, mental health conditions and other factors that impact outcomes.

Identify inequities that negatively impact health and address them.



Focus on specific populations by geography, condition or other factors and target interventions.

Consider: high-risk pregnancy, homeless, incarcerated, high/low utilizers.

Address environmental, transportation or other needs needs through services in benefits package.

Improve access to non-Medicaid services such as food banks, rent assistance, supported employment.

HUMAN SERVICES DEPARTMENT

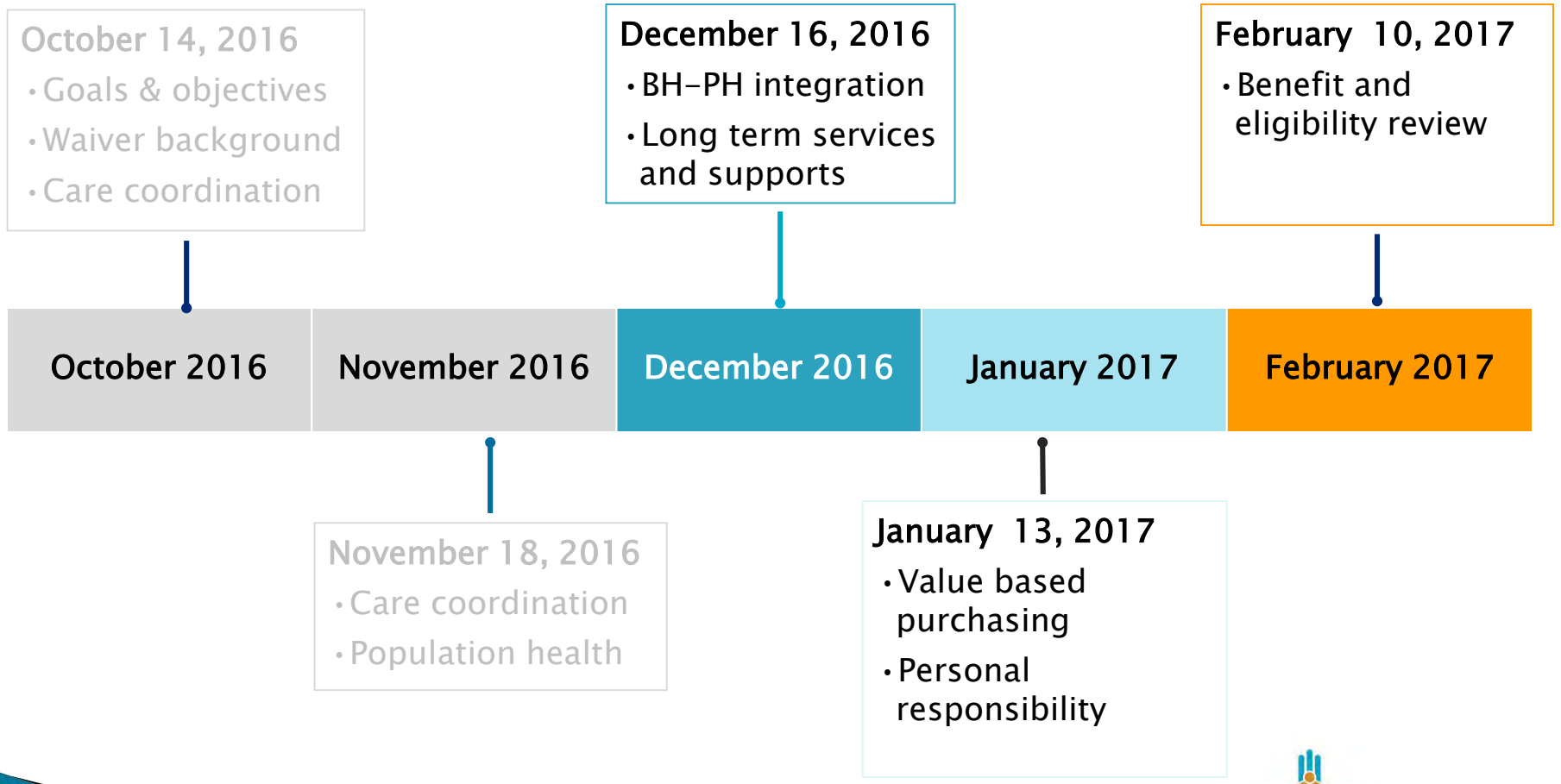
Population Health
Starting the Discussion

Needs	Concepts	Further Discussion
➢ Food ➢ Housing ➢ Transportation (work, school, social needs) ➢ Employment	➢ Chronic disease monitoring and education ➢ Health assessments and data collection ➢ Medication compliance ➢ Condition or region specific initiatives funding and outcomes goals ➢ Housing ➢ Job coaching and support. ➢ Food pharmacies ➢ Linkages to community resources and supports beyond health services	1. What population(s) should we target? Why? 2. Which factors/determinants impact outcomes for this population? How could Medicaid address those factors? 3. How do we move the organization to population-based analysis? Do we have necessary data or analytical capability? 4. How do we create a nimble system that can respond to factors that impact population health?

HUMAN SERVICES DEPARTMENT

Subcommittee Meetings

Timeframe for Discussion



HUMAN SERVICES DEPARTMENT

Permanent Supportive Housing Information Sheet

What is Permanent Supportive Housing (PSH)?

PSH is an evidence-based practice, centered on the philosophy that people with disabilities can live and thrive in their own housing, regardless of their support needs.

Core elements of PSH include:

- Rights of tenancy – Individuals sign a lease and enjoy the same rights and obligations of tenancy as the general population.
- Choice of housing – Choice includes preferences such as convenience to transportation, physical and behavioral health services, family, shopping, and other essentials.
- Decent, safe, and affordable housing – Tenants pay no more than 30 percent of their income toward rent plus basic utilities. Rental assistance through HUD, state-funded Linkages, and other housing programs subsidizes rent.
- Housing integration – Scattered-site housing is preferable to congregate settings.
- Functional separation of housing and services – Property management functions (reviewing rental applications, collecting rent, eviction/renewal decisions) operate independently of support services (pre-tenancy and tenancy sustaining activities).
- Access to housing – Housing is not based on accepting supportive services.
- Flexible, voluntary, and recovery focused services – Tenants choose which supportive services will help them succeed in their desired housing. Services are tailored toward recovery, improved functioning, and life satisfaction.

What difference does PSH make?

- Better population health outcomes – Providing housing and flexible supports lead to significant improvements in physical and behavioral health. Draft data from a five-year study of a peer-delivered PSH model in Santa Fe shows:[1]
  -PSH associated with good to excellent overall health at 6 and 12 month reassessments
  -Overall health of individuals receiving PSH was higher than the comparison group that received no housing
  -Lower psychological distress at 6 month reassessment
  -Less bothersome symptoms at 6 month reassessment
  -Housing satisfaction significantly correlated with positive outcomes
- Cost efficiency – A 2013 UNM study of Albuquerque supportive housing showed cost savings of $12,831.68 per person through reduced use of shelters, emergency rooms, crisis services, and detention facilities.[2]

[1] Crisanti, Annette, Daniele Duran,R. Neil Greene, Jessica Reno, Carol Luna-Anderson, Deborah Altschul, *A Longitudinal Analysis of Peer-Delivered Permanent Supportive Housing: Impact of Housing on Mental and Overall Health in a Rural, Ethnically Diverse Population.*

- Housing stability – On average, 88% of individuals in the state Linkages PSH program remain housed after one year.
- Federal compliance – PSH complies with the U.S. Supreme Court's decision in Olmstead v. L.C. that individuals with disabilities must be accorded the ability to live in the most integrated setting possible.

What PSH programs does the state of New Mexico currently fund?

- Linkages rental assistance and support services – 165 units
- Transitions rental assistance and support services – 20 units
- Local Lead Agency support for Low Income Housing Tax Credit, Special Needs Units – 509 units

Who does PSH currently assist in New Mexico?

- Homeless (including precariously housed)
- Behavioral health and/or other disabilities
- Extremely Low income
- Youths aged 18-21 transitioning out of CYFD Juvenile Justice or Protective Services (Transitions)

Why include PSH incentives in the 1115 Demonstration Waiver revision?

- We can tailor it to the behavioral health population we believe would be best served by PSH.
- We could choose to allow MCOs to target individuals with both developmental disability and behavioral health conditions.
- We can include all pre-tenancy/transition services, tenancy sustaining services, and state-level housing-related collaborative activities recommended in CMS Information Bulletin dated June 26, 2015.
- We can use the opportunity to evaluate the potential health improvements and cost savings of PSH based on defined outcomes.

What are the challenges to inclusion of PSH incentives in the 1115 Demonstration Waiver revision?

- Shortages of affordable housing in many communities
- Selecting mechanisms for financing housing and services
- Identification of MCO target population of members
- Obtaining CMS approval
- Establishing outcomes for measuring success of the PSH incentives

[2] Guerin, Paul and Alexandra Tonigan, *Report in Brief: City of Albuquerque Heading Home Cost Study*, University of New Mexico Institute for Social Research, September 2013.

Non-Traditional Medicaid and Non-Medicaid Supports
November 17, 2016

Non-Medicaid Covered Services	Service Description
Employment supports	Job training assessments, vocational care coordination services, supported employment, referral to support, skill building and training
Educational supports	Client Based - Educational care coordination services, referral to support, consumer skill building Community & Agency Based - Alcohol, tobacco and other drug related harm reduction, alcohol and tobacco advertising practices, technical assistance on monitoring enforcement of availability and distribution, media campaigns
Child Care	Childcare coordination services, referral to support
Transportation	Transportation coordination services
Supportive Housing	Client Based - Emergency shelter, eviction prevention, housing placement, housing support group, referral to support, transitional living services, Oxford Houses Community & Agency Based - Developing and inventory of supportive housing
Self-advocacy	Education on client rights, arranging legal representation meetings, resiliency goal support, informational support group
Respite	Arrangement of respite services, referral to support
Family Supports	Education of family members, referral to support
Peer Support	Client Based - Peer operated Wellness Centers Community & Agency Based - Warmline
Health Support	Smoking cessation classes, nutritional guidance, physical activity, acupuncture, acu-detox, yoga, traditional healing, referral to support, health and wellness education
Related goods	Veteran's Food Boxes, Naloxone purchase & distribution, referral to clothing/food
Community training	Multi-agency coordination and collaboration, community team-building, neighborhood action training
Education	Parenting and family management, mentors, preschool prevention, youth education groups, learning communities
Research	Outcomes collection and analysis, establishment and replication of best practice.

Centennial Care Covered Benefit	Services	Service Description
General Medicaid Benefits	Nutritional counseling	Nutritional services and interventions consistent with the members physical medical condition.
	Community Interveners	Develop critical connections to a member and their environment. Opens channels of communication between members and others, facilitates the development of independent living. For blind-deaf members age 5+
Community Benefit - Agency Based*	Community transition services	Non-recurring set-up expenses for a member who is transitioning from an institution or other provider operated living arrangement to residence in a private residence.
	Employment supports	job development; job seeking; and job coaching assistance
Community Benefit - Self-Direction*	Customized Community Supports	Activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills.
	Employment supports	job development; job seeking; and job coaching assistance
	Transportation (non-medical)	Access to services and activities in the community as specified in the care plan.
	Nutritional counseling services	Assessment, development of nutritional plan, counseling and intervention and observation and technical assistance related to implementation of nutritional plan.
	Related goods	Equipment, supplies, fees not otherwise provided through MCO general benefits.

*Only available to members with a Nursing Facility Level of Care

Stakeholder Engagement Process Leading to Development of Concept Paper

3. MAC 1115 Waiver Renewal Subcommittee, December 16, 2016

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

1474 Rodeo Road, Santa Fe, NM

December 16, 2016

8:30 – 11:45 AM

Topic	Time
Introductions	8:30 – 8:40 am
Review Minutes, Feedback from November Meeting	8:40 – 8:45 am
Long Term Services and Supports (LTSS)	8:45 – 10:15 am
Break	10:15 – 10:20 am
Physical Health – Behavioral Health (PH-BH) Integration	10:20 – 11:20 am
Public comment & Wrap up	11:20 – 11:45 am

Medicaid 1115 Wavier Renewal Subcommittee Meeting

Meeting Minutes

December 16 — 8:30am – 11:45am

Administrative Services Division / Human Services Department, 1474 Rodeo Road, Santa Fe, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department	Joie Glenn, New Mexico Association for Home & Hospice Care
Doris Husted, The Arc of New Mexico	Lauren Reichert (proxy for Steve Kopelman), New Mexico Association of Counties
Bryce Pittenger, Children, Youth and Families Department	Patricia Montoya, New Mexico Coalition for Healthcare Value
Dawn Hunter, Department of Health	Linda Sechovec, New Mexico Health Care Association
Jim Jackson, Disability Rights New Mexico	Rick Madden, New Mexico Medical Society
Sandra Winfrey, Indian Health Service	David Roddy, New Mexico Primary Care Association
Christine Boerner, Legislative Finance Committee	Lisa Rossignol, Parents Reaching Out
Carol Luna-Anderson, The Life Link	Liz Lacouture (proxy for Mary Eden), Presbyterian Health Plan
Mary Kay Pera, New Mexico Alliance for School-Based Health Care	

Absent Members:

Kris Hendricks, Dentistry for Kids	Carolyn Montoya, University of New Mexico, School of Nursing
Jeff Dye, New Mexico Hospital Association	Dave Panana, Kewa Pueblo Health Corp.

Staff and Visitors Attending:

Kristin Jones, CYFD	Jeanene Kerestes, Blue Cross Blue Shield of New Mexico
Rachel Wexler, DOH	Shawna Romero, Blue Cross Blue Shield of New Mexico
Shannon Cupka, HSD/ALTSD	Ellen Pinnes, The Disability Coalition
Gail Trotter, HSD/ALTSD	Leonard Thomas, Indian Health Services
Lisa Howley, HSD/BHSD	Debi Peterman, Health Insight New Mexico
Wayne Lindstrom, HSD/BHSD	Andrew Conticelli, Molina Healthcare of New Mexico
Karen Meador, HSD/BHSD	Steve DeSaulniers, Molina Healthcare of New Mexico
Theresa Belanger, HSD/MAD	Mary Kate Nash, Molina Healthcare of New Mexico
Michael Nelson, HSD	Deanna Talley, Molina Healthcare of New Mexico
Kari Armijo, HSD/MAD	Theresa Turietta, New Mexico Association for Home & Hospice Care
Kim Carter, HSD/MAD	

Dan Clavio, HSD/MAD Crystal Hodges, HSD/MAD Angela Medrano, HSD/MAD Megan Pfeffer, HSD/MAD Nancy Smith-Leslie, HSD/MAD Tallie Tolen, HSD/MAD Robyn Nardone, HSD/NMICSS Jared Nason, Mercer Jessica Osborne, Mercer Son Yong Pak, Mercer Cindy Ward, Mercer	Michael Ruble, New Mexico Behavioral Health Planning Council Tom Starke, Santa Fe Behavioral Health Alliance Sarah Howse, Presbyterian Medical Services Kira Ochoa, Santa Fe County Community Services Department Sylvia Barela, Santa Fe Recovery Center Jean Crosbie, Senior Link Mark Abeyta, United Healthcare Amilia Ellis, United Healthcare Raymond Mensack, United Healthcare Curt Schatz, United Healthcare Elly Rael, United Healthcare Ruth Williams, Youth Development, Inc.

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Review minutes. • Feedback from the November 18th meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal, and all are encouraged to use the website to submit comments. • October 14th meeting focused on care coordination, November 18th meeting focused on population health and today's meeting is focused on long-term services and supports (LTSS) and behavioral health/physical health (BH/PH) integration. • Summary of recommendations for care coordination and population health are in the packet. • MAD has not received any comments to the October 14th meeting minutes. Therefore, the draft meeting minutes is finalized. • Draft meeting minutes from the November 18th meeting is included and comments are requested by the next meeting, January 13, 2017.
II. Long-Term Services and Supports (LTSS)	• Automatic renewal of nursing facility (NF) level of care (LOC) for certain members. • Align benefits for the Agency-Based Community Benefits (ABCB) and the Self-Directed Community Benefits (SDCB). • Establish levels for ABCB and SDCB budget ranges based on need that may include provisions for one time transition costs. • Implement new MCO reimbursement methodology for members who use fewer PCS hours. • Diversification of services provided by nursing homes. • Explore provider fees / taxes:	• In regards to the Consumer Directed Model under personal care services (PCS), Lauren commented that there are additonal complexities with billing the administrative fees related to required administrative activities of the agency. HSD and the MCOs will provide technical assistance to Rio Arriba Senior Services as needed to ensure that they are informed of how to bill correctly. • Joie commented that the provider reimbursements for ABCB and SDCB do not take into consideration the cost for performing supevision and that supervisory requirements should be factored into the reimbursement. • Doris echoed that it makes sense to align benefits for ABCB and SDCB as the current benefits are very confusing.

Agenda Item	Details	Discussion
	– Legislative process. – The Centers for Medicare and Medicaid Services approval.	• Lisa commented that individuals over eighteen years of age receive homemaker services. For those under eighteen years of age, she wants the possibility of access to similar support under Centennial Care rather than wait for a waiver slot. • In regards to assessing a child's ADLs, Lisa commented that assessors need to ask questions related to the child's development level to accurately obtain the child's ADL needs and set aside their own personal biases. • Jessica commented that as part of the assessment process, MCOs are assessing the whole situation including the member's natural supports, the caregiver's stress and they need to be cognizant about what is working and not working for the family. • Lauren commented that the DOH licensure requirements for adult day care is challenging to work with as DOH staff do not explain the requirements and refer proivders to the statute. Also, the adult day care reimbursement rate does not take into consideration no-shows and transportation costs, which could endanger the program. She recommends that the reimbursement rate should take these costs into consideration for the agency's financial viability and increase the billing unit from 2 hours to half day and per diem. • Joie commented that adult day care regulations are outdated and has asked DOH to re-visit the regulations. Also, she stated that MCOs would like to have adult day care as an option of care model. • Jim cautioned the Department about moving towards limiting access such as increasing the number of ADLs to access services. He commented that the Department could look at different payment levels based on the

Agenda Item	Details	Discussion
		outcome of the assessment. • Jim also asked why hours are decreasing for those individuals with no health status changes durding the annual renewal process. In order to maintain their hours, these individuals are forced to go through the fair hearing process. Instead, Jim stated that we need a process for renewing services when there is no change in status as this would be easier for the recipient and the State. • Jim commented that although he appreciates that the Department is doing more waiver allocations for LTC services, he is discouraged that not more people are eligible. • Tallie commented that the Department makes a concerted effort to conduct outreach to allocated individuals by sending multiple packets and tracking them through the eligiblity process. Some do not respond and others are found ineligible. The Department is currently gathering data on attrition of members with waiver slots. • In regards to the NF census, Linda suggested that we need to look at more real time data rather than claims data due to claims lag times. Linda also stated that underfunding of NF must be addressed as mentioned in the Legislative Finance Committee report. Finally, in regards to the NF diversification, she said that NFs can provide adult day care services and provide follow-up services in the community. • Myles commented that NFs can specialize in serving individuals with dementia as part of the diversification strategy. • Dawn commented that increasing the number of ADLs will have an impact on the DOH facilities. She will submit more details in writing.

Agenda Item	Details	Discussion
		• Wayne commented that we should address how to incentivize NFs to work with members with complex behavoral health needs in the waiver renewal application as this is a critical need. • In regards to the NF access issues, Linda commented that we need to better understand the root cause in order to address this issue. For example, a 5 pm admission on a Friday and lack of beds would require different approaches. • In regards to value-based purchasing (VBP) for NFs, Dawn commented that the DOH/DHI lincensing bureau is identifying quality measures that could be helpful to the Department. • Linda thanked Molina Healthcare for its VBP proposal that focuses on incentives rather than using sanctions to achieve better quality. • Jim encouraged the Department to work with providers groups and explore reimbursement rates since revenue is required for doing the work.
III. Physical Health – Behavioral Health (PH-BH) Integration	• Provider education on PH-BH integration models and best practices. • 3 practice structures and 6 levels of collaboration. • Improve identification of behavioral health and substance use issues and linkage to treatment. • Substance abuse treatment availability. • Improve physical health conditions and reduce in morbidity and mortality. • Direct care management: early assessment; treatment engagement; active follow-up; structured patient	• Linda asked if the Department is interested in PH-BH integration for the LTSS program in addition to collaboration with PH providers, and the response was yes to all. • Carol commented that due to long term drug use, BH providers are seeing physical health issues related to brain atrophy which become long-term service needs. In addition, this impacts staff to client ratio when members can no longer take care of themselves in the community. • In regards to telehealth such as Project ECHO, Lisa asked the Department to speak more about how this is being used. — Karen responded that Project ECHO connects

Agenda Item	Details	Discussion
	education; standardized psychotherapy. • Linkage to community resources and population health supports beyond health services	specialists, including psychiatrists, to those who need care especially in rural communities. – IHS representative commented that from an Indian Health Services perspective, they began using telehealth to address the shortage of practitioners and having access to practitioners via telehealth has been very successful. – Lisa commented that she is supportive of telehealth and that we should be mindful that some populations such a monolingual population may not like using telehealth. • Rick commented that substance abuse prevention should be a high priority given the epidemic of opioid and prescription drug abuse and dependence. – Wayne commented that both DOH and BHSD have a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address this issue. – Last week, the federal government signed the 21st Century Cures Act which allows the State to apply for more funding to address the opioid epidemic. We have until Febrary 17, 2017 to apply. – We are putting together a project team and will meet next week to strategize on how to garner stakeholders feedback. – Total amount being requested is $4.8M for the next two years. • In regards to information sharing with in-home service providers, Joie stated that MCOs are not sharing behavioral health information with caregivers and are citing confidentiality issues. Consequently, caregivers are

Agenda Item	Details	Discussion
		ill prepared and refuse to return if they have encountered unsafe situations. She stated that the caregivers have the right to know about the member's conditions in order to perform their job. – Bryce commented that in the children's world, this is called a run-around and asked the Subcommittee to consider implementing a high-fidelity wrap around with a single care plan. – Wayne echoed that the Subcommittee should investigate how Medicaid can support this model. • Lauren commented that in Rio Arriba County, the county health department conducts a joint case staffing with contracted providers and jails and that this model has been successful. The county's goal is to sustain this program by billing Medicaid. She will submit the details in writing. • David commented that having access to a shared medical record helps with care coordination. • Mary Kay stated that school-based health centers represent a great PH-BH integration model since both PH and BH providers work together and coordinate services and perform shared-decision making. • Dawn echoed Mary Kay's comment by stating that we can support building the SBHC network. Also, she thanked HSD for sharing the Milbank report as it contains good ideas on next steps. • Wayne commented that integration is a heavy lift and encouraged the Subcommittee to consider a broader framework as we work on this issue and reminded the group that integration is not limited to the practice level. – He commented that State departments and MCOs should pay more attention to integration challenges in

Agenda Item	Details	Discussion
		their respective spheres. – Payment structure is a barrier. We need to move away from fee-for-service which rewards quantity and focus on quality and outcomes by treating individuals more holistically. – Finally, we need to look at the whole lifespan from babies being born with opioid addiction to aging and long-term care. • Rick echoed Wayne's comments and commented that having providers co-located makes a huge difference to achieving integration as it allows practitioners to communicate more readily. Both Rick and Wayne stated that not all co-located practices provide integrated care and emphasized the importance of timely communication among practitioners and a holistic approach to treatment. • Lauren commented that in her county, they co-located all of the departments which forced staff to speak more frequently to one another. She felt that it is not necessarily important to have a co-location, but that the value is in building relationships. • Pat suggested leveraging resources from the Medicare/Medicaid ACOs. • Doris and Bryce commented that we need workforce development to focus on working with individuals with intellectual and developmental disabilities as many BH providers do not know how to treat this population. • Carol suggested that using flexible funding to assist members could be helpful. • IHS representative commented that Screening, Brief Intervention and Referral to Treatment (SBIRT) is a good model for looking at outcomes. – Dawn commented that many states are looking at

Agenda Item	Details	Discussion
		SBIRT and that Medicaid (in New Mexico) does not pay for it.
IV. Public Comments	• Focus on quality and not cutting services arbitrarily. • In regards to care coordination, utilize youth support workers. • DOH and HSD consider administrative reorganization to co-create and support regionally in rural areas to advance health care. • Care coordination central hub. • The Subcommittee shouldn't be limited to making recommendations. Instead, require MCOs and providers to provide certain services such as medication-assisted therapy and Screening, Brief Intervention and Referral to Treatment.	• Commenter applauded the Committee for its focus on improving outcomes for Medicaid recipients and reducing costs through focusing on quality and not reducing services arbitrarily. However, the discussion on increasing NF LOC from 2 ADLs to 3 ADLs seems arbitrary. • New Mexico is a recipient of the SAMHSA's Healthy Transitions Grant[1], which is aimed to improve support services for adolescents and young adults with, or at risk of, serious mental health conditions. • Peer support workers should be expanded to include youth since youth relates better to young people who share his/her experience(s). • Through the Healthy Transitions Grant, New Mexico is developing a strategic plan that includes developing outreach and engagement activities for targeted adolescents and young adults. • For those rural areas that will not have health homes or patient-centered medical homes, DOH and HSD should consider administrative reorganization to co-create and support the community in how to pay for services (value). In lieu of health homes, health home look alike models could benefit rural communities. • Establishing a regionally appropriate care coordination hub, that is either independent of MCOs or with assistance from MCOs, may be a viable option.
V. Meeting Close	• Follow-up materials • HSD contact protocol	• Comments on population health, LTSS and PH-BH integration comments are due from committee members

[1] For more information on the SAMHSA's Healthy Transitions Grant, visit https://www.samhsa.gov/nitt-ta/healthy-transitions-grant-information .

Agenda Item	Details	Discussion
	• Next meeting date	by January 6, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • Next meeting is on January 13, 2017 in Albuquerque at the Department of Transportation District Three Auditorium.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
ACO – Accountable Care Organization
ADL – Activity of Daily Living
ALTSD – NM Aging and Long Term Services Department
BCBSNM – Blue Cross Blue Shield of NM
BH – Behavioral Health
BHSD – Behavioral Health Services Division of the HSD
CB – Community Benefit
CBSQ - Community Benefit Services Questionnaire
CCBHCs - Certified Community Behavioral Health Clinic
CC – Care Coordination
CCP – Comprehensive Care Plan
CCS – Comprehensive Community Support
CHIP – Children's Health Insurance Program
CHR – Community Health Resources
CMS – Centers for Medicaid and Medicaid Services, division of the HHS
CNA – Comprehensive Needs Assessment
CPSW – Certified Peer Support Worker
CSA – Core Service Agency
CYFD – NM Children, Families and Youth Department
DD – Developmental Disability and Developmentally Disabled
D&E – Disabled and Elderly
DOH – NM Department of Health
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
ED – Emergency Department
EDIE – Emergency Department Information Exchange
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
EVV – Electronic Visit Verification
FAQ – Frequently Asked Questions
FF – Face to Face
FFS – Fee for Service
FIT – Family Infant Toddler Program
FQHC – Federally Qualified Health Center
HCBS – Home and Community-Based Services
HH – Health Home
HHS – US Health and Human Service Department
HRA – Health Risk Assessment
HSD – NM Human Services Department
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports
MAD – Medical Assistance Division of the HSD

MC – Managed Care
MCO – Managed Care Organization
MH – Mental Health
MMIS – Medicaid Management Information System
MMISR – Medicaid Management Information System Replacement
NATAC – Native American Technical Advisory Committee
NF – Nursing Facility
NF LOC – Nursing Facility Level of Care
NMICSS – NM Independent Consumer Support System
PCMH – Patient-Centered Medical Home
PCP – Primary Care Physician
PCS – Personal Care Services
PH – Physical Health
PH-BH – Physical Health – Behavioral Health
PHP – Presbyterian Health Plan
PMS – Presbyterian Medical Services (FQHC)
SA – Substance Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
SDCB – Self-Directed Community Benefit
SED – Severe Emotional Disturbance
SMI – Serious Mental Illness
SOC – Setting of Care
SUD – Substance Use Disorder
UHC – United Health Care
VBP – Value-Based Purchasing

HUMAN SERVICES
DEPARTMENT

CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
December 16, 2016

Agenda

Introductions	8:30 – 8:40
Feedback from November meeting	8:40 – 8:45
LTSS	8:45 – 10:15
Break	10:15 – 10:20
PH-BH Integration	10:20 – 11:20
Public comment	11:20 – 11:40
Wrap up	11:40 – 11:45

HUMAN SERVICES DEPARTMENT

Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Provider adequacy
- Benefit alignment and member responsibility

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports (LTSS)

HUMAN SERVICES DEPARTMENT

LTSS
Overview

Under Centennial Care all members who meet the NF LOC have access to the community benefit

- Increase in the number of unique members who have access to the community benefit:
  - 24,013 users in CY2014
  - 27,836 users in CY2015
  - 27,593 users in 9 months of CY16
  - Community benefit is included in the expansion benefit package
- Average monthly cost of a nursing home is approximately 2.8 times as expensive as the average community benefit
- Recent analysis conducted by the LFC indicated that the overall occupancy rate at nursing facilities has been declining since 2011
- NM ranked in the 2nd best quartile overall in the 2014 national State Long Term Care Scorecard [1]

LTSS Population
Setting of Care Enrollment Mix
(Long Term Nursing Facility vs. Community)

Setting	Nursing Facility	Community Benefit
2011	18.7%	81.3%
2012	18.9%	81.1%
2013	17.3%	82.7%
2014	15.9%	84.1%
2015	14.3%	85.7%

[1] http://www.longtermscorecard.org/

HUMAN SERVICES DEPARTMENT

Community-Based Models for Care

Agency Based Community Benefit (ABCB)

- Community-based alternative to institutional care that maintains members in the home or community
- Member chooses consumer delegated or directed model for personal care services (PCS)

Self Directed Community Benefit (SDCB)

- Community-based alternative to institutional care that facilitates greater member choice, direction and control over covered services
- Member receives annual budget based on need.
- Member directs how to spend the annual budget on services.
- Member (or representative) is common-law employer of providers

Benefits and services vary based on model

HUMAN SERVICES DEPARTMENT

LTSS

Beginning the Discussion

Needs	Concepts	Further Discussion

➢ Streamline NF LOC renewals and improve assistance to individuals
➢ Improve comparability of service offerings between community benefit options and improve transition into SDCB
➢ Continue successes of rebalancing effort between institutionalization and community care
➢ Fiscal sustainability of nursing homes
	➢ Automatic NF LOC renewal for certain members
	➢ Align benefits for ABCB and SDCB
	➢ Establish levels for ABCB and SDCB budget ranges based on need that may include provisions for one time transition costs
	➢ Implement new cohort for members who use fewer PCS hours
	➢ Diversification of services provided by nursing homes
	➢ Explore provider fees / taxes:
	  ➢ Legislative process
	  ➢ CMS approval
	➢ NF LOC ADL change from 2 ADLs to 3 ADLs
	➢ Value-based purchasing arrangements with LTSS providers
		1. What other areas are important to streamline for members?
		2. What other enhancements should be considered for members to remain in the community?
		3. Nursing facility diversification

HUMAN SERVICES DEPARTMENT

Physical Health-Behavioral Health Integration

HUMAN SERVICES DEPARTMENT

BH/PH Integration

Key Terms

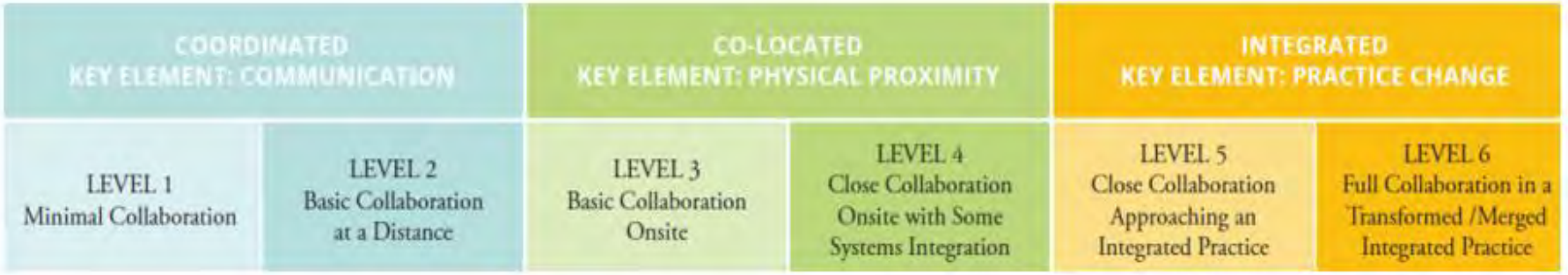
Intent of Integration

- "Integration of services through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help recipients manage their health and their use of the health care system."
- "What New Mexico now challenges its plans to do is manage care and deliver outcomes that can be measured in terms of a healthier population. In order to effectively drive the kind of system change New Mexico seeks, plans will have to think and behave differently and support the movement towards care integration and payment reform."

-from current 1115 Waiver

HUMAN SERVICES DEPARTMENT

BH/PH Integration
Models



http://www.milbank.org/publications/evolving-models-of-behavioral-health-integration-evidence-update-2010-2015/

HUMAN SERVICES
DEPARTMENT

PH-BH Integration

Opportunities/Goals

- More than mental illness and addiction
- Early onset; early death (>8 million each year)
- Medicaid = largest payer
- Provider and Plan Challenges:
  - Workforce
  - EHR capacity
  - Continuity of care gaps

Increase provider competency to serve members with co-morbid PH-BH conditions

Improve screening for BH conditions, including substance-use disorders

Leverage the emergency department information exchange to identify members who require linkage to mental health and substance abuse treatment

Improve information sharing challenges due to varied interpretations of privacy rules

HUMAN SERVICES DEPARTMENT

PH-BH Integration

Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Increase provider's competency and capacity to manage both physical and behavioral conditions ➢ Increase behavioral health screening across the continuum of care ➢ Remove barriers to sharing information between providers ➢ Value-based payment strategies for integrated care	➢ Provider education on PH-BH integration models and best practices ➢ 3 practice structures and 6 levels of collaboration ➢ Improve identification of behavioral health and substance use issues and linkage to treatment ➢ Substance abuse treatment availability ➢ Improve physical health conditions and reduce in morbidity and mortality ➢ Direct Care management: early assessment; treatment engagement; active follow-up; structured patient education; standardized psychotherapy ➢ Linkages to community resources and population health supports beyond health services	1. Are all three practice models present in New Mexico? What is working well? 2. How can we support provider's capacity to manage co-morbid conditions? 3. How can MCOs encourage patient engagement? Provider engagement? 4. Can MCOs work with local and regional leaders to create stronger forms of integrated care that affect health outcomes? 5. Should HSD identify screening tools that they recommend providers use? 6. What ways can HSD support better information sharing? 7. Can value-based payment models address provider and plan challenges? What models are better suited for integrated providers?

HUMAN SERVICES DEPARTMENT

PH-BH Integration

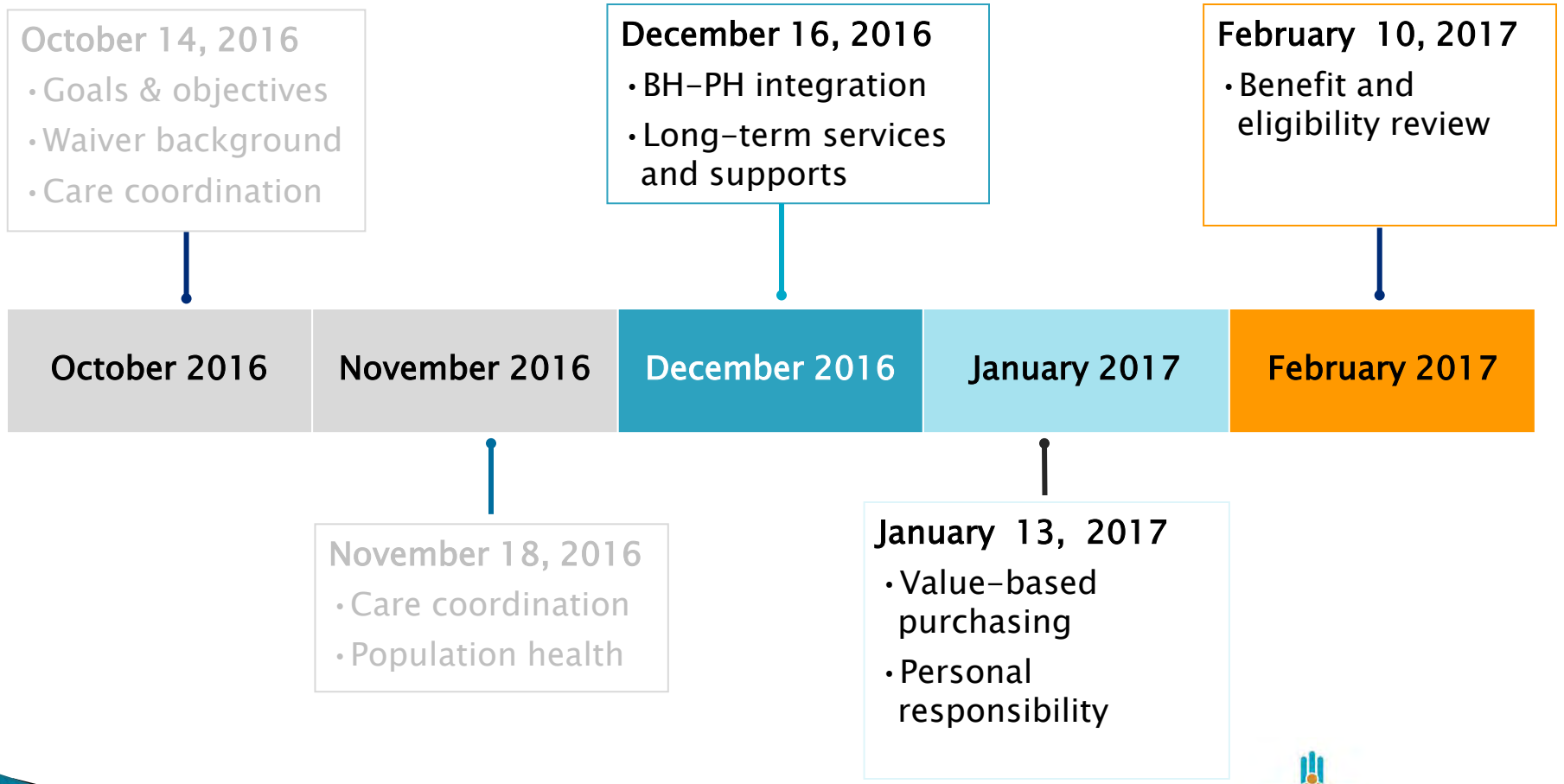
Ideas

- Increase the number of health homes to additional counties
- Submit an additional health home SPA or amendment to add substance use disorders as primary diagnoses
- Build capacity through additional tele-behavioral health clinical supervision and tele-psychiatry development
- Increase implementation of value-based purchasing or prospective payment methodologies
- Others?

HUMAN SERVICES DEPARTMENT

Subcommittee Meetings

Timeframe for Discussion



HUMAN SERVICES DEPARTMENT

Centennial Care 1115 Waiver Renewal Subcommittee
Long-Term Care Brief

Background

Launched on January 1, 2014, Centennial Care provides a comprehensive delivery system for Medicaid members that integrates physical health, behavioral health and long-term services and supports; ensures cost-effective care; and focuses on quality of health care over quantity of services delivered.

Essential to the program is the Community Benefit (CB) home and community-based services (HCBS) program for members who require long-term services and supports (LTSS) to remain in the family residence, in their own home or in community residences. The CB is an alternative to placement in a Nursing Facility (NF) and is available to members who meet Nursing Facility Level of Care (NF LOC). CB services supplement a member's natural supports but do not provide 24-hour care.

With the implementation of Centennial Care, eligibility for HCBS does not require a waiver allocation ("slot") to access HCBS services if the member is eligible for full Medicaid. Also, personal care service (PCS) benefits were changed from being a state plan service to a component of the CB service package. Under the former Coordination of Long-Term Services (CoLTS) program, individuals who were Medicaid eligible could receive PCS under the state plan, and were required to wait for a waiver allocation in order to have access to the full array of CoLTS HCBS. Under Centennial Care, members have access to all CB services that they are assessed to need, without an allocation, upon meeting the NF LOC criteria. Individuals who do not meet full Medicaid financial eligibility requirements require an allocation or waiver "slot". HSD increased its annual waiver enrollment limit (slots) from 3,989 to 4,289 during the 1115 Waiver period (CY 2014-2018).

The member's managed care organization (MCO) provides the CB services as determined appropriate based on the Comprehensive Needs Assessment (CNA). Members eligible for CB services have the option of selecting the Agency-Based Community Benefit (ABCB) or the Self-Directed Community Benefit (SDCB).

Number of LTC Users

	December 2013	CY2014	CY2015	9 months of CY2016
ABCB and SDCB[1]	21,300 (Includes PCO, Mi Via and CoLTS Waiver)	24,013	27,836	27,593
Nursing Facility (long term)	3,529	3,711	3,591	3,530

1 – Includes members who are enrolled as LTSS and Medicaid Expansion.

According to a recent report by the Legislative Finance Committee (LFC) released in October 2016, *Cost, Quality and Financial Performance of Nursing Homes in New Mexico*, the number of individuals living in New Mexico nursing homes declined by 12 percent over the last five years as options for home and community-based care have expanded under Centennial Care. "As such, nursing homes are caring for residents who are gradually becoming more dependent on others for activities of daily living, leading to higher costs of care. This has considerable implications in New Mexico, where 64 percent of nursing home residents rely on Medicaid to pay for their care."

The report recommended that the Department consider pursuing a reimbursement system for nursing homes that takes into account additional categories of patient acuity, as well as provider quality and performance. The Department began exploration of transitioning to a case mix reimbursement structure with the New Mexico Health Care Association and its consultant. It also engaged its audit contractor to conduct an initial analysis of the impact to implement such a transition. The Association's consultant estimated it would require significant additional funds to move to a case mix reimbursement. Considering current budgetary constraints, the Department has been unable to continue to move forward with such an implementation.

The trend of more members choosing to stay in the community rather than residing in nursing homes supports the person-centric goals of Centennial Care and improves their overall quality of life. However, it also results in reduced occupancy rates for nursing facilities and higher average costs to care for those who are residing in nursing facilities. Another recommendation in the LFC report is to pursue payment reform initiatives for nursing facilities, including value-based purchasing (VBP) arrangements that reward quality of care rather than quantity of care. This recommendation aligns with efforts in Centennial Care to advance VBP arrangements. Molina Healthcare recently informed the Department that it is implementing a Nursing Facility Quality Program that will financially reward facilities for achieving quality measures.

The program will begin on January 1, 2017. While these efforts will take time to implement and assess, they represent a movement in the right direction in terms of achieving better healthcare outcomes for members in institutional care settings.

In overall performance of its LTSS program, New Mexico ranks in the second best quartile in the 2014 National State Long-Term Care (LTC) Scorecard published by the AARP and the Commonwealth Fund. Our LTC system is especially strong in terms of:

- Affordability and access (top quartile)
- Choice of setting and provider (top quartile)
- Effective transitions across settings of care (second quartile)

Long-Term Care (LTC) Monitoring

LTC Committee

In late 2015, several LTC related issues were reported to the Human Services Department (HSD) from members and disability rights advocates. HSD created a LTC Committee that included state staff and key representation from each MCO. Meetings began in December 2015 and continue to occur at least monthly.

The LTC Committee's agenda has included:

- MCO care coordination procedures, including the comprehensive needs assessment (CNA);
- How to educate the member on the full array of CB services that may be available to him or her;
- Solutions to improve and document care coordinator discussions with members about CB services and any risks involved when a member declines certain benefits; and
- Compliance with the Federal HCBS Settings Rule by 2019.

The committee created and piloted a supplemental Community Benefit Services Questionnaire (CBSQ) with a risk agreement that is to be used along with the CNA. The risk agreement ensures that a member or his/her representative is aware of risks that may occur when he/she refuses to accept assessed services. The committee also created a CB services brochure to be given to the member during the in-home CNA that explains the services that are covered under the ABCB and the SDCB models.

Based on the results of the pilot and surveys conducted with members and care coordinators, the CBSQ was finalized in September 2016. The MCOs were directed to fully implement the CBSQ beginning in November 2016. HSD is monitoring the implementation through "ride-alongs" with care coordinators. HSD staff will attend random in-home assessments to observe the administration of the CNA and CBSQ and provide feedback to the MCOs regarding improvements as necessary.

MCO Reporting

Since the beginning of Centennial Care, HSD staff review and analyze monthly, quarterly, semi-annual and annual reports related to LTC to monitor over and under-utilization of services, gaps in care and timeliness for nursing facility level-of-care (NF LOC) determinations. Any findings are addressed with the MCOs.

Accomplishments Related to Long-Term Care

MCO Training

In 2016, HSD provided detailed direction and training to the MCOs related to NF LOC and Setting of Care (SOC) reporting timelines for NF LOC determinations, denials and closures. In March of 2016, HSD conducted training for all care coordinators on CB services to ensure that they correctly inform members about available services.

Medicare Alignment

With Centennial Care, the MCOs are required to offer Dual Eligible Special Need Plans (D-SNPs), which allow them to coordinate the full array of a member's Medicaid and Medicare benefits under a single plan and offer enhanced benefits for this population. The goal is to more effectively manage the members' benefits and improve customer service by having a single provider directory and member handbook, one drug plan and no copayments. In October 2016, HSD worked with the MCOs to send a letter to members who are dually eligible for Medicaid and Medicare. The letter and Frequently Asked Questions (FAQ) sheet offered information about the benefits of selecting one MCO for both Medicaid and Medicare coverage. The goal of this mailing was to align enrollment for dual eligible members to ensure better health outcomes and coordination of Medicaid and Medicare benefits. HSD will analyze data to determine the success of the mailing in January 2017 and plan for future outreach to dual-eligibles.

Allocations and Central Registry

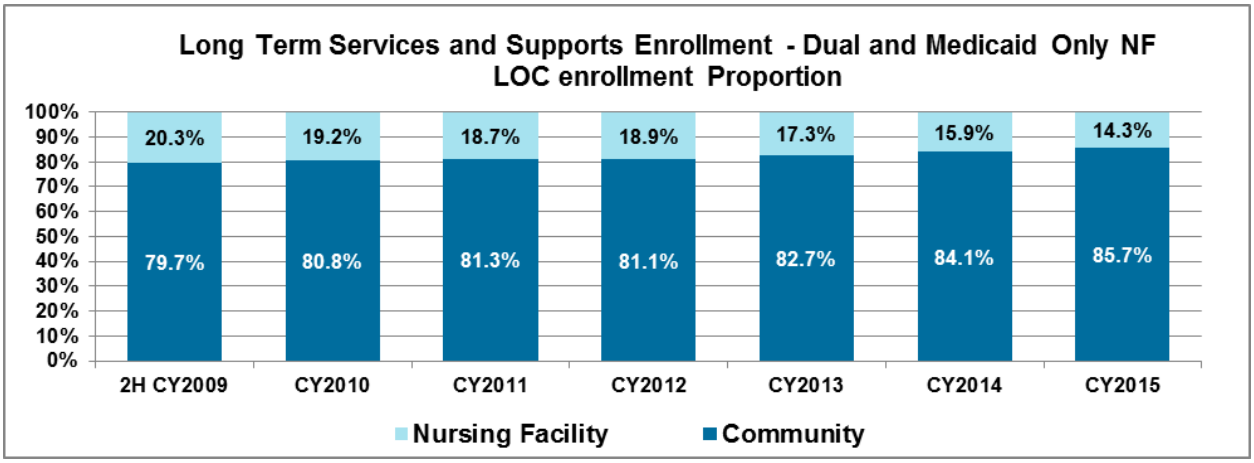
HSD has increased allocation activity throughout Centennial Care as illustrated in the chart below. As of October 2016, there are 15,288 active registrations on the central registry, and regular registrations from 2007 are currently being allocated. Community reintegration and expedited allocations are also being processed. Unfortunately, overall response rates are very low. This may be due to outdated address information in the allocation system and the complexities inherent to Medicaid enrollment.

Number of Allocations

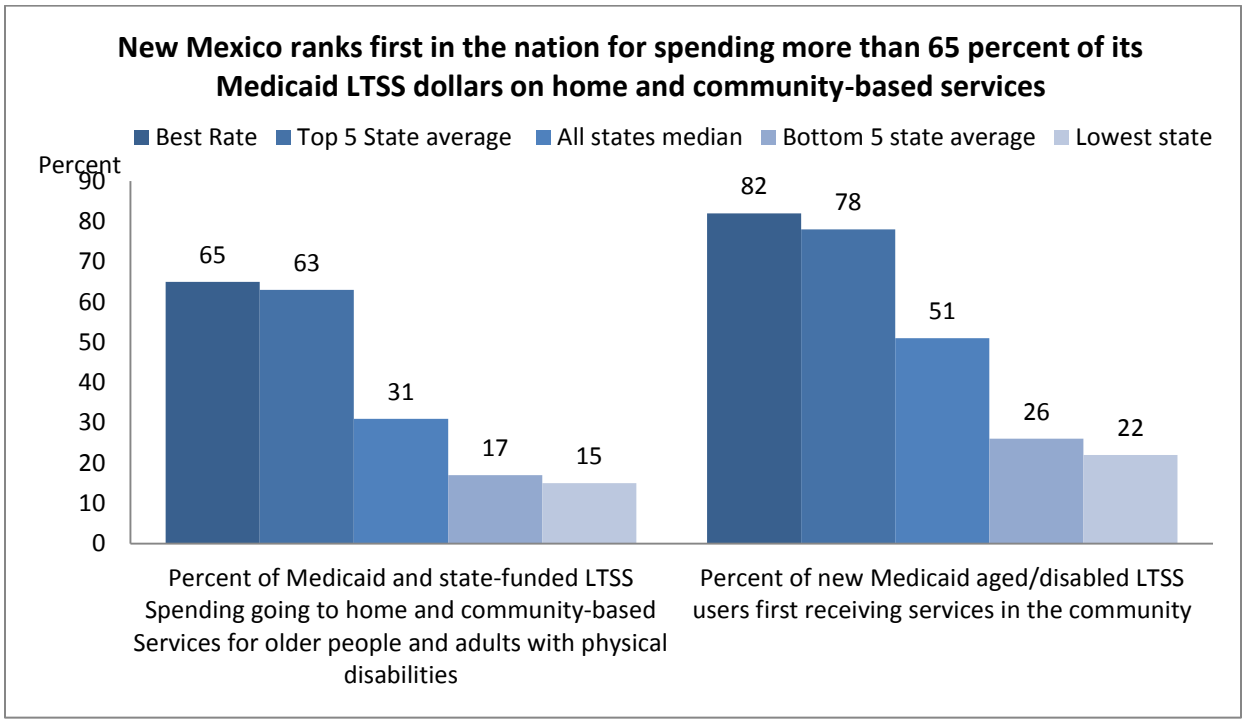
	Allocations Mailed	**Responses Received**	**Response Rates**	**Eligible for Waiver**
2014	1103	630	57%	168
2015	1725	786	46%	106
2016	3347	1476	44%	304

Community Reintegration/Rebalancing

Under Centennial Care, NM has continued to reintegrate members from nursing facilities into the community, with 85.7% of members in the long-term care program being served in the community in 2015.



In the AARP's annual report for 2014, *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, New Mexico ranks first in the nation for spending more than 65 percent of its long-term care dollars on home and community-based services.



Top 5 states:

1 New Mexico	**1 Alaska**
2 Minnesota	**2 Minnesota**
3 Washington	**3 New Mexico**
4 Alaska	**4 District of Columbia**
5 Oregon	**5 Idaho**

Data: LTSS Spending - AARP Public Policy Institute analysis of Truven Health Analytics, Medicaid Expenditures for Long Term Services and Supports in 2011 (Revised October 2013); AARP Public Policy Institute Survey (2012); New Medicaid Users - Mathematica Policy Research analysis of 2008/2009 Medicaid Analytical Extract (MAX).

Source: State Long-Term Services and Supports Scorecard, 2014.

Personal Care Services

Personal Care Services (PCS) is the most utilized CB service. Total PCS expenditures have increased from $263 Million with 19,500 users in 2013 to $345.8 Million with 27,836 users in 2015. The state fully implemented an Electronic Verification System (EVV) in November 2016 to ensure members are receiving the approved level of PCS. Many PCS caregivers use MCO supplied tablets with location service to monitor work activities.

NM Independent Consumer Support System (NMICSS)

HSD created an independent system that links together resources throughout the state to assist Medicaid Centennial Care enrollees receiving LTSS. The NMICSS provides Centennial Care beneficiaries, their advocates and counselors with information and referral resources in the following areas:

- Centennial Care health plan choice counseling
- Grievance, appeals rights and fair hearings
- Understanding care coordination and levels of care

The NMICSS provides informational brochures to inform beneficiaries and advocates on how to access the NMICSS and which participating organizations can help with specific topics. HSD developed an NMICSS website www.nmicss.com which provides the following information:

- Central location for resources, links and important phone numbers
- Listing of NMICSS partnering entities and description of available services
- Printable fact sheets regarding LTSS, step-by-step grievance, appeals and fair hearings flow charts, care coordination, the ABCB and the SDCB, and NFs

HSD partners with members of the NMICSS advisory team in planning and hosting semi-annual regional roundtable discussion groups with a focus on long-term services and supports (LTSS) in Centennial Care. The purpose of these meetings is to offer an environment conducive to open discussion regarding LTSS for Centennial Care members, provider advocates, executive leadership from the four MCOs, the Director of the Medical Assistance Division (MAD) and MAD LTSS Bureau. The regional discussions are held at the San Juan Center for Independence in Farmington, the UNM Center for Development and Disability (CDD) Information Network in Albuquerque and The Ability Center in Las Cruces. These discussions have led to increased MCO trainings for care coordination; process improvements between the MCOs, HSD and LTSS providers; and trust building at the community level with MCOs, members and provider advocates. Participating advocacy and provider organizations acknowledge improved relationships with the MCOs and support on-going regional discussions.

Policy Manual Updates

HSD updates the Centennial Care MCO Policy Manual twice a year to include policy clarification for the MCOs and providers. HSD solicits public comment as part of this process. As a result of feedback from advocacy groups and stakeholders, including the NMICSS roundtable discussions, changes have included:

- Removed MCO environmental modification documentation requirement that all other viable resources must be contacted and refuse to provide the service.
- Allowed PCS agencies to create a flexible individualized schedule for members as appropriate.
- Clarified PCS agency transfer process with timeframes.
- Added the purchase of cell phone data in self-directed related goods. There is a $100 per month limit for cell phone services.
- Increased limit from 50 miles to 75 mile radius in self-directed non-medical transportation.
- Clarified that non-medical transportation under self-direction for the purpose of picking up pharmacy prescriptions is allowed.

The CB sections of the Policy Manual will be updated again in March 2017.

LTC Challenges

CB Service Package Alignment

A major issue within the CB is the difference in the CMS approved available benefits in the self-directed and agency-based models. Several services are only available in the self-directed model such as related goods and specialized therapies. Members who struggle with the added employer related requirements of self-direction do not want to switch to ABCB because they will lose access to certain services not included in the ABCB package. HSD may more closely align the available benefits in the 1115 renewal, however, current budget constraints do not allow for an expansion of the program.

Children and Youth Appropriate Services in Centennial Care

The Community Benefit package was designed to meet the needs of the disabled and elderly population. There are many youth (under age 21) on the central registry or receiving CB services while they wait for an allocation to the Developmental Disabilities Waiver that may more appropriately meet their needs. The majority of CB services are not available to children, as they access services through the EPSDT benefit. In most instances, in the agency-based model, they are only eligible for CB respite or BH support consultation services. If a youth

switches to the self-directed model after 120 days in agency-based, he/she may be eligible for other services such as related goods or specialized therapies.

New Ideas for LTC

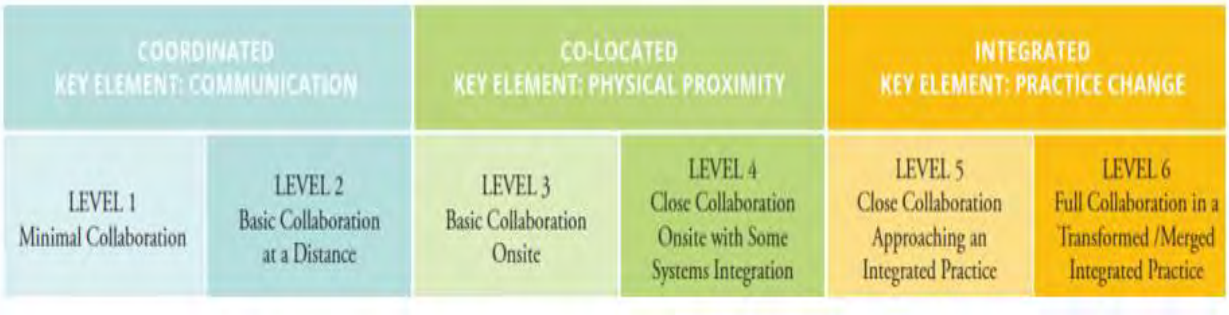
HSD has identified a few areas where improvement for LTC can be made in the waiver renewal if budget availability allows for such changes. These include:

- Aligning the benefits for both ABCB and SDCB models to allow for equity and smoother transitions between models.
- Explore service alternatives under both CB models that may better address members' needs.
- Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change. For example, this could pertain to members with certain conditions such as: renal failure, Alzheimer's, Parkinson's, quadriplegia etc. This would reduce the burden of annual assessments for the member, increase administrative simplicity and possibly bring cost savings. MCOs would still be required to complete an annual CNA and develop an annual care plan.
- Currently, members must need assistance with two activities of daily living (ADLs) to meet NF LOC. The requirement could be changed so that members would need to meet the requirement of assistance with three ADLs to qualify for NF LOC.
- Implement a new cohort/benefit category that would include members with few PCS hours (lower ADL needs).
- Establish CB budget level ranges based on assessed need. There could be three levels: high, middle and low with corresponding dollar amount ranges that would be available to members regardless of chosen CB model.

Behavioral Health-Physical Health Integration Considerations

The Context

- Mental illness and substance use disorders are common, affect people of all ages, and result in substantial disability and cost. Approximately 8 million deaths each year are attributable to behavioral health conditions but come from untreated comorbid health conditions, infections or suicide. Untreated mental illness (including substance use disorders) is not only a source of individual deaths and co-morbidity but also a largely preventable drain on health care system funds.
- New Mexico held a series of Expert Panel meetings in 2010/2011 to review the national and state experience with efforts to integrate mental health (including addiction) and general medical care. The Expert Panel recommendations contributed to the design of the 1115 Waiver with its emphasis on care coordination and its encouragement of a variety of patient-centered clinical practice models.
- Since then collaborative care management research has increased substantially, the strongest evidence of improved health outcomes coming from reviews of depression and diabetes treatment with a growing research base for other mental health conditions as well as interventions incorporating team-based direct care approaches.
- Since then also the deluge of prescription opioid use, dependency and death challenges behavioral health and general medical systems alike, driving up costs as well as creating new urgency for effective prevention and early intervention as well as treatment options.
- Mental disorders are largely chronic illnesses that, while very treatable, are characterized by relapses and recurrences.
- Mental health and substance use treatment is one of the 'essential benefits' in the Centennial Care program. Three-quarters of all serious mental disorders in adults – like major depression, schizophrenia and anxiety disorders – are present by age 25.
- The policy questions New Mexico and other states face is no longer *whether* to promote integration but *how* to provide the infrastructure and financial incentives needed to implement, ensure fidelity, foster innovation and sustain the model.



Successes in Centennial Care

- Integrated financing of BH and PH through capitation payments to MCOs
- Initiation of health homes for Centennial Care members with serious mental illnesses
- Development of the behavioral health provider networks through additional FQHCs delivering specialty behavioral health services
- Submission of application for CCBHC demonstration project
- Movement of care coordination to increasing number of provider/direct service locations
- Integrated Quality Service Review training and New Mexico's Treat First model
- Demystification of medical detox through
    - Partnership between UNM, PHP and the Hospital Association to increase substance use screening in emergency departments
    - Medical detox (withdrawal management) trainings in Gallup, Las Cruces and Albuquerque for hospital and other medical staff

Ideas for next steps

- Increase the number of health homes to additional counties
- Submit an additional health home SPA or amendment to add substance use disorders as primary diagnoses
- Build capacity through additional tele-behavioral health clinical supervision and tele-psychiatry development
- Increase implementation of value-based purchasing or prospective payment methodologies
-

Additional materials:

An updated version of the first behavioral health "Evolving Models of Behavioral Health Integration in Primary Care" that was considered by New Mexico's 'expert panel' describes the proliferation of research since 2010 on the integration of BH and PH through collaborative care models.

http://www.milbank.org/publications/evolving-models-of-behavioral-health-integration-evidence-update-2010-2015/

An executive summary of the full report can be found at: http://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI-Exec-Sum.pdf

Stakeholder Engagement Process Leading to Development of Concept Paper

4. MAC 1115 Waiver Renewal Subcommittee, January 13, 2017

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

NM Dept. of Transportation District Three Auditorium
7500 Pan American Freeway NE , Albuquerque, NM 87109

January 13, 2017

8:30 – 11:30AM

Topic	
Introductions	8:30 – 8:40 am
Review Minutes, Feedback from November Meeting	8:40 – 8:45 am
Value-Based Purchasing (VBP)	8:45 – 10:00 am
Break	10:00 – 10:10 am
Member Engagement / Personal Responsibility	10:10 – 11:10 am
Public comment & Wrap up	11:10 – 11:30 am

Medicaid 1115 Wavier Renewal Subcommittee Meeting

Meeting Minutes

January 13, 2017 — 8:30am – 11:30am

District Three Auditorium / Department of Transportation / 7500 Pan American Freeway NE, Albuquerque, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department Doris Husted, The Arc of New Mexico Bryce Pittenger, Children, Youth and Families Department Dawn Hunter, Department of Health Ellen Pinnes (proxy for Jim Jackson), Disability Rights New Mexico Sandra Winfrey, Indian Health Service Carol Luna-Anderson, The Life Link Dave Panana, Tribal Representative, Kewa Pueblo Health Corp. Nancy Rodriguez (proxy for Mary Kay Pera), New Mexico Alliance for School-Based Health Care Lauren Reichert, New Mexico Association of Counties	Teresa Turietta, New Mexico Association for Home & Hospice Care Patricia Montoya, New Mexico Coalition for Healthcare Value Linda Sechovec, New Mexico Health Care Association Jeff Dye, New Mexico Hospital Association Rick Madden, New Mexico Medical Society David Roddy, New Mexico Primary Care Association Carolyn Montoya, University of New Mexico, School of Nursing Lisa Rossignol, Parents Reaching Out Liz Lacouture (proxy for Mary Eden), MCO Representative, Presbyterian Health Plan

Absent Members:

Christine Boerner, Legislative Finance Committee	Kris Hendricks, Dentistry for Kids

Staff and Visitors Attending:

Rachel Wexler, DOH Wayne Lindstrom, HSD/BHSD Mark Barnand, HSD/BHSD Theresa Belanger, HSD/MAD Michael Nelson, HSD Kari Armijo, HSD/MAD Dan Clavio, HSD/MAD Angela Medrano, HSD/MAD Megan Pfeffer, HSD/MAD Nancy Smith-Leslie, HSD/MAD	Joie Glenn, Advocacy for Home and Hospice Care Erik Lujan, APCG Health Committee Shawna Romero, Blue Cross Blue Shield of New Mexico Debi Peterman, Health Insight New Mexico Beverly Nomberg, New Mexico Behavioral Health Association and La Familia Gayle Geis-O'Dowd, Molina Healthcare of New Mexico Patty Kehoe, Molina Healthcare of New Mexico Susan Dezavelle, Molina Healthcare of New Mexico Beth Landon, New Mexico Hospital Association

Tallie Tolen, HSD/MAD Robyn Nardone, HSD/NMICSS Jared Nason, Mercer Jessica Osborne, Mercer Son Yong Pak, Mercer Cindy Ward, Mercer	Kathleen Derby, Peer / Certified Peer Support Worker Anthony Yepa, Pueblo de Cochiti Rick Henley, Senior Link Carla V. Martinez, United Healthcare Amilia Ellis, United Healthcare Raymond Mensack, United Healthcare Curt Schatz, United Healthcare Josh Ahrens, United Healthcare Sunah Hoeferkamp, United Healthcare Veronica Esparza, United Healthcare Rodney McNease, University of New Mexico Hospitals

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Review minutes. • Feedback from the December 16th meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal, and all are encouraged to use the website to submit comments. • This is the 4th Subcommittee Meeting: — October 14th meeting focused on care coordination. — November 18th meeting focused on population health. — December 16th meeting focused on long-term services and supports (LTSS) and behavioral health/physical health (BH/PH) integration. — Today's meeting is focused on value-based purchasing and member engagement and personal responsibility. • MAD has not received any comments to the November 18th meeting minutes. Therefore, the draft meeting minutes are finalized. • Draft meeting minutes from the December 16th meeting is included and comments are requested by January 31, 2017. — Rick commented that on page 9, the meeting minutes need to emphasis the need for a shared electronic medical record to drive integration within a practice. The minutes were amended to reflect the comment.
II. Value-Based Purchasing (VBP)	• Providers have varied levels of readiness for VBP payment strategies and concerns about bearing more risk. • Providers need reliable data, particularly related to costs of services they do not deliver, and technical assistance to utilize data sources. • BH and LTSS providers can be particularly	• Pat commented that New Mexico started aligning quality and focusing on health plans moving towards VBP models under Aligning Forces for Quality (AF4Q). Currently, one of the challenges in implementing VBP is information technology (IT) systems that can manage VBP models at the managed care organization (MCO) and provider levels. She stated that nationally based MCOs tend to lead this charge and asked what they are

Agenda Item	Details	Discussion
	challenged by risk based VBP strategies and often require unique models. • Quality outcome measures can more resource intensive to collect (hybrid measures). • Alignment with other payers is challenging due to population differences and quality measure differences. • Population-based models require providers to think more broadly about unmet non-medical needs (social determinants of health) and how best to keep patients healthy. • No single entity to convene and coordinate a common vision across payers.	doing to build on the infrastructure in New Mexico. • Nancy SL.commented that Molina Healthcare of New Mexico (Molina) and Presbyterian Medical Services (PMS) have made a lot of progress with their IT system to support various VBP models. • Susan from Molina commented that it has a software program that shows providers their total cost of care, and it is able to manipulate data by providers to include the total cost of care, gaps in care and quality measures. Molina makes the data available through an online provider portal and is currently working with providers on how to use the data to improve care. • Liz from Presbyterian Health Plan commented that it provides a hard copy report to providers on a monthly basis and holds regular meetings with providers to review reports. Presbyterian Health Plan is currently building an online interface. • Carol, in respons to Molina and Presbyterian Health Plan comments asked if physical health and behavioral health were intergrated. • David R. commented that Federally Qualified Healthcare Centers are participating in VBP and stated that higher number of members are required to participate in risk-based models. In addition, he commented that having access to data is great; however, it is challenging to access data from multiple sources. • Pat commented that there are some barriers to sharing data from the federal and state regulations perspective and stated that we need to address the State statutes during the current legislative session. She also commented that we need to identify the funding streams to build a better infrastructure to support data sharing.

Agenda Item	Details	Discussion
		• Pat asked if HSD has performed a crosswalk on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) quality measures when building the core Medicaid measures. – Nancy SL. replied that New Mexico has requested the Centers for Medicare and Medicaid Services collaborate with the states on the development of quality measures but has received limited traction since the Medicare leadership's focus differs significantly from Medicaid. • Rick commented that it is important to support providers who are in early stages of readiness such as organizing the data, evaluating reports and data. He further commented that some of the MACRA incentives can help providers who want to participate in VBP but said that incentives are currently limited. • Lauren commented that counties are creating Behavioral Health Investment Zones (BHIZ), which is an accountable care organization (ACO)-like model where providers partner together. She stated that smaller providers and counties get limited attention from MCOs and have limited knowledge about payment structures. She commented that smaller providers and counties would benefits from education and support to get ready for VBP models. • Jeff commented that smaller providers face statistical challenges given the limited volume of members they serve and suggested a phase-in approach for small providers based on established member volume threshold. • Carol commented that small providers would like to participate in VBP and recommended that smaller providers be given an opportunity to participate.

Agenda Item	Details	Discussion
		• Dave commented that Indian Health Services (IHS) and 638 tribal facilities are not engaged in VBP as they are providing services in a fee-for-service environment and asked for a per member per month (PMPM) payment from HSD so that they can provide more robust care management. – Jessica commented that establishing Health Homes could be a mechanism to draw down a PMPM for coordinating care for IHS and 638 facilities. • Linda commented that the LTSS program has unique challenges and the Medicaid payment model does not support the staffing mix. She recommended a case-mix model which expands staff to accommodate night and weekend admissions in nursing facilities. She further commented that she would be introducing legislation during the legislative session. • Nancy R. commented that the younger generation seeks services from different providers such as minute clinic, urgent care, primary care, so limiting access to a specific provider is challenging. The younger generation wants to take their medical record with them. She recommends building technology where all providers can access information. • Rick commented that this issue is not unique to the younger generation and thinks that this is how most members access care regardless of their age. • Nancy R noted that transportation benefit was important for people when determining where to seek care. • Lauren noted that urgent care is often the last choice because of provider shortages. • Pat commented that the Bailit Health has issued a briefing document for the National Association of

Agenda Item	Details	Discussion
		Medicaid Directors that contains information on the prospective payment system[1]. She praised the State for establishing VBP targets for MCOs and commented that the Interagency Benefits Advisory Committee is establishing targets in their contracts on the commercial side with the MCOs. In regards to patient engagement, Pat commented that there are existing campaigns such as Choosing Wisely[2], an initiative of the American Board of Internal Medicine Foundation, that focus on advancing conversations between providers and members to help facilitate making wise decisions about the most appropriate care. • Sandra commented that incentives and penalties should be weighed carefully. For example, the Physician Quality Reporting System (PQRS) quality incentive reporting was so onerous and costly that some smaller providers took the penalty instead. • Ellen commented that ability of providers to meet the members' needs varies. Some people are able get a same day appointment while others cannot, and those that cannot get a same day appointment seek care in urgent care or emergency department. She also commented that MCO provider network changes are a factor in fragmentation of care and should be considered as a contributing factor. • Myles commented that VBP for geriatric population should be incentivized differently since their care needs are unique and members require longer examination time to address multiple chronic conditions.

[1] For further information, see http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf
[2] For further information, see http://www.choosingwisely.org/

Agenda Item	Details	Discussion
		• Carolyn commented that nurse practitioners have full practice authority in the State. She also commented that long wait time and short visits are an access issue. As a result, complex needs may not get addressed. • Doris commented that individuals with disabilities need longer appointments as they have unique challenges such as communication issues and the quality measures for this population may not align with members who are healthy. • Ellen commented that specialty providers are scarce for even those insured by private coverage. There is not enough supply. • Rick commented that New Mexico has a large population of individuals with developmental disabilities and elderly and commented that having advocates that can accompany the member results in better care. • Linda commented that New Mexico has a shortage of workforce, and this requires a critical examination. • Bryce commented that about 65% of New Mexico's children are on Medicaid and many people have adverse childhood experiences that create chronic care conditions. In regards to VBP, providers and MCOs should take on more risk for this population. • Myles commented that we need to look for opportunities to incent partnership with members, families and advocates. • Dawn commented that community health worker could function as advocates. • Lisa commented that pediatricians' workload for children with special needs is high, and pediatricians perform many activities that are not reimbursed by MCOs. She further commented that Colorado families can become

Agenda Item	Details	Discussion
		certified nursing assistants and receive compensation from insurance companies for performing care coordination activities. • Lauren commented that trained volunteers could become advocates for members with special needs. • Nancy R. commented that pediatric population's needs may not align with Medicare quality measures. • Carolyn commented that larger pediatrics practices have social workers or nutritionists on staff and in the office available for members to see; however, this is not financially feasible for small providers especially in rural areas. • Wayne commented that telehealth and Project ECHO can fill some gap in access to care. Also, he commented that we need to equalize the playing field by taking into consideration of member's severity levels when designing VBP models.
III. Member Engagement and Personal Responsibility	• Add new areas of focus, conditions, or behaviors for Centennial Rewards. • Changes to Reward values or expanded Rewards for major or sustained improvements. • Allow Rewards for potential cost-sharing requirements. • Improve engagement and participation in Rewards program through data mining, risk assessment, or technology. • Reduce no-show appointments. • Implement copayments for certain member's use of services. • Implement premiums for higher income members.	• Liz commented that when the copayment determination is left at the provider's discretion, it becomes even more challenging to collect copay. • Ellen commented that cost / benefit should be evaluated prior to implementing copayments. She believes these practices actually result in increased cost for the system. • Lauren commented that general public is passive / not typically active participants in health care. Advocacy should be incentivized and independence encouraged. • Nancy R. commented that a member must be 18 years of age to access the Centennial Rewards Program. Therefore, the program limits participation from teen parents and recommends modifying the minimum age to 14 years of age. In addition, recommended the Centennial Rewards Program should be more user

Agenda Item	Details	Discussion
		friendly such as having mobile access. If the State chooses to apply cost sharing, then the Centennial Rewards Program could cover copayments as an incentive. • Lisa commented that she likes the idea of having a mobile option related to the Centennial Rewards Program as many young individuals are technically savvy; however, she noted that many New Mexicans are not technically savvy and do not have access to the Internet. • Dawn recommended including tobacco cessation and partnering with the Public Health Division on this effort. She also commented that we need to assess member experience in Centennial Rewards Program and incorporate their feedback on the program. • Sandra commented that Native Americans do not get the opportunity to participate in the Centennial Rewards Program and recommended that HSD should explore opportunities to grow Native Americans' participation. • Jeff commented about passive enrollment versus active participation in the rewards program and recommended that the program should be designed to encourage active participation for earning rewards point and not count participants who use services in the normal course as participation. • Nancy SL. commented that the reward redemptions rate is increasing as people learn more about the program. • Lisa commented that copays can be very challenging financially for members and members may need to make a choice between paying for their healthcare or other needs such as food, utility. She further commented that providers will end up absorbing the costs, and cost sharing is barrier to care.

Agenda Item	Details	Discussion
		• Ellen commented that there are many reasons that drive what is viewed as not responsible behavior, and we talk about personal responsibility in terms of finance. She further noted that health system is complicated, and Centennial Care members have added pressures and circumstances. Therefore, she recommended that we need to better understand the drivers for missed appointments rather than consider this population as irresponsible and penalize them. • Dawn recommended that we use data to inform decision making such as evaluating the population who miss appointments and use emergency departments, exploring alternatives to penalties, improving health literacy, teaching members how to use services and accessing right level of care. • Nancy R. recommended that members enrolled in the Children's Health Insurance Program should be excluded from copays. She also commented that clinics already absorb copay costs for children who are accessing "private care", so they cannot afford to absorb more costs. She also commented about poor public transportation in Albuquerque and the long length traveling time. • David commented that he does not support assessing copays and recommends educating on the most cost efficient service such as using generic drugs. • Linda commented that we need to find a way that members could earn enough in rewards to cover copays or other penalties if HSD implement cost share. • Nancy S. reminded the group that HB2 requires the Department to implement cost sharing measures for the Medicaid program.

Agenda Item	Details	Discussion
IV. Public Comments	• Increase Medicaid spending on certified peer support workers	• Commenter discussed the benefits of using CPSW particularly in BH for below reasons: — It is cost effective. — It is an antidote for mental illness stigma. — It promotes wellness and recovery through shared experience and acceptance of illness.
V. Meeting Close	• Follow-up materials • Next meeting date	• Comments on VBP and member engagement and personal responsibility are due from committee members by January 31, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • Next meeting is on February 10, 2017, at the Administrative Services Division/Human Services Department.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
ACO – Accountable Care Organization
ADL – Activity of Daily Living
ALTSD – NM Aging and Long Term Services Department
BCBSNM – Blue Cross Blue Shield of NM
BH – Behavioral Health
BHSD – Behavioral Health Services Division of the HSD
CB – Community Benefit
CBSQ - Community Benefit Services Questionnaire
CCBHCs - Certified Community Behavioral Health Clinic
CC – Care Coordination
CCP – Comprehensive Care Plan
CCS – Comprehensive Community Support
CHIP – Children's Health Insurance Program
CHR – Community Health Resources
CMS – Centers for Medicaid and Medicaid Services, division of the HHS
CNA – Comprehensive Needs Assessment
CPSW – Certified Peer Support Worker
CSA – Core Service Agency
CYFD – NM Children, Families and Youth Department
DD – Developmental Disability and Developmentally Disabled
D&E – Disabled and Elderly
DOH – NM Department of Health
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
ED – Emergency Department
EDIE – Emergency Department Information Exchange
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
EVV – Electronic Visit Verification
FAQ – Frequently Asked Questions
FF – Face to Face
FFS – Fee for Service
FIT – Family Infant Toddler Program
FQHC – Federally Qualified Health Center
HCBS – Home and Community-Based Services
HH – Health Home
HHS – US Health and Human Service Department
HRA – Health Risk Assessment
HSD – NM Human Services Department
IBAC – Interagency Benefits Advisory Committee
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports

MACRA – Medicare Access and CHIP Reauthorization Act of 2015
MAD – Medical Assistance Division of the HSD
MC – Managed Care
MCO – Managed Care Organization
MH – Mental Health
MMIS – Medicaid Management Information System
MMISR – Medicaid Management Information System Replacement
NATAC – Native American Technical Advisory Committee
NF – Nursing Facility
NF LOC – Nursing Facility Level of Care
NMICSS – NM Independent Consumer Support System
PCMH – Patient-Centered Medical Home
PCP – Primary Care Physician
PCS – Personal Care Services
PH – Physical Health
PH-BH – Physical Health – Behavioral Health
PHP – Presbyterian Health Plan
PMPM – per member per month
PMS – Presbyterian Medical Services (FQHC)
PQRS – Physician Quality Reporting System
SA – Substance Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
SDCB – Self-Directed Community Benefit
SED – Severe Emotional Disturbance
SMI – Serious Mental Illness
SOC – Setting of Care
SUD – Substance Use Disorder
UHC – United Health Care
VBP – Value-Based Purchasing

HUMAN SERVICES
DEPARTMENT

CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
January 13, 2017

Agenda

Introductions	8:30 – 8:40
Feedback from December meeting	8:40 – 8:45
Value-Based Purchasing	8:45 – 10:00
Break	10:00 – 10:10
Member engagement and personal responsibility	10:10 – 11:10
Public comment	11:10 – 11:25
Wrap up	11:25 – 11:30

HUMAN SERVICES DEPARTMENT

Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Member engagement and personal responsibility
- Benefit alignment & Provider adequacy

HUMAN SERVICES DEPARTMENT

Value Based Purchasing (VBP)

HUMAN SERVICES DEPARTMENT

VBP

Opportunities/Goals

- Pay for value, not volume
- Improve quality of care and member outcomes
- Reward care that keeps members healthy or reduces disease burden
- Providers partnering with payers to achieve better outcomes and share in savings
- Bend the cost curve of Medicaid expenditures
- Align VBP strategies with program goals to increase care coordination, improve transitions of care, increase physical and behavioral health integration, reduce health disparities through population health strategies and improve member engagement.

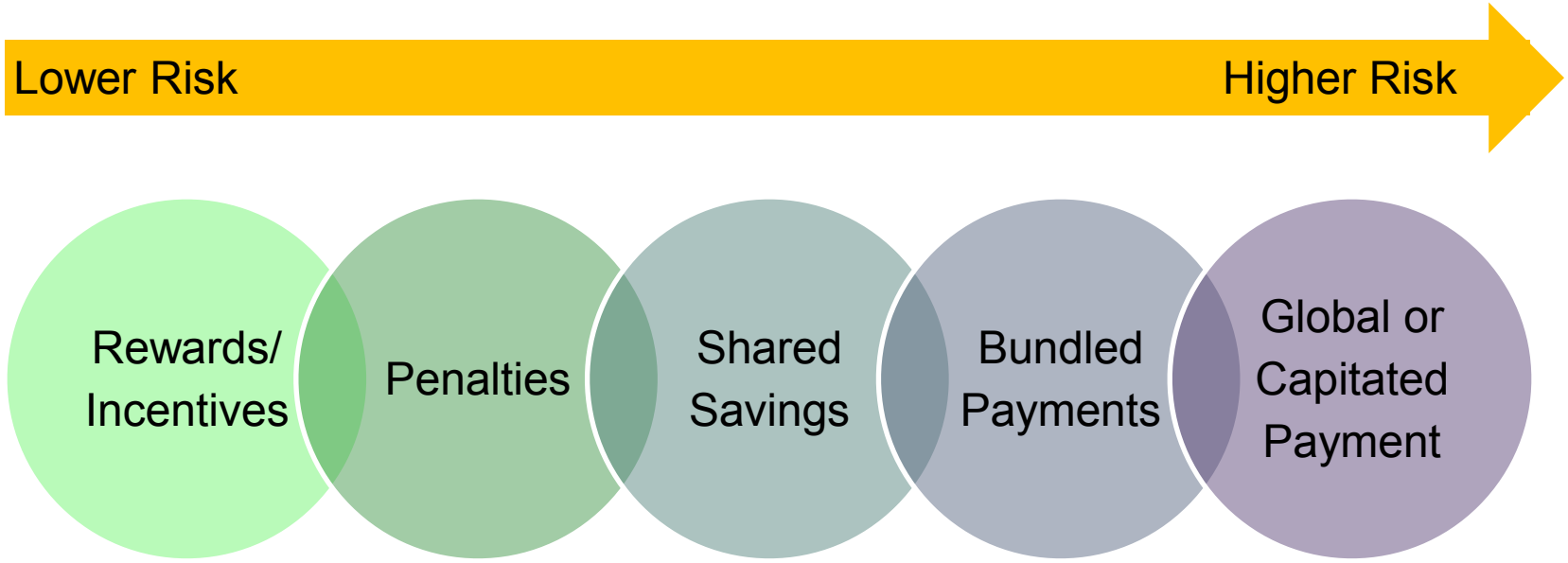
HUMAN SERVICES DEPARTMENT

VBP Guiding Principles

- High value care—best health outcomes at lowest cost.
- Phasing-in of increasingly advanced VBP models.
- Allowing for MCO flexibility of models—considering predominance of certain populations, i.e., percentage of long-term care members, as well as prevalence of chronic and/or high-cost conditions in the population.
- Allowing for provider flexibility—different points of readiness and ability to participate.
- Development of uniform quality goals that align with Centennial Care goals.
- Commitment to training, data sharing and technical assistance to support providers.

HUMAN SERVICES DEPARTMENT

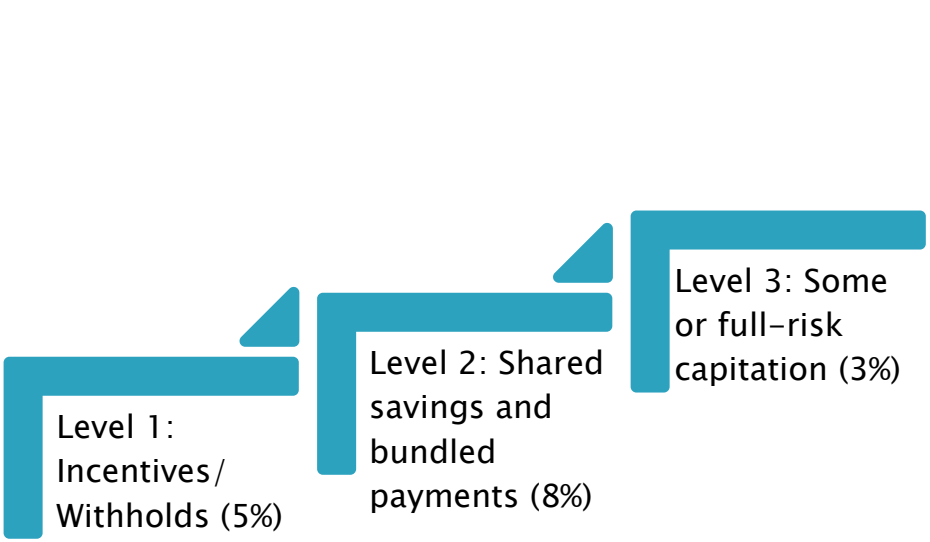
VBP Models

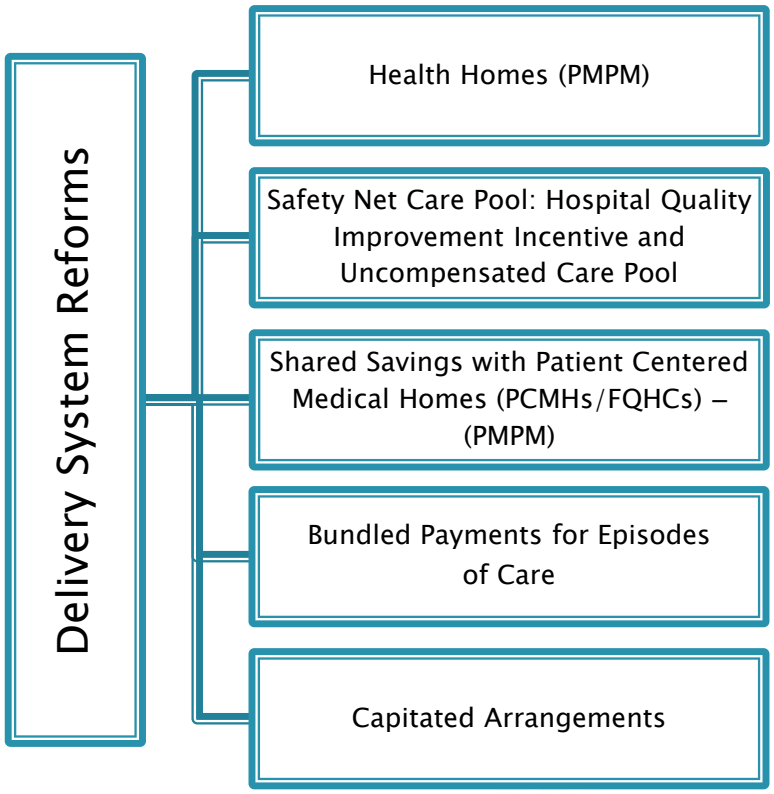


HUMAN SERVICES DEPARTMENT

Current VBP Landscape

- In CY17, MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements





HUMAN SERVICES DEPARTMENT

VBP
Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Improving provider readiness for VBP and willingness to bear more risk. ➢ Providers desire flexibility within VBP options. ➢ Minimum threshold of attributed lives to participate in some models. ➢ Actionable and reliable data and reporting. ➢ Standardization of quality measures across payers. ➢ Methods to ensure consistent quality measure reporting and validation.	➢ Providers have varied levels of readiness for VBP payment strategies and concerns about bearing more risk. ➢ Providers need reliable data, particularly related to costs of services they do not deliver, and technical assistance to utilize data sources. ➢ BH and LTSS providers can be particularly challenged by risk based VBP strategies and often require unique models. ➢ Quality outcome measures can more resource intensive to collect (Hybrid Measures).	1. How can we continue to develop our VBP strategy with flexibility for MCOs and providers, but move to more advanced models to achieve greater value and alignment with better healthcare outcomes? 2. How can we support providers who are in early stages of readiness? 3. What modifications are needed in payment structure to facilitate provider transitions to bear more risk over time?

HUMAN SERVICES DEPARTMENT

VBP

Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Eliminating barriers to data sharing/transparency of costs. ➢ Member engagement in improving health outcomes. ➢ State staff skill set and resources to monitor/evaluate VBP. ➢ Continuing to define "value" for Centennial Care Program.	➢ Alignment with other payers is challenging due to population differences and quality measure differences. ➢ Population-based models require providers to think more broadly about unmet non-medical needs (social determinants of health) and how best to keep patients healthy. ➢ No single entity to convene and coordinate a common vision across payers.	4. How can models and payments be designed to support care for patients with high non-medical challenges? 5. What outcomes have the most "value" within the Centennial Care program? 6. What VBP strategies are more effective for BH and LTSS providers?

HUMAN SERVICES DEPARTMENT

Member Engagement & Personal Responsibly

HUMAN SERVICES DEPARTMENT

Member Engagement
Centennial Rewards

Incentive program for members to engage and complete healthy activities and behaviors

Reward opportunities in the form of a credit for redemption in catalog:

- Healthy Smiles $25 annual dental visit
- Step-up Challenge $50
- Annual asthma controller Rx maintenance $60
- Healthy pregnancy $100
- Diabetes management $60
- Schizophrenia Rx maintenance $60
- Bipolar disorder Rx maintenance $60
- Bone density testing $35

Members participating in the program vs non-participants:

- Reduction in inpatient admissions
- Higher HEDIS and quality outcomes
- Higher risk members tend to participate in program
- Increase in Rx refills and medication adherence
- Increase in HbA1c testing compliance

Challenges:

- Participation and redemption rates are increasing each year but are only reaching 206k members

HUMAN SERVICES DEPARTMENT

Member Engagement
Disease Management

The right care – at the right place – at the right time

- Diabetes Self-Management Programs
- Wellness Programs
- Disease Specific Education Classes
- Communication Coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic diseases
- Targeted Education and self-help materials

Members participating in the program :

- Learn ways to manage their Diabetes independently
- Incorporate healthier eating opportunities and exercise
- Improved understanding of condition
- Improve confidence when speaking to providers about their condition
- Support smoking cessation needs of members
- Improve health outcomes and quality of life

Additional Member Engagement:

- Member Advisory Committee
- Ombudsman Program to assist Members with MCO processes
- Care coordinators developing alternative methods to engage members who are over utilizing the Emergency Department

HUMAN SERVICES DEPARTMENT

Member Engagement
Community Heath Workers

Community health workers role in engaging the member

The right care – at the right place – at the right time

- Improve health and health care literacy
- Make linkages to community supports
- Support care coordination
- CHW's function where the member lives

- Molina community connector
  - Vital member of care coordination team (eyes and ears)
  - Community based (member's home, providers office, statewide agencies)
  - Face-to-face, hands on with the member

- Presbyterian
  - Tribal-based public health announcements that target priority health conditions and promote health literacy
  - Agreements to have community heath representatives assist with completing HRAs
  - Help navigate healthcare systems, educate, and translate

HUMAN SERVICES DEPARTMENT

Member Engagement & Personal Responsibility Cost Sharing

Copayments	Require copayments for certain services and populations
	➢ Expansion, Working disabled, CHIP
	  ➢ Inpatient stays
	  ➢ Outpatient surgeries
	  ➢ Office visits
	  ➢ Non-ER transportation (urban only)
	➢ Most populations
	  ➢ Non-emergency use of emergency room
	  ➢ Use of non-preferred drugs

Premium contribution	➢ Income based
Appointment no-shows	➢ Reduce missed appointments ➢ Expand treat first model

HUMAN SERVICES DEPARTMENT

Member Engagement & Personal Responsibility Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Continue to encourage greater personal responsibility for members engagement in their own health.	➢ Add new areas of focus, conditions, or behaviors for Centennial Rewards. ➢ Changes to Reward values or expanded Rewards for major or sustained improvements. ➢ Allow Rewards for potential cost-sharing requirements. ➢ Improve engagement and participation in Rewards program through data mining, risk assessment, or technology.	1. How to further improve member engagement in the Rewards program? 2. Other ideas for increasing member engagement?

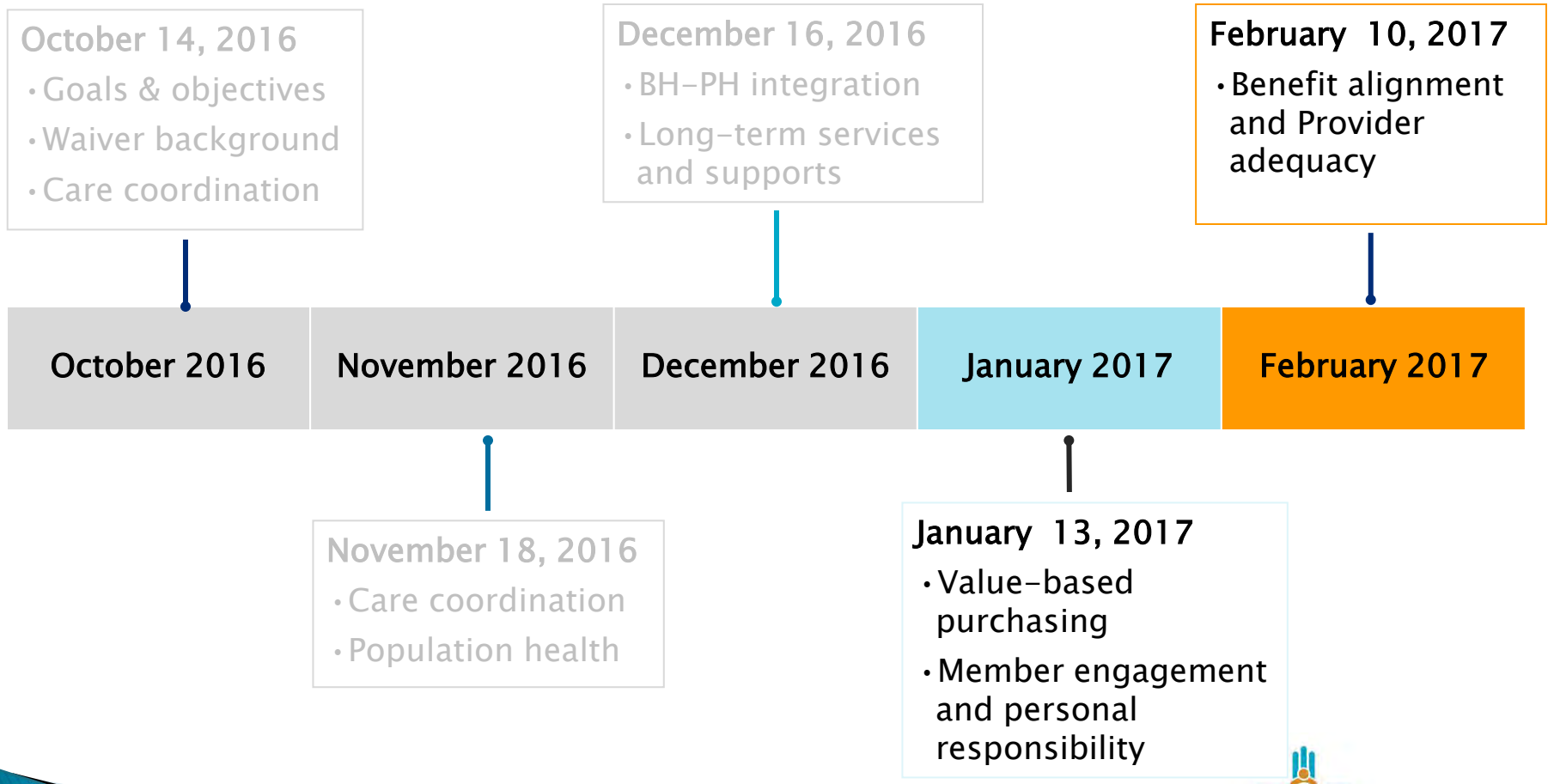
HUMAN SERVICES DEPARTMENT

Member Engagement & Personal Responsibility Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Implement policies that will encourage greater personal responsibility and financial accountability for higher income members. ➢ Financial disincentives for accessing health care in the least efficient manner.	➢ Reduce no-show appointments. ➢ Implement copayments for certain members use of services. ➢ Implement premiums for higher income members.	1. How to structure to incentivize healthy behaviors and use of services? 2. Premium hardship waiver circumstances. 3. Other initiatives beyond financial penalties to reduce appointment no-shows 4. Other ideas to align member engagement and value based purchasing?

HUMAN SERVICES DEPARTMENT

Subcommittee Meetings
Timeframe for Discussion



HUMAN SERVICES DEPARTMENT

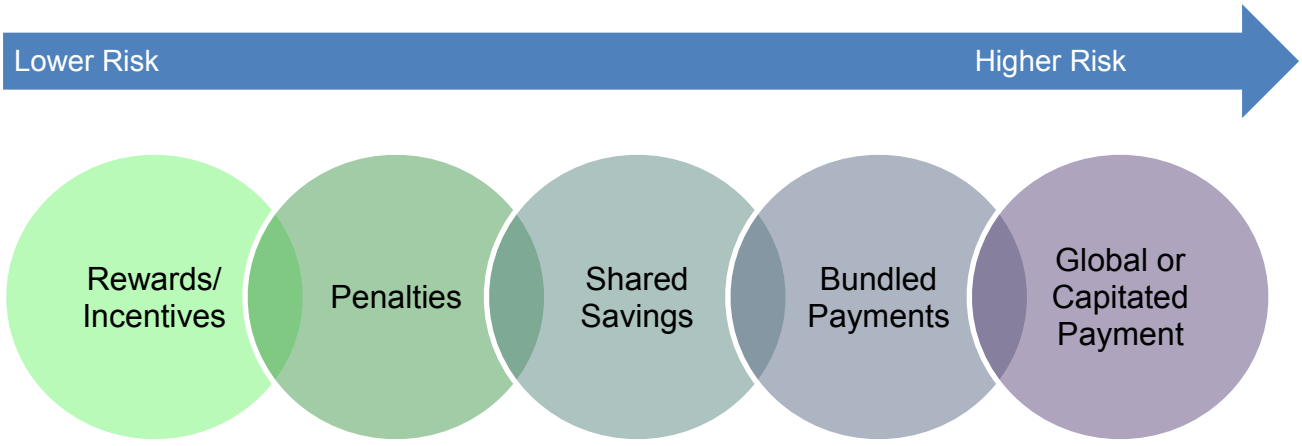
Centennial Care Value-Based Purchasing Brief

Background

The need to improve quality and efficiency in state Medicaid programs has led to implementation of a variety of payment reform efforts across the nation. As states face increasing pressures to maximize the value of their Medicaid spending while enrollment continues to increase, many are seeking strategies that will move the delivery system away from payments on a fee for service basis to paying for improved healthcare outcomes for recipients. The most costly Medicaid members with complex medical needs are served, for the most part, by a system that is not incentivized to improve care coordination or healthcare outcomes.

In its 1115 waiver that authorizes Centennial Care, New Mexico included payment reform as a key goal for its Medicaid managed care program. The Centennial Care contractual agreements required the Managed Care Organizations (MCOs) to pilot payment reform projects that focused on paying for value rather than volume of services. In 2015, the MCOs launched 10 pilot projects with an aim to begin to move the delivery system toward payment for improved quality. The New Mexico Human Services Department (HSD) collaborated with the MCOs to develop key performance measures for the projects in an effort to achieve better alignment for the providers, primarily utilizing a set of HEDIS measures in combination with several efficiency metrics, such as decreasing inpatient readmission rates.

In their value-based payment arrangements, the Centennial Care MCOs are expected to expand pay for value strategies within their provider networks using a variety of value-based purchasing models. Models are generally defined based on the level of up-side or down-side risk incurred within the arrangements.



Value-based purchasing models at the lower risk of the spectrum include incentives or pay for performance where providers are rewarded for hitting defined quality of care goals. Shared savings

models reward providers for meeting quality of care outcomes that save money for the program. Providers generally share in a portion of the savings realized. Risk models include capitated payments for providers who incur full or partial risk in caring for their population or panel of members. Bundled or global payment options reimburse providers an agreed upon rate that includes all services provided to address a specific condition. Examples of bundled payments are maternity care and joint replacement surgeries).

In their recent publication summarizing state approaches to value-based payment models in Medicaid, the Center for Health Care Strategies outlined five approaches states are using within their Managed Care Contracts[1]:

1. Requiring MCOs to adopt standardized value-based purchasing models
2. Requiring MCOs to make a specific percentage of provider payments through approved VBP arrangements *(a current initiative with Centennial Care MCO contracts)*
3. Require MCOs to move toward more sophisticated (more risk based) VBP arrangements over the life of the contract *(a current initiative with Centennial Care MCO contracts)*
4. Require MCOs to actively participate in a multi-payer VBP alignment initiative
5. Require MCOs to launch VBP pilot projects subject to state approval *(a current initiative with Centennial Care MCO contracts)*

Delivery system reforms within Centennial Care include shared savings and bonus payment arrangements with Patient Centered Medical Home practices and Federally-Qualified Health , Centers, which reward providers for achieving agreed-upon quality measures and improved member experience with the practice; provider-delivered, comprehensive care coordination through Health Homes targeted to members with Serious Mental Illness and Severe Emotional Disturbance; bundled payment arrangements for episodes of care, such as maternity and orthopedic services; subcapitated arrangements for providers willing to assume greater risk; and the Safety Net Care Pool that includes the Hospital Quality Improvement Incentive and Uncompensated Care Pool.

VBP Project	Type of Payment Reform			Project Description
	Bundled Payment	P4P-Shared Savings	Some Risk	
Accountable Care-Link Model		X		ACO-like model with shared savings for improving quality and reducing total cost of care.
Bundled Payment for Episodes	X			Bundles for bariatric surgery and maternity.
Subcapitated Payment for Defined Population			X	For primary care and multi-specialty groups that have care management infrastructure; subcapitation allows both upside/downside risks for defined population.

[1] Leddy, T. McGinnis, T. Howe, G.; Center for Health Care Strategies Inc. “Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches”; Brief, February 2016. http://www.chcs.org/resource/value-based-payments-in-medicaid-managed-care-an-overview-of-state-approaches/

Three-tiered Reimbursement for PCMHs		X		PMPM increases for base care coordination; date transfer to HIE; telehealth; use of EHRs; and performing HRAs. A total performance incentive per member payment is possible if the targets for every measure are met.
Bundled Payments for Targeted Admission Episodes	X			Working to bundle payments for pneumonia and colonoscopies.
PCMH Shared Savings		X		Builds upon current PCMH pay-for-performance model that rewards quality by adding shared savings targets after total medical costs are below a budget threshold.
Obstetrics Gain Sharing		X		Reducing unnecessary primary C-section by developing savings targets that reward appropriate use of C-sections. Obstetricians can earn enhanced payment for meeting metrics related to reducing unwarranted C-sections.

To continue to advance value-based purchasing initiatives, HSD has included new contractual requirements in its 2017 MCO agreements, see Appendix A. In CY17, MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements. Within the 16% HSD identified minimums across the spectrum of three VBP levels in order to ensure flexibility for providers that may not have the level of sophistication or resources needed to bear risk while providing opportunities for those providers that do.

After completing a series of site visits with providers participating in the VBP arrangements, it was evident to HSD that providers wanted flexibility within the VBP options and, in order to bear greater risk, needed comprehensive data and agreed-upon calculations of total cost of care. The MCOs are addressing those needs by regularly meeting with providers and sharing data, including score cards, claims data and, in some cases, providing a software program that enables providers to view utilization and expenditure data for attributed patients.

Defining Value

In order to effectively pay for value, the Centennial Care program is working to refine what “value” means for the program and how that value will be measured to ensure quality of care. This means identifying the appropriate metrics and measures, data sources and reporting strategies that are necessary to monitor VBP arrangements with an eye to our overarching goal of driving administrative simplicity and alignment where possible. Areas that Centennial Care is targeting as value areas are those topics being vetting through the subcommittee process and include:

- Care Coordination
- Physical and behavioral health integration
- Long-term services and supports
- Improving transitions of care
- Population Health

Key Considerations

Advancing value-based purchasing models is a change for the Medicaid program and participating providers. Key consideration areas include:

- **Health Care Providers and MCOs**
  - Engaging and supporting providers in migration to risk
  - Data analytics
  - Data sharing
  - Attribution of members and
  - Member engagement in improving health
  - Flexibility—not all providers are able to take on risk
  - Multi-Payer alignment on payment and measurement of quality
  - Lack of single convener across payers/delivery System
- **Improving Provider Readiness**
  - Capital Investments (including software / technology)
  - Technical Assistance
  - Clear and Consistent Path forward with reasonable milestones
  - Provider feedback / engagement in process
- Data Reporting Quality and Consistency
  - MCO ability to share information with providers
  - Providers' ability and capacity to utilize data and reporting
- **State policy development and monitoring**
  - No clear pathway to engage with CMS to work on alignment of federal and state VBP strategies and quality metrics
  - Resources and expertise at state to monitor VBP
  - How best to evaluate VBP models
- **Identifying ideal VBP strategies for behavioral health and LTSS providers**

Additional Challenges and Barriers

- Continued Use of FFS Payment in Reform Models
- Simply adding P4P bonuses to FFS structure
- Data for Setting Payment Amounts—need transparency around costs
- Provider accountability for costs not within their control
- Patient Engagement—providers must know their patients to be successful
- Member churn within provider practices
- Current Reforms Favor Larger Providers and require minimum number of members
- Transitional Payment Systems
- Staffing / Resource Challenges—State / Provider

Appendis A

VBP in Delivery System Improvement Targets – Centennial Care MCO Contract Language

Value-Based Purchasing

The CONTRACTOR must implement value-based purchasing as outlined in the table below. In order to meet the target, the CONTRACTOR must have met the percentages established below in all three levels; however, CONTRACTORs with more advanced VBP strategies may substitute higher percentages in Level 2 and/or Level 3 for lower percentages in Level 1 as long as the overall target of 16% of payments in VBP arrangements is met for the calendar year.

VBP LEVEL 1	VBP LEVEL 2	VBP LEVEL 3
A minimum of 5% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 8% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 3% of all CONTRACTOR provider payments for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:
• Fee schedule based with bonus or incentives and/or withhold (at least 5% of provider payment)—available when outcome / quality scores meet agreed-upon targets.	• Fee schedule based, upside-only shared savings— available when outcome / quality scores meet agreed-upon targets (may include downside risk), and • Two or more bundled payments for episodes of care.	• Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or • Global or capitated payments with full risk.

Additional requirements for VBP in CY17

- At least 3% of the overall 16% in VBP contracting must be with high volume hospitals and require readmission reduction targets of at least 5% of the hospital's baseline.
- CONTRACTOR must include behavioral health community providers in its VBP arrangements.
- CONTRACTOR must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements.

MCOs may exclude provider payments for dually-eligible members from the calculation.

Centennial Care 1115 Waiver Renewal Subcommittee
Issue Brief: Member Engagement & Personal Responsibility
January 2017

Overview

One of the core principles of the New Mexico Centennial Care program is to encourage greater personal responsibility of members to facilitate their active participation and engagement in their own health so they can become more efficient users of the health care system. As the Human Services Department (HSD) seeks to renew the Centennial Care waiver, the Department is looking to build on and incorporate policies that seek to enhance beneficiaries' ability to make informed decisions about their health and health care, and to become more active, responsible and involved participants in the health care system.

Member Engagement – Centennial Rewards

The Centennial Rewards program was developed with the launch of Centennial Care in 2014 as a way of providing incentives to members for engaging in and completing healthy activities and behaviors, including:

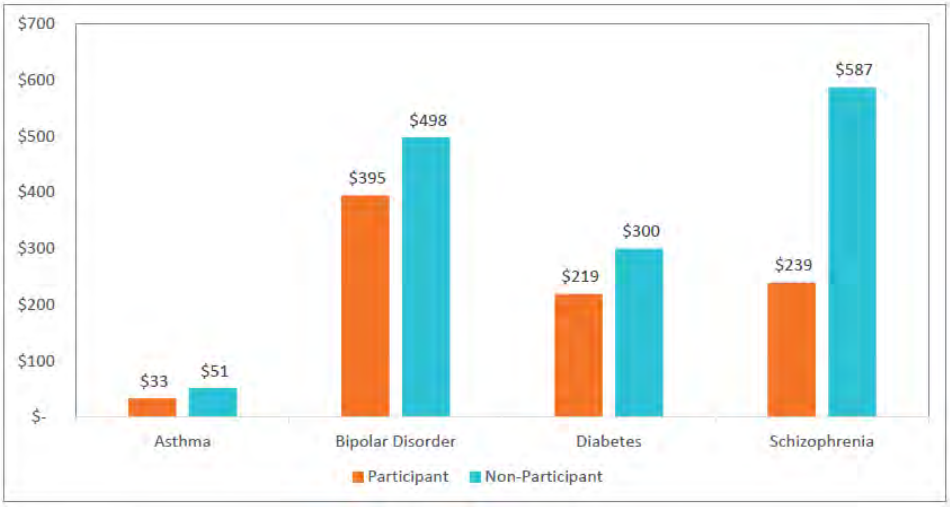
- **Healthy Smiles** to reward annual dental visits for adults and children;
- **Step-Up Challenge** to reward completion of a 3-week or 9-week walking challenge;
- **Asthma Management** to reward refills of asthma controller medications for children;
- **Healthy Pregnancy** to reward members who join their MCO's prenatal program;
- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes;
- **Schizophrenia and/or Bipolar Disorder Management** to reward members who refill their medications; and
- **Bone Density Testing** to reward women age 65 or older who complete a bone density test during the year.

Members who complete these activities can earn credits, which can then be redeemed for items in a Centennial Rewards catalog.

Centennial Rewards Accomplishments

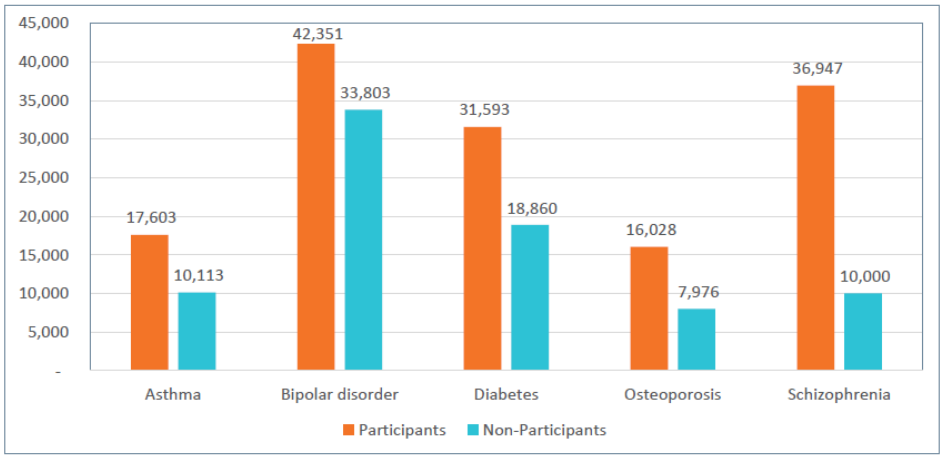
- Inpatient admissions have decreased among participants in the program, resulting in a cost-savings of approximately $23 million in calendar year (CY) 2015.
- The average redemption rate of earned rewards is 24 percent, with the notable exception of the Step-Up Challenge, which has a redemption rate of 85 percent. This suggests that the proactive enrollment required for the Step-Up Challenge has had a substantial positive impact on member use of their rewards.
- Overall cost-savings attributed to the Centennial Rewards program increased by one-third from 2014 to 2015. Reduced inpatient admissions and costs per admission have been the dominant driver behind cost-savings across conditions. See Table 1, below.

Table 1: Reduced Costs Across Conditions



- Participants across all conditions had higher compliance with HEDIS measures and other quality outcomes than non-participants.
- A comparison of risk scores indicates that higher risk members tend to participate in the Centennial Rewards program.
- With a full year of data for the Step-Up Challenge, HSD continues to see positive results regarding cost-savings, utilization and quality measures.
- Prescription drug refills are higher for participants compared to non-participants. Medication adherence for schizophrenia and bipolar disorder have both increased substantially year-over-year and were above 90 percent for participants in 2015. See Table 2, below.

Table 2: Prescription Drug Refill Rates



- HbA1c test compliance for participants increased substantially – nearly 20 percent from 2014 to 2015 – while the year-over-year increase for nonparticipants was only one percent.

Centennial Rewards Challenges

- Despite the decrease in inpatient admissions, emergency room visits were higher among participants in the program than among non-participants. This is true for all conditions in the Centennial Rewards program, except for schizophrenia.
- While the number of participants and redemption rate of rewards continues to increase, HSD seeks to continue growing the number of participants and improve member engagement and motivation. Approximately 206,000 Centennial Care members are currently enrolled in the Rewards program.
- HSD has made some changes to the program to reduce administrative costs and better align rewards with the acuity of the Centennial Care population.

Waiver Renewal Discussion Points

HSD might consider restructuring rewards to either focus on new conditions or to promote more proactive engagement, similar to the active enrollment process for the Step-Up Challenge. Ideas for discussion include:

- **Should Centennial Rewards remain tied to HEDIS or should HSD identify new focus conditions and behaviors?** Examples might include lowering blood pressure, meeting weight loss goals, or smoking cessation, and these conditions might be accompanied by a more proactive opt-in enrollment and tracking process, similar to the Step-Up Challenge.
- **Should the reward values change?** Examples might include items that encourage a healthier lifestyle, such as vouchers for a gym membership or weight loss program, or healthy nutrition assistance through gift cards or the WIC program. Higher-value rewards might also be offered for members that achieve major and sustained improvements in their health (i.e., reversal of diabetes or obesity). Rewards might also include exemptions from cost-sharing requirements, such as co-pays or premiums; or they might be restructured to allow members to accumulate rewards as a type of health savings account that could be used toward payment of cost-sharing responsibilities.
- **How can we improve member engagement through the Rewards program?** Examples might include mining data and risk assessments, using text and email to reach and inform members, and other means to allow members to more easily track their rewards (i.e., through mobile technology).

Member Engagement – Disease Management & Care Coordination

In addition to Centennial Rewards, the Centennial Care program has engaged members through multiple initiatives aimed at helping members better manage their chronic conditions. The Centennial Care MCOs have developed strategies that include member engagement through:

- Diabetes self-management programs and other disease-specific education classes
- Wellness programs
- Communication coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic conditions

- Targeted education and self-help materials
- Use of community health workers to engage members in meeting their care needs and addressing social determinants of health

The MCOs have also incorporated member engagement through their member advisory committees, ombudsman programs to assist members with understanding MCO processes, and by using care coordinators to develop alternative ways of engaging members who frequently use the emergency department. In addition, members in need of long-term services and supports are able to review Community Benefit services together with their care coordinator to determine which services they are interested in receiving through the Community Benefit Services Questionnaire (CBSQ). Self-Directed Community Benefit members are also actively engaged in developing their plan of care, hiring their own providers and determining rates of pay within the state's approved range of rates. These members are responsible for completing employer-related tasks, such as approving and submitting employee timesheets to the fiscal management agency for payment.

Personal Responsibility – Cost-Sharing

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL). In 2012, the U.S. Supreme Court issued a ruling that effectively made Medicaid expansion optional for states. As of January 1, 2017, a total of 32 states – including New Mexico – have expanded Medicaid. The expansion of Medicaid to new low-income adults has resulted in a significant enrollment surge of nearly 600 percent compared to enrollment of low-income adults before the Adult Expansion. Additionally, enrollment in the Children's Health Insurance Program (CHIP) has increased by 85 percent since early 2014. Compared to other states, New Mexico has generous eligibility thresholds for both children and adults, with the CHIP program extending to 300 percent FPL for children age 0-5 and to 240% FPL for children age 6-18.

Under today's Centennial Care program, Medicaid Expansion Adults are not subject to any form of cost-sharing, and co-pays for CHIP recipients are minimal. In New Mexico, there are also minimal co-pays for individuals enrolled in the Working Disabled Individuals (WDI) program, which provides coverage for individuals up to 250 percent FPL.

For the Centennial Care waiver renewal, HSD is considering incorporating policies that will encourage greater personal responsibility and financial accountability for individuals in higher-income Medicaid categories, including the Adult Expansion, CHIP and WDI. Please note that Native Americans would be exempt from any cost-sharing proposal set forth by HSD. Ideas under consideration might include:

- **Requiring co-payments.** HSD is considering requiring co-payments for outpatient office visits, inpatient hospital stays, outpatient surgeries, and non-emergency medical transportation (in urban areas only) for Expansion Adults, CHIP and WDI enrollees. In addition, HSD is considering co-payments that would apply to most Medicaid enrollees for using certain non-preferred prescription drugs and for non-emergency utilization of the emergency room.
- **Assessing premiums for populations above 100 percent of poverty.** Premiums are the norm for private insurance and coverage on the federal marketplace, and HSD is considering whether they should be assessed to certain Medicaid populations as well. Many states are pursuing approval of premiums for the Adult Expansion population from the federal government, with some proposing to charge premiums for recipients with income as low as 50% FPL. For an

individual with income between 101-150 percent FPL, a monthly premium of one percent or less of income would be $10 monthly.

- **Minimizing appointment "no-shows".** With the Adult Expansion of Medicaid, providers have expressed serious concern about rising rates of missed appointments. Under current rules, Medicaid recipients cannot be required to pay fees or sign financial responsibility forms for missed appointments. HSD might consider whether policies should implemented under the renewed waiver to either allow providers to charge nominal fees for missed appointments or to more positively incentivize appointment adherence (i.e., expansion of the Treat First model).

Waiver Renewal Discussion Points

HSD might consider a movement toward policies that promote greater personal and financial responsibility for members, to include co-pays, premiums and ways to minimize missed appointments. Ideas for discussion include:

- **If cost-sharing (either co-pays or premiums) is imposed, how can it be structured to incentivize healthy behaviors and efficient use of the health care system?** Examples might include waiving cost-sharing requirements for members who engage in healthy behaviors, such as preventive visits and well-child checks, completion of the Health Risk Assessment (HRA) and/or Comprehensive Needs Assessment (CNA), or putting contributions into a health savings account to offset health care costs or to offer vouchers that support healthy behaviors.
- **If premiums are assessed, what type of hardship waiver should be developed?** Examples might include exemptions from premiums for individuals who are homeless, who are late paying their rent, mortgage or utilities, or who have had a large and unexpected increase in basic expenses.
- **What types of initiatives would work to reduce appointment no-shows in lieu of financial penalties?** HSD is considering expansion of the Treat First clinical model, which is designed to reduce the behavioral health missed appointment rate for second appointments. The Treat First approach emphasizes the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a response to the reason the individual came to the agency during the first visit – rather than spending time at the first appointment on assessments. Results from the model show that it has reduced no-show rates and improved the quality of assessments and treatment plans over the first four encounters. How can this model be replicated? Is there an adjustment of this model that can be translated in the primary care practice environment?
- **What other ways can be used to align member engagement and value-based purchasing quality metrics?** Strategies could include member collaboration with providers to meet agreed-upon goals, such as adherence to medication, obtaining certain preventive screenings, or other outcomes that align with the member's individualized health targets.

Stakeholder Engagement Process Leading to Development of Concept Paper

5. NATAC, January 20, 2017

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

January 17, 2017

NATAC 1115 Waiver Renewal Meeting

January 20, 2017 1:30-3:30 pm

Albuquerque Area Indian Health Service
4101 Indian School Road, NE, Suite 225
Albuquerque, NM 87110

Call in Number: 1-888-394-8197
Passcode: 175512

AGENDA

I. Introductions

II. Review 1115 Waiver Renewal Areas of Focus

- A. Care Coordination
- B. Population Health
- C. Long Term Services & Supports
- D. BH & PH Integration
- E. Value Based Purchasing
- F. Member Engagement & Personal Responsibility
- G. Benefit Alignment & Provider Adequacy

III. Review November & December Presentations & Briefs

IV. NATAC Input on 1115 Waiver Renewal

V. Meeting close

HUMAN SERVICES DEPARTMENT

CENTENNIAL CARE NEXT PHASE

NATAC 1115 Waiver Renewal Subcommittee

January 20, 2017

Renewal Waiver
Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address social determinants of health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

Care Coordination
Opportunities/Goals

- Improve transitions of care: *The movement of a member from one setting of care (examples: inpatient facilities, rehabilitation settings, skilled settings and after incarceration) to another setting or home*[1]
- Focus on higher need populations
- Provider's role in care coordination

[1] Adapted from CMS' definition of terms, Eligible Professional Meaningful Use Menu Set of Measures; Measure 7 of 9; Stage 1 (2014 Definition) updated: May 2014. retrieved: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downl

Improve Transitions of Care

Feedback	Concepts	Further Discussion

➢ Communication across health providers and managed care is a challenge
➢ Real time information is critical to transitions
➢ Care Coordinator's access in hospitals is challenging
	➢ Identify funding to focus on facilities improving discharge planning
	➢ Enhanced care coordination as part of transitions (short-term):
	  ➢ Jail release
	  ➢ Inpatient stay
	  ➢ Nursing facility to community
	  ➢ Children in residential facilities
	➢ Incentives for outcomes of a successful discharge:
	  ➢ Attend follow up PCP visit
	  ➢ No unnecessary ED visit post discharge for 30-days
	  ➢ No preventable readmission post discharge for 30-days
	  ➢ Filling medications
	  ➢ Completing medication reconciliation (provider)
	➢ Incentives for member adherence to recommended follow-up:
	  ➢ member rewards
		1. Are there ideas here that will have more impact than others?
		2. What are good measures for defining a successful discharge?
		3. Carrot or stick for adherence to discharge plan?
		4. Any other at-risk populations we should address?

Focus on Higher Needs Populations

Feedback	Concepts	Further Discussion

➢ Improve education to members about use of public health services
➢ Increase member education and use of community supports such as public health services:
  ➢ Community Health Workers / Certified Peer Support Worker (CPSW)
  ➢ School-based health centers
  ➢ Expand Health homes
	➢ Improved engagement of family and other community supports:
	  ➢ Family/caregiver role
	  ➢ Increase use of community health workers / CPSWs
	➢ Promote creative approaches by MCOs to support unique high needs populations.
	➢ Focused education and interventions that are condition or location specific:
	  ➢ Areas with fewer providers, transportation issues and/or specific cultural aspects
	  ➢ Areas with high risk pregnancies, with high prevalence of diabetes, COPD and other chronic diseases
	➢ Use of Community Health Workers for more intensive "touch" for these members
	➢ Expand health homes
	➢ Use of population health information to develop targeted education and interventions
		1. How can we incentivize member participation in care coordination? In their healthcare? In preventative care?
		2. How can we use Community Health Workers and others as resources for a more intensive role for these members?
		3. What are some interventions to engage hard to reach members?
		4. Who are higher need populations we should consider?

Provider's Role in Care Coordination

Feedback	Concepts	Further Discussion
➢ Information sharing with local providers is key. ➢ Need for further definition of care coordination roles based on where a member is receiving care (FQHC, Senior Center, Jail, ER) ➢ Need to increase consistent use of terms (case management, care coordination, care management) ➢ Increase use of local/community supports to support MCO care coordination. More use of CPSW, peer navigator: ➢ Teen parents, cancer center	➢ Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination ➢ MCOs could share dollars with local programs for direct linkages to members ➢ MCO and Provider Incentives for outcomes ➢ Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals ➢ Value-based payment approaches will involve / delegate care coordination to providers	1. How do we build capacity and readiness in the provider community? 2. Where should care coordination be provided (physical location)? 3. How do you avoid duplication of efforts between MCO care coordination and provider level? 4. How do you promote communication and coordination between the MCO and provider level care coordination?

Population Health
Key Terms

- Population Health

"A population-based approach to health care and preventative services improves health outcomes for all populations and helps individuals achieve their highest health-related quality of life" [2]

- Social Determinants of Health

Factors that enhance quality of life and can have a significant influence on population health outcomes. Examples include safe and affordable housing, access to education, a safe environment, availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins [3]

[2] Centers for Medicaid and Medicare, CMS Strategy: The Road Forward (2013-2017); retrieved: https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf

[3] Adapted from :Office of Disease Prevention and Health Promotion, Health People 2020; 2020 Topics and Objectives: Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Population Health
Starting the Discussion

Needs	Concepts	Further Discussion
➢ Food ➢ Housing ➢ Transportation (work, school, social needs) ➢ Employment	➢ Chronic disease monitoring and education ➢ Health assessments and data collection ➢ Medication compliance ➢ Condition or region specific initiatives funding and outcomes goals ➢ Housing ➢ Job coaching and support. ➢ Food pharmacies ➢ Linkages to community resources and supports beyond health services	1. What population(s) should we target? Why? 2. Which factors/determinants impact outcomes for this population? How could Medicaid address those factors? 3. How do we move the organization to population-based analysis? Do we have necessary data or analytical capability? 4. How do we create a nimble system that can respond to factors that impact population health?

LTSS Overview

Under Centennial Care all members who meet the NF LOC have access to the community benefit

- Increase in the number of unique members who have access to the community benefit:
  - 23,000 users in CY2014
  - 26,600 users in CY2015
  - 26,300 in the 9 months of CY16
  - Community benefit is included in the expansion benefit package
- Average monthly cost of a nursing home is approximately 2.8 times as expensive as the average community benefit
- Recent analysis by the LFC indicated that the overall occupancy rate at nursing facilities has been declining since 2011
- NM ranked in the 2nd best quartile overall in the 2014 national State Long Term Care Scorecard [1]

Rebalancing
LTSS Enrollment Mix (Nursing Facility vs Community)

Setting	Nursing Facility	Community Benefit
2011	18.7%	81.3%
2012	18.9%	81.1%
2013	17.3%	82.7%
2014	14.0%	86.0%
2015	13.5%	86.5%

[1] http://www.longtermscorecard.org/

LTSS
Beginning the Discussion

Needs	Concepts	Further Discussion

➢ Streamline NF LOC renewals and improve assistance to individuals
➢ Improve comparability of service offerings between community benefit options and improve transition into SDCB
➢ Continue successes of rebalancing effort between institutionalization and community care
➢ Fiscal sustainability of nursing homes
	➢ Automatic NF LOC renewal for certain members
	➢ Align benefits for ABCB and SDCB
	➢ Establish levels for ABCB and SDBC budget ranges based on need that include provisions for one time transition costs
	➢ Implement new cohort for members who use fewer PCS hours
	➢ Diversification of services provided by nursing homes
	➢ Explore provider fees / taxes:
	  ➢ Legislative process
	  ➢ CMS approval
	➢ NF LOC ADL change from 2 ADLs to 3 ADLs
	➢ Value-based purchasing arrangements with LTSS providers
		1. What other areas are important to streamline for members?
		2. What other enhancements should be considered for members to remain in the community?
		3. Nursing facility diversification

BH/PH Integration
Key Terms

Intent of Integration

- "Integration of services through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service to help recipients manage their health and their use of the health care system."
- "What New Mexico now challenges its plans to do is manage care and deliver outcomes that can be measured in terms of a healthier population. In order to effectively drive the kind of system change New Mexico seeks, plans will have to think and behave differently and support the movement towards care integration and payment reform."

PH-BH Integration
Opportunities/Goals

- More than mental illness and addiction
- Early onset; early death (>8 million each year)
- Medicaid = largest payer
- Provider and Plan Challenges:
  - Workforce
  - EHR capacity
  - Continuity of care gaps

Increase provider competency to serve members with co-morbid PH-BH conditions

Improve screening for BH conditions, including substance-use disorders

Leverage the emergency department information exchange to identify members who require linkage to mental health and substance abuse treatment

Improve information sharing challenges due to varied interpretations of privacy rules

PH-BH Integration
Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Increase provider's competency and capacity to manage both physical and behavioral conditions ➢ Increase behavioral health screening across the continuum of care ➢ Remove barriers to sharing information between providers ➢ Value-based payment strategies for integrated care	➢ Provider education on PH-BH integration models and best practices ➢ 3 practice structures and 6 levels of collaboration ➢ Improve identification of behavioral health and substance use issues and linkage to treatment ➢ Substance abuse treatment availability ➢ Improve physical health conditions and reduce in morbidity and mortality ➢ Direct Care management: early assessment; treatment engagement; active follow-up; structured patient education; standardized psychotherapy ➢ Linkages to community resources and population health supports beyond health services	1. Are all three practice models present in New Mexico? What is working well? 2. How can we support provider's capacity to manage co-morbid conditions? 3. How can MCOs encourage patient engagement? Provider engagement? 4. Can MCOs work with local and regional leaders to create stronger forms of integrated care that affect health outcomes? 5. Should HSD identify screening tools that they recommend providers use? 6. What ways can HSD support better information sharing? 7. Can value-based payment models address provider and plan challenges? What models are better suited for integrated providers?

Next Steps

- Next meeting February 13, 2017
- Email for follow-up questions/clarifications
  - Email Address: **HSD-PublicComment2016@state.nm.us**
  - Include "Waiver Renewal" in email subject line:
  - Include a background, proposed solution and impact in your correspondence

- **Information Links**
  - Centennial Care (CC) 1115 Waiver Submission Documents:
  - http://www.hsd.state.nm.us/Centennial_Care_Waiver_Documents.aspx

  - Centennial Care 1115 Waiver Approval Documents:
  - http://www.hsd.state.nm.us/approvals.aspx

  - Centennial Care Reports:
  - http://www.hsd.state.nm.us/reports.aspx

Stakeholder Engagement Process Leading to Development of Concept Paper

6. NATAC, February 10, 2017

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

NATAC 1115 Waiver Renewal Meeting

February 10, 2017

Human Services Department
Administrative Services Division
1474 Rodeo Road
Santa Fe, New Mexico

AGENDA

I. Introductions

II. Review Minutes, Feedback from January meeting

IV. Member Engagement & Personal Responsibility

V. Benefit & Eligibility Alignment

VI. Next Steps

VII. Meeting Close

HUMAN SERVICES DEPARTMENT

CENTENNIAL CARE NEXT PHASE

NATAC 1115 Waiver Renewal Subcommittee

February 10, 2017

Renewal Waiver
Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address social determinants of health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility

Member Engagement & Personal Responsibly

Member Engagement
Centennial Rewards

Incentive program for members to engage and complete healthy activities and behaviors

Reward opportunities in the form of a credit for redemption in catalog:

- Healthy Smiles $25 annual dental visit
- Step-up Challenge $50
- Annual asthma controller Rx maintenance $60
- Healthy pregnancy $100
- Diabetes management $60
- Schizophrenia Rx maintenance $60
- Bipolar disorder Rx maintenance $60
- Bone density testing $35

Members participating in the program vs non-participants:

- Reduction in inpatient admissions
- Higher HEDIS and quality outcomes
- Higher risk members tend to participate in program
- Increase in Rx refills and medication adherence
- Increase in HbA1c testing compliance

Challenges:

- Participation and redemption rates are increasing each year but are only reaching 206k members

Member Engagement
Disease Management

The right care – at the right place – at the right time

- Diabetes Self-Management Programs
- Wellness Programs
- Disease Specific Education Classes
- Communication Coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic diseases
- Targeted Education and self-help materials

Members participating in the program :

- Learn ways to manage their Diabetes independently
- Incorporate healthier eating opportunities and exercise
- Improved understanding of condition
- Improve confidence when speaking to providers about their condition
- Support smoking cessation needs of members
- Improve health outcomes and quality of life

Additional Member Engagement:

- Member Advisory Committee
- Ombudsman Program to assist Members with MCO processes
- Care coordinators developing alternative methods to engage members who are over utilizing the Emergency Department

Member Engagement
Community Heath Workers

Community health workers role in engaging the member

The right care – at the right place – at the right time

- Improve health and health care literacy
- Make linkages to community supports
- Support care coordination
- CHW's function where the member lives

- Molina community connector
  - Vital member of care coordination team (eyes and ears)
  - Community based (member's home, providers office, statewide agencies)
  - Face-to-face, hands on with the member

- Presbyterian
  - Tribal-based public health announcements that target priority health conditions and promote health literacy
  - Agreements to have community heath representatives assist with completing HRAs
  - Help navigate healthcare systems, educate, and translate

Member Engagement & Personal Responsibility
Cost Sharing – Native Americans are exempt

Copayments	Require copayments for certain services and populations
	➢ Expansion, Working disabled, CHIP
	  ➢ Inpatient stays
	  ➢ Outpatient surgeries
	  ➢ Office visits
	  ➢ Non-ER transportation (urban only)
	➢ Most populations
	  ➢ Non-emergency use of emergency room
	  ➢ Use of non-preferred drugs

Premium contribution	➢ Income based
Appointment no-shows	➢ Reduce missed appointments ➢ Expand treat first model

Member Engagement & Personal Responsibility Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Continue to encourage greater personal responsibility for members engagement in their own health.	➢ Add new areas of focus, conditions, or behaviors for Centennial Rewards. ➢ Changes to Reward values or expanded Rewards for major or sustained improvements. ➢ Allow Rewards for potential cost-sharing requirements. ➢ Improve engagement and participation in Rewards program through data mining, risk assessment, or technology.	1. How to further improve member engagement in the Rewards program? 2. Other ideas for increasing member engagement?

Benefit & Eligibility Alignment

Benefit & Eligibility Alignment
Streamlining Eligibility

Justice Involved Individuals	➢ HSD has worked to develop policies, processes and IT infrastructure to streamline Medicaid eligibility for individuals involved in the justice system
	➢ Goal is to close the gaps for individuals through:
	  ➢ Timely and automated eligibility reactivations
	  ➢ Earlier start date for eligibility (while incarcerated)

Family Planning Program	➢ In 2016 72,000 people were covered and 91% of the members did NOT use services through the program
	➢ Administratively burdensome and costly to HSD for renewal processing (approximately 6,000 cases per month)
	➢ Coverage overlaps with other insurance coverage
	➢ Considerations aim to reduce administrative costs while maintaining services for individuals who use them:
	  ➢ Narrow coverage for certain age groups
	  ➢ Narrow coverage for populations who do not have other health insurance coverage

Benefit & Eligibility Alignment
Streamlining Eligibility

Simplify Eligibility Processes	➢ HSD has developed real-time eligibility for initial and renewal determinations (roll-out Spring 2017)
	➢ Federal eligibility rules are difficult to navigate, are structurally complicated and costly
	➢ Considerations include:
	  ➢ Waive 3 month retro-active eligibility for initial applicants
	  ➢ Extending continuous eligibility to adults to reduce administrative workload associated with mid-year redeterminations resulting from reported income changes

Shorten time period for transitional Medicaid	➢ Transitional Medical Assistance (TMA), predates the ACA and was intended to provide expiring coverage for parent/caretaker adults whose income increases above the eligibility threshold for the group for up to 12 months
	➢ Considerations include:
	  ➢ Request more frequent reporting of income (i.e., quarterly)
	  ➢ Shorten period of TMA to 30 – 90 days
	  ➢ Eliminate coverage

Benefit & Eligibility Alignment
Benefit Design

Uniform Benefit Package for Parent /Caretaker adults and Medicaid Expansion

- Currently parent/caretaker adults receive a different benefit than Medicaid expansion members:
  - Parents/caretaker adults = "Standard Medicaid"
  - Alternative Benefit Plan (ABP) = "essential health benefits"; modeled on commercial health plan benefit design (approximately 260,000 Expansion adults)
  - ABP Exempt = "Standard Medicaid" for Medically Frail Expansion adults (approximately 3,500 members)
  - Expansion adults between the ages of 19-20 also receive EPSDT benefits
- Considerations include:
  - Align benefit packages for parent/caretaker adults and Medicaid expansion population
  - Allow the same option for members to opt-into ABP exempt (if qualified)
  - Request waiver to exclude EPSDT coverage requirement for Expansion members between ages 19-20

Benefit & Eligibility Alignment
Benefit Design

Benefits options	
	➢ Increase availability of long acting reversible contraceptives (LARC) through increased FMAP (90%) to maintain inventory for providers (i.e., School Based Health Centers, etc.) ➢ Allow cost-effective non-covered service alternative to opioids for pain management such as acupuncture or chiropractic services ➢ Explore affordable alternatives to full dental and vision coverage in the form of riders similar to the design available to state employees, if necessary due to cost containment

Benefit & Eligibility Alignment
Beginning the Discussion

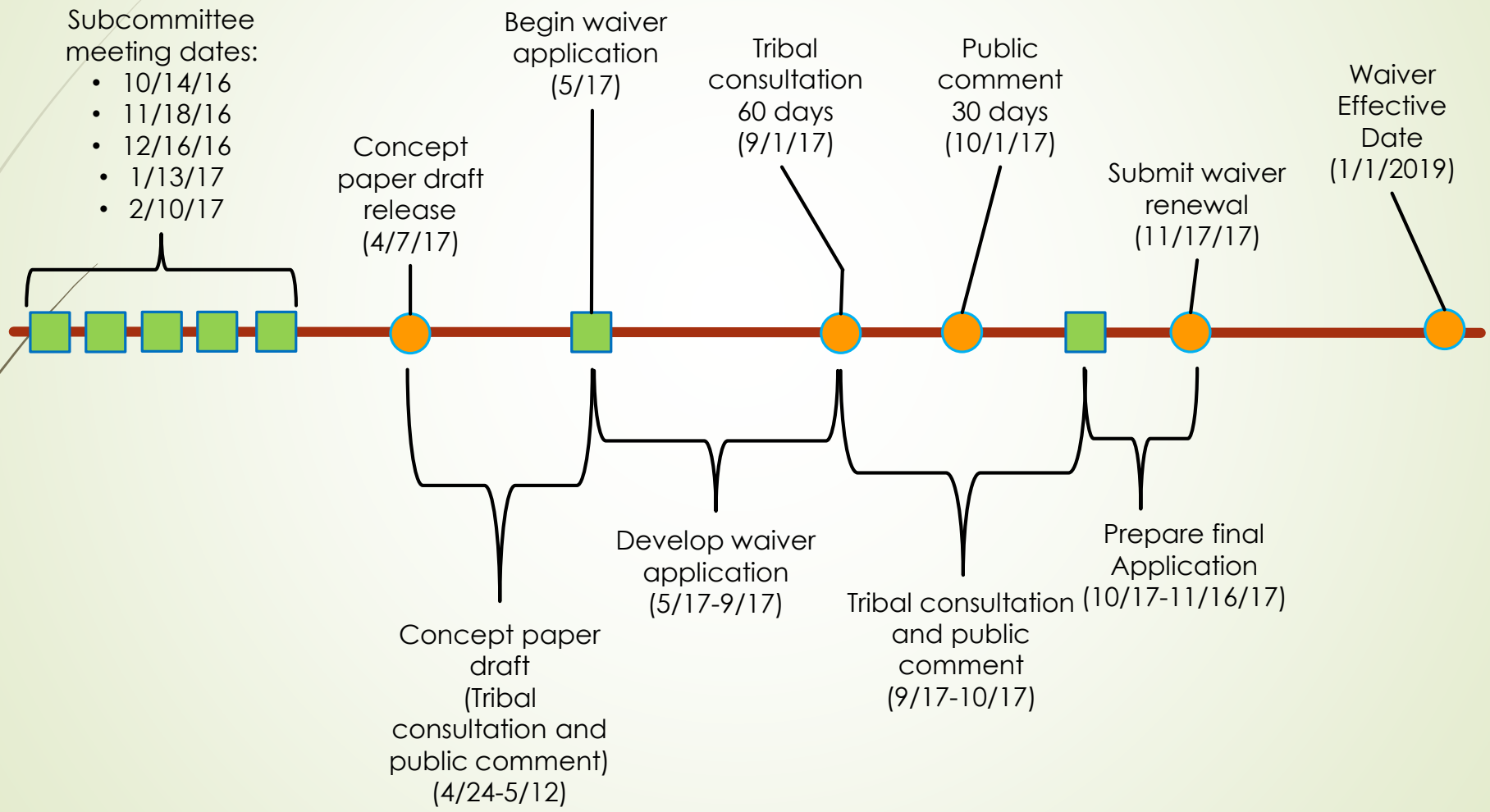
Needs	Concepts	Further Discussion
➢ Close gaps in eligibility for justice-involved individuals ➢ Achieve administrative cost savings ➢ Simplify eligibility processes ➢ Shorten time period for transitional Medicaid ➢ Uniform benefit package for most adults ➢ Benefit options ➢ Consider alternatives to service reductions	➢ Earlier start date or reactivation of eligibility (i.e., 30 days prior to release) ➢ Changes to eligibility and recertification for certain programs and policies to save administrative expenditures ➢ Align benefit packages, where appropriate to simplify operations ➢ Increase the availability of certain services ➢ Maintaining access to services that may be reduced due to cost containment	1. Are there other areas that eligibility can be streamlined to positively impact treatment for health conditions or reduce administrative burdens? 2. Are there other benefit packages or service availability that HSD should consider?

Next Steps
Summary of Process

- Consolidate recommendations from today's subcommittee meeting (due 2/17/2017)
- Consolidate and publish subcommittee and public feedback (2/24/2017)
- HSD will develop and publish draft concept paper (4/7/2017)
- Conduct concept paper stakeholder (public and Tribal) meetings (4/24-5/12/2017)
- Aggregate feedback and develop 1115 Waiver Renewal application (5/17-9/1/2017)
- Publish 1115 Waiver Renewal application and conduct stakeholder (public and Tribal meetings) (9/1/17-10/31/2017)

1115 Waiver Renewal

Updated Timeframe



Thank you for:

- Your time
- Recommendations
- Positive Feedback

Stakeholder Engagement Process Leading to Development of Concept Paper

7. MAC 1115 Waiver Renewal Subcommittee, February 10, 2017

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

AGENDA

MAC 1115 Waiver Renewal Subcommittee Meeting

NM HSD Administrative Services Division
1474 Rodeo Road, Santa Fe, NM

February 10, 2017
8:30 – 11:30AM

Topic	
Introductions	8:30 – 8:40 am
Review Minutes, Feedback from January Meeting	8:40 – 8:50 am
Eligibility and Benefit Alignment	8:50 – 10:10 am
Break	10:10 – 10:25 am
Next Steps	10:25 – 11:10 am
Public Comment & Wrap up	11:10 – 11:30 am

Medicaid 1115 Wavier Renewal Subcommittee Meeting
Meeting Minutes
February 10, 2017 — 8:30am – 11:30am
Administrative Services Division/ Human Services Department/ 1474 Rodeo Road, Santa Fe, New Mexico

Subcommittee Members:

Myles Copeland, Aging & Long-Term Services Department Van Nunley (proxy for Doris Husted), The Arc of New Mexico Bryce Pittenger, Children, Youth and Families Department Dawn Hunter, Department of Health Jim Jackson, Disability Rights New Mexico Sandra Winfrey, Indian Health Service Dave Panana, Tribal Representative, Kewa Pueblo Health Corp. Mary Kay Pera, New Mexico Alliance for School-Based Health Care Kyra Ochoa (proxy for Lauren Reichert), New Mexico Association of Counties	Teresa Turietta, New Mexico Association for Home & Hospice Care Patricia Montoya, New Mexico Coalition for Healthcare Value Linda Sechovec, New Mexico Health Care Association Rick Madden, New Mexico Medical Society David Roddy, New Mexico Primary Care Association Carolyn Montoya, University of New Mexico, School of Nursing Lisa Rossignol, Parents Reaching Out Mary Eden, MCO Representative, Presbyterian Health Plan

Absent Members:

Carol Luna-Anderson, The Life Link Christine Boerner, Legislative Finance Committee	Kris Hendricks, Dentistry for Kids Jeff Dye, New Mexico Hospital Association

Staff and Visitors Attending:

Rachel Wexler, DOH Karen Meador, HSD/BHSD Theresa Belanger, HSD/MAD Michael Nelson, HSD Kari Armijo, HSD/MAD Kim Carter, HSD/MAD Dan Clavio, HSD/MAD Angela Medrano, HSD/MAD Megan Pfeffer, HSD/MAD Nancy Smith-Leslie, HSD/MAD	Joie Glenn, Advocacy for Home and Hospice Care Melissa Garrett, Anthem, Inc. Erik Lujan, APCG Health Committee Shawna Romero, Blue Cross Blue Shield of New Mexico Ellen Pinnes, The Disability Coalition Debi Peterman, Health Insight New Mexico Leonard Thomas, M.D., Indian Health Services Deanna Talley, Molina Healthcare of New Mexico Tina Rigler, Molina Healthcare of New Mexico Liz Lacouture, Presbyterian Health Plan

Jason Sanchez, HSD/MAD Tallie Tolen, HSD/MAD Robyn Nardone, HSD/NMICSS Deidra Abbott, Mercer Jared Nason, Mercer Jessica Osborne, Mercer Son Yong Pak, Mercer Cindy Ward, Mercer	Amilia Ellis, United Healthcare Raymond Mensack, United Healthcare Angela Flores Montoya, University of New Mexico Al Galves, public member/psychologist Jake Wingard, public member

Agenda Item	Details	Discussion
I. Introductions	• Angela Medrano delivered opening comments. • Reviewed January minutes. • Feedback from the January 13, 2017 meeting. • Presented agenda overview.	• Medical Assistance Division (MAD) would like everyone to have the opportunity to contribute ideas and recommendations for the waiver renewal, and all are encouraged to use the website to submit comments. • This is the fifth and final Subcommittee Meeting related to the 1115 waiver renewal: — October 14, 2016 meeting focused on Care Coordination. — November 18, 2016 meeting focused on Population Health. — December 16, 2016 meeting focused on Long-Term Services and Supports (LTSS) and Behavioral Health/Physical Health (BH/PH) Integration. — January 13, 2017 meeting focused on Value-Based Purchasing and Member Engagement and Personal Responsibility. — Today's meeting will focus on Eligibility Alignment and Benefit Design. • Draft minutes from the January 13, 2017 meeting is included and comments are requested by February 17, 2017. — On page 9, Lisa commented that the meeting minutes need to be amended to state: Colorado families can become certified nursing assistants and receive compensation from insurance companies for performing care coordination activities. — On page 10, Lisa commented that the meeting minutes need to be amended by adding: many New Mexicans are not technically savvy and do not have access to the internet. — On page 10, Sandra commented that the meeting minutes need to be amended to state: Native

Agenda Item	Details	Discussion
		Americans do not get the opportunity to participate in the Centennial Rewards Program. – The minutes were amended to reflect the comments.
II. Eligibility Alignment	• Earlier start date or reactivation of eligibility (i.e., 30 days prior to release) for justice involved population. • Changes to eligibility and recertification for certain programs and policies to save administrative expenditures. – Narrow coverage for Family Planning Program – Waive 3 month retro-active eligibility – Extend continuous eligibility to adults – Shorten or eliminate transitional Medicaid coverage	• Bryce commented that it takes a long time to determine eligibility when a child is placed out-of-home and when a child goes into short term incarceration, the eligibility process could take weeks and the decision process could take about a month. Also, when a child needs to be placed with an out-of-state provider, the provider will not accept the child without the Medicaid eligibility affirmation. Bryce recommended a streamlined and automated eligibility process for children who are placed out-of-home. • Kari commented that former foster care youth are Medicaid eligible through age 26. After age 26, youth needs to apply for Medicaid. • Kari explained that when an individual is incarcerated for more than 30 days, his/her eligibility is suspended. However, inpatient hospital services are covered during the individual's incarceration; and eligibility is reactivated when the individual is released. • Kyra recommended establishing a memorandum of understanding between HSD and counties which allows care coordinators to enter jails and facilitate transition into the community setting prior to being released. • Lisa commented, in regards to family planning that educating members on the benefit is worthwhile to improve use of the benefit. • Dawn commented that the age band could be limited to 19 to 45 years of age and recommended coordinating family planning services with the Public Health Division at the Department of Health.

Agenda Item	Details	Discussion
		• Sandra recommended in regards to the eligibility process, that Native Americans be excluded from retroactive waiver based on the Affordable Care Act (ACA) rules. • Pat would like the committee to acknowledge that this work is going on within a period of great uncertainty with State Budget implications for Medicaid as well as the uncertainty at the federal level with a new Administration in transition, new leadership, different philosophy and not being clear on implications for the ACA, Health Insurance Exchange and Medicaid in general. • Jim recommended continuous eligibility for 12 months. • Lisa commented that she does not support eliminating the 3 months retroactive eligibility since this would have a negative impact to those individuals' receiving services. • Carolyn commented that having 3 months retroactive eligibility is critical especially to children. • Rick commented that having 3 months retroactive eligibility is not only critical to children but also to adults as well since costs accumulate in gradual ways and some individuals do not realize that they need to apply for Medicaid to continue their treatment. • In regards to reducing the time period for Transitional Medicaid, Jim commented that if HSD were to reduce the time period, then we need to ensure that all individuals have care coordinators to assist them with transitioning to Exchange benefits. • David asked for clarification on the federal poverity level (FPL) for the Transitional Medicaid population, and Kari stated it is above 138% FPL. • David recommended that the transitional period should be between 90 to 100 days.

Agenda Item	Details	Discussion
		• Lisa recommended that working individuals with disabilities should be excluded from this consideration.
III. Benefits Design	• Align benefit packages, where appropriate to simplify operations. • Increase the availability of certain services. • Maintaining access to services that may be reduced due to cost containment.	• In regards to the uniform benefit package, Jim commented that his understanding about the Medically Frail population is that once they qualify for regular Medicaid they remain eligible unless they opt-out, and Kari confirmed his understanding. Also, Kari commented that Parent/Caretaker population is not Medically Frail and this population defaults to Alternative Benefit Plan (ABP). • Lisa asked for a clarification on how HSD designates Parent/Caretaker, and Kari commented it is based on family income. • Jim commented that he does not think that care coordinators are aware of needing to assist individuals with deciding between Standard Medicaid versus ABP. Kari commented that ABP has a robust benefit package, and there may be no reason to switch. • Lisa commented that not having environmental modifications benefits for Medically Frail is concerning, and they frantically try to get environmental modifications done before they age out. • In regards to benefits options, Teresa applauded HSD for considering acupuncture and chiropractic services and stated that this is important to address as part of the opioid epidemic. • Mary Kay commented that she supports including long-acting reversible contraception (LARC). • Carolyn commented that both dental and vision services are critical to children's overall health and not treating early could last a lifetime. • Sandra recommended including acupuncture and

Agenda Item	Details	Discussion
		chiropractic services in the fee-for-service (FFS) program since 85% of Native Americans are not enrolled in managed care organizations (MCO). • Dawn commented that she also supports including LARC and echoed comments on dental and vision services. • David commented that dental services are not abused or overused, and it impacts physical health. • Lisa recommended including dental coverage for maternity services as oral health is linked to preterm deliveries. Also, she commented that according to the American Academy of Ophthalmology more than two thirds of children with the attention deficit hyperactivity disorder have vision issues. • Dave commented that the committee should be aware of different rules governing Native Americans and that the tribes want to continue the conversation about ensuring that the 1115 waiver has a carve-out for FFS for Native Americans. • Mary Kay echoed comments on vision and dental services and recommended that HSD does not reduce services for children receiving services through the school-based health centers. • Van commented that individuals with developmental disabilities are required to have dental and vision benefits. • Kari clarified that HSD is only considering limiting vision and dental services for parent/caretaker adults and expansion adults, and not children. • Dawn commented that DOH has New Mexico specific dental outcomes survey data for low income families and as well as other evidence based information that supports dental services.

Agenda Item	Details	Discussion
		• Lisa commented that behavioral health respite is only available through three institutions and recommended developing home-based respite services.
IV. Next Steps	• Develop Draft Concept Paper • Conduct Statewide Public Input Sessions • Conduct Tribal Consultation	• Jim commented that we are currently in the midst of healthcare landscape changes and encouraged HSD to consider reconvening the Subcommittee for input for additional feedback to react to changes. He also commented that the State has a revenue shortfall and the Medicaid spending per capita has decreased, so the problem is not with the Medicaid program. • Pat commented that HSD should remain nimble with the timeline given the reality of the questionable status of the ACA and Healthcare Exchange, and she encouraged HSD to inform the Governor and the legislature about how it engaged this Subcommittee for input. She also applauded the State for convening the Subcommittee under very uncertain economic challenges. • Kyra also applauded HSD for its tremendous work on community engagement and outreach to help understand what is going on at the State level. She also commented that State Innovation Models teams be revised for this project to solicit community input and have a placeholders in the waiver for this type of innovation. • Nancy commented that the State is planning to issue the final draft concept paper by mid to late April 2017. She reminded the Subcommittee that the concept paper will only address recommendations pertaining to the waiver. Non-waivers issues may get addressed through other avenues such as changes to policies and/or the MCO contract. • Nancy also commented that HSD is planning to conduct regional stakeholder meetings to discuss the draft

Agenda Item	Details	Discussion
		concept paper. She also commented that HSD will share the dates and locations as this information becomes available. – Lisa offered assistance with developing an informational video and closed captions. • Nancy also announced that HSD released the draft State Plan Amendment on co-payments through the HSD website and asked for feedback. – Rick thanked Nancy for bringing up the co-payment issue and commented that the co-payment requirement is essentially a provider tax since many individuals will not pay co-payments. • Linda asked for clarification on co-payments for the nursing facility resident's use of emergency departments (ED) and brand drugs. Nancy clarified that co-payments will apply to non-emergency use of ED and non-preferred drugs. • Nancy thanked the Subcommittee for their time and for thoughtful input.
V. Public Comments		• Al Galves requested that HSD consider supporting the Soteria House model as a Medicaid benefit in NM; he claims it is beneficial to the community as it offers a different treatment modality for individuals with behavioral health needs. • Monica Nera commented the original 1115 waiver contained expanding respite services for children with severe emotional disturbance (SED); however, this did not occur. She encouraged the State to expand respite services to support families for children with SED. • Angela Flores Montoya encouraged HSD to look at larger costs to the system rather than short term savings by reducing benefits and taxing providers.

Agenda Item	Details	Discussion
VI. Meeting Close	• Follow-up materials	• Comments on eligibility alignment and benefit design are due from Subcommittee members by February 17, 2017. • Comments should include recommendations, outcome measures, as well as measurement methods. • HSD will issue an aggregate recommendations document during the week of February 20, 2017 and comments are due from the Subcommittee by February 24, 2017.

Acronym Guide for MAD / HSD 1115 Waiver Renewal Process

ABCB – Agency-Based Community Benefit
ACEs – Adverse Childhood Experiences
ACO – Accountable Care Organization
ADL – Activity of Daily Living
ALTSD – NM Aging and Long Term Services Department
BCBSNM – Blue Cross Blue Shield of NM
BH – Behavioral Health
BHSD – Behavioral Health Services Division of the HSD
CB – Community Benefit
CBSQ - Community Benefit Services Questionnaire
CCBHCs - Certified Community Behavioral Health Clinic
CC – Care Coordination
CCP – Comprehensive Care Plan
CCS – Comprehensive Community Support
CHIP – Children's Health Insurance Program
CHR – Community Health Resources
CMS – Centers for Medicaid and Medicaid Services, division of the HHS
CNA – Comprehensive Needs Assessment
CPSW – Certified Peer Support Worker
CSA – Core Service Agency
CYFD – NM Children, Families and Youth Department
DD – Developmental Disability and Developmentally Disabled
D&E – Disabled and Elderly
DOH – NM Department of Health
DHI – Division of Health Improvement
D-SNP – Dual Eligible Special Need Plan
ED – Emergency Department
EDIE – Emergency Department Information Exchange
EPSDT – Early and Periodic Screening, Diagnostic, and Treatment
EVV – Electronic Visit Verification
FAQ – Frequently Asked Questions
FF – Face to Face
FFS – Fee for Service
FIT – Family Infant Toddler Program
FQHC – Federally Qualified Health Center
HCBS – Home and Community-Based Services
HH – Health Home
HHS – US Health and Human Service Department
HRA – Health Risk Assessment
HSD – NM Human Services Department
IBAC – Interagency Benefits Advisory Committee
I/DD – Intellectual and Developmental Disabilities
IHS – Indian Health Service
IP – In-patient
LEAD – Law Enforcement Assisted Diversion
LFC – Legislative Finance Committee
LOC – Level of Care
LTC – Long Term Care
LTSS – Long-Term Services and Supports

MACRA – Medicare Access and CHIP Reauthorization Act of 2015
MAD – Medical Assistance Division of the HSD
MC – Managed Care
MCO – Managed Care Organization
MH – Mental Health
MMIS – Medicaid Management Information System
MMISR – Medicaid Management Information System Replacement
NATAC – Native American Technical Advisory Committee
NF – Nursing Facility
NF LOC – Nursing Facility Level of Care
NMICSS – NM Independent Consumer Support System
PCMH – Patient-Centered Medical Home
PCP – Primary Care Physician
PCS – Personal Care Services
PH – Physical Health
PH-BH – Physical Health – Behavioral Health
PHP – Presbyterian Health Plan
PMPM – per member per month
PMS – Presbyterian Medical Services (FQHC)
PQRS – Physician Quality Reporting System
SA – Substance Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services
SBHC – School-Based Health Center
SBIRT – Screening, Brief Intervention and Referral to Treatment
SDCB – Self-Directed Community Benefit
SED – Severe Emotional Disturbance
SMI – Serious Mental Illness
SOC – Setting of Care
SUD – Substance Use Disorder
UHC – United Health Care
VBP – Value-Based Purchasing

HUMAN SERVICES
DEPARTMENT

CENTENNIAL CARE NEXT PHASE

1115 Waiver Renewal Subcommittee
February 10, 2017

Agenda

Introductions	8:30 – 8:40
Feedback from January meeting	8:40 – 8:50
Eligibility and benefit alignment	8:50 – 10:10
Break	10:10 – 10:25
Next steps	10:25 – 11:10
Public comment	11:10 – 11:25
Wrap up	11:25 – 11:30

HUMAN SERVICES DEPARTMENT

Renewal Waiver
Areas of Focus

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports (LTSS)
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Member engagement and personal responsibility
- Benefit & eligibility alignment

HUMAN SERVICES DEPARTMENT

Benefit & Eligibility Alignment

HUMAN SERVICES DEPARTMENT

Benefit & Eligibility Alignment

Streamlining Eligibility

Justice Involved Individuals	➢ HSD has worked to develop policies, processes and IT infrastructure to streamline Medicaid eligibility for individuals involved in the justice system
	➢ Goal is to close the gaps for individuals through:
	  ➢ Timely and automated eligibility reactivations
	  ➢ Earlier start date for eligibility (while incarcerated)

Family Planning Program	➢ In 2016 72,000 people were covered and 91% of the members did NOT use services through the program
	➢ Administratively burdensome and costly to HSD for renewal processing (approximately 6,000 cases per month)
	➢ Coverage overlaps with other insurance coverage
	➢ Considerations aim to reduce administrative costs while maintaining services for individuals who use them:
	  ➢ Narrow coverage for certain age groups
	  ➢ Narrow coverage for populations who do not have other health insurance coverage

HUMAN SERVICES DEPARTMENT

Benefit & Eligibility Alignment

Streamlining Eligibility

Simplify Eligibility Processes	➢ HSD has developed real-time eligibility for initial and renewal determinations (roll-out Spring 2017)
	➢ Federal eligibility rules are difficult to navigate, are structurally complicated and costly
	➢ Considerations include:
	  ➢ Waive 3 month retro-active eligibility for initial applicants
	  ➢ Extending continuous eligibility to adults to reduce administrative workload associated with mid-year redeterminations resulting from reported income changes

Shorten time period for transitional Medicaid	➢ Transitional Medical Assistance (TMA), predates the ACA and was intended to provide expiring coverage for parent/caretaker adults whose income increases above the eligibility threshold for the group for up to 12 months
	➢ Considerations include:
	  ➢ Request more frequent reporting of income (i.e., quarterly)
	  ➢ Shorten period of TMA to 30 – 90 days
	  ➢ Eliminate coverage

HUMAN SERVICES DEPARTMENT

Benefit & Eligibility Alignment

Benefit Design

Uniform Benefit Package for Parent /Caretaker adults and Medicaid Expansion

- Currently parent/caretaker adults receive a different benefit than Medicaid expansion members:
  - Parents/caretaker adults = "Standard Medicaid"
  - Alternative Benefit Plan (ABP) = "essential health benefits"; modeled on commercial health plan benefit design (approximately 260,000 Expansion adults)
  - ABP Exempt = "Standard Medicaid" for Medically Frail Expansion adults (approximately 3,500 members)
  - Expansion adults between the ages of 19-20 also receive EPSDT benefits
- Considerations include:
  - Align benefit packages for parent/caretaker adults and Medicaid expansion population
  - Allow the same option for members to opt-into ABP exempt (if qualified)
  - Request waiver to exclude EPSDT coverage requirement for Expansion members between ages 19-20

HUMAN SERVICES DEPARTMENT

Benefit & Eligibility Alignment

Benefit Design

Benefits options	
	➢ Increase availability of long acting reversible contraceptives (LARC) through increased FMAP (90%) to maintain inventory for providers (i.e., School Based Health Centers, etc.) ➢ Allow cost-effective non-covered service alternative to opioids for pain management such as acupuncture or chiropractic services ➢ Explore affordable alternatives to full dental and vision coverage in the form of riders similar to the design available to state employees, if necessary due to cost containment

HUMAN SERVICES DEPARTMENT

Benefit & Eligibility Alignment

Beginning the Discussion

Needs	Concepts	Further Discussion
➢ Close gaps in eligibility for justice-involved individuals ➢ Achieve administrative cost savings ➢ Simplify eligibility processes ➢ Shorten time period for transitional Medicaid ➢ Uniform benefit package for most adults ➢ Benefit options ➢ Consider alternatives to service reductions	➢ Earlier start date or reactivation of eligibility (i.e., 30 days prior to release) ➢ Changes to eligibility and recertification for certain programs and policies to save administrative expenditures ➢ Align benefit packages, where appropriate to simplify operations ➢ Increase the availability of certain services ➢ Maintaining access to services that may be reduced due to cost containment	1. Are there other areas that eligibility can be streamlined to positively impact treatment for health conditions or reduce administrative burdens? 2. Are there other benefit packages or service availability that HSD should consider?

HUMAN SERVICES DEPARTMENT

Next Steps

HUMAN SERVICES DEPARTMENT

Next Steps
Summary of Process

- Consolidate recommendations from today's subcommittee meeting (due 2/17/2017)
  - Consolidate and publish subcommittee and public feedback (2/24/2017)
    - HSD will develop and publish draft concept paper (4/7/2017)
      - Conduct concept paper stakeholder (public and Tribal) meetings (4/24-5/12/2017)
        - Aggregate feedback and develop 1115 Waiver Renewal application (5/17-9/1/2017)
          - Publish 1115 Waiver Renewal application and conduct stakeholder (public and Tribal meetings) (9/1/17-10/31/2017)

HUMAN SERVICES DEPARTMENT

Next Steps

Waiver vs. Non-Waiver Topics

Waiver

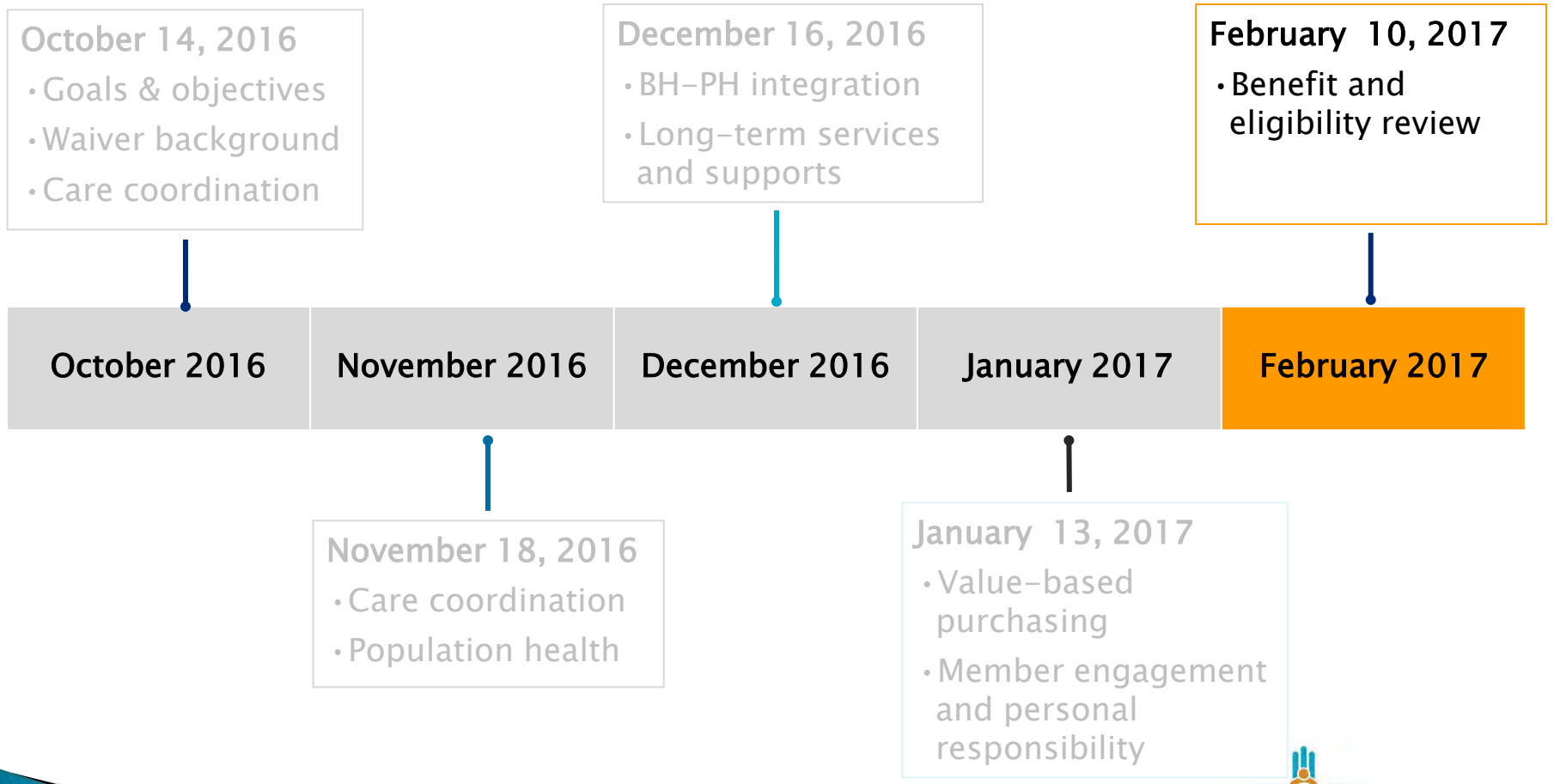
- System Transformation: Items that require waiver authority to implement
- Eligibility changes or expansions
- Benefit packages
- Financing

Non-Waiver

- Policy or implementation issues
- New contract terms, process, or tools
- Modification of provider qualifications
- Implementation of quality strategy and monitoring approaches

HUMAN SERVICES DEPARTMENT

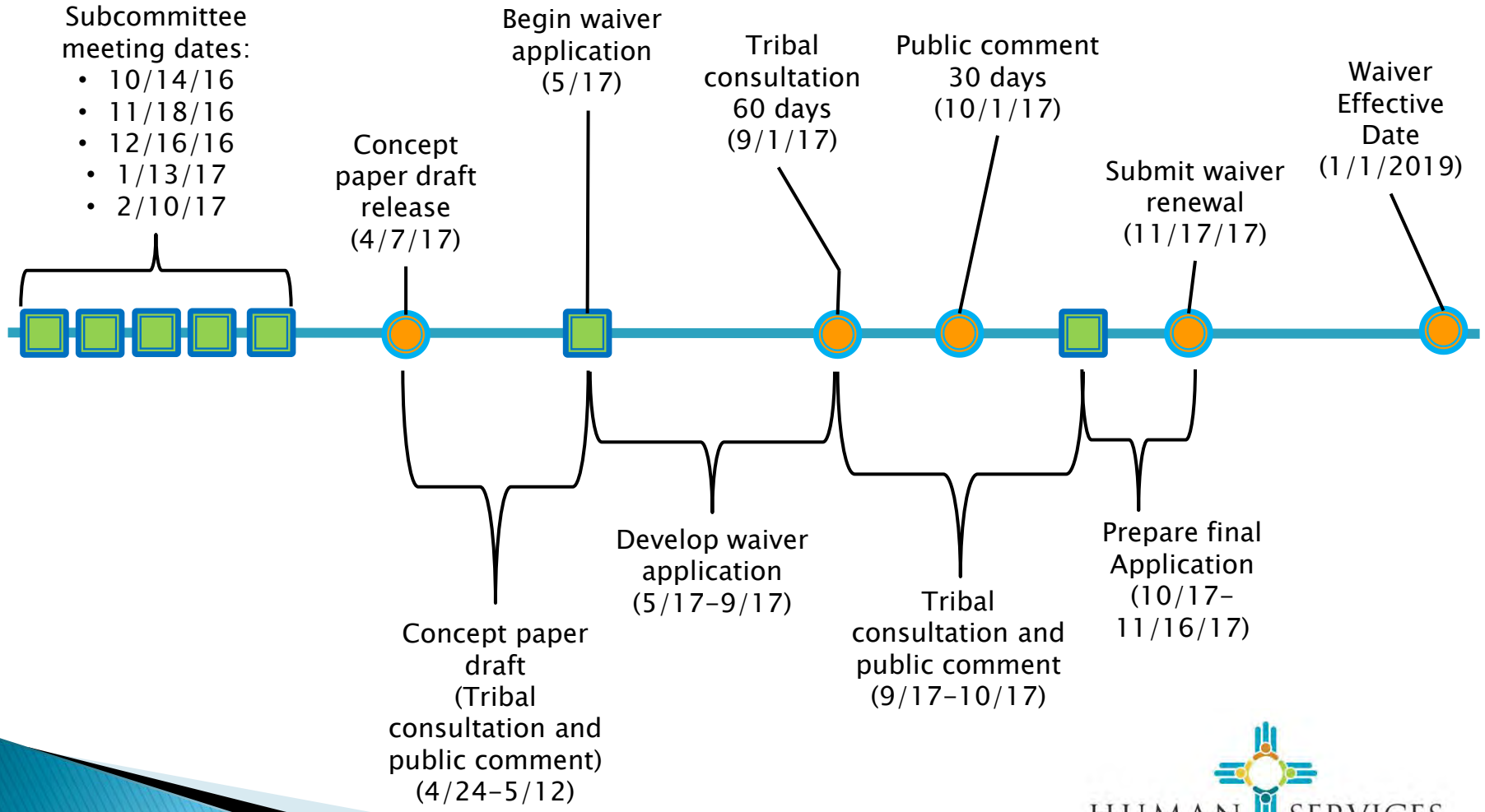
Subcommittee Meetings
Timeframe for Discussion



HUMAN SERVICES DEPARTMENT

1115 Waiver Renewal

Updated Timeframe



HUMAN SERVICES DEPARTMENT

Thank you for:

- Your Time
- Recommendations
- Positive Feedback

HUMAN SERVICES DEPARTMENT

Alternative Benefit Plan (ABP)
ABP Comparison to Standard Medicaid Services

Most adults who qualify for the Medicaid category known as the "Other Adult Group" receive services under the New Mexico Alternative Benefit Plan (ABP). The ABP covers doctor visits, preventive care, hospital care, emergency department and urgent care, specialist visits, behavioral health care, substance abuse treatment, prescriptions, certain dental services, and more.

Medicaid recipients in the Other Adult Group who have special health care needs may qualify to receive Standard Medicaid services instead of the ABP. Individuals who have a serious or complex medical condition, a terminal illness, a chronic substance use disorder, a serious mental illness, or a disability that significantly impairs their ability to perform one or more activities of daily living, may choose to receive services under the ABP ***or*** under Standard Medicaid.

The table below offers a comparison of the ABP services package to the services that are covered under Standard Medicaid. Since individuals who have ABP coverage will always be ages 19-64, the comparison to Standard Medicaid coverage is for the same age range (ages 19 and above).

Benefit Category & Service	**ABP Coverage (Recipients ages 19-64)**	**Standard Medicaid Coverage (For ages 19 and above)**
Outpatient Services		
Acupuncture	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Cancer clinical trials	Covered	Covered (Same as ABP)
Chiropractic services	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.

Dental services (8.310.7 NMAC) • Diagnostic dental • Dental radiology • Preventive dental • Restorative dental • Prosthodontics (removable) • Oral surgery • Endodontic services for anterior teeth	Covered Preventive dental services are covered based on a periodicity schedule	Covered (Same as ABP)
Dialysis	Covered	Covered (Same as ABP)
Hearing aids and hearing aid testing	Not covered, except for recipients age 19-20	Covered
Holter monitors and cardiac event monitors	Covered	Covered (Same as ABP)
Home health care and intravenous services	Covered Home health care is limited to 100 four-hour visits per year	Covered No limitation on number of visits
Hospice care services	Covered	Covered (Same as ABP)
Infertility treatment	Not covered	Not covered
Naprapathy	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Non-emergency transportation	Covered	Covered (Same as ABP)
Outpatient diagnostic labs, x-ray and pathology	Covered	Covered (Same as ABP)
Outpatient surgery	Covered	Covered (Same as ABP)
Primary care to treat illness/injury	Covered	Covered (Same as ABP)
Radiation and chemotherapy	Covered	Covered (Same as ABP)
Special medical foods for inborn errors of metabolism	Not covered, except for recipients age 19-20	Coverage is the same as ABP (covered for recipients age 19-20 only)
Specialist visits	Covered	Covered (Same as ABP)
Telemedicine services	Covered	Covered (Same as ABP)
TMJ or CMJ treatment	Not covered	Not covered
Treatment of diabetes	Covered	Covered (Same as ABP)
Vision care for eye injury or disease	Covered Does not include vision refraction, except for	Covered Standard Medicaid covers vision refraction

	recipients age 19-20	and routine vision services
Vision hardware (eyeglasses or contact lenses)	Covered only following the removal of cataracts from one or both eyes. Vision hardware covered for recipients age 19-20 following a periodicity schedule.	Covered Contact lenses require prior authorization
Emergency Services		
Emergency ground or air ambulance services	Covered	Covered (Same as ABP)
Emergency department services/facilities	Covered	Covered (Same as ABP)
Urgent care services/facilities	Covered	Covered (Same as ABP)
Hospitalization		
Bariatric surgery	Covered Limited to one per lifetime	Covered No limitation on number of surgeries, as long as medical necessity is met
Inpatient medical and surgical care	Covered	Covered (Same as ABP)
Organ and tissue transplants	Covered Limited to two per lifetime	Covered No limitation on number of transplants, as long as medical necessity is met
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease	Covered	Covered (Same as ABP)
Maternity Care		
Delivery and inpatient maternity services	Covered	Covered (Same as ABP)
Non-hospital births	Covered	Covered (Same as ABP)
Pre- and post-natal care	Covered	Covered (Same as ABP)
Mental/Behavioral Health & Substance Use Disorder Services		
Inpatient hospital services in a psychiatric unit of a general hospital, including inpatient substance abuse detoxification	Covered	Covered (Same as ABP)
Medication-assisted therapy for opioid addiction	Covered	Covered (Same as ABP)
Outpatient behavioral health professional services (includes evaluation, testing, assessment, medication management and	Covered	Covered (Same as ABP)

therapy)		
Outpatient services for alcoholism and drug dependency, including Intensive Outpatient Program (IOP)	Covered	Covered (Same as ABP)
Assertive Community Treatment (ACT)	Covered	Covered (Same as ABP)
Psychosocial Rehabilitation (PSR)	Covered	Covered (Same as ABP)
Electroconvulsive Therapy (ECT)	Covered	Not covered The MCOs have the option to cover this service; check with the MCO.
Behavioral health supportive services (family support, recovery services, respite services)	Not covered	Covered when provided through a MCO
Medications		
Prescription medicines	Covered	Covered (Same as ABP)
Over-the-counter medicines	Coverage limited to prenatal drug items, and low-dose aspirin as preventive for cardiac conditions. Other OTC items may be considered for coverage only when the item is considered more medically or economically appropriate than the prescription drugs, contraceptive drugs and devices and items for treating diabetes.	Coverage limitations same as ABP
Rehabilitative & Habilitative Services and Devices		
Autism spectrum disorder	Covered for recipients age 19 or younger; or age 22 or younger when enrolled in high school. Includes physical, occupational and speech therapy and applied behavioral analysis.	Coverage ends at age 21
Cardiovascular rehabilitation	Covered Limited to 36 visits per cardiac event	Covered No limitation on visits as long as medical necessity is met
Durable medical equipment (DME), medical supplies, orthotic appliances and prosthetic	Covered Requires a provider's prescription.	Coverage is the same as ABP, except that most medically necessary disposable medical

devices, including repair or replacement	DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics including shoes and arch supports are only covered when an integral part of a leg brace, or are diabetic shoes.	supplies are also covered when prescribed by a practitioner.
Inpatient rehabilitative facilities	Covered Skilled nursing or acute rehabilitation facility	Covered (Same as ABP)
Internal prosthetics	Covered	Covered (Same as ABP)
Physical, speech and occupational therapy (rehabilitative and habilitative services)	Covered Short-term therapy limited to two consecutive months per condition. Long-term therapies are not covered	Rehabilitative services covered. No limitation on duration of therapy as long as medical necessity is met. Habilitative services are not covered.
Pulmonary therapy	Covered Limited to 36 visits per year	Covered No limitation on duration of therapy as long as medical necessity is met.
Skilled nursing	Covered primarily through home health agencies; subject to home health benefit limitations (100 four-hour visits per year).	Covered through home health agencies. No limitation on number of visits as long as medical necessity is met.
Laboratory and Radiology Services		
Diagnostic imaging	Covered	Covered (Same as ABP)
Lab tests, x-ray services and pathology	Covered	Covered (Same as ABP)
Preventive & Wellness Services and Chronic Disease Management		
Allergy testing and injections	Covered	Covered (Same as ABP)
Annual consultation to discuss lifestyle and behavior that promote health and well-being	Covered	Covered for age 19-20.
Annual physical exam	Covered Eye refractions, eyeglasses and contact lenses, are not covered, except for age 19-20. Hearing aids and hearing aid testing are not covered, except for age 19-20.	Periodic physical exams are only covered for age 19-20. Additional annual physical exams may be provided through a MCO. Vision services, including refractions, eyeglasses and contact lenses, are covered but are limited to

		a set periodicity schedule.
Chronic disease management	Covered through primary care provider services. Additional benefits may be available when provided through a MCO.	Covered through primary care provider services. Additional benefits may be available when provided through a MCO.
Diabetes equipment, supplies and education	Covered	Covered (Same as ABP)
Genetic evaluation and testing	Covered Triple serum test and genetic testing for the diagnosis or treatment of a current illness	Covered (same as ABP)
Immunizations	Covered Includes ACIP-recommended vaccines	Covered (Same as ABP)
Insertion and/or removal of contraceptive devices	Covered	Covered (Same as ABP)
Nutritional evaluations and counseling	Covered Dietary evaluation and counseling as medical management of a documented disease, including obesity.	Not covered, except for age 19-20 and during pregnancy. Additional benefits may be available when provided through a MCO.
Osteoporosis diagnosis, treatment and management	Covered	Covered (Same as ABP)
Periodic glaucoma eye test (age 35 or older)	Covered	Covered (Same as ABP)
Periodic colorectal examination (age 35 or older)	Covered	Covered (Same as ABP)
Periodic mammograms (age 35 or older)	Covered	Covered (Same as ABP)
Periodic stool examination (age 40 or older)	Covered	Covered only when medically indicated
Periodic test to determine blood hemoglobin, blood pressure, blood glucose level and blood cholesterol level or a fractionated cholesterol level	Covered	Covered (Same as ABP)
Podiatry and routine foot care	Covered when medically necessary	Covered (Same as ABP)
Preventive care	Covered Includes US Preventive Services Task Force “A” & “B” recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and preventive services for women recommended by the	Coverage is limited. Many screening services are covered when appropriate based on age or family history. Additional benefits may be available when provided through a MCO.

	Institutes of Medicine	
Screening pap tests	Covered	Covered (Same as ABP)
Sleep studies	Not covered, except for age 19-20	Covered
Smoking cessation treatment	Covered Diagnosis, counseling and prescription medicines	Covered only for recipients age 21 and under, and for pregnant women. Additional benefits may be available when provided through a MCO.
Voluntary family planning services	Covered	Covered (Same as ABP)
Weight loss programs	Not covered The MCOs have the option to cover this service; check with the MCO.	Not covered The MCOs have the option to cover this service; check with the MCO.
Long-Term Services & Supports		
Community benefits	Not covered	Covered when the requirements to access these services are met, including nursing facility level of care (NF LOC) criteria
Nursing facility care	Not covered, except as a step down level of care from a hospital prior to being discharged to home when skilled nursing services on a short-term basis are medically necessary.	
Mi Via	Not covered	

Centennial Care 1115 Waiver Renewal Subcommittee
Issue Brief: Eligibility & Benefit Alignment
February 2017

Overview

One of the core principles of the New Mexico Centennial Care program is to improve administrative effectiveness and simplicity. In Medicaid, this is a difficult challenge – the program currently subsumes nearly 40 different categories of eligibility, multiple complicated eligibility determination methodologies, and manifold benefit packages for both children and adults. As the Human Services Department (HSD) seeks to renew the Centennial Care waiver, the Department is looking at opportunities to simplify some of these administrative complexities and, at the same time, is seeking innovations in program design aimed at addressing and resolving certain specific issues and concerns that are currently impeded due to limits imposed by federal regulations.

Streamlining Eligibility

- **Close gaps in eligibility for justice-involved individuals.** HSD has worked persistently to develop the IT systems, policies and processes to facilitate eligibility "suspensions" for individuals who are involved in the criminal or juvenile justice system, and to ensure timely and automated eligibility reactivations upon the release of these individuals from custody. While this process is working effectively in most instances – in particular for those in the custody of the Corrections Department – in some cases there are delays in reactivating eligibility that are due to the following issues:

    - Uncertain or undefined release date (a common problem for individuals in the county jail system)
    - Spontaneous or unplanned discharge from custody, often occurring during evening or nighttime hours
    - Postponed entry of release date into IT files coming from the prison or jail

    HSD is considering whether an eligibility waiver strategy might help to close gaps in coverage for justice-involved individuals. The State of New York has proposed allowing an earlier start-date or reactivation of eligibility – i.e., 30 days prior to release – which would ensure that individuals can have an active MCO card when they leave the facility. While HSD might consider a similar approach, concerns remain that it may not directly solve the problems noted above when the release date is either unknown or occurs spontaneously.

- **Preserve the Family Planning program for those who need it.** The Family Planning program currently covers more than 72,000 New Mexicans, providing a very limited benefit package of family planning services and contraceptives to individuals with income below 250% FPL who do not qualify for any other full coverage Medicaid category. Individuals covered under Family Planning receive those services through fee-for-service and not through Centennial Care. Only a small fraction (approximately 9 percent) of those covered under the Family Planning category actually use services or obtain contraceptives through the program. The program is administratively burdensome for HSD because all covered individuals must be renewed yearly (a volume of approximately 6,000 cases per month); in addition, many individuals are confused or

dissatisfied about the limited Family Planning benefit package and find it insufficient to meet most of their health care needs.

As it is currently structured, Family Planning operates as a limited benefit entitlement to anyone with income below the maximum threshold of 250% FPL, regardless of age or other health coverage status. HSD is considering reverting the Family Planning program to a waiver that is designed specifically for certain age groups and only for those who do not have other health insurance coverage. In effect, this would place limits on who could be covered under the Family Planning program so it would not be a catchall for everyone who does not qualify for full Medicaid. This strategy would maintain the program for those who need it but would significantly reduce the administrative burden associated with operating the program today.

- **Simplify eligibility processes.** HSD is moving toward an environment in which Medicaid eligibility – both initial determinations and renewals – is streamlined where possible. Real-Time Eligibility (RTE) is scheduled to roll-out in the Spring of 2017, meaning that many individuals will receive an eligibility determination at the point of application. However, there are some federal eligibility rules in the Medicaid environment that are structurally complicated and extremely costly for HSD to administer. HSD may consider requesting a waiver of the three-month retroactive eligibility period, which is accompanied with an intensive reconciliation process; and may also consider extending continuous eligibility to adults to reduce the administrative workload associated with mid-year redeterminations, particularly when there is a SNAP or TANF case attached to the household that results in interim reporting of income.

- **Speed up the transition off Medicaid.** Under current eligibility rules, when an individual in the Parent/Caretaker Category has earned income that increases above the eligibility threshold for that group (or the upper threshold of the Expansion Category), a 12-month Transitional Medical Assistance (TMA) eligibility span is approved. HSD may consider requesting authority from CMS for more frequent reporting of income (i.e., quarterly), a limitation of TMA to a shorter time period (i.e., 30-90 days), or elimination of the TMA program. Individuals would need to seek subsidized coverage through the Marketplace or other private insurance. It should be noted that the TMA provision pre-dates the Affordable Care Act (ACA) and was designed to protect individuals from losing coverage due to increased earned income. With other coverage options made available through the ACA, HSD believes that TMA may no longer be necessary or could be shortened to encourage individuals to obtain other coverage more quickly.

<u>Benefit Design</u>

- **Provide a uniform benefit package for most Medicaid adults.** Most adults who qualify for the Medicaid Expansion Category receive services under the Alternative Benefit Plan (ABP). The ABP is a very comprehensive benefit package that covers all services that are defined under the ACA as “essential health benefits”, including doctor visits, hospital care, emergency department and urgent care, specialist visits, behavioral health care, substance abuse treatment, prescriptions, certain dental services, and more. Medicaid recipients in the Expansion Category who have a special health care need such as a serious or complex medical condition, a terminal illness, a chronic substance use disorder, a serious mental illness, or a disability that significantly impairs their ability to perform one or more activities of daily living (ADLs) may choose to receive services under the ABP *or* under Standard Medicaid. Currently, there are approximately 3,500 individuals in the Adult Expansion who have opted to receive Standard Medicaid services

instead of the ABP due to their health condition, an indication that for most of the 260,000 individuals covered by the ABP, the benefit package satisfactorily meets their health care needs.

HSD is considering seeking waiver authority that would allow the Department to cover adults in the Parent/Caretaker Category under the ABP, with a similar opt-out process for individuals with special health care needs. This would place limitations on certain services, such as physical therapy and home health services. In addition, HSD might consider a request to waive the federal provision requiring adults age 19-20 who are in the Medicaid Expansion category to be covered under the EPSDT rule, which requires full coverage of any medically necessary service regardless of whether the service is included in the benefit package. The EPSDT rule is administratively burdensome and requires that 19-20 year-olds be treated as children, even when they are covered under an adult category.

- **Increase the availability of Long-Acting Reversible Contraceptives (LARC).** HSD has made access to LARC a high priority over the past several years, successfully "unbundling" LARC reimbursement from other services in Federally Qualified Health Centers (FQHCs), School-Based Health Centers (SBHCs) and at point of labor/delivery or during postnatal care to safeguard adequate payment and to ensure that providers are not discouraged from informing women about LARC or making it readily and immediately available. HSD is considering a request for federal waiver authority to obtain increased administrative funding (i.e., 90 percent, in line with the federal matching rate for Family Planning services and contraceptives) to maintain an inventory of LARC for certain providers, such as SBHCs. Under such a proposal, the state would incur an administrative expense to purchase a stock of LARC for the provider to use for Medicaid beneficiaries; once the entire stock is used, HSD would be able to re-stock the provider with more LARC supplies.

- **Consider allowing cost-effective non-covered services as an alternative to opioids for pain management.** Given the current risk of addiction to opioids in individuals seeking to manage pain, HSD believes it is important to consider policies that present safe and cost-effective alternatives to opioid use among Medicaid beneficiaries. HSD might consider requesting waiver authority that would allow the Centennial Care MCOs to provide services not listed in the Medicaid State Plan or in the covered services section of the MCO contracts when the use of such alternative services is both medically appropriate and cost-effective. Non-covered services that present a first-stop alternative to opioid use to manage pain might include acupuncture or chiropractic services.

- **Offer affordable alternatives to full dental and vision coverage, if necessary due to cost-containment.** HSD hopes that reductions in covered services and benefits will not be necessary, but the Department may need to scale back benefit design for adults to ensure the ongoing sustainability of the Medicaid program. Services that are considered "optional" under federal law include dental and vision coverage. Should HSD need to reduce or eliminate these types of services due to financial constraints, the Department is considering the development of dental and/or vision riders that individuals could purchase at an affordable premium, similar to the design of dental and vision coverage available to state employees. The development of any type of rider program would need to be included in the waiver to ensure the availability of federal matching funds.

Stakeholder Engagement Process Leading to Development of Concept Paper

8. New Mexico Association of Home and Hospice Care and the New Mexico Association for Home Care, March 2, 2017

HUMAN SERVICES
DEPARTMENT

Presentation to the New Mexico Association of Home & Hospice Care and the New Mexico Association for Home Care

Secretary Brent Earnest

March 2, 2017

Today's Topics

- Centennial Care Update
- New Mexico's Medicaid Long Term Services and Supports
- Medicaid Budget Update
- Centennial Care Waiver Renewal

Program Successes

Principle 1

Creating a comprehensive delivery system

The right amount of care, delivered at the right time and in the most cost-effective and appropriate setting

- Care coordination
  - 950 care coordinators
  - 60,000 in care coordination L2 and L3
  - Focus on high cost/high need members
- Enrollment in the program has grown by 65% from 2014 to 2016, while per capita costs are down by 1% in same period. Costs associated with inpatient stays are lower and PCP visits and BH visits are higher.
- Increase in members served by PCMH
  - 200k to 250k between 2014 and 2015
- Telemedicine – 45% increase over 2014
- Health Home – Implemented Clovis and San Juan (SMI/SED)
- Expanding HCBS - 85.5% served in community and expanded access to community benefit services
- Implemented Electronic Visit Verification system
- Reduction in the use of ED for non-emergent conditions
  - Implementation of real-time Emergency Dept Information Exchange to notify MCOs when members at seeking care at ER

Program Successes

Principle 2

Increasing Emphasis on Payment Reforms

Ensuring that the expenditures for care and services being provided are measured in terms of quality and not quantity

- July 2015, 10 payment reform projects approved
  - Accountable Care Organizations (ACO)-like models
  - Bundled payments
  - Shared savings
- Subcapitated payment for defined population
- Three-tiered reimbursement for PCMHs
- Bundled payments for episodes of care
- PCMH Shared Savings
- Obstetrics gain sharing
- Developed standardized set of metrics that included process measures and efficiency metrics
- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts—16% of provider payments must be in Value Based Purchasing (VBP) arrangements

Program Successes

Principle 3

Encouraging Personal Responsibility

Encouraging more personal responsibility of members to facilitate active participation and engagement in their own health

- Rewarding Healthy Behaviors: Centennial Rewards
  - health risk assessments
  - dental visits
  - bone density screenings
  - refilling asthma inhalers
  - diabetic screenings
  - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: $23 million
  - Reduced IP admissions
  - 43% higher asthma controller refill adherence
  - 40% higher HbA1c test compliance
  - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

Program Successes

Principle 4

Simplify Administration

Streamline and modernize the Medicaid program to achieve greater administrative effectiveness and simplicity

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; and develop strategies with MCOs to reduce provider administrative burden
- One application for Medicaid and subsidized coverage through the Marketplace
- Streamlined enrollment and re-certifications
- MCO provider billing training around the State for all BH providers and Nursing Facilities
- Standardized the BH prior authorization form for managed care and FFS
- Standardized Health Risk Assessment (HRA)
- Standardized the BH level of care guidelines
- Standardized the facility/organization credentialing application
- Standardized the single ownership and controlling interest disclosure form for credentialing.
- Created FAQs for credentialing and BH provider billing

Long Term Services and Supports Key Policy Changes ➡ Expansion

- Effective 1/1/2014, two key policy changes are driving increased utilization and expenditures for Home and Community-Based Services (HCBS):
  - Centennial Care waiver allows any individual who meets a nursing facility (NF) level of care to receive HCBS waiver services, including Personal Care Services (PCS), without having to wait for a waiver slot
  - Medicaid Adult Expansion:
    - Newly eligible adults also able to receive HCBS services without waiver slot if meet nursing facility level of care criteria

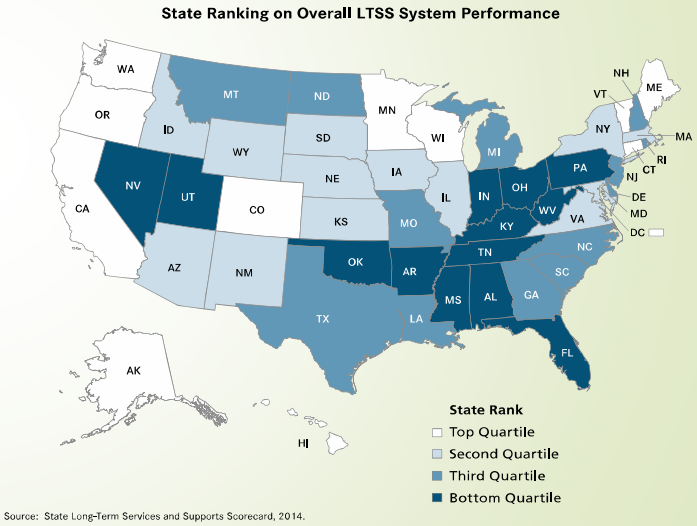
Personal Care Service (PCS) Utilization/Expenditures

Calendar Year	Users	Expenditures	Unit Cost	Average Spend per User
2013 (Pre-CC) Long Term Services & Supports (LTSS)/PCS	19,500	$ 263,072,327	$13.51	$13,491
2014 LTSS + Adult Expansion	23,645	$266,007,940	$13.89	$11,250
2015 LTSS + Adult Expansion	26,883	$280,527,396	$14.19	$10,435

Long Term Services and Supports Program

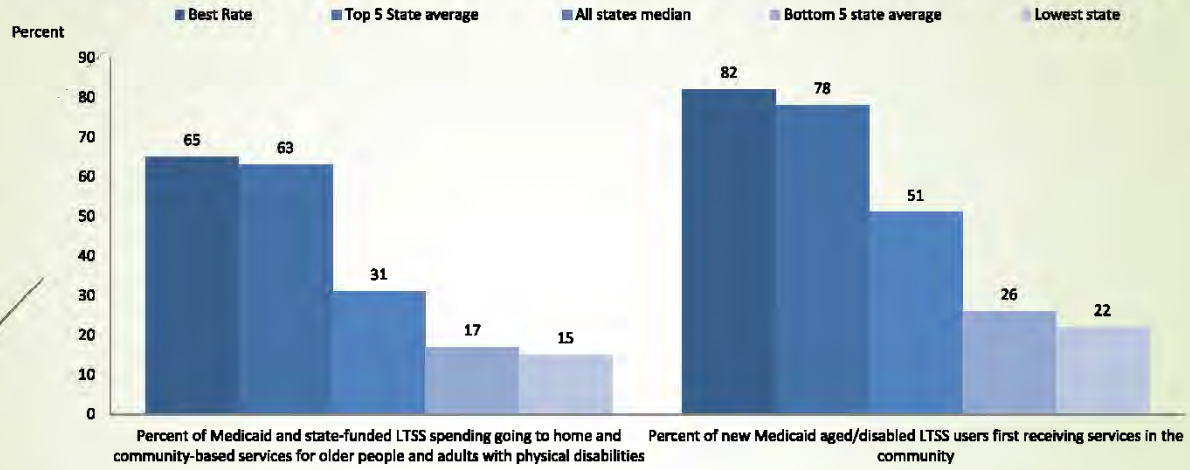
- In overall performance, New Mexico's LTSS program ranks in the second best quartile in the 2014 National State Long-Term Care (LTC) Scorecard published by the AARP and the Commonwealth Fund.

- Our LTC system is especially strong in terms of:
  - Affordability and access (top quartile)
  - Choice of setting and provider (top quartile)
  - Effective transitions across settings of care (second quartile)



Source: State Long-Term Services and Supports Scorecard, 2014.

New Mexico ranks first in the nation for spending more than 65 percent of its Medicaid LTSS dollars on home and community-based services



Top 5 states:

1 New Mexico	1 Alaska
2 Minnesota	2 Minnesota
3 Washington	3 New Mexico
4 Alaska	4 District of Columbia
5 Oregon	5 Idaho

Data: LTSS Spending - AARP Public Policy Institute analysis of Truven Health Analytics, Medicaid Expenditures for Long Term Services and Supports in 2011 (Revised October 2013); AARP Public Policy Institute Survey (2012); New Medicaid Users - Mathematica Policy Research analysis of 2008/2009 Medicaid Analytical Extract (MAX).

Nursing Facility Initiatives & Issues

- Nursing Facilities continue to play an important role in the Medicaid continuum of care
- Nursing Facilities were exempted from the 2016 provider rate reductions
- 2016 LFC recommendation: Consider payment mechanism that take into account quality and performance in nursing facilities.
- In 2017, Molina Healthcare is implementing a Nursing Facility Quality program that will financially reward facilities for achieving quality measures
- Total Nursing Facility Expenditures:
  - 2013 - $236 million
  - 2014 - $210 million
  - 2015 - $230 million
- HSD and the MCOs continue to work with the Nursing Facilities to resolve billing and eligibility issues.

Medicaid Budget in Context

- From FY14 to FY17, total Medicaid spending grew 35.8 percent, but general fund spending grew only 0.73 percent.
- Centennial Care – the state's 5-year Medicaid reform effort – focuses on care coordination, payment reform, personal responsibility and member engagement, and administrative simplification to slow the rate of growth in spending.
- Costs in Centennial Care are 1 percent lower than a year ago, on a per capita basis – i.e., how much we spend for health care services for each person on average – despite national and regional health care cost inflation.
- Following the 2016 legislative session, HSD had to take several cost containment actions:
  - Reduce MCO rates for administration and modified the Centennial Rewards program (~$2.5 million general fund savings)
  - Lowered reimbursement rates for many providers (~$22 million general fund savings) – Nursing Facility rates were not decreased and PCS rates were decreased by 1%
  - Pursuing additional federal funding for services to Native Americans (~$11.8 million general fund savings

FY18 General Fund Recommendations for the Medicaid Program

(excluding Administrative Costs)

(in millions)	House Bill 2 (as passed by the House)	Governor's Recommendation	HB 2 Over/(Under) Gov's Rec.
General Fund (GF)	$915.63	$940.17*	($24.54)*
Federal and Other Funds	$4,804.70	$4,949.4	($144.7)
Total	$5,720.33	$5,889.50	($169.24)

*Includes an additional $26 million from counties for County Supported Medicaid Fund

Key Differences In House Budget and Governor's Recommendation for Medicaid

- Governor's Budget Recommendation
  - Restructured state financing of NM Medical Insurance Pool and Health Insurance Exchange to reduce general fund spending by $8 million
  - Expand County Supported Medicaid Fund because Medicaid now covers New Mexicans who previously accessed County Indigent Programs ($26 million)
  - Additional cost containment of $7.7 million (~$37 million total)
- House Bill 2 assumes cost containment to reduce general fund spending by $15 million (~$71 million total)
  - Hepatitis C treatment
  - Expand Co-pays and add premiums
  - Other unspecified reductions to benefits, eligibility or provider rates
  - Eliminate Centennial Rewards program
  - Assumes Congress eliminates the Health Insurance Provider Fee (as part of ACA)
- Base recommendations already assumed cost containment to save $16 million of general fund spending.

Centennial Care Waiver Renewal Areas of Focus:

- Refine care coordination
- Address social determinants of health
- Opportunities to enhance long-term services and supports (LTSS)
- Continue efforts for BH and PH integration
- Expand value-based purchasing
- Member engagement and personal responsibility
- Benefit & eligibility alignment

Waiver Renewal

- Created subcommittee of Medicaid Advisory Committee to develop recommendations for waiver - October 2016 – February 2017
- Develop a Concept Paper – April 2017
- Develop Draft Waiver – July - August 2017
- Conduct Tribal Consultation – September 2017
- Submit Waiver to CMS – November 2017
- Waiver Effective – January 1, 2019

Caveat: Federal changes may require changes to this timeline.

Waiver Renewal Recommendations

- Email for recommendations:
  - Email Address: HSD-PublicComment2016@state.nm.us
  - Include “Waiver Renewal” in email subject line:
  - Include a background, proposed solution and impact in your correspondence

Stakeholder Engagement Process Leading to Development of Concept Paper

9. Tribal Consultation – Albuquerque, June 23, 2017

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, June 12, 2017 11:39 AM
To: 'pyazzie@jan-riskmgmt.com'
Subject: Formal Tribal Consultation

Good morning Felicia,
The formal Tribal Consultation is:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

Please let me know if you have any questions.
Thank you.
Theresa

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD NATAC

From:	Belanger, Theresa, HSD
Sent:	Tuesday, June 20, 2017 4:24 PM
To:	Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Brogdon, Mary, HSD; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; rvigil@pueblooftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Harrison, Shanita R., HSD; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Cc:	Earnest, Brent, HSD; Nelson, Michael, HSD; Zunie, Kelly, IAD; Smith-Leslie, Nancy, HSD; Slater-Huff, Katherine, HSD; Medrano, Angela, HSD; Vasquez, Orlando, HSD; Clavio, Daniel, HSD; Milton Bluehouse, Jr.; Barbara Ahasteen
Subject:	Formal Tribal Consultation Agenda
Attachments:	Tribal Consultation Agenda 6.23.17.doc

I have attached the agenda for Friday's Tribal Consultation at the Indian Pueblo Cultural Center.

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Friday, June 16, 2017 10:30 AM
To: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Emily Haozous; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; 'rvigil@puebloofteSuque.org'; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Shanita Harrison; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Subject: FW: Formal Tribal Consultation

Good morning NATAC members,
This is a reminder of the formal Tribal Consultation scheduled for Friday, June 23, 2017 at 9:00 am at the Indian Pueblo Cultural Center. The address is:
Indian Pueblo Cultural Center
2401 12th Street, NW
Albuquerque, NM 87104

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Belanger, Theresa, HSD
Sent: Thursday, May 18, 2017 12:48 PM
To: Anthony Yepa; Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Emily Haozous; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; 'rvigil@puebloofteSuque.org'; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Shanita Harrison; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Subject: Public meetings for Centennial Care 2.0

Good afternoon NATAC members,

I wanted to let you know about the scheduled public meetings for Centennial Care 2.0. The list is below.

For additional information you can also go to our website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Schedule of meetings related to the waiver application development process for Centennial Care 2.0:

Public Meetings *(Presentations and Public Comments):*

- **Albuquerque: Wednesday, June 14, 2017,** 3:30 – 5:30 p.m.
  Albuquerque Public Library (501 Copper NW, Albuquerque, NM 87102)
- **Silver City: Monday, June 19, 2017,** 4:00 – 6:00 p.m.
  WNMU – GRC Auditorium (1000 W. College Ave, Silver City, NM 88061)
- **Farmington: Wednesday, June 21, 2017,** 4:30 – 6:30 p.m.
  Bonnie Dallas Senior Center (109 E La Plata St, Farmington, NM 87401)
- **Roswell: Monday, June 26, 2017,** 4:30 – 6:30 p.m.
  Roswell Public Library (301 N Pennsylvania Ave, Roswell, NM 88201)

Tribal Consultation:

- **Albuquerque: Friday, June 23, 2017,** 9:00 a.m. – 12:00 p.m.
  Indian Pueblo Cultural Center (2401 12th Street, NW, Albuquerque, NM 87104)

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Wednesday, May 31, 2017 9:41 AM
To: '1rezdog@gmail.com'
Subject: FW: 1115 Waiver Renewal Concept Paper

From: Belanger, Theresa, HSD
Sent: Wednesday, May 31, 2017 9:39 AM
To: Anthony Yepa
Subject: FW: 1115 Waiver Renewal Concept Paper

From: Belanger, Theresa, HSD
Sent: Wednesday, May 31, 2017 9:38 AM
To: Anthony Yepa; Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; rvigil@pueblooftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Harrison, Shanita R., HSD; Sharon Krantz; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Subject: 1115 Waiver Renewal Concept Paper

Good morning NATAC members,
I wanted to inform you that the pre-application concept paper for the Centennial Care 2.0 waiver renewal is posted on our website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx
Please let me know if you have any questions or comments and share the link with any interested parties.
For a list of public meetings, , please scroll down the page at the link above.

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Jose R. Benavides
P.O. Box 1270
Isleta Pueblo, New Mexico 87022

Subject: **Formal Tribal Consultation**

Dear Governor Benavides,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael J. Nelson

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Thursday, May 18, 2017 12:54 PM
To: 'melody.Price-Yonts@ihs.gov'; 'lbenally@ansbi.org'; 'sgene@aaihb.org'; 'john.Rael@ihs.gov'; 'Maureen.Cordova@ihs.gov'; 'Barbara.Felipe@ihs.gov'; 'iris_reano@pueblodecochiti.org'; 'leslie.dye@ihs.gov'; 'vzamora@islclinic.net'; 'david.tempest@jemezpueblo.org'; 'sandra.lahi@ihs.gov'; 'kpacheco@lagunapueblo-nsn.gov'; 'alan.tatz@ihs.gov'; 'Dorlynn.Simmons@ihs.gov'; 'janay.maupin@ihs.gov'; 'alvin.rafaelito@ihs.gov'; 'csarnicky@sandiapueblo.nsn.us'; 'rgreene@sfpueblo.com'; 'Leslie.dye@ihs.gov'; 'John.Rael@ihs.gov'; 'leslie.dye@ihs.gov'; 'leslie.dye@ihs.gov'; 'dpanana@kp-hc.org'; 'losawe@southernute--nsn.gov'; 'sidney.daniel@ihs.gov'; 'Clinton.Gropp@ihs.gov'; 'John.Rael@ihs.gov'; 'jean.othole@ihs.gov'; 'leonard.thomas@ihs.gov'; 'sandra.winfrey@ihs.gov'; 'Debra.Feathers@ihs.gov'; 'linda.son-stone@fnch.org'; 'mlopez@ydsp-nsn.gov'; 'ron.tso@ihs.gov'; 'anslem.roanhorse@ihs.gov'; 'fannessa.comer@ihs.gov'; 'sandi.aretino@fdihb.org'; 'fannessa.comer@ihs.gov'; 'vida.khow@ihs.gov'; '1miche@yahoo.com'; 'leland.leonard@fdihb.org'; 'Carenda.Robinson@ihs.gov'; 'anslem.roanhorse@ihs.gov'; 'fannessa.comer@ihs.gov'; 'anslem.roanhorse@ihs.gov'; 'fannessa.comer@ihs.gov'; 'ali.ali@ihs.gov'; 'fawn.damon@ihs.gov'; 'joseph.engleken@tchealth.org'; 'dsinger@unhsinc.org'; 'john.hubbard@ihs.gov'; 'Floyd.Thompson@ihs.gov'; 'Douglas.Peter@ihs.gov'; 'sharon.brokeshoulder@ihs.gov'; 'theresa.galvan@nndoh.org'; 'k.dempsey@ihs.gov'; 'ella.dayzie@ihs.gov'; 'sally.pete@wihcc.org'; 'ron.tso@ihs.gov'; 'beverly.lewis@wihcc.org'
Subject: Public input meetings for Centennial Care 2.0

Good afternoon IHS and Tribal 638 providers,

I wanted to let you know about the scheduled public meetings on the waiver development process for Centennial Care 2.0.

For additional information you can also go to our website at http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Schedule of meetings related to the waiver application development process for Centennial Care 2.0:

Public Meetings *(Presentations and Public Comments)*:

- **Albuquerque: Wednesday, June 14, 2017,** 3:30 – 5:30 p.m.
  Albuquerque Public Library (501 Copper NW, Albuquerque, NM 87102)
- **Silver City: Monday, June 19, 2017,** 4:00 – 6:00 p.m.
  WNMU – GRC Auditorium (1000 W. College Ave, Silver City, NM 88061)
- **Farmington: Wednesday, June 21, 2017,** 4:30 – 6:30 p.m.
  Bonnie Dallas Senior Center (109 E La Plata St, Farmington, NM 87401)
- **Roswell: Monday, June 26, 2017,** 4:30 – 6:30 p.m.
  Roswell Public Library (301 N Pennsylvania Ave, Roswell, NM 88201)

Tribal Consultation:

- **Albuquerque: Friday, June 23, 2017,** 9:00 a.m. – 12:00 p.m.
  Indian Pueblo Cultural Center (2401 12th Street, NW, Albuquerque, NM 87104)

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Tuesday, May 09, 2017 4:47 PM
To: 'Alicia Ortega'
Subject: RE: APCG Meeting

Hi Alicia,
It's okay. As long as we can still hold the formal Tribal Consultation on June 23rd I am okay. Can I call you on your cell?
Thanks.
Theresa

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Alicia Ortega [mailto:APCG@indianpueblo.org]
Sent: Tuesday, May 09, 2017 4:44 PM
To: Belanger, Theresa, HSD
Subject: APCG Meeting
Importance: High

Good Afternoon Theresa,

My sincerest apologies for the delay and for being the bearer of bad news but we actually just had a major shift in meeting plans as of yesterday and today and have to move the date to the 22nd and reschedule all non APCG committee meetings to July for review. We have had quite a few pressing issues that our APCG Legislative, Health and Chaco Committees have been facing and working on and at the Governor's request, they asked that the next 2 meetings be solely dedicated to dealing with the state issues that lie ahead especially with the special session reconvening on May 24th and have asked to hold off on all informational presentations for the next two months. Please let me know if you are still interested in presenting after July. I am sincerely sorry for any and all inconveniences this may cause. It's just been a chaotic time for tribes at both the federal and state levels in almost all areas impacting us. I apologize for the shift and thank you for your understanding. I will make sure that they are fully aware of the tribal consultation taking place on June 23rd from 9-12 and that we have APCG representation at that consultation meeting.

Respectfully,

Alicia Ortega
Executive Director
All Pueblo Council of Governors
2401 12th Street NW, Suite 214 S
Albuquerque, NM 87104
505.212.7041
APCG@indianpueblo.org

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Thursday, May 04, 2017 3:48 PM
To: 'Alicia Ortega'
Subject: RE: HSD Tribal Consultation

Hello Alicia,
Yes, we have scheduled it for Friday, June 23, 2017 at 9:00 -12 noon. Secretary Zuni from IAD assisted me with getting a room. I will report on it briefly at the May 18th APCG meeting if the request is approved.
Thank you for all of your help!
Theresa

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Alicia Ortega [mailto:APCG@indianpueblo.org]
Sent: Thursday, May 04, 2017 3:06 PM
To: Belanger, Theresa, HSD
Subject: HSD Tribal Consultation

Good Afternoon Theresa,

I wasn't sure if you've already reached out to IPCC about the Tribal Consultation. If not, Clarissa Baca or Analisa Aragon are our contacts:

INDIAN PUEBLO CULTURAL CENTER
Gateway to the 19 Pueblos of New Mexico

Analisa A. Aragon
Sales Coordinator
Indian Pueblo Cultural Center
Indian Pueblos Marketing, Inc.
2401 12th St. NW
Albuquerque, NM 87104
Ph: (505) 724-3509/ Fax: (505) 724-3551

Thanks so much!

Respectfully,

Alicia Ortega
Policy Coordinator
All Pueblo Council of Governors
Indian Pueblo Cultural Center

2401 12th Street NW
Albuquerque, NM 87104
505.212.7041
APCG@indianpueblo.org

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Jose R. Benavides
P.O. Box 1270
Isleta Pueblo, New Mexico 87022

Subject: **Formal Tribal Consultation**

Dear Governor Benavides,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Kurt Riley
P.O. Box 309
Acoma, New Mexico 87034

Subject: **Formal Tribal Consultation**

Dear Governor Riley,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Virgil A. Siow
P.O. Box 194
Laguna Pueblo, New Mexico 87026

Subject: **Formal Tribal Consultation**

Dear Governor Siow,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Peter Garcia, Jr.
P.O. Box 1099
San Juan Pueblo, New Mexico 87566

Subject: **Formal Tribal Consultation**

Dear Governor Garcia,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Phillip A. Perez
Route 1, Box 117-BB
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Perez,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael J. Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Anthony Ortiz
P.O. Box 4339
San Felipe Pueblo, New Mexico 87001

Subject: **Formal Tribal Consultation**

Dear Governor Ortiz,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Mark Mitchell
Route 42, Box 360-T
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Mitchell,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael J. Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor James R. Mountain
02 Tunyo Po
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Mountain,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Carl Schildt
135 Capitol Square Drive
Zia Pueblo, New Mexico 87053-6013

Subject: **Formal Tribal Consultation**

Dear Governor Schildt,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael J. Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Navajo Nation
President Russell Begaye
P.O. Box 9000
Window Rock, AZ 86515

Subject: **Formal Tribal Consultation**

Dear President Begaye,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael J. Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Ft. Sill Apache Tribe
Chairman Jeff Haozous
Route 2, Box 121
Apache, OK 73006

Subject: **Formal Tribal Consultation**

Dear Chairman Haozous,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Eugene Herrera
P.O. Box 70
Cochiti Pueblo, New Mexico 87072

Subject: **Formal Tribal Consultation**

Dear Governor Herrera,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael J. Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Craig Quanchello
P.O. Box 127
Penasco, New Mexico 87553

Subject: **Formal Tribal Consultation**

Dear Governor Quanchello,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Lawrence A. Montoya
2 Dove Road
Santa Ana Pueblo, New Mexico 87004

Subject: **Formal Tribal Consultation**

Dear Governor Montoya,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Val Panteah, Sr.
P.O. Box 339
Zuni, New Mexico 87327

Subject: **Formal Tribal Consultation**

Dear Governor Panteah,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor J. Michael Chavarria
P.O. Box 580
Espanola, New Mexico 87532

Subject: **Formal Tribal Consultation**

Dear Governor Chavarria,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

President Edward Velarde
P.O. Box 507
Dulce, New Mexico 87528

Subject: **Formal Tribal Consultation**

Dear President Velarde,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Eight Northern Indian Pueblos Council
Gil L. Vigil, Executive Director
P.O. Box 969
San Juan Pueblo, New Mexico 87566

Subject: **Formal Tribal Consultation**

Dear Mr. Vigil,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Joseph A. Toya
P.O. Box 100
Jemez Pueblo, New Mexico 87024

Subject: **Formal Tribal Consultation**

Dear Governor Toya,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Joseph M. Talachy
78 Cities of Gold Road
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation**

Dear Governor Talachy,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Brian Coriz
P.O. Box 99
Santo Domingo Pueblo, New Mexico 87052

Subject: **Formal Tribal Consultation**

Dear Governor Coriz,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Malcolm Montoya
481 Sandia Loop
Bernalillo, New Mexico 87004

Subject: **Formal Tribal Consultation**

Dear Governor Montoya,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

Governor Ruben Romero
P.O. Box 1846
Taos, New Mexico 87571

Subject: **Formal Tribal Consultation**

Dear Governor Romero,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

President Danny Breuninger, Sr.
P.O. Box 227
Mescalero, New Mexico 88340

Subject: **Formal Tribal Consultation**

Dear President Breuninger,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Sean Pearson, Deputy Secretary

May 19, 2017

All Indian Pueblos Council
E. Paul Torres, Chairman
2401 12th Street, NW
Albuquerque, New Mexico 87013

Subject: **Formal Tribal Consultation**

Dear Chairman Torres,

Our office sent out a *Save the Date* notice on May 1, 2017, regarding a formal Tribal Consultation on a concept paper that outlines proposed changes to Medicaid's Section 1115 Demonstration Waiver for the Centennial Care program. On behalf of Brent Earnest, Secretary of the New Mexico Human Services Department, we are confirming this meeting for:

Friday, June 23, 2017
9:00 am to 12:00 pm
Indian Pueblo Cultural Center
2401 12th St. NW
Albuquerque, NM 87104

We hope that you will be able to join us for this meeting. The concept paper is attached and you may also find it on our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please feel free to send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We look forward to discussing the Centennial Care concept paper on June 23rd.

Sincerely,

Michael Nelson
Deputy Cabinet Secretary
New Mexico Human Services Department

Cc:
Kelly Zunie, Secretary, Indian Affairs Department
Brent Earnest, Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Enclosure: 1115 Waiver concept paper

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Centennial Care 2.0
1115 Waiver Renewal Formal Tribal Consultation

Friday, June 23, 2017
9:00 to 12:00 p.m.

Location
Indian Pueblo Cultural Center
2401 12th Street, NW
Albuquerque, New Mexico 87104

Consultation Protocol: Individuals representing a Tribe, Pueblo, or Nation shall present a letter of authorization from their governor, president, or chairperson before the session begins. The letter must be on official tribal letterhead.

AGENDA

9:00	Invocation
9:10	Welcome and Introductions – Secretary Brent Earnest, Human Services Dept. and Secretary Kelly Zunie, Indian Affairs Dept. Introductions from Tribal leadership Review of consultation protocol – Milton Bluehouse
9:30	Human Services Presentation on Centennial Care 2.0 (PowerPoint) and Tribal leadership discussion
11:30	Public Comment (3 Minute Limit)
12:00	Closing

HUMAN SERVICES DEPARTMENT

NTENNIALCARE2.0

1115 Waiver Renewal Tribal Consultation June 23, 2017

New Mexico Human Services Department

Today's Agenda & Goals

Centennial Care 2.0 Concepts

- Provide information about Centennial Care: overview, goals, accomplishments.
- Discuss proposed improvements and reforms by identified area of focus as presented in the concept paper.

Public Comments

- Break after each area of focus to hear your comments on the ideas presented in that section.
- Consider your feedback for the federal 1115 Waiver Renewal application.

Wrap Up

- Provide Next Steps including timeframe for additional input.
- Thank you for your time and feedback.

HUMAN SERVICES DEPARTMENT

Why Are We Meeting Today?

Ideas

Our focus is on how to improve the current program so it is more effective and efficient with better quality outcomes, yet sustainable.

Perspective

How will the ideas we present impact you and your community?

Feedback

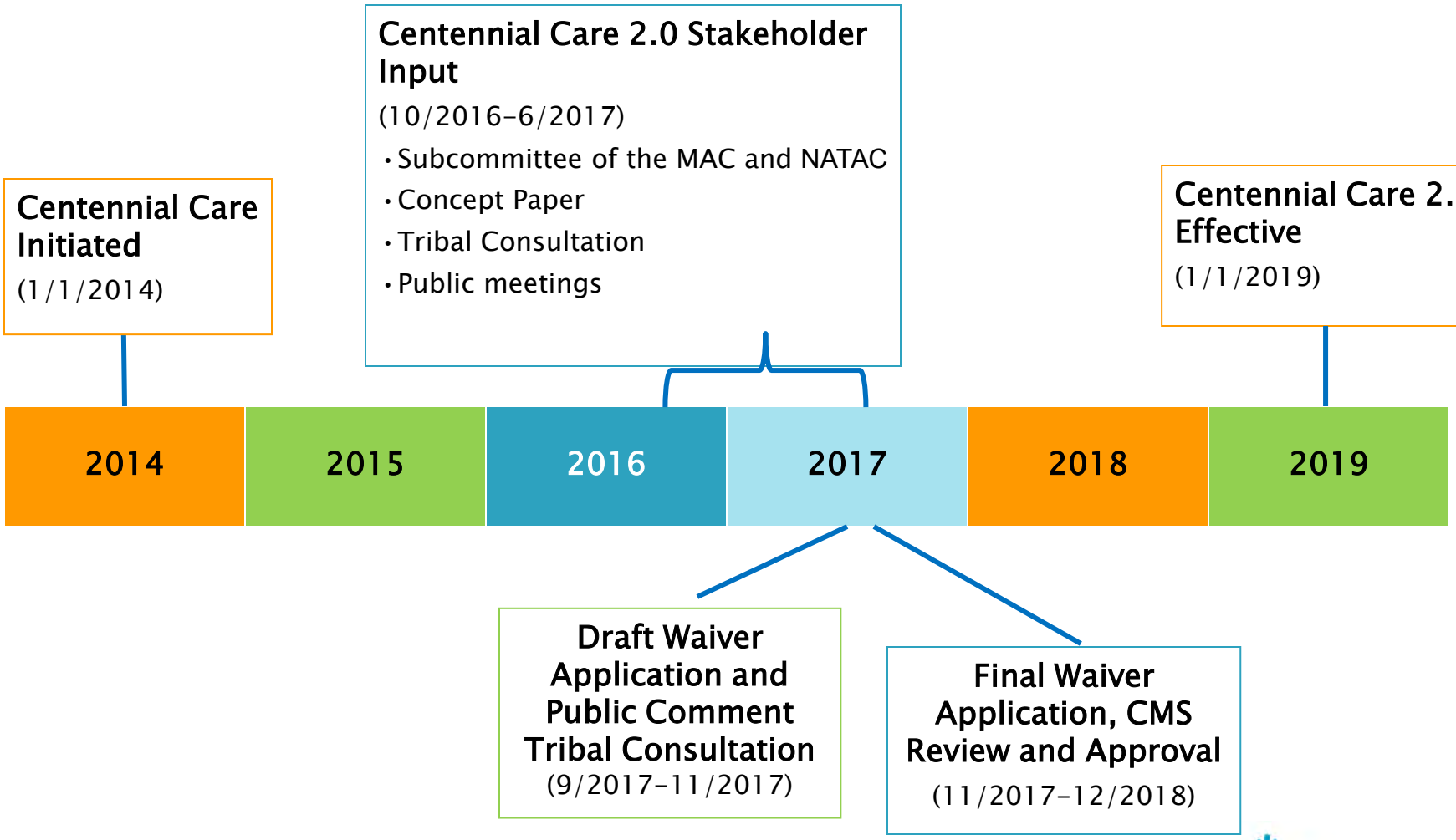
What ideas do you have?

What else should we be thinking about?

We will take comments at the end of each area of focus during the presentation.
There are note cards available, if you want to write your comments as you think of them.

HUMAN SERVICES DEPARTMENT

Centennial Care Timeline

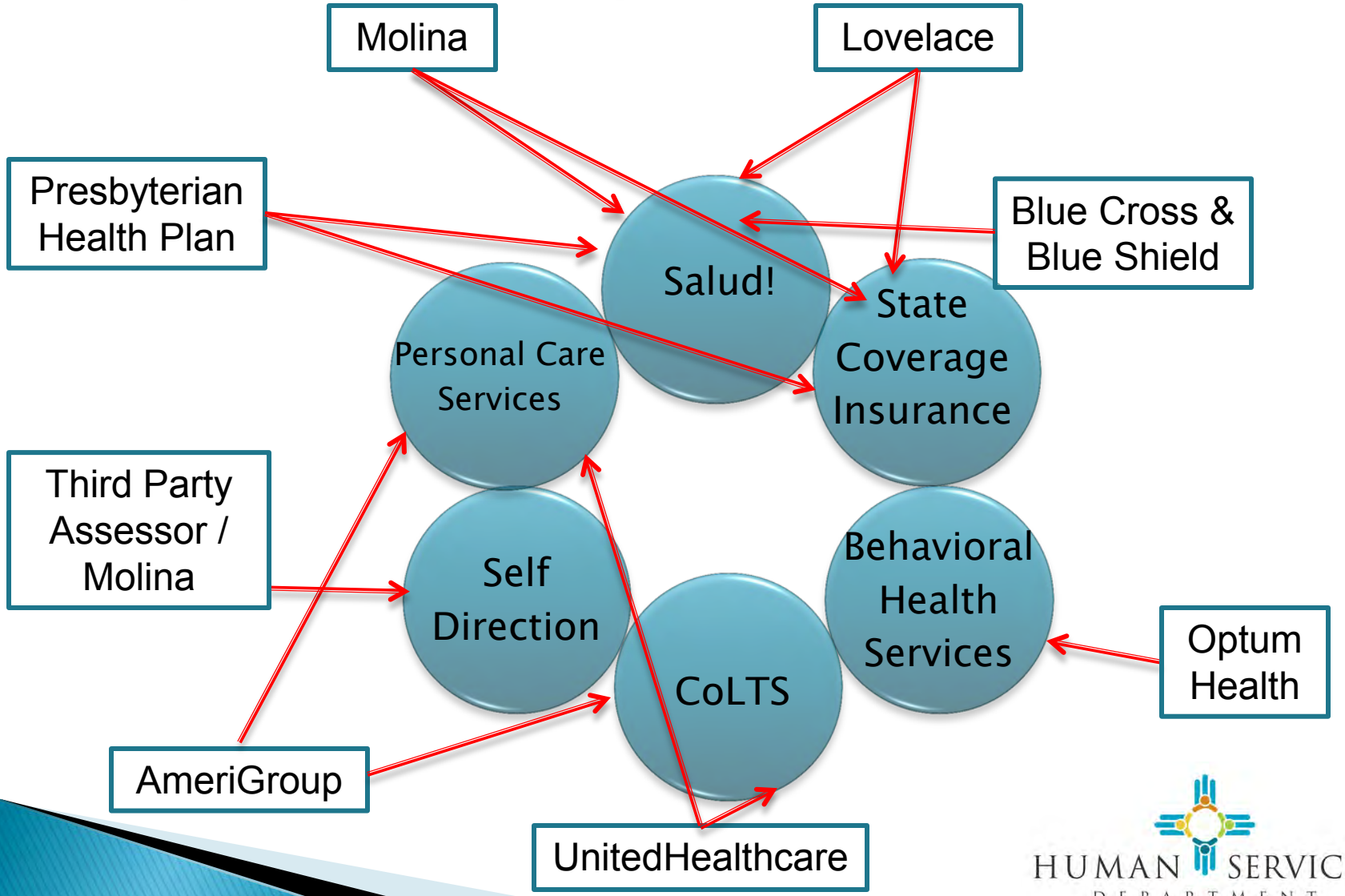


HUMAN SERVICES DEPARTMENT

Pre- and Post- Centennial Care

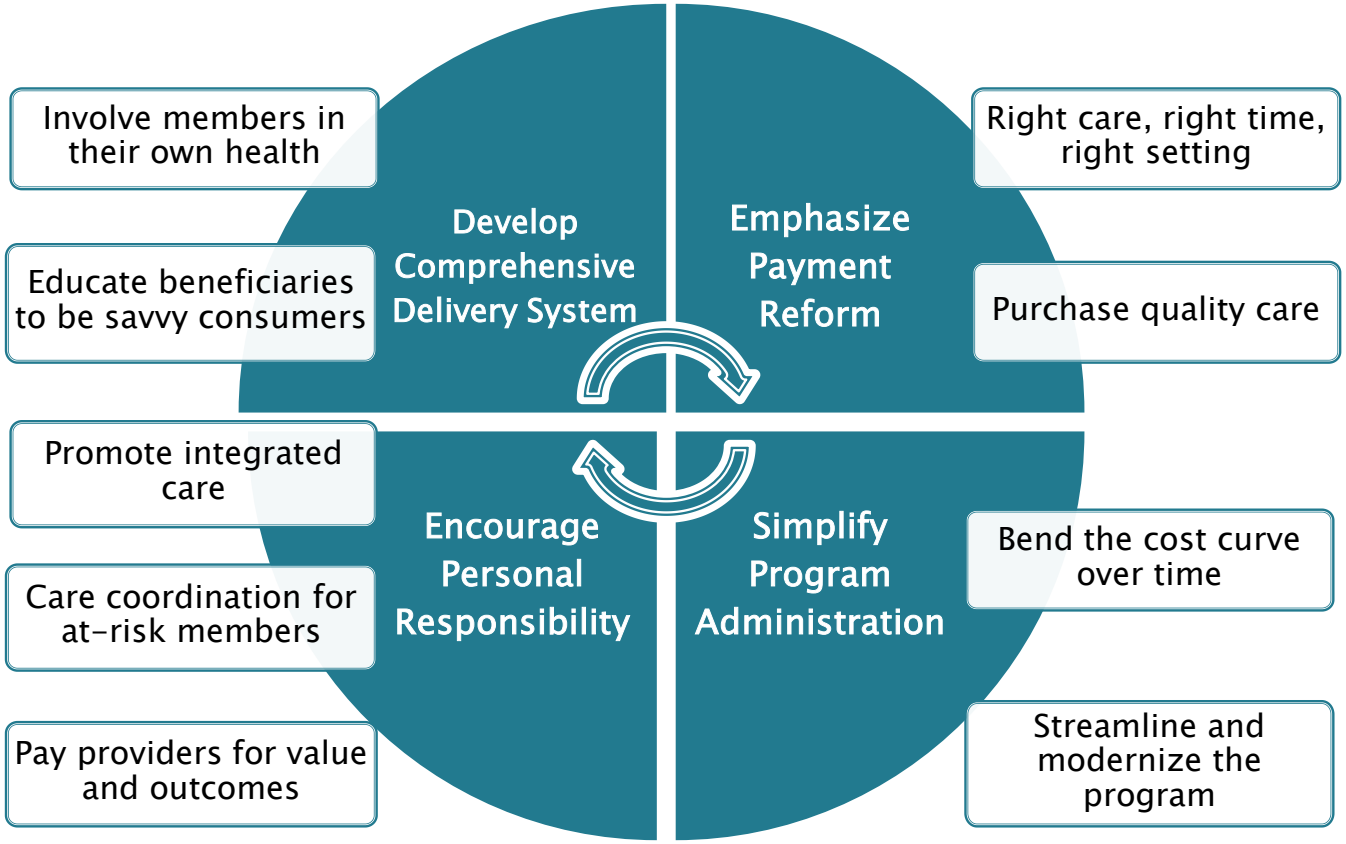
HUMAN SERVICES DEPARTMENT

Medicaid in 2013
Pre-Centennial Care



HUMAN SERVICES DEPARTMENT

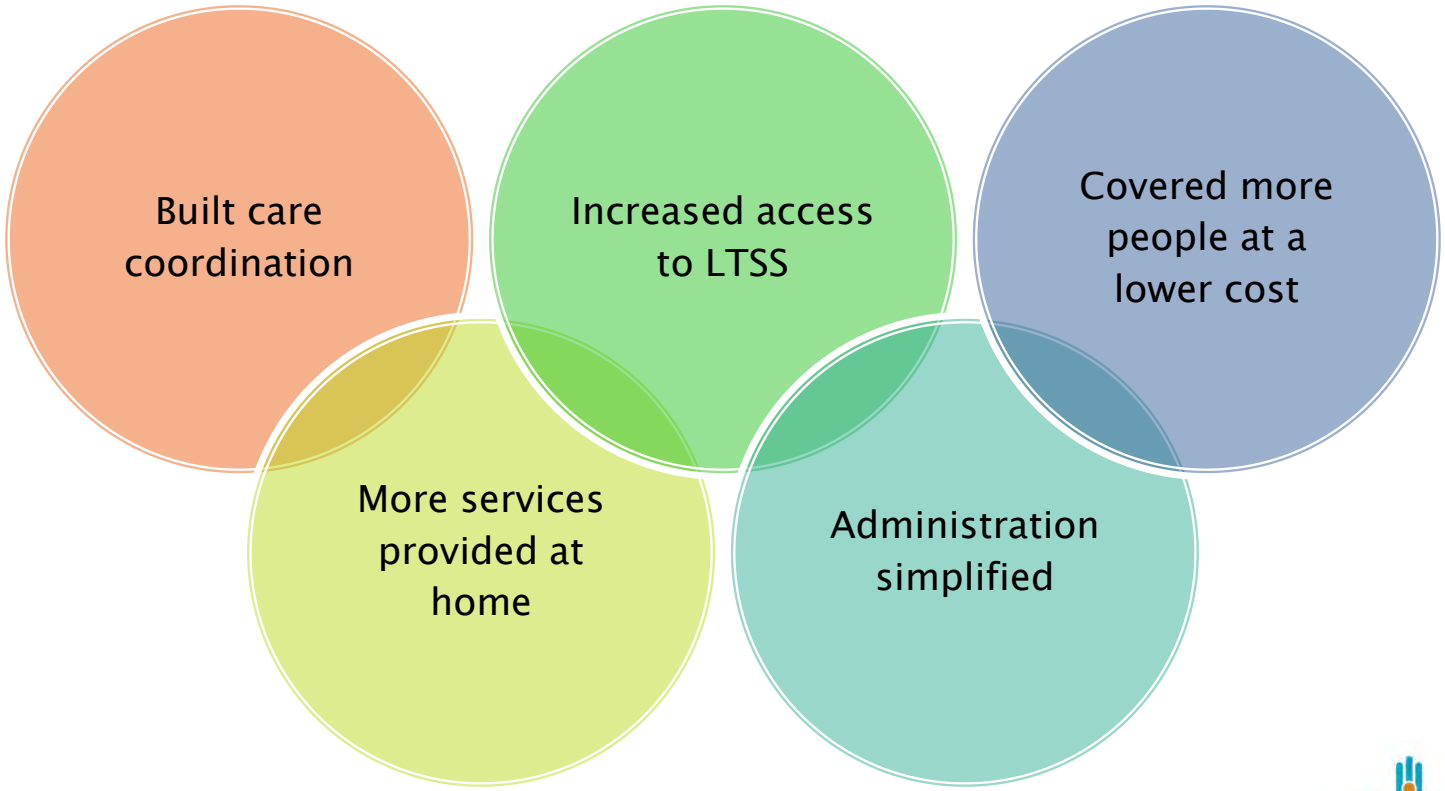
Centennial Care
Guiding Principles



HUMAN SERVICES DEPARTMENT

Centennial Care 1.0

Key Accomplishments 2014–2016



HUMAN SERVICES DEPARTMENT

Current Landscape

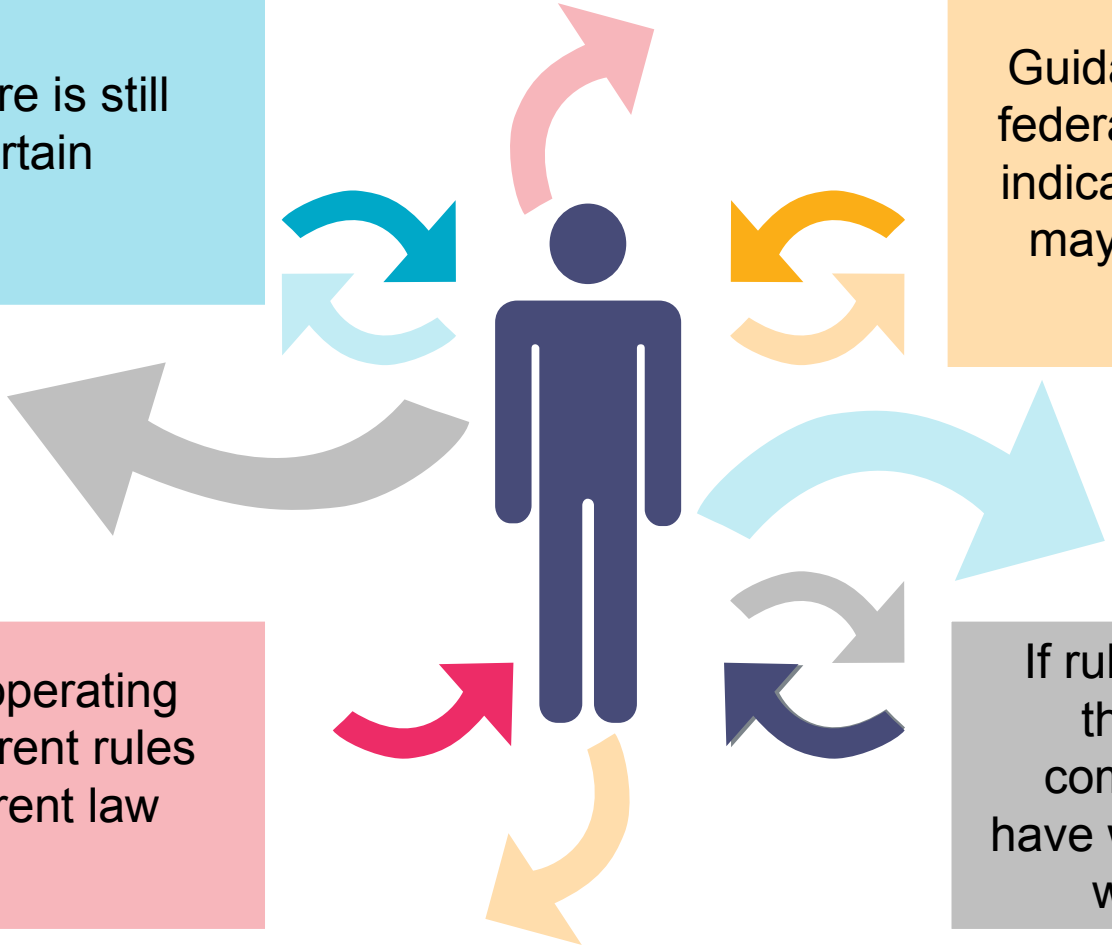
Federal/State Impacts to Consider

HUMAN SERVICES DEPARTMENT

Federal Medicaid Changes

The future is still uncertain

Guidance from the federal government indicated that there may be changes



We are operating under current rules and current law

If rules do change, there may be components that have worked well that we will keep

HUMAN SERVICES DEPARTMENT

New Mexico Medicaid Spending

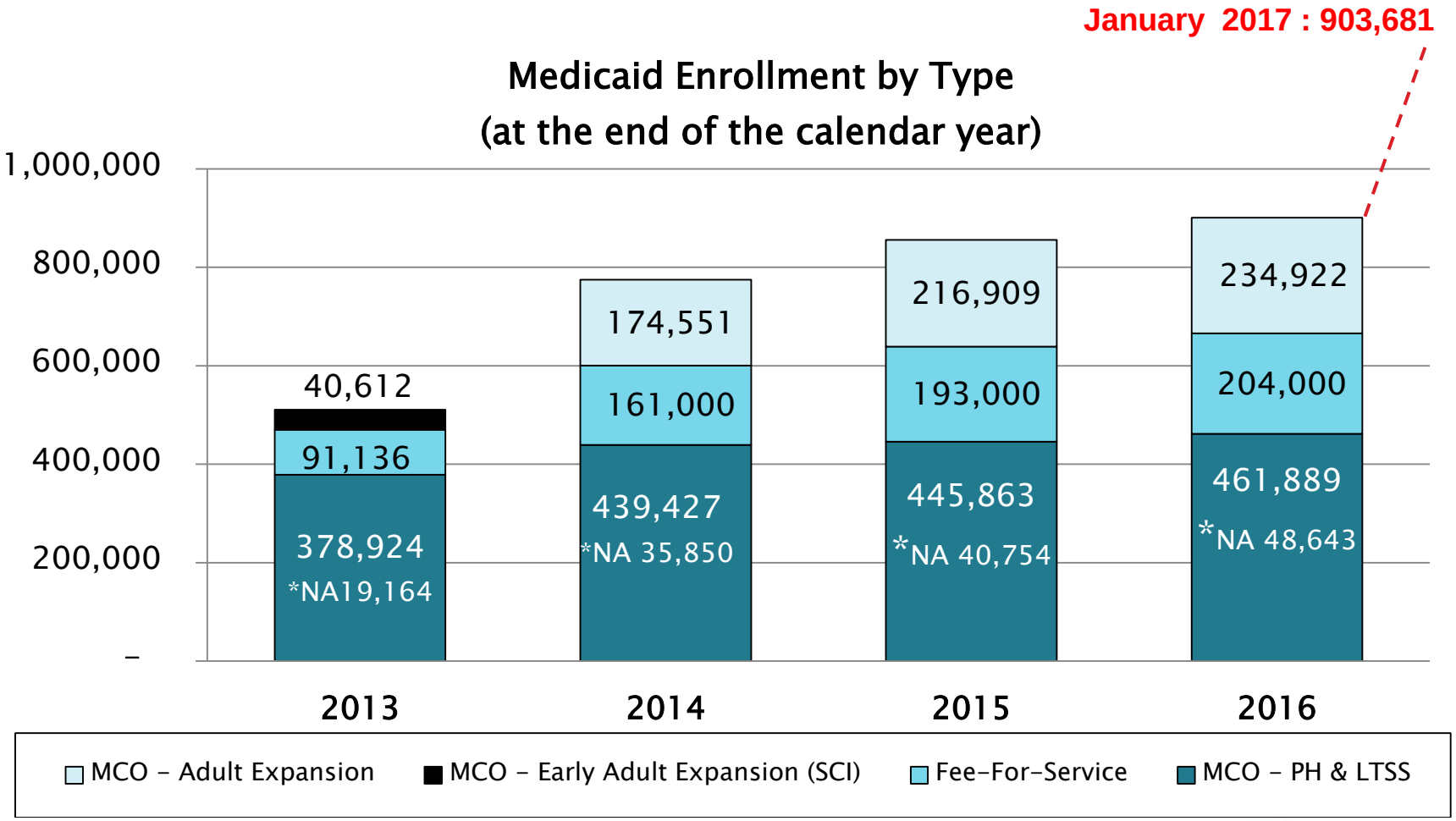
- Total Medicaid spending is increasing, primarily due to enrollment growth.
- The FY18 general fund (GF) need for Medicaid is **$ 947.5 million**, an increase of **$32.9 million** from FY17. The Legislature has appropriated **$915.6 million**, resulting in a deficit of **$31.9 million** in FY 18.

($ in millions)	FY14 Actual	FY15 Projection	FY16 Projection*	FY17 Projection*	FY18 Projection*
Total Budget	$4,200.6	$5,162.3	$5,412.4	$5,570.4	$5,859.7
General Fund Need	$901.9	$894.1	$912.9	$914.6	$947.5

*Projection data as of January 2017. The projections include all push forward amounts between SFYs. FY16 general fund includes $18 million supplemental appropriation and general fund transfers from other divisions. These figures exclude Medicaid administration.

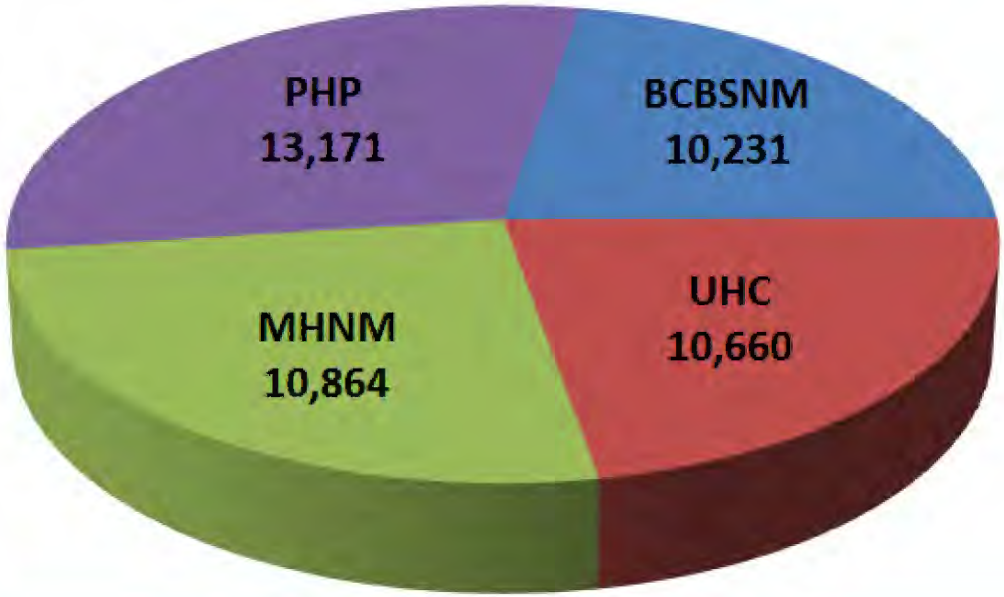
HUMAN SERVICES DEPARTMENT

Key Driver of Costs



HUMAN SERVICES DEPARTMENT

Native American Centennial Care Enrollment



Native American's in Fee for Service = 90,318 (67%)
Native American's in Managed Care = 44,926 (33%)
Total Native American's in Medicaid = 135,244

Source: Medicaid Eligibility Reports, June 1, 2017

HUMAN SERVICES DEPARTMENT

Managing Cost Growth

- Healthcare cost inflation grew an average of 2.6% in 2015 and growth averaged more than 3% in 2016

- Other national studies estimate medical cost inflation (price and utilization) at 6.5%

Centennial Care Stats

- Per capita medical services cost in Centennial Care **growing only 1.3%, driven primarily by pharmacy costs**
- Managing cost through care coordination and other efforts
- Increases in preventive services and decreases in inpatient hospital costs
- Per person costs are lower in Centennial Care

HUMAN SERVICES DEPARTMENT

Proposed Improvements and Reforms

HUMAN SERVICES DEPARTMENT

CENTENNIALCARE2.0

Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

HUMAN SERVICES DEPARTMENT

Care Coordination

Goals

Better care coordination for members

Promote patient-centered, integrated care

Ensure right care, in the right setting

Accomplishments

950 care coordinators hired to help Members

300,000 Members served by Patient-Centered Medical Homes

Coordinated Medicare/Medicaid plans for LTSS members

Lowered inpatient costs

Reduction of non-emergent ER use

Focused on Super Utilizers

Health Homes serving Members with complex behavioral health needs

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

Opportunity #1: Increase care coordination at the provider level

- Transition care coordination functions from the health plans to providers ie. Tribal 638 Organizations
- Support approaches that increase use of community providers to conduct care coordination functions, such as Community Health Workers, Tribal organizations and Community Health Representatives (CHRs), school-based health centers and other community agencies

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

Opportunity #2: Improve transitions of care

- More help for Members during challenging care transitions:
  - Discharged from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement
- Potential changes include:
  - In-home assessments for Members who recently transitioned from a hospital or facility
  - Allow care coordination services to begin before release for Members leaving prison, jail, or juvenile detention facilities
  - Piloting wraparound services (intensive care coordination) for youth involved with the Children Youth and Families Department

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Opportunities

Opportunity #3: Expand programs working with high needs populations

- Collaborate with successful community programs such as: First Responders, wellness centers, personal care agencies and Project ECHO
- More use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists
- Promote use of Community Health Representatives with Tribal organizations
- Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood services; and
- Leverage federal funding for supportive housing services

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Care Coordination

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration

Goals

Promote integration of physical and behavioral health services

Expand access to care

Enhance Member engagement

Emphasize the use of technology

Accomplishments

Launched Health Home Model for Members with complex behavioral health needs

Increased number of FQHCs providing behavioral health services

Expanded access to methadone for substance use disorders

Increased tele-psychiatry services

Implemented Treat First model

Added new behavioral health services

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration 2.0

Opportunities

Opportunity #1: Expanding Health Homes (CareLink NM)

- Expand Health Homes to additional providers in the state including Tribal 638 providers to provide intensive care coordination services through CareLink NM health homes for adults with Serious Mental Illness (SMI) or children with Severe Emotional Disturbance (SED)
- Currently, two Health Home sites provide comprehensive care coordination for members with complex behavioral health needs
- All of the care coordination is provided through a mental health provider who works closely with members' physical health providers

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration 2.0

Opportunities

Opportunity #2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Behavioral Health Integration

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports

Goals

Continue to serve more members in home and community settings

Ensure community benefit services are provided as authorized

Promote Member independence and satisfaction

Accomplishments

Increased access to home-and community-based services

1st in nation for spending 65% of LTSS dollars in the community

Implemented electronic visit verification system

Increased utilization of self-directed model

Implemented Independent Consumer Support System

Allowed more flexibility in use of personal care hours

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #1: Allow for one-time start-up goods for transitions when a member transitions from agency based to self directed

- Up to $2,000 may be added to the eligible member's annual budget to buy needed items (such as a computer and printer)

Opportunity #2: Additional caregiver respite

- Increase the current limit from 100 to 300 hours. This increase will provide eligible members with up to 30 days of respite per year

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #3: To continue to provide access to Community Benefit services for all eligible members meeting a NF LOC and establish some limits on costs for certain services

Self-Directed CB Service	Annual Limit
Related goods and services separate from one-time funding for start-up goods	$2,000
Non-medical transportation	$1,000
Specialized therapies such as acupuncture, chiropractic, or Native American healing	$2,000

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #4: Implement an automatic NF LOC approval for members whose condition is not expected to change

- MCOs would still be required to complete an annual plan of care

Opportunity #5: Partnership with nursing facilities and Project ECHO for consultation services to nursing home staff to better manage members with complex behavioral health needs

Opportunity #6: HSD will work with Tribal providers to develop their capacity to enroll as Long Term Services and Supports providers for Agency Based Community Benefits

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Long-Term Services and Supports

HUMAN SERVICES DEPARTMENT

Payment Reform

Goals

Pay for value and quality

Reward care that keeps members healthy or reduces disease

Manage costs to ensure sustainability of program

Accomplishments

Providers partnering with payers to achieve improved healthcare outcomes

16% of provider payments in value-based arrangements in 2017

Reduced Uncompensated Care by 41% for NM hospitals

Implemented hospital quality initiatives as part of the Safety Net Care Pool

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

Opportunity #1: Pay for better quality and value by increasing percentage of payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee per service to paying for quality and improved outcomes.
  - Improve provider readiness
  - Identify models for behavioral health, LTSS providers and smaller volume providers
  - Reduce administrative burden and improve data sharing

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

Opportunity #2: Use Value Based Purchasing (VBP) to drive program goals, such as: Increase care coordination at provider level, including the use of CHRs for care coordination; improve transitions of care; increase physical and behavioral health integration; and improve member engagement

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Payment Reform

HUMAN SERVICES DEPARTMENT

Member Engagement & Personal Responsibility

Goals

Engage and empower members to participate in their care

Enhance Members' ability to make informed decisions about their care

Reward healthy choices

Accomplishments

70% of Members participated in rewards program

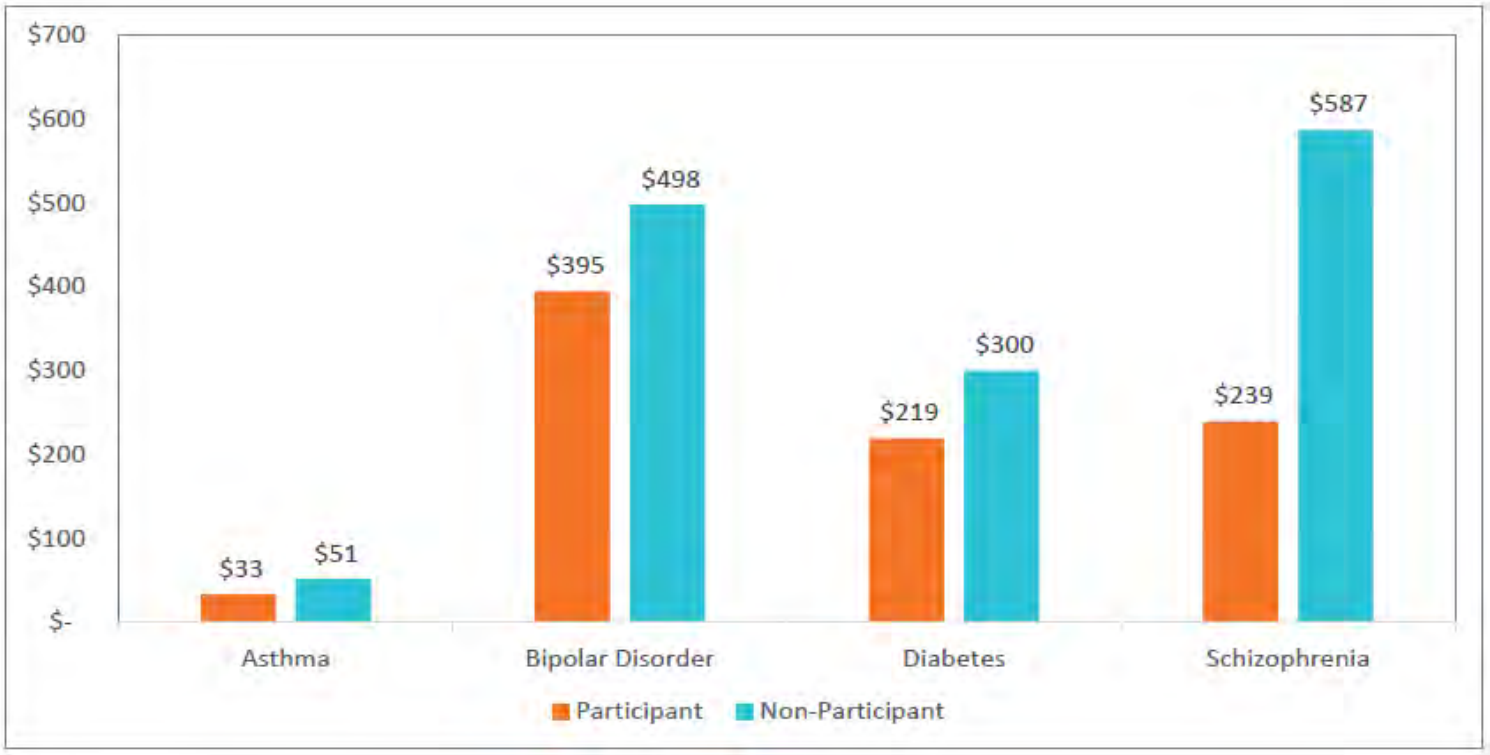
Among Members using rewards program, improved quality measures, health outcomes and lower costs

MCOs required to have disease management programs, Native American member advisory boards, Ombudsman programs and Native American liaisons

HUMAN SERVICES DEPARTMENT

Centennial Rewards

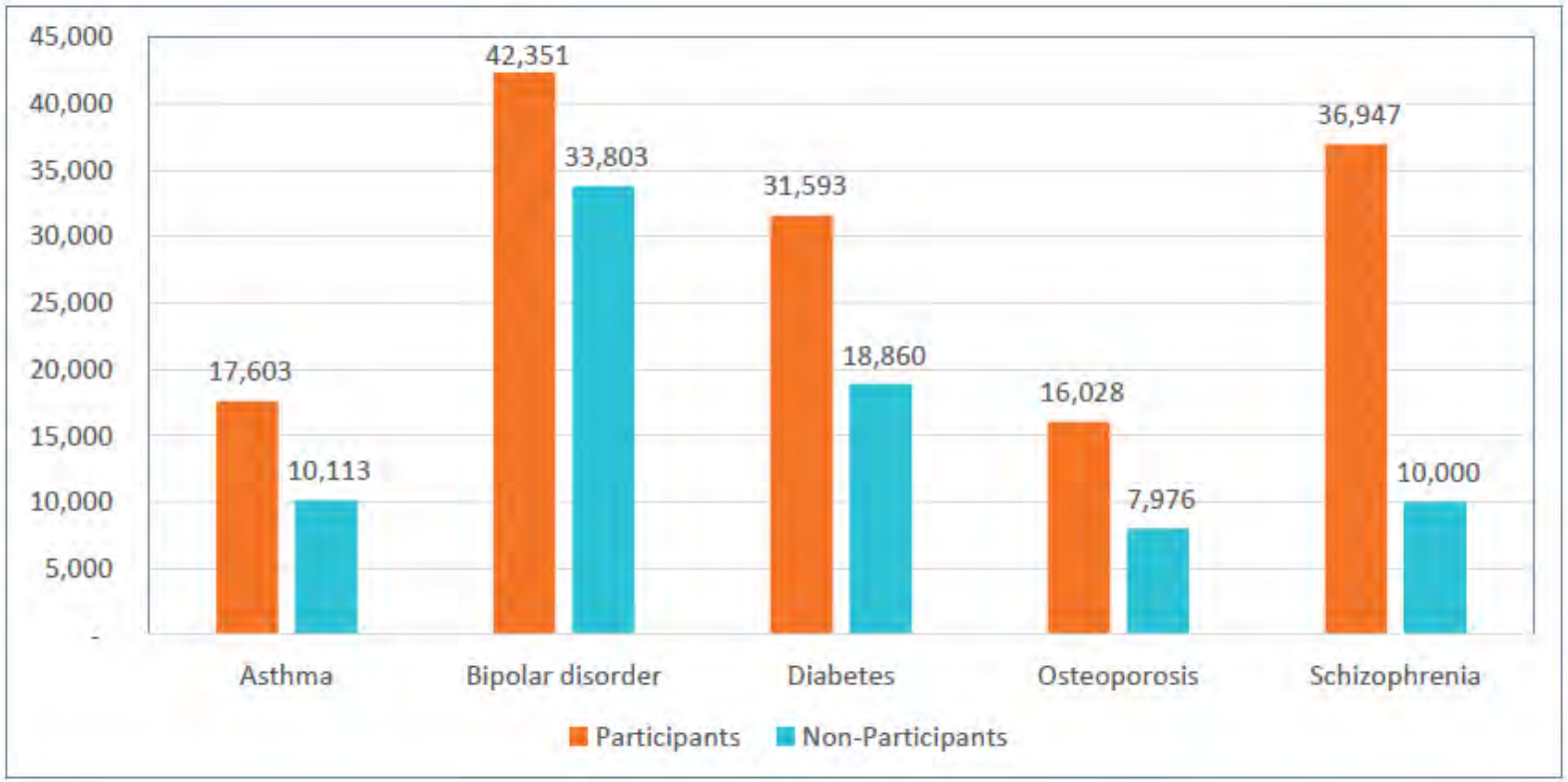
Table 1: Reduced Costs Across Conditions



HUMAN SERVICES DEPARTMENT

Centennial Rewards

Table 2: Prescription Drug Refill Rates



HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility 2.0

Opportunities

Opportunity #1: Advance the Centennial Rewards Program

- Lower age to participate to 15 years old so that teens can earn rewards and bonuses
- Add mobile application technology

Opportunity #2: Allow providers to charge small fees for three or more missed appointments

- Nominal fee for missed appointments

HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility 2.0

Opportunities

Opportunity #3: HSD is interested in receiving proposals from a Tribal entity partnering with a MCO to deliver Centennial Care services to Native American members, ie., Native American Managed Care Organization

- HSD is releasing an RFP 09/01/2017 to reprocure Centennial Care MCOs to provide the next iteration of Centennial Care beginning on January 1, 2019

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Member Engagement and Personal Responsibility

HUMAN SERVICES DEPARTMENT

Administrative Simplification

Goals	Accomplishments
Consolidate waiver programs to improve efficiency Reduce number of MCOs and cover full spectrum of benefits under single MCO Prepare for expanded enrollment	Consolidated nine separate federal waivers into one 1115 waiver Single MCO provides an integrated care model for all of its members Covered more individuals through expansion Established the Native American Technical Advisory Committee (NATAC)

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #1: Cover most adults under one comprehensive benefit plan

- Today, HSD administers 2 different benefit packages for most adults in Medicaid—Parent/Caretaker category and Expansion Adult category
- HSD proposes to consolidate the 2 different plans under a single, comprehensive benefit package that more closely aligns with private insurance coverage
- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package, which is a process that exists today

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #2: Develop buy-in premiums for dental and vision services for adults

- If HSD needs to eliminate optional dental and/or vision services for adults to contain costs, then it proposes to offer dental and vision riders that members may purchase from the MCOs as is standard practice with most private insurance coverage

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Populations covered in FFS would be exempt from this change
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that put them over the eligibility guidelines

- Since the ACA, this program has become less needed as evidenced by declining enrollment; most individuals with increased earnings move to the Adult Group.
- In 2013: 26,000 individuals in this category

  Today: fewer than 2,000 individuals
- Individuals with income above the Adult Group guidelines can receive subsidies to purchase coverage through the Exchange

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #5: More frequent checks of income through trusted data sources

- This was not intended to result in more frequent recertification of eligibility but only to check trusted data sources more regularly to verify income
- HSD has received numerous concerns associated with this proposed change and is no longer considering it for inclusion in the waiver renewal going forward

HUMAN SERVICES DEPARTMENT

Group Discussion

Please share your comments on Administrative Simplification

HUMAN SERVICES DEPARTMENT

Public Comment

Share your comments

If you are unable to make your comment today, please submit your note cards or send via email HSD-PublicComment@state.nm.us or on the website http://www.hsd.state.nm.us/centennial-care-2-0.aspx .

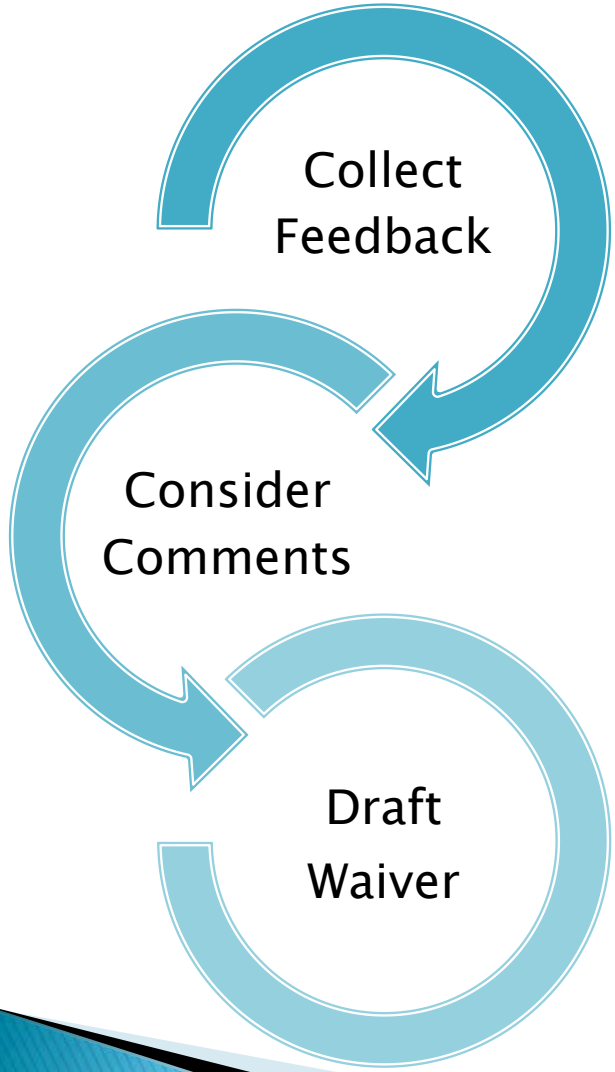
Limited time for Comments

1115 Waiver Renewal Application will be drafted this summer.

Share your comments by Saturday, July 15, 2017

HUMAN SERVICES DEPARTMENT

Next Steps



We are recording your comments today and will take additional written comments through our website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Additional opportunities will be available to help shape Centennial Care after the Waiver Application is submitted and posted.

HUMAN SERVICES DEPARTMENT

THANK YOU

Your time and input are valuable

HUMAN SERVICES DEPARTMENT

Public Notice

1. HSD website

Public Information and Communications Overview

Opportunity for Public Comment

Bench Warrant Program

Centennial Care 2.0 (PROPOSED)

Centennial Care 2.0

2017 Centennial Care 2.0 MCO RFP & Procurement Library

2017-2018 Centennial Care 2.0 Procurement Schedule

Centennial Care (CURRENT)

HSD Presentations

IPRA Requests

Legislative Session

Medicaid Eligibility Reports

Newsroom

Monthly Statistical Reports

Waiver Documents

Centennial Care 2.0

Request for Comments

The Human Services Department, Medical Assistance Division (MAD), is accepting comments from the public about the Medicaid health care program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. Comments will be accepted until **5:00 pm MST on Monday, November 6, 2017.** Read below to learn more about the Centennial Care waiver renewal.

The Department will hold four public hearings in different regions of the state to receive comments about the draft waiver. Please see below for the locations and times of the hearings.

To submit a comment electronically, you may complete the online form at the bottom of this page or email your comments directly to MAD at HSD-PublicComment@state.nm.us.

To submit a comment by phone, please call: (505) 827-1337

To submit a comment by mail, please send to:
Human Services Department
ATTN: HSD Public Comments
PO Box 2348
Santa Fe, NM 87504-2348

The Department has held a series of Public Hearings. The final hearing will be held in Albuquerque on October 30, 2017. The meeting will have a phone line available for any member of the public to join the public hearing or provide comments by phone. The event location and call in information is as follows.

Albuquerque – Monday, October 30, 2017
National Hispanic Cultural Center
Bank of America Theatre
1701 4th Street SW
Albuquerque, NM
5:30 pm – 7:30 pm

Call-in Information: Toll Free **1-888-757-2790**, enter participant code **991 379#**
If you have connection issues or problems joining the conference line, please call or text 505-570-7268, or email Katherine.Slater-Huff@state.nm.us

Public Hearing Presentation

Previous Public Hearings

Las Cruces – Thursday, October 12, 2017

Farm and Ranch Museum
4100 Dripping Springs Road
Las Cruces, NM
1:30 pm – 3:30 pm

Santa Fe – Monday, October 16, 2017
Medicaid Advisory Committee Meeting
NM State Library
1209 Camino Carlos Rey
Santa Fe, NM

1-4pm

Las Vegas – Wednesday, October 18, 2017
Highlands University - Student Union Building/Student Center
800 National Avenue
Las Vegas, NM
1:30 pm – 3:30 pm
A phone line will be available for the Las Vegas event on October 18 for call-in participants to listen to or provide comments via telephone.
Call (toll-free) 1-888-850-4523; participant code: 323 675#

There will also be a formal Tribal consultation conducted on Friday, October 20, 2017 at the Institute of American Indian Arts in Santa Fe at 9am. All comments will be reviewed and evaluated to inform additional modifications prior to submission of the final application to CMS.

About Centennial Care 2.0

The New Mexico Human Services Department (HSD) is looking at improvements to the Centennial Care (NM Medicaid managed care) program that can be implemented in the "second generation" of that program, which we call "Centennial Care 2.0". Those changes will be proposed with the input from – and following a thorough review by -- stakeholders throughout New Mexico, and they must be approved through a waiver issued by the federal government (CMS).

HSD has released its draft Section 1115 Demonstration Waiver renewal application for Centennial Care 2.0. The draft application outlines how the Department will modify and improve the program for its next iteration that begins in January 2019. The draft application can be reviewed at this link. **1115 Waiver Renewal - Draft Application** (revised October 6, 2017)

The public will have several opportunities to provide feedback to the Department about the changes outlined in the draft application during four public hearings in October 2017. After the hearings, the Department will develop its final waiver renewal application for submission to CMS in November 2017. CMS requires states to submit 1115 waiver applications at least one year in advance to allow for sufficient time to negotiate the final terms of the waiver.

The state released a revised draft waiver application on October 6, 2017. A summary of revisions can be found below.

Draft Waiver Application Summary of Revisions – October 6, 2017

(Original Draft Released on September 5, 2017)

Section and Page Number	Summary of Revision
Cover page	1.Revised the date from "September 5, 2017" to "Revised October 6, 2017."
Member Engagement and Cost Sharing Proposal #2: Implement premiums for populations with income that exceeds 100% FPL • Original Application Pages 29-30 • Revised Application Page 29-30	1.After receiving feedback from public that the premium enforcement policy was too vague, HSD revised the language below Table 3 to include additional detail about the premium policy and its enforcement.
Member Engagement Proposal #6: Expand opportunities for Native Americans enrolled in Centennial Care • Original Application Pages 31-32 • Revised Application Page 32-33	1.After receiving public feedback that the section about collaboration with the Navajo Nation did not provide sufficient detail, HSD revised the language to allow additional collaborations and clarify other requirements related to Indian Managed Care Entities.

Section and Page Number	Summary of Revision
Benefits and Eligibility Proposal #1: Redesign the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered Adults • Original Application Pages 32-33 • Revised Application Page 33-34	1.HSD revised the language in the first bullet about redesigning the ABP to clarify that it will not eliminate non-emergency medical transportation for the adult package, but instead include option to leverage new service providers, such as ride sharing companies and new technologies, such as mobile applications.
Section 3: Waiver List • Original Application Pages 36-38 • Revised Application Page 37-40	1.HSD updated the waiver authority request language.
Table 6 – Renewal Timeline • Original Application Page 45 • Revised Application Page 47	1.HSD added the public meeting scheduled on October 30, 2017 in Albuquerque in the evening. 2.HSD revised the final waiver application submission date to November 30, 2017 to extend the public comment period and allow 30 days from posting the draft waiver application revisions.

I. Program Description, Goals, and Objectives

The Centennial Care waiver renewal provides opportunities for HSD to build upon the accomplishments achieved since implementation of Centennial Care. At the same time, HSD has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system. Based on feedback received over the past three years at the annual Centennial Care public forums and through recent input sessions with advocacy groups and stakeholders, HSD has identified key areas of refinement for Centennial Care 2.0.

The following list is a summary of program modifications for Centennial Care 2.0 that leverage successful elements of the existing program design, expand initiatives that directly benefit members, and ensure the financial viability and sustainability of the program over the long term:

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to Long-Term Services and Supports (LTSS) and maintain the progress achieved in rebalancing efforts;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Build upon and incorporate policies that seek to enhance beneficiaries' ability to become more active, responsible and involved participants in their own health care, including the introduction of modest premiums for higher income populations; and

- Further simplify administrative complexities and implement refinements in program and benefit design, some of which will be achieved with the replacement of the Medicaid Management Information System, including advanced data analytics capability. (A summary of this project may be found HERE.

II. Proposed Health Care Delivery System and Eligibility Requirements, Benefit Coverage, and Cost-Sharing

A. **Delivery System & Eligibility Requirements**

Centennial Care provides a comprehensive benefit package to eligible populations through an integrated managed care model that includes a number of innovations. The following is a description of the current eligible populations and covered benefits:

Table 1: Eligibility Groups Covered in Centennial Care

Population Group	Populations
TANF and Related	Newborns, infants, and children Children's Health Insurance Program (CHIP) Foster children Adopted children Pregnant women Low-income parent(s)/caretaker(s) and families Breast and Cervical Cancer Refugees Transitional Medical Assistance
Supplemental Security Income (SSI) Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years-old up to 133% of Modified Adjusted Gross Income (MAGI)

The following populations are excluded from Centennial Care:

- Qualified Medicare Beneficiaries;
- Specified Low-Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency services;
- Program of All-Inclusive Care for the Elderly (PACE);
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs);
- Medically Fragile 1915(c) waiver participants for Home- and Community-Based Services (HCBS);
- Developmentally Disabled 1915(c) waiver participants for HCBS; and
- Individuals eligible for family planning services only.

B. **Benefit Coverage**

Centennial Care provides a comprehensive package of services that includes behavioral health, physical health, and long-term care services and supports (LTSS). Members meeting a Nursing Facility Level of Care (NF LOC) are able to access LTSS through Community Benefit (CB) services (i.e., home- and community-based services) without a waiver slot. The CB is available through Agency-Based Community Benefit (ABCB) services (services provided by a provider agency) and Self-Directed

Community Benefit (SDCB) services (services that a participant can control and direct). Individuals under age 21 who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP) receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Under Centennial Care today, most adults who are enrolled in the Medicaid Expansion category receive services under an Alternative Benefit Plan (ABP). The ABP is a comprehensive benefit package that covers all services that are defined under the Patient Protection and Affordable Care Act (ACA) as "essential health benefits", as well as adult dental services. Centennial Care 2.0 proposes to redesign the ABP into a single, comprehensive adult benefit package that would cover both the Medicaid Expansion Category as well as Medicaid adults in the Parent/Caretaker category. The state proposes adding a limited vision benefit to the ABP, and waiving EPSDT services for 19-20 year-olds who are covered under the Adult Expansion or Parent/Caretaker categories. Adults who are considered "medically frail" are exempt from the ABP and may receive the standard Medicaid benefit package, including access to CB services and nursing facility care for individuals who meet the NF LOC criteria.

As outlined in the draft waiver application, the state has proposed some additional refinements to benefits and eligibility, including:

- Developing buy-in premiums (i.e., riders) for dental and vision services, if needed due to state financial constraints;
- Incorporating eligibility requirements of the Family Planning program into Centennial Care 2.0, so that it covers men and women through age 50 with no other health insurance (with certain exceptions);
- Eliminating the three-month retroactive eligibility period for most (non-SSI) Centennial Care members;
- Accelerating the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increased income;
- Addressing limitations imposed on the use of Institutions for Mental Disease (IMDs);
- Requesting federal financial participation to cover former foster care individuals up to age 26 who are former residents of other states;
- Piloting wrap-around services (intensive care coordination) for youth involved with the Children, Youth and Families Department (CYFD);
- Piloting a home visiting program that focuses on prenatal care, post-partum care and early childhood development in collaboration with CYFD and the New Mexico Department of Health;
- Securing enhanced administrative funding to expand the availability of Long-Acting Reversible Contraceptives (LARC) for certain providers;
- Expanding the health home model and developing peer-delivered, pre-tenancy and tenancy support housing services to individuals with complex behavioral health conditions;
- Continuing to provide access to Community Interveners for deaf and blind individuals;
- Continuing to allow all Medicaid-eligible members who meet a NF LOC to have access to home and community-based waiver services without the need for an allocation to the waiver;
- Implementing an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change;
- Increasing the limit of respite hours in the Community Benefit from 100 hours to 300 hours annually;
- Allowing for one-time start-up goods funding when a member transitions from the agency-based community benefit model to self-direction; and
- Establishing limits on costs for certain self-directed Community Benefit services:
    - Related Good & Services - $2,000 annual limit
    - Non-medical transportation - $1,000 annual limit
    - Specialized Therapies - $2,000 annual limit

C. Cost-Sharing

The Centennial Care 2.0 waiver renewal proposal includes new premiums (monthly payments) for higher income categories of Medicaid. Centennial Care 2.0 also refines co-payment responsibilities that are already in place for some categories of Medicaid, adds co-payments for higher-income individuals in the Adult Expansion Group, and adds new co-payments for individuals in most categories of Medicaid for non-emergency use of the hospital Emergency Department and non-

preferred prescription drugs. The charts below summarize the proposed cost-sharing under Centennial Care 2.0. Additional details may be found in the proposed waiver application.

Table 2: Proposed Premium Structure

Note: Native Americans exempt from premiums

FPL Range	Annual Household Income (Household of 1)	Aggregate Household Maximum – 5% of Income (Household of 1)	Applicable Category of Eligibility (COE)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101-150% FPL	$12,060-$18,090	$600	• Other Adult Expansion Group (OAG) • Working Disabled Individuals (WDI) • Children's Health Insurance Program (CHIP)	$10	$20	$20	$40
151-200% FPL	$18,091-$24,120	$900	• WDI • CHIP • Transitional Medical Assistance (TMA)	$15	$30	$30	$60
201-150% FPL	$24,121-$30,150	$1,200	• WDI • CHIP • TMA	$20	$40	$40	$80
251-300% FPL	$30,151-$36,180	$1,500	• CHIP • TMA	$25	$50	$50	$100

Table 3: Proposed Co-Payment Structure

Note: Native Americans exempt from co-payments

	Children's Health Insurance Program (CHIP)	Working Disabled Individuals	Other Adult Expansion Group (OAG)	All Other Medicaid
	Age 0-5: 241-300% FPL	Up to 250% FPL	Co-pays apply if income is	

Population Characteristics & Eligibility	Age 6-18: 191-240% FPL		greater than 100% FPL	
Outpatient office visits (non-preventive) • Behavioral health exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment, and supplies • Psychotropic Rx exempt • Family Planning Rx exempt • Not charged if non-preferred Rx co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All FPLs and Categories of Eligibility; certain exemptions will apply			
Non-emergency use of the hospital Emergency Department	$8/visit All FPLs and Categories of Eligibility; certain exemptions will apply			

III. Estimated Expected Increase or Decrease in Annual Aggregate Expenditures

The following projections utilize actual Centennial Care Demonstration Year 1-3 expenditures, aggregate per capita cost trend data, and enrollment trend data for the program, based on the populations expected to be enrolled in the Centennial Care 2.0 Demonstration.

Historical Enrollment and Expenditure Data					
	DY01 (1/1/2014 – 12/31/2014)	**DY02 (1/1/2015 – 12/31/2015)**	**DY03 (1/1/2016 – 12/31/2016)**	**DY04* (1/1/2017 – 12/31/2017)**	**DY05* (1/1/2018 – 12/31/2018)**
Members	7,360,554	8,162,036	8,660,504	8,946,301	9,241,529

Aggregate Expenditures	$4,007,889,032	$4,657,506,017	$4,571,113,953	$4,816,400,126	$5,074,848,193

**Estimated*

Centennial Care 2.0 - Demonstration Years (DY)					
	DY01 (1/1/2019 –12/31/2019)	**DY02 (1/1/2020 –12/31/2020)**	**DY03 (1/1/2021 –12/31/2021)**	**DY04 (1/1/2022 –12/31/2022)**	**DY05 (1/1/2023 –12/31/2023)**
Members	9,426,360	9,614,887	9,807,185	10,003,329	10,203,396
Aggregate Expenditures	$5,278,7691,600	$5,490,100,477	$5,707,781,670	$5,941,977,426	$6,183,257,976

IV. Hypothesis and Evaluation Parameters of the Demonstration

During Centennial Care 2.0, HSD will maintain the original hypotheses and evaluation design plan of Centennial Care, but will add new metrics in order to evaluate the impact of proposed policies and programs presented within this waiver renewal application. The table below describes these hypotheses and how HSD will evaluate the impact.

Table 4 – Quality Goals and Evaluation

	Hypothesis	**Methodology**	**Data Sources**
Goal 1: Improve Member outcomes with refinements to care coordination			
1.1	Enhancements to care coordination will result in decreases for avoidable emergency room visits and hospital readmissions.	Track and trend member utilization of avoidable emergency room visits and hospital readmissions and monitor MCO adherence to common chronic disease management and other social support services requirements for care coordination.	Claims data HEDIS reports MCO reporting
1.2	Birthing outcomes will improve with pregnant women participating in the home visiting pilot.	Track and trend low birthweight, pre-term birth, prenatal/post-partum visits and well child visits for members in pilot.	Claims data HEDIS reports MCO reporting
Goal 2: Increase Behavioral Health Integration			
2.1	Member's utilization of Health Homes will increase.	Track and trend the number of members participating in Health Homes.	Claims data MCO reporting
2.2	Treatment outcomes of members participating in Health Homes will improve.	Track and trend Health Homes' treatment outcomes of common behavioral/physical health conditions and care coordination outcomes such as avoidable emergency room visits, hospital readmissions and	Claims data HEDIS reports MCO reporting

	Hypothesis	Methodology	Data Sources
		follow up after hospitalization for mental illness.	
Goal 3: Expand member access to Long Term Services and Supports			
3.1	Allowing all Medicaid-eligible members who meet a nursing facility level of care to access the Community Benefit will maintain New Mexico's accomplishments in rebalancing efforts.	Track and trend members accessing community benefits.	Claims data
3.2	Increasing caregiver respite hours will improve member outcomes and utilization.	Track and trend member utilization and member outcomes.	Claims data HEDIS reports
3.3	Automatic Nursing Facility Level of Care (NFLOC) approvals will achieve administrative simplification for HSD, the MCOs and members.	Track and trend automatic NFLOC approvals.	MCO reporting
Goal 4: Increase quality of care with Value Based Payment (VBP) arrangements.			
4.1	Healthcare outcomes will improve for members served by providers that have VBP arrangements for the full delegation of care coordination.	Track and trend member utilization and common chronic disease management outcomes of providers with VBP arrangements that include full delegation of care coordination.	Claims data HEDIS reports MCO reporting
4.2	Implementing incremental minimum VBP requirements will support bending the cost curve of Medicaid program costs through alignment with Centennial Care 2.0 program goals of improving care coordination, focus on transitions of care.	Track and trend program expenditure.	Claims data HEDIS reports MCO reporting
Goal 5: Promoting Member Engagement and Responsibility			
5.1	Members participating in the Centennial Rewards program will continue to have improved healthcare outcomes with decreases in higher-cost services, such as inpatient stays.	Track and trend member utilization of preventive services and rewards credits.	Claims data HEDIS reports MCO/Reward Program Contractor reporting
5.2	Copayments for certain services will drive more appropriate use of services, such as reducing non-emergent use of the emergency department.	Track and trend member utilization of avoidable emergency room visits	Claims data MCO reporting

	Hypothesis	Methodology	Data Sources
5.3	Premiums will ensure member engagement and smooth the cost-sharing "cliff" between Medicaid and the commercial market.	Track and trend enrollment rates and rate of churn between Medicaid and commercial/private coverage	Enrollment data Premium collections da
Goal 6: Improve administrative effectiveness and simplicity.			
6.1	Engaging justice-involved members prior to release will improve their health outcomes and begin to reduce recidivism in time.	Track and trend health outcomes and recidivism rates for justice-involved members who are actively participating in the care coordination program.	Claims data MCO reporting HEDIS reports
6.2	Members will have increased access to inpatient services at an Institution for Mental Disease (IMD).	Track and trend member utilization of IMDs.	Claims data
Goal 7: Improve Delivery System and Access to Services			
7.1	Members will have increased access to CHWs and CHRs.	Track and trend member utilization.	MCO reporting
7.2	Members will have increased access to telehealth.	Track and trend member utilization.	Claims data
7.2	Members will have increased access to Patient Centers Medical Homes.	Track and trend member utilization.	MCO reporting

V. Waiver and Expenditure Authorities

A. Title XIX Waiver Requests

1.	**Reasonable Promptness**	**Section 1902(a)(8)**
Consistent with existing Home- and Community-Based Services (HCBS) waiver authority (Section 1915(c) of the Social Security Act), to the extent necessary to enable the State to establish enrollment targets for certain HCBS for those who are not otherwise eligible for Medicaid. The State will take into account current demand and utilization rates and will look to increase such enrollment targets in order to appropriately meet the long term care needs of the community. To the extent necessary to enable the State to begin benefit coverage on the first day of the first month following receipt of the required premium by the premium due date for individuals in a Medicaid category of eligibility that requires premiums. To the extent necessary to enable the State to prohibit reenrollment for 3 months for individuals who fail to pay required premiums.		
2.	**Amount, Duration and Scope of Services**	**Section 1902(a)(10)(B)** **42 CFR 400 Subpart B**
To the extent necessary to enable the State to permit managed care plans to offer different value added services or cost-effective alternative benefits to enrollees in Centennial Care.		

To the extent necessary to enable the State to offer certain HCBS and care coordination services to individuals who are Medicaid eligible and who meet nursing facility level of care.

To the extent necessary to allow the State to place expenditure boundaries on HCBS and personal care options.

To permit the State to serve adults in the Parent/Caretaker category under the same benefit package as Expansion adults using Secretary-approved ABP coverage.

3.	**Recipient Rewards**	**Section 1902(a)(10)(C)(i)**

To the extent necessary to enable the State to exclude funds provided through recipient reward programs from income and resource tests established under State and Federal law for purposes of establishing Medicaid eligibility.

4.	**Freedom of Choice**	**Section 1902(a)(23)** **42 CFR 431.51**

To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care.

Moreover, all services will be provided through managed care including behavioral health, HCBS and institutional services, except for services received under the existing Developmental Disabilities 1915(c) waiver, Medically Fragile 1915(c) waiver, and the accompanying Mi Via Self-Directed 1915(c) waiver, individuals in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and individuals in the Program of All-Inclusive Care for the Elderly (PACE).

Consistent with the current demonstration, mandatory enrollment of American Indians/Alaska Natives is only permitted for receipt of LTSS.

5.	**Cost Sharing**	**Sections 1902(a)(14) and 1916** **42 CFR 447.51-447.56**

To permit the State to impose co-payments for non-emergency use of the emergency room and non-preferred prescription drugs for most categories and income levels; and to impose co-payments on certain populations with household incomes above 100% of the federal poverty level. Co-payments will not be imposed on individuals for whom Indian health care providers, as specified in section 1932(h) of the SSA, have the responsibility to treat.

To permit the State to impose an alternative tracking methodology for the aggregate limit on cost-sharing.

To permit Centennial Care providers to impose missed appointment fees on members.

6.	**Self-Direction of Care**	**Section 1902(a)(32)**

To permit persons receiving certain services to self-direct their care for such services.

7.	**Retroactive Eligibility**	**Section 1902(a)(34)** **42 CFR 435.914**
To enable the State, beginning on January 1, 2019, to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for Medicaid for some eligibility groups.		
8.	**Transitional Medical Assistance (TMA)**	**Section 1902(e)**
To permit the state to waive participation in the TMA program for individuals who lose eligibility due to increased earnings.		
9.	**Long-Acting Reversible Contraception (LARC)**	
To permit the State to provide enhanced administrative funding for LARC to certain Medicaid providers.		
10.	**EPSDT for Adults (19-20 years old)**	**Section 1905(a)(4)(B)**
To permit the State to waive the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for adults in the Expansion Adult and Parent/Caretaker categories who are 19–20 years-old.		
11.	**Premiums**	**Section 1902(a) (14), 1916, 1916A** **42 CFR 447.55, 42 CFR 447.56(f)**
To permit the State to impose premiums on certain populations. To permit the State to impose an alternative tracking methodology for the aggregate limit on premiums.		
12.	**Alternative Benefit Package**	**Section 1902(k)(1) and 1937(b)** **42 CFR 440.347**
To enable the State to not provide coverage for habilitative services to the new adult population.		
13.	**Nursing Facility Level of Care Redeterminations**	**Section 1902(a)(10)(A)(ii)(IV)** **42 CFR 441.302(c)(2)**
To enable to State to grant Members that meet specified criteria ongoing NF LOC determination.		

B. Expenditure Authority Requests

Under the authority of the Social Security Act (SSA), Section 1115(a)(2), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under Section 1903 shall, for the period of this demonstration, be regarded as expenditures under the Medicaid State Plan but are further limited by the special terms and conditions for the Section 1115 demonstration.

1. Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the SSA specified below. Managed care plans participating in the demonstration will have to meet all the requirements of Section 1903(m), except the following:
    - Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90-days or less in the same managed care plan from which the individual was previously enrolled.
2. Expenditures for recipient reward programs.

3. To the extent necessary, expenditures for valued added services and/or cost-effective alternative services to the extent those services are provided in compliance with federal regulations and the 1115 demonstration.
4. Expenditures for direct payments made by the State to the Safety Net Care Pool (SNCP), where hospitals receive payments out of a pool.
5. Expenditures under contracts with managed care entities where either the State or the managed care entity will provide for payment for Indian health care providers as specified in Section 1932(h) of the SSA for covered services furnished to Centennial Care managed care plan recipients at the Office of Management and Budget (OMB) rates.
6. Expenditures for Centennial Care recipients who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under SSA Section 1902(a)(10)(A)(ii)(VI) and 42 CFR §435.217 in conjunction with SSA section 1902(a)(10)(A)(ii)(V), if the services they receive under Centennial Care were provided under an Home and Community-Based Services (HCBS) waiver granted to the State under SSA Section 1915(c) as of the initial approval date of this demonstration. This includes the application of spousal impoverishment eligibility rules.
7. Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid.

Centennial Care 2.0 Concept Paper

Since October of 2016, the Department has been soliciting ideas and feedback from various stakeholders (and the public) to inform the changes it plans to implement. A pre-application Concept Paper was released in May 2017 and numerous public input sessions were held throughout the state in June 2017 to receive comments about the concepts presented in the paper. The Department incorporated feedback received into the development of the draft waiver application.

The pre-application Concept Paper and presentation for the Centennial Care 2.0 waiver renewal can be found here:

- **Centennial Care 2.0 Concept Paper**
- **Centennial Care 2.0 Presentation**
- **Centennial Care 2.0 Tribal Meeting Presentation**

Proposed changes in Centennial Care are explained in the concept paper, and they will be discussed further in public meetings around the state (see schedule below). Additionally, the public is welcome to submit comments to HSD using the link below.

Other documents related to the waiver renewal application development process for Centennial Care 2.0:

- MAC Subcommittee Member Recommendations
- NATAC Recommendations
- Public Comments from Subcommittee Process
- MMIS Replacement Project Overview

Schedule of past meetings related to the waiver application development process for Centennial Care 2.0:

Public Meetings *(Presentations and Public Comments):*

Centennial Care Waiver Renewal Concept Paper Presentation

- **Albuquerque: Wednesday, June 14, 2017,** 3:30 – 5:30 p.m.
  CNM Workforce Training Center (5600 Eagle Rock Ave. NE, Albuquerque, NM 87113)
  - Albuquerque Meeting Notes
- **Silver City: Monday, June 19, 2017,** 4:00 – 6:00 p.m.
  WNMU – GRC Auditorium (1000 W. College Ave., Silver City, NM 88061)
  - Silver City Meeting Notes
- **Farmington: Wednesday, June 21, 2017,** 4:30 – 6:30 p.m.
  Bonnie Dallas Senior Center (109 E. La Plata St., Farmington, NM 87401)
  - Farmington Meeting Notes
- **Roswell: Monday, June 26, 2017,** 4:30 – 6:30 p.m.
  Roswell Public Library (301 N. Pennsylvania Ave., Roswell, NM 88201)
  - Roswell Meeting Notes

Tribal Consultation:

Centennial Care Waiver Renewal Tribal Consultation Presentation

- **Albuquerque: Friday, June 23, 2017,** 9:00 a.m. – 12:00 p.m.
  Indian Pueblo Cultural Center (2401 12th Street NW, Albuquerque, NM 87104)
    - Tribal Consultation Meeting Notes

Meetings and documents related to the Centennial Care 2.0 waiver renewal application process:

February 10, 2017, 1115 Waiver Renewal Subcommittee

- Agenda
- Minutes
- Presentation
- Other Meeting Documents
- Recommendations
- NATAC Recommendations
- Public Comments

January 13, 2017, 1115 Waiver Renewal Subcommittee

- Agenda
- Presentation
- Minutes
- Value-Based Purchasing
- Member Engagement

December 16, 2016, 1115 Waiver Renewal Subcommittee

- Agenda
- Minutes
- Presentation
- Long-Term Care
- Behavioral Health Integration

November 14, 2016, 1115 Waiver Renewal Subcommittee

- Agenda
- Meeting Documents
- HCV Presentation
- Audio Recording
- Minutes / Español

October 14, 2016, 1115 Waiver Renewal Subcommittee

- Agenda
- Minutes
- Presentation
- Care Coordination Brief

Submit a comment:

HSD continues to welcome input from New Mexicans regarding the Centennial Care program. To submit a comment, please fill out the online form below. You may also email it directly to HSD-PublicComment@state.nm.us or send it by mail to:

Human Services Department
ATTN: HSD Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

What are your ideas? Type here or upload a file using the button below.

File Upload:	Upload a file
Name:	
Email:	
Address 1:	
Address 2:	
City/Town:	
Zip Code:	
* State:	New Mexico

Submit

Back to Top

OUR STRATEGIC GOALS:

Goal 2: Slow the Growth Rate of Health Care Costs and Improve Health Outcomes

Designed and Developed by RealTimeSolutions

Public Notice

2. Public notice (abbreviated notice) in the state's newspaper

In October, 2017, HSD held a series of Public Hearings to record public comments on the Centennial Care waiver renewal. These sessions were held in four different locations in the state and were publicized via legal notice advertisements. A toll-free call in number was also available for participants for the Albuquerque event to listen to the proceedings and provide comments via phone.

Publication Name	**Publication Dates**	**Event City/Date**
Albuquerque Journal	September 6, 2017 September 27, 2017 October 22, 2017	Albuquerque/ October 30, 2017
Las Cruces Sun News	September 5, 2017 September 24, 2017	Las Cruces / October 12, 2017
Las Vegas Optic `	September 8, 2017 October 25, 2017 October 29, 2017	Las Vegas / October 18, 2017
Santa Fe New Mexican	September 5, 2017 October 22, 2017	Santa Fe / October 16, 2017

In addition to legal notices, all event dates were posted on the HSD web site. Hand-out cards with web site information were distributed at all events. The web site information included the on-line access to the full draft waiver application.

The call-in number for the Albuquerque event had the ability to host a maximum of 300 callers. During the course of the meeting, a total of 29 calls were received.

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Bernalillo
Printed In: Albuquerque Journal
Printed On: 2017/10/22

Return to Found List | New Search | Return To Current Search Criteria

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place: Albuquerque, NM: Monday, October 30, 2017, 5:30 p.m. â€" 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM) Participate in this Public Hearing Event By Phone: Monday, October 30, 2017, 5:30 p.m. â€" 7:30 p.m. A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll-free 1-888-757-2790 and enter participant code 991 379. If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@ state.nm.us The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252. Journal: October 22, 2017

Public Notice ID: 24405081

Print This Notice

Return to Found List | New Search | Return To Current Search Criteria

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Bernalillo
Printed In: Albuquerque Journal
Printed On: 2017/09/27

Return to Found List | New Search | Return To Current Search Criteria

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place: Las Cruces, NM: Thursday, October 12, 2017, 1:30 p.m. â€" 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM). Santa Fe, NM: Monday, October 16, 2017, 1:00 p.m. â€" 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM). Las Vegas, NM: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM). Albuquerque, NM: Monday, October 30, 2017, 5:30 p.m. â€" 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM) Participate in a Public Hearing Event By Phone: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#. The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Journal: September 27, 2017

Public Notice ID: 24364876

Print This Notice

Return to Found List | New Search | Return To Current Search Criteria

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Bernalillo
Printed In: Albuquerque Journal
Printed On: 2017/09/06

Return to Found List | New Search | Return To Current Search Criteria

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place: Las Cruces, NM: Thursday, October 12, 2017, 1:30 p.m. â€" 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM). Santa Fe, NM: Monday, October 16, 2017, 1:00 p.m. â€" 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM). Las Vegas, NM: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM). Participate in a Public Hearing Event By Phone: Wednesday, October 18, 2017, 1:30 p.m. â€" 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#. The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252. Journal: September 6, 2017

Public Notice ID: 24328994

Print This Notice

Return to Found List | New Search | Return To Current Search Criteria

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Dona Ana
Printed In: Las Cruces Sun-News
Printed On: 2017/10/22

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. **Call toll-free 1-888-757-2790 and enter participant code 991 379.**

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff @state.nm.us
The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1217970
Run Date: Oct. 22, 2017

Public Notice ID: 24405055
Print This Notice

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Dona Ana
Printed In: Las Cruces Sun-News
Printed On: 2017/09/24

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. - 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. - 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free **1-888-850-4523 and enter participant code: 323675#.**

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1212933
Run Date: Sept. 24, 2017

Public Notice ID: 24359918
Print This Notice

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: Dona Ana
Printed In: Las Cruces Sun-News
Printed On: 2017/09/05

Public Notice:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. - 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. - 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free **1-888-850-4523 and enter participant code: 323675#.**

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1209172
Run Date: Sept. 5, 2017

Public Notice ID: 24327017
Print This Notice

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: San Miguel
Printed In: Las Vegas Optic
Printed On: 2017/10/29

Return to Found List | New Search | Return To Current Search Criteria

Public Notice:

NOTICE
The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:
Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. ï¿½ 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)
Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. ï¿½ 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll-free 1-888-757-2790 and enter participant code 991 379.
If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@state.nm.us
The public may view the draft waiver application that outlines changes being considered on HSDï¿½s website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.
If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
PUB: Las Vegas Optic, Oct 25, 29, 2017
#29856

Public Notice ID: 24414615
Print This Notice

Return to Found List | New Search | Return To Current Search Criteria

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: San Miguel
Printed In: Las Vegas Optic
Printed On: 2017/10/25

Return to Found List | New Search | Return To Current Search Criteria

Public Notice:

NOTICE
The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:
Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. ï¿½ 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)
Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. ï¿½ 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll-free 1-888-757-2790 and enter participant code 991 379.
If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@state.nm.us
The public may view the draft waiver application that outlines changes being considered on HSDï¿½s website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.
If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
PUB: Las Vegas Optic, Oct 25, 29, 2017
#29856

Public Notice ID: 24407606
Print This Notice

Return to Found List | New Search | Return To Current Search Criteria

Public Notice

Print This Notice

Search in this notice, CTRL+F or APPLE+F
NOTE: Some notices are extracted from PDF files and may be difficult to read.

County: San Miguel
Printed In: Las Vegas Optic
Printed On: 2017/09/08

Public Notice:

PUBLIC HEARING
The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:
Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. ï¿½ 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).
Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. ï¿½ 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).
Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. ï¿½ 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).
Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. ï¿½ 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#.
The public may view the draft waiver application that outlines changes being considered on HSDï¿½s website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.
If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
PUB: Las Vegas Optic, Sept 8, 2017
#29764

Public Notice ID: 24332720

www.lcsun-news.com

LAS CRUCES SUN-NEWS

PROOF OF PUBLICATION

I, being duly sworn, Rynni Henderson deposes and says that she is the President, a newspaper published daily in the county of Dona Ana, State of New Mexico; that the 1209172 is an exact duplicate of the notice that was published once a week/day in regular and entire issue of said newspaper and not in any supplement thereof for 1 consecutive week(s)/day(s), the first publication was in the issue dated September 5, 2017, the last publication was September 5, 2017. Despondent further states this newspaper is duly qualified to publish legal notice or advertisements within the meaning of Sec. Chapter 167, Laws of 1937.

Signed

President
Official Position

STATE OF NEW MEXICO
ss.
County of Dona Ana
Subscribed and sworn before me this
6th day of September 2017

Maria Isabel Del Villar
Notary Public in and for
Dona Ana County, New Mexico

September 11, 2020
My Term Expires

OFFICIAL SEAL
MARIA ISABEL DEL VILLAR
Notary Public
State of New Mexico
My Comm. Expires 9/11/20

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. - 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. - 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1209172
Run Date: Sept. 5, 2017

HUMAN SERVICES

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to receive public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2018. The public hearings will take place:

Las Cruces, NM
Thursday, October 12, 2017, 1:30 p.m. - 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd, Las Cruces, NM)

Santa Fe, NM
Monday, October 16, 2017, 1:00 p.m. - 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM
Wednesday, October 18, 2017, 1:30 p.m. - 5:30 p.m. at the NM Highlands University Student Union Building Student Center (600 National St, Las Vegas, NM).

Participate in a Public Hearing Every By Phone
Wednesday, October 18, 2017, 1:30 p.m. - 5:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-866-850-4523 and enter participant code: 3236754#.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/LookingForward/20172018.aspx

If you do not have internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-3252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-3252.
Journal: September 6, 2017

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO

County of Bernalillo SS

Anita L. Montoya , the undersigned, on oath states that she is an authorized Representative of The Albuquerque Journal, and that this newspaper is duly qualified to publish legal notices or advertisements within the meaning of Section 3, Chapter 167, Session Laws of 1937, and that payment therefore has been made of assessed as court cost; that the notice, copy of which hereto attached, was published in said paper in the regular daily edition, for 1 time(s) on the following date(s):

09/06/2017

Anita L. Montoya

OFFICIAL SEAL
Sandra B. Gutierrez
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires 2-18-21

Sandra B. Gutierrez

Sworn and subscribed before me, a Notary Public, in and for the County of Bernalillo and State of New Mexico this 6 day of September of 2017

PRICE $49.44

Statement to come at the end of month.

ACCOUNT NUMBER 1009565

Legal
29764

AFFIDAVIT OF PUBLICATION

COUNTY OF SAN MIGUEL }
STATE OF NEW MEXICO } ss.

Jason Brooks, being first duly sworn,
(publisher)

on oath states: that he is the General Manager of the Las Vegas Optic, a tri-weekly newspaper of general paid circulation and of general circulation in San Miguel County, New Mexico, entered under the second class postal privilege in said county, being the county in which the notice hereto attached is required to be published and said paper has been published in said San Miguel County continuously and uninterruptedly during a period of six months prior to the first issue thereof containing said notice. That the notice of which a copy as published is hereto attached and hereby made a part hereof was published in the English language in said newspaper once each week for ____ consecutive weeks on the following dates, to wit:

First Publication on the 5th day of Sept, 2017.

Second Publication on the ____ day of ____, 20__.

Third Publication on the ____ day of ____, 20__.

Fourth Publication on the ____ day of ____, 20__.

That such notice is a legal notice and was published in said newspaper duly qualified for that purpose within the meaning of the provisions of Chapter 167, session Laws of 1937, and that payment therefor has been made—assessed as Court costs.

Jason W. Brooks
General Manager Publisher

PUBLISHER'S BILL

55 lines one time @ $ 1300
13 lines @ $ 375
Tax $
Total $ 74.19
Received payment.

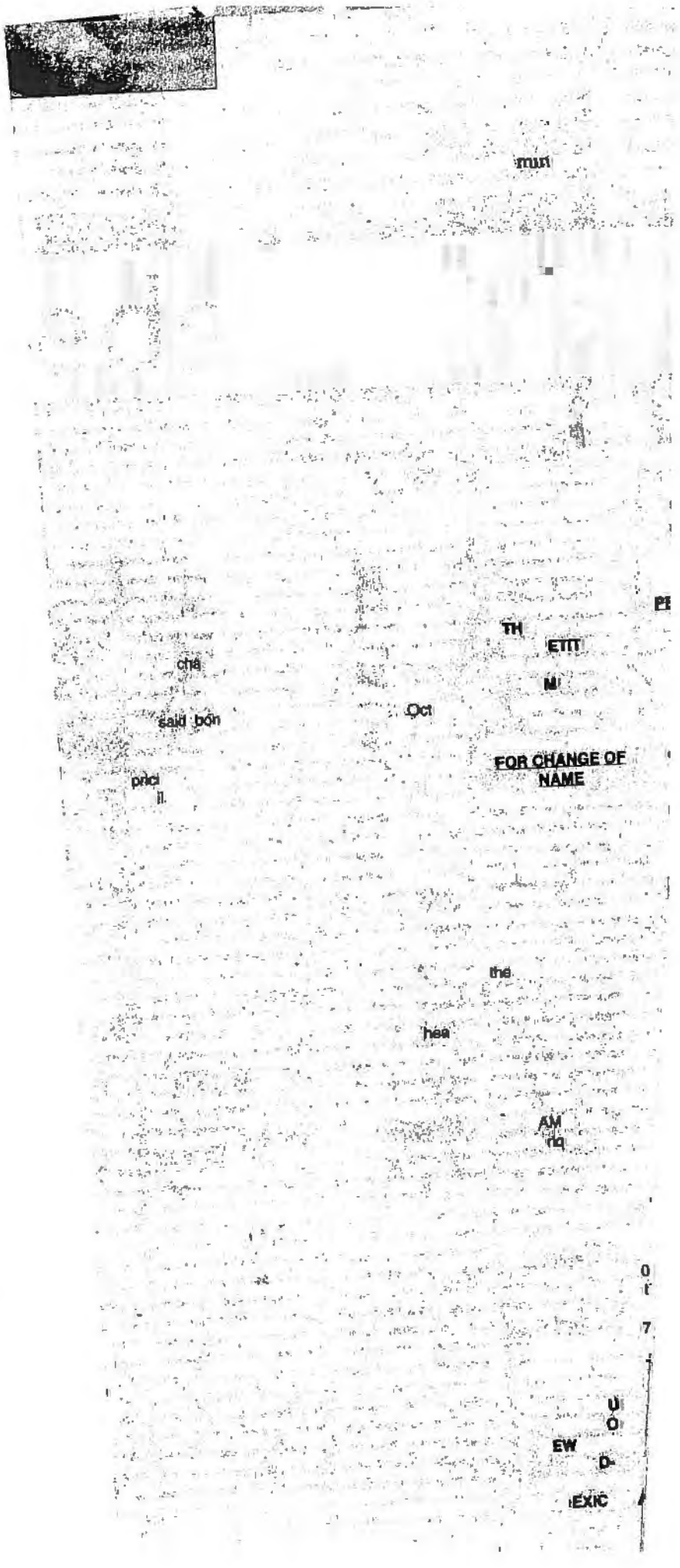
Subscribed and sworn to before me this 8th day of September 2017

Notary Public

5/30/2021 Expires

SPC35432

Official Seal
MARIA S. SANCHEZ
Notary Public
State of New Mexico
My Commission Expires 5/30/21


mun
TH
ETIT
chq
Oct
said bon
FOR CHANGE OF NAME
prici
the
hea
AM
rq
EW
D-
EXIC

www.lcsun-news.com

LAS CRUCES SUN-NEWS

PROOF OF PUBLICATION

I, being duly sworn, Rynni Henderson deposes and says that she is the President, a newspaper published daily in the county of Dona Ana, State of New Mexico; that the 1212933 is an exact duplicate of the notice that was published once a week/day in regular and entire issue of said newspaper and not in any supplement thereof for 1 consecutive week(s)/day(s), the first publication was in the issue dated September 24, 2017, the last publication was September 24, 2017. Despondent further states this newspaper is duly qualified to publish legal notice or advertisements within the meaning of Sec. Chapter 167, Laws of 1937.

Signed

President
Official Position

STATE OF NEW MEXICO
ss.
County of Dona Ana
Subscribed and sworn before me this

27th **day of** September 2017

Maria Isabel Del Villar
Notary Public in and for
Dona Ana County, New Mexico

September 16, 2020
My Term Expires

OFFICIAL SEAL
MARIA ISABEL DEL VILLAR
Notary Public
State of New Mexico
My Comm. Expires 9/16/20

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. - 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. - 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. - 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.
Pub#1212933
Run Date: Sept. 24, 2017

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO

County of Bernalillo SS

Bernadette Gonzales , the undersigned, on oath states that she is an authorized Representative of The Albuquerque Journal, and that this newspaper is duly qualified to publish legal notices or advertisements within the meaning of Section 3, Chapter 167 Session Laws of 1937, and that payment therefore has been made of assessed as court cost; that the notice, copy of which hereto attached, was published in said paper in the regular daily edition, for 1 time(s) on the following date(s):

09/27/2017

OFFICIAL SEAL
Sandra B. Gutierrez
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 2-16-21

Sworn and subscribed before me, a Notary Public, in and for the County of Bernalillo and State of New Mexico this 27 day of September of 2017

PRICE $54.86

Statement to come at the end of month.

ACCOUNT NUMBER 1009565

HUMAN SERVICES DEPARTMENT

S
A
)

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. – 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. – 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. at the NM Highlands University Student Union Building/Student Center (800 National St., Las Vegas, NM).

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in a Public Hearing

Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m.: A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: **3236734**.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Journal: September 27, 2017

HUMAN SERVICES

The Human Services Department (Department) has filed an emergency rule in order to implement the Department of Health and Human Services (HHS) updates to the Federal Poverty Level (FPL) income guidelines for the Medical Assistance Program (MAP) Categories of eligibility to be effective September 14, 2017 as required by (HHS). The FPL is used in determining monthly income standards for MAP categories of eligibility and these FPL guidelines are contained in 8.200.520 NMAC and 8.291.430 NMAC. The Department is holding a public hearing on October 26, 2017 to receive testimony on the emergency rules of 8.200.520 NMAC and 8.291.430 NMAC and to receive written, recorded, or electronic comments.

Summary of Changes:

Section 11 of 8.200.520 NMAC Medicaid Eligibility - Income Standards will be amended to reflect current FPL mandates.

Section 10 of 8.291.430 NMAC Medicaid Eligibility - Affordable Care will be amended to reflect current FPL mandates.

A current recipient or new applicant's eligibility for a MAP category of eligibility may be affected based on updated income limits.

NM Stat Section 9-8-6 NMSA 1978 (2016) authorizes the Department Secretary to promulgate rules and regulations that may be necessary to carry out the duties of the Department and its divisions.

The register for these emergency amendments to these rules will be available September 14, 2017 on the HSD web site at http://www.hsd.state.nm.us/LookingForInformation/registers.aspx or at http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx

If you do not have internet access, a copy of the proposed rules may be requested by contacting MAD in Santa Fe at 505-827-6252.

A public hearing to receive testimony on these rules will be held in Hearing Room 1, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, New Mexico, 87505 on Thursday, October 26, 2017 from 10 a.m to 11 a.m. Mountain Daylight Time (MDT).

Interested parties may submit written comments directly to: Human Services Department, Office of the Secretary, ATT: Medical Assistance Division Public Comments, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. Recorded comments may be left by calling (505) 827-1337. Electronic comments may be submitted to: medrules@state.nm.us. Written, electronic, and recorded comments will be given the same consideration as oral testimony made at the public hearing. All comments must be received no later than 5:00 p.m. MDT, October 26, 2017.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact MAD in Santa Fe at 505-827-6252. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

Journal: September 26, 2017

HUMAN SERVICES DEPARTMENT

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2018. The last of these public hearings will take place:

Albuquerque, NM
Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll-free 1-888-757-2790 and enter participant code 941 379 4#.

If you have connection issues or problems joining the conference line, please call or text 505-570-7288 or e-mail Katherine.Slade-Hall@state.nm.us

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Journal: October 22, 2017

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO

County of Bernalillo SS

Bernadette Gonzales , the undersigned, on oath states that she is an authorized Representative of The Albuquerque Journal, and that this newspaper is duly qualified to publish legal notices or advertisements within the meaning of Section 3, Chapter 167, Session Laws of 1937, and that payment therefore has been made of assessed as court cost; that the notice, copy of which hereto attached, was published in said paper in the regular daily edition, for 1 time(s) on the following date(s):

10/22/2017

OFFICIAL SEAL
Sandra B. Gutierrez
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 2-18-21

Sandra B. Gutierrez

Sworn and subscribed before me, a Notary Public, in and for the County of Bernalillo and State of New Mexico this 22 day of October of 2017

PRICE $44.70

Statement to come at the end of month.

ACCOUNT NUMBER 1009565

SANTA FE NEW MEXICAN

Founded 1849

NM HSD MEDICAL ASSIST DIV COMM A
P O BOX 2348
SANTA FE, NM 87504-2348

ACCOUNT: 13964
AD NUMBER: 0000207828
LEGAL NO 83157 P.O. #: 63000-000003047

1 TIME(S)	95.76
AFFIDAVIT	10.00
TAX	8.79
TOTAL	114.55

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO
COUNTY OF SANTA FE

I, W. Barnard, being first duly sworn declare and say that I am Legal Advertising Representative of THE SANTA FE NEW MEXICAN, a daily newspaper published in the English language, and having a general circulation in the Counties of Santa Fe, Rio Arriba, San Miguel, and Los Alamos, State of New Mexico and being a newspaper duly qualified to publish legal notices and advertisements under the provisions of Chapter 167 on Session Laws of 1937; that the Legal No 83157 a copy of which is hereto attached was published in said newspaper 1 day(s) between 09/05/2017 and 09/05/2017 and that the notice was published in the newspaper proper and not in any supplement; the first date of publication being on the 5th day of September, 2017 and that the undersigned has personal knowledge of the matter and things set forth in this affidavit.

/S/ _____
LEGAL ADVERTISEMENT REPRESENTATIVE

Subscried and sworn to before me on this 5th day of September, 2017

Notary Ofelia M Martinez

Commission Expires: 10/25/20

OFFICIAL SEAL
OFELIA MARTINEZ
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 10/25/20

SANTA FE NEW MEXICAN
Founded 1849

LEGAL #83157

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The public

Continued...

hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. – 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. – 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209

Continued...

Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. A

Continued...

phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. Call toll-free 1-888-850-4523 and enter participant code: 323675#.

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-

Continued...

care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Published in the Santa Fe New Mexican on September 5, 2017.

SANTA FE NEW MEXICAN

Founded 1849

NM H S D POLICY AND PROGRAMS DE
2009 S PACHECO POLLON PLAZA
SANTA FE, NM 87504

ACCOUNT: 19247
AD NUMBER: 0000211895
LEGAL NO 83383 P.O. #: 63000-000003060

1 TIME(S)	85.68
AFFIDAVIT	20.00
TAX	7.95
TOTAL	103.63

AFFIDAVIT OF PUBLICATION

STATE OF NEW MEXICO
COUNTY OF SANTA FE

I, S. Jaramillo, being first duly sworn declare and say that I am Legal Advertising Representative of THE SANTA FE NEW MEXICAN, a daily newspaper published in the English language, and having a general circulation in the Counties of Santa Fe, Rio Arriba, San Miguel, and Los Alamos, State of New Mexico and being a newspaper duly qualified to publish legal notices and advertisements under the provisions of Chapter 167 on Session Laws of 1937; that the Legal No 83383 a copy of which is hereto attached was published in said newspaper 1 day(s) between 10/22/2017 and 10/22/2017 and that the notice was published in the newspaper proper and not in any supplement; the first date of publication being on the 22nd day of October, 2017 and that the undersigned has personal knowledge of the matter and things set forth in this affidavit.

/S/ _____
LEGAL ADVERTISEMENT REPRESENTATIVE

Subscried and sworn to before me on this 24th day of October, 2017

Notary Ofelia Martinez

Commission Expires: 10/25/20

OFFICIAL SEAL
OFELIA MARTINEZ
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 10/25/20

THE SANTA FE
NEW MEXICAN
Founded 1849

be effective on January 1, 2019. The last of these public hearings will take place:

Albuquerque, NM: Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone: Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m.
A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. **Call toll-free 1-888-757-2790 and enter participant code 991 379.**

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@state.nm.us

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Published in the Santa Fe New Mexican on October 22, 2017.

LEGAL #83383

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will

Continued...

Legal
298560

AFFIDAVIT OF PUBLICATION

COUNTY OF SAN MIGUEL
STATE OF NEW MEXICO } ss.

Jason Brooks, being first duly sworn,
(publisher)

on oath states: that he is the General Manager of the Las Vegas Optic, a tri-weekly newspaper of general paid circulation and of general circulation in San Miguel County, New Mexico, entered under the second class postal privilege in said county, being the county in which the notice hereto attached is required to be published and said paper has been published in said San Miguel County continuously and uninterruptedly during a period of six months prior to the first issue thereof containing said notice. That the notice of which a copy as published is hereto attached and hereby made a part hereof was published in the English language in said newspaper once each week for _____ consecutive weeks on the following dates, to wit:

First Publication on the 25th day of Oct 20 17.
Second Publication on the 26th day of Oct 20 17.
Third Publication on the _____ day of _____ 20__.
Fourth Publication on the _____ day of _____ 20__.

That such notice is a legal notice and was published in said newspaper duly qualified for that purpose within the meaning of the provisions of Chapter 167, session Laws of 1937, and that payment therefor has been made or assessed as Court costs.

Joan M. Baca
General Manager Publisher

Subscribed and sworn to before me this 30th day of October 20 17.

Maria Sanchez
Notary Public

5/30/2021
Expires

Official Seal
MARIA S. SANCHEZ
Notary Public
State of New Mexico
My Commission Expires 5/30/21

SPC35432

PUBLISHER'S BILL

_____ lines one time @ _____ $ 58.18
_____ lines @ _____ $ 26.00
_____ Tax _____ $ 9.61
_____ Total _____ $ 12.09
Received payment.

ass

ssified ad call: 505-42

p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM).

Participate in this Public Hearing Event By Phone:

Monday, October 30, 2017, 5:30 p.m. - 7:30 p.m.

A phone line will be available for any member of the public to join the Albuquerque public hearing to hear or provide comments via telephone. Call toll free: 1-888-757-2790 and enter participant code 991 879.

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slaton-Huff@state.nm.us.

The public may view the draft waiver application that outlines changes being considered by HSD's Website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

If you do not have internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

PUB: Las Vegas Optic, Oct 25, 29, 2017

tion date, judgment by default will be entered against you.

DAVIS MILES McGUIRE GARDNER PLLC

Kelley L. Thurston

Attorneys for Plaintiff

320 Gold Ave. SW, Suite 1111

Albuquerque, New Mexico 87102

Telephone No. 848-5050

kthurston@davismiles.com

PUB: Las Vegas Optic, Oct 29, 2017

Legal Notice

The Northeast Regional Education Cooperative Governing Board meeting on Wednesday, November 8, 2017 at 11:00 a.m. at NREC, 1903 7th Street, Las Vegas, NM.

PUB: Las Vegas Optic, Oct 29, Nov 3, 5, 2017

Informal Request for Proposals Presidential Search Firm/Consulting

Luna Community College invites proposals from firms or individuals capable of providing consulting services for the recruitment and selection process for the College's next President who will assume office on or about July 1, 2018. The College will receive electronic proposals until 2:00 p.m. on November 10, 2017. Proposals may be submitted via e-mail to Ricky A. Serna, Ph.D., President at rserna@luna.edu.

General Services

patio, landscaping grey-water, garage. $800/MO. 575-421-3487

3 bedroom, 2 bath, Contact Isabel 429-1737. $750 plus utilities

725 Manufactured Homes for Rent

2 br, 1 bath, mobile home. 429-7353/425-5340

2 bed, 1 bath, Mobile Home for Rent. 429-2961

Clean 2 br, 1 ba, fenced & gated off-street parking $500/mo. $400/dep. 1988 Century Limited Buick Reliable for Sale. 454-0607

#29947

NOTICE

The Human Services Department, Medical Assistance Division (MAD) has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:

Albuquerque, NM: Monday, October 30, 2017, 5:30 p.m. - 7:30

Bright Beginnings
Child Development Center

Janitorial/Custodian

Needed for Evenings. Must be dependable and able to work alone.

Applications may be picked up at
Bright Beginnings Child Development Center
2302 Collins Drive
Las Vegas, NM 87701

C0008979

PAYMENT
FAIR HOUSING
ADJUSTMENTS
DEADLINE
PUBLISHER'S NOTICE

Public Notice

3. Proposal posting (abbreviated notice) via the State's electronic mail lists

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

September 7, 2017

Dear Interested Parties:

The Human Services Department, Medical Assistance Division (MAD), will be holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. **Comments will be accepted until 5:00pm MST on Wednesday, October 18, 2017.**

The public hearings will take place:

Las Cruces, NM:
Thursday, October 12, 2017, 1:30 p.m. – 3:30 p.m. at the Farm and Ranch Museum (4100 Dripping Springs Rd., Las Cruces, NM).

Santa Fe, NM:
Monday, October 16, 2017, 1:00 p.m. – 4:00 p.m. at the Medicaid Advisory Committee meeting, to be held at the New Mexico State Library (1209 Camino Carlos Rey, Santa Fe, NM).

Las Vegas, NM:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. at the NM Highlands University-Student Union Building/Student Center (800 National St., Las Vegas, NM).

Participate in a Public Hearing Event By Phone:
Wednesday, October 18, 2017, 1:30 p.m. – 3:30 p.m. A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. **Call toll-free 1-888-850-4523 and enter participant code: 323675#.**

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. You may submit a comment by using the online form available through the website. You may also email comments directly to MAD at HSD-PublicComment@state.nm.us or mail your comments to:

Human Services Department
ATTN: HSD Public Comments
PO Box 2348
Santa Fe, NM 87504-2348

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

October 6, 2017

Dear Interested Parties:

The Human Services Department, Medical Assistance Division (HSD/MAD) has issued a revised draft of the 1115 Centennial Care waiver application. The revised draft waiver application is posted on HSD's website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. A summary of HSD/MAD's proposed revisions can be found below.

Please note that the comment period has been extended until **5:00pm Mountain Time on Monday, November 6, 2017**. Comments may be submitted through HSD's website, by email to HSD-PublicComment@state.nm.us, or by postal mail to: Human Services Department, ATTN: HSD Public Comments, PO Box 2348, Santa Fe, NM 87504-2348.

Public hearing dates to receive comments about the draft waiver application have not changed and are posted on HSD's website.

Draft Waiver Application Summary of Revisions – October 6, 2017
(Original Draft Released on September 5, 2017)

Section and Page Number	Summary of Revision
Cover page	1. Revised the date from "September 5, 2017" to "Revised October 6, 2017."
Member Engagement and Cost Sharing Proposal #2: Implement premiums for populations with income that exceeds 100% FPL • Original Application Pages 29-30 • Revised Application Page 29-30	1. After receiving feedback from public that the premium enforcement policy was too vague, HSD revised the language below Table 3 to include additional detail about the premium policy and its enforcement.
Member Engagement Proposal #6: Expand opportunities for Native Americans enrolled in Centennial Care • Original Application Pages 31-32 • Revised Application Page 32-33	1. After receiving public feedback that the section about collaboration with the Navajo Nation did not provide sufficient detail, HSD revised the language to allow additional collaborations and clarify other requirements related to Indian Managed Care Entities.
Benefits and Eligibility Proposal #1: Redesign the Alternative Benefit Plan and provide a	1. HSD revised the language in the first bullet about redesigning the ABP to clarify that it will not eliminate non-emergency

Section and Page Number	Summary of Revision
uniform benefit package for most Medicaid-covered Adults • Original Application Pages 32-33 • Revised Application Page 33-34	medical transportation for the adult package, but instead include option to leverage new service providers, such as ride sharing companies and new technologies, such as mobile applications.
Section 3: Waiver List • Original Application Pages 36-38 • Revised Application Page 37-40	1. HSD updated the waiver authority request language.
Table 6 – Renewal Timeline • Original Application Page 45 • Revised Application Page 47	1. HSD added the public meeting scheduled on October 30, 2017 in Albuquerque in the evening. 2. HSD revised the final waiver application submission date to November 30, 2017 to extend the public comment period and allow 30 days from posting the draft waiver application revisions.

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

The Human Services Department, Medical Assistance Division (MAD), has been holding public hearings to record public comments about the Medicaid health care program known as Centennial Care and changes to the program that are being considered as part of the renewal of the Centennial Care federal waiver that will be effective on January 1, 2019. The last of these public hearings will take place:

Albuquerque, NM:
Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m. at the National Hispanic Cultural Center, Bank of America Theatre (1701 4th Street SW, Albuquerque, NM)

Participate in this Public Hearing Event By Phone:
Monday, October 30, 2017, 5:30 p.m. – 7:30 p.m.
A phone line will be available for any member of the public to join the Las Vegas public hearing to hear or provide comments via telephone. **Call toll-free 1-888-757-2790 or 1-719-359-9722 and enter participant code 991 379.**

If you have connection issues or problems joining the conference line, please call or text 505-570-7268 or e-mail Katherine.Slater-Huff@state.nm.us

The public may view the draft waiver application that outlines changes being considered on HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at (505) 827-6252. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in a public hearing, please contact MAD at (505) 827-6252.

Public Hearings on the 1115 Waiver Application

1. Public Hearing Materials
    e. Las Cruces, October 12, 2017
    f. Santa Fe, October 16, 2017
    g. Las Vegas, October 18, 2017
    h. Albuquerque, October 30, 2017

HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0
1115 Demonstration Waiver Renewal Application – Public Hearings
October 2017
Las Cruces, Las Vegas, Santa Fe, & Albuquerque

Formal Public Hearing

- The Department is accepting comments from the public about the Medicaid program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal 1115 waiver that will be effective on January 1, 2019.
- Comments will be accepted until **5:00 pm MST on Monday, November 6, 2017.**
- We are conducting four public hearings in different regions of the state:

Las Cruces – Thursday, October 12, 2017
Farm and Ranch Museum (1:30 pm – 3:30 pm)

Santa Fe – Monday, October 16, 2017
Medicaid Advisory Committee Meeting
NM State Library (1–4pm)

Las Vegas – Wednesday, October 18, 2017
Highlands University – Student Union Building/Student Center (1:30 pm – 3:30 pm)
Call (toll-free) 1-888-850-4523; participant code: 323 675#

Albuquerque – Monday, October 30, 2017
National Hispanic Cultural Center
Albuquerque, NM (5:30 pm – 7:30 pm)

Formal Public Hearing

- Comments are also being accepted directly at HSD-PublicComment@state.nm.us or by mail:

  Human Services Department
  ATTN: HSD Public Comments
  PO Box 2348
  Santa Fe, NM 87504-2348

  More information about the waiver renewal and public comment process may be found on the Department's website:

  http://www.hsd.state.nm.us/centennial-care-2-0.aspx

  - The Public Hearing process is more formal than the statewide public input sessions conducted by the Department in June 2017 to obtain public feedback about the waiver renewal through release of a concept paper

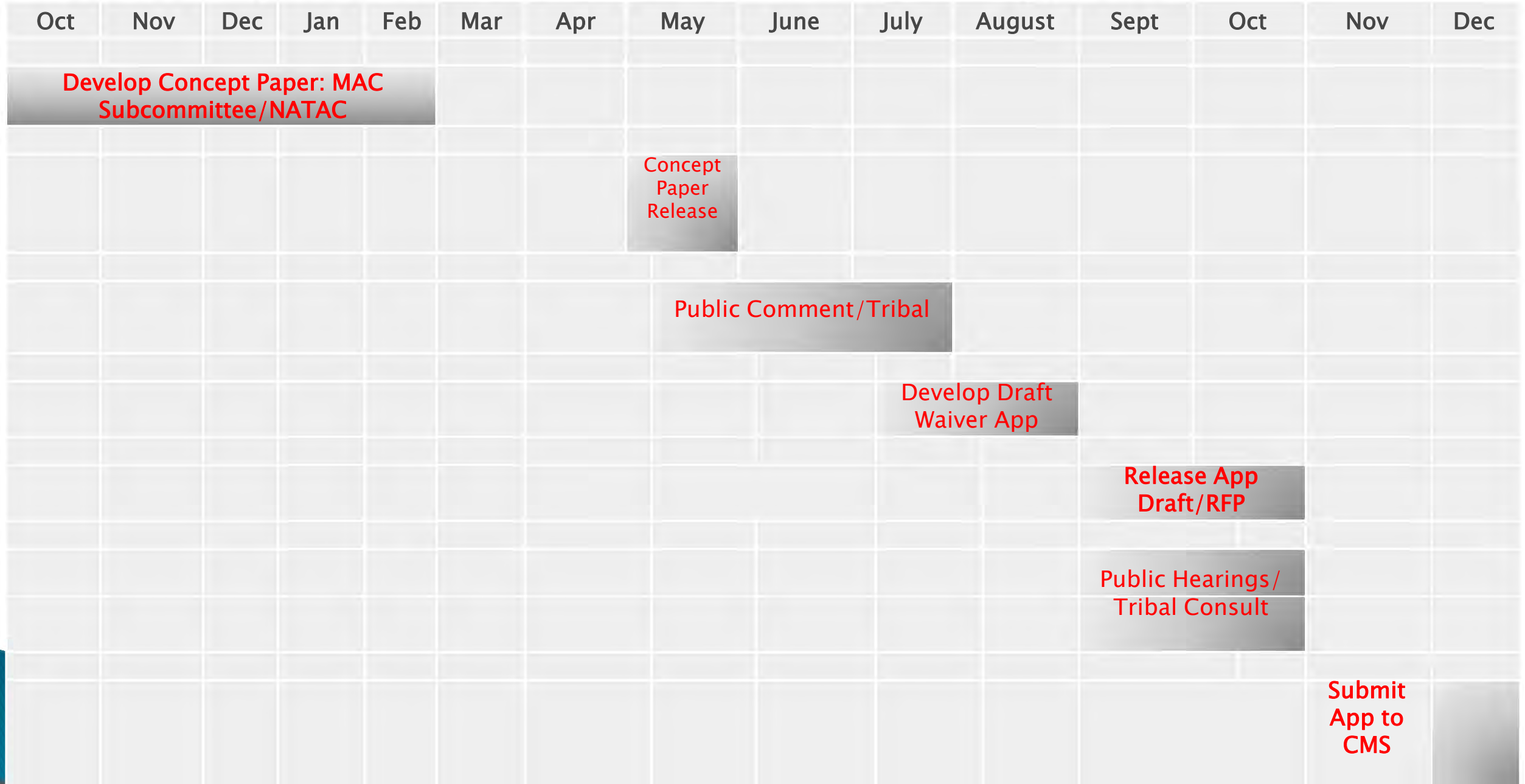
Year-Long Public Input Process

Public Input Opportunities in the Development of Concept Paper (before May 2017)	Public Input Meetings about Draft Concept Paper (after May 2017)	Other Input Opportunities
Medicaid Advisory Subcommittee: October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe) *Public Comment at end of each meeting*	**Statewide Public Input Sessions & Attendees:** **Albuquerque** – June 14, 2017 – 160 attendees **Silver City** – June 19, 2017 – 22 attendees **Farmington** – June 21, 2017 – 41 attendees **Roswell** – June 26, 2017 – 30 attendees	**Written Comments:** May – July 2017 – 21 letters received
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees – Albuquerque **Native American Technical Advisory Committee**: July 10, 2017 – NATAC Membership	**HSD Email Address Established:** Ongoing from October 2016– July 2017 137 emails received
MAC Meetings with Public Input: November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)	**MAC Meetings with Public Input:** July 24, 2017 – (Santa Fe)	**Public Hearings to be held in October 2017:** • Las Cruces • Las Vegas • Santa Fe • Albuquerque

Formal Public Hearing

- We appreciate your attendance today and look forward to your comments after the presentation
- Today's presentation is a summary of the proposed changes to the 1115 waiver that are outlined in the draft waiver renewal application that was released on September 5, 2017 (revised on October 6, 2017) and available to review on the HSD website
- As part of the formal hearing process, we will accept and record all of your comments but will not engage in a discussion about the comments today
- Our response to the comments will be documented in a section of the final 1115 waiver renewal application that is submitted to the Centers for Medicare and Medicaid Services in November 2017

Centennial Care 2.0 Waiver Renewal



CENTENNIALCARE2.0

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Benefit and delivery system modifications
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to eligibility

Person-Centered Initiatives in Centennial Care 2.0

- MCO Care Coordinators focused on High-Need Members
- 300,000 Members Served in Patient -Centered Medical Homes
- Care Coordination at Provider Level
- Home Visiting Pilot for Prenatal, Post Partum and Early Childhood Services
- Full Delegation Model with Value Based Purchasing Arrangements
- Shared Functions Model with Providers and Community Partners
- Health Homes for Members with Complex Behavioral Health Needs
- Use of Community Health Workers, Community Health Reps and Peer Support Specialists
- Supportive Housing Specialists and Justice-Involved Liaisons
- Expanded Access to Home and Community Based Services

Care Coordination

Proposals

#1: Increase care coordination at the provider level

- Full Delegation Model for providers entering into Value-Based Purchasing agreements to manage total cost of members' care and Shared Functions Model for providers and/or community partners conducting more limited care coordination activities

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations

- First Responders, wellness centers, personal care agencies and Project ECHO (Extension for Community Health Outcomes) ;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

Care Coordination

Proposals

#4: Initiate care coordination for justice-involved prior to release from incarceration

- Allowing care coordination activities to be conducted by county/facility prior to release
- Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities

#5: Obtain 100% federal funding for Native American members for services received through Indian Health Services (IHS) and/or Tribal 638 facilities

Benefit and Delivery System Modifications

Proposals

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Individuals with higher needs who are determined to meet the "medically frail" criteria may receive the standard Medicaid benefit package and not the ABP
- Eliminate habilitative services from the ABP, but add a limited vision benefit similar to the standard Medicaid package vision benefit, expanding access for the 250,000 members currently enrolled
- Expand service providers for the non-emergent medical transportation benefit to include ride sharing companies and leverage new technologies such as mobile apps

#2: Waive federal EPSDT rule for 19-20 year olds enrolled in the single adult plan to further streamline the benefit package so that all adults receive the same comprehensive benefits

#3: Develop buy-in premiums for dental and vision services for adults (if necessary due to budgetary shortfall)

Benefit and Delivery System Modifications

Proposals

#4: Allow for one-time, start-up funding for Community Benefit members who transition from the agency-based model to self-directed model -- up to $2,000

#5: Increase caregiver Community Benefit respite limit (from 100 hours to up to 300 hours annually) for caregivers of both adults and children

#6: Continue expanded access to Community Benefit services for all eligible members who meet a Nursing Facility Level of Care (NF LOC) but establish annual limits on costs for certain home and community-based services:

- Related Goods & Services – $2,000 annual limit
- Non-medical transportation – $1,000 annual limit for carrier pass & mileage only
- Specialized Therapies – $2,000 annual limit

Benefit and Delivery System Modifications

Proposals

#7: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development services

- Collaborate with the Dept. of Health and Children, Youth & Families Dept. to implement a home visiting pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women

#8: Develop Peer-Delivered, Pre-Tenancy and Tenancy Support Housing Services

- Create a supportive housing service that provides some peer-delivered tenancy support services to participants with complex behavioral health needs

#9: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)

- Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

Benefit and Delivery System Modifications

Proposals

#10: Expand Health Homes (CareLink NM) for individuals with complex behavioral health needs who may require more intensive care coordination services

#11: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

#12: Request waiver authority for enhanced administrative funding to expand availability of Long Acting Reversible Contraception (LARC) for certain providers

- HSD has made access to LARC a high priority over past several years by unbundling LARC reimbursement from other services
- Requesting authority to receive increased administrative funding to expand availability by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

Payment Reform

Proposals

#1: Pay for improved healthcare outcomes for members by requiring better quality and value from providers and increasing the percentage of provider payments that are risk-based (providers responsible for total cost of care)

- Expand requirements for MCOs to shift provider payments from fee-for-service that pays for volume of services to paying more for quality and improved member outcomes

#2: Use Value Based Purchasing to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.
- Include nursing facilities in Value Based Purchasing arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

Payment Reform

Proposals

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network

Member Engagement and Personal Responsibility

Proposals

#1: Advance the Centennial Rewards Program that rewards members for completing healthy activities, such as obtaining preventive screenings

#2: Implement premiums for populations with income that exceeds 100% of the Federal Poverty Level (FPL).

- Applies to three categories of eligibility:
  1) Adults in the Expansion with income greater than 100%
  2) CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
  3) Working Disabled Individuals (WDI) Category (income extends to 250% FPL)
- Revised premium amounts to be lower in initial years (1% of household income) with flexibility to be higher in out-years (up to 2% of income)
- Included a household rate
- Annual maximum of 5% of household income

Proposed Premium Structure

Annual Household Income (Household of 1)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
$12,060 – $18,090	$10	$20	$20	$40
$18,091 – $24,120	$15	$30	$30	$60
$24,121 – $30,150	$20	$40	$40	$80
$30,151 – $36,180	$25	$50	$50	$100

Proposed Premium Policies

- The state seeks to develop premium enforcement policies based on its experience operating a premium-based program known as State Coverage Insurance
- Individuals in a category of eligibility that requires premiums must pay the monthly premium to maintain benefits
- Effective date of coverage is prospective—on the first day of the first month following receipt of the required premium
- Failure to pay the premium will result in a loss of benefits after a 90-day grace period
- Failure to pay will result in a 3 month lock out from the program
- Eligibility will be suspended rather than terminated
- Individuals may begin receiving services after the 3 month lock out upon receipt of required premiums

Member Engagement and Personal Responsibility

Proposals

#3: Require co-payments for certain populations

- Seeking to streamline copayments across populations
- HSD currently has copayment requirements for the Children's Health Insurance Program and for Working Disabled Individuals
- Add copayments for the adult expansion population with income greater than 100% FPL
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the Emergency Department
- The following populations would be exempt from all copayments:
  - Native Americans
  - Intermediate Care Facility for Individuals with Intellectual Disabilities
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the Program of All Inclusive Care for the Elderly
  - Individuals on the Developmental Disabilities and Medically Fragile waivers
  - People receiving hospice care

Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH visits are exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx- exempt • Family Planning Rx- exempt • Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All Categories of Eligibility; certain exemptions will apply			
Non-emergency ER visits	$8/visit All Categories of Eligibility; certain exemptions will apply			

Outpatient office visits – $5/visit	Exempt Services • Community benefits and waiver services • Family planning visits/procedures • Preventive visits (ie, Well Child and immunizations) • Preventive dental • BH outpatient • Maternity, prenatal, postnatal care • Diagnostic lab/x-ray • Treatment related to Diabetes
Inpatient hospital stays – $50/stay	Exempt Services • BH inpatient • NF stays • Labor and delivery; pregnancy-related care
Outpatient surgeries – $50/procedure	Exempt Services • Family planning procedures • Pregnancy-related care
Prescription drugs, medical equipment and supplies – $2/prescription	Exempt Items • Psychotropic drugs • Pregnancy-related drug items, including tobacco cessation and prenatal drug items • Family planning items/contraceptives • Not charged if non-preferred co-pay is applied
Non-preferred prescription drugs – $8/prescription	Exempt Items • Psychotropic drugs (legend drugs that are classified as psychotropic drugs to treat BH conditions) • Pregnancy-related/prenatal drug items • Family planning items/contraceptives • Drugs that are determined by the provider as medically necessary
Non-emergency use of the ER – $8/visit	Exempt Services • Emergency services

Member Engagement and Personal Responsibility

Proposals

#4: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#5: Allow providers to charge small fees for three or more missed appointments

#6: Expand opportunities for Native American members in Centennial Care

- Require MCOs to expand contractual or employment arrangements with Community Health Representatives throughout the state
- Work with Tribal providers to develop capacity to enroll as Long Term Services and Supports providers and/or health home providers
- Seek authority to collaborate with Indian Managed Care Entities (IMCE), including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements

Administration Simplification through Refinements to Eligibility

Proposals

#1: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
- Does not include retroactive status changes processed by the Social Security Administration
- Native Americans and individuals residing in nursing facilities would be exempt from this provision

#2: Implement an automatic NF LOC re-approval for certain members whose condition is not expected to change

Administration Simplification through Refinements to Eligibility

Proposals

#3: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or are eligible to receive subsidies to purchase coverage through the federal Exchange
- Since the implementation of the Affordable Care Act, use of the category dropped from 26,000 individuals to 2,000 (most Parent/Caretaker individuals with increased earnings now covered under the Adult Expansion)

Administration Simplification through Refinements to Eligibility

Proposals

#4: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

#5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

Thank you for attending and participating in the public hearing process

We will now receive and record your feedback related to the information presented

Public Hearings on the 1115 Waiver Application

2. MAC Meeting — Santa Fe, October 16, 2017

MEDICAID ADVISORY COMMITTEE MEETING

Monday, October 16, 2017

AGENDA

Time: 1:00pm-4:00pm **Location**: Garrey Carruthers State Library, 1205 Camino Carlos Rey, Santa Fe 87507

MAC Chairperson: Larry Martinez, Presbyterian Medical Services
Committee Support Persons: Maria Roybal-Varela, HSD/MAD

Committee Members:

Sylvia Barela, Santa Fe Recovery Center
Michael Batte, Public Member
Natalyn Begay, Ohkay Owingeh
Jim Copland, NM Department of Health
Ramona Dillard, Pueblo of Laguna
Jeff Dye, NM Hospital Association
Mary Eden, Presbyterian Healthcare Services
Michael Hely, NM Legislative Council Service
Kristin Hendricks, Pediatric Dentist
Ruth Hoffman, Lutheran Advocacy Ministry NM
Jim Jackson, Disability Rights
Monique Jacobson, NM Children, Youth, and Families Department
Kim Jevertson, Public Member
KyKy Knowles, Aging & Long Term Services Department
Meggin Lorino, NM Association for Home and Hospice Care
Carol Luna-Anderson, The Life Link/Behavioral Health Planning Council
Richard Madden, NM Chapter of the American Academy of Family Physicians
Steve McKernan, UNM Hospital
Carolyn Montoya, UNM College of Nursing
Eileen Goode, NM Primary Care Association
Linda Sechovec, NM Health Care Association
Laurence Shandler, Pediatrician
Dale Tinker, NM Pharmacists Association
Gene Varela, AARP New Mexico

HSD Representatives:

Nancy Smith-Leslie, HSD/MAD Director
Angela Medrano, HSD/MAD Deputy Director
Jason Sanchez, HSD/MAD Deputy Director
Kari Armijo, HSD/MAD Deputy Director
Brent Earnest, HSD Secretary
Michael Nelson, HSD Deputy Secretary

DISCUSSION ITEM	DISCUSSION LEADER	DESCRIPTION	TIME
I. Introductions	Larry Martinez, MAC Chairperson	Introduction of all committee members, staff and guests	**1:00**
II. Approval of Agenda	Larry Martinez, MAC Chairperson	Approval of agenda	**1:05**
III. Approval of Minutes	Larry Martinez, MAC Chairperson	Committee approval of minutes from previous meetings held July 24, 2017	**1:10**
IV. Medicaid Budget Projections	Jason Sanchez, Deputy Director, Medical Assistance Division, Human Services Department	Updated budget projection presentation	**1:15**
V. Director's Update • 1115 Waiver Renewal Presentation	Nancy Smith-Leslie, Director Medical Assistance Division, Human Services Department	Update on Centennial Care program and 1115 Waiver Renewal Presentation	**1:45**
VI. Centennial Care 2.0 Public Hearing	Nancy Smith-Leslie, Director, Medical Assistance Division, Human Services Department	Opportunity for the public to comment on Centennial Care 2.0	**2:15**
VII. Adjournment	Larry Martinez, MAC Chairperson		**4:00**

HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0
1115 Demonstration Waiver Renewal Application – Public Hearings
October 2017
Las Cruces, Las Vegas, Santa Fe, & Albuquerque

Formal Public Hearing

- The Department is accepting comments from the public about the Medicaid program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal 1115 waiver that will be effective on January 1, 2019.
- Comments will be accepted until **5:00 pm MST on Monday, November 6, 2017.**
- We are conducting four public hearings in different regions of the state:

Las Cruces – Thursday, October 12, 2017
Farm and Ranch Museum (1:30 pm – 3:30 pm)

Santa Fe – Monday, October 16, 2017
Medicaid Advisory Committee Meeting
NM State Library (1–4pm)

Las Vegas – Wednesday, October 18, 2017
Highlands University – Student Union Building/Student Center (1:30 pm – 3:30 pm)
Call (toll-free) 1-888-850-4523; participant code: 323 675#

Albuquerque – Monday, October 30, 2017
National Hispanic Cultural Center
Albuquerque, NM (5:30 pm – 7:30 pm)

Formal Public Hearing

- Comments are also being accepted directly at HSD-PublicComment@state.nm.us or by mail:

  Human Services Department
  ATTN: HSD Public Comments
  PO Box 2348
  Santa Fe, NM 87504-2348

  More information about the waiver renewal and public comment process may be found on the Department's website:

  http://www.hsd.state.nm.us/centennial-care-2-0.aspx

  - The Public Hearing process is more formal than the statewide public input sessions conducted by the Department in June 2017 to obtain public feedback about the waiver renewal through release of a concept paper

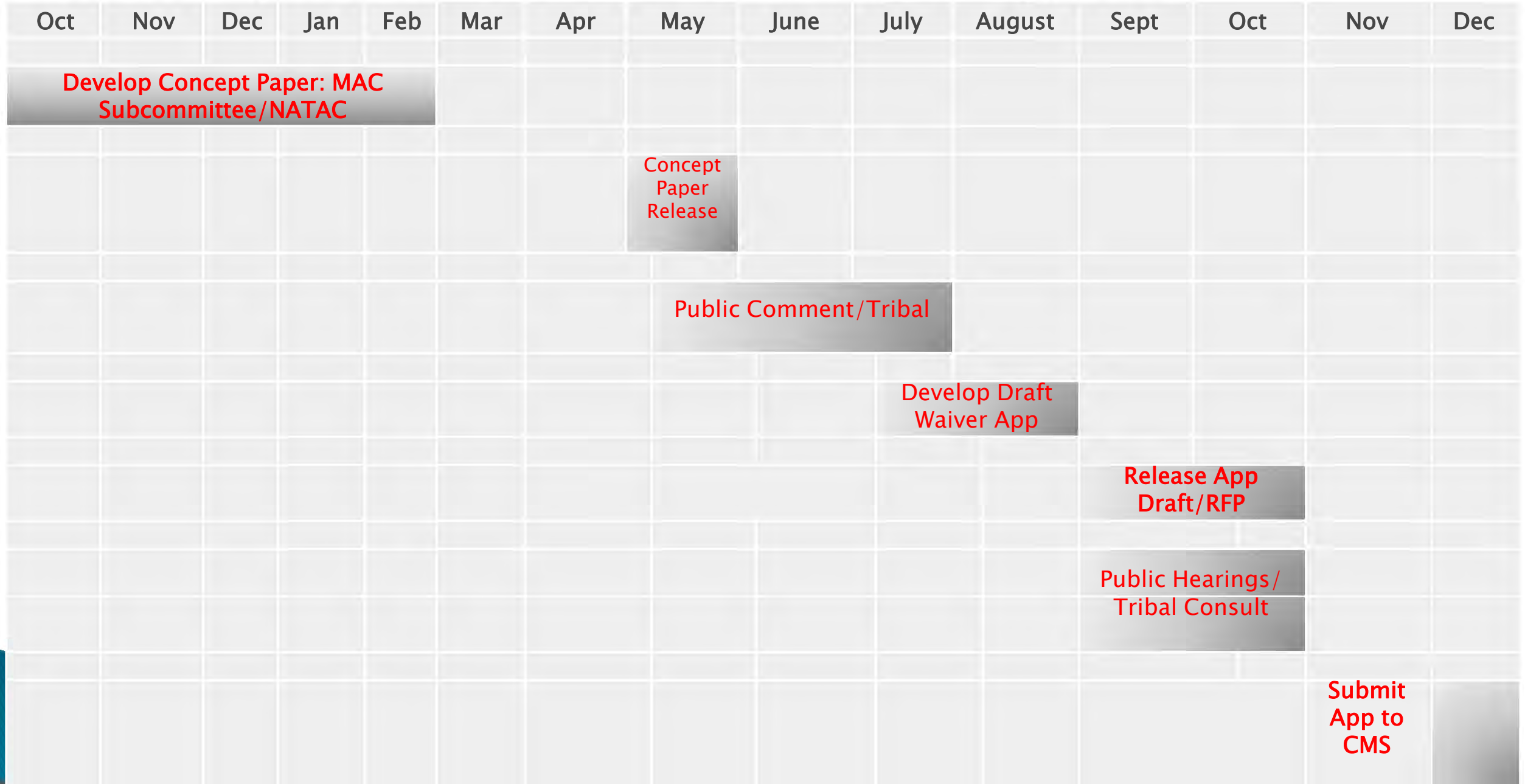
Year-Long Public Input Process

Public Input Opportunities in the Development of Concept Paper (before May 2017)	Public Input Meetings about Draft Concept Paper (after May 2017)	Other Input Opportunities
Medicaid Advisory Subcommittee: October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe) *Public Comment at end of each meeting*	**Statewide Public Input Sessions & Attendees:** **Albuquerque** – June 14, 2017 – 160 attendees **Silver City** – June 19, 2017 – 22 attendees **Farmington** – June 21, 2017 – 41 attendees **Roswell** – June 26, 2017 – 30 attendees	**Written Comments:** May – July 2017 – 21 letters received
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees – Albuquerque **Native American Technical Advisory Committee**: July 10, 2017 – NATAC Membership	**HSD Email Address Established:** Ongoing from October 2016– July 2017 137 emails received
MAC Meetings with Public Input: November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)	**MAC Meetings with Public Input:** July 24, 2017 – (Santa Fe)	**Public Hearings to be held in October 2017:** • Las Cruces • Las Vegas • Santa Fe • Albuquerque

Formal Public Hearing

- We appreciate your attendance today and look forward to your comments after the presentation
- Today's presentation is a summary of the proposed changes to the 1115 waiver that are outlined in the draft waiver renewal application that was released on September 5, 2017 (revised on October 6, 2017) and available to review on the HSD website
- As part of the formal hearing process, we will accept and record all of your comments but will not engage in a discussion about the comments today
- Our response to the comments will be documented in a section of the final 1115 waiver renewal application that is submitted to the Centers for Medicare and Medicaid Services in November 2017

Centennial Care 2.0 Waiver Renewal



CENTENNIALCARE2.0

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Benefit and delivery system modifications
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to eligibility

Person-Centered Initiatives in Centennial Care 2.0

- MCO Care Coordinators focused on High-Need Members
- 300,000 Members Served in Patient -Centered Medical Homes
- Care Coordination at Provider Level
- Home Visiting Pilot for Prenatal, Post Partum and Early Childhood Services
- Full Delegation Model with Value Based Purchasing Arrangements
- Shared Functions Model with Providers and Community Partners
- Health Homes for Members with Complex Behavioral Health Needs
- Use of Community Health Workers, Community Health Reps and Peer Support Specialists
- Supportive Housing Specialists and Justice-Involved Liaisons
- Expanded Access to Home and Community Based Services

Care Coordination

Proposals

#1: Increase care coordination at the provider level

- Full Delegation Model for providers entering into Value-Based Purchasing agreements to manage total cost of members' care and Shared Functions Model for providers and/or community partners conducting more limited care coordination activities

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations

- First Responders, wellness centers, personal care agencies and Project ECHO (Extension for Community Health Outcomes) ;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

Care Coordination

Proposals

#4: Initiate care coordination for justice-involved prior to release from incarceration

- Allowing care coordination activities to be conducted by county/facility prior to release
- Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities

#5: Obtain 100% federal funding for Native American members for services received through Indian Health Services (IHS) and/or Tribal 638 facilities

Benefit and Delivery System Modifications

Proposals

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Individuals with higher needs who are determined to meet the "medically frail" criteria may receive the standard Medicaid benefit package and not the ABP
- Eliminate habilitative services from the ABP, but add a limited vision benefit similar to the standard Medicaid package vision benefit, expanding access for the 250,000 members currently enrolled
- Expand service providers for the non-emergent medical transportation benefit to include ride sharing companies and leverage new technologies such as mobile apps

#2: Waive federal EPSDT rule for 19-20 year olds enrolled in the single adult plan to further streamline the benefit package so that all adults receive the same comprehensive benefits

#3: Develop buy-in premiums for dental and vision services for adults (if necessary due to budgetary shortfall)

Benefit and Delivery System Modifications

Proposals

#4: Allow for one-time, start-up funding for Community Benefit members who transition from the agency-based model to self-directed model -- up to $2,000

#5: Increase caregiver Community Benefit respite limit (from 100 hours to up to 300 hours annually) for caregivers of both adults and children

#6: Continue expanded access to Community Benefit services for all eligible members who meet a Nursing Facility Level of Care (NF LOC) but establish annual limits on costs for certain home and community-based services:

- Related Goods & Services – $2,000 annual limit
- Non-medical transportation – $1,000 annual limit for carrier pass & mileage only
- Specialized Therapies – $2,000 annual limit

Benefit and Delivery System Modifications

Proposals

#7: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development services

- Collaborate with the Dept. of Health and Children, Youth & Families Dept. to implement a home visiting pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women

#8: Develop Peer-Delivered, Pre-Tenancy and Tenancy Supportive Housing Services

- Create a supportive housing service that provides some peer-delivered tenancy support services to participants with complex behavioral health needs

#9: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)

- Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

Benefit and Delivery System Modifications

Proposals

#10: Expand Health Homes (CareLink NM) for individuals with complex behavioral health needs who may require more intensive care coordination services

#11: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

#12: Request waiver authority for enhanced administrative funding to expand availability of Long Acting Reversible Contraception (LARC) for certain providers

- HSD has made access to LARC a high priority over past several years by unbundling LARC reimbursement from other services
- Requesting authority to receive increased administrative funding to expand availability by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

Payment Reform

Proposals

#1: Pay for improved healthcare outcomes for members by requiring better quality and value from providers and increasing the percentage of provider payments that are risk-based (providers responsible for total cost of care)

- Expand requirements for MCOs to shift provider payments from fee-for-service that pays for volume of services to paying more for quality and improved member outcomes

#2: Use Value Based Purchasing to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.
- Include nursing facilities in Value Based Purchasing arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

Payment Reform

Proposals

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network

Member Engagement and Personal Responsibility

Proposals

#1: Advance the Centennial Rewards Program that rewards members for completing healthy activities, such as obtaining preventive screenings

#2: Implement premiums for populations with income that exceeds 100% of the Federal Poverty Level (FPL).

- Applies to three categories of eligibility:
  1) Adults in the Expansion with income greater than 100%
  2) CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
  3) Working Disabled Individuals (WDI) Category (income extends to 250% FPL)
- Revised premium amounts to be lower in initial years (1% of household income) with flexibility to be higher in out-years (up to 2% of income)
- Included a household rate
- Annual maximum of 5% of household income

Proposed Premium Structure

Annual Household Income (Household of 1)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
$12,060 – $18,090	$10	$20	$20	$40
$18,091 – $24,120	$15	$30	$30	$60
$24,121 – $30,150	$20	$40	$40	$80
$30,151 – $36,180	$25	$50	$50	$100

Proposed Premium Policies

- The state seeks to develop premium enforcement policies based on its experience operating a premium-based program known as State Coverage Insurance
- Individuals in a category of eligibility that requires premiums must pay the monthly premium to maintain benefits
- Effective date of coverage is prospective—on the first day of the first month following receipt of the required premium
- Failure to pay the premium will result in a loss of benefits after a 90-day grace period
- Failure to pay will result in a 3 month lock out from the program
- Eligibility will be suspended rather than terminated
- Individuals may begin receiving services after the 3 month lock out upon receipt of required premiums

Member Engagement and Personal Responsibility

Proposals

#3: Require co-payments for certain populations

- Seeking to streamline copayments across populations
- HSD currently has copayment requirements for the Children's Health Insurance Program and for Working Disabled Individuals
- Add copayments for the adult expansion population with income greater than 100% FPL
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the Emergency Department
- The following populations would be exempt from all copayments:
  - Native Americans
  - Intermediate Care Facility for Individuals with Intellectual Disabilities
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the Program of All Inclusive Care for the Elderly
  - Individuals on the Developmental Disabilities and Medically Fragile waivers
  - People receiving hospice care

Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH visits are exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx- exempt • Family Planning Rx- exempt • Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All Categories of Eligibility; certain exemptions will apply			
Non-emergency ER visits	$8/visit All Categories of Eligibility; certain exemptions will apply			

Outpatient office visits – $5/visit	Exempt Services • Community benefits and waiver services • Family planning visits/procedures • Preventive visits (ie, Well Child and immunizations) • Preventive dental • BH outpatient • Maternity, prenatal, postnatal care • Diagnostic lab/x-ray • Treatment related to Diabetes
Inpatient hospital stays – $50/stay	Exempt Services • BH inpatient • NF stays • Labor and delivery; pregnancy-related care
Outpatient surgeries – $50/procedure	Exempt Services • Family planning procedures • Pregnancy-related care
Prescription drugs, medical equipment and supplies – $2/prescription	Exempt Items • Psychotropic drugs • Pregnancy-related drug items, including tobacco cessation and prenatal drug items • Family planning items/contraceptives • Not charged if non-preferred co-pay is applied
Non-preferred prescription drugs – $8/prescription	Exempt Items • Psychotropic drugs (legend drugs that are classified as psychotropic drugs to treat BH conditions) • Pregnancy-related/prenatal drug items • Family planning items/contraceptives • Drugs that are determined by the provider as medically necessary
Non-emergency use of the ER – $8/visit	Exempt Services • Emergency services

Member Engagement and Personal Responsibility

Proposals

#4: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#5: Allow providers to charge small fees for three or more missed appointments

#6: Expand opportunities for Native American members in Centennial Care

- Require MCOs to expand contractual or employment arrangements with Community Health Representatives throughout the state
- Work with Tribal providers to develop capacity to enroll as Long Term Services and Supports providers and/or health home providers
- Seek authority to collaborate with Indian Managed Care Entities (IMCE), including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements

Administration Simplification through Refinements to Eligibility

Proposals

#1: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
- Does not include retroactive status changes processed by the Social Security Administration
- Native Americans and individuals residing in nursing facilities would be exempt from this provision

#2: Implement an automatic NF LOC re-approval for certain members whose condition is not expected to change

Administration Simplification through Refinements to Eligibility

Proposals

#3: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caretakers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or are eligible to receive subsidies to purchase coverage through the federal Exchange
- Since the implementation of the Affordable Care Act, use of the category dropped from 26,000 individuals to 2,000 (most Parent/Caretaker individuals with increased earnings now covered under the Adult Expansion)

Administration Simplification through Refinements to Eligibility

Proposals

#4: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

#5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

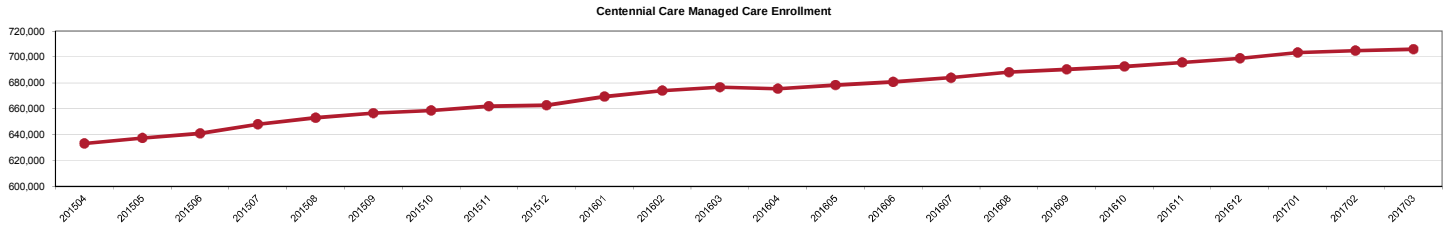
Thank you for attending and participating in the public hearing process

We will now receive and record your feedback related to the information presented

State of New Mexico - All MCOs
All Centennial Care Populations
Centennial Care Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Centennial Care Monthly Enrollment



2. Total Centennial Care Dollars and Member Months by Program

Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	4,763,223	4,933,747	4%
Long Term Services and Supports	573,218	593,078	3%
Other Adult Group	2,535,904	2,771,677	9%
Total Member Months	**7,872,345**	**8,298,502**	**5%**

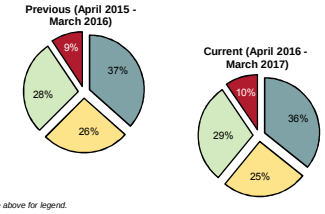
Aggregate Medical Costs by Program

Programs	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,245,916,497	$ 1,268,160,787	2%
Long Term Services and Supports	$ 883,544,015	$ 892,892,521	1%
Other Adult Group Physical Health	$ 955,821,072	$ 1,047,329,283	10%
Behavioral Health - All Members	$ 319,652,064	$ 338,134,929	6%
Total Medical Costs	**$ 3,404,933,649**	**$ 3,546,517,520**	**4%**
Aggregate Non-Medical Costs			
Admin, care coordination, Centennial Rewards	$ 371,292,953	$ 352,538,974	-5%
NMMIP Assessment	$ 53,676,377	$ 61,941,886	15%
Premium Tax - Net of NIMMP Offset	$ 133,873,146	$ 142,126,353	6%
Total Non-Medical Costs	**$ 558,842,476**	**$ 556,607,214**	**0%**
Estimated Total Centennial Care Costs	**$ 3,963,776,125**	**$ 4,103,124,734**	**4%**

Per Capita Medical Costs by Program (PMPM)

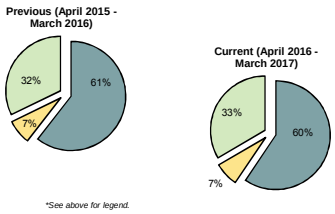
Programs	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 261.57	$ 257.04	-2%
Long Term Services and Supports	$ 1,541.38	$ 1,505.52	-2%
Other Adult Group Physical Health	$ 376.92	$ 377.87	0%
Behavioral Health - All Members	$ 40.60	$ 40.75	0%
Total Medical Costs	**$ 432.52**	**$ 427.37**	**-1%**
Aggregate Non-Medical Costs			
Admin, care coordination, Centennial Rewards	$ 47.16	$ 42.48	-10%
NMMIP Assessment	$ 6.82	$ 7.46	9%
Premium Tax - Net of NIMMP Offset	$ 17.01	$ 17.13	1%
Total Non-Medical Costs	**$ 70.99**	**$ 67.07**	**-6%**
Estimated Total Centennial Care Costs	**$ 503.51**	**$ 494.44**	**-2%**

Centennial Care Medical



*See above for legend.

Centennial Care Member Months



*See above for legend.

3. Total Program Medical/Pharmacy Dollars

Aggregate Costs by Service Categories

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 3,051,771,754	$ 3,142,469,362	3%
Pharmacy	$ 353,161,894	$ 404,048,158	14%
Total	**$ 3,404,933,649**	**$ 3,546,517,520**	**4%**

Per Capita Medical Costs by Program (PMPM)

	Previous (12 mon)	Current (12 mon)	% Change
	$ 387.66	$ 378.68	-2%
	$ 44.86	$ 48.69	9%
	$ 432.52	**$ 427.37**	**-1%**

Aggregate Costs by Service Categories

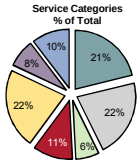
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 721,794,228	$ 746,641,122	3%
Acute Outp/Phy	$ 733,096,102	$ 753,649,351	3%
Nursing Facility	$ 218,561,107	$ 213,948,031	-2%
Community Benefit/PCO	$ 373,609,690	$ 382,695,362	2%
Other Services	$ 745,368,264	$ 771,981,507	4%
Behavioral Health	$ 259,342,364	$ 273,553,989	5%
Pharmacy (All)	$ 353,161,894	$ 404,048,158	14%
Total Costs	**$ 3,404,933,649**	**$ 3,546,517,520**	**4%**

Per Capita Medical Costs by Program (PMPM)

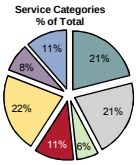
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 91.69	$ 89.97	-2%
Acute Outp/Phy	$ 93.12	$ 90.82	-2%
Nursing Facility	$ 27.76	$ 25.78	-7%
Community Benefit/PCO	$ 47.46	$ 46.12	-3%
Other Services	$ 94.68	$ 93.03	-2%
Behavioral Health	$ 32.94	$ 32.96	0%
Pharmacy (All)	$ 44.86	$ 48.69	9%
Total Costs	**$ 432.52**	**$ 427.37**	**-1%**

** Per capita not normalized for case mix changes between periods.*

Previous (12 mon) service distribution



Current (12 mon) service distribution



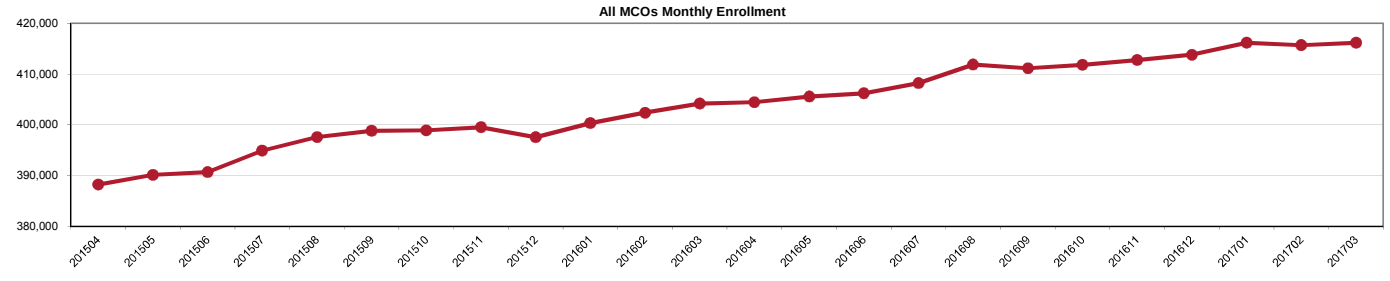
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. Other Adult Group continues to see enrollment growth. Dollar comparisons between previous and current periods reflect this significant change in enrollment.
3. Other Services includes, but is not limited to, the following services emergency department utilization, emergent transportation, non-emergent transportation, vision, and dental.

State of New Mexico - All MCOs
Total Population (TANF, Aged, Blind, Disabled, CYFD, Pregnant Women)
Physical Health Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

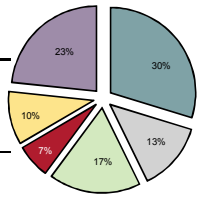
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,128,087,718	$ 1,139,903,833	1%
Pharmacy	$ 117,828,779	$ 128,256,954	9%
Total	**$ 1,245,916,497**	**$ 1,268,160,787**	**2%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 378,469,103	$ 377,069,157	0%
Outpatient (OP)	$ 164,563,298	$ 165,188,345	0%
Physician (PH)	$ 220,038,234	$ 220,034,572	0%
Emergency Department (ED)	$ 82,340,934	$ 81,687,303	-1%
Pharmacy (RX)	$ 117,828,779	$ 128,256,954	9%
Other (OTH)	$ 282,676,149	$ 295,924,457	5%
Total Population Costs	**$ 1,245,916,497**	**$ 1,268,160,787**	**2%**
Per Capita Cost (PMPM)	**$ 261.57**	**$ 257.04**	**-2%**
Total Member Months	**4,763,223**	**4,933,747**	**4%**

Service Categories % of Cost

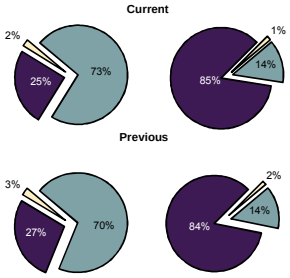


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 82,491,877	$ 93,225,043	13%
Generic	$ 32,376,263	$ 32,060,824	-1%
Other Rx	$ 2,960,640	$ 2,971,087	0%
Total	**$ 117,828,779**	**$ 128,256,954**	**9%**

% of Rx Spend **% of Scripts**



** "Other Rx" represents supplies such as diabetic test strips.*

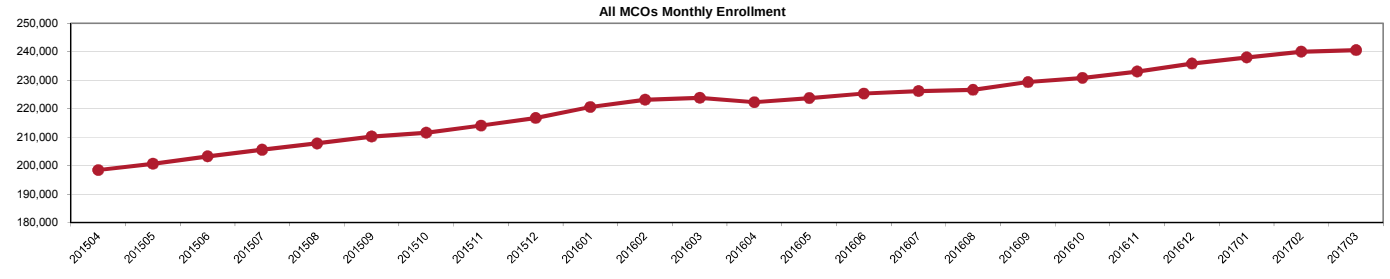
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
Total Population
Other Adult Group Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



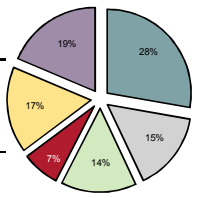
2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 811,939,299	$ 873,364,266	8%
Pharmacy	$ 143,881,774	$ 173,965,018	21%
Total	**$ 955,821,072**	**$ 1,047,329,283**	**10%**

Aggregate Costs by Service Categories

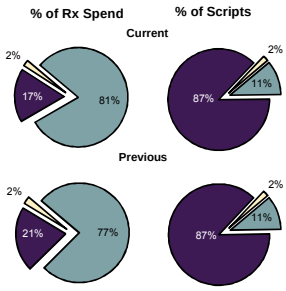
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 262,634,396	$ 290,667,060	11%
Outpatient (OP)	$ 151,507,284	$ 159,666,364	5%
Physician (PH)	$ 144,534,402	$ 152,337,821	5%
Emergency Department (ED)	$ 73,932,072	$ 75,831,483	3%
Pharmacy (RX)	$ 143,881,774	$ 173,965,018	21%
Other (OTH)	$ 179,331,144	$ 194,861,538	9%
Total Population Costs	**$ 955,821,072**	**$ 1,047,329,283**	**10%**
Per Capita Cost (PMPM)	**$ 376.92**	**$ 377.87**	**0%**
Total Member Months	**2,535,904**	**2,771,677**	**9%**



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 110,020,422	$ 140,110,160	27%
Generic	$ 30,362,722	$ 30,320,490	0%
Other Rx	$ 3,498,630	$ 3,534,368	1%
Total	**$ 143,881,774**	**$ 173,965,018**	**21%**



** "Other Rx" represents supplies such as diabetic strips.*

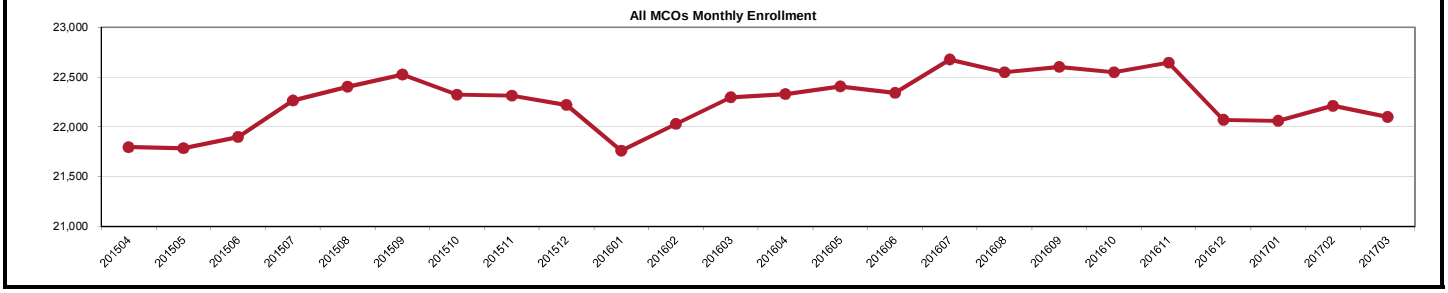
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Healthy Dual Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

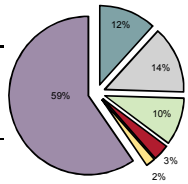
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 64,031,626	$ 56,667,189	-12%
Pharmacy	$ 1,224,592	$ 1,118,502	-9%
Total	**$ 65,256,218**	**$ 57,785,690**	**-11%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 7,553,850	$ 6,771,490	-10%
Outpatient (OP)	$ 8,256,393	$ 7,945,896	-4%
Physician (PH)	$ 5,718,171	$ 5,612,554	-2%
Emergency Department (ED)	$ 2,056,886	$ 1,920,612	-7%
Pharmacy (RX)	$ 1,224,592	$ 1,118,502	-9%
Other (OTH)	$ 40,446,326	$ 34,416,637	-15%
Total Population Costs	**$ 65,256,218**	**$ 57,785,690**	**-11%**
Per Capita Cost (PMPM)	**$ 245.68**	**$ 215.18**	**-12%**
Total Member Months	**265,620**	**268,544**	**1%**

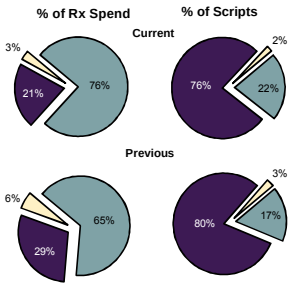
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 797,748	$ 845,724	6%
Generic	$ 358,379	$ 238,340	-33%
Other Rx	$ 68,465	$ 34,437	-50%
Total	**$ 1,224,592**	**$ 1,118,502**	**-9%**



** "Other Rx" represents supplies such as diabetic strips.*

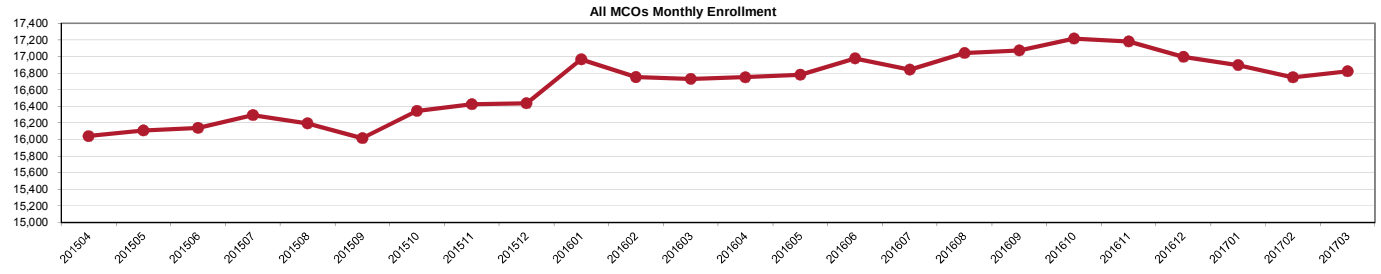
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Nursing Facility Level of Care Dual Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

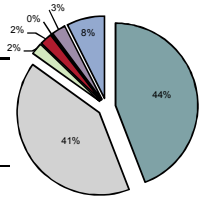
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 466,740,955	$ 466,121,896	0%
Pharmacy	$ 941,784	$ 870,157	-8%
Total	**$ 467,682,739**	**$ 466,992,053**	**0%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 205,461,826	$ 206,140,277	0%
Nursing Facility (NF)	$ 192,424,049	$ 190,428,427	-1%
Inpatient (IP)	$ 13,455,802	$ 10,632,636	-21%
Outpatient (OP)	$ 10,527,163	$ 11,254,145	7%
Pharmacy (RX)	$ 941,784	$ 870,157	-8%
HCBS	$ 11,120,743	$ 12,887,497	16%
Other (OTH)	$ 33,751,372	$ 34,778,914	3%
Total Population Costs	**$ 467,682,739**	**$ 466,992,053**	**0%**
Per Capita Cost (PMPM)	**$ 2,380.62**	**$ 2,296.93**	**-4%**
Total Member Months	**196,454**	**203,311**	**3%**

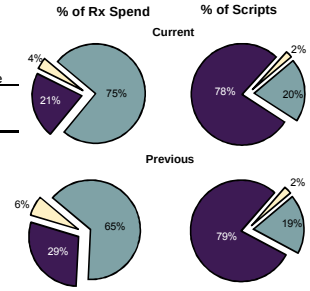
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 609,003	$ 651,022	7%
Generic	$ 271,943	$ 185,957	-32%
Other Rx	$ 60,838	$ 33,178	-45%
Total	**$ 941,784**	**$ 870,157**	**-8%**



** "Other Rx" represents supplies such as diabetic test strips.*

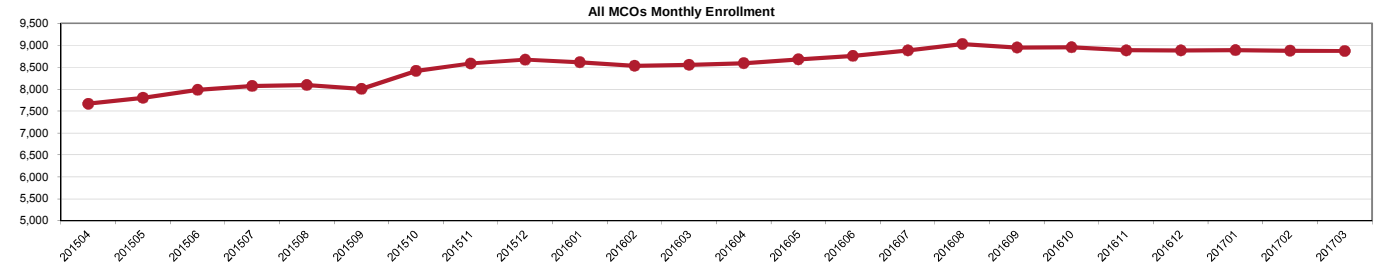
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Nursing Facility Level of Care Medicaid Only Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

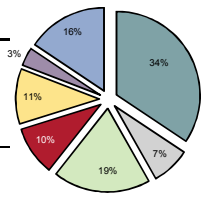
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 274,184,393	$ 279,778,435	2%
Pharmacy	$ 27,858,396	$ 33,445,128	20%
Total	**$ 302,042,789**	**$ 313,223,563**	**4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 107,374,411	$ 107,593,552	0%
Nursing Facility (NF)	$ 25,853,284	$ 23,309,900	-10%
Inpatient (IP)	$ 57,475,310	$ 59,057,568	3%
Outpatient (OP)	$ 26,751,753	$ 29,862,794	12%
Pharmacy (RX)	$ 27,858,396	$ 33,445,128	20%
HCBS	$ 8,926,436	$ 11,056,184	24%
Other (OTH)	$ 47,803,200	$ 48,898,437	2%
Total Population Costs	**$ 302,042,789**	**$ 313,223,563**	**4%**
Per Capita Cost (PMPM)	**$ 3,051.25**	**$ 2,948.29**	**-3%**
Total Member Months	**98,990**	**106,239**	**7%**

Service Categories % of Cost

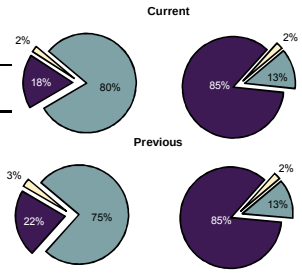


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 21,031,894	$ 26,899,140	28%
Generic	$ 6,065,195	$ 5,871,533	-3%
Other Rx	$ 761,307	$ 674,455	-11%
Total	**$ 27,858,396**	**$ 33,445,128**	**20%**

% of Rx Spend **% of Scripts**



** "Other Rx" represents supplies such as diabetic test strips.*

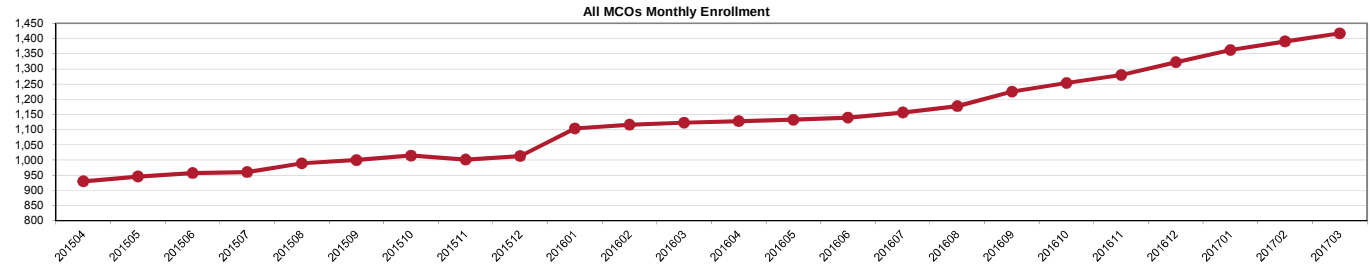
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
LTSS - Self Directed Population
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

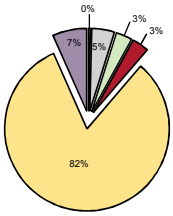
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 47,445,400	$ 53,079,754	12%
Pharmacy	$ 1,116,870	$ 1,811,461	62%
Total	**$ 48,562,269**	**$ 54,891,215**	**13%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 283,774	$ 209,704	-26%
Inpatient (IP)	$ 2,205,768	$ 2,443,210	11%
Outpatient (OP)	$ 1,199,403	$ 1,746,861	46%
Pharmacy (RX)	$ 1,116,870	$ 1,811,461	62%
HCBS	$ 40,726,274	$ 45,017,852	11%
Other (OTH)	$ 3,030,181	$ 3,662,126	21%
Total Population Costs	**$ 48,562,269**	**$ 54,891,215**	**13%**
Per Capita Cost (PMPM)	**$ 3,995.58**	**$ 3,663.32**	**-8%**
Total Member Months	**12,154**	**14,984**	**23%**

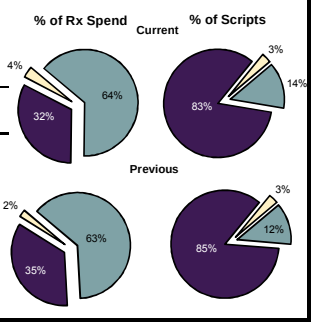
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 703,872	$ 1,161,843	65%
Generic	$ 388,472	$ 587,285	51%
Other Rx	$ 24,525	$ 62,332	154%
Total	**$ 1,116,870**	**$ 1,811,461**	**62%**



** "Other Rx" represents supplies such as diabetic test strips.*

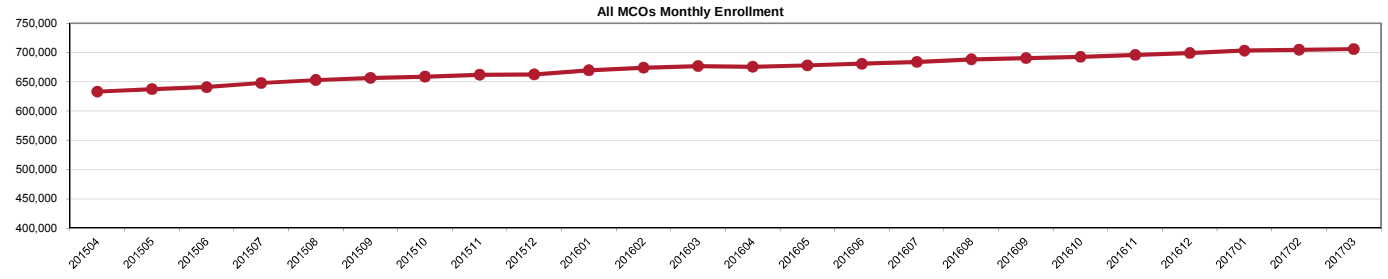
4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

State of New Mexico - All MCOs
Total Population (Physical Health, Long Term Services and Support, and Other Adult Group)
Behavioral Health Utilization and Cost Review

Reported Encounters for Enrolled Members as of: June 30, 2017
Previous Period: April 1, 2015 to March 30, 2016
Current Period: April 1, 2016 to March 30, 2017

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

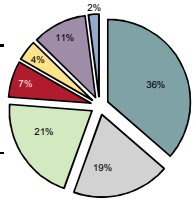
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 259,342,364	$ 273,553,989	5%
Pharmacy	$ 60,309,700	$ 64,580,939	7%
Total	**$ 319,652,064**	**$ 338,134,929**	**6%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 106,453,969	$ 123,111,055	16%
Pharmacy (RX)	$ 60,309,700	$ 64,580,939	7%
Res. Treatment Ctr. (RTC)	$ 74,819,449	$ 69,954,963	-7%
Behavioral Health Prov (BHP)	$ 23,436,133	$ 23,912,955	2%
Core Service Agencies (CSA)	$ 14,987,778	$ 13,696,896	-9%
Inpatient (IP)	$ 30,129,389	$ 35,922,599	19%
Other (OTH)	$ 9,515,648	$ 6,955,523	-27%
Total Population Costs	**$ 319,652,064**	**$ 338,134,929**	**6%**
Per Capita Cost (PMPM)	**$ 40.60**	**$ 40.75**	**0%**
Total Member Months	**7,872,345**	**8,298,502**	**5%**

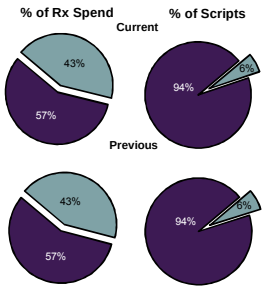
Services Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 25,918,799	$ 27,591,506	6%
Generic	$ 34,390,901	$ 36,989,433	8%
Total	**$ 60,309,700**	**$ 64,580,939**	**7%**



4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 17 Lag Model with Centennial Care and Medicaid Expansion with Actual Data Thru June 2017 ($000s)

No.	Description	FY 16 Title XIX Projection	FY 17 % Completion	Title XIX Actual YTD	Actual Paid Lump Sum/ Others YTD	Projected Lump Sum	Others	FY 17 Title XIX Projection	% Change from FY 16	CHIP Actual Paid YTD	CHIP Projection	FY 17 TOTAL Medicaid Projection	Mar 2016 Data Projection	Change from Previous	No.
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	Inpatient Hospital	88,428	78.93%	60,609	-	-	-	76,722	-13.24%	352	513	77,236	76,549	687	1
2	DSH	31,516	75.01%	23,566	23,566	31,417	-	31,417	-0.32%	-	-	31,417	31,417	-	2
3	GME	10,015	100.00%	18,500	18,500	18,500	-	18,500	84.72%	-	-	18,500	18,500	-	3
4	IME	72,799	75.00%	64,219	64,219	85,625	-	85,625	17.62%	-	-	85,625	83,630	1,995	4
5	Safety Net Care	68,856	75.00%	51,667	51,667	68,889	-	68,889	0.05%	-	-	68,889	68,889	-	5
6	HQII Pool	2,824	100.00%	7,359	7,359	7,359	-	7,359	160.55%	-	-	7,359	5,765	1,594	6
7	Physician Services	38,996	87.21%	34,354	3,902	5,525	-	39,407	1.06%	427	476	39,883	40,681	(798)	7
8	IHS Hospital	116,302	87.26%	109,258	-	-	-	125,213	7.66%	-	-	125,213	125,425	(212)	8
9	ICF-IID	26,988	92.38%	25,571	-	-	-	27,680	2.56%	-	-	27,680	28,427	(747)	9
10	Clinic Services	46,264	30.54%	14,185	-	-	-	49,837	7.72%	1,581	1,787	51,624	52,277	(653)	10
11	Federal Qualified Health Centers	3,882	78.66%	3,630	-	-	-	4,615	18.89%	77	98	4,713	4,671	42	11
12	Other Practitioners	28,854	90.92%	27,676	-	-	-	30,439	5.49%	956	1,052	31,490	31,253	237	12
13	Outpatient Hospital	41,974	89.56%	36,966	-	-	-	41,285	-1.64%	487	535	41,820	42,493	(673)	13
14	PACE	12,116	99.85%	11,912	-	-	-	11,930	-1.53%	-	-	11,930	12,278	(348)	14
15	Others	39,438	93.23%	45,828	(2,245)	(4,365)	2,219	49,187	24.72%	1,523	1,600	50,787	53,489	(2,702)	15
16	BH FFS	34,370	87.56%	32,901	-	-	-	37,570	9.31%	665	764	38,334	37,878	456	16
17	**Subtotal**	**663,622**	**80.60%**	**568,202**	**166,968**	**212,950**	**2,219**	**705,675**	**6.34%**	**6,068**	**6,825**	**712,500**	**713,623**	**(1,123)**	17
18	Traditional DD and MF Waiver (DOH)	280,516	61.05%	170,830	663	149	514	279,821	-0.25%	-	-	279,821	278,647	1,174	18
19	Mi Via Waivers (DOH)	69,617	96.51%	83,966	3,982	59	3,923	87,001	24.97%	-	-	87,001	86,138	863	19
20	**Subtotal**	**350,133**	**69.46%**	**254,796**	**4,646**	**208**	**4,437**	**366,822**	**4.77%**	**-**	**-**	**366,822**	**364,785**	**2,037**	20
21	Centennial Care-Physical Health	1,420,772	99.03%	1,406,708	-	30,818	(18,370)	1,420,914	0.01%	81,950	82,290	1,503,203	1,509,876	(6,673)	21
22	Centennial Care-LTSS	1,069,101	98.42%	1,049,940	-	12,195	-	1,066,765	-0.22%	1,112	1,112	1,067,876	1,073,805	(5,928)	22
23	Centennial Care-Behavioral Health	318,520	98.95%	322,619	-	3,044	-	326,021	2.36%	18,959	19,191	345,212	344,498	714	23
24	**Subtotal**	**2,808,393**	**98.80%**	**2,779,267**	**-**	**46,057**	**(18,370)**	**2,813,699**	**0.19%**	**102,020**	**102,592**	**2,916,292**	**2,928,179**	**(11,887)**	24
25	Medicare Part A	1,300	100.00%	1,710	-	-	-	1,710	31.53%	-	-	1,710	1,774	(64)	25
26	Medicare Part B	109,909	100.00%	131,716	-	-	-	131,716	19.84%	-	-	131,716	131,722	(6)	26
27	Medicare Part D	36,702	100.00%	43,958	-	-	-	43,958	19.77%	-	-	43,958	43,915	43	27
28	**Subtotal**	**147,911**	**100.00%**	**177,384**	**-**	**-**	**-**	**177,384**	**71.14%**	**-**	**-**	**177,384**	**177,411**	**(27)**	28
29	Utilization	4,326	50.25%	2,512	2,512	-	5,000	5,000	15.57%	-	-	5,000	5,000	-	29
30	HIT	9,100	100.00%	23,725	23,725	23,725	-	23,725	160.70%	-	-	23,725	21,933	1,791	30
31	Contracts	-	0.00%	-	-	1,970	-	1,970	--	-	-	1,970	1,970	-	31
32	**Subtotal**	**13,427**	**85.48%**	**26,237**	**26,237**	**25,695**	**5,000**	**30,695**	**128.61%**	**-**	**-**	**30,695**	**28,904**	**1,791**	32
33	Rate Increase for Primary Care Services	12,732	100.00%	233	233	233	-	233	-98.17%	-	-	233	233	-	33
34	Health Insurance Providers Fee	90,219	--	-	-	-	-	-	-100.00%	-	-	-	-	-	34
35	**Subtotal**	**102,951**	**100.00%**	**233**	**233**	**233**	**-**	**233**	**-99.77%**	**-**	**-**	**233**	**233**	**-**	35
36	Medicaid Expansion - Physical Health	1,027,441	110.02%	1,318,424	-	22,318	(144,920)	1,198,385	16.64%	-	-	1,198,385	1,202,273	(3,888)	36
37	Medicaid Expansion - Behavioral Health	101,098	98.03%	110,431	-	2,005	-	112,650	11.43%	-	-	112,650	112,980	(330)	37
38	**Subtotal**	**1,128,539**	**108.99%**	**1,428,855**	**-**	**24,323**	**(144,920)**	**1,311,035**	**16.17%**	**-**	**-**	**1,311,035**	**1,315,253**	**(4,218)**	38
39															39
40	**Prior Years Charged to Current Year**	**113,467**	**na**	**-**	**-**	**-**	**43,502**	**43,502**	**-61.66%**	**-**	**-**	**43,502**	**42,012**	**1,490**	40
41	**Current Year Charged to Future Year**	**(43,502)**	**na**	**-**	**-**	**-**		**-**	**-100.00%**	**-**	**-**	**-**	**-**	**-**	41
42															42
43	**Grand Total**	**5,284,942**	**96.12%**	**5,234,973**	**198,083**	**309,466**	**(108,132)**	**5,449,045**	**3.11%**	**108,088**	**109,417**	**5,558,463**	**5,570,399**	**(11,936)**	43

Notes:

1. (Line 10)Clinic Services consists primarily of Medicaid School-Based Services (MSBS) with small amounts also going to clinics providing a variety of services.
2. (Line 15) Others contains: Transportation, Lab/X-Ray, Prosthetics, RHC, Hospice, Home Health, Medical Supplies, Prescribed Drugs, Dental Services, EPSDT, Nursing Facility, Maintenance, Family Planning.
3. (Lines 21-23, 37-38, Columns E and K) Actual YTD payments are from the MCO database, instead of Share Accounting Detailed File (SADF), because SADF doesn't show payments by programs.
4. (Lines 21, 37, Column H) Others under the managed care projection lines reflect retroactive eligibility reconciliation and Medicaid Expansion risk corridor for CY16, Hepatitis-C reconciliation.
5. (Line 34) Health Home budget has been built into the MCO rates starting from April 2016 for Behavior Health program for both Medicaid Base and Expansion population, so the expenditures on Health Home is not shown in this line.
6. (Line 35) Health Insurance Providers Fee is suspended for the 2016 data year, but will be resumed for data year 2017 and forward.

8/2/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT — **FY 17 Lag Model with Centennial Care and Medicaid Expansion with Actual Data Thru June 2017 ($000s)**
Medical Assistance Division

No.	Description	FY 17 Projection	Federal Medicaid Expenditure Type and Federal Financial Participation Rates: HIT, IHS, Refugees, Medicaid Expansion (100% FFP) [1]	Medicaid Expansion (95% FFP) [1]	Health Homes, Sterilization & Family Planning Services (90% FFP) [2]	Breast & Cervical Cancer (EFMAP) [3]	Title XXI CHIP (EFMAP) [4]	Utilization Review (75% FFP) [5]	Title XIX Medicaid (FMAP) [6]	Admin and Fees (50% FFP) [7]	Non-Federal Financial Participation Expenses (0% FFP) [8]	Federal Share	% of Composite Federal Share
A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Inpatient Hospital	77,236	18,625	15,491	169	76	513	-	42,361	-	-	64,156	83.06%
2	DSH	31,417	-	-	-	-	-	-	31,417	-	-	22,347	71.13%
3	GME	18,500	-	-	-	-	-	-	18,500	-	-	13,159	71.13%
4	IME	85,625	-	-	-	-	-	-	85,625	-	-	60,905	71.13%
5	Safety Net Care	68,889	-	-	-	-	-	-	68,889	-	-	49,001	71.13%
6	HQII Pool	7,359	-	-	-	-	-	-	7,359	-	-	5,235	71.13%
7	Physician Services	39,883	5,632	5,643	-	17	476	-	28,028	-	87	31,388	78.70%
8	IHS Hospital	125,213	123,973	-	-	-	-	-	1,240	-	-	124,855	99.71%
9	ICF-IID	27,680	71	162	-	-	-	-	27,447	-	-	19,705	71.19%
10	Clinic Services	51,624	111	190	-	-	1,787	-	49,535	-	-	37,302	72.26%
11	Federal Qualified Health Centers	4,713	393	801	(1)	0	98	-	3,422	-	-	3,681	78.10%
12	Other Practitioners	31,490	353	520	-	0	1,052	-	29,566	-	-	22,892	72.69%
13	Outpatient Hospital	41,820	7,126	6,550	-	24	535	-	27,585	-	-	33,488	80.08%
14	PACE	11,930	-	-	-	-	-	-	11,930	-	-	8,462	70.93%
15	Others	50,787	9,735	7,724	1,889	99	1,667	-	29,657	-	16	40,681	80.10%
16	BH FFS	38,334	16,578	2,075	0	3	764	-	18,903	-	10	32,740	85.41%
17	**Subtotal**	**712,500**	**182,598**	**39,156**	**2,057**	**220**	**6,891**	**-**	**481,465**	**-**	**113**	**569,996**	**80.00%**
18	Traditional DD and MF Waiver (DOH)	279,821	-	-	-	-	-	514	278,720	587	-	198,515	70.94%
19	Mi Via Waivers (DOH)	87,001	-	-	-	-	-	1,926	82,991	2,084	-	61,427	70.60%
20	**Subtotal**	**366,822**	**-**	**-**	**-**	**-**	**-**	**2,440**	**361,712**	**2,670**	**-**	**259,941**	**70.86%**
21	Centennial Care-Physical Health	1,503,203	30,613	-	13,696	1,193	82,290	-	1,375,413	-	-	1,101,938	73.31%
22	Centennial Care-LTSS	1,067,876	12,195	-	-	720	1,112	-	1,053,850	-	-	761,483	71.31%
23	Centennial Care-Behavioral Health	345,212	3,044	-	1,529	121	19,191	-	321,327	-	-	251,633	72.89%
24	**Subtotal**	**2,916,292**	**45,851**	**-**	**15,224**	**2,034**	**102,592**	**-**	**2,750,590**	**-**	**-**	**2,115,054**	**72.53%**
25	Medicare Part A	1,710	-	-	-	-	-	-	1,710	-	-	1,216	71.13%
26	Medicare Part B	131,716	5,379	-	-	-	-	-	110,982	-	15,355	84,125	63.87%
27	Medicare Part D	43,958	-	-	-	-	-	-	-	-	43,958	-	0.00%
28	**Subtotal**	**177,384**	**5,379**	**-**	**-**	**-**	**-**	**-**	**112,691**	**-**	**59,313**	**85,341**	**48.11%**
29	Utilization	5,000	-	-	-	-	-	5,000	-	-	-	3,750	75.00%
30	HIT	23,725	23,725	-	-	-	-	-	-	-	-	23,725	100.00%
31	Contracts	1,970	-	-	-	-	-	-	376	1,595	-	1,065	54.03%
32	**Subtotal**	**30,695**	**23,725**	**-**	**-**	**-**	**-**	**5,000**	**376**	**1,595**	**-**	**28,539**	**92.98%**
33	Rate Increase for Primary Care Services	233	31	-	-	-	-	-	201	-	-	174	75.04%
34	**Subtotal**	**233**	**31**	**-**	**-**	**-**	**-**	**-**	**201**	**-**	**-**	**174**	**75.04%**
35	Medicaid Expansion - Physical Health	1,198,385	524,531	673,854	-	-	-	-	-	-	-	1,164,693	97.19%
36	Medicaid Expansion - Behavioral Health	112,650	56,208	56,442	-	-	-	-	-	-	-	109,828	97.49%
37	**Subtotal**	**1,311,035**	**580,739**	**730,296**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,274,521**	**97.21%**
38													
39	**Prior Years Charged to Current Year**	**43,502**	**-**	**-**	**-**	**-**	**-**	**-**	**43,502**	**-**	**-**	**30,612**	**70.37%**
40	**Current Year Charged to Future Year**												
41													
42	**Grand Total**	**5,558,463**	**838,323**	**769,452**	**17,282**	**2,254**	**109,484**	**7,440**	**3,750,537**	**4,265**	**59,427**	**4,364,179**	**78.51%**

State Share Revenues:	**FY 17 Op. Budget**	**Billed Amount**	**Collection YTD**	**HSD Projection**	**Change from Previous**
Department of Health (Line 18 & 19) [9,16]	103,360	90,403	90,285	105,103	(128)
Department of Health Additional Need /(Surplus)			-	463	229
Department of Health for Early Intervention	8,062	7,177	6,531	8,292	
Department of Health for FQHCs	462	462	462	560	
Department of Health for EC	1			1	
Children, Youth and Families	-			-	
County Supported Medicaid Fund	33,533	25,081	23,454	31,835	2,090
Tobacco Settlement Revenue, Base	27,319		27,319	27,319	
Tobacco Settlement Revenue	-			-	
UNM IGT	43,007	40,600	35,900	40,600	
Total Operating Transfers In	**215,744**	**163,723**	**183,952**	**214,173**	**2,191**
Physician UPL UNM	1,993	1,160	1,160	1,605	
Safety Net Care [11]	-			-	
County Supported Hospital Payments [11]	26,618	23,259	23,210	23,259	
Additional County Supported Hospital Payments [12]	-			-	
Miner's Colfax [14]	771				(1,036)
County Contribution for Incarcerated Population [15]	-				
Drug Rebates	20,434		28,413	28,413	(489)
Fraud	872		322	375	
Income Diversion Trust	486		639	800	
Buy-In Recovery	215		15	20	
Cost Settlement	500		174	250	
Estate Recovery	9		9	9	
Misc. Revenue			336	336	236
HMS-RAC-TPL/Subrogation	500				
Total Other Revenues	**52,398**		**54,277**	**55,067**	**(1,289)**
General Fund Need				**910,722**	(3,926)
HB 2 / SFC				**913,637**	
DSH Settlement				**16,806**	
BHSD Previous Year Reversion				**500**	
Transfer to support MMISR				**(5,000)**	
State Revenue Surplus / (Shortfall)				**15,220**	**3,926**

PROJECTED REVENUES	
Federal Revenues	4,364,179
Federal Disallowance [10]	11,607
MSBS CPE [13]	14,322
IHS Referral 100% FFP	11,607
All State Revenues	1,179,962

Notes:

1. HIT, IHS, QI-1 Medicare Part B premiums, Refugees, Medicaid Expansion are eligible for 100% FFP. Under ACA, the Medicaid Expansion population will be federally funded 100% in CY2016 and 95% in CY2017.
2. Health Homes, sterilization and family planning service costs are eligible for 90% FFP.
3. Breast and cervical cancer (BCC) program with enhanced FMAP.
4. CHIP is a Title XXI program with enhanced FMAP. FY17 will have 100% FFP. Under the ACA beginning Oct. 2015, Medicaid will receive 100% match for CHIP kids through FFY2019.
5. Utilization review is federally matched at 75%; admin. expenses.
6. Title XIX expenditures with regular FMAP. The FFY 2017 FMAP is from FFIS, released September 2015, based on revised income data.
7. Administration expenditures are eligible for 50% FFP.
8. Pregnancy termination, special needs, state only buy-in for Medicare Part B and all Medicare Part D buy-ins (Claw back) expenditures are not eligible for federal financial participation.
9. DOH for Medicaid DD traditional and Mi Via waiver services; projected revenue is without the 3% for admin. MF GF appropriation is under HSD.
10. Includes potential disallowance for 100% IHS referral.
11. The sum of lines 62 and 63 is the 1/12th% of the gross receipts tax contributed by the counties to support the Safety Net Care Pool and Hospital Payments.
12. Line 64 represents the additional county support to fully fund the Safety Net Care Pool.
13. Starting from FY16, school districts will contribute the state share of Medicaid School Based Services through Certified Public Expenditures.
14. Miner's Colfax hospital will contribute the state share of Safety Net Care Pool supplemental payments. The current estimate is for payments issued in CY2016.
15. Senate Bill 42 stated that counties will contribute the state share of payments for fee-for-service inpatient services for their respective incarcerated populations.
16. DOH Budget request is for Developmental Disabled waiver only, budget request for Medically Fragile waiver is through HSD.

8/2/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 18 Trend Model with Centennial Care and Medicaid Expansion ($000s)

No.	Description	FY 17 Title XIX Projection	FY 17 Title XIX Projected Claims	Δ Price	$ Impact	Δ Recipient	$ Impact	Δ Utilization	$ Impact	Projected Lump Sum	Others	FY 18 Title XIX Projection	% Change from FY 17	FY 17 Title XXI Projection	FY 18 Title XXI Projection	FY 18 Total Medicaid Projection	March 2017 Data Projection	Change from Previous	No.
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Inpatient Hospital	76,722	76,722	0.00%	-	1.26%	963	0.00%	-	-	-	77,685	1.26%	513	522	78,208	77,843	365	1
2	DSH	31,417	-	--	-	--	-	--	-	31,275	-	31,275	-0.45%	-	-	31,275	31,275	-	2
3	GME	18,500	-	--	-	--	-	--	-	18,926	-	18,926	2.30%	-	-	18,926	18,926	(1)	3
4	IME	85,625	-	--	-	--	-	--	-	85,625	-	85,625	0.00%	-	-	85,625	84,526	1,099	4
5	Safety Net Care	68,889	-	--	-	--	-	--	-	68,889	-	68,889	0.00%	-	-	68,889	68,889	-	5
6	HQII Pool	7,359	-	--	-	--	-	--	-	8,826	-	8,826	19.93%	-	-	8,826	8,826	-	6
7	Physician Services	39,407	33,883	0.00%	-	2.38%	806	0.00%	-	5,525	-	40,214	2.05%	476	484	40,698	41,282	(584)	7
8	IHS Hospital	125,213	125,213	2.30%	2,880	-0.75%	(964)	0.00%	-	-	-	127,129	1.53%	-	-	127,129	128,309	(1,180)	8
9	ICF-IID	27,680	27,680	0.00%	-	-0.05%	(15)	0.00%	-	-	-	27,665	-0.05%	-	-	27,665	28,515	(850)	9
10	Clinic Services	49,837	49,837	0.00%	-	2.21%	1,102	0.00%	-	-	-	50,938	2.21%	1,787	1,819	52,757	52,757	-	10
11	Federal Qualified Health Centers	4,615	4,615	2.69%	124	-0.64%	(30)	0.00%	-	-	678	5,387	16.72%	98	101	5,488	5,475	13	11
12	Other Practitioners	30,439	30,439	0.00%	-	1.66%	505	0.00%	-	-	-	30,944	1.66%	1,052	1,071	32,015	31,813	202	12
13	Outpatient Hospital	41,285	41,285	0.00%	-	2.39%	988	0.00%	-	-	-	42,273	2.39%	535	544	42,818	43,220	(402)	13
14	PACE	11,930	11,930	0.00%	-	0.00%	-	0.00%	-	-	-	11,930	0.00%	-	-	11,930	12,278	(348)	14
15	Others	49,187	51,332	0.00%	-	5.59%	2,870	0.00%	-	(4,115)	100	50,187	2.03%	1,600	1,629	51,816	52,363	(547)	15
16	BH FFS	37,569	37,569	0.05%	18	1.27%	476	0.00%	-	-	-	38,063	1.31%	764	778	38,841	38,416	425	16
17	**Subtotal**	**705,675**	**490,505**	**0.62%**	**3,022**	**1.36%**	**6,701**	**0.00%**	**-**	**214,951**	**778**	**715,957**	**1.46%**	**6,825**	**6,949**	**722,906**	**724,715**	**(1,809)**	17
18	Traditional DD and MF Waiver (DOH)	279,821	279,158	0.00%	-	-0.27%	(753)	0.00%	2	152	523	279,083	-0.26%	-	-	279,083	277,911	1,172	18
19	Mi Via DD and MF Waiver (DOH)	87,001	83,019	0.00%	-	5.74%	4,764	0.86%	755	60	3,989	92,586	6.42%	-	-	92,586	91,674	912	19
20	**Subtotal**	**366,822**	**362,176**	**0.00%**	**-**	**1.11%**	**4,012**	**0.21%**	**757**	**212**	**4,512**	**371,669**	**1.32%**	**-**	**-**	**371,669**	**369,585**	**2,084**	20
21	Centennial Care-Physical Health	1,420,914	1,408,466	0.00%	-	-0.42%	(5,945)	1.30%	18,172	30,856	478	1,452,027	2.19%	82,290	83,004	1,535,031	1,556,417	(21,387)	21
22	Centennial Care-LTSS	1,066,765	1,054,570	0.00%	-	1.83%	19,313	0.80%	8,637	12,195	3,046	1,097,761	2.91%	1,112	257	1,098,018	1,149,239	(51,221)	22
23	Centennial Care-Behavioral Health	326,021	322,977	0.00%	-	-0.18%	(583)	-3.94%	(12,687)	3,044	5,341	318,092	-2.43%	19,191	17,897	335,989	336,720	(731)	23
24	**Subtotal**	**2,813,699**	**2,786,013**	**0.00%**	**-**	**0.46%**	**12,784**	**0.50%**	**14,122**	**46,095**	**8,866**	**2,867,880**	**1.93%**	**102,592**	**101,158**	**2,969,039**	**3,042,377**	**(73,338)**	24
25	Medicare Part A	1,710	1,710	1.38%	24	-1.48%	(26)	0.00%	-	-	-	1,708	-0.12%	-	-	1,708	1,772	(65)	25
26	Medicare Part B	131,716	131,716	2.86%	3,770	2.06%	2,791	0.00%	-	-	-	138,277	4.98%	-	-	138,277	138,281	(3)	26
27	Medicare Part D	43,958	43,958	2.51%	1,103	6.59%	2,968	0.00%	-	-	-	48,029	9.26%	-	-	48,029	48,866	(837)	27
28	**Subtotal**	**177,384**	**177,384**	**2.76%**	**4,897**	**3.15%**	**5,733**	**0.00%**	**-**	**-**	**-**	**188,014**	**5.99%**	**-**	**-**	**188,014**	**188,919**	**(905)**	28
29	Utilization	5,000	-	--	-	--	-	--	-	-	5,000	5,000	0.00%	-	-	5,000	5,000	-	29
30	HIT	23,725	-	--	-	--	-	--	-	20,000	-	20,000	-15.70%	-	-	20,000	9,000	11,000	30
31	Contracts	1,970	-	--	-	--	-	--	-	1,970	-	1,970	0.00%	-	-	1,970	1,970	-	31
32	**Subtotal**	**30,695**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**21,970**	**5,000**	**26,970**	**-12.13%**	**-**	**-**	**26,970**	**15,970**	**11,000**	32
33	Health Insurance Providers Fee	-	-	--	-	--	-	--	-	-	88,338	88,338	--	-	2,849	91,187	93,028	(1,841)	33
34	**Subtotal**	-	-	**--**	**-**	**--**	-	**--**	-	-	**88,338**	**88,338**	**--**	**-**	**2,849**	**91,187**	93,028	**(1,841)**	34
35	Medicaid Expansion - Physical Health	1,198,385	1,320,987	0.00%	-	1.41%	18,616	-3.07%	(41,180)	22,318	970	1,321,711	10.29%	-	-	1,321,711	1,356,504	(34,792)	35
36	Medicaid Expansion - Behavioral Health	112,650	110,646	0.00%	-	1.41%	1,559	3.68%	4,127	2,005	1,650	119,987	6.51%	-	-	119,987	123,879	(3,892)	36
37	**Subtotal**	**1,311,035**	**1,431,632**	**-**	**-**	**1.41%**	**20,175**	**-2.55%**	**(37,053)**	**24,323**	**2,620**	**1,441,698**	**9.97%**	**-**	**-**	**1,441,698**	**1,480,383**	**(38,685)**	37
38																			38
39	**Prior Years Charged to Current Year**	**43,502**	**-**	**na**	**-**	**na**	**-**	**na**	**-**	**-**		**-**	**-100.00%**	**-**	**-**	**-**	**-**	**-**	39
40	**Additional Cost Containment**										**-**	**-**	**--**			**-**	**(55,325)**	**55,325**	40
41																			41
42	**Grand Total**	**5,448,812**	**5,247,711**	**0.15%**	**7,919**	**0.94%**	**49,405**	**-0.42%**	**(22,174)**	**307,551**	**110,114**	**5,700,527**	**4.62%**	**109,417**	**110,956**	**5,811,482**	**5,859,652**	**(48,170)**	42

Notes:

1. (Line 10) Clinic Services consists primarily of Medicaid School-Based Services (MSBS) with small amounts also going to clinics providing a variety of services.
2. (Line 15) Others contains: Transportation, Lab/X-Ray, Prosthetics, RHC, Hospice, Home Health, Medical Supplies, Prescribed Drugs, Dental Services, EPSDT, Nursing Facility, Maintenance, Family Planning, PCO .
3. (Lines 21-23, 36-37, Column L) Others under the managed care projection lines reflect the cost of additional NMMIP for second half of FY18, retroactive eligibility reconciliation.

8/2/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 18 Trend Model with Centennial Care and Medicaid Expansion ($000s)

No.	Description	FY 18 Projection	Federal Medicaid Expenditure Type and Federal Financial Participation Rates: HIT, IHS, Refugees (100% FFP) [1]	Medicaid Expansion (95% FFP)[2]	Medicaid Expansion (94% FFP)[2]	Health Homes, Sterilization & Family Planning Services (90% FFP) [3]	Breast & Cervical Cancer, CCBHC Program (EFMAP) [4]	Title XXI CHIP (EFMAP) [5]	Utilization Review (75% FFP) [6]	Title XIX Medicaid (FMAP) [7]	Admin and Fees (50% FFP) [8]	Non-Federal Financial Participation Expenses (0% FFP) [9]	Federal Share	% of Composite Federal Share
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Inpatient Hospital	78,208	407	13,691	14,831	187	-	522	-	48,570	-	-	63,015	80.57%
2	DSH	31,275	-	-	-	-	-	-	-	31,275	-	-	22,568	72.16%
3	GME	18,926	-	-	-	-	-	-	-	18,926	-	-	13,657	72.16%
4	IME	85,625	-	-	-	-	-	-	-	85,625	-	-	61,787	72.16%
5	Safety Net Care	68,889	-	-	-	-	-	-	-	68,889	-	-	49,711	72.16%
6	HQII Pool	8,826	-	-	-	-	-	-	-	8,826	-	-	6,369	72.16%
7	Physician Services	40,698	67	5,127	5,554	-	17	484	-	29,364	-	85	31,795	78.13%
8	IHS Hospital	127,129	127,129	-	-	-	-	-	-	(0)	-	-	127,129	100.00%
9	ICF-IID	27,665	-	114	123	-	-	-	-	27,429	-	-	19,959	72.14%
10	Clinic Services	52,757	-	138	149	-	-	1,819	-	50,628	-	24	38,603	73.17%
11	Federal Qualified Health Centers	5,488	-	575	623	-	-	101	-	4,189	-	-	4,249	77.42%
12	Other Practitioners	32,015	-	399	433	-	-	1,071	-	30,112	-	-	23,531	73.50%
13	Outpatient Hospital	42,818	144	6,251	6,772	-	23	544	-	29,083	-	-	33,948	79.29%
14	PACE	11,930	-	-	-	-	-	-	-	11,904	-	26	8,560	71.76%
15	Others	51,816	3,955	6,871	7,444	2,274	29	1,629	-	29,614	-	-	42,484	81.99%
16	BH FFS	38,841	12,247	3,271	3,544	-	2	778	-	18,998	-	-	33,149	85.35%
17	**Subtotal**	**722,906**	**143,949**	**36,437**	**39,473**	**2,460**	**71**	**6,949**	**-**	**493,432**	**-**	**135**	**580,513**	**80.30%**
18	Traditional DD and MF Waiver (DOH)	279,083	-	-	-	-	-	-	523	277,968	592	-	200,714	71.92%
19	Mi Via DD and MF Waiver (DOH)	92,586	-	-	-	-	-	-	1,958	88,510	2,118	-	66,263	71.57%
20	**Subtotal**	**371,669**	**-**	**-**	**-**	**-**	**-**	**-**	**2,481**	**366,478**	**2,710**	**-**	**266,977**	**71.83%**
21	Centennial Care-Physical Health	1,535,031	30,613	-	-	13,696	1,203	83,004	-	1,406,272	-	244	1,138,159	74.15%
22	Centennial Care-LTSS	1,098,018	12,195	-	-	-	-	257	-	1,085,566	-	-	793,083	72.23%
23	Centennial Care-Behavioral Health	335,989	3,044	-	-	2,506	86	18,016	-	312,337	-	-	247,986	73.81%
24	**Subtotal**	**2,969,039**	**45,851**	**-**	**-**	**16,202**	**1,289**	**101,277**	**-**	**2,804,175**	**-**	**244**	**2,179,228**	**73.40%**
25	Medicare Part A	1,708	-	-	-	-	-	-	-	1,708	-	-	1,228	71.90%
26	Medicare Part B	138,277	5,716	-	-	-	-	-	-	116,644	-	15,917	89,595	64.79%
27	Medicare Part D	48,029	-	-	-	-	-	-	-	-	-	48,029	-	0.00%
28	**Subtotal**	**188,014**	**5,716**	**-**	**-**	**-**	**-**	**-**	**-**	**118,351**	**-**	**63,946**	**90,823**	**48.31%**
29	Utilization	5,000	-	-	-	-	-	-	5,000	-	-	-	3,750	75.00%
30	HIT	20,000	20,000	-	-	-	-	-	-	-	-	-	20,000	100.00%
31	Contracts	1,970	-	-	-	-	-	-	-	376	1,595	-	1,068	54.23%
32	**Subtotal**	**26,970**	**20,000**	**-**	**-**	**-**	**-**	**-**	**5,000**	**376**	**1,595**	**-**	**24,818**	**92.02%**
33	Health Insurance Providers Fee	91,187	-	35,782	-	-	-	2,849	-	52,556	-	-	74,766	81.99%
34	**Subtotal**	**91,187**	**-**	**35,782**	**-**	**-**	**-**	**2,849**	**-**	**52,556**	**-**	**-**	**74,766**	**81.99%**
35	Medicaid Expansion - Physical Health	1,321,711	22,318	584,775	714,618	-	-	-	-	-	-	-	1,249,596	94.54%
36	Medicaid Expansion - Behavioral Health	119,987	2,005	53,174	64,808	-	-	-	-	-	-	-	113,440	94.54%
37	**Subtotal**	**1,441,698**	**24,323**	**637,950**	**779,425**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,363,035**	**94.54%**
38														
39	**Prior Years Charged to Current Year**	**-**	-	-		-	-	-	-	-	-		-	-
40	**Additional Cost Containment**	**-**											-	**71.08%**
41														
42	**Grand Total**	**5,811,482**	**239,840**	**710,169**	**818,899**	**18,662**	**1,360**	**111,075**	**7,481**	**3,835,368**	**4,304**	**64,325**	**4,580,161**	**78.81%**

	State Share Revenues:	FY 18 Op Budget	HSD Projection	Change from Previous
47	Department of Health (Line 18 & 19) [10,17]	103,360	102,216	-
48	Department of Health Additional Need /(Surplus)		2,177	1,083
49	Department of Health for Early Intervention	8,292	8,292	-
50	Department of Health for FQHCs	560	560	-
51	Department of Health for EC	1	1	-
52	Children, Youth and Families	-	-	-
53	County Supported Medicaid Fund	28,515	28,515	1,241
54	Tobacco Settlement Revenue, Base	29,319	29,319	-
55	Tobacco Settlement Revenue	-	-	-
56	UNM IGT	44,482	42,347	-
57	**Total Operating Transfers In**	**214,529**	**213,428**	2,324
58				-
59	Physician UPL UNM	1,681	1,605	-
60	Safety Net Care [12]	-	-	-
61	County Supported Hospital Payments [12]	22,790	22,585	-
62	Additional County Supported Hospital Payments [13]	-	-	-
63	Miner's Colfax[15]	500		(500)
64	County Contribution for Incarcerated Population[16]			-
65	Drug Rebates	28,867	30,792	440
66	Fraud	872	872	-
67	Income Diversion Trust	486	486	-
68	Buy-In Recovery	215	215	-
69	Cost Settlement	500	500	-
70	Estate Recovery	9	9	-
71	HMS-RAC-TPL/Subrogation	500	-	-
72	**Total Other Revenues**	**56,420**	**57,064**	(60)
73				-
74	**General Fund Need**		**938,280**	**(9,239)**
75				-
76	**FY 2018 Appropriation**	**915,637**	**915,637**	-
77				-
78	**State Revenue Surplus/(Shortfall)**		**(22,643)**	**9,239**

PROJECTED REVENUES	
Federal Revenues	4,580,161
Federal Disallowance [11]	-
MSBS CPE[14]	14,155
IHS Referral 100% FFP[18]	8,394
All State Revenues	1,208,772

Notes:

1. HIT, IHS, QI-1 Medicare Part B premiums, Refugees are eligible for 100% FFP.
2. Under ACA, the Medicaid Expansion population will be federally funded 95% in CY2017 and 94% in CY2018.
3. Health Homes, sterilization and family planning service costs are eligible for 90% FFP.
4. Breast and cervical cancer (BCC) program with enhanced FMAP. Certified Community Behavioral Health Clinics program with enhanced FMAP.
5. CHIP is a Title XXI program with enhanced FMAP. FY18 will have 100% FFP. Under the ACA beginning Oct. 2015, Medicaid will receive 100% match for CHIP kids through FFY2019.
6. Utilization review is federally matched at 75%; admin. expenses.
7. Title XIX expenditures with regular FMAP. The FFY 2018 final FMAP is from FFIS, released September 2016, based on revised income data.
8. Administration expenditures are eligible for 50% FFP.
9. Pregnancy termination, special needs and state only buy-in for Medicare Part B and all Medicare Part D buy-ins (Claw back) expenditures are not eligible for federal financial participation.
10. DOH for Medicaid DD, MF and Mi Via waiver services; projected revenue is without the 3% for admin.
11. Includes potential disallowance for 100% IHS Referral
12. The sum of lines 62 and 63 is the 1/12th% of the gross receipts tax contributed by the counties to support the Safety Net Care Pool and Hospital Payments.
13. Line 64 represents the additional county support to fully fund the Safety Net Care Pool.
14. Starting from FY16, school districts will contribute the state share of Medicaid School-Based Services through Certified Public Expenditures.
15. Miner's Colfax hospital will contribute the state share of Safety Net Care Pool supplemental payments. The current estimate is for services provided in CY2017.
16. Senate Bill 42 stated that counties will contribute the state share of payments for fee-for-service inpatient services for their respective incarcerated populations.
17. DOH Budget request is for Developmental Disabled waiver only, budget request ($1.4 million) for Medically Fragile waiver is through HSD.
18. This amount is pending, subject to approval of 100% FFP for IHS Referrals.

8/2/2017

STATE OF NEW MEXICO DRAFT
HUMAN SERVICES DEPARTMENT
Medical Assistance Division **FY 19 Trend Model with Centennial Care and Medicaid Expansion ($000s)**

No.	Description	FY 18 Title XIX Projection	FY 18 Title XIX Projected Claims	Δ Price	$ Impact	Δ Recipient	$ Impact	Δ Utilization	$ Impact	Projected Lump Sum	Others	FY 19 Title XIX Projection	% Change from FY 18	FY 18 Title XXI Projection	FY 19 Title XXI Projection	FY 19 TOTAL Medicaid Projection	FY18 Projection	Change from FY18	No.
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Inpatient Hospital	77,685	77,685	0.00%	-	0.03%	20	0.00%	-	-	-	77,706	0.03%	522	527	**78,233**	**78,208**	25	1
2	DSH	31,275	-	--	-	--	-	--	-	31,275	-	31,275	0.00%	-	-	**31,275**	**31,275**	-	2
3	GME	18,926	-	--	-	--	-	--	-	18,926	-	18,926	0.00%	-	-	**18,926**	**18,926**	(1)	3
4	IME	85,625	-	--	-	--	-	--	-	85,625	-	85,625	0.00%	-	-	**85,625**	**85,625**	-	4
5	Safety Net Care	68,889	-	--	-	--	-	--	-	68,889	-	68,889	0.00%	-	-	**68,889**	**68,889**	-	5
6	HQII Pool	8,826	-	--	-	--	-	--	-	12,012	-	12,012	36.10%	-	-	**12,012**	**8,826**	3,186	6
7	Physician Services	40,214	34,689	0.00%	-	2.34%	811	0.00%	-	5,525	-	41,025	2.02%	484	493	**41,518**	**40,698**	820	7
8	IHS Hospital	127,129	127,129	2.30%	2,924	0.93%	1,208	0.00%	-	-	-	131,261	3.25%	-	-	**131,261**	**127,129**	4,132	8
9	ICF-IID	27,665	27,665	0.00%	-	3.32%	919	0.00%	-	-	-	28,584	3.32%	-	-	**28,584**	**27,665**	919	9
10	Clinic Services	50,938	50,938	0.00%	-	0.53%	268	0.00%	-	-	-	51,206	0.53%	1,819	1,852	**53,058**	**52,757**	301	10
11	Federal Qualified Health Centers	5,387	4,709	2.69%	127	-0.38%	(18)	0.00%	-	-	678	5,495	2.01%	101	103	**5,599**	**5,488**	111	11
12	Other Practitioners	30,944	30,944	0.00%	-	0.26%	79	0.00%	-	-	-	31,023	0.26%	1,071	1,090	**32,113**	**32,015**	98	12
13	Outpatient Hospital	42,273	42,273	0.00%	-	1.55%	654	0.00%	-	-	-	42,928	1.55%	544	554	**43,482**	**42,818**	664	13
14	PACE	11,930	11,930	0.00%	-	0.00%	-	0.00%	-	-	-	11,930	0.00%	-	-	**11,930**	**11,930**	-	14
15	Others	50,187	54,202	0.00%	-	1.74%	944	0.00%	-	(4,100)	100	51,146	1.91%	1,629	1,658	**52,804**	**51,816**	988	15
16	BH FFS	38,063	38,063	0.05%	18	-0.31%	(120)	0.00%	-	-	-	37,962	-0.27%	778	792	**38,754**	**38,841**	(87)	16
17	**Subtotal**	**715,957**	**500,228**	**0.61%**	**3,069**	**0.95%**	**4,766**	**0.00%**	**-**	**218,152**	**778**	**726,993**	**1.54%**	**6,949**	**7,070**	**734,063**	**722,906**	**11,157**	17
18	Traditional DD Waiver (DOH)	279,083	278,408	0.00%	-	-0.36%	(1,010)	0.00%	-	76	523	277,996	-0.39%	-	-	**277,996**	**279,083**	(1,087)	18
19	Mi Via DD Waiver (DOH)	92,586	88,537	0.00%	-	0.00%	-	0.00%	-	59	3,841	92,438	-0.16%	-	-	**92,438**	**92,586**	(148)	19
20	**Subtotal**	**371,669**	**366,945**	**0.00%**	**-**	**-0.28%**	**(1,010)**	**0.00%**	**-**	**135**	**4,364**	**370,434**	**-0.33%**	**-**	**-**	**370,434**	**371,669**	**(1,235)**	20
21	Centennial Care-Physical Health	1,452,027	1,420,692	0.00%	-	0.00%	-	0.74%	10,576	30,856	3,590	1,465,715	0.94%	83,004	83,622	**1,549,337**	**1,535,031**	14,306	21
22	Centennial Care-LTSS	1,073,261	1,082,520	0.00%	-	3.40%	36,828	0.75%	8,343	12,195	(18,408)	1,121,478	4.49%	257	257	**1,121,735**	**1,098,018**	23,717	22
23	Centennial Care-Behavioral Health	318,092	309,707	0.00%	-	0.37%	1,152	0.70%	2,187	3,044	6,333	322,423	1.36%	17,897	18,224	**340,647**	**335,989**	4,658	23
24	**Subtotal**	**2,843,380**	**2,812,919**	**0.00%**	**-**	**1.35%**	**37,979**	**0.74%**	**21,106**	**46,095**	**(8,484)**	**2,909,615**	**2.33%**	**101,158**	**102,103**	**3,011,719**	**2,969,039**	**42,680**	24
25	Medicare Part A	1,708	1,708	0.00%	-	1.20%	20	0.00%	-	-	-	1,728	1.20%	-	-	**1,728**	**1,708**	20	25
26	Medicare Part B	138,277	138,277	-0.72%	(996)	2.80%	3,838	0.00%	-	-	-	141,120	2.06%	-	-	**141,120**	**138,277**	2,843	26
27	Medicare Part D	48,029	48,029	2.01%	965	2.53%	1,240	0.00%	(2)	-	-	50,232	4.59%	-	-	**50,232**	**48,029**	2,203	27
28	**Subtotal**	**188,014**	**188,014**	**-0.02%**	**(30)**	**2.71%**	**5,098**	**0.00%**	**(2)**	**-**	**-**	**193,080**	**2.69%**	**-**	**-**	**193,080**	**188,014**	**5,066**	28
29	Utilization	5,000	-	--	-	--	-	--	-	-	5,000	5,000	0.00%	-	-	**5,000**	**5,000**	-	29
30	HIT	20,000	-	--	-	--	-	--	-	8,000	-	8,000	-60.00%	-	-	**8,000**	**20,000**	(12,000)	30
31	Contracts	1,970	-	--	-	--	-	--	-	1,970	-	1,970	0.00%	-	-	**1,970**	**1,970**	-	31
32	**Subtotal**	**26,970**	**-**	**--**	**-**	**--**	**-**	**--**	**-**	**9,970**	**5,000**	**14,970**	**-44.49%**	**-**	**-**	**14,970**	**26,970**	**(12,000)**	32
33	Rate Increase for Primary Care Services	-	-	--	-	--	-	--	-	-	-	-	--	-	-	**-**		-	33
34	Health Home	-	-	--	-	--	-	--	-	-	-	-	--	-	-	**-**		-	34
35	Health Insurance Providers Fee	88,338	-	--	-	--	-	--	-	-	89,732	89,732	1.58%	2,849	2,875	**92,607**	**91,187**	1,420	35
36	**Subtotal**	**88,338**	**-**	**--**	**-**	**--**	**-**	**--**	**-**	**-**	**89,732**	**89,732**	**1.58%**	**2,849**	**2,875**	**92,607**	**91,187**	**1,420**	36
37	Medicaid Expansion - Physical Health	1,321,711	1,298,423	0.00%	-	1.35%	17,491	0.74%	9,796	22,318	4,903	1,352,931	2.36%	-	-	**1,352,931**	**1,321,711**	31,220	37
38	Medicaid Expansion - Behavioral Health	119,987	116,332	0.00%	-	1.35%	1,567	0.74%	878	2,005	1,650	122,432	2.04%	-	-	**122,432**	**119,987**	2,445	38
39	**Subtotal**	**1,441,698**	**1,414,755**	**-**	**-**	**1.35%**	**19,058**	**0.74%**	**10,673**	**24,323**	**6,553**	**1,475,363**	**2.34%**	**-**	**-**	**1,475,363**	**1,441,698**	**33,665**	39
40																			40
41	**Additional Cost Containment**	**-**	**-**	**na**	**-**	**na**	**-**	**na**	**-**	**-**		**-**	**--**	**-**	**-**	**-**			41
42																			42
43																			43
44	**Grand Total**	**5,676,027**	**5,282,861**	**0.06%**	**3,038**	**1.25%**	**65,892**	**0.59%**	**31,778**	**298,676**	**97,943**	**5,780,188**	**1.84%**	**110,956**	**112,049**	**5,892,236**	**5,811,482**	**80,754**	44

Notes:

1. (Line 10) 1. (Line 10) Clinic Services consists primarily of Medicaid School-Based Services (MSBS) with small amounts also going to clinics providing a variety of services.
2. (Line 15) Others contains: Transportation, Lab/X-Ray, Prosthetics, RHC, Hospice, Home Health, Medical Supplies, Prescribed Drugs, Dental Services, EPSDT, Nursing Facility, Maintenance, Family Planning, PCO .
3. (Lines 21-23, 36-37 - Column L) Others under the managed care projection lines reflect the additional cost of NMMIP.

8/22/2017

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

FY 19 Trend Model with Centennial Care and Medicaid Expansion ($000s)

No.	Description	FY 19 Projection	HIT, IHS, Refugees (100% FFP) [1]	Medicaid Expansion (94% FFP)[2]	Medicaid Expansion (93% FFP)[2]	Health Homes, Sterilization & Family Planning Services (90% FFP) [3]	Breast & Cervical Cancer Program (EFMAP) [4]	Title XXI CHIP (FMAP) [5]	Utilization Review (75% FFP) [6]	Title XIX Medicaid (FMAP) [7]	Admin and Fees (50% FFP) [8]	Non-Federal Financial Participation Expenses (0% FFP) [9]	Federal Share	% of Composite Federal Share
			Federal Medicaid Expenditure Type and Federal Financial Participation Rates											
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Inpatient Hospital	78,233	411	13,793	14,943	187	-	527	-	48,372	-	-	62,727	80.18%
2	DSH	31,275	-	-	-	-	-	-	-	31,275	-	-	22,568	72.16%
3	GME	18,926	-	-	-	-	-	-	-	18,926	-	-	13,657	72.16%
4	IME	85,625	-	-	-	-	-	-	-	85,625	-	-	61,787	72.16%
5	Safety Net Care	68,889	-	-	-	-	-	-	-	68,889	-	-	49,711	72.16%
6	HQII Pool	12,012	-	-	-	-	-	-	-	12,012	-	-	8,668	72.16%
7	Physician Services	41,518	68	5,166	5,596	-	17	493	-	30,094	-	85	32,213	77.59%
8	IHS Hospital	131,261	131,261	-	-	-	-	-	-	-	-	-	131,261	100.00%
9	ICF-IID	28,584	-	115	125	-	-	-	-	28,344	-	-	20,677	72.34%
10	Clinic Services	53,058	-	139	150	-	-	1,852	-	50,893	-	24	38,330	72.24%
11	Federal Qualified Health Centers	5,599	-	591	640	-	-	103	-	4,265	-	-	4,302	76.85%
12	Other Practitioners	32,113	-	402	436	-	-	1,090	-	30,185	-	-	23,351	72.72%
13	Outpatient Hospital	43,482	145	6,298	6,823	-	23	554	-	29,638	-	-	34,216	78.69%
14	PACE	11,930	-	-	-	-	-	-	-	11,930	-	-	8,609	72.16%
15	Others	52,804	4,026	6,923	7,500	2,274	29	1,658	-	30,369	-	26	42,688	80.84%
16	BH FFS	38,754	12,357	3,296	3,571	-	2	792	-	18,726	-	9	32,862	84.80%
17	**Subtotal**	**734,063**	**148,268**	**36,722**	**39,783**	**2,460**	**71**	**7,070**	**-**	**499,545**	**-**	**144**	**587,627**	**80.05%**
18	Traditional DD Waiver (DOH)	277,996	-	-	-	-	-	-	523	276,909	564	-	200,526	72.13%
19	Mi Via DD Waiver (DOH)	92,438	-	-	-	-	-	-	1,840	88,511	2,087	-	66,292	71.71%
20	**Subtotal**	**370,434**	**-**	**-**	**-**	**-**	**-**	**-**	**2,362**	**365,421**	**2,651**	**-**	**266,818**	**72.03%**
21	Centennial Care-Physical Health	1,549,337	30,613	-	-	13,696	1,212	83,622	-	1,419,951	-	244	1,128,868	72.86%
22	Centennial Care-LTSS	1,121,735	12,195	-	-	-	-	257	-	1,109,283	-	-	812,839	72.46%
23	Centennial Care-Behavioral Health	340,647	3,044	-	-	1,756	87	18,224	-	317,535	-	-	246,974	72.50%
24	**Subtotal**	**3,011,719**	**45,851**	**-**	**-**	**15,452**	**1,299**	**102,103**	**-**	**2,846,769**	**-**	**244**	**2,188,680**	**72.67%**
25	Medicare Part A	1,728	-	-	-	-	-	-	-	1,728	-	-	1,247	72.16%
26	Medicare Part B	141,120	5,780	-	-	-	-	-	-	119,511	-	15,829	92,019	65.21%
27	Medicare Part D	50,232	-	-	-	-	-	-	-	-	-	50,232	-	0.00%
28	**Subtotal**	**193,080**	**5,780**	**-**	**-**	**-**	**-**	**-**	**-**	**121,239**	**-**	**66,061**	**93,266**	**48.30%**
29	Utilization	5,000	-	-	-	-	-	-	5,000	-	-	-	3,750	75.00%
30	HIT	8,000	8,000	-	-	-	-	-	-	-	-	-	8,000	100.00%
30	Contracts	1,970	-	-	-	-	-	-	-	376	1,595	-	1,068	54.23%
31	**Subtotal**	**14,970**	**8,000**	**-**	**-**	**-**	**-**	**-**	**5,000**	**376**	**1,595**	**-**	**12,818**	**85.63%**
32	Rate Increase for Primary Care Services	-	-	-	-	-	-	-	-	-	-	-	-	
33	Health Home	-	-	-	-	-	-	-	-	-	-	-	-	
34	Health Insurance Providers Fee	92,607	-	36,534	-	-	-	2,875	-	53,197	-	-	74,804	80.78%
35	**Subtotal**	**92,607**	**-**	**36,534**	**-**	**-**	**-**	**2,875**	**-**	**53,197**	**-**	**-**	**74,804**	**80.78%**
36	Medicaid Expansion - Physical Health	1,352,931	22,318	572,507	758,106	-	-	-	-	-	-	-	1,265,514	93.54%
37	Medicaid Expansion - Behavioral Health	122,432	2,005	51,899	68,528	-	-	-	-	-	-	-	114,521	93.54%
38	**Subtotal**	**1,475,363**	**24,323**	**624,406**	**826,634**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,380,034**	**93.54%**
39														
40														
41	**Additional Cost Containment**	**-**	**-**	**-**		**-**	**-**	**-**	**-**	**-**	**-**		**-**	**0.00%**
42														
43														
44	**Grand Total**	**5,892,236**	**232,222**	**697,663**	**866,417**	**17,912**	**1,370**	**112,049**	**7,362**	**3,886,547**	**4,245**	**66,449**	**4,604,048**	**78.14%**

	State Share Revenues:	FY 19 Budget Request	HSD Projection
###	Department of Health (Line 18 & 19) [10,17]	103,616	103,616
50	Department of Health for Early Intervention	7,662	7,662
51	Department of Health for FQHCs	560	560
52	Department of Health for EC	1	1
53	Children, Youth and Families	-	-
54	County Supported Medicaid Fund	26,176	26,176
55	Tobacco Settlement Revenue, Base	26,319	26,319
56	Tobacco Settlement Revenue	-	-
57	UNM IGT	42,347	42,347
58	UNM IGT Additional Revenue		
59	**Total Operating Transfers In**	**206,682**	**206,682**
60			-
61	Physician UPL UNM	1,605	1,605
62	Safety Net Care [12]	-	-
63	County Supported Hospital Payments [12]	22,585	22,585
64	Additional County Supported Hospital Payments [13]	-	-
65	Miner's Colfax [15]	1,036	1,036
66	SB 42 Inpatient Services-Counties [16]		
67	Drug Rebates	33,265	33,265
68	Fraud	872	872
69	Income Diversion Trust	486	486
70	Buy-In Recovery	215	215
71	Cost Settlement	500	500
72	Estate Recovery	9	9
73	HMS-RAC-TPL/Subrogation		
74	**Total Other Revenues**	**60,573**	**60,573**
75			
76	**General Fund Need**		**997,184**
77			
78	**FY 2018 Appropriation**		**915,637**
79			
80	**State Revenue Surplus/(Shortfall)**		**(81,547)**

8/22/2017

PROJECTED REVENUES	
Federal Revenues	4,604,048
Federal Disallowance [11]	-
IHS Referrals at 100% FFP	8,394
MSBS CPE [14]	15,355
All State Revenues	1,264,439

Notes:

1. HIT, IHS, QI-1 Medicare Part B premiums, Refugees are eligible for 100% FFP.
2. Under ACA, the Medicaid Expansion population will be federally funded 94% in CY2018 and 93% in CY2019.
3. Health Homes, sterilization and family planning service costs are eligible for 90% FFP.
4. Breast and cervical cancer (BCC) program with enhanced FMAP.
5. CHIP is a Title XXI program with enhanced FMAP. However is assumed FY19 will have regular FMAP Medicaid was originally expected to receive 100% match for CHIP kids through FFY2019.
6. Utilization review is federally matched at 75%; admin. expenses.
7. Title XIX expenditures with regular FMAP. The FFY 2018 FMAP is from FFIS, released March 2016, based on preliminary income data.
8. Administration expenditures are eligible for 50% FFP.
9. Pregnancy termination, special needs and state only buy-in for Medicare Part B and all Medicare Part D buy-ins (Claw back) expenditures are not eligible for federal financial participation.
10. DOH for Medicaid DD, MF and Mi Via waiver services; projected revenue is without the 3% for admin.
11. There is a placeholder for potential federal disallowances.
12. The sum of lines 61 and 62 is the 1/12th% of the gross receipts tax contributed by the counties to support the Safety Net Care Pool and Hospital Payments.
13. Line 63 represents the additional county support fo fully fund the Safety Net Care Pool.
14. Starting from FY16, school districts will contribute the state share of Medicaid School-Based Services through Certified Public Expenditures.
15. Miner's Colfax hospital will contribute the state share of Safety Net Care Pool supplemental payments. The current estimate is for services provided in CY2018.
16. SB 42 stated that counties will contribute the state share of payments for fee-for-service inpatient services for their respective incarcerated populations.
17. DOH Budget request is for Developmental Disabled waiver only, budget request ($1.4 million) for Medically Fragile waiver is through HSD.

Public Hearings on the 1115 Waiver Application

3. Tribal consultation — Santa Fe, October 20, 2017

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Tuesday, October 17, 2017 12:34 PM
To: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dee Hutchison; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Brogdon, Mary, HSD; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Rufus Greene, Jr. PhD; rvigil@pueblooftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Shije, Suzette, IAD; Terrie Chavarria; Thelma Gonzales; Zamora, Volelle
Cc: Shije, Suzette, IAD; Earnest, Brent, HSD
Subject: Agenda for Tribal Consultation 10/20/2017
Attachments: Tribal Consultation Agenda10.20.2017.pdf; IAIA_CampusMap_v71217.pdf

Importance: High

Good afternoon NATAC members,
This consultation will be at IAIA at the Center for Lifelong Education (CLE) on the second floor. See map attached.

Respectfully,
Theresa Belanger

Theresa Belanger, LBSW, MA Medical Assistance Division
Native American Liaison (Chippewa)
Office: 505-827-3122 Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Friday, October 06, 2017 4:53 PM
To: Carla Martinez, Jicarilla Apache Nation; Chairman Jeff Haozous; Govenor Lawrence Montoya; Sandoval, Sheri; Governor Brian Coriz; Governor Carl Schildt; Archuleta, Sherry; DryWater, Janine; Mountain, James; Governor Jose Benavidez; Governor Joseph Talachy; Governor Joseph Toya; Riley, Kurt; Quintana, Charlene; Governor Michael Chavarria; Ortiz, Nancy; Perez, Phillip A.; Governor Ruben Romero; Governor Val Panteah, Sr.; Pino, Tina; Mark Freeland (m.freeland@navajo-nsn.gov); President Danny Breuninger, Sr.; President Edward Velarde
Cc: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dee Hutchison; Dempsey, K L (IHS/NAV); Haozous, Emily; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Brogdon, Mary, HSD; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Rufus Greene, Jr. PhD; rvigil@pueblooftesuque.org; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Shije, Suzette, IAD; Terrie Chavarria; Thelma Gonzales; Zamora, Volelle
Subject: Revised Draft Waiver Application
Attachments: NoticetoInterestedParties_AmendedDraft_100617.pdf

Importance: High

Good afternoon Honorable Tribal Leaders,
This email is to inform you that the Human Services Department/Medical Assistance Division has issued a revised draft of the 1115 Centennial Care waiver application. The website as well as a summary of the proposed revisions are in the above attachment and can also be found at on HSD's website at: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Please note that the comment period has been extended until **5:00 pm Mountain Time on Monday, November 6, 2017**. Comments may be submitted through HSD's website, by email to HSD-PublicComment@state.nm.us, or by postal mail to: Human Services Department, ATTN: HSD Public Comments, PO Box 2348, Santa Fe, NM 87504-2348.

The formal Tribal Consultation will still be held on Friday, October 20, 2017 at 9:00 a.m. at the Institute of American Indian Arts in Santa Fe.

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA Medical Assistance Division
Native American Liaison (Chippewa)
Office: 505-827-3122 Theresa.belanger@state.nm.us

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Kurt Riley
Pueblo of Acoma
P.O. Box 309
Acoma, New Mexico 87034

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Riley,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program— Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Tuesday, September 05, 2017 3:39 PM
To: 'Alicia Ortega'
Subject: RE: Connecting

Importance: High

Hi Alicia,
No problem. I have been working with Erik Lujan on a date. We agreed to hold the Tribal consultation on **Friday, October 20, 2017 at 9:00 a.m. at IAIA.**
I will send APCG a copy of the announcement soon. All the governors received a Save the Date letter last week.

Who should I ask from APCG for a formal appointment to the MAC (Medicaid Advisory Committee) meetings? Currently Ramona Dillard is the APCG representative, but she would like APCG to appoint someone to this important committee as well as an alternate appointee. Thank you Alicia.

Best,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

From: Alicia Ortega [mailto:APCG@indianpueblo.org]
Sent: Friday, September 01, 2017 1:43 PM
To: Belanger, Theresa, HSD
Subject: Connecting

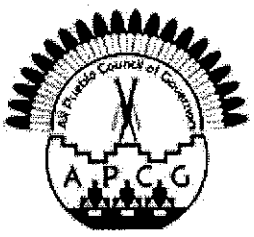
Hello Theresa,

I am so sorry for the delay. Things have gotten extremely busy and I'm just trying to keep afloat lately. My apologies. I hope you have been able to connect with Erik on the matter as well. Have you all decided on a date(s) or have an idea of what time/where? October 16th?

Respectfully,

Alicia Ortega

Executive Director
All Pueblo Council of Governors
2401 12th Street NW, Suite 214 S
Albuquerque, NM 87104
505.212.7041
APCG@indianpueblo.org



Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, August 28, 2017 2:04 PM
To: Anthony Yepa (1rezdog@gmail.com); Belanger, Theresa, HSD; 'birdena.sanchez@ashiwi.org'; Carrie Sarnicky Sandia Pueblo; Dempsey, K L (IHS/NAV); Emily Haozous; Erik Lujan (elujan78@gmail.com); Feathers, Debra (IHS/ALB); Harriet Zamora; Iris Reano Cochiti Pueblo; Jean Pino; linda son-stone; Lisa C. Maves; Mark Freeland (m.freeland@navajo-nsn.gov); Mary Brogdon; Mary Scott; Medrano, Angela, HSD; nathan.tsosie@santaana-nsn.gov; Nelson, Michael, HSD; Oneida Cate, Santo Domingo Tribe ; Robina Henry Acting EO; Rufus Greene, Jr. PhD; 'rvigil@pueblooftesuque.org'; Sandra Platero; Sandra Winfrey (Sandra.winfrey@ihs.gov); Shanita Harrison; Siowassociates@outlook.com; Smith-Leslie, Nancy, HSD; Terrie Chavarria; Thelma Gonzales; Zamora, Volelle; Zunie, Kelly, IAD
Cc: Clavio, Daniel, HSD; Roybal-Varela, Maria, HSD
Subject: Save the Date Announcement for next Tribal Consultation

This email is to inform you that the Human Services Department along with the Medical Assistance Division has scheduled a formal Tribal Consultation to review the draft 1115 Demonstration Waiver Application for the Centennial Care program. It is scheduled for:

Friday, October 20, 2017
9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

You will be notified of the website address where you can review the draft 1115 Demonstration Waiver application in the next few days. **This Tribal consultation will take the place of our October NATAC meeting so there will not be a meeting on October 16th.**

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, August 28, 2017 1:57 PM
To: Carla Martinez, Jicarilla Apache Nation; Chairman Jeff Haozous; Govenor Lawrence Montoya; Governor Anthony Ortiz; Governor Brian Coriz; Governor Carl Schildt; Governor Craig Quanchello; Governor Eugene Herrera; Governor James Mountain; Governor Jose Benavidez; Governor Joseph Talachy; Governor Joseph Toya; Governor Kurt Riley; Governor Mark Mitchell; Governor Michael Chavarria; Governor Peter Garcia, Jr.; Governor Phillip Perez; Governor Ruben Romero; Governor Val Panteah, Sr.; Governor Virgil Siow; Mark Freeland (m.freeland@navajo-nsn.gov); President Danny Breuninger, Sr.; President Edward Velarde
Cc: Earnest, Brent, HSD; Nelson, Michael, HSD; Michelle N. Trujillo (michellen.trujillo@state.nm.us); Smith-Leslie, Nancy, HSD (Nancy.Smith-Leslie@state.nm.us); Medrano, Angela, HSD; Clavio, Daniel, HSD; Belanger, Theresa, HSD; Roybal-Varela, Maria, HSD; Sanchez, Jason S, HSD; Armijo, Kari, HSD; Pearson, Sean, HSD; Shije, Suzette, IAD; 'Philip Cooney'
Subject: SAVE the DATE for Tribal Consultation

Importance: High

********** **Save the Date** **********

This email is to inform you that the Human Services Department along with the Medical Assistance Division has scheduled a formal Tribal Consultation to review the draft 1115 Demonstration Waiver Application for the Centennial Care program. It is scheduled for:

Friday, October 20, 2017
9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

You will be notified of the website address where you can review the draft 1115 Demonstration Waiver application in the next few days along with a formal invite to the consultation.

Please let me know if you have any questions.

Respectfully submitted,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Monday, August 21, 2017 12:23 PM
To: 'Erik Lujan'
Subject: RE: second Tribal Consultation

Thanks Erik. This helps a lot.
Theresa

From: Erik Lujan [mailto:elujan78@gmail.com]
Sent: Monday, August 21, 2017 12:06 PM
To: Belanger, Theresa, HSD
Subject: Re: second Tribal Consultation

Hi, Theresa,

In that week Fridays (10/20) are usually best, Wednesday (10/18) would be my next suggestion.

Erik Lujan
Health Policy Consultant
(505) 280-2811

On Mon, Aug 21, 2017 at 9:25 AM, Belanger, Theresa, HSD <Theresa.Belanger@state.nm.us> wrote:

Good morning Erik,

We are looking at scheduling the second Tribal consultation on the Centennial Care 2.0 renewal sometime the week of October 16th at IAIA in Santa Fe. I have asked Alicia Ortega with APCG to see if a day that week works for Tribal leadership. I would also like to ask you the same. Could you assist me with finding a good day that week for the Tribal consultation?

Many thanks Erik.

Theresa

Theresa Belanger, LBSW, MA

Native American Liaison (Chippewa)

Medical Assistance Division

505-827-3122

Theresa.belanger@state.nm.us

Belanger, Theresa, HSD

From: Belanger, Theresa, HSD
Sent: Thursday, August 10, 2017 4:20 PM
To: Alicia Ortega
Subject: scheduling formal Tribal Consultation

Good afternoon Alicia,
I hope you have had a chance to enjoy the summer before it's over!
I would like to schedule a formal Tribal Consultation for the week of October 16th. Could you please provide me with some dates that work for the AIPC Governors? I know Laguna has a feast on October 17th.
The venue will be somewhere in Albuquerque most likely. We could schedule it in the morning or afternoon based on the Governors' wishes.
Many thanks for your help on this Alicia.

Sincerely,
Theresa Belanger

Theresa Belanger, LBSW, MA
Native American Liaison (Chippewa)
Medical Assistance Division
505-827-3122
Theresa.belanger@state.nm.us

"Do a good deed daily"

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Kurt Riley
Pueblo of Acoma
P.O. Box 309
Acoma, New Mexico 87034

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Riley,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Jose R. Benavides
Pueblo of Isleta
P.O. Box 1270
Isleta Pueblo, New Mexico 87022

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Benavides,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Virgil A. Siow
Pueblo of Laguna
P.O. Box 194
Laguna Pueblo, New Mexico 87026

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Siow,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Peter Garcia Jr.
Ohkay Owingeh
P.O. Box 1099
San Juan, New Mexico 87566

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Garcia Jr.,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Eugene Herrera
Pueblo of Cochiti
P.O. Box 70
Cochiti, New Mexico 87072

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Herrera,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Joseph A. Toya
Pueblo of Jemez
P.O. Box 100
Jemez Pueblo, New Mexico 87024

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Toya,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program— Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Phillip A. Perez
Pueblo of Nambe
Route 1, Box 117-BB
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Perez,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Craig Quanchello
Pueblo of Picuris
P.O. Box 127
Penasco, New Mexico 87553

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Quanchello,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Joseph M. Talachy
Pueblo of Pojoaque
78 Cities of Gold Road
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Talachy,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Anthony Ortiz
Pueblo of San Felipe
P.O. Box 4339
San Felipe Pueblo, New Mexico 87001

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Ortiz,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Brian Coriz
Pueblo of Santo Domingo
P.O. Box 99
Santo Domingo, New Mexico 87052

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Coriz,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Val Panteah, Sr.
Pueblo of Zuni
P.O. Box 339
Zuni, New Mexico 87327

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Panteah,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Malcolm Montoya
Pueblo of Sandia
481 Sandia Loop
Bernalillo, New Mexico 87004

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Montoya,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor J. Michael Chavarria
Pueblo of Santa Clara
P.O. Box 580
Espanola, New Mexico 87532

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Chavarria,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Ruben Romero
Pueblo of Taos
P.O. Box 1846
Taos, New Mexico 87571

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Romero,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Carl Schildt
Pueblo of Zia
135 Capitol Square Drive
Zia Pueblo, New Mexico 87053-6013

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Schildt,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

President Edward Velarde
Jicarilla Apache Nation
P.O. Box 507
Dulce, New Mexico 87528

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear President Velarde,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

September 5, 2017

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

President Danny Breuninger, Sr.
Mescalaro Apache Tribe
P.O. Box 227
Mescalero, New Mexico 88340

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear President Breuninger,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

President Russell Begaye
Navajo Nation
P.O. Box 9000
Window Rock, Arizona 86515

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear President Begaye,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Chairman Jeff Haozous
Fort Sill Apache Tribe
Route 2, Box 121
Apache, Oklahoma 73006

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Chairman Haozous,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Executive Director Gil Vigil
Eight Northern Indian Pueblos Council
P.O. Box 969
San Juan Pueblo, New Mexico 87566

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Mr. Vigil,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Mark Mitchell
Pueblo of Tesuque
Route 42, Box 360-T
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Mitchell,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor James Mountain
Pueblo of San Ildefonso
02 Tunyo Po
Santa Fe, New Mexico 87506

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Mountain,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Governor Lawrence A. Montoya
Pueblo of Santa Ana
2 Dove Road
Santa Ana Pueblo, New Mexico 87004

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Governor Montoya,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary

September 5, 2017

Chairman E. Paul Torres
All Indian Pueblo Council
2401 12th Street, NW
Albuquerque, New Mexico 87103

Subject: **Formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application**

Dear Chairman Torres,

Our office sent out a *Save the Date* notice via email on August 28, 2017, regarding a formal Tribal Consultation on the Draft Section 1115 Demonstration Waiver Renewal Application for the Medicaid managed care program, Centennial Care. We are confirming this meeting for:

Friday, October 20, 2017 at 9:00 am
Institute of American Indian Arts (IAIA)
83 Avan Nu Po Road
Santa Fe, NM 87508

Please review the Draft Section 1115 Demonstration Waiver Renewal Application that outlines the improvements and modifications that HSD plans to implement for the next iteration of the program—Centennial Care 2.0. The draft application may be reviewed at the following website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx.

Written comments may also be submitted directly to HSD at the website listed above. **The deadline to submit comments to HSD about the draft application is Wednesday, October 25, 2017.**

Please send any comments or questions to the MAD Native American Liaison Theresa Belanger, at (505) 827-3122 or by email to Theresa.belanger@state.nm.us. We hope that you are able to join us for this meeting and look forward to discussing the draft waiver renewal application on October 20th.

Sincerely,

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Cc:
Suzette Shije, Acting Secretary, Indian Affairs Department
Michael Nelson, Deputy Secretary, Human Services Department
Nancy Smith Leslie, Medicaid Director

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Centennial Care 2.0
Draft Application for Renewal of Section 1115 Demonstration Waiver
Tribal Consultation

Friday, October 20, 2017
9:00 AM

Location
Institute of American Indian Arts (IAIA) – Center for Lifelong Education
83 Avan Nu Po Road
Santa Fe, NM 87508

Consultation Protocol: Individuals representing a Tribe, Pueblo, or Nation shall present a letter of authorization from their governor, president, or chairperson before the session begins. The letter must be on official Tribal letterhead.

AGENDA

9:00 Invocation – Former Governor Rick Vigil, Tesuque Pueblo

9:10 Welcome and Introductions – Secretary Brent Earnest, Human Services Dept.
Suzette Shije, Acting Cabinet Secretary, Indian Affairs Dept.

Introductions from Tribal leadership

Review of consultation protocol – Theresa Belanger, Tribal Liaison, Medical Assistance Division

9:30 HSD Presentation on Centennial Care 2.0 Draft Application for Renewal of Section 1115 Demonstration Waiver (PowerPoint)

Tribal leadership discussion

11:30 Public Comment (3 Minute Limit)

Adjourn

HUMAN SERVICES DEPARTMENT

Centennial Care 2.0: 1115 Demonstration Waiver Renewal Application

Tribal Consultation

October 20, 2017
Santa Fe, NM

Today's Agenda & Goals

Centennial Care 2.0 Concepts

- Discuss recent changes in current managed care program
- Discuss proposed changes for Centennial Care 2.0 by area of focus as presented in the draft 1115 waiver renewal application.

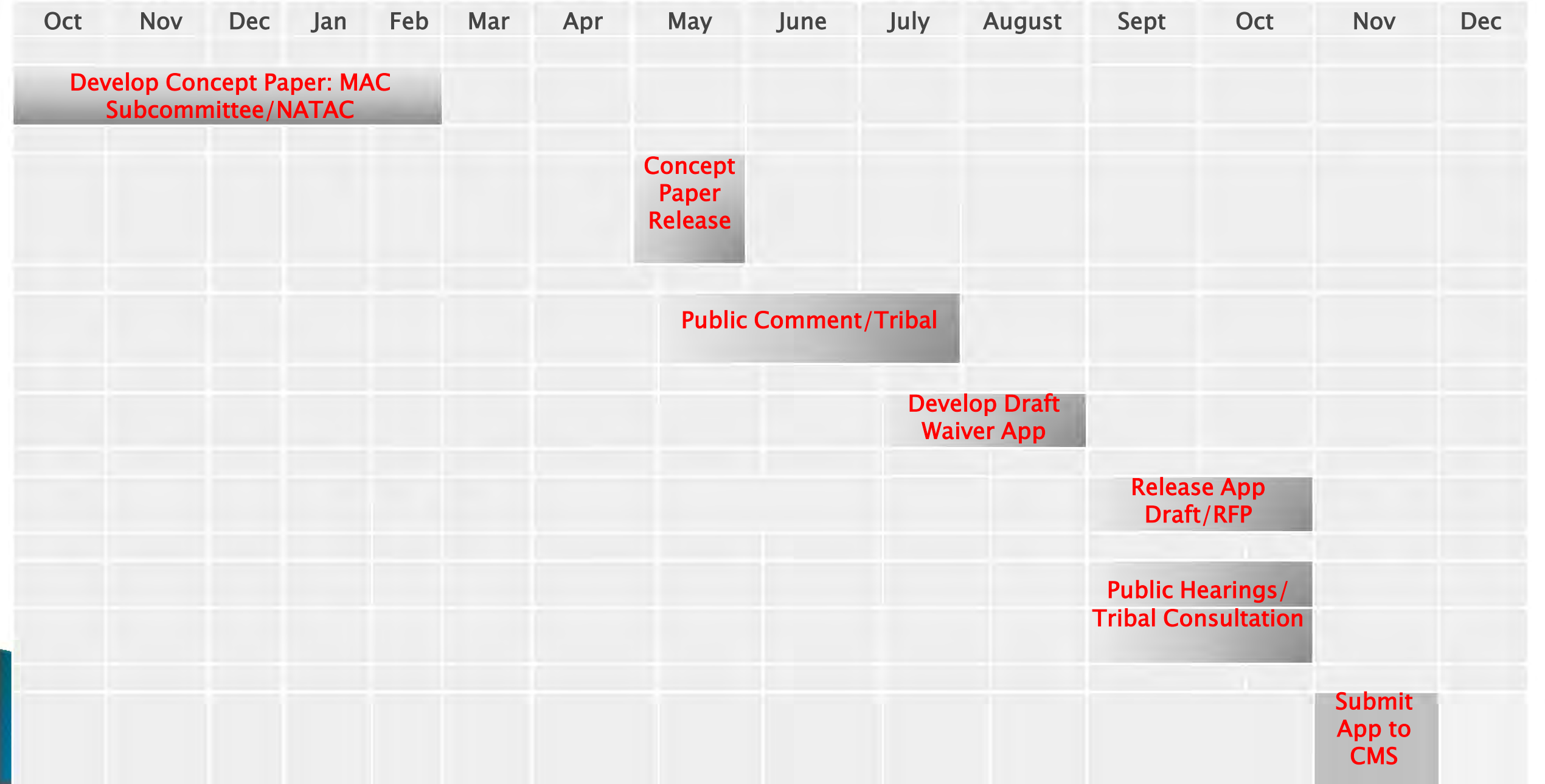
Comments/Discussion

- Consider your feedback and recommendations for Centennial Care 2.0 final waiver application.

Wrap Up

- Present timeframe for public comment.
- Thank you for your time and feedback.

Centennial Care 2.0 Waiver Renewal



Year-Long Public Input Process

Public Input Opportunities in the Development of Concept Paper (before May 2017)	Public Input Meetings about Draft Concept Paper (after May 2017)	Other Input Opportunities
Medicaid Advisory Subcommittee: October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe) *Public Comment at end of each meeting*	**Statewide Public Input Sessions & Attendees:** **Albuquerque** – June 14, 2017 – 160 attendees **Silver City** – June 19, 2017 – 22 attendees **Farmington** – June 21, 2017 – 41 attendees **Roswell** – June 26, 2017 – 30 attendees	**Written Comments:** May – July 2017 – 21 letters received
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees – Albuquerque **Native American Technical Advisory Committee**: July 10, 2017 – NATAC Membership	**HSD Email Address Established:** Ongoing from October 2016– July 2017 137 emails received
MAC Meetings with Public Input: November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)	**MAC Meetings with Public Input:** July 24, 2017 – (Santa Fe)	**Public Hearings to be held in October 2017:** • Las Cruces • Las Vegas • Santa Fe • Albuquerque **Formal Tribal Consultation** – Oct 20, 2017

Waiver Versus Non-Waiver Topics

- Broad changes to the Medicaid program may require waiver authority from CMS to implement while other changes may be implemented through contractual provisions with the managed care organizations (MCOs) or rule promulgation

Waiver

- System Transformation: Items that require waiver authority to implement
- Eligibility changes or expansions
- New benefit packages
- Financing

Non-Waiver

- Policy or implementation issues
- New contract terms or processes
- Modification of provider qualifications
- Implementation of monitoring approaches

Waiver Versus Non-Waiver Topics

- Several recommendations received from Tribal organizations are being implemented through changes to the MCO contracts:
- Effective CY 2018:

Expanding the use of Community Health Representatives (CHRs):

- A minimum of 10% increase in number of members served by CHWs, CHRs, and/or Certified Peer Support Workers for activities such as care coordination, home visiting, health education, health literacy, translation support
- The MCO's project plan for its delivery system improvements must include efforts to create a sustainable funding stream for CHWs/CHRs/CPSWs
- The MCOs must provide quarterly reports to HSD that indicate the number of CHRs supported at Tribal 638 facilities

Native American members requesting a Native American care coordinator:

4.4.12.11: If a Native American Member requests assignment to a Native American care coordinator, the MCO must employ or contract with a Native American care coordinator or CHR to serve as the care coordinator

CENTENNIALCARE2.0

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Benefit and delivery system modifications
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to eligibility

Person-Centered Initiatives in Centennial Care 2.0

- MCO Care Coordinators focused on High-Need Members
- 300,000 Members Served in Patient -Centered Medical Homes
- Care Coordination at Provider Level
- Home Visiting Pilot for Prenatal, Post Partum and Early Childhood Services
- Full Delegation Model with Value Based Purchasing Arrangements
- Shared Functions Model with Providers and Community Partners
- Health Homes for Members with Complex Behavioral Health Needs
- Use of Community Health Workers, Community Health Reps and Peer Support Specialists
- Supportive Housing Specialists and Justice-Involved Liaisons
- Expanded Access to Home and Community Based Services

Care Coordination

Proposals

#1: Increase care coordination at the provider level

- Full Delegation Model for providers entering into Value-Based Purchasing agreements to manage total cost of members' care and Shared Functions Model for providers and/or community partners conducting more limited care coordination activities—using local resources to assist with care coordination, including **Community Health Representatives**

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations

- First Responders, wellness centers, personal care agencies and Project ECHO (Extension for Community Health Outcomes) ;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

Care Coordination

Proposals

#4: Initiate care coordination for justice-involved prior to release from incarceration

- Allowing care coordination activities to be conducted by county/facility prior to release
- Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities and facilitate the care coordination, including for Native American members transitioning from incarceration

#5: Obtain 100% federal funding for Native American members for services received through Indian Health Services (IHS) and/or Tribal 638 facilities to leverage CMS's reinterpretation of federal guidance

Benefit and Delivery System Modifications

Proposals

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Individuals with higher needs who are determined to meet the "medically frail" criteria may receive the standard Medicaid benefit package and not the ABP
- Eliminate habilitative services from the ABP, but add a limited vision benefit similar to the standard Medicaid package vision benefit, expanding access for the 250,000 members currently enrolled
- Expand service providers for the non-emergent medical transportation benefit to include ride sharing companies and leverage new technologies such as mobile apps

#2: Waive federal EPSDT rule for 19-20 year olds enrolled in the single adult plan to further streamline the benefit package so that all adults receive the same comprehensive benefits

#3: Develop buy-in premiums for dental and vision services for adults (if necessary due to budgetary shortfall)

Benefit and Delivery System Modifications

Proposals

#4: Allow for one-time, start-up funding for Community Benefit members who transition from the agency-based model to self-directed model -- up to $2,000

#5: Increase caregiver Community Benefit respite limit (from 100 hours to up to 300 hours annually) for caregivers of both adults and children

#6: Continue expanded access to Community Benefit services for all eligible members who meet a Nursing Facility Level of Care (NF LOC) but establish annual limits on costs for certain home and community-based services in Self-Directed model:

- Related Goods & Services - $2,000 annual limit
- Non-medical transportation - $1,000 annual limit for carrier pass & mileage only
- Specialized Therapies - $2,000 annual limit

Based on 2016 data, 17 Native American members would be impacted by the new limitations

Benefit and Delivery System Modifications

Proposals

#7: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development services

- Collaborate with the Dept. of Health and Children, Youth & Families Dept. to implement a home visiting pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women

#8: Develop Peer-Delivered, Pre-Tenancy and Tenancy Supportive Housing Services

- Create a supportive housing service that provides some peer-delivered tenancy support services to participants with complex behavioral health needs

#9: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)

- Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

Benefit and Delivery System Modifications

Proposals

#10: Expand Health Homes (CareLink NM) for individuals with complex behavioral health needs who may require more intensive care coordination services

- HSD has approved Kewa Pueblo Health Clinic as a new Health Home Provider beginning next year

#11: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

#12: Request waiver authority for enhanced administrative funding to expand availability of Long Acting Reversible Contraception (LARC) for certain providers

- Requesting authority to receive increased administrative funding to expand availability of LARC by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

Payment Reform

Proposals

#1: Pay for improved healthcare outcomes for members by requiring better quality and value from providers and increasing the percentage of provider payments that are risk-based (providers responsible for total cost of care of assigned members)

- Expand requirements for MCOs to shift provider payments from fee-for-service that pays for volume of services to paying more for quality and improved member outcomes

#2: Use Value Based Purchasing to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.
- Include nursing facilities in Value Based Purchasing arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

Payment Reform

Proposals

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network

Member Engagement and Personal Responsibility

Proposals

#1: Advance the Centennial Rewards Program that rewards members for completing healthy activities, such as obtaining preventive screenings

#2: Implement premiums for populations with income that exceeds 100% of the Federal Poverty Level (FPL).

- **Applies to three categories of eligibility:**
  1) Adults in the Expansion with income greater than 100%
  2) CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
  3) Working Disabled Individuals (WDI) Category (income extends to 250% FPL)

Native American members are exempt from all cost-sharing

Proposed Premium Structure (not applicable)

Annual Household Income (Household of 1)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
$12,060 – $18,090	$10	$20	$20	$40
$18,091 – $24,120	$15	$30	$30	$60
$24,121 – $30,150	$20	$40	$40	$80
$30,151 – $36,180	$25	$50	$50	$100

Member Engagement and Personal Responsibility

Proposals

#3: Require co-payments for certain populations

- Seeking to streamline copayments across populations
- HSD currently has copayment requirements for the Children's Health Insurance Program and for Working Disabled Individuals
- Add copayments for the adult expansion population with income greater than 100% FPL
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the Emergency Department
- The following populations would be exempt from all copayments:
  - Native Americans
  - Intermediate Care Facility for Individuals with Intellectual Disabilities
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the Program of All Inclusive Care for the Elderly
  - Individuals on the Developmental Disabilities and Medically Fragile waivers
  - People receiving hospice care

Member Engagement and Personal Responsibility

Proposals

#4: Allow providers to charge small fees for three or more missed appointments

#5: Expand opportunities for Native American members in Centennial Care

- Require MCOs to expand contractual or employment arrangements with Community Health Representatives throughout the state
- Work with Tribal providers to develop capacity to enroll as Long Term Services and Supports providers and/or health home providers
- Seek authority to collaborate with Indian Managed Care Entities (IMCE), including a pilot project with the Navajo Nation. An IMCE may operate in a defined geographic service area, but would be required to meet all other aspects of federal and state managed care requirements, including but not limited to financial solvency, licensing, provider network adequacy and access requirements. An ICME must be able to demonstrate compliance with the requirements in the Centennial Care managed care agreement, including delivery of all covered services. Implementation may require several phases during the waiver.

Administration Simplification through Refinements to Eligibility

Proposals

#1: Eliminate the three month retroactive eligibility period for most Centennial Care members

- Native American members and individuals residing in nursing facilities would be exempt from this provision

#2: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caretakers who have increased earnings that make them ineligible for the program

- The individuals previously using the category are now either transitioned to the adult expansion category or are eligible to receive subsidies to purchase coverage through the federal Exchange
- Since the implementation of the Affordable Care Act, use of the category dropped from 26,000 individuals to 2,000 (most Parent/Caretaker individuals with increased earnings now covered under the Adult Expansion)
- **Currently, there are 326 Native American members in this category**

Administration Simplification through Refinements to Eligibility

Proposals

#3: Implement an automatic NF LOC re-approval for certain members whose condition is not expected to change

#4: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance (with certain exceptions)

#5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

Public Comment

- The Department is accepting comments from the public about the Medicaid program known as Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care federal 1115 waiver that will be effective on January 1, 2019.
- Comments will be accepted until **5:00 pm MST on Monday, November 6, 2017.**
- We are conducting four public hearings in different regions of the state:

Las Cruces – Thursday, October 12, 2017
Farm and Ranch Museum (1:30 pm – 3:30 pm)

Santa Fe – Monday, October 16, 2017
Medicaid Advisory Committee Meeting
NM State Library (1–4pm)

Las Vegas – Wednesday, October 18, 2017
Highlands University – Student Union Building/Student Center (1:30 pm – 3:30 pm)

Albuquerque – Monday, October 30, 2017
National Hispanic Cultural Center
Albuquerque, NM (5:30 pm – 7:30 pm)
Call toll-free 1-888-757-2790 or 1-719-359-9722 and enter participant code 991 379.

Public Comment

- Comments are also being accepted directly at HSD-PublicComment@state.nm.us or by mail:

  Human Services Department
  ATTN: HSD Public Comments
  PO Box 2348
  Santa Fe, NM 87504-2348

  More information about the waiver renewal and public comment process may be found on the Department's website:

  http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Thank you

Your time and input are valuable

Presentation to State Legislative Committees

1. Presentation to the Legislative Finance Committee, June 7, 2017

HUMAN SERVICES
DEPARTMENT

Presentation to LFC: Behavioral Health Collaborative Strategic Plan, SFY2015-SFY2017

Wayne Lindstrom, CEO, BH Collaborative

June 7, 2017

New Mexico Human Services Department

Strengthening NM's Behavioral Health Service Delivery System

New Mexico's behavioral health service delivery system cannot sufficiently make necessary quality gains while continually being overstressed by the demands associated with complex regulations, inflexible financial incentives, and an inadequate workforce

HUMAN SERVICES DEPARTMENT

Strategic Planning Process

- Planning Session held July 30, 2015
- Diverse group of stakeholders included:
  - Senior managers from BH Collaborative agencies
  - Two cabinet secretaries (Indian Affairs and Veteran Services)
  - Three deputy secretaries (HSD, PED, CYFD)
  - County Commissioners
  - Behavioral Health Planning Council
  - Local Collaboratives
  - MCOs
  - Behavioral Health Providers Association
  - Other BH professional associations
  - UNM partners
  - Peers and family members
  - Legislative Finance Committee
  - Association of Counties

HUMAN SERVICES DEPARTMENT

Initial Steps

- December 2015 – draft report completed
- January 2016 – final plan adopted by Behavioral Health Collaborative
- Work groups formed and goals identified in three areas:
  - Finance
  - Regulations
  - Workforce
- Executive Team created with reps from BHSD, MAD and CYFD
  - Meets bi-monthly to monitor implementation

HUMAN SERVICES DEPARTMENT

Finance Goals

I. To increase the productivity, efficiency, and effectiveness of New Mexico's current behavioral health delivery system.

II. To implement a value-based purchasing system that supports integrated care and reinforces better health outcomes.

III. To identify, develop, and promote the implementation of effective strategies for state, counties, and municipalities to work together to fund the provision of better BH care, especially for high utilizers.

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

- Strengthening Sustainability of Services:
  - Medicaid Rule Change to be promulgated in Summer, 2017 to streamline service and staffing requirements
  - CCSS will no longer require certification
  - Recovery Services to be delivered for both individuals & groups
  - ACT regulations modified to broaden staffing
  - IOP certification process simplified
  - Training & TA for peers in CCSS & supervision of CSWs
  - Reimbursing Nursing-based services in BH settings

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

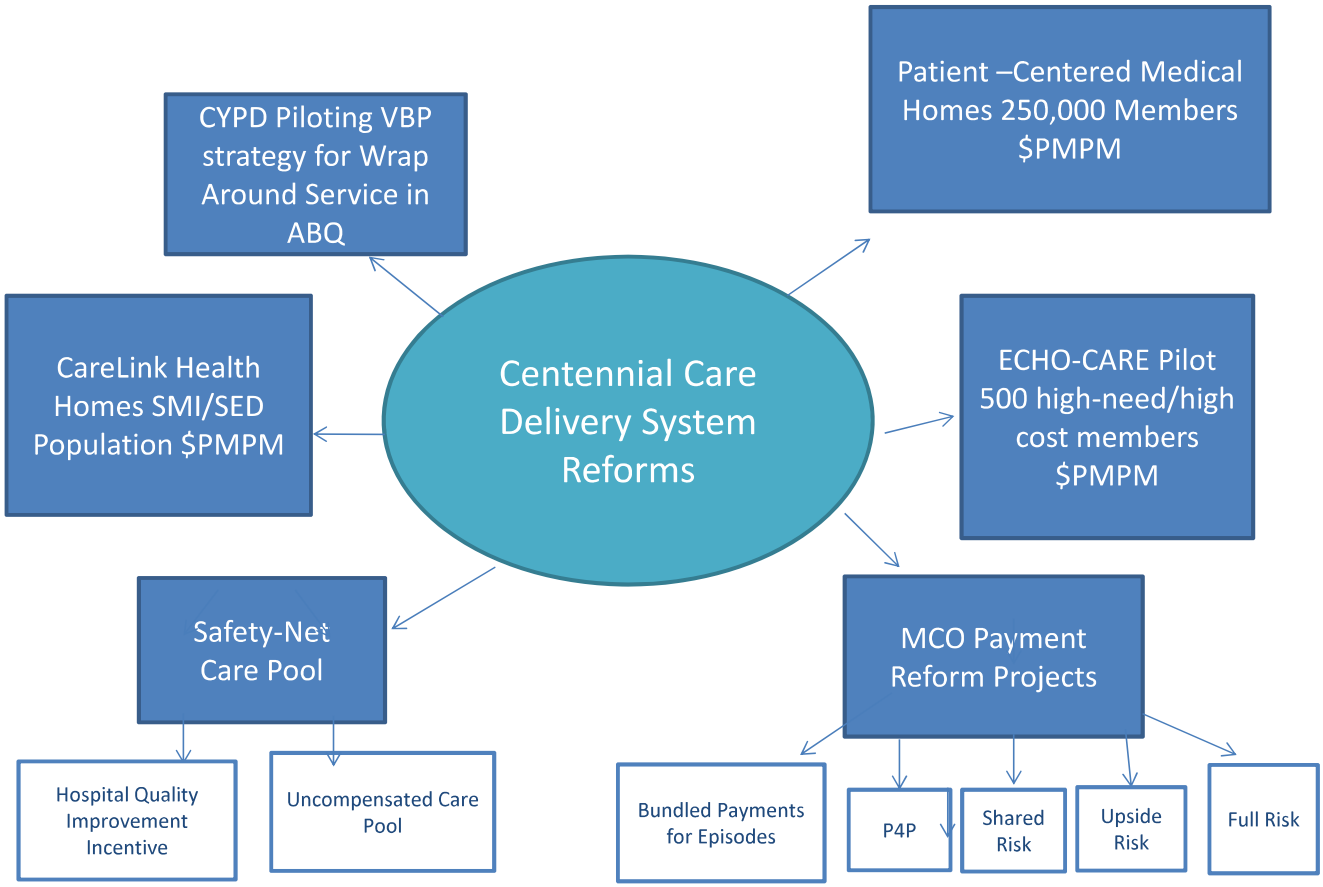
- Implementing Evidence-Based Practices:
  - Wrap Around
  - Infant Mental Health
  - Multi-Systemic Therapy
  - Dialectical Behavioral Therapy
  - Assertive Community Treatment
- Implementing Innovations:
  - Integrated Quality Services Review
  - CareLink
  - Treat First
  - Opioid State Targeted Response

HUMAN SERVICES DEPARTMENT

Value-Based Purchasing

HUMAN SERVICES DEPARTMENT

Pathways to Value-Based Purchasing



Accomplishments – Finance

- Supporting EMR Infrastructure Development:
  - Emergency Department Information Exchange (EDIE) now implemented in 8 hospitals statewide and expanding
  - Expanded Care Link advancing payment reform through capitated payments for 6 services in selected CMCH's & 2 FQHC's

- Partnering with Counties & Municipalities to fund better provision of behavioral health services:
  - The January 2017 Association of Counties Conference showcased BH innovations in the counties of McKinley, Rio Arriba, Bernalillo, and Dona Ana. Program is set for AOC's June conference and focuses on opioid crisis with attendees receiving Naloxone kits.

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

- Developed and funded two Investment Zones; Rio Arriba County has implemented county-wide Pathways care coordination system; McKinley County has renovated the Gallup Detox center, converted old hospital into a SUD RTC.
- Bernalillo County approved $16 million to fund behavioral health services, and 4 BHSD staff have received certificates of appreciation for participating in the 4 subcommittees.

HUMAN SERVICES DEPARTMENT

Regulations Goals

I. To identify, align, and eliminate inconsistencies in BH statutes, regulations, data, and policies in order to allow for a more effective and efficient operation of the publicly funded service delivery system.

II. Increase the adoption of person-centered interventions.

HUMAN SERVICES DEPARTMENT

Accomplishments – Regulations

- MMISR to be completed by 2018; progress on six-module RPF:
  - 2 Proposals being submitted (Data system & Integration platform)
  - 2 RFP's in review stage (Financial services & Quality assurance)
  - 2 RFP's to be developed (Population Health Mgmt & Unified Public Interface)
- Collaboration by DOH, CYFD, and BHSD on joint standards for Crisis Triage Centers
- *Treat First* operating across 13 agencies in 18 local communities. In 15 months, 2,600 clients served. "No Show" rate is only 17.7% (compared to previous range of 20-45%)

HUMAN SERVICES DEPARTMENT

Accomplishments – Regulations

- BHSD policy will reflect acceptance of adult RTC national accreditation

- Current challenges: Consolidating provider audit processes
  - Medicaid parity review may impact strategies
  - NCQA requirement a barrier to MCO centralized certification and consolidation of audits
  - Contractual language on standard credentialing deferred for upcoming 1115 waiver application and procurement cycle

HUMAN SERVICES DEPARTMENT

Workforce Goals

I. Support the development of behavioral health practitioners.
II. Build a more multidisciplinary and competent BH workforce.
III. Promote the future of excellence in the BH workforce and prepare for integrated care.
IV. Improve the public image of BH professions, raise awareness of its impact of the population, and promote the effectiveness of the service delivery system.

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- Supporting BH Interns
  - PED establishing a web-based clearinghouse for internship opportunities
  - BH Workforce Subcommittee has reviewed other states and provided recommendations given to the NM Health Care Workforce Committee
- Reciprocity
  - Each of the professional boards is undertaking steps toward reciprocity through rule changes
- Building a more competent, multidisciplinary workforce
  - Promoting cross-disciplinary supervision

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- A BH Clinical Practice Provider Guide has been developed and presentations will be given to senior classes at all major universities
- Have posted job opportunities on the NM Network of Care website
- Presented at workforce booths at the National Council on Behavioral Health, the National Association of Social Workers, NM Counseling Association Conference and the NASW-NM Conference
- A NM Behavioral Health Workforce Development Summit is planned for Fall, 2017 bringing together disciplines in academia and BH & primary care practitioners

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- A gap analysis conducted to determine EHR usage across BH providers. Sponsored an EHR Vendor event.
- CBHTR developing tele-supervision statewide for Social Workers working towards independent licensure
- *Pay It Forward* campaign to identify certified practitioners willing to volunteer as Supervisors.
- Completed Clinical Supervision Certification. Expands ability to fund non-independently licensed therapists.
- CMS approved NM State Plan amendment for the FQHC Community-based psychiatric Residency Program in Dona Ana County
- BH Collaborative to submit an MOU to NM Credentialing Board for BH Professionals – creates a joint credential on behalf of CYFD & BHSD for peer and family support specialists.

HUMAN SERVICES DEPARTMENT

For More Information

- Detailed Strategic Plan Implementation document will be posted on the New Mexico Network of Care website in mid-July, 2017
- Plan will be presented to BH Collaborative on July 13, 2017
- http://newmexico.networkofcare.org

HUMAN SERVICES DEPARTMENT

New Mexico Behavioral Health Collaborative: Strengthening New Mexico's Behavioral Health Service Delivery System

New Mexico's behavioral health service delivery system cannot sufficiently make necessary quality gains while continually being overstressed by the demands associated with complex regulations, inflexible financial incentives, and an inadequate workforce.

Finance	Regulations	Workforce
Goal:	***Goal:***	***Goal:***
I. To increase the productivity, efficiency, and effectiveness of New Mexico's current behavioral health delivery system.	***I. To identify, align, and eliminate inconsistencies in BH statutes, regulations, data, and policies in order to allow for a more effective and efficient operation of the publicly funded service delivery system.***	***I. Support the development of behavioral health practitioners.***
II. To implement a value-based purchasing system that supports integrated care and reinforces better health outcomes.	***II. Increase the adoption of person-centered interventions.***	***II. Build a more multidisciplinary and competent BH workforce.***
III. To identify, develop, and promote the implementation of effective strategies for state, counties, and municipalities to work together to fund the provision of better BH care, especially for high utilizers.		***III. Promote the future of excellence in the BH workforce and prepare for integrated care.***
		IV. Improve the public image of BH professions, raise awareness of its impact on the population, and promote the effectiveness of the service delivery system.

HUMAN SERVICES
DEPARTMENT

Presentation to LFC: Behavioral Health Collaborative Strategic Plan, SFY2015-SFY2017

Wayne Lindstrom, CEO, BH Collaborative

June 7, 2017

New Mexico Human Services Department

Strengthening NM's Behavioral Health Service Delivery System

New Mexico's behavioral health service delivery system cannot sufficiently make necessary quality gains while continually being overstressed by the demands associated with complex regulations, inflexible financial incentives, and an inadequate workforce

HUMAN SERVICES DEPARTMENT

Strategic Planning Process

- Planning Session held July 30, 2015
- Diverse group of stakeholders included:
  - Senior managers from BH Collaborative agencies
  - Two cabinet secretaries (Indian Affairs and Veteran Services)
  - Three deputy secretaries (HSD, PED, CYFD)
  - County Commissioners
  - Behavioral Health Planning Council
  - Local Collaboratives
  - MCOs
  - Behavioral Health Providers Association
  - Other BH professional associations
  - UNM partners
  - Peers and family members
  - Legislative Finance Committee
  - Association of Counties

HUMAN SERVICES DEPARTMENT

Initial Steps

- December 2015 – draft report completed
- January 2016 – final plan adopted by Behavioral Health Collaborative
- Work groups formed and goals identified in three areas:
  - Finance
  - Regulations
  - Workforce
- Executive Team created with reps from BHSD, MAD and CYFD
  - Meets bi-monthly to monitor implementation

HUMAN SERVICES DEPARTMENT

Finance Goals

I. To increase the productivity, efficiency, and effectiveness of New Mexico's current behavioral health delivery system.

II. To implement a value-based purchasing system that supports integrated care and reinforces better health outcomes.

III. To identify, develop, and promote the implementation of effective strategies for state, counties, and municipalities to work together to fund the provision of better BH care, especially for high utilizers.

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

- Strengthening Sustainability of Services:
  - Medicaid Rule Change to be promulgated in Summer, 2017 to streamline service and staffing requirements
  - CCSS will no longer require certification
  - Recovery Services to be delivered for both individuals & groups
  - ACT regulations modified to broaden staffing
  - IOP certification process simplified
  - Training & TA for peers in CCSS & supervision of CSWs
  - Reimbursing Nursing-based services in BH settings

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

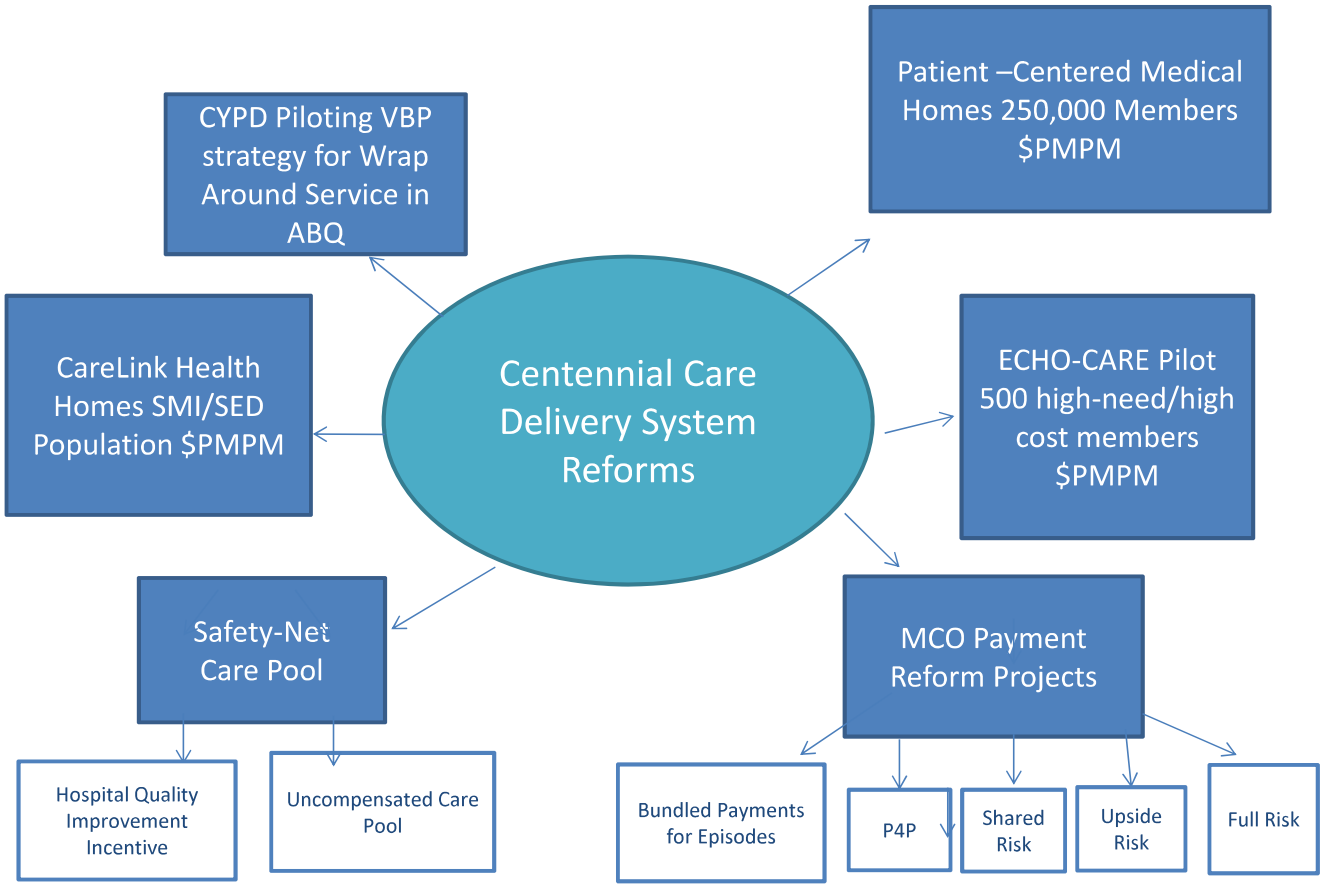
- Implementing Evidence-Based Practices:
  - Wrap Around
  - Infant Mental Health
  - Multi-Systemic Therapy
  - Dialectical Behavioral Therapy
  - Assertive Community Treatment
- Implementing Innovations:
  - Integrated Quality Services Review
  - CareLink
  - Treat First
  - Opioid State Targeted Response

HUMAN SERVICES DEPARTMENT

Value-Based Purchasing

HUMAN SERVICES DEPARTMENT

Pathways to Value-Based Purchasing



Accomplishments – Finance

- Supporting EMR Infrastructure Development:
  - Emergency Department Information Exchange (EDIE) now implemented in 8 hospitals statewide and expanding
  - Expanded Care Link advancing payment reform through capitated payments for 6 services in selected CMCH's & 2 FQHC's

- Partnering with Counties & Municipalities to fund better provision of behavioral health services:
  - The January 2017 Association of Counties Conference showcased BH innovations in the counties of McKinley, Rio Arriba, Bernalillo, and Dona Ana. Program is set for AOC's June conference and focuses on opioid crisis with attendees receiving Naloxone kits.

HUMAN SERVICES DEPARTMENT

Accomplishments – Finance

- Developed and funded two Investment Zones; Rio Arriba County has implemented county-wide Pathways care coordination system; McKinley County has renovated the Gallup Detox center, converted old hospital into a SUD RTC.
- Bernalillo County approved $16 million to fund behavioral health services, and 4 BHSD staff have received certificates of appreciation for participating in the 4 subcommittees.

HUMAN SERVICES DEPARTMENT

Regulations Goals

I. To identify, align, and eliminate inconsistencies in BH statutes, regulations, data, and policies in order to allow for a more effective and efficient operation of the publicly funded service delivery system.

II. Increase the adoption of person-centered interventions.

HUMAN SERVICES DEPARTMENT

Accomplishments – Regulations

- MMISR to be completed by 2018; progress on six-module RPF:
  - 2 Proposals being submitted (Data system & Integration platform)
  - 2 RFP's in review stage (Financial services & Quality assurance)
  - 2 RFP's to be developed (Population Health Mgmt & Unified Public Interface)
- Collaboration by DOH, CYFD, and BHSD on joint standards for Crisis Triage Centers
- *Treat First* operating across 13 agencies in 18 local communities. In 15 months, 2,600 clients served. "No Show" rate is only 17.7% (compared to previous range of 20-45%)

HUMAN SERVICES DEPARTMENT

Accomplishments – Regulations

- BHSD policy will reflect acceptance of adult RTC national accreditation

- Current challenges: Consolidating provider audit processes
  - Medicaid parity review may impact strategies
  - NCQA requirement a barrier to MCO centralized certification and consolidation of audits
  - Contractual language on standard credentialing deferred for upcoming 1115 waiver application and procurement cycle

HUMAN SERVICES DEPARTMENT

Workforce Goals

I. Support the development of behavioral health practitioners.
II. Build a more multidisciplinary and competent BH workforce.
III. Promote the future of excellence in the BH workforce and prepare for integrated care.
IV. Improve the public image of BH professions, raise awareness of its impact of the population, and promote the effectiveness of the service delivery system.

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- Supporting BH Interns
  - PED establishing a web-based clearinghouse for internship opportunities
  - BH Workforce Subcommittee has reviewed other states and provided recommendations given to the NM Health Care Workforce Committee
- Reciprocity
  - Each of the professional boards is undertaking steps toward reciprocity through rule changes
- Building a more competent, multidisciplinary workforce
  - Promoting cross-disciplinary supervision

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- A BH Clinical Practice Provider Guide has been developed and presentations will be given to senior classes at all major universities
- Have posted job opportunities on the NM Network of Care website
- Presented at workforce booths at the National Council on Behavioral Health, the National Association of Social Workers, NM Counseling Association Conference and the NASW-NM Conference
- A NM Behavioral Health Workforce Development Summit is planned for Fall, 2017 bringing together disciplines in academia and BH & primary care practitioners

HUMAN SERVICES DEPARTMENT

Accomplishments – Workforce

- A gap analysis conducted to determine EHR usage across BH providers. Sponsored an EHR Vendor event.
- CBHTR developing tele-supervision statewide for Social Workers working towards independent licensure
- *Pay It Forward* campaign to identify certified practitioners willing to volunteer as Supervisors.
- Completed Clinical Supervision Certification. Expands ability to fund non-independently licensed therapists.
- CMS approved NM State Plan amendment for the FQHC Community-based psychiatric Residency Program in Dona Ana County
- BH Collaborative to submit an MOU to NM Credentialing Board for BH Professionals – creates a joint credential on behalf of CYFD & BHSD for peer and family support specialists.

HUMAN SERVICES DEPARTMENT

For More Information

- Detailed Strategic Plan Implementation document will be posted on the New Mexico Network of Care website in mid-July, 2017
- Plan will be presented to BH Collaborative on July 13, 2017
- http://newmexico.networkofcare.org

HUMAN SERVICES DEPARTMENT

Presentation to State Legislative Committees

2. Presentation to the Legislative Health and Human Services Committee, June 16, 2017

HUMAN SERVICES
DEPARTMENT

Update on Medicaid
Presentation to the Legislative Health & Human Services Committee

Brent Earnest, Secretary, HSD
Nancy Smith-Leslie, Director, Medical Assistance Division, HSD
June 16, 2017

HUMAN SERVICES
DEPARTMENT

New Mexico Medicaid Spending

- Total Medicaid spending is increasing, primarily due to enrollment growth.
- The FY18 general fund (GF) need for Medicaid is **$ 947.5 million**. The Legislature appropriated **$915.6 million**, resulting in a deficit of **$31.9 million** in FY 18.

($ in millions)	FY14 Actual	FY15 Projection	FY16 Projection*	FY17 Projection*	FY18 Projection*
Total Budget	$4,200.6	$5,162.3	$5,412.4	$5,570.4	$5,859.7
General Fund Need	$901.9	$894.1	$912.9	$914.6	$947.5

*Projection data as of January 2017. The projections include all push forward amounts between SFYs. FY16 general fund includes $18 million supplemental appropriation and general fund transfers from other divisions. These figures exclude Medicaid administration. FY18 General Fund projection some cost containment.

HUMAN SERVICES DEPARTMENT

Medicaid FY18 General Fund Budget Details

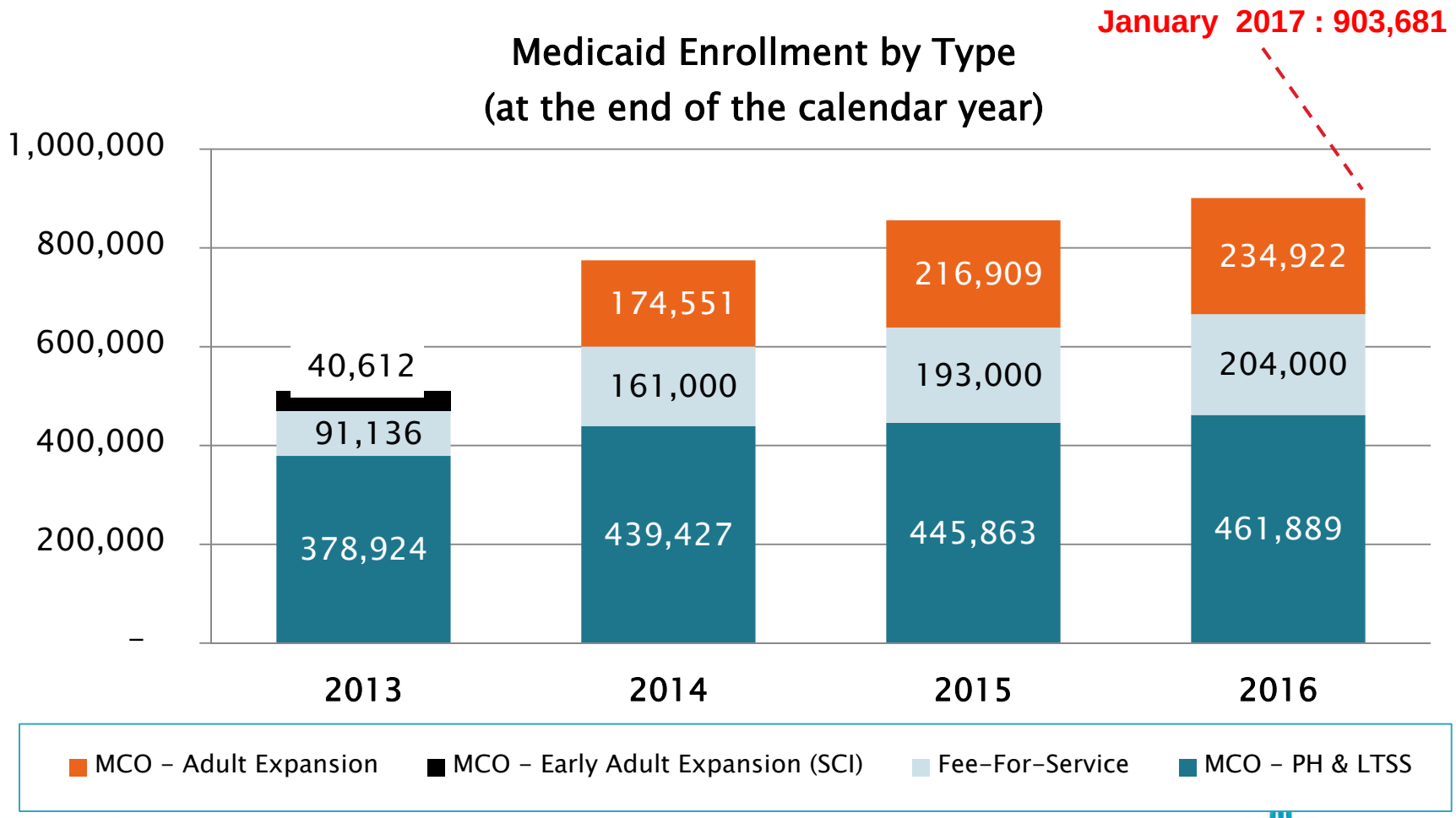
	GAA	Current Projection
Full Medicaid GF need	971.83	963.54
GF Cost Containment/Changes in Projection*N1	(16.00)	(7.71)
Medicaid Projection GF	**955.83**	**955.83**
Proposed Changes		
Additional Tobacco Revenue	(4.23)	(1.50)
Additional I.H.S. Revenue	(4.00)	-
Federal Delay in Health Insurers fee*	(17.00)	-
Additional Copays and Premiums*	(3.00)	-
Discontinue Centennial Rewards*	(2.00)	-
Other Cost Containment*	(4.10)	(38.63)
Reduce Hep C Treatment*	(5.80)	-
Total Proposed Changes	**(40.13)**	**(40.13)**
GAA General Fund Appropriation	**915.70**	**915.70**

*Cost Containment Item

N1 - Slightly lower enrollment growth and lower spending due to proposed co-pays are included in the projection

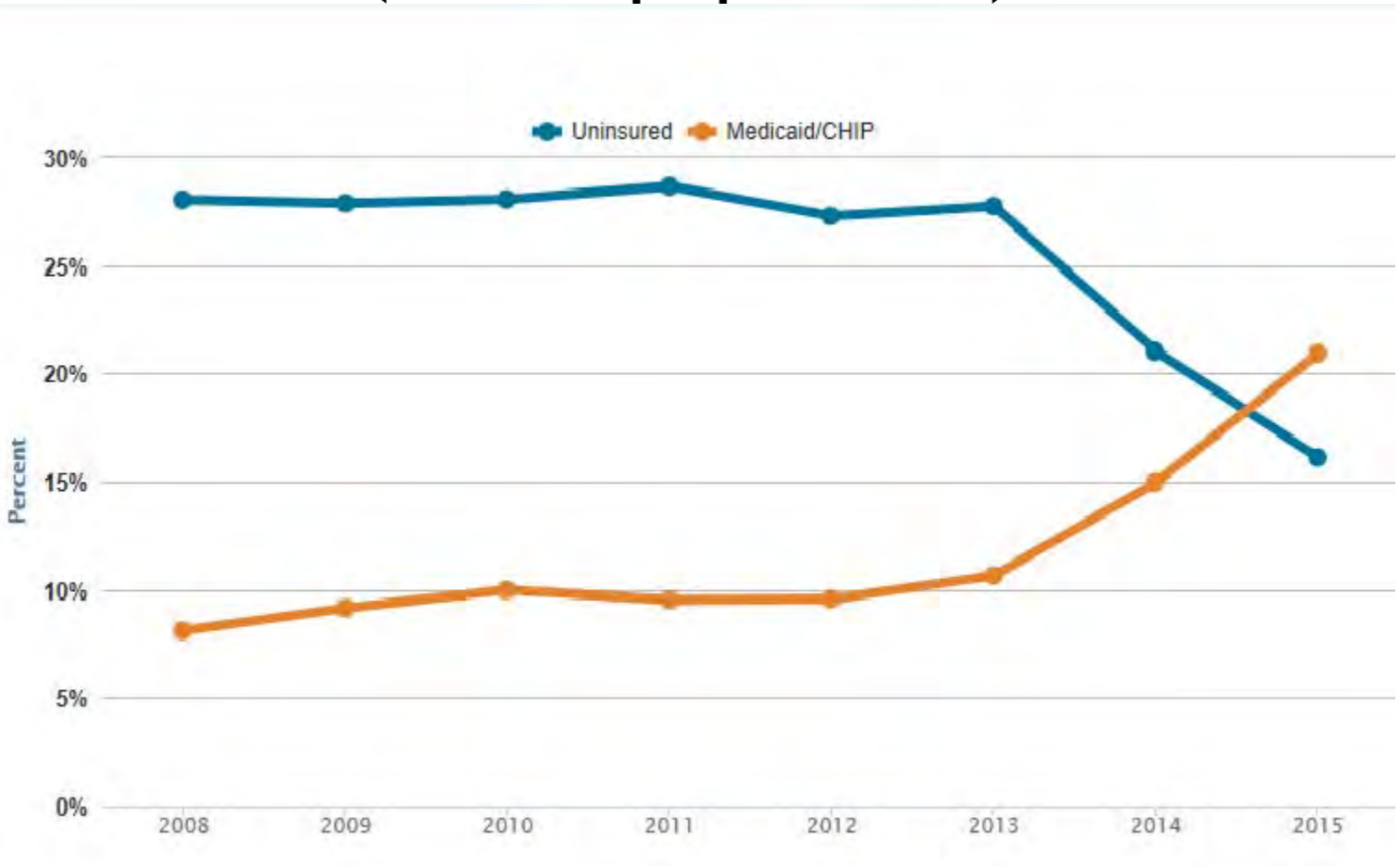
HUMAN SERVICES DEPARTMENT

Key Driver of Costs



HUMAN SERVICES DEPARTMENT

New Mexico Uninsured and Medicaid-Insured (19-64 population)



Source: SHADAC State Health Compare, University of Minnesota

HUMAN SERVICES DEPARTMENT

Managing Cost Growth

- Healthcare cost inflation grew an average of 2.6% in 2015 and growth averaged more than 3% in 2016
- Other national studies estimate medical cost inflation (price and utilization) at 6.5%

Centennial Care Stats

- Per capita medical services cost in Centennial Care **growing only 1.3%, driven primarily by increased enrollment and pharmacy costs**
- Managing cost through care coordination and other efforts
- Increases in preventive services and decreases in inpatient hospital costs
- Per person costs are lower in Centennial Care

HUMAN SERVICES DEPARTMENT

UPDATE: CO-PAYS FOR CY17

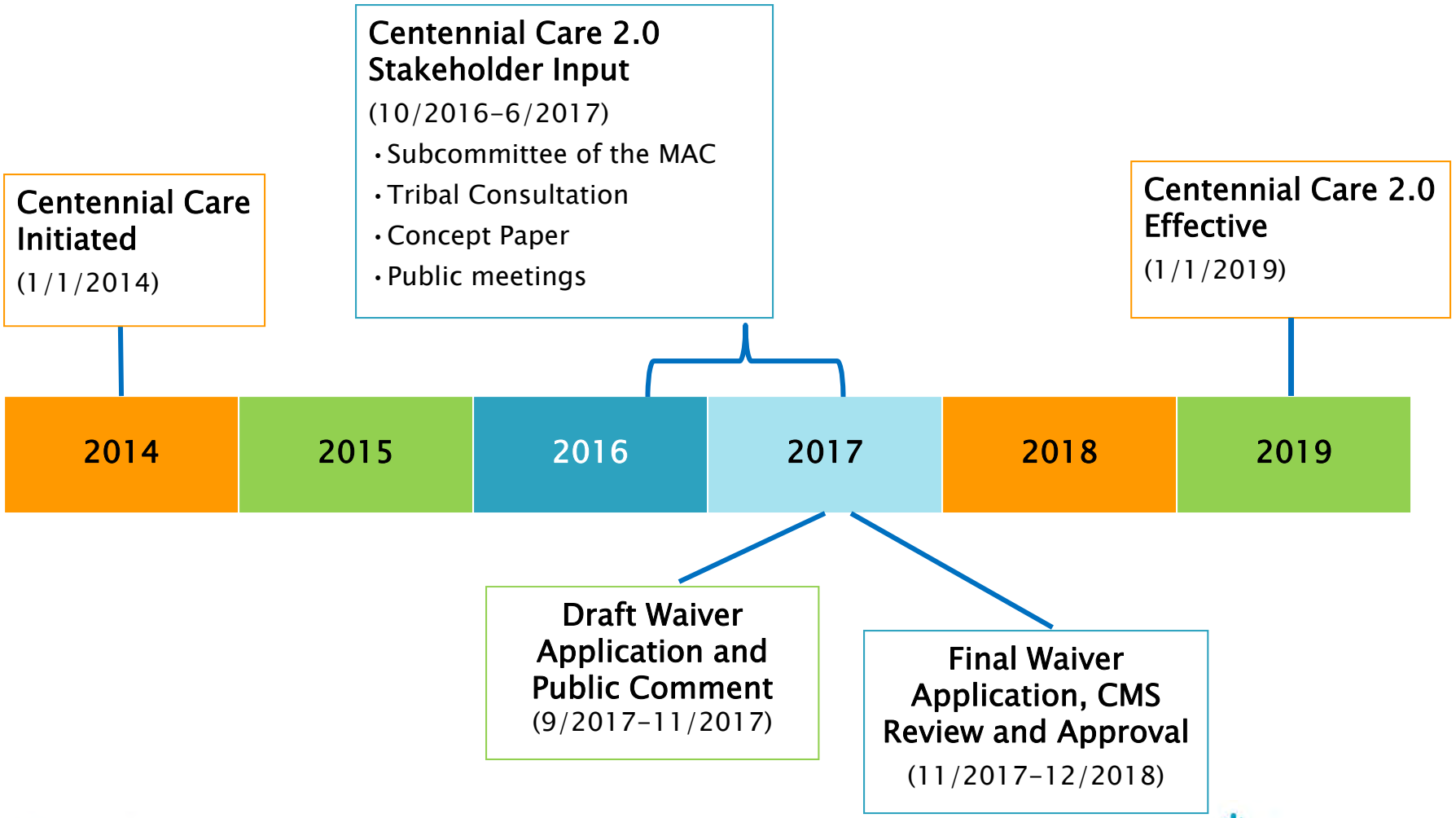
Note: Native Americans exempt from all co-pays. Notice of Proposed Rulemaking published on 6/13/17; public hearing scheduled on 7/14/17. Proposed rules are posted at www.hsd.state.nm.us/LookingforInformation/registers.aspx. Effective date 10/1/17.

	CHIP Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	**WDI** Up to 250% FPL	**Expansion Adults** Co-pays only for individuals with income greater than 100% FPL	**Other Medicaid**
Outpatient office visits • Preventive visits exempt • BH outpatient exempt	**$5/visit**	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	**$50/stay**	$50/stay	$50/stay	No co-pay
Outpatient surgeries	**$50/procedure**	$50/procedure	$50/procedure	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic drugs and family planning drugs/supplies exempt • Not charged if non-preferred drug co-pay is applied	**$2/prescription**	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic drugs and family planning drugs/supplies exempt	$8/prescription All FPLs and COEs, certain exemptions will apply			
Non-emergency ER visits	$8/visit All FPLs and COEs, certain exemptions will apply			

HUMAN SERVICES DEPARTMENT

NTENNIALCARE2.0

Centennial Care Timeline



HUMAN SERVICES DEPARTMENT

CENTENNIALCARE2.0

Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

Opportunity #1: Increase care coordination at the provider level

Opportunity #2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Opportunities

Opportunity #3: Expand programs working with high needs populations

- Collaborate with successful community programs such as: First Responders, wellness centers, personal care agencies and Project ECHO
- More use of Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists
- Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood services; and
- Leverage federal funding for supportive housing services

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration 2.0

Opportunities

Opportunity #1: Expanding Health Homes (CareLink NM)

Opportunity #2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #1: Allow for one-time start-up goods for transitions when a member transitions from agency based to self directed

Opportunity #2: Increase caregiver respite hours

- Increase the current limit from 100 to 300 hours.

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain Community Benefits

Self-Directed CB Service	Annual Limit
Related goods and services separate from one-time funding for start-up goods	$2,000
Non-medical transportation	$1,000
Specialized therapies such as acupuncture or chiropractic	$2,000

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

Opportunity #4: Implement an automatic NF LOC approval for members whose condition is not expected to change

Opportunity #5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff.

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

Opportunity #1: Pay for better quality and value by increasing percentage of providers payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee per service to paying for quality and improved outcomes.

Opportunity #2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, improving transitions of care, increasing physical and behavioral health integration and improving member engagement.

HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility 2.0

Opportunities

Opportunity #1: Advance the Centennial Rewards Program

Opportunity #2: Allow providers to charge small fees for three or more missed appointments

Opportunity #3: Premiums for populations with income that exceeds 100% FPL (applies only to 3 categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP children (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
- Working Disabled Individuals

HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility

- Proposed premium amounts

FPL Range	Annual Income (Household of 1)	Approximate Monthly Premium
101-150% FPL	$11,881-$16,404	$20
151-200% FPL	$16,405-$23,760	$30
201% FPL and up	$23,761-$29,700	$40

- Premiums could be 'paid' by participating in healthy behaviors through the Centennial Rewards program

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #1: Cover most adults under one comprehensive benefit plan

- Today, HSD administers 2 different benefit packages for most adults in Medicaid—Parent/Caretaker category and Expansion Adult category
- HSD proposes to consolidate the 2 different plans under a single comprehensive benefit package that more closely aligns with private insurance coverage (similar to the Alternative Benefit Plan we have today for Expansion)
- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #2: Develop buy-in premiums for dental and vision services for adults

- If HSD needs to eliminate optional dental and/or vision services for adults to contain costs, then it proposes to offer dental and vision riders that members may purchase from their MCO as is standard practice with most private insurance coverage

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Populations covered in FFS would be exempt from this change
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that put them over the eligibility guidelines

- Since the ACA, this program has become less needed as evidenced by declining enrollment; most individuals with increased earnings move to the Adult Expansion Group.
- In 2013: 26,000 individuals in this category

  Today: fewer than 2,000 individuals
- Individuals with income above the Adult Group guidelines may receive subsidies to purchase coverage through the Exchange

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

Opportunity #5: More frequent checks of income through trusted data sources

- This was not intended to result in more frequent recertification of eligibility but only to check trusted data sources on a more regular basis to verify income
- HSD has listened to numerous concerns associated with this proposed change and is no longer considering it for inclusion in the renewal going forward

HUMAN SERVICES DEPARTMENT

Public Comment

Share your comments

If you are unable to make your comment today, please submit your note cards or send via the website www.hsd.state.nm.us/Meetings.aspx.

Limited time for Comments

1115 Waiver Renewal Application will be drafted this summer.

Share your comments by Saturday, July 15, 2017

HUMAN SERVICES DEPARTMENT

Presentation to State Legislative Committees

3. Presentation to the Legislative Finance Committee, August 16, 2017

HUMAN SERVICES
DEPARTMENT

Medicaid Reform, Controlling Costs and Improving Quality
Hearing before the Legislative Finance Committee
August 16, 2017

Brent Earnest, Secretary, HSD

HUMAN SERVICES
DEPARTMENT

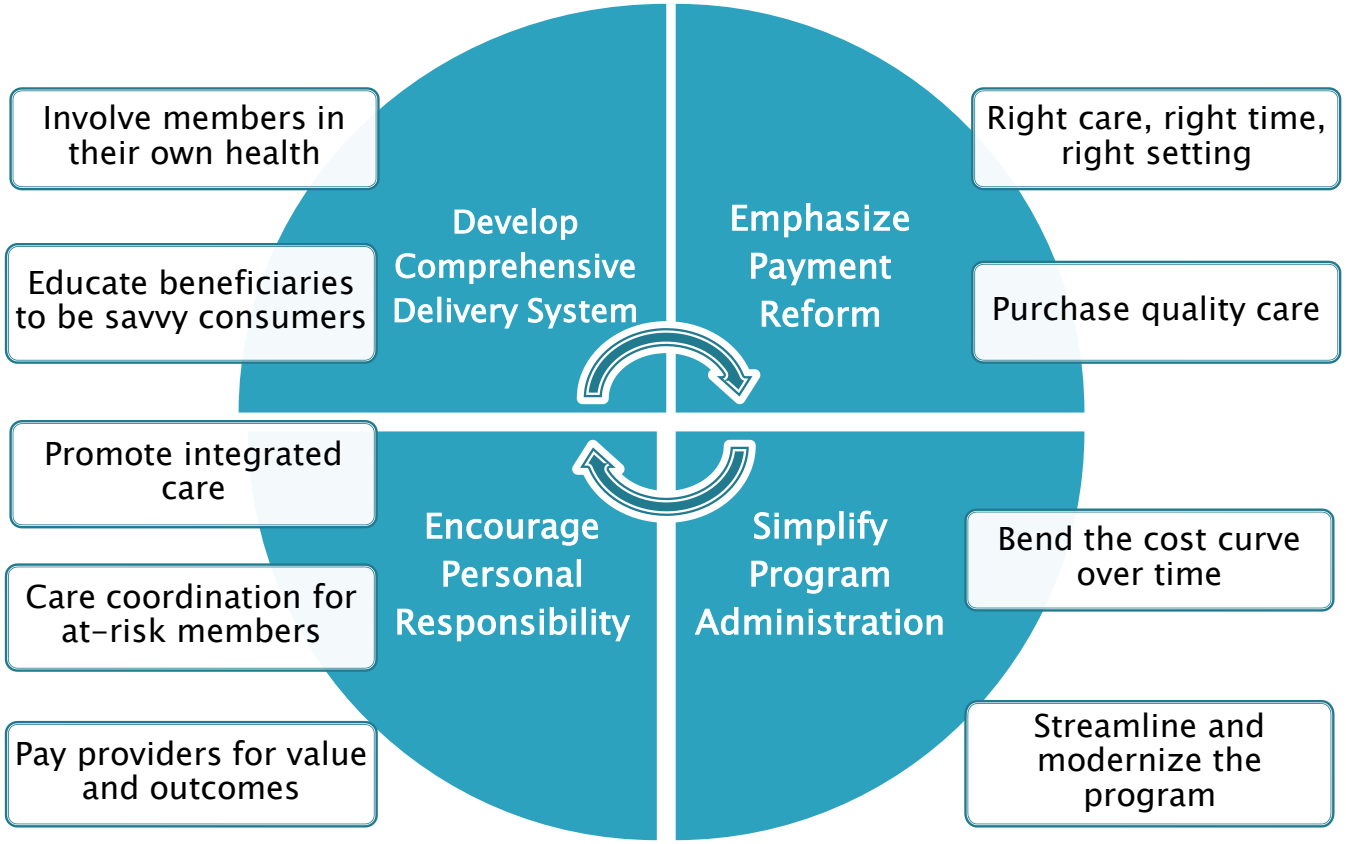
Today's Topics

- Centennial Care
  - Medicaid reforms reducing per person costs, expanding access, driving performance and quality improvements
- Centennial Care 2.0
  - Opportunities and process for the second five-year waiver agreement
- Federal Outlook
  - Health care reform legislation
  - Possible FY19 Budget Impacts

HUMAN SERVICES DEPARTMENT

Centennial Care

Guiding Principles for Medicaid Reform



HUMAN SERVICES DEPARTMENT

Centennial Care: Reforming Medicaid

- A Comprehensive Service Delivery System
  - Managed Care Organizations are responsible for integrating care to address all health needs of the member through robust care coordination
- Personal Responsibility
  - Engage recipients in their personal health decisions through incentives and disincentives
- Payment Reform
  - Use innovative payment methodologies to reward quality care and improve health outcomes instead of the quantity of care
- Administrative Simplification
  - Combine all Medicaid waivers (except the Developmental Disabilities waiver) into a single, comprehensive 1115 waiver

HUMAN SERVICES DEPARTMENT

Centennial Care: Reforming Medicaid

Principle 1

Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an ***integrated, person-centered model of care***

- Care coordination
  - 950 care coordinators
  - 60,000 in care coordination L2 and L3
  - Focus on high cost/high need members
- Health risk assessment
  - Standardized HRA across MCOs
  - 610,000 HRAs
- Increased use of community health workers
  - ~100 employed by MCOs
- Increase in members served by Patient Centered Medical Homes
  - 334,000 members now receiving services through a PCMH
- Health Homes – Two pilot sites for adults and kids with co-occurring behavioral health diagnoses
- Expanding home and community based services
  - Implemented electronic visit verification for personal care services
- Reduction in the use of ER for non-emergent conditions

HUMAN SERVICES DEPARTMENT

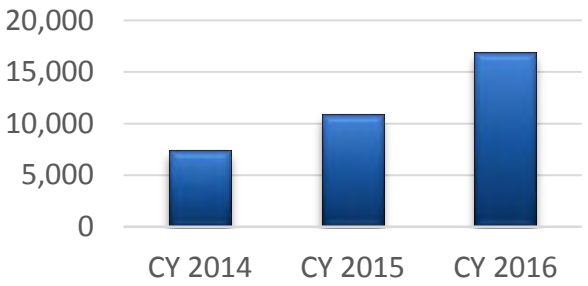
Centennial Care: Reforming Medicaid

Principle 1

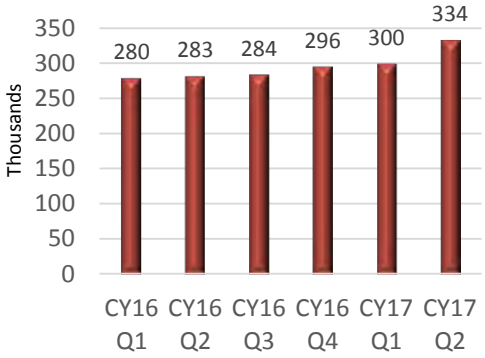
Creating a comprehensive delivery system

Build a care coordination infrastructure for members with more complex needs that coordinates the full array of services in an ***integrated, person-centered model of care***

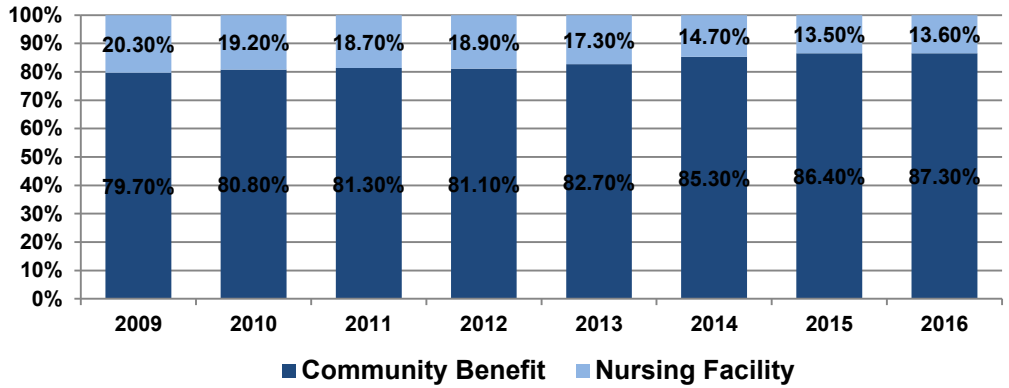
Number of visits through Telehealth in rural and frontier counties



Number Served Through a PCMH



Long Term Services and Supports Enrollment – Setting of Care



HUMAN SERVICES DEPARTMENT

Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a member rewards program to incentivize members to ***engage in healthy behaviors***

- Centennial Rewards
  - health risk assessments
  - dental visits
  - bone density screenings
  - refilling asthma inhalers
  - diabetic screenings
  - refilling medications for bipolar disorder and schizophrenia

- 70% participation in rewards program
- Majority participate via mobile devices
- Estimated cost savings in 2015: $23 million
  - Reduced hospital admissions
  - 43% higher asthma controller refill adherence
  - 40% higher test compliance for diabetes
  - 76% higher medication adherence for individuals with schizophrenia
- 70k members participating in step-up challenge

- Co-pays to drive better health care decisions

HUMAN SERVICES DEPARTMENT

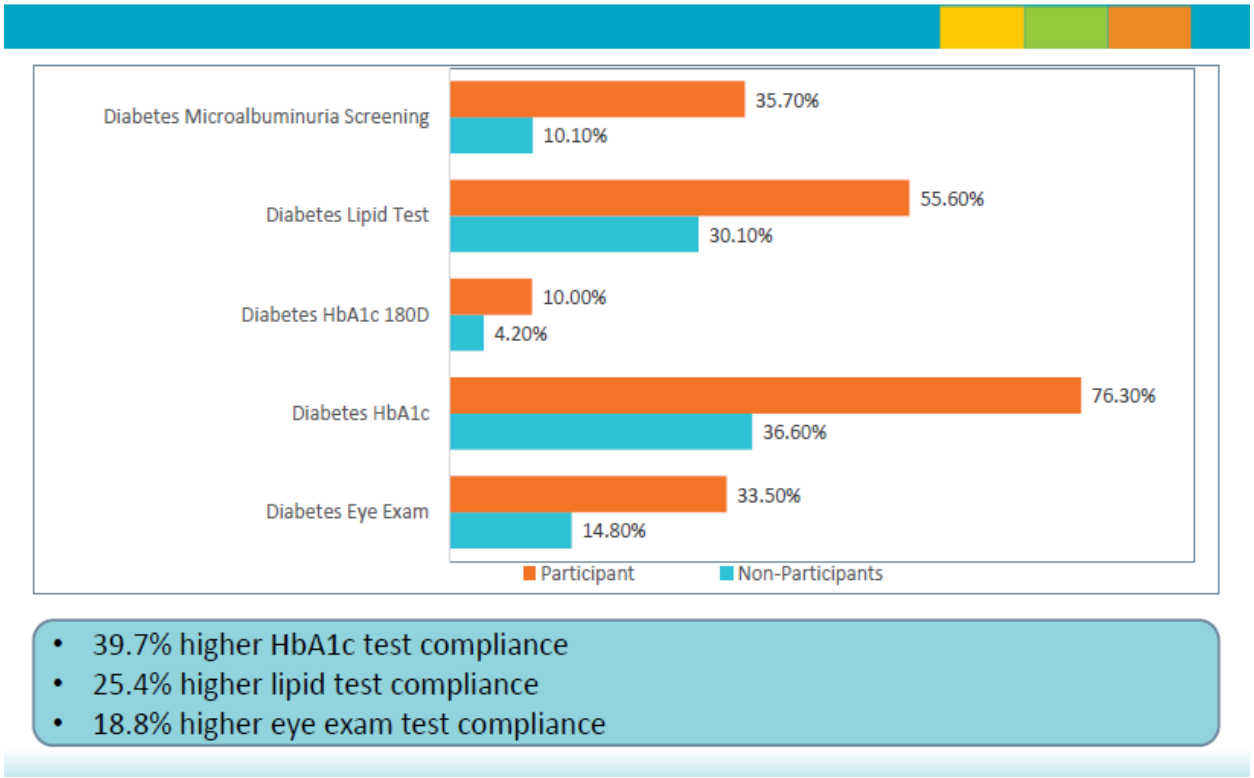
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer **a member rewards program** to incentivize members to ***engage in healthy behaviors***

Quality/Compliance Summary – Diabetes



- 39.7% higher HbA1c test compliance
- 25.4% higher lipid test compliance
- 18.8% higher eye exam test compliance

HUMAN SERVICES DEPARTMENT

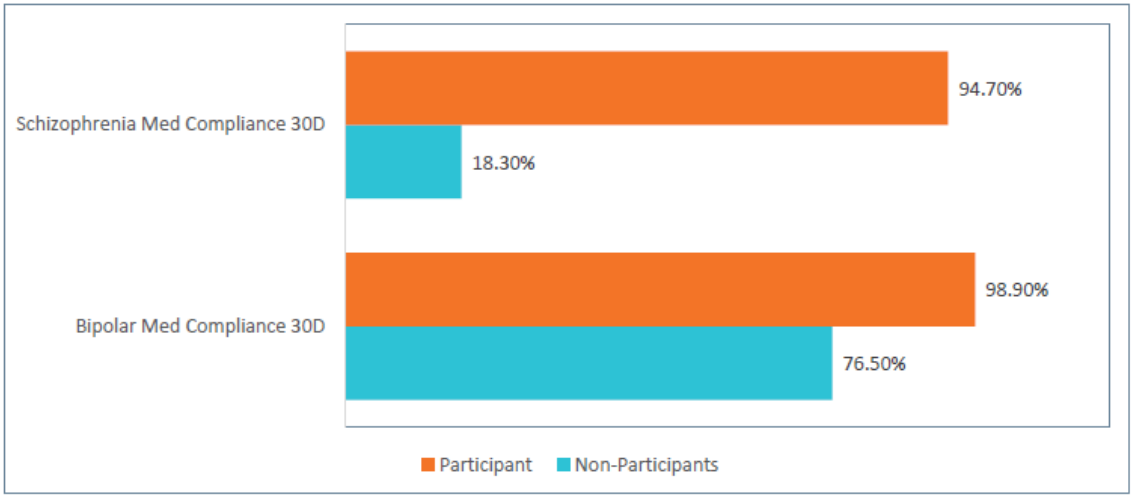
Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a **member rewards program** to incentivize members to ***engage in healthy behaviors***

Quality/Compliance Summary – Behavioral Health



Medication adherence is substantially higher for participants in the bipolar and schizophrenia programs compared to non-participants.

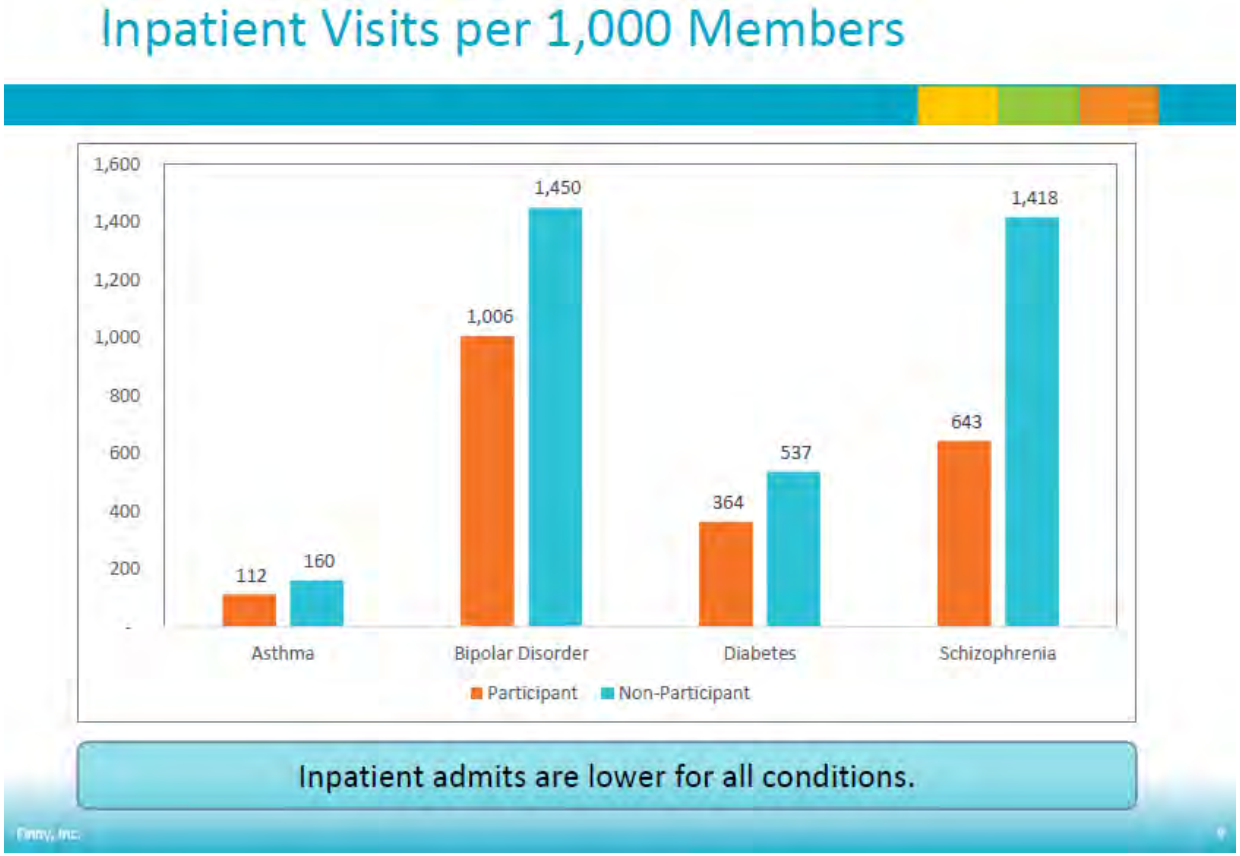
HUMAN SERVICES DEPARTMENT

Centennial Care: Reforming Medicaid

Principle 2

Encouraging Personal Responsibility

Offer a **member rewards program** to incentivize members to ***engage in healthy behaviors***



HUMAN SERVICES DEPARTMENT

Centennial Care: Reforming Medicaid

Principle 3

Increasing Emphasis on Payment Reforms

Create an incentive payment structures that ***reward providers for high quality of care to improve members' health***

- July 2015, 10 pilot projects approved
  - Accountable care organization (ACO)-like models
  - Bundled payments for all services related to a condition
  - Shared savings

- Developed quarterly reporting templates and agreed-upon set of metrics that included process measures and efficiency metrics

- Sub capitated Payment for Defined Population
- Three-tiered Reimbursement for PCMHs
- Bundled Payments for Episodes of Care
- PCMH Shared Savings
- Obstetrics Gain Sharing

- Implemented minimum payment reform thresholds for provider payments in CY2017 in MCO contracts

HUMAN SERVICES DEPARTMENT

Centennial Care: Reforming Medicaid

Principle 4

Simplify Administration

Create a coordinated delivery system that focuses on ***integrated care and improved health outcomes***; increases accountability for more limited number of MCOs and ***reduces administrative burden*** for both providers and members

- Consolidation of 11 different federal waivers that siloed care by category of eligibility; reduce number of MCOs and require each MCO to deliver the full array of benefits; streamline application and enrollment processes for members; and develop strategies with MCOs to reduce provider administrative burden
- One application for Medicaid and subsidized coverage through the Health Insurance Exchange Marketplace
- Streamlined enrollment and re-certifications, added more online application tools
- Fewer Managed Care Organizations
- Standardizing forms and procedures
  - BH Prior Authorization Form for Managed Care and FFS
  - BH Level of Care Guidelines
  - Facility/Organization Credentialing Application
  - Single Ownership and Controlling Interest Disclosure Form for credentialing.
- Created FAQs for Credentialing and BH Provider Billing

HUMAN SERVICES DEPARTMENT

Centennial Care: Managing Cost Growth

2. Total Centennial Care Dollars and Member Months by Program

Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	%Change
Physical Health	4,763,194	4,918,215	3%
Long Term Services and Supports	572,988	589,577	3%
Other Adult Group	2,536,906	2,757,481	9%
Total Member Months	**7,873,088**	**8,265,273**	**5%**

Aggregate Medical Costs by Program

Programs	Previous (12 mon)	Current (12 mon)	%Change
Physical Health	$ 1,245,916,497	$ 1,262,498,696	1%
Long Term Services and Supports	$ 883,544,015	$ 898,665,309	2%
Other Adult Group Physical Health	$ 955,821,072	$ 1,054,867,891	10%
Behavioral Health - All Members	$ 319,161,964	$ 335,419,279	5%
Total Medical Costs	**$ 3,404,443,548**	**$ 3,551,451,175**	**4%**

Per Capita Medical Costs by Program (PMPI

	Previous (12	Current (12 mon)	%Change
Physical Health	$ 261.57	$ 256.70	-2%
Long Term Services and Supports	$ 1,541.99	$ 1,524.25	-1%
Other Adult Group Physical Health	$ 376.77	$ 382.55	2%
Behavioral Health - All Members	$ 40.54	$ 40.58	0%
Total Medical Costs	**$ 432.42**	**$ 429.68**	**-1%**

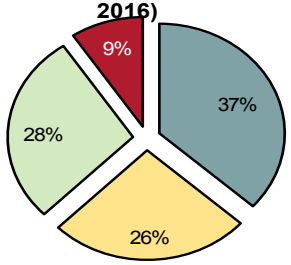
Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	%Change
Admin, care coordination, Centennial Rewards	$ 371,292,953	$ 351,377,344	-5%
NMMIP Assessment	$ 53,676,377	$ 61,948,430	15%
Premium Tax - Net of NIMMP Offset	$ 133,873,146	$ 142,065,842	6%
Total Non-Medical Costs	**$ 558,842,476**	**$ 555,391,616**	**-1%**

	Previous (12	Current (12 mon)	%Change
	$ 70.98	$ 67.20	-5%

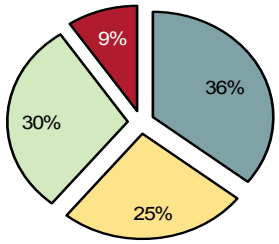
Estimated Total Centennial Care Costs	$ 3,963,286,024	$ 4,106,842,791	4%	$ 503.40	$ 496.88	-1%

Centennial Care Medical Expenditures

Previous (April 2015 - March 2016)



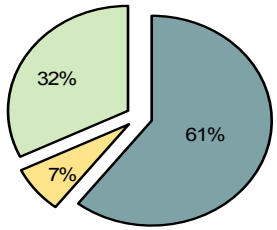
Current (April 2016 - March 2017)



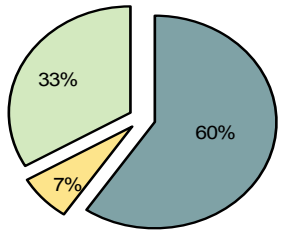
*See above for legend.

Centennial Care Member Months

Previous (April 2015 - March 2016)

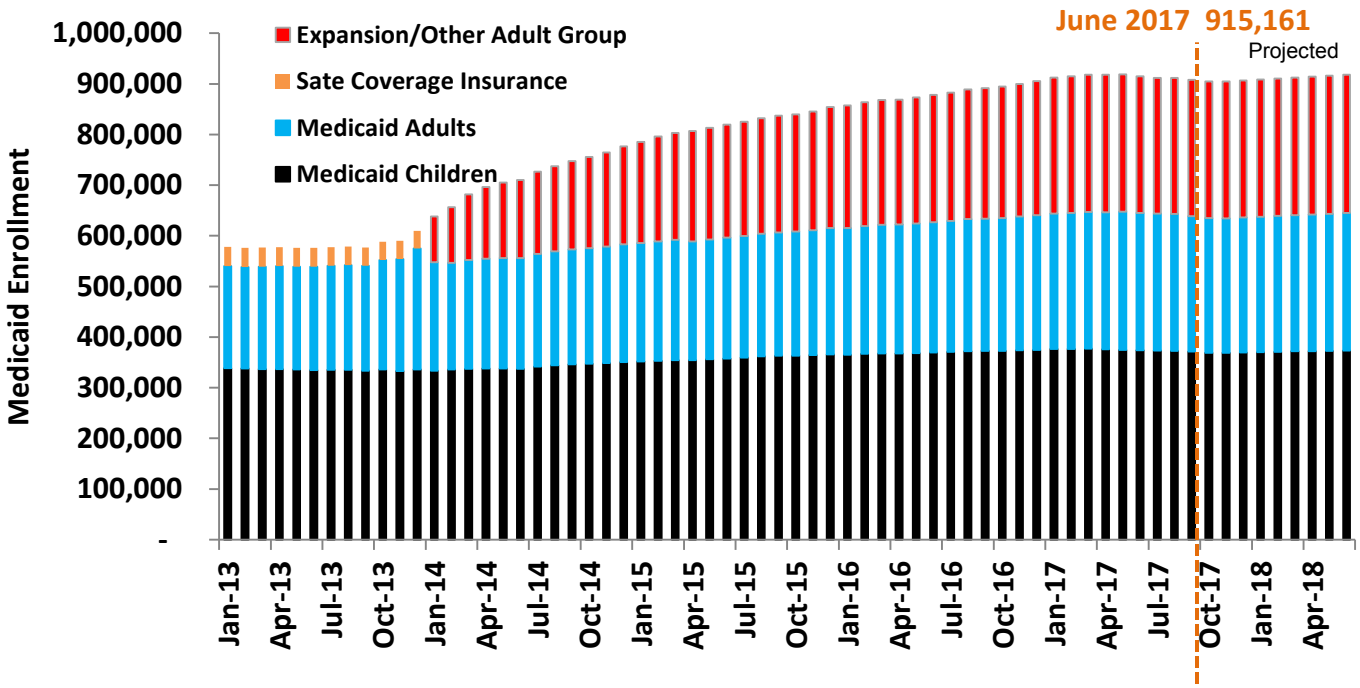


Current (April 2016 - March 2017)



*See above for legend.

Medicaid Enrollment



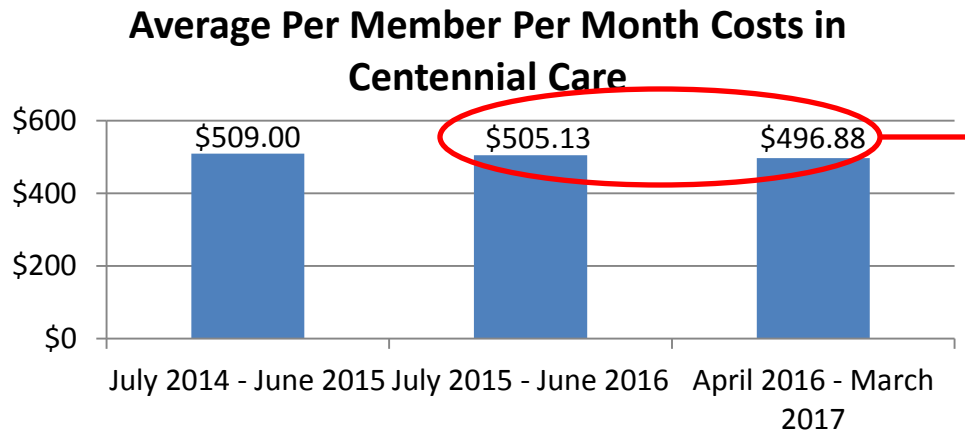
June 2018 Projected Enrollment

OAG: 272,954*

Medicaid Adults: 271,609

Medicaid Children: 373,390*

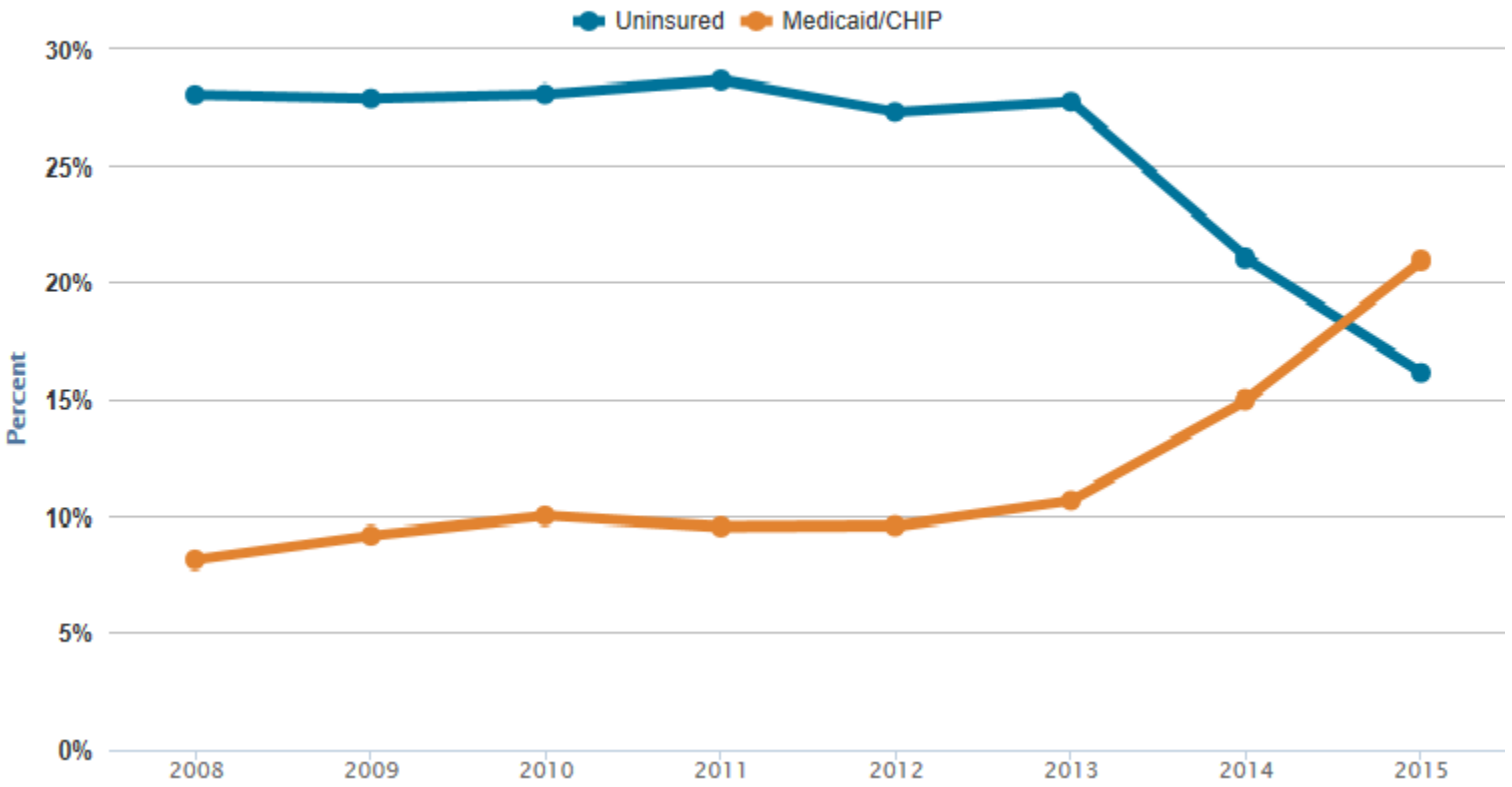
*children 19-21 y.o. counted in OAG



Reduced spending by $68.2 million

HUMAN SERVICES DEPARTMENT

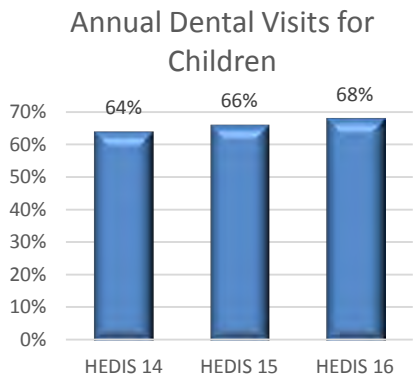
New Mexico Uninsured and Medicaid-Insured (19-64 population)

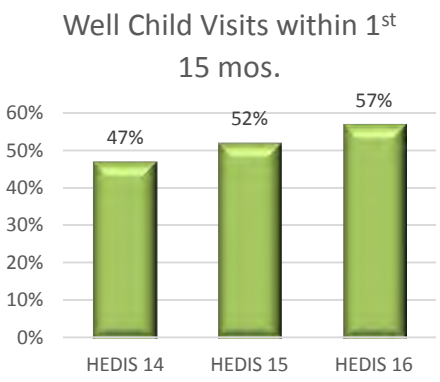


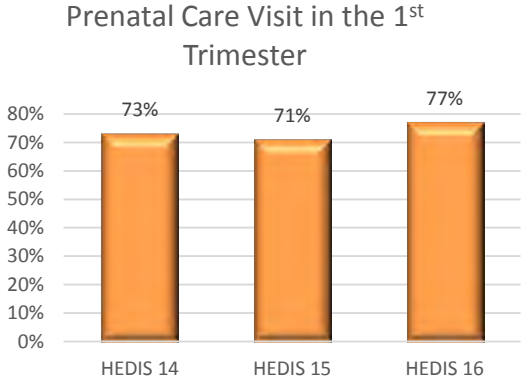
Source: SHADAC State Health Compare, University of Minnesota

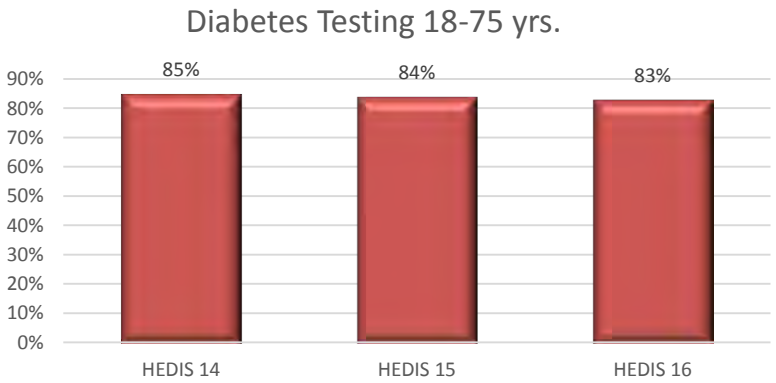
HUMAN SERVICES DEPARTMENT

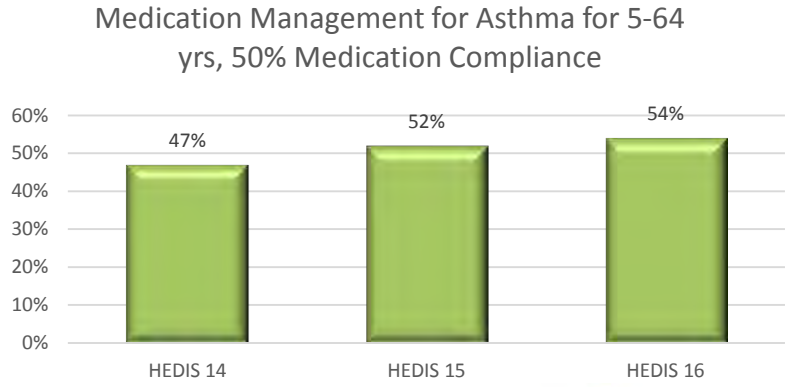
Centennial Care: HEDIS Performance











HUMAN SERVICES DEPARTMENT

ENTENNIALCARE2.0

Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

#1: Increase care coordination at the provider level

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations:

- First Responders, wellness centers, personal care agencies and Project ECHO;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists
- Pilot a home visiting program; and
- Expand supportive housing.

HUMAN SERVICES DEPARTMENT

Behavioral Health Integration 2.0

Opportunities

Opportunity #1: Expanding Health Homes (CareLink NM)

Opportunity #2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

#1: Allow for one-time start-up goods for transitions when a member transitions from agency-based to self-directed care

#2: Increase caregiver respite hours (from 100 to 300 hours).

#3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain Community Benefits

#4: Implement an automatic NF LOC approval for members whose condition is not expected to change

#5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff.

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

Opportunity #1: Pay for better quality and value by increasing percentage of providers payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee-for-service to paying for quality and improved outcomes.

Opportunity #2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, improving transitions of care, increasing physical and behavioral health integration and improving member engagement.

HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility 2.0

Opportunities

#1: Advance the Centennial Rewards Program

#2: Allow providers to charge small fees for three or more missed appointments

#3: Premiums for populations with income that exceeds 100% FPL (applies only to three categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP program (income guideline extends to 300% FPL for children age 0–5 and to 240% FPL for children age 6–18)
- Working Disabled Individuals

FPL Range	Annual Income (Household of 1)	Monthly Premium
101–150% FPL	$11,881–$16,404	$20
151–200% FPL	$16,405–$23,760	$30
201% FPL and up	$23,761–$29,700	$40

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#1: Cover most adults under one comprehensive benefit plan

- HSD proposes to consolidate the two different plans under a single comprehensive benefit package that more closely aligns with private insurance coverage
  - similar to the Alternative Benefit Plan we have today for the Other Adult Group (a.k.a., expansion population)

- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#2: Develop buy-in premiums for dental and vision services for adults (if necessary)

#3: Eliminate the three month retroactive eligibility period for most Centennial Care members

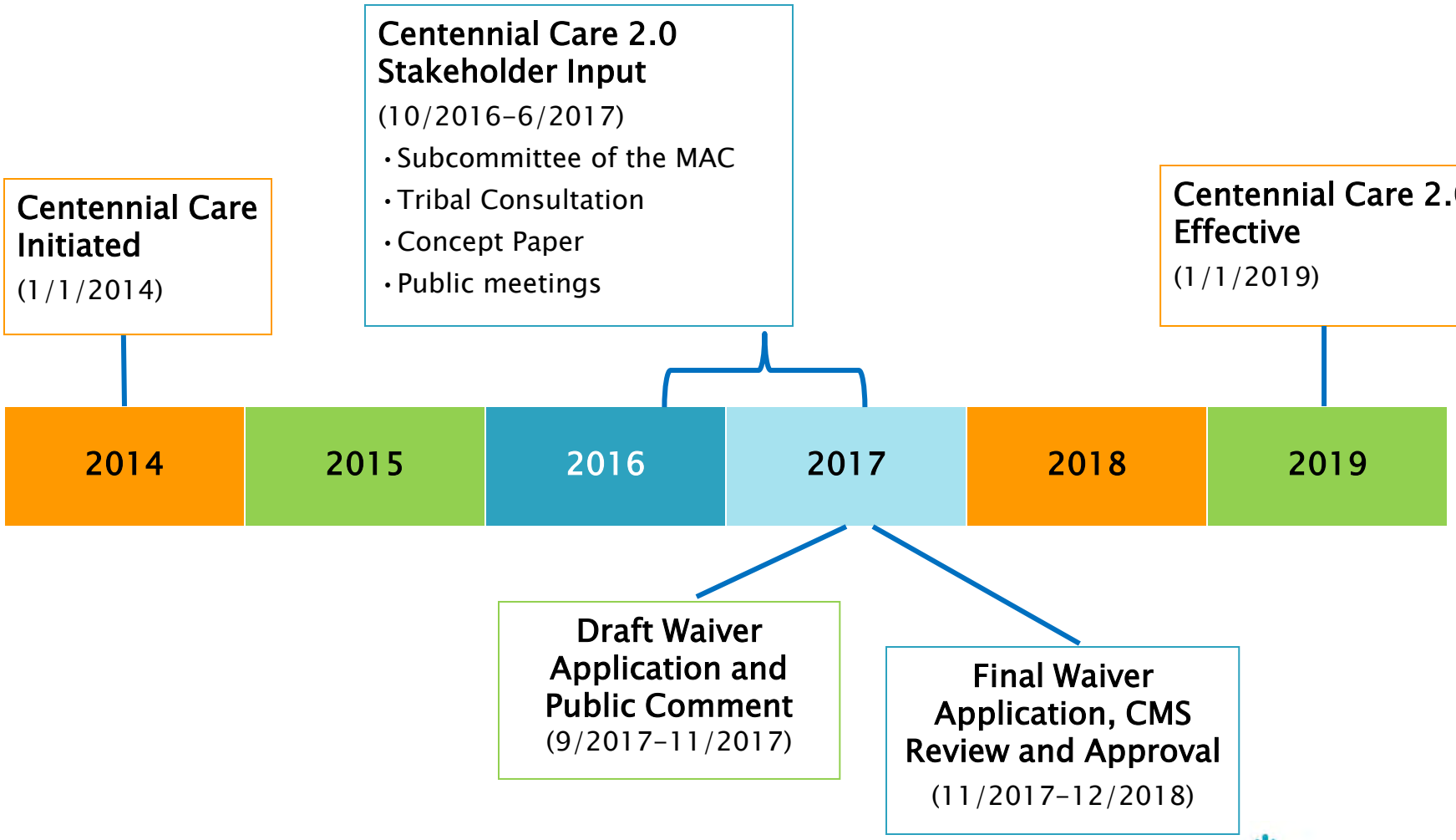
- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Populations covered in FFS would be exempt from this change
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services

#4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that put them over the eligibility guidelines

- Use of the category dropped from 26,000 individuals to 2,000
- Individuals with income above the Adult Group guidelines may receive subsidies to purchase coverage through the Exchange

HUMAN SERVICES DEPARTMENT

Centennial Care Timeline

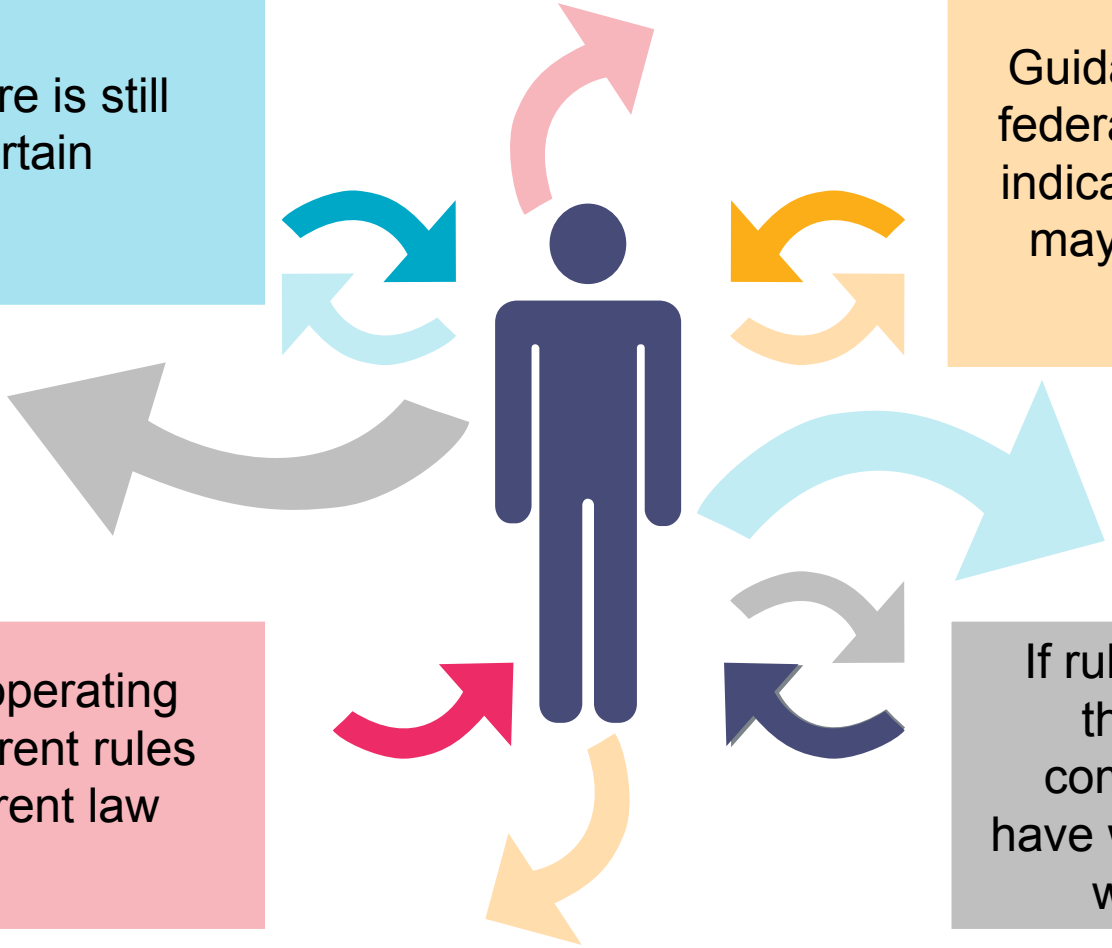


HUMAN SERVICES DEPARTMENT

Federal Medicaid Changes

The future is still uncertain

Guidance from the federal government indicated that there may be changes



We are operating under current rules and current law

If rules do change, there may be components that have worked well that we will keep

HUMAN SERVICES DEPARTMENT

Federal Outlook

- AHCA, BCRA, "Skinny" BCRA, Other proposals
  - Application of Per Capita Caps / Block Grants
  - Reduced federal spending for Medicaid
  - Budget impacts are more significant in the out years (three to six years)
- Changes in policy and practice likely at CMS
- Federal budget likely vehicle for other changes
- Efficient programs like NM's do not have a large margin to absorb health care cost inflation changes in a per capita cap or block grant proposal

HUMAN SERVICES DEPARTMENT

Federal Outlook
(FY19 Budget Issues)

- Expansion FMAP steps down again on January 1, 2018, to 93%
- Regular FMAP rates expected to improve slightly for NM
- CHIP Reauthorization "up in the air"
  - Expires September 30, 2017
  - Scenarios:
    - No action/reauthorization
    - Full reauthorization (including higher ACA matching rate)
    - Reauthorization at regular or lower FMAP rates

HUMAN SERVICES DEPARTMENT

Other State Responses and Options

- Restructure financing and responsibility for state and county health care services
  - With the expansion of Medicaid, counties' responsibility for indigent health care has been reduced while the state's responsibility has increased
  - Financing and funding has not followed this change
- Reduce Medicaid's responsibility for other care programs for higher income populations
  - Health Insurance Exchange
  - NM Medical Insurance Pool (High Risk Pool)

HUMAN SERVICES DEPARTMENT

Questions?

HUMAN SERVICES DEPARTMENT

Presentation to State Legislative Committees

4. Presentation to the Legislative Health and Human Services Committee, September 20, 2017

HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0 Update
Legislative Health and Human Services Committee

Brent Earnest, Secretary
Nancy Smith-Leslie, Director, Medical Assistance Division
September 20, 2017

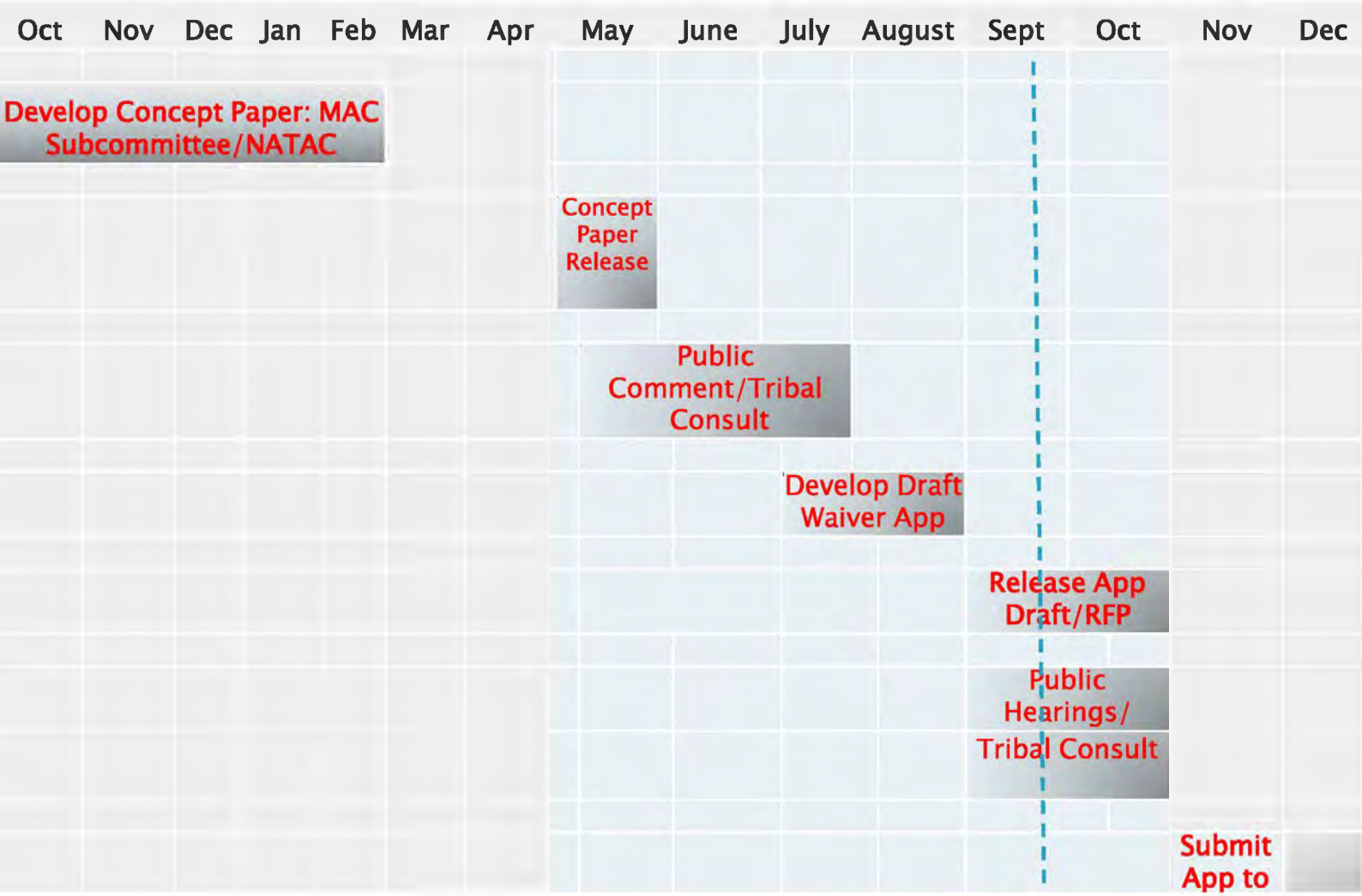
HUMAN SERVICES
DEPARTMENT

Today's Topics

- Update on 1115 Waiver Renewal
  - Renewal process
  - Centennial Care—first 4 years
  - Centennial Care 2.0
- Medicaid Budget Update
  - FY19 Appropriation Request
  - Federal update
- Overview of 1115 Waiver Authority

HUMAN SERVICES DEPARTMENT

Centennial Care 2.0 Waiver Renewal



Waiver Renewal Public Input Meetings

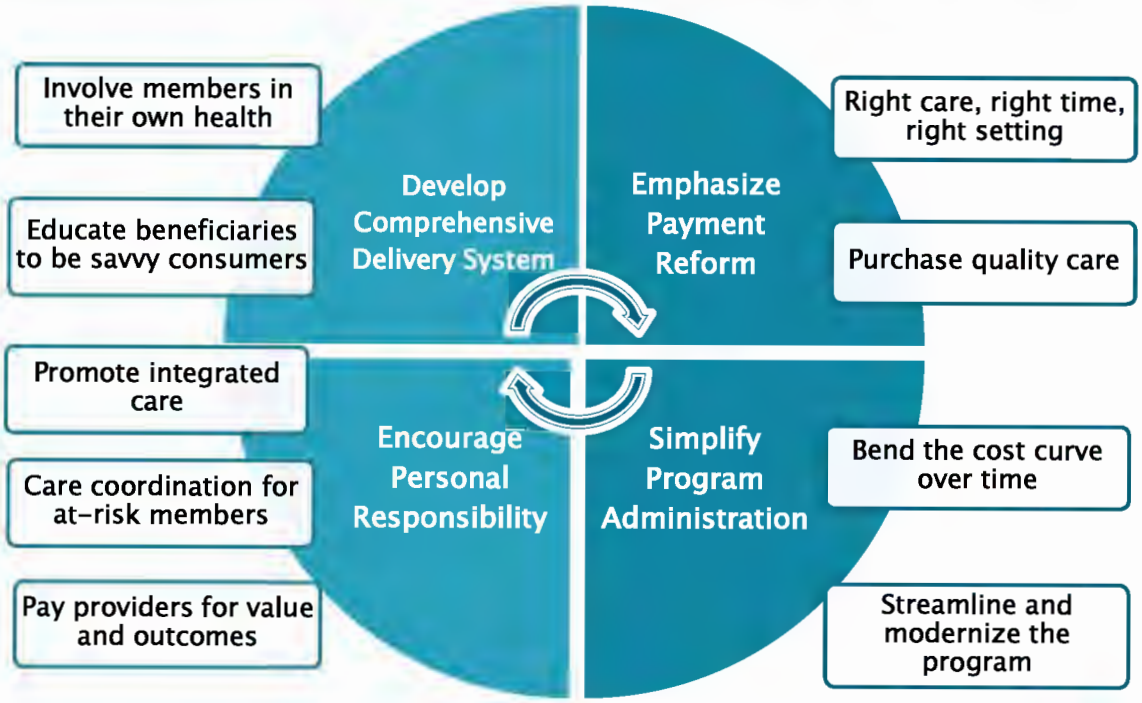
Public Input Opportunities Prior to Development of Concept Paper (before May 2017)	Public Input Meetings on Draft Concept Paper (after May 2017)	Other Input Opportunities
Medicaid Advisory Subcommittee: October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe) *Public Comment at end of each meeting*	**Statewide Public Input Sessions & Attendees:** **Albuquerque** – June 14, 2017 – 160 attendees **Silver City** – June 19, 2017 – 22 attendees **Farmington** – June 21, 2017 – 41 attendees **Roswell** – June 26, 2017 – 30 attendees	**Written Comments:** May – July 2017 – 21 letters received
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees – Albuquerque **Native American Technical Advisory Committee**: July 10, 2017 – NATAC Membership	**HSD Email Address Established:** Ongoing from October 2016– July 2017 137 emails received
MAC Meetings with Public Input: November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)	**MAC Meetings with Public Input:** July 24, 2017 – (Santa Fe)	**Public Hearings to be held in October 2017:** • Las Cruces • Las Vegas • Santa Fe

Centennial Care:

CY 2014 - 2017

Centennial Care

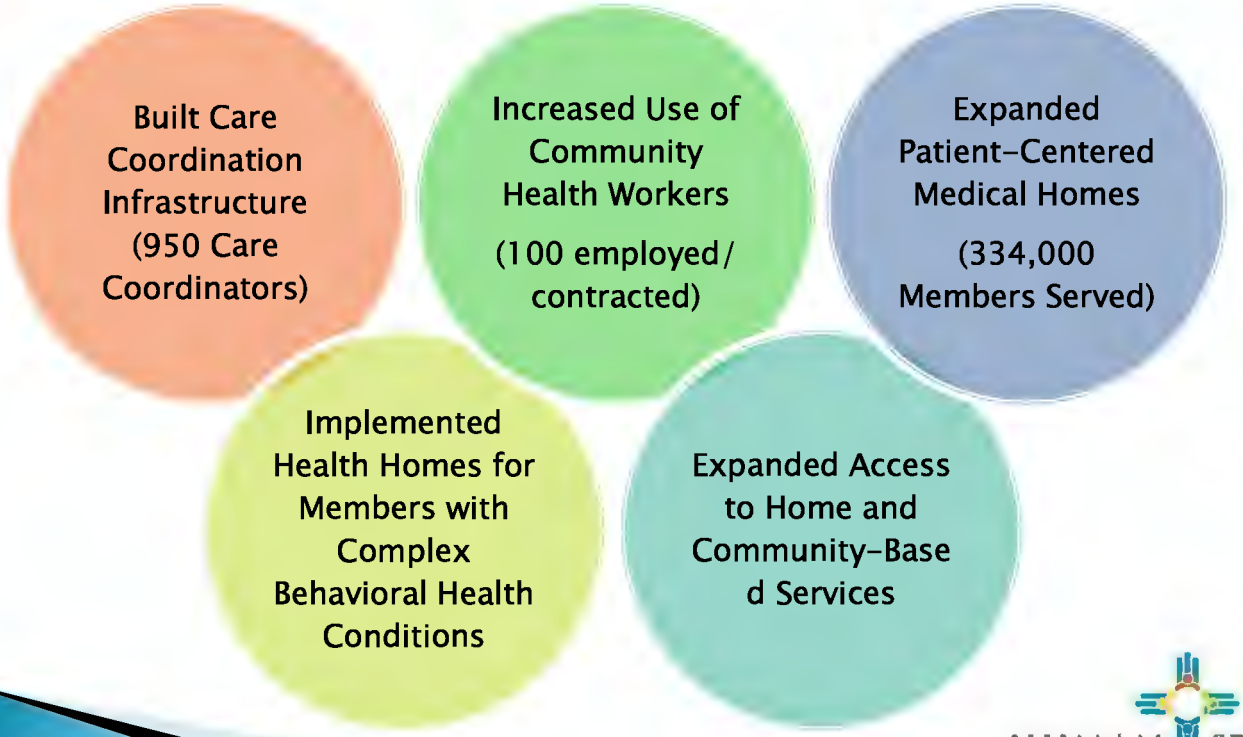
Guiding Principles for Medicaid Reform



HUMAN SERVICES DEPARTMENT

Centennial Care

Create a Comprehensive Delivery System



HUMAN SERVICES DEPARTMENT

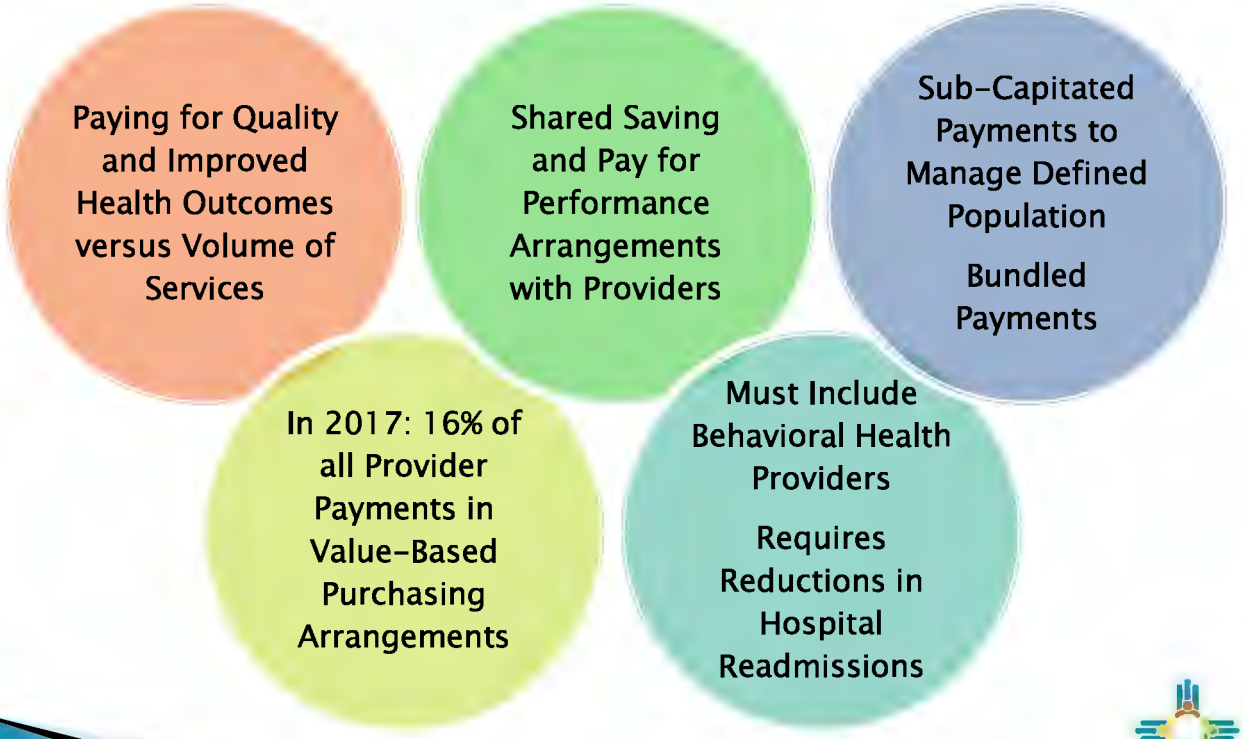
Centennial Care

Encourage Personal Responsibility

HUMAN SERVICES DEPARTMENT

Centennial Care

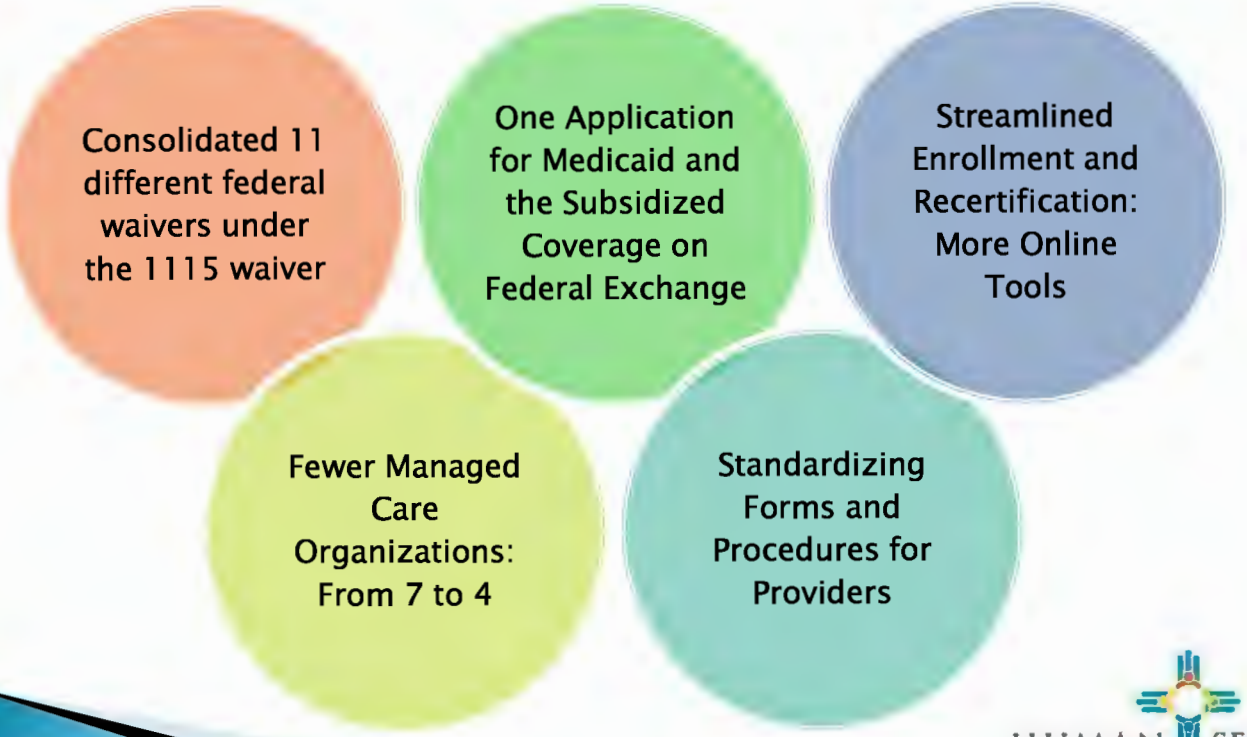
Emphasize Payment Reform



HUMAN SERVICES DEPARTMENT

Centennial Care

Simplify Administration



HUMAN SERVICES DEPARTMENT

NTENNIALCARE2.0

CENTENNIALCARE2.0

Vision for the future of Centennial Care

Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while preserving comprehensive services.

Areas of focus

- Care coordination
- Behavioral health integration
- Long-Term Services and Supports (LTSS)
- Payment reform
- Member engagement and personal responsibility
- Administrative simplification through refinements to benefits and eligibility

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

#1: Increase care coordination at the provider level

#2: Improve transitions of care

- More intensive care coordination for members during discharges from inpatient or nursing home stays, released from jails/prisons, returning home from foster care placement

#3: Expand programs working with high needs populations:

- First Responders, wellness centers, personal care agencies and Project ECHO;
- Certified Peer Support Workers and Certified Family Support Workers, including youth peer support specialists

HUMAN SERVICES DEPARTMENT

Care Coordination 2.0

Identified Opportunities

#4: Initiate care coordination for justice-involved prior to release from incarceration

- Allowing of delegation of care coordination to county/facility for activities that occur prior to release
- Strengthening MCO contract requirements regarding after-hour transitions and requiring a dedicated staff person at each MCO to serve as a liaison with the facilities

#5: Pilot a home-visiting program focused on pre-natal, post-partum and early childhood development

- Collaborate with the DOH and CYFD to implement a pilot in designated counties to provide Medicaid-reimbursable services to eligible pregnant women

#6: Obtain 100% federal funding for Native American members for services received through IHS/Tribal Facilities

Behavioral Health Integration 2.0

Opportunities

#1: Expanding Health Homes (CareLink NM)

#2: Support workforce development

- Support training for both primary care and psychiatric resident physicians working in community-based practices in rural and underserved parts of New Mexico
- Focus on areas of the state where it is most difficult to attract and keep healthcare providers

#3: Develop Peer-Delivered, Pre-Tenancy and Tenancy Support Housing Services

- Create a supportive housing service that provides some peer-delivered tenancy support services to active participants with Serious Mental Illness (SMI)

HUMAN SERVICES DEPARTMENT

Long-Term Services and Supports 2.0

Opportunities

#1: Allow for one-time start-up goods for transitions when a member transitions from agency-based to self-directed care

#2: Increase caregiver respite hours (from 100 to 300 hours)

#3: In order to continue to provide access to the Community Benefit services for all eligible members who meet a NF LOC, establish some limits on costs for certain services in the Self-Directed Community Benefit model

#4: Implement an automatic NF LOC approval for members whose condition is not expected to change

#5: Include nursing facilities in Value Based Purchasing (VBP) arrangements and use Project ECHO (Extension for Community Health Outcomes) to provide expert help for nursing home staff

HUMAN SERVICES DEPARTMENT

Payment Reform 2.0

Opportunities

#1: Pay for better quality and value by increasing percentage of providers payments that are risk-based

- Expand requirements for MCOs to shift provider payments from fee-for-service to paying for quality and improved outcomes.

#2: Use Value Based Purchasing (VBP) to drive program goals, such as:

- Increasing care coordination at provider level, expanding the health home model, improving transitions of care, and improving provider shortage issues.

Payment Reform 2.0

Opportunities

#3: Advance Safety-Net Care Pool Initiatives

- Incrementally shift the funding ratio between the Uncompensated Care Pool and the Hospital Quality Improvement Incentive Pool so that more dollars are directed toward improved hospital quality initiatives
- Expand participation to all willing hospitals and allow other providers to participate, such as nursing facilities
- Require good-faith contracting efforts between the MCOs and providers that participate to ensure a robust provider network

Safety Net Care Pool and Hospitals

- Eliminated uncompensated care in Medicaid for 29 SNCP hospitals (2015)

Uncompensated Care Pool Requests, Payments and Capacity

($ in millions)	2014	2015	2016
Requested Uncompensated Care Payments	$176.3	$121.1	$104.4
Actual UC Payment Capacity	$107.3	$67.3	Determined in 2018
Actual UC Payments	$68.9	$67.3	$68.9

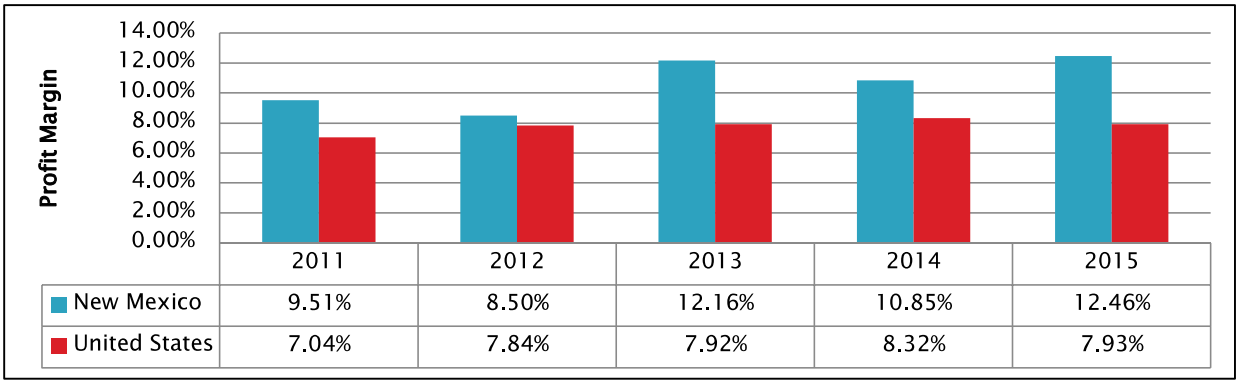
Inpatient and Selected Outpatient Hospital Payments for Services Provided to Expansion Population

Category of Service	2014	2015	2016
Inpatient Hospital – General Acute and Specialty	$193.7	$246.6	$286.3
Outpatient Hospital – Emergency Room and Urgent Care	$ 31.4	$60.2	$90.8
Total	$ 225.1	$306.8	$377.1
Note: Data from May 2017; $ in millions			

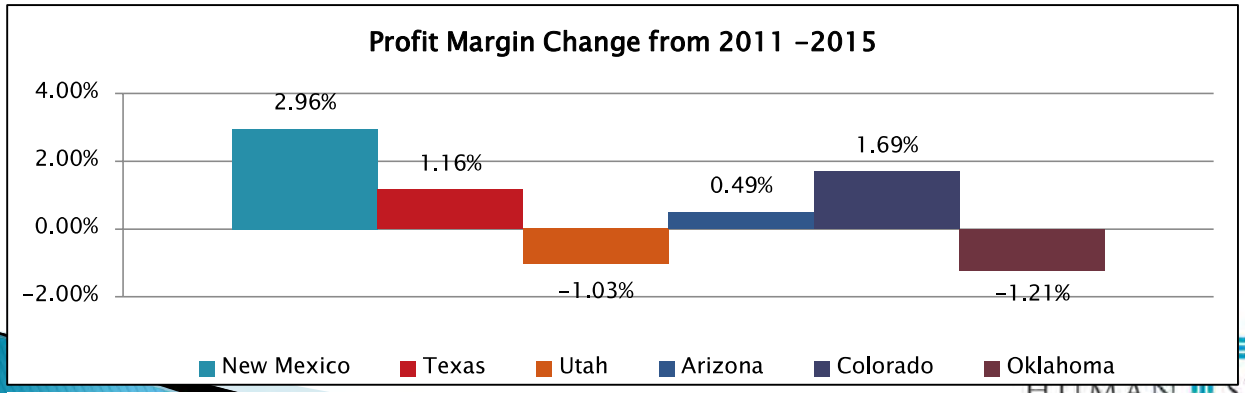
HUMAN SERVICES DEPARTMENT

Safety Net Care Pool and Hospitals

- NM Hospitals continue to outperform hospitals in the region and nation



	2011	2012	2013	2014	2015
New Mexico	9.51%	8.50%	12.16%	10.85%	12.46%
United States	7.04%	7.84%	7.92%	8.32%	7.93%



Source: American Hospital Association

HUMAN SERVICES DEPARTMENT

Member Engagement and Personal Responsibility 2.0

Opportunities

#1: Advance the Centennial Rewards Program

#2: Allow providers to charge small fees for three or more missed appointments

#3: Premiums for populations with income that exceeds 100% FPL (applies only to three categories of eligibility)

- Adults in the Expansion with income greater than 100%
- CHIP program (income guideline extends to 300% FPL for children age 0-5 and to 240% FPL for children age 6-18)
- Working Disabled Individuals (WDI) Category
- Revised premium amounts to be lower in initial years (1% of household income) and higher in out-years
- Included a household rate

Proposed Premium Structure

FPL Range	Annual Household Income (HH of 1)	Aggregate HH Maximum – 5% of Income (HH of 1)	Applicable Category of Eligibility (COE)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101–150%	$12,060 – $18,090	$600	OAG, WDI, TMA	$10	$20	$20	$40
151–200%	$18,091 – $24,120	$900	WDI, TMA, CHIP	$15	$30	$30	$60
201–250%	$24,121 – $30,150	$1,200	WDI, TMA, CHIP	$20	$40	$40	$80
251–300%	$30,151 – $36,180	$1,500	TMA, CHIP	$25	$50	$50	$100

Member Engagement and Personal Responsibility 2.0

Opportunities

#4: Require co-payments for certain populations

- HSD currently has copayment requirements for its CHIP and WDI populations
- Seeking to streamline copayments across populations
- Add copayments for the adult expansion population with income greater than 100% FLP
- Most Centennial Care members will have copayments for non-preferred prescription drugs and for non-emergent use of the ED
- The following populations would be exempt from all copayments:
  - Native Americans
  - ICF-IDD individuals
  - QMB/SLIMB/QI1 individuals
  - Individuals on Family Planning only
  - Individuals in the PACE program
  - Individuals on the DD waivers
  - People receiving hospice care

HUMAN SERVICES DEPARTMENT

Proposed Co-Payment Structure

	CHIP	WDI	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240%	Up to 250% FPL	If income is greater than 100% FPL	
Outpatient office visits (non-preventive) • BH exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic Rx exempt • Family Planning Rx exempt • Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic and Family Planning Rx exempt	$8/prescription All FPLs and COEs; certain exemptions will apply			
Non-emergency ER visits	$8/visit All FPLs and COEs; certain exemptions will apply			

Member Engagement and Personal Responsibility 2.0

Opportunities

#5: Modify tracking requirements for cost sharing

- Request authority to track the out-of-pocket maximum cost sharing amounts on an annual basis rather than quarterly or monthly
- Apply an annual out-of-pocket maximum based on four FPL tiers

#6: Expand opportunities for Native American members in Centennial Care

- Requires MCOs to expand contractual or employment arrangements with CHRs throughout the state
- Work with Tribal providers to develop capacity to enroll as LTSS providers and/or health home providers
- Request authority to implement a project in collaboration with the Navajo Nation as it seeks to establish a managed care organization sponsored by the Navajo Nation

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#1: Cover most adults under one comprehensive benefit plan

- Consolidate two different adult benefit plans under a single comprehensive benefit package that more closely aligns with private insurance coverage by redesigning the Alternative Benefit Plan (ABP) for adult expansion population to also cover the Parent/Caretaker adult population
- Add a limited vision benefit to the ABP
- Waive federal EPSDT rule for 19-20 year olds in this plan
- Individuals who are determined "medically frail" may receive the standard Medicaid benefit package

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#2: Develop buy-in premiums for dental and vision services for adults (if necessary)

#3: Eliminate the three month retroactive eligibility period for most Centennial Care members

- In CY16 only 1% of the Medicaid population requested retro coverage (10,000 individuals)
- Hospital and Safety Net Clinics are able to immediately enroll individuals at point of service through Presumptive Eligibility Program and receive payment for services
- Does not include retroactive status changes processed by SSA
- Native Americans and individuals residing in nursing facilities would be exempt from this provision

HUMAN SERVICES DEPARTMENT

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#4: Eliminate the Transitional Medicaid Coverage that provides an additional year of coverage to Parents/Caregivers with increased earnings that result in ineligibility per income guidelines

- The individuals previously using the category are now either transitioned to the adult expansion category or eligible to receive subsidies to purchase coverage through the federal Exchange
- Since ACA, use of the category dropped from 26,000 individuals to 2,000

#5: Incorporate eligibility requirements of the Family Planning program

- Benefits are limited to reproductive health care, contraceptives and related services—not comprehensive coverage
- 6% of population on Family Planning utilize coverage today
- HSD proposes to better target this program by designing it for men and women who are through the age of 50 who do not have other insurance(with certain exceptions)

Administration Simplification through Refinements to Benefits and Eligibility 2.0

Opportunities

#6: Request waiver from limitations imposed on the use of Institutions of Mental Disease (IMD)

- Request expenditure authority for members in both managed care and fee-for-service to receive inpatient services in an IMD so long as the cost is the same as, or more cost effective, than a setting that is not an IMD.

#7: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

#8: Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers

- HSD has made access to LARC a high priority over past several years by unbundling LARC reimbursement from other services
- Requesting authority to receive increased administrative funding to expand availability by reimbursing DOH or other sponsoring agencies for the cost of purchasing and maintaining LARCs

HUMAN SERVICES DEPARTMENT

Upcoming Public Meetings

- **Las Cruces – Thursday, October 12, 2017, 1:30 pm to 3:30 pm**
  - Farm and Ranch Museum
- **Santa Fe – Monday, October 16, 2017, 1 pm to 4 pm**
  - Medicaid Advisory Committee Meeting, NM State Library
- **Las Vegas – Wednesday, October 18, 2017, 1:30 pm to 3:30 pm**
  - Highlands University – Student Union Building/Student Center
  - *Call (toll-free) 1-888-850-4523; participant code: 323 675#*
- **Tribal Consultation – Friday, October 20, 2017, 9 am**
  - Institute of American Indian Arts, Santa Fe
- Additional info: http://www.hsd.state.nm.us/centennial-care-2-0.aspx

HUMAN SERVICES DEPARTMENT

Medicaid Budget Update

- FY19 Budget Request
- Enrollment
- Cost Drivers
- Federal Outlook

HUMAN SERVICES DEPARTMENT

Medicaid Budget Update

- The FY18 general fund (GF) need for Medicaid is **$ 938.3 million.** The Legislature appropriated **$915.6 million**, resulting in a deficit of **$22.6 million** in FY 18.
- The FY19 general fund (GF) request for Medicaid is **$ 997.2 million.** This is an increase of **$81.5 million** above the FY18 appropriation.

($ in millions)	FY14 Actual	FY15 Projection	FY16 Projection*	FY17 Projection*	FY18 Projection*	FY19 Projection*
Total Budget	$4,200.6	$5,162.3	$5,413.9	$5,558.5	$5,811.5	$5,892.2
General Fund Need	$901.9	$894.1	$912.9	$898.4	$938.3	$997.2

*Projection data as of June 2017. The projections include all push forward amounts between SFYs. FY16 general fund includes $18 million supplemental appropriation and general fund transfers from other divisions. These figures exclude Medicaid administration.

HUMAN SERVICES DEPARTMENT

Medicaid Budget Update

(Changes from FY18 Budget to FY19 Request)

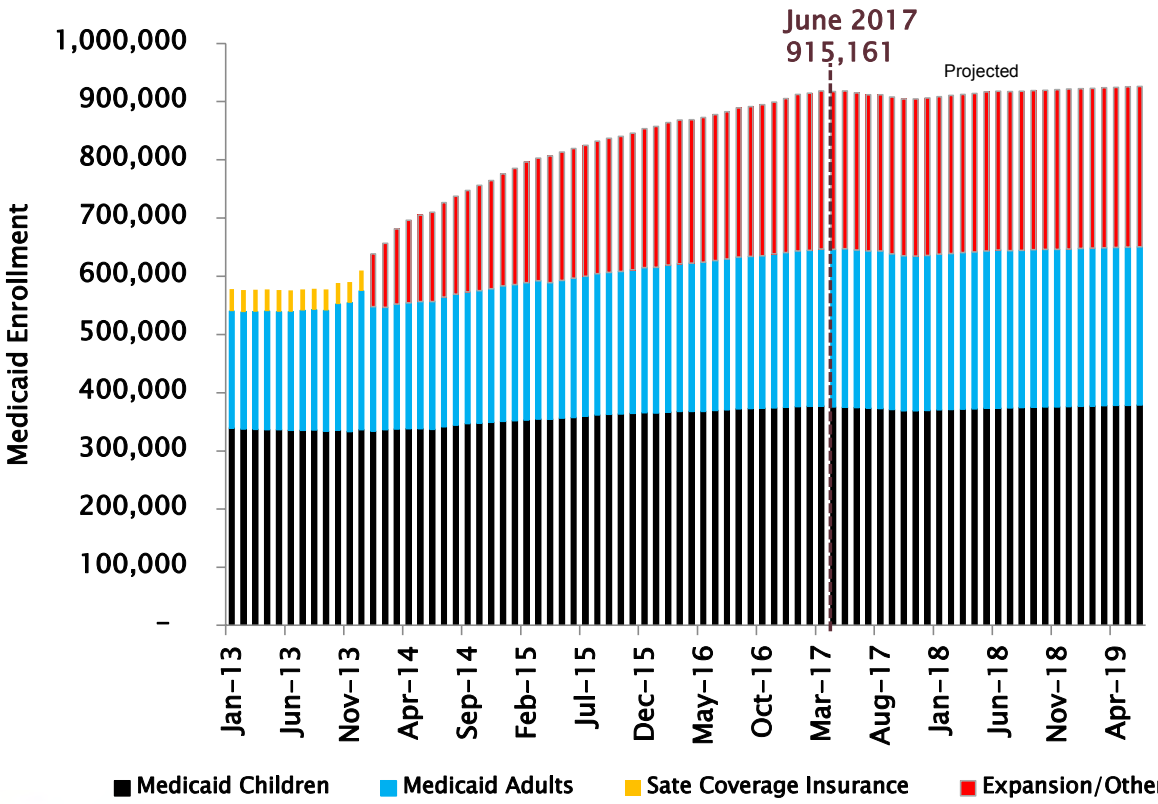
($ in millions)	Total	General Fund
FY18 To FY19 Adjustments		
FY 19 Starting Deficit (after MCO reconciliations)	82.34	15.82
Expenditure Changes		
Price and Utilization	56.31	11.66
Enrollment	57.11	11.73
Medicare Buy Ins	5.07	2.62
Health Information Technology	(12.00)	
Revenue Changes		
Medicaid Expansion Change (94.5% to 93.5%)		14.70
CHIP FMAP Reduction (100% to 72.13%)		31.23
FMAP Change (71.90 to 72.13)		(7.18)
Added Miner's Colfax Revenue		(1.04)
Added Drug Rebates and Other Revenue		(3.34)
Less County Supported Medicaid Fund		2.34
Less Tobacco Settlement Revenue		3.00
Total:	$188.83	$81.55

FY19 – What to Watch

- Enrollment trends
- Federal action on CHIP
- Other Federal Action on the ACA and Budget
- CMS policy changes

HUMAN SERVICES DEPARTMENT

Medicaid Enrollment



June 2019 Projected Enrollment

OAG: 275,685*

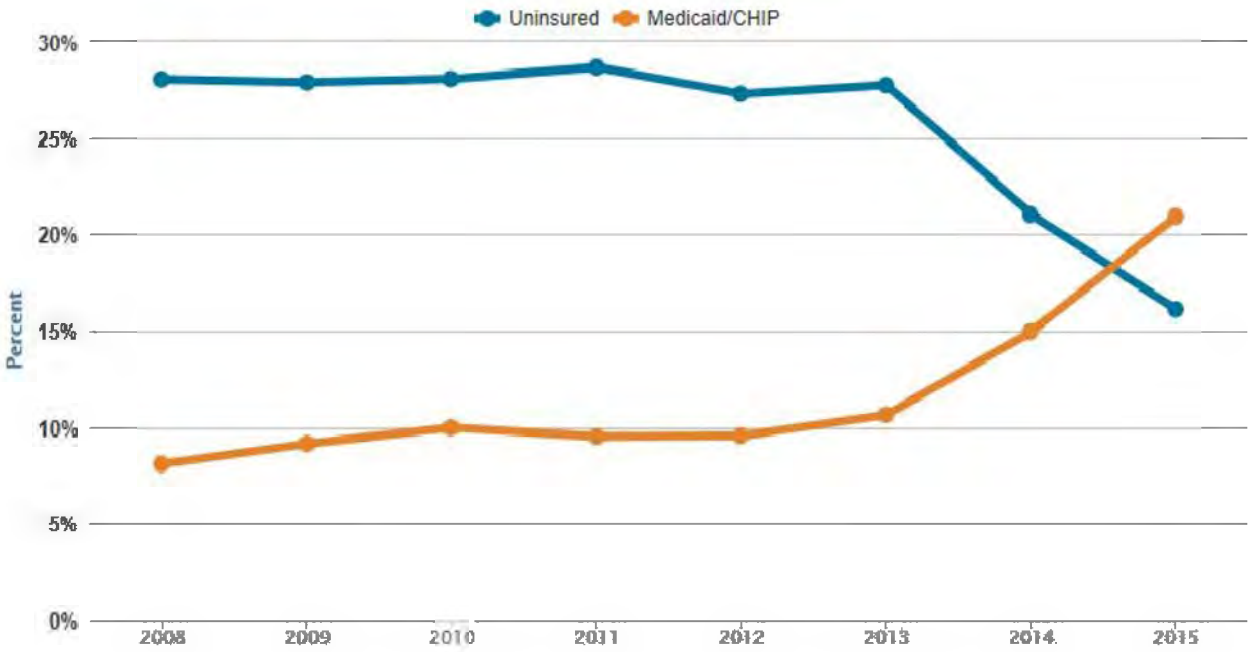
Medicaid Adults: 271,512

Medicaid Children: 379,107*

*children 19-21 y.o. counted in OAG

HUMAN SERVICES DEPARTMENT

New Mexico Uninsured and Medicaid-Insured (19-64 population)



Source: SHADAC State Health Compare, University of Minnesota

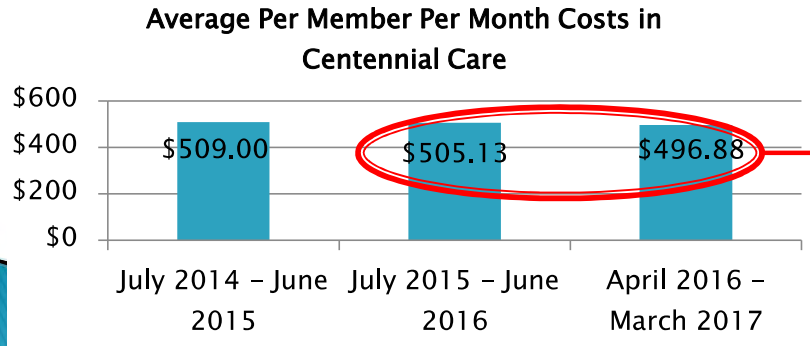
HUMAN SERVICES DEPARTMENT

Managing Cost Growth

- Healthcare cost inflation grew an average of 2.6% in 2015 and growth averaged more than 3% in 2016
- Other national studies estimate medical cost inflation (price and utilization) at 6.5%

Centennial Care Stats

- Per capita medical services cost in Centennial Care **growing only 1.3%, driven primarily by increased enrollment and pharmacy costs**
- Managing cost through care coordination and other efforts
- Increases in preventive services and decreases in inpatient hospital costs
- Per person costs are lower in Centennial Care



Reduced spending by $68.2 million

HUMAN SERVICES DEPARTMENT

Section 1115 Demonstration Waiver Authority

HUMAN SERVICES DEPARTMENT

1115 Demonstration Authority

- Under Section 1115 of the Social Security Act, the Secretary of HHS may permit states to waive certain requirements of Medicaid and CHIP to carry out experimental, pilot or demonstration projects, which the Secretary believes are likely to promote the objectives of the Medicaid program
- Permits the HHS Secretary to allow states to use federal Medicaid funds in ways that are not otherwise allowed under the federal rules
- Permits states to make changes in Medicaid eligibility, benefits and cost-sharing.

HUMAN SERVICES DEPARTMENT

1115 Waivers—CMS Communication

- HHS Secretary Price and CMS Administrator sent letter to Governors in March 2017 with intent of extending greater flexibility to states, particularly through 1115 waivers.
- Key areas that the letter highlights are:
  - *Streamlined Program Management*. This involves making the State Plan Amendment process more transparent and efficient, "fast tracking" the approval of waiver and demonstration waiver extensions, and consistently evaluating waiver proposals.
  - *Alignment with Commercial Insurance*. The letter suggests that states consider aligning Medicaid design and benefit structures with those of commercial insurance. It offers specific examples of what states may do:
    - Encouraging Health Savings Accounts
    - Waiving enrollment and eligibility procedures that are inconsistent with continuous coverage
    - Reasonable, enforceable premium requirements
    - Waivers of non-emergency transportation benefits
    - Expanded options to design emergency room copayments

HUMAN SERVICES DEPARTMENT

1115 Demonstration Authority

Waiver of Cost Sharing Requirements:

- CMS can waive federal premium or cost-sharing statutory requirements in section 1916 of the Social Security Act (the Act) under 1115 Waiver Demonstrations.
- The authority lies in section 1902(a)(14) of the Act (42 USC 1396a), which provides that "premiums, or similar charges,. . .cost sharing, or similar charges, may be imposed only as provided in section 1916 of [the Act]." Section 1115(a) demonstration projects may waive provisions under section 1902 of the Act and grant authority for expenditures not otherwise matchable pursuant to section 1903 of the Act.
- Arizona, Arkansas, Indiana are among the states with a waiver of section 1902(a)(14) of the Act to permit collection of monthly premiums for individuals with incomes from 101% to 133% of the FPL.

HUMAN SERVICES DEPARTMENT

1115 Demonstration Authority

Waiver of Retroactive Coverage:

- Section 1902(a)(34) of the Act (42 USC 1396(a)(34) is the substantive requirement for retroactive eligibility under the State plan.
- CMS has issued waivers of section 1902(a)(34) of the Act to permit states to limit retroactive eligibility to the date of application for Medicaid coverage. *See, e.g.,* Delaware, Indiana, New Hampshire,
- Secretary Price's March 2017 letter to governors identified waivers of retroactive coverage as a supported state reform to "align Medicaid and private insurance policies for non-disabled adults."

Transitional Medical Assistance (TMA):

Wisconsin has existing authority to charge premiums for TMA adults above 133% FPL from the first day of enrollment as well as for TMA adults from 100%-133% FPL after 6 months of coverage. It is anticipated that additional states will request such authority.

HUMAN SERVICES DEPARTMENT

1115 WAIVERS IN OTHER STATES

Note: Reflects CMS-approved 1115 waivers as of June 2017. Kaiser Family Foundation – http://www.kff.org/medicaid/issue-brief/key-themes-in-section-1115-medicaid-expansion-waivers/

	AR	AZ	IA	IN	MI	MT	NH	WI	ME
Premiums for populations below 150% FPL, including Adult Expansion group and/or TMA	X	X	X	X	X	X			
Healthy behavior incentives		X	X	X	X				
Waive required benefits such as NEMT and EPSDT for 19-20 year-olds	X		X	X					
Waive retroactive eligibility	X			X			X		
Waive or reduce TMA program								X Proposed; not yet approved	X Proposed; not yet approved

HUMAN SERVICES DEPARTMENT

Questions?

HUMAN SERVICES DEPARTMENT

Public Comment Summary for the Draft 1115 Waiver Renewal Application

Comment Overview

The Human Services Department (HSD) received comments from 255 people related to its Draft 1115 Demonstration Waiver renewal application (released on September 5, 2017 and revised and re-released on October 6, 2017) through multiple public comment opportunities that included four public hearings, a Tribal Consultation, email submissions and voicemail comments. Comments were submitted from Centennial Care members, the general public, Tribal representatives, Centennial Care providers, provider organizations, legal advocates, advocacy groups, non-profit organizations, religious organizations, and healthcare management entities. The majority of commenters expressed opposition to several proposals in the waiver that advance member engagement and personal responsibility, in particular about proposed cost-sharing for Medicaid participants. More than a third of commenters provided feedback opposing specific proposals in benefit design and eligibility refinements, viewing those as reductions to services and an attempt to decrease enrollment.

Two letters with comments were submitted on behalf of organizations and individuals expressing strong opposition to Medicaid benefits and coverage reductions. One of the letters submitted on behalf of and signed by 24 organizations and 19 individuals stated that proposals in the draft waiver are cuts to the program that will leave thousands without healthcare coverage, create health and financial hardships for families and drive-up long-term costs for the state's healthcare system. The second letter, submitted on behalf of 58 organizations and 271 individuals also strongly opposed proposals in the waiver that they perceived as reductions to health coverage and services that will result in medical debt for families, deter patients from seeking care, and shift costs to healthcare providers. A number of comments received expressed support for the state's effort to improve the Centennial Care program with a strong emphasis on improving care coordination, behavioral health services and provider network adequacy even if they shared opposition to other sections of the waiver proposal.

Response: Many dedicated organizations, advocates, stakeholders and community members have expended significant effort to review and comment on various draft proposals that ultimately informed the final waiver application. HSD appreciates and acknowledges those efforts and the valuable input it received throughout the year-long process. This feedback has been incorporated throughout the process—from discussions during the early subcommittee meetings, to comments received on the draft concept paper and most recently, for the draft waiver renewal application. HSD developed many of its initial proposals based on public feedback and has since modified them in response to the comments received. For example, it reduced premium amounts that were initially set at two percent of income in the concept paper to one percent in the draft waiver renewal application. It also removed the CHIP and WDI programs from premium requirements in the final waiver renewal application. Additionally, the six copayment requirements in the draft waiver renewal were reduced to only two copayments in the final waiver application. HSD is also eliminating the copayments that exist today in the CHIP and WDI programs in order to align incentives across the system for the most appropriate care, in the most appropriate setting. It is also continuing to provide retroactive eligibility for one month during the first year of the renewal in response to concerns about members in crisis who should receive presumptive eligibility at the point of service but are not completing the process. This will provide additional time for HSD to retrain hospital staff and other safety net providers in the presumptive eligibility process.

Summary of Comments by Waiver Proposal Subject

The summary of comments that follows is organized by subject area. Throughout the public input process, HSD has presented the proposed waiver modifications by subject, including: care coordination, benefit and delivery system (including long term supports and services and physical and behavioral health integration), payment reform, member engagement and personal responsibility, and administrative simplification through eligibility modifications.

1. Care Coordination

1. a. Increase care coordination at the provider level *(13 comments)*

Many commenters expressed support for increasing care coordination activities at the provider level as part of Value Based Purchasing (VPB). Providers and advocates speaking in support of care coordination expressed concern that appropriate oversight and quality measures are needed and should be imposed on MCOs and providers as part of VBP arrangements. Providers suggested that funding flow from MCOs to providers as part of VBP arrangements to allow for infrastructure development. Commenters encouraged expansion of Patient-Centered Medical Homes (PCMHs) and more inclusive care coordination for behavioral health needs. Pediatric provider groups expressed concerns with PCMHs and said reimbursement rates are inadequate and achieving National Committee for Quality Assurance (NCQA) certification is burdensome. One commenter representing hospitals expressed support for the opportunity for more hospitals to participate but providers will need technical assistance and infrastructure support. A commenter asked the state to require MCOs to assist. One commenter recommended the state provide Medicaid claims data and other data which will enable providers to plan interventions and track progress.

Some advocacy organizations believe care coordination has not met the goals promoted in Centennial Care and is need of improvement. Advocates from the disability and aging community recommended including information on community supports, reasonable ratio of care coordinators to members, and adequate reimbursement. Commenters asked the state to make care coordination a priority for the dually-eligible population and individuals using long-term services and supports (LTSS) adding that these individuals can benefit from targeted interventions to improve health and bring costs down.

Comments from Tribal organizations were supportive of increasing care coordination at the provider lever, but concerns were expressed regarding the reimbursement process and recommendations were made for contracts between Tribes and the state.

Response: In response to comments about care coordination during the year-long public input process, HSD developed the proposal to target care coordination efforts to high-need, high-cost members and improve transitions of care. Efforts in these areas are being implemented today, through strengthening requirements in the managed care organizations' contracts rather than through changes via the waiver renewal. HSD has also responded to providers who requested increased delegation of care coordination at the provider level by developing a comprehensive plan to implement VBP goals over four years and include requirements for a full delegation model and a shared functions model of care coordination activities. The plan offers flexibility within the VBP arrangements and the delegated structure for both providers and the MCOs. Additionally, HSD has added contractual requirements that will increase the use of Community Health Representatives working with Tribal organizations to conduct care coordination activities, which was in response to comments received through the NATAC. HSD continues to work with the NATAC and meet on a quarterly basis to discuss areas in need of improvement, including care coordination.

1. b. Improve transitions of care *(8 comments)*
Commenters expressed support to improve transitions of care and target care coordination. One commenter expressed support of in-home assessments for members in need of Community Benefit (CB) services when transitioning from a facility. One commenter recommended transitions of care could be improved by using VPB initiatives. Advocates warned that MCOs may be incentivized to deny access to subsequent treatments that impacted their VBP revenue. The state was asked by one commenter to include family caregivers in the discharge process from inpatient and nursing homes stays. One commenter stated the Lay Caregiver Act of 2015 requires hospitals to record designated caregiver information, and a commenter suggested that the MCOs train care coordinators about the law.

Response: In response to comments about improving transitions of care, HSD included clarifying language in the sample MCO contract for Centennial Care 2.0 to include a variety of transitions that the MCOs will be required to address such as members transitioning from a nursing facility to the community or from an inpatient-hospital stay to home. Care coordinators must address the member's service needs such as Home and Community Based Services, follow-up appointments, treatments, medications and durable medical equipment. The contract also requires the MCOs to perform an in-home assessment within three calendar days of discharge followed by three monthly contacts after a transition from in-patient hospital or nursing facility stay to assess the member's needs and ensure the needs are being met. HSD will review its training requirements for care coordinators and identify additional educational opportunities about family caregivers.

1. c. Leverage partnerships to expand successful programs that target high-needs populations *(7 comments)*
Commenters expressed support for efforts to leverage partnerships to expand successful programs targeting high-needs populations. Support was expressed for increased utilization of community health workers (CHW) with requirements that contractors describe sustainable funding streams for CHW. One commenter expressed concern for inadequate funding and resources that are needed to have successful programs. Organizations and individuals expressed support of the wraparound approach for youth involved with the Children, Youth, and Families Department (CYFD). A few commenters suggested collaboration with providers at the community level. One advocacy group supportive of wraparound approaches had a concern that this could be used to deny services to children in need of residential treatment center (RTC) placement.

Response: In response to comments about targeting high-need populations, HSD developed a new section in the sample MCO contract for Centennial Care 2.0 to address this population. The MCOs are required to employ or contract with dedicated care coordinators to meet the needs of individuals with intellectual disabilities, special health care needs, housing insecurity, and/or complex behavioral health needs and individuals that are considered medically-fragile and/or justice-involved individuals. Specialized care coordinators are required to pursue training specific to the particular population's needs and be familiar with available services. In addition, HSD added requirements for the MCOs to include Community Health Workers (CHWs) and Community Health Representatives (CHRs) as part of their delivery system and included goals specific to CHWs and CHRs within a Delivery System Improvement Performance Target.

1. d. Initiate care coordination for justice-involved individuals prior to their release from incarceration *(9 comments)*
Providers and individuals support care coordination for justice-involved individuals prior to their release from incarceration. One organization recommended MCOs collaborate with community organizations to identify best practices to effectively coordinate healthcare needs for this population. One commenter expressed support stating individuals in the facilities are often in need of community supports and do not know how to access them.

Response: In response to comments regarding care coordination for justice-involved individuals, HSD added language to the sample MCO contract for Centennial Care 2.0 that requires the MCOs to participate in care coordination efforts for justice-involved individuals to facilitate the transition of members from prisons, jails and detention facilities into the community. Care coordination for the justice involved will require the MCOs to collaborate with criminal justice partners to identify members with physical and behavioral health chronic/complex care needs prior to release. The MCOs will also be required to designate a justice-involved liaison to be the point of contact for the prisons, jails, and detention facilities and ensure appropriate transition of care prior to release.

1. e. Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood development with the Department of Health and the early Childhood Service Program within CYFD *(9)*
Commenters expressed support for piloting an evidence-based home visiting project and improving birth outcomes. Legal advocates commented this proposal will encourage state agencies to work together which could lead to reducing administrative waste and duplication of services. One commenter believes home visiting programs are needed to improve better health outcomes.

Response: HSD added language in this section to further clarify the home visiting models, services and provider qualifications for the pilot.

1. f. Obtain 100% Federal Funding for covered services delivered to Native American members in Centennial Care that are received through Indian Health Services (IHS) or Tribal Facilities *(4)*
Support was expressed for efforts to obtain 100% federal funding for covered services delivered to Native American members in Centennial Care that are received through IHS or Tribal Facilities. Native American providers clarified their interpretation for the referral process to come from IHS or Tribal site and that the MCOs are not allowed to require prior authorization. One commenter stated that collecting more federal dollars to help Native Americans would benefit the state.

Response: HSD included this proposal in the waiver to primarily address long-term care services. Since Native American members in need of long term care services are required to enroll in Centennial Care, the MCOs have contractual relationships with long-term care providers, including nursing facilities and personal care service agencies, while IHS does not typically have such contractual relationships nor traditionally refer for such services. Additionally, the MCOs are responsible for developing and maintaining the care plans of those members, and so having them serve as the responsible party for record custody but share the records with IHS/ITUs will reduce administrative burden and barriers to care in such circumstances.

2. Long-Term Services and Supports (LTSS)

2. a. Align Services between ABCB and SDCB models *(8 comments)*
Strong support was expressed by commenters for an aligned process between ABCB and SDCB models. Some advocates believe all Community Benefits (CB) should be available to both models which would equalize the service array options. One organization expressed gratitude for the development of the Community Benefit Service Questionnaire (CBSQ) but wanted more focus on ensuring CB participants are properly assessed.

Response: Several Self-Directed services such as related goods and specialized therapies were added to the Self-Directed benefit package under the previous Mi Via Waiver prior to Centennial Care and were never intended to be managed or provided by an MCO in the agency-based model. The MCOs are implementing the CBSQ with members as required by HSD. As of September 30, 2017, and 11 months with full implementation of the CBSQ, over 19,000 CBSQs have been completed with members in the long-term care program. HSD also monitors CB assessments though ride-alongs with care coordinators and quality audits. It also has its External Quality Review Organization conduct reviews.

2. b. Allow for one-time start-up goods when a member transitions from ABCB to SDCB *(3 comments)*
Commenters support the allowance for one-time start-up goods when a member transitions from ABCB to SDCB. One commenter asked that allowance for rare exceptions to limits for unusual cases be considered for additional resources for the transition to be successful.

Response: This a new benefit added to the list of self-direction services. Prior to recommending a $2000 cap for start-up goods, HSD researched the average cost of items that are beneficial for individuals who are self-directing services, such as computers, printers and fax machines. All of these items may be purchased within the $2000 cap.

2. c. Address the need for additional caregiver respite *(6 comments)*
Commenters support adding additional hours to address the need for additional caregiver respite. One commenter stated that any proposed limit to the use of respite must be sufficiently flexible to allow for exceptions to avoid violating the Americans with Disabilities ACT (ADA). Commenters expressed appreciation for needed respite hours to help relieve caregivers. Advocates from the aging community expressed support for the additional respite hours to support people using LTSS. One commenter asked the state to not impose a program cap on the hours and suggested using a sliding scale.

Response: HSD has had an exception process in Centennial Care to allow additional respite over the 100 hour limit when a member's health and safety needs exceed the limit and will preserve this policy under Centennial Care 2.0. See 8.308.12.13.K.(4) NMAC.

2. d. Establish limitations on costs for certain services in the SDCB model *(6 comments)*
Advocacy organizations believe establishing limitations on costs for certain services in the SDCB model violates the ADA. Providers expressed support for hippotherapy, biofeedback and cognitive rehabilitation specialty services and are concerned about caps. One commenter stated that the cap is arbitrary and will ensure a lack of supportive therapies that maintain or improve health. One commenter stated caps will result in a lack of continuity of care and poorer health outcomes. A few commenters asked the state to allow individuals in SDCB to make their own decisions on how much to spend depending on their needs and not target certain services. One commenter stated limiting non-

emergency transportation will negatively impact older adults in rural areas with limited access to public transportation.

Response: As the SDCB program continues to experience increased enrollment, the limitations will help to ensure long-term sustainability of the program and continue to allow HSD to offer access to the community benefit to all eligible Medicaid members who meet a NF LOC without needing a waiver allocation for such services. HSD will "grandfather" budgets that exceed the limits for existing SDCB members, and their approved amounts over the proposed cost limits will become their on-going cost limit for as long as they remain in the SDCB model. To clarify, the MCOs are responsible for providing non-emergency medical transportation to all members and there is not a limit or cap for this service. The SDCB transportation benefit that will be subject to the limit provides non-medical transportation to social activities including community events, libraries, museums etc.

2. e. Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change *(3 comments)*
Commenters strongly support implementing an ongoing automatic NF LOC approval with specific members whose condition is not expected to change. One commenter stated this policy will help alleviate stressors for members and preserve access to services.

Response: HSD has not made any additional changes to this proposal in the final waiver application.

2. f. Require inclusion of nursing facilities in VBP arrangements and leverage Project ECHO and the UNM Section of Geriatrics to provide expert consultation to nursing home staff working with members with complex conditions, systemic improvements in nursing home quality of care, and reductions in avoidable readmissions from nursing facilities to hospitals *(2 comments)*
Two comments were offered in support of VBP arrangements with nursing facilities and working with Project ECHO. One commenter would like to see more information that supports using an alternative reimbursement method through VBP and allocate more LTSS funding for HCBS.

Response: HSD's collaborative work with Project ECHO and UNM Section of Geriatrics will begin in 2018 and include the New Mexico Health Care Association in the development of the VBP plan for nursing facilities in 2019. New Mexico continues to be a national leader in spending more of its long-term care program dollars in home and community-based settings rather than institutional settings.

3. <u>Physical Health and Behavioral Health Integration</u>

3. a. Expand the Health Home model *(5 comments)*
Comments were expressed in favor of expanding Health Home models to better integrate physical and behavioral health with one commenter asking for more data demonstrating successful models. Support was provided for expansion of the CareLink NM model to additional sites, including a Native American Health Home provider site. One commenter suggested the state provide explicit expectations with respect to behavioral health network adequacy, and evaluate and enforce network adequacy when the MCOs are operational. One commenter expressed concern that it is not clear what services Health Home members receive compared to other Medicaid members.

Response: The purpose of the Health Home model is to provide more comprehensive care coordination and whole-person chronic condition care management to groups of Medicaid beneficiaries with complex health care needs. The goals of the CareLink NM are to 1) Promote acute and long term health; 2)

Prevent risk behaviors; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED; and 5) Reduce avoidable utilization of emergency department, inpatient and residential services. Early quality evaluations of CareLink NM are very positive and member satisfaction is reported as high.

3. b. Establish an alternative payment methodology to support workforce development *(10 comments)*
Commenters expressed support for an alternative payment methodology to support workforce development to improve access to care. One legal advocacy organization referenced New Mexico's designation as a "Health Professional Shortage Area" and although is supportive of funding that is dedicated to increasing provider access believes it is not enough. One commenter stated the proposal does not address the insufficiencies in the state's behavioral health system. One commenter asked for clarification from the state, on behalf of primary care providers, of the difference between funding Graduate Medical Education (GME) for Family Medicine and Psychiatry as opposed to Primary Care. One commenter is concerned the state intends to require training for family physicians in an integrated Primary Care and Behavioral Health services setting. Two commenters recommended that Accreditation Council of Graduate Medical Education (ACGME) be the standard for clinic eligibility to participate in the alternative payment methodology program, and requested that the state provide Indirect Graduate Medical Education (IME) support for the hospital's portion of the training costs. These commenters also requested clarifying language on an existing State Plan Amendment and state regulations for IME and GME. A commenter from the Native American community suggested funding increases for Primary Care Physicians, Psych Nurses, Nurse Practitioners and Physician Assistants. A hospital provider expressed concerns with moving residency resources from hospital settings and recommends a comprehensive approach to enhance reimbursement across the system. One commenter expressed concerns with moving residency resources from hospital settings to community clinics, which could reduce resources that will contribute to workforce shortages that already exist. Commenter speaking on behalf of hospitals expressed opposition to shifting dollars when GME funding should be maintained for existing GME slots and enhanced for expanded opportunities and new hospital slots.

Response: HSD's proposed alternative payment methodology is designed to support primary care, family medicine, and psychiatric resident physicians. The state's proposal seeks flexibility to choose clinics that are located in primarily rural, frontier or tribal communities to maximize the state's ability to address workforce shortages within the constraints of available funding. The state does not intend to impose additional training requirements for family physicians. Waiver language was revised to clarify that HSD is not moving residents out of hospital-based settings. HSD disagrees that ACGME accreditation should be the standard for clinic eligibility to receive alternative payments under this program, as this would greatly reduce the likelihood that clinics can participate across different regions of the state. As proposed in the final waiver, HSD is seeking to support the full cost of the resident, which may include the hospital's portion of training costs. HSD will consider comments relating the state's SPA and IME/GME regulations separately.

3. c. Develop Peer-Delivered Pre-Tenancy and Tenancy Support *(7 comments)*
Commenters expressed support in developing peer-delivered pre-tenancy and tenancy support to participants with Serious Mental Illness (SMI). Advocates view this approach as an addition to other fully integrated behavioral health treatments. One commenter in expressing support said he/she believes it will help people with SMI. One health plan commented that this expansion will have a beneficial impact for members and reduce unnecessary hospitalizations and emergency department use.

Response: HSD added language in the final waiver application to further describe this benefit.

4. Payment Reform

4. a. Pay for value versus volume and increase the share of provider payment arrangements that are risk-based *(6 comments)*
Commenters expressed support for pay for value versus volume and increase the share of provider payment arrangement that is risk-based. One health plan suggested a flexible range of models including shared savings, shared risk, and partial and full capitation payment. Advocates support efforts to improve outcomes but asked the state to monitor MCOs possible denial or reduction of services to meet VBP goals.

Response: HSD has been incrementally increasing the amount of provider payments that are in value-based purchasing arrangements since 2015. For CY 18, 20 percent of provider payments must be in VBP arrangements. The ultimate goal of VBP arrangements is to improve healthcare outcomes for members and ensure that members are receiving high-quality care. These arrangements are not designed to reduce or deny services, but rather to incentivize providers to achieve improved rates for routine and preventive care services while reducing rates for potentially preventable services such as emergency room visits and readmissions to hospitals. The Centennial Care 2.0 MCO sample contract requirements outline a four-year plan to continue to drive VBP goals with annual increases in the percentage of provider payments in VBP arrangements, including requirements to include nursing facilities, rural providers and behavioral health providers.

4.b. Leverage VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization *(7 comments)*
Comments were offered in support of leveraging VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization. One commenter recommended including MCOs in developing solutions and evaluating performance against goals. Advocates expressed concerns that VBP could translate into MCO cost savings instead of health outcomes. One commenter expressed concern the MCOs will take away services to meet their VBP goals. One commenter asked the state to include hospital associations and hospitals in efforts to improve readiness to participate in risk-based payment arrangements and to leverage VBP arrangements that drive key program goals. Commenter stated that VBP arrangements should be consistent across MCOs and enable achievement of mutually-agreed upon goals based on hospital capacity and performance.

Response: As stated in response above, HSD has outlined a detailed plan for its VBP program in its Centennial Care 2.0 MCO contracts, with specific targets and provider payment thresholds in three different VBP levels over four years. The plan includes requirements for inclusion of rural, behavioral health and nursing facility providers, data reporting requirements and specific targets for achieving certain quality metrics. The 2.0 sample contract may be found at this website:

http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended_Version__RFP_A2__RFP_Sample_Contract.pdf

4. c. Advance Safety Net Care Pool (SNCP) Initiatives *(5 comments)*
Commenters support advancing SNCP initiatives to expand participation to all willing hospitals. Support was expressed for initiatives that are data-informed and focus on health outcomes. One hospital provider expressed concerns with MCO contractual requirements and adding stress on safety net hospitals. One commenter stated that under federal law, states must assure Medicaid payments are sufficient to enlist healthcare providers to the same extent they are available to the general population in the same geographic area. One commenter representing hospitals stated that Medicaid payments to all New Mexico hospitals in aggregate are approximately 85 percent of actual costs for delivering services. Hospital representatives believe the "enhanced rate" does not fully cover their shortfall and is unsustainable. Commenter cited a report that was commissioned by Manatt to provide an analysis with examples from other states to illustrate the rationale for not reducing the uncompensated care (UC) pool and recommended that the state maintain the UC pool at $68.8 million, or expand it.

One commenter expressed concern with the proposal to expand the range of provider groups participating in SNCP, specifically the inclusion of nursing homes. Commenter explained the SNCP program aligns with county funding and state law, and is applicable only to hospitals. One commenter recommended creating a related program specific to nursing homes and funded separately from hospitals as a more logical approach. Commenter asked the state to consider removing any suggestion about "requiring participating providers to be network providers with each Centennial Care MCO". Hospital providers expressed concern with the requirement that hospitals must contract with all Medicaid health plans to receive funds from the safety net care pool and that it unreasonably interferes with the free market by mandating that hospitals enter into certain business arrangements.

Response: HSD seeks authority to retain the Safety Net Care Pool funding. It proposes to incrementally shift the funding ratio between the Uncompensated Care Pool and Hospital Quality Improvement Incentive Pool (HQII) so that 43% of the funding is allocated for the UC pool and 57% for the HQII. This ratio aligns with Centennial Care's goal to prioritize paying for quality versus volume.

In addition to the revised allocation of funding, HSD proposes:

- *Expanded flexibility to modify or update measures that factor into funding of the HQII pool;*
- *Continue increases to the enhanced inpatient rates and increase outpatient rates; and*
- *Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network for the Centennial Care MCOs.*

HSD did remove language that included nursing facilities in this section as it has advanced other proposals in the final waiver application specific to nursing facilities and removed the expansion to all willing hospitals.

5. Advance Member Engagement and Personal Responsibility

5. a. Advance Centennial Rewards Program *(5 comments)*
Support was expressed for Centennial Rewards Program and suggestions were made to better educate members about how the rewards program works. Support for utilizing rewards towards premiums was expressed and one health plan recommended a 90-day buffer for processing. Advocates and individual commenters expressed support for rewards improving health outcomes. One commenter stated support for the rewards program but thinks people don't know about it or how to use it.

Response: HSD did not modify this section in the final waiver.

5. b. Implement premiums for populations with income that exceeds 100% FPL *(141 comments plus joint organizational sign-on letters)*
The majority of the comments received explicitly oppose the implementation of premiums for populations with income that exceeds 100% FPL. Many of the comments in opposition to premiums were submitted as form letters or as part of a joint organizational and individual letter. Commenters consistently argued against imposing premiums and offered examples of research that discourages the use of premiums. Commenters suggested the Medicaid program would see enrollment decline and people would lose coverage. One commenter expressed concern that adding more expenses for Medicaid individuals, such as premiums, will directly impact their health. Individuals expressed fear and worry about their ability to afford other expenses like housing, food and transportation. One commenter expressed concern for families living on the edge of poverty, children in CHIP and working disabled individuals. One commenter expressed worry about having to pay both premiums and co-payments. A broad range of providers including family physicians, pediatricians, nurses, social workers, behavioral health providers and others strongly oppose premiums and other forms of cost sharing and believe it will lead to a reluctance to seek care and result in chronic diseases leading to higher emergency care utilization and hospitalizations. Hospital providers expressed concern that premiums will have an effect on enrollment and impact members' ability to stay consistently connected to the Medicaid program. Some commenters suggested the state look for new revenue streams for New Mexico that could benefit the Medicaid program. Some cited an increased administrative burden on the state to collect premiums, which would outweigh any potential savings from cost sharing.

A few commenters expressed support for cost sharing in Medicaid and were in support of premiums.

Response: HSD carefully considered the comments related to premiums and made the decision to restrict premiums to only one category of eligibility—the Expansion Adult population with income greater than 100% of the FPL. It removed premium requirements for the CHIP and WDI programs in the final application. With this change, the premium structure is simplified, consisting of one income tier for adults with income between 101 and 138% FPL, so that the monthly premium amount is the same for all adults in this category ($10). The annual premium amount is calculated at one percent of the lowest annual income in the tier, which is $12,060. At its discretion, HSD is requesting authority to increase the premium amount to two percent of annual income in future years of the Demonstration. HSD does not consider this policy as a reduction to eligibility or services—eligible individuals have the ability to retain coverage and continue accessing all covered services by complying with the premium requirements. Additionally, the premium requirement for this subgroup of the Adult Expansion population with higher income lessens the impact of the cost sharing cliff that is experienced when individuals transition from Medicaid coverage to coverage through the federal Marketplace or commercial market where cost sharing responsibilities are much higher.

5. c. Require co-payments for certain populations *(136 comments plus joint organization sign-on letters)*
The majority of the comments received explicitly oppose requiring co-payments for certain populations. Most of the comments in opposition to co-payments were submitted as form letters or as part of a joint organizational and individual letter. Commenters consistently argued against and offered examples of research that discourages imposing co-payments. Commenters suggested the Medicaid program would see enrollment decline and people would lose coverage leading to poor health outcomes. Individuals

expressed fear and worry about their ability to afford other expenses like housing, food and transportation. One commenter stated that the department is applying moral judgement that people need to have more "skin in the game". One commenter stated that research should be used to prove co-payments work. Families and individuals with chronic health conditions worry about out of pocket cost becoming unaffordable. Concern was expressed for families living on the edge of poverty, children in CHIP and working disabled individuals. A broad range of providers including family physicians, pediatricians, nurses, social workers, behavioral health and others strongly oppose co-pays and other forms of cost sharing and believe it will lead to a reluctance to seek care and result in chronic diseases leading to higher emergency care utilization and hospitalizations.

Hospital providers commented that requirements around co-payments and cost sharing for Medicaid members create increasing administrative burdens for healthcare providers and could impact a rate reduction for services requiring co-payments. They also suggested the administrative burden will offset system savings for Medicaid by increasing costs for providers.

A few commenters expressed support for cost sharing in Medicaid and co-payments.

Response: HSD carefully considered the comments related to copayment requirements and made the decision to remove most copayments from the final waiver application. Furthermore, it is removing copayments that exist today in the CHIP and WDI programs with the commencement of the waiver renewal. HSD is requesting authority to apply only two copayments in the final waiver, which are consistent with policy priorities to reduce unnecessary use in the delivery system and to incentivize preventive and routine care. HSD's decision to reduce the number of copayments addresses concerns raised about the complexity of the former copayment structure and increasing the administrative burden for providers.

5. d. Seek authority to modify the tracking requirements for cost sharing *(2 comments)*
Commenters oppose efforts by the state to seek authority to modify the tracking requirements for cost sharing.

Response: Since HSD has made decisions to restrict the premium payment requirements and to reduce the copayment requirements, tracking the five percent out of pocket maximum is simplified. HSD is requesting authority to waive federal tracking requirements for the two copayments since the members are choosing those service options rather than alternative options that do not require copayments. Because the premium amount is calculated at one percent of annual household income it should not exceed any member's out of pocket maximum, which is calculated at five percent of annual household income. This simplified cost sharing structure reduces any potential administrative costs that may have been incurred to track member cost sharing.

5. e. Seek authority for providers to charge nominal fees for three or more missed appointments *(62 comments plus joint organization sign-on letters)*
The majority of commenters expressed opposition to fees for missed appointments and pointed to obstacles some members face, for example, with access to reliable transportation, health issues that affect their ability to keep appointments, or cognitive issues related to a disability. One commenter expressed concerns for people with behavioral health issues being penalized. One commenter stated that transportation is limited in rural areas. Commenters stated that transportation is not reliable and people sometimes miss appointments. Some providers expressed concerns with administrative burdens they would face in collecting fees. One provider association expressed support for fees as a way to

reduce missed appointments. One commenter suggested using a multiple reminder approach. Some commenters who oppose co-pays and premiums support a small fee for missed appointments but suggested lowering the amount.

Response: HSD appreciates the feedback received related to this proposal. It is at the provider's discretion to charge the nominal fee after three missed appointments without notification to the provider in a calendar year. HSD has not made any additional changes in the final waiver as a result of these comments.

5. f. Expand opportunities for Native American members enrolled in Centennial Care *(8 comments)*
Commenters were supportive of expanding opportunities for Native Americans enrolled in Centennial Care. Native American providers and tribes expressed support for the states effort to seek authority to collaborate with Indian Managed Care Entities (IMCE). One commenter emphasized that this effort would not negate the need for fee-for-service (FFS) in New Mexico. Commenter believes the language in the draft waiver does not include a mandate for Native Americans to join an ICME. Most of the commenters reminded the state that they are sovereign. Some Tribal organizations expressed interest in becoming an IMCE as well as becoming other types of Medicaid providers. One commenter stated that because tribes are sovereign, agreements should be between the state and Tribal governments. All of the commenters encouraged the state to work directly with the Tribal community.

Response: HSD continues to collaborate with the Navajo Nation as it seeks to establish an IMCE. It will also work with other interested Tribal organizations at their request. HSD is not requesting mandatory enrollment for Native American members as part of this proposal to expand opportunities for Native American members. HSD expanded the language in this section of the draft waiver application to clarify expectations for establishment of IMCEs, including the requirement to meet all other aspects of federal and state managed care requirements, including but not limited to, financial solvency, licensing, provider network adequacy and access requirements and to demonstrate compliance with the requirements in the Centennial Care Managed Care Professional Services Agreement, including delivery of all Medicaid services as listed.

6. <u>Administrative Simplification through Eligibility Modifications</u>

6. a. Redesign the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered adults *(85 comments plus joint organization sign-on letters)*
The majority of the comments received explicitly opposes redesigning the Alternative Benefit Plan (ABP) and provide a uniform benefit package for most Medicaid-covered adults. Most of the comments in opposition to redesigning the ABP were submitted as form letters or as part of a joint organizational and individual letter. Many individual commenters expressed concern with cutting essential benefit and EPSDT for 19-20-year-olds and believe it will have a negative effect. One commenter believes elimination of EPSTD in the ABP will impact families. Physical, Occupational and Speech-Language therapy providers strongly oppose changes that would reduce or eliminate therapy services. Providers, advocacy organizations and individuals commented changes would create higher costs for members and shift costs to healthcare providers.

Response: HSD carefully considered the comments related to this proposal and made the following change to the benefit design—it removed the proposed elimination of habilitative services. However, HSD is seeking a waiver of federal EPSDT requirements for 19 and 20 year olds in the ABP to streamline the adult benefit package and since individuals who qualify for a medically-frail exemption in the ABP

have access to the traditional Medicaid benefits that includes EPSDT services. The medically frail exemption criteria includes a list of specific conditions as well as the condition of needing assistance with one activity of daily living. HSD is proposing to add a limited vision benefit to the ABP which will provide access to this service to more than 240,000 adults who previously did not have this benefit. The ABP will continue to offer comprehensive benefits, including routine and preventive services, inpatient and outpatient services, pharmacy, non-emergency medical transportation, physical, occupational and speech therapy services and a dental benefit.

6. b. Develop buy in premiums for dental and vision services for adults, if needed *(33 comments)*
The majority of commenters oppose buy-in premiums for dental and vision services for adults and any cuts to services that exist. One commenter expressed opposition to another cost to people who have limited income or lack coverage from their employer. Opposition to changes to adult dental services was received from the oral health coalition and hygienists expressing concern for increased disease risk like heart disease, diabetes and prenatal complications if dental services are reduced. Providers in ophthalmology and optometry also expressed opposition to premiums and changes to vision services stating that it would lead to reductions in thousands of eye exams and contribute to health risks and conditions.

A few commenters expressed support for buy-in premiums for dental and vision services. One commenter stated that the state does not have the money to pay for everything.

Response: HSD appreciates the comments it received related to this proposal and did not make any changes to this proposal in the final waiver application. This proposal remains to allow flexibility in future years to address potential federal financing policy changes and/or state general fund budgetary deficits.

6. c. Incorporate eligibility requirements of the Family Planning program *(10 comments)*
Commenters oppose incorporating eligibility requirements of the Family Planning program.
One commenter expressed concerns that limits on the age of recipients would deny access for treatments available through the family planning program. One commenter specifically opposes the age cap of 50 for family planning. Advocates raised concerns that people with disabilities will lack reproductive health coverage and recipients will face co-payments for family planning services in Medicaid and the ABP. Individuals commented that New Mexico already has a high unintended pregnancy rate that leads to cycles of poverty and the state should not reduce access. One commenter stated that risks for sexually transmitted infections with older adults are growing and they need to have access to these services.

Response: HSD appreciates the comments it received related to this proposal and did not make any changes to this proposal in the final waiver. HSD's policy to target the family planning to those who are accessing the services aligns with the age limitation of up to 50 years old. There are no proposed copayments for family planning services in the Medicaid program.

6. d. Eliminate the three-month retroactive eligibility period for most Centennial Care members *(86 comments plus joint organization sign-on letters)*
The majority of commenters expressed strong opposition to eliminating the three-month retroactive eligibility period for most Centennial Care members. Most of the comments in opposition were submitted as form letters or as part of a joint organizational and individual letter. One commenter stated opposition to eliminating the retroactive coverage and that it will leave families exposed to massive financial debt. Advocates and individuals believe ending coverage would take away important

protections that protect people from medical debt. UNMH specifically asks the state to remove this provision from the Waiver proposal. They state that the elimination retroactive cases would have a disproportionate impact on hospitals and other safety net providers. One hospital association commenter stated that the limitation of retroactive eligibility cases would have a disproportionate impact on hospitals and other safety net providers.

Response: In consideration to the comments received to this proposal, HSD has modified the proposal. The final policy decision is to phase out the retroactive period of eligibility by reducing it to one month in 2019, then eliminating it with the start of the second year of the demonstration (2020). Providing one month of retroactive eligibility to new recipients during the first year of the waiver renewal allows ample time for the delivery system to develop the necessary processes to secure coverage at point of service and provides additional time for HSD to retrain hospitals and other safety net providers in presumptive eligibility determinations. Additionally, HSD is moving toward an environment in which Medicaid eligibility, both initial determinations and renewals, is streamlined where possible. Real-Time eligibility is scheduled to roll-out by the end of 2018, meaning that many individuals will receive an eligibility determination at the point of application. Additionally, the ACA and expansion of Medicaid to adults who were previously uninsured have dramatically changed the landscape of coverage options. New Mexico hospitals have substantially reduced their uncompensated care needs and are able to make individuals presumptively eligible for Medicaid at the time of service. In calendar year 2016, only one percent of the Medicaid population requested retroactive coverage (10,000 individuals). Safety Net Clinics are also able to immediately enroll individuals at point of service through the Presumptive Eligibility program and receive payment for services. These changes provide an opportunity to reduce the administratively complex reconciliation process with the MCOs for retroactive eligibility periods.

6.e. Accelerate the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increase income *(73 comments plus joint organization sign-on letters)*
The majority of commenters expressed strong opposition to accelerating the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increased income. Most of the comments in opposition were submitted as form letters or as part of a joint organizational and individual letter. Many individuals expressed opposition and are concerned this will cause financial problems for families changing jobs or accepting raises.

One commenter stated that ending transitional Medicaid would result in coverage loss for the lowest income families. One commenter expressed concern the proposal will penalize people for working and earning more money. Legal advocates stated that TMA cannot be waived under Section 1115 authority and cautioned the state. One legal advocate commented that ending transitional Medicaid will make it difficult for families to gain economic security and will disrupt healthcare coverage.

Response: HSD appreciates the comments it received for this proposal. No changes were made as a result of the comments. As an expansion state, New Mexico has an option available to individuals in the Parent/Caretaker category when their earnings increase and make them ineligible for the Parent/Caregiver category, which it did not have prior to the passage of the Affordable Care Act (ACA). As stated in the final waiver application:

- *TMA is a concept that predates the ACA and was intended to provide coverage to Parent/Caretaker adults whose income increases above the eligibility standard for full coverage. Most of these individuals are transitioned to the adult expansion category, which has resulted in diminishing enrollment in TMA;*

- *In 2013, 26,000 individuals were enrolled in the TMA category; today, fewer than 2,000 individuals are enrolled; and*
- *Parent/Caretakers that have increased earnings above the income threshold for the adult expansion category (138% of the FPL) are eligible to receive subsidies to purchase coverage through the federal Marketplace.*

6. f. Request waiver from limitations imposed on the use of Institutions for Mental Disease *(3 comments)*
One commenter expressed support in waiving limitations imposed on the use of institutions for mental disease. Disability advocates do not support incentivizing the use of institutional care and asked the state to focus on funding community-based services reducing the need for hospitalization. One commenter representing hospitals commended the state for requesting a waiver of the IMD exclusion and stated it would greatly expand access to inpatient psychiatric care and reduce the administrative burden on MCOs.

Response: HSD appreciates the comments submitted for this proposal. Other proposals in the final waiver application support use of community-based services rather than institutional settings of care; however, when necessary and in certain circumstances, individuals may require services in an IMD and the State seeks authority to utilize IMDs in those instances without exclusions. Additionally, HSD has added new language to this section of the final application to add several behavioral health services to the benefit package that are needed to fill gaps in care, including expanding use of Screening, Brief Invention, and Referral to Treatment (SBIRT) services through primary care settings, community health centers, and urgent care facilities; and including residential treatment for adults with substance use disorder (ASAM Level 3).

6. g. Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states *(2 comments)*
Commenters expressed support for requesting waiver authority to cover former foster care individuals up to age 26. One advocate believes foster care is overrepresented by people with disabilities and behavioral health needs.

Response: HSD did not modify this proposal in the final waiver application.

6. h. Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers *(5 comments)*
Commenters expressed support for enhanced administrative funding to expand availability of LARC for certain providers. One commenter raised concerns for people with disabilities covered by Medicare and do not have access to LARC would need the Family Planning program for services not available to them.

Response: HSD did not modify this proposal in the final waiver application.

6. i. Continue to provide access to Community Interveners *(3 comments)*
Commenter expressed support for continuing to provide access to Community Interveners. Disability advocates think this opportunity has been underutilized. One commenter expressed support for expanding use of Community Interveners.

Response: HSD did not modify this proposal in the final waiver application.

7. Comments for related to Multiple or Not Specific Wavier Proposals

7. a. Miscellaneous Comments *(6 comments)*
Comments were received from independent pharmacists and pharmacies offering recommendations for the state to consider. One commenter asked that the state require all pharmacy reimbursement through Centennial Care be in compliance with NADAC pricing. One commenter asked the state to clarify the prior-authorization process for pharmacy and expressed concern that MCOs are using prior-authorization as a way to deny access to prescription drugs. One commenter asked the state to raise reimbursement rates and expressed concerns with contracting with the MCOs. One commenter expressed concerns with the lack of enforcement regarding use of tamper-resistant prescription pads.

One commenter representing hospitals expressed concerns with current infrastructure for oversight of the MCOs and believes it is significantly under-resourced. Commenter stated providers do not have a formal appeal process with the Department and asked the state for a complete restructuring of the fair hearing process.

One commenter expressed frustration with the state's lack of creating new revenue that could help the Medicaid program. One commenter suggested that the state create a tax on New Mexico corporations.

Response: HSD appreciates these comments; however, the comments are best addressed through review of contractual requirements with and monitoring of the MCOs and review of the agency's internal procedures and processes. Revenue enhancement and modifications to the tax structure are not within the scope of the Medicaid agency's authority.

Comments on Centennial Care 2.0 Draft Waiver Renewal Application: September 2017 – November 2017

(*Comments through Nov. 6, 2017*)

Comments received from emails and public meetings are included below.
Content from attachment and letters are not included here.

Comments (all via HSD website unless noted otherwise)	Date Submitted	Submitter Name, location and email
Letter from NAMI NM	10/30/17	David Gonzales, ED, NAMI NM
Letter from NM American Physical Therapy Association, NM Occupational Therapy Assoc, and NM Speech-Language Hearing Assoc.	10/30/17	NMAPTA, NMOTA, NMSPHA
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. I am a social worker who interacts with many of Albuquerque's most vulnerable. These proposed changes in Medicaid services would be devastating to the folks I works with. Kevin Arthun, Housing Specialist for those experiencing homelessness	11/6/17	Kevin Arthun Albq kevin-a@nmceh.org
I understand there are proposed changes to New Mexico Medicaid which I find disturbing. Those changes in the Centennial Care 2.0 draft waive application, such as imposing co-pays and premiums, ending retroactive coverage and transitional Medicaid and, most importantly, reducing health benefits will unduly harm New Mexicans who rely on Medicaid. I strongly oppose these changes. K Gomes	11/6/17	K Gomes Las Cruces karogo@optonline.net
This is a repeat of comments I have submitted earlier-- Charging premiums saves money in the short run only by discouraging people from seeking care. In general, the administrative cost out strips any savings and care will only be more costly in the future when illness has not been treated. Collecting co-pays becomes an administrative burden for health care providers which results in transferring the costs to the providers. Providers will not refuse care to patients who are unable to pay, although the need to pay may discourage patients from seeking care. This information comes from testimony at many hearings and deliberative meetings looking at Medicaid reform in New Mexico. Susan Loubet, New Mexico Women's Agenda	11/6/17	Susan Loubet, New Mexico Women's Agenda sloubet12@gmail.com
I'm writing to express my concern about the proposed changes to the Medicaid program here in NM. While I understand that there are financial constraints affecting the Medicare program, the proposed changes would shift the a chunk of the financial burden of providing healthcare to those least able to pay it, with the consequence that fewer people will be able to access care. This is	11/6/17	Heidi Topp Brooks, J.D., M.P.H. Albuquerque heiditoppbrooks@me.com

unacceptable to me and antithetical to the purpose of the program. Very truly yours, Heidi Topp Brooks, J.D., M.P.H.		
Attached are the New Mexico Behavioral Health Providers Association comments on the Centennial Care 2.0 Waiver Application. Thank you Maggie McCowen, LISW, MBA, Executive Director Behavioral Health Providers' Association of New Mexico	11/6/17	Maggie McCowen, LISW, MBA Executive Director Behavioral Health Providers' Association of New Mexico Las Cruces mrmccowen@nmbhpa.org
Please see the attached comments. Thank you, Sandra Cancer Action Network	11/6/17	Sandra Adondakis, New Mexico Government Relations Director American Cancer Society Cancer Action Network, Inc. Albuquerque sandra.adondakis@cancer.org
Hello, Please find our comments regarding Centennial Care 2.0 attached. Thank you, Simone National Multiple Sclerosis Society	11/6/17	Simone Nichols-Segers Senior Manager, Advocacy National Multiple Sclerosis Society Austin, TX Simone.Nichols-Segers@nmss.org
The plan to eliminate day habilitation will have a significant negative impact on many New Mexicans currently receiving services. This will hit rural NM especially hard where there are very few activities in the community in which these clients can participate. This will hit families in the family living hard, because Day Hab is a structured program which gets the consumer out of the home and into the community. These services should be maintained. Ken Harmon	11/6/17	Ken Harmon kharmonjr@yahoo.com
Annual caps of $2000 for specialized therapies and related goods and services within Self Directed Community Benefits are dangerous, short sighted, and unlikely to be cost effective. An original precept in the formation of self directed care was that given opportunity, individuals would find creative solutions to issues plaguing those with unique health care needs in NM. For example, in rural and frontier areas of the state, physical therapists who work with those with chronic needs are almost non existent. The option of using a massage therapist for ongoing care instead of a PT helps mitigate this issue. The pain relief afforded by frequent chiropractic care allows someone to eliminate the use of opioid drugs and their horrific side effects and dependency. These services are contained within the individual "allocated resource allotment," and do not change the overall total for that allocation. However, severely limiting the access to these would in no way impact the allocation per person-if the funding was not used on therapies,	11/6/17	Althea Mcluckie 4advocacyonlynow@gmail.com Taos

it would be used on direct care, and be less effective: in addition to increased direct care hours to help manage the behavioral problems that would result from chronic pain, there would then be the ADDITIONAL costs of medications and secondary medical interventions as a result of the side effects of those medications. As physical therapy simply does not exist as an option in many areas, limiting access to massage therapy would result in a lack of mobility. Secondary issues such as contractures and the need for surgery to release overly tightened muscles and ligaments would not only result in a decreased quality of life for the person, it would drive the costs of care UP. With regards to related goods and services, my comments are similar in nature. Limiting the line item allocation of related goods and services would not affect the overall allocation, and would therefore not reduce the cost to Medicaid. Instead, it would force someone to choose between the fax/phone/internet access that is required to submit time sheets for employees, positioning devices that compensate for severe muscle weakness and keep the airway open/prevent suffocation, or hypoallergenic supplies that reduce and prevent skin breakdown and hospitalization due to ulceration of the skin, for example. There are already very vigorous protocols in place that vet requested items: they must be specifically related to the participant's disability, must help with activities of daily living or be medically necessary, they must decrease the participant's use of other Medicaid services, and so forth. As all approved related goods and services meet these requirements already, an arbitrary monetary cap would risk a participant being forced to forgo something that is medically necessary and create complications that (at least in our case) would lead to hospitalizations when that could be prevented for a comparatively low cost annually. Althea Mcluckie		
Dear Human Services People, The proposed waiver for the State of New Mexico to reduce Medicaid coverage is a bad idea for the state. Il implemented, it will have numerous negative effects that greatly outweigh the upfront savings to the state from cutting Medicaid expenses. First, the economic effects of such an action will be harmful to the state's economy, resulting in lower tax income, and increases in some expenses. With fewer people on Medicaid there will be a drop in the number of people using medical services. This will cause a loss of income to the medical profession, one of the largest sectors in the New Mexico economy. That will cause a significant loss of jobs in the medical sector, and a multiplier effect in loss of income by business the out of work people buy from. This in turn will reduce tax revenue. In addition, with more people not regularly using medical services, including receiving vaccinations, this will cause more spread of illness in the population, resulting in increased lost work time, with some loss of income and tax revenue, not offset by some increase in purchase of pharmaceuticals and use of medical services. In addition, many people no longer able to afford to see physicians when their illnesses or medical conditions are not yet serious, will wait until their conditions are serious and then visit	11/6/17	Stephen M. Sachs, Ph.D., Professor Emeritus of Political Science, IUPUI Albuquerque Stephen M. Sachs ssachs@earthlink.net

emergency rooms, which are expensive and in many cases will not be reimbursed. This will add to hospital costs and cause additional loss of medical jobs. All of this will worsen New Mexico's ability to attract new businesses and keep existing ones. Second, in human terms, cutting Medicaid would be harmful to the people of the state. More people will be unable to receive needed medical services, leading to increased suffering, death, loss of work and income. The resulting increase in disease will result in more spread of disease to other New Mexicans. Conclusion: Funding Medicaid as fully as possible is an essential investment for the state of New Mexico and its people. Sincerely, Stephen M. Sachs, Ph.D., Professor Emeritus of Political Science, IUPUI		
Please see the attached comments from the National Association of Social Workers - New Mexico Chapter on the proposed Centennial Care 2.0 1115 waiver application.		
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, impose penalties for missed appointments and reduce health benefits. These changes will harm New Mexicans who rely on Medicaid.	11/6/17	Luther & Susan Ludwig luthersusan@bellsouth.net
Dear HSD Officials, As President Elect of NAMI-NM, I strongly urge you to withdraw the penalties, the co-pays, and monthly premiums for our citizens with serious mental illness. The very condition of SMI can make it very difficult to follow through on rigid time requirements. In addition, many of our Peers (those with SMI) are on disability and cannot afford to pay more than they are already paying. Without appropriate mental health services and medications, some of our most vulnerable citizens will be put at even greater risk. Homelessness and psychotic episodes and even suicide are real possibilities. We, of NAMI NM, urge you to reconsider the penalties, co-pays and monthly premiums, especially for those with Serious Mental Illness. Sincerely, Betty Whiton, President-Elect NAMI NM	11/6/17	Betty Ann Whiton bwhiton@msn.com
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays & premiums, and retroactive coverage and transitional Medicare, that would impose penalties for missed appointment and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Sincerely, Kathleen Podzimek		Kathleen Podzimek Las Cruces kathleenpodzimek@yahoo.com
Because of the affordable care act I have access to preventative health care for the first time in 15 years. Instead of going to the emergency room with asthma attacks 16-18 times every spring, I am able to see an allergist for injections. Instead of the police taking me to the psychiatric hospital, I am able to see a psychiatrist and be	11/5/17	Taren Hill taren.hill@yahoo.com

managed effectively on an outpatient basis. Because of the Medicaid coverage that I get through the Affordable Care Act, I am less expensive and I have a higher quality of life. I am able to work part time, pay taxes, and volunteer in my community. The proposed changes will create obstacles to accessing care for people like me. It might seem like a way to save money, but it actually costs more in the long run. It is hard enough to deal with hallucinations and delusions with treatment. It is impossible without. I believe that people choose to enter politics because they want to make the world a better place. I ask you please to take a stand right now to make the world a better place. Taren Hill		
To whom it may concern, I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Sincerely, Kevin	11/4/17	Kevin Foust kevin.foust@protocallservices.com
DON'T DO IT! Changes to Medicaid would be disastrous for many of our elderly, including me & my husband. We would end up getting bills we cannot pay, which will cost our providers. You don't really want to make Dr.s & other providers angry do you? I hereby promise if you do this, we will send any bills we cannot pay to your office. Sincerely, Mrs. Lee Sides	11/4/17	Mrs. Lee Sides Roswell leesds1984@gmail.com
Greetings, Thank you for all you do to support New Mexicans. I know that these are hard decisions to make as you look at how to best balance the budget. I do have some concerns about upcoming proposed changes. I am a person who works with people with New Mexico Medicaid benefits. I believe that these proposed cuts may be more harmful than good. So, I'm writing to you to state that I oppose the proposed changes in the Centennial Care 2.0 draft waiver application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. I believe that these changes will harm New Mexicans who rely on Medicaid. Thank you for allowing me a moment of your time.	11/4/17	Wendy Linebrink wow_wendy@yahoo.com
Hello, I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Thank you and have a good weekend, Robert Nelson	11/3/17	Robert Nelson robert.nelson.abq@gmail.com
Hello,	11/3/17	Meg Brauckmann

I am a resident of Las Cruces and I am writing because I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. As someone who works closely with families that are experiencing poverty these revisions would only further burden the most vulnerable amongst us and do not represent good policy for future health equity. Meg Brauckmann The Beloved Community Project, Inclusive Community Organizer		The Beloved Community Project Inclusive Community Organizer Border Servant Corps '17-'18 meg.brauck@gmail.com
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, impose penalties for missed appointments and reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Sincerely, Michael Striker	11/3/17	Michael Striker mstriker999@gmail.com
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Regards- Erin Boyd	11/3/17	Erin Boyd erinboyd999@gmail.com
Hello, I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Jack Turney Camp Hope Outreach Coordinator, Mesilla Valley Community of Hope	11/3/17	Jack Turney Camp Hope Outreach Coordinator Mesilla Valley Community of Hope Border Servant Corps Volunteer, 2017-2018 jturney999@gmail.com
I oppose the proposed changes in the Centennial Care 2.0 draft waiver application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid.	11/3/17	Abby Vines theghostroad@icloud.com
Dear Action Committee, I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Sincerely, Jennifer Squyres, Valencia County Resident	11/3/17	Jennifer Squyres jewelljenniferr@gmail.com Valencia County
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would	11/3/17	Katrina Marti, Case Manager

impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Katrina Marti, Case Manager Rehoboth McKinley Christian Health Care, Behavioral Health Services		Rehoboth McKinley Christian Health Care, Behavioral Health Services kmarti@rmchcs.org
Dear Secretary Brent Earnest, I am commenting on the proposed 1115 Medicaid Waiver program. I am not in support of proposed changes to charge our state's most vulnerable population a copay to receive care. Second, I am not in support of limiting rehabilitation services to people receiving Medicaid. Rehabilitation is a key service helping people attain or retain capability for independence or self-care and is demonstrated to prevent unnecessary hospitalizations or placement into expensive long-term care. Third, I am opposed to eliminating habilitation services for adults. Habilitative services for adult persons are provided to assist the individual attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. There are many people transitioning into adult life who will need habilitative services, for example adults receiving cochlear implants to treat hearing loss, those with psychiatric illnesses and substance abuse disorders, and adults with cerebral palsy or developmental disabilities learning independent living skills. Lastly, I am against any changes in the waiver that would alter the essential health benefits of people insured under Medicaid. Sincerely, Jane Prince-Smith, LISW	11/3/17	Jane Smith jarly@me.com
Greetings, I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Thank you, Katherine Meehan , Housing Case Manager and Domestic Violence Advocate	11/3/17	Katherine Meehan scaryscarab78@yahoo.com
To whom it may concern, My name is Dr. Thomas A. Paz and I am an optometrist in Las Cruces, New Mexico. I would like to comment on the importance of Vision Health for all New Mexicans including those adults who receive Medicaid Adult Vision Services. As a Medicaid provider, I believe all vision services, including Adult Vision Services, provided by the NM Medicaid program are vital to the health and welfare of the citizens who receive these benefits and we believe these benefits should remain unchanged. Optometrists serving Adult Medicaid populations provide comprehensive eye examination and other primary clinical services that prevent disease, reduce disability, improve quality of life, and promote the adoption of healthy lifestyles, which in turn facilitate lifelong health and reduced Medicaid expenses. Many health issues have important clinical ties to vision and eye health that can be detected by	11/2/17	Thomas Paz 2tjpaz@gmail.com Las Cruces

an optometrist during the comprehensive eye exam. Here are a few important reasons to keep the Adult Vision Services in Medicaid: ▪ Eye diseases are common and can go unnoticed for a long time—some have no symptoms at first. A comprehensive dilated eye exam by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective. ▪ During the exam, visual acuity, depth perception, eye alignment, and eye movement are tested. The exam may even spot other conditions such as high blood pressure or diabetes, sometimes before your primary care doctor does. ▪ Early treatment is critically important to prevent some common eye diseases <https://www.cdc.gov/visionhealth/basics/ced/index.html> from causing permanent vision loss or blindness: o Cataracts, the leading cause of vision loss in the United States o Diabetic retinopathy, the leading cause of blindness in American adults o Glaucoma o Age-related macular degeneration ▪ Over 14% of the people in New Mexico have diabetes. Of these, an estimated 59,000 don't know it. Diabetic retinopathy is also one of the most preventable causes of vision loss and blindness. Early detection and treatment can prevent or delay blindness due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don't get their eyes examined or are diagnosed too late for effective treatment. ▪ Diabetes is expensive. People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes. Providing Adult Vision Services can save the Medicaid program by lowering the future costs associated with Diabetes. ▪ Providing basic vision correction with glasses to the Adult Medicaid population is one of the most cost-effective ways to improve a person's ability to obtain and maintain employment, attain a higher level of education, and function as a productive member of society. I do not believe the proposed changes to the Adult Vision Services meets the Demonstration Waiver criteria outlined by CMS to included better coverage, better access, better outcomes, and better efficiency. In fact, we believe the changes to the Adult Vision Services in New Mexico fail such criteria, and would weaken the state's waiver request. I also strongly believe the benefit to 19 and 20-year-olds covered under the EPSDT benefit providing comprehensive health care should remain unchanged. The proposed change would be a reduction of benefits for this important age group at a critical time in their lives. As an optometrist providing Medicaid Adult Vision Services I can attest that the program is crucial to keep this population healthy and productive. I ask that you keep the Adult Vision Services in its current form as a benefit without a buy-in premium. Please call me for further information or to discuss any questions you may have my cell phone number is 575-644-3267 Sincerely, Dr. Thomas A. Paz		
To the NMHSD:	10/31/17	Adele Jacobson

I am already not able to buy food due to my lack of income and have to go to a food bank three times a month. If I didn't have Medicaid coverage I would literally be dead. I receive a life preserving treatment once or twice a year for a blood disorder. I'm already barred from getting certain preventative treatment. At this point my income is below the level where you are charging copays and premiums. If I would get a part time job then my income would possibly allow me to buy food however then if your proposal passes I would be spending it on healthcare vs. buying food again. A never ending cycle. If you move forward with these costs you will see: 1. More homeless individuals and families 2. More unwanted pregnancies 3. More deaths due to diseases that are treatable and curable. 4. More pain and suffering. 5. More crime 6. More gangs 7. More drugs being sold illegally 8. More abuse Perhaps you can work on creating more jobs so people can truly afford decent healthcare rather than ripping apart the lives the those that can't. There must be another way. Go back to the drawing board and figure it out! Sincerely, Miranda Jacobson		vidamor33@yahoo.com
Dear Cabinet Secretary Brent Earnest, I am writing to you as a voting resident of Bernalillo County, and as a future healthcare provider. In regards to the HSD open comment period on the Centennial Care 2.0 Proposal, I plead with you as legislators: NO copay, no premium, and no missed visit fee for our poorest residents. YES for full Essential health benefits including rehabilitation, habilitation, dental, mental health services, and vision care. Thank you very much for the work you do. Sincerely, Khizer Ashraf	10/31/17	Khizer Ashraf khizer.ashraf@gmail.com
Medicaid should have better restrictions on individuals with child support and health care support. If a child is receiving medical support from a noncustodial parent why are most still getting Medicaid. This seems redundant and is taking away funds for someone who may need Medicaid. Also if you are a certain age and capable of working then you should be required to work to continue to get services. I see so many moms not working and getting free assistance from the state and not being held accountable for taking care of their own children. This is our tax money being used up by people who are capable of working. I have to struggle to pay for health care because I don't qualify for Medicaid then why shouldn't other capable working adults be held to the same standards.	10/30/17	(unidentified)
I am commenting on the proposed 1115 Medicaid Waiver program. I am NOT in support of proposed changes to charge our state's most vulnerable population a copay to receive care.	10/30/17	Mary Ann Bosworth, MA CCC SLP Albuquerque

Second, I am not in support of limiting rehabilitation services to people receiving Medicaid. Rehabilitation is a key service helping people attain or retain capability for independence or self-care and is demonstrated to prevent unnecessary hospitalizations or placement into expensive long-term care. Third, I am opposed to eliminating habilitation services for adults. Habilitative services for adult persons are provided to assist the individual attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. There are many people transitioning into adult life who will need habilitative services, for example adults receiving cochlear implants to treat hearing loss, those with psychiatric illnesses and substance abuse disorders, and adults with cerebral palsy or developmental disabilities learning independent living skills. Lastly, I am against any changes in the waiver that would alter the essential health benefits of people insured under Medicaid. Thank you for your attention. Sincerely, Mary Ann Bosworth, MA CCC SLP		bosworthslp@comcast.net
I agree with the plan of cost sharing, especially by Medicaid expansion recipients. However, the premium structure at the lowest end of the income scale needs adjustment. I think $10 a month for someone making just over $12000 a year is too high. I think this should be lowered. I do agree with small income based copays and monetary incentives to use care wisely (increased costs for brand drugs with available generics and non- emergency use of the ED. Mary Roach	10/30/17	Mary Roach maryroach100@yahoo.com Albuquerque
As a member of NAMI, I am very concerned about proposed cuts to mental health services and medications. Serious mental illness affects 1 in 5 families and NM has the highest, per-capita rate of mental illness in the US. To prevent people with mental illness from receiving services and necessary medications is unethical. The disastrous potential for millions of citizens with untreated serious mental is staggering. Families and communities will also suffer. It is essential that Centennial cover mental health services and medications. Sincerely, Betty Whiton, MA, LPC President Elect, NAMI NM	10/27/17	Betty Whiton, MA, LPC President Elect, NAMI NM bwhiton@msn.com
The Medicaid/Subsidized health care program needs to install measures that reflect much more fairness (particularly to those of us who are actually having to pay for it) and personal responsibility. As it stands now, it is yet another massive welfare program that consumes a huge chunk of other peoples' money and government budgets. It is rife with fraud and abuse. Co-pays should be no less than $20 and EVERYONE should be required to pay nominal fees regardless of income. Another glaring problem is that new proposals still make exemptions for families with children - this is the absolute worst approach: It provides absolutely zero incentive for individuals to stop producing children they simply cannot afford. Instead, it conveys the message that they can continue to have all the babies they want while the state and other private individuals essentially assume financial stewardship of them. To aggravate matters, these irresponsible parents turn right around and use these same children for "tax breaks" and a plethora of other welfare	10/25/17	Ray Diaz idiaz3704@gmail.com Las Cruces

programs which are bankrupting not only New Mexico, but the country as a whole. These types of practices only facilitate and enable the cycle of poverty and learned helplessness that will only feed and grow the problem and continue it far into the foreseeable future. Lastly but perhaps most importantly - especially in states like New Mexico - no government entity can engage in an honest, productive discussion with honest, fair and responsible solutions without first formally recognizing and addressing the adverse repercussions of immigration, illegal AND legal. I urge you to engage this problem with fairness and accountability to the shrinking pool of us who are being forced to take on a bigger and bigger financial burden and whose quality of life and standard of living continue to rapidly decline. STOP THE REDISTRIBUTION OF PERSONAL RESPONSIBILITY. Ray Diaz		
Abandon these inhumane cuts! This will destroy the lives of children, working disabled, and the elderly who are barely hanging on now! How are underpaid women going to pay for their birth control? Emergency rooms will be choked with citizens needing health care. That will be the only option for so many. This makes no sense economically as some 50,000 health related workers will be out of a job! These cuts will have a Tragic impact on so many of our citizens. You must revisit this alarming proposal! Respectfully, Percyne Gardner, Las Vegas, NM PS A study needs to be done before any of these cuts.	10/19/17	Percyne Gardner Las Vegas percynegardner@gmail.com
I, Cole Burns, am opposed to the Medicaid Waiver Proposal to change Essential Healthcare Benefits. Thank you, Cole Burns, MOT/S	10/19/17	Cole Burns, MOT/S University of New Mexico justgocole@gmail.com
I am a nurse practitioner working in women's health. A large majority of my patients are on Medicaid. I COMPLETELY SUPPORT requiring Medicaid recipients to pay nominal premiums and co-pays for office visits. In my opinion, patients should have a monetary investment in their health care. Jaymi McKay CFNP	10/16/17	Jaymi McKay CFNP jaymimckay@yahoo.com Albuquerque
Hello. I fully support the ideas presented by HSD to begin charging premiums, copays, and financial penalties for Medicaid recipients. I cannot believe that our state spends so much of its resources in providing such a rich benefit program to recipients with currently zero financial incentive to manage this spending wisely. We are effectively giving our revenues to the "poor" and asking that they make sound financial decisions.	10/16/17	A concerned Taxpayer (unidentified) Albuquerque

Frankly, I think that we should be paring down the benefits even more by not covering everything that the recipients want. Recipients should not receive benefits that are better than our active duty or retired military. Sadly, we are giving so much of our revenues away to recipients with zero to miniscule return on investment. Where is the data that shows how our billions spent annually are improving health, creating jobs, and bettering our already last-in-place economy? It's time to rethink and reprioritize how much money should be spent on these entitlements. We should be providing the bare minimum not a "comprehensive benefit program" as described by Centennial Care. Meaning that generic drugs are always dispensed, period. If the recipient prefers a brand name, then the drug is not covered. If recipients wants transportation to an appointment they should be required to use public transportation, that is already funded by tax payers. Non-emergency transportation should only be available for special circumstances, and should never be available if the recipient has their own means for transportation. If a recipient wants diapers they should only be covered for a medical reason and be prescribed by a physician. It would be more fiscally responsible to cut benefits and invest our money in infrastructure where all taxpayers benefit. It would be more fiscally responsible to cut eligibility and pare down the vast amount of enrollees and choose to invest in our economy where all taxpayers benefit from a larger tax base. I really hope that my comment will be listened to and heard. A concerned Taxpayer		
I oppose Governor Martinez's and the Health and Human Services proposed cuts to the Medicaid plan that help the poor with their health care needs. Rebecca Shankland	10/12/17	Rebecca Shankland White Rock rebecca.shankland@gmail.com
Dear Sir/madam, I strongly oppose any cuts to Medicaid benefits in New Mexico including increased co-pays, and eliminating retroactive benefits. It is our duty to take care of the less fortunate members of society. Furthermore eliminating prevention will lead to increased costs in uncompensated care. Please do not cut Medicaid. Robert M. Libby	10/12/17	Robert M. Libby Las Cruces robertm.libby81@gmail.com
To whom it may concern, this would truly hurt alot of us disabled citizens, I'm struggling as is to get by month to month this is such a burden not to mention stressful at the thought of Medicaid cuts, I therefore am very stressed out of the whole idea. This would not be a good thing for so many people and their family's so I respectably disagree with the Medicaid cut proposal. Respectfully, Sincerely Mr.Peralta	10/2/17	Curtis Peralta curtisperalta505@gmail.com
To whom it may concern , I am a senior citizen who is on Medicaid QMB and literally living hand to mouth and don't ever make it to the end of the month with any money . I am totally opposed to any cuts in the Medicaid program as it would take away all of the medical help I need .	9/21/17	Lynda Carol La Jara tsalagilyncobn@gmail.com

Lynda Carol		
WHAT DOES RESEARCH SAY ABOUT COST-SHARING'S IMPACT ON FAMILIES? www.aradvocates.org/wp-content/uploads/Co-Pay-Brief-Web.pdf In short, cost-sharing in Medicaid reduces access to care for low-income enrollees and can worsen their health outcomes. When individuals cannot access preventive care and early treatment, it often means they use the costly emergency room or let health issues worsen before they finally receive treatment. • In one example, Medicaid-enrolled cancer patients had more emergency room visits when copayments were added and each patient's total costs were $2,000 higher in a six-month period than they were for those without copayments. • Prescription drug copayments led to a 78 percent increase in emergency room use in Quebec. • Oregon's experiment with cost-sharing caused nearly half of adults to drop coverage, with most citing cost-sharing as a reason. Cost-sharing is more likely to affect children negatively, with low-income children being less likely than adults to receive effective care. • Even with no cost-sharing, families with children who have special health care needs spent $141 more on premiums and $432 more on out-of-pocket costs than other families did; increased cost-sharing would worsen this disparity. Out-of-pocket costs place a heavier burden on families living in poverty, especially those with serious health needs. • Nationally, half of households have credit card debt from medical expenses, and medical debt contributes to 62 percent of bankruptcies. Victoria Parrill	9/7/17	Victoria Parrill Santa Fe Victoria Parrill victoripar@gmail.com
Comments above were found in the email junk mail folder		
On behalf of the New Mexico Podiatric Medical Association (NMPMA), I am submitting comments regarding Table 10 where podiatry services are listed and have "limits apply" documented in the ABP column. NMPMA had contacted Dr. Burapa and received response that is documented below. 1. Coverage of podiatry and routine foot care is limited in scope. NMPMA suggests that this sentence if found in any HSD documents be modified for it may be interpreted to mean that services provided by Doctors of Podiatric Medicine are being limited by HSD due to provider credentialing. NMPMA is aware of routine foot care limitations based on medical necessity and Medicare policy guidelines that are frequently followed by non-Medicare insurances but this sentence does not clearly indicate this meaning. 2. NMPMA strongly suggests that the usage of podiatry services be updated with substitute verbiage of foot and ankle services in all HSD policies to avoid any inference of provider discrimination based on credentialing. NMPMA supports Member Engagement and Personal Responsibility Proposal #5 - Seek authority	11/5//17	Janet Simon, DPM Executive Director, New Mexico Podiatric Medical Association Albuquerque janetpod@aol.com

for providers to charge nominal fees for three or more missed appointments. Respectfully submitted, Janet Simon, DPM		
The Jemez Pueblo Health and Human Services would like to submit the following comments regarding Centennial Care 2.0: 1. First, we would like to thank you for changes already made to the initial draft based on previous comments from us and from other tribes. 2. Second, we oppose conversion of the Parent-Caretaker category to the Alternative Benefits Package as it will translate to a loss of benefits for those previously eligible for Parent-Caretaker. 3. While we appreciate that Native Americans would be exempt from the elimination of three-month, retroactive coverage, we still oppose this as there is some potential for impact on tribal clinics who provide care to non-natives (such as the Jemez Pueblo Health Center). I did not mention this at the Consultation, but though the state feels this is a mechanism which is not used very often, 10,000 instances in the last year is actually a large number of individuals who could have been placed in some very tough financial circumstances if it weren't for retroactive coverage availability. A portion of this will always be passed on to providers. 4. The addition of monthly premiums for Medicaid recipients is more likely to insure member dropout than member engagement and people whose incomes are low enough to qualify for Medicaid really don't have it to spare. a. A three month "lock-out" period for non-payment of premiums again, serves only to reduce enrollment, rather than engage members. While this may save the state money, it just means more uninsured New Mexicans. 5. Contracts for Care Coordination reimbursement really need to happen between the state and the tribes rather than the MCO's and tribes, as this further dilutes the government to government relationship by leaving up to each MCO what services will be reimbursed and to what level and by requiring tribes to contract with MCO's to receive that reimbursement. 6. Any proposed change which relies on the Marketplace to close a gap is at high risk for allowing enrollees to fall through the cracks in our current political environment, as the future of the Marketplace is highly questionable. We should not implement changes which rely on the Marketplace to "catch" Medicaid enrollees being pushed off of coverage. Once again, thank you for the opportunity to provide input regarding proposed changes which have the potential to affect so many New Mexicans. Lisa C. Maves, MA, LPCC	11/6/17	Lisa C. Maves, MA, LPCC Clinical Social Work Jemez Pueblo Health Center lisa.maves@jemezpueblo.us
To: Brent Earnest, Cabinet Secretary, New Mexico Human Services Department (HSD) From: Planned Parenthood of the Rocky Mountains, which includes Planned Parenthood of New	11/6/17	Julianna Koob juliannakoob@gmail.com

Mexico RE: Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0 Date: November 6, 2017 Dear Mr. Earnest, As representatives of Planned Parenthood of the Rocky Mountains, which includes Planned Parenthood of New Mexico, we are writing today to first thank you and your staff for hearing the community's concerns with providing access to LARC to Medicaid patients, particularly given the significant fluctuations and high costs involved in stocking LARC devices. The administrative fee you've included in the 1115 waiver will allow for all providers offering LARC to increase this important healthcare service. We are also writing with concerns about plans for renewal of the state's section 115 waiver, which oversees the state's Centennial Care program. We join many of our partner organizations, advocates, patients and providers in sharing concerns around several provisions that we believe will harm New Mexicans with Medicaid for the following reasons: 1. We are concerned that requiring premiums and co-pays will result in New Mexicans not getting the care they need. Additional costs to patients will result in patients dropping off the Medicaid roles and going back to costly emergency rooms for care, a trend that is contrary to the important work that HSD Medicaid has done over the past several years to get patients to primary care providers. 2. We are concerned with the changes to the family planning services. Although the proposal makes it clear that there will be no co-pay for family planning services within the family planning program, it does not make clear that patients will not pay a co-pay for family planning services within the Medicaid and Medicaid expansion population. 3. We also urge you to either get rid of or raise the age cap to 67, when Medicare is available for most people. A forty-five or even fifty year age cap fails to recognize the concerning data that has recently emerged about spikes in sexually transmitted diseases in populations forty-five and older. 4. The proposed provision to drop patients from the family planning program who have another form of insurance appears harmless on its face, but is in fact very harmful to those whose second form of insurance does not have comprehensive coverage for family planning. People with disabilities, for example, who have federal health insurance have very limited family planning benefits and would suffer from a lack of healthcare coverage for sexually transmitted diseases and a diverse coverage of contraception. Again, we ask that the HSD Medicaid Department not take steps backward on the important work it has accomplished over the past several years. The cost savings HSD has accomplished have been due to the increased preventative care that patients have received. Thank you for consideration of our comments.		Planned Parenthood of the Rocky Mountains, which includes Planned Parenthood of New Mexico

Sincerely, Planned Parenthood of the Rocky Mountains, which includes Planned Parenthood of New Mexico		
Please find Young Women United's Public Comments on the proposed changes to Centennial Care 2.0. Care Coordination: • We applaud HSD's considerations to strengthen requirements for care coordination of justice involved people being released from incarceration. We understand how important access to healthcare can be for people leaving detention facilities and prison. It would be helpful if HSD, in concert with MCO's, established a collaborative working group with community organizations and partners to review and identify best practices to effectively coordinate the healthcare needs of this population. Young Women United offers to support this coordination by facilitating opportunities to include the expertise of previously incarcerated people in policy and implementation discussions (we already do this alongside HSD in other healthcare areas). • Young Women United is excited about HSD's commitment to growing a wraparound approach for youth involved in CYFD. Through Young Women United's leadership in the "Deep End Girls Working Group", alongside CYFD and other partners we have identified the importance of gender specific strategies and interventions and recommend that the HSD pilot approach also be gender specific. Young Women United has extensive expertise we would like to share with HSD as the agency moves towards implementation. Member Engagement & Personal Responsibility: • Young Women United agrees with concerns articulated by many of our organizational partners regarding continuing co-payments and establishing new premiums for specific populations. We take a firm stance against co-payments and premiums for those individuals and families falling at or below the 200% FPL range. • If the cost-sharing proposal within Centennial 2.0 is moved forward, Young Women United strongly recommends that the 1% income/premium rates be held over the course of approved 1115 waiver, while this program is evaluated for efficacy and impact. • If the cost-sharing proposal within Centennial 2.0 is moved forward, Young Women United recommends that the drafted monthly premium table and structured premium and co-pay cost sharing rates begin at the 201-250% FPL range ($10 premium for individual, $20 premium for household and extend to the 251-300% FPL range ($15 premium for individual, $30 premium household rate). Benefits & Eligibility Opportunities: • Benefits and Eligibility Proposal #3: Young Women United strongly disagrees with HSD's	11/6/17	Micaela Lara Cadena, Research Director, Young Women United mcadena@youngwomenunited.org

proposal to cap family planning at age 50. We also disagree with the proposal to eliminate family planning Medicaid for those who have other health care coverage. As one example, we are deeply concerned about disabled women with reproductive health needs currently covered by Medicare who would not have all of their needs met by Medicare (i.e. LARC is explicitly not covered by Medicare). While we appreciate HSD's justifications, HSD's resources would be better spent by creating a mechanism for people who have been enrolled in family planning to opt out if they do not have a need/desire to utilize family planning services. Low rates of usage likely indicate people are not aware of their coverage and/or the full range of services provided under family planning. We encourage HSD to invest in improving notifications and consumer outreach materials for better understanding and accessibility. • Benefits and Eligibility Proposal #4: Young Women United disagrees with the elimination of the three-month retroactive eligibility period. Many women and families with low levels of health literacy and/or low rates of health care usage often seek care sporadically when an urgent or timely need arises. For these individuals, health care debt is likely to be devastating, and will increase other costs to New Mexico safety nets if the individual is also facing lost earnings, job loss, etc. Young Women United feels strongly that the current retroactive eligibility period serves to meet the health care needs of New Mexico families in real time. If someone shows up for care and submits a Medicaid application, knowing the visit will likely be covered means less people are avoiding care or delaying because they don't have a mechanism to pay. For young women and others, the inability to receive retroactive coverage may hinder their progress toward financial stability and may cause a domino effect with far-reaching implications. • Benefits and Eligibility Proposal #5: Young Women United recommends maintaining the current time frame for Transitional Medical Assistance. Those in a position to potentially earn more and advance their careers and/or financial situation should not be penalized with a shortened opportunity to move into health coverage. Realistically, many employers have a probationary period in which new employees are not eligible for coverage. Allowing for a year to embrace and establish themselves in their new circumstances lays a foundation for continued success. • Benefits and Eligibility Proposal #7: Young Women United applauds HSD's effort to support young people who have been in the foster care system • Benefits and Eligibility Proposal #8: Young Women United has been proud to work alongside HSD staff who have prioritized debundling LARC and making billing systems more efficient. Thank you for your continued commitment to making LARC more accessible to NM Families. Micaela Lara Cadena, Research Director , Young Women United		
Date: November 6, 2017	11/6/17	Carol A. Bottjer, O.D., M.S.

To: New Mexico Health Services Department From: Carol A. Bottjer, O.D., M.S. My name is Dr. Bottjer; I am an optometrist in Albuquerque, New Mexico. I would like to comment on the importance of vision services for all New Mexicans, including those adults who receive Medicaid Adult Vision Services. I believe all vision services, including Adult Vision Services, provided by the NM Medicaid program are vital to the health and welfare of the citizens who receive these benefits. As such, I believe these benefits should remain unchanged. Optometrists and ophthalmologists serving Adult Medicaid populations provide comprehensive eye examinations and other primary clinical services that prevent/treat disease, reduce disability, improve quality of life, and promote the adoption of healthy lifestyles. With healthier patients, government Medicaid expenses are thus reduced. Here are a few important reasons to keep the Adult Vision Services in Medicaid: 1. Eye diseases are common and can go unnoticed for a long time—some have no symptoms at first. A comprehensive eye examination by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective. a. Example: Asymptomatic retinal detachments—I have detected many of these during the dilated fundus examination portion of NM Medicaid vision service-sponsored examinations. These patients were then referred for the appropriate treatment by a retinal specialist, the majority with in-office procedures (e.g. barrier laser). This means that the eyes with the earlier detected/treated retinal detachments still have usable vision. That is a much better outcome than a patient who, with a lack of preventative vision services, does not present until her/his eye is completely unable to see (and probably will present to an emergency or urgent care setting), at which point the retinal detachment may be so advanced that it is no longer treatable. b. Example: Visually significant cataracts-- I have detected many of these during NM Medicaid vision service-sponsored examinations. Research studies have determined that treatment of visually significant cataracts reduces the risk of falls in the elderly. To the Medicaid program as a whole, the cost of a periodic vision service-covered comprehensive eye examination and cataract surgery (when warranted) is much less that if an elder falls and then needs time in a residential rehabilitative facility to recover from fall-related injuries. 2. An optometrist or ophthalmologist may detect undiagnosed systemic pathology during the dilated fundus examination portion of a comprehensive eye examination before it its detected by the patient's primary care provider. a. Example: Diabetes Type II—Based on retinal appearance and shifts in spectacle script, I have been the first provider to diagnose DM II in several		Albq. carol.bottjer1@gmail.com

patients. Diabetes is the leading cause of blindness in this country. Over 14% of the people in New Mexico have diabetes. Of these, an estimated 59,000 don't know it. Diabetic retinopathy is also one of the most preventable causes of vision loss and blindness. Early detection and treatment can prevent or delay blindness due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don't get their eyes examined or are diagnosed too late for effective treatment. Also, Diabetes is expensive. People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes. Providing Adult Vision Services can save the Medicaid program by lowering the future costs associated with Diabetes. 3. Providing basic vision correction with glasses to the Adult Medicaid population is one of the most cost-effective ways to improve a person's ability to obtain and maintain employment, attain a higher level of education, and function as a productive member of society. I do not believe the proposed changes to the Adult Vision Services meets the Demonstration Waiver criteria outlined by CMS to included better coverage, better access, better outcomes, and better efficiency. In fact, I believe the changes to the Adult Vision Services in New Mexico fail such criteria, and would weaken the state's waiver request. I also strongly believe the benefit to 19 and 20-year-olds covered under the EPSDT benefit providing comprehensive health care should remain unchanged. The proposed change would be a reduction of benefits for this important age group at a critical time in their lives. As an optometrist who has provided Medicaid Adult Vision Services for several years, I can attest that the program is crucial to keep this population healthy and productive. I ask that you keep the Adult Vision Services in its current form as a benefit without a buy-in premium. Thank you for your consideration of my thoughts on this matter.		
See attached file. Tim Gardner Disability Rights New Mexico	11/6/17	Tim Gardner Disability Rights New Mexico Albq. TGardner@DRNM.org
Good Afternoon, On behalf of Blue Cross and Blue Shield of New Mexico, we are formally providing comments to the Human Services Department, Medical Assistance Division regarding Centennial Care and changes to the program being considered as part of the renewal of the Centennial Care Federal Waiver that will be effective on January 1, 2019. Attached is our comments for consideration. Should you have any follow up questions, please feel free to contact me. Best regards, Janice Torrez	11/6/17	Janice Torrez DVP External Affairs and Chief of Staff Blue Cross and Blue Shield of New Mexico Albuquerque, janice_torrez@bcbsnm.com
Please accept this letter with comments on the draft NM Human Services Department's	11/6/17	Jennifer L. Metzler

Centennial Care 2.0 Medicaid waiver proposal. Respectfully, Jenny Metzler		Executive Director Albuquerque Health Care for the Homeless, Inc. Albuquerque, jennymetzler@abqhch.org
The comments of The Disability Coalition are attached. Ellen Pinnes	11/6/17	Ellen Pines The Disability Coalition EPinnes@msn.com
Good Afternoon, Please see attached public comment for Centennial Care Program: Centennial Care 2.0 Renewal Draft, last revised October 6, 2017. Please feel free to contact me with any questions or concerns. Thank you for the opportunity to provide comments on the proposal. Thank you, Sarah Coffey NM Legal Aid	11/6/17	Sarah Coffey Domestic Violence Staff Attorney New Mexico Legal Aid, Inc. Albuquerque SarahC@nmlegalaid.org
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Alexandria V. Taylor	11/6/17	Alexandria Taylor Los Lunas alexandriat@valenciashelterservices.org
Hello, I am submitting these comments to HSD on proposed Medicaid cuts. The following people do not have access to send their stories themselves and wanted to make sure they were submitted. Thanks for your attention to these important accounts of their experiences. Thanks Adriann Barboa Kena Chavez Hinojos Medicaid works for my family. After being affected with hearing loss for a long time and IHS denied me services despite being diagnosed to be deaf within 5 years. I was told at first these hearing services were not necessary. Now I've been seeing a speech therapist. IHS health services does not have adequate resources and some of staff only there for short period/don't want to be there, so I always had to retake the same tests; once was given wrong medication and overdosed which reversed my thyroid issues. So I've had both hypothyroidism and hyperthyroidism. Seems like with IHS no matter the problem you have to be close to dying, or in my case have thyroid swell like a man's Adam's apple, to get care, and there is still lack of good care. Access is a problem as well; I've had to travel to receive many services and that's difficult. I Have had 4 births- 1 natural; #2 induced; #2 induced early; #3 induced 2 months early, #4 high risk pregnancy and feel I could have had better care. I am glad to have these services but they could be much better. Do not understand why people want to cut Medicaid when we need to improve on it. Do NOT cut Medicaid. Malina Sangre,	11/6/17	Adriann Barboa adriann@forwardtogether.org

Healthcare for all; don't cut Medicaid. Native American exempt. IHS Healthcare.13 years old had problems with a bloody nose that was unstoppable. Had to see many different doctor coats. At 17 years old might have problems with white blood cells, see new specialists. 20 years old, diagnosed with rare blood disease and more specialists. 26 years old high blood pressure during pregnancy. 27 years old, loss baby due to problems. 31 years old baby #3, I needed blood thinners all 9 months. Had to take shots every day that left bruises, and my sister would cry for me all the time. Now, still have uncontrollable blood issues, still root issue unknown. I have limited healthcare and zero Doctors. I've had different Doctor's diagnoses; going from specialist to specialist. Always wondering, what is really wrong with me and my health? At the same time getting the run around with IHS IHS will not help with meds or help.. Having to see different specialists and having costs which sometime you choose no healthcare and it makes problems worse and continue without help and health coverage. Especially while working. I've learned that learning your family history is important, life cycle passed down some; and being on borderline of sickness and disease. Medicaid helped me get seen by the specialists I needed; we need to make it better and have healthcare for all. Don't Cut MEDICAID.		
To Whom It May Concern: My name is Dr. Dr. Mamie Chan and I am a second generation New Mexican optometrist practicing in Albuquerque, New Mexico. I would like to comment on the importance of Vision Health for all New Mexicans including those adults who receive Medicaid Adult Vision Services. As a Medicaid provider, I believe all vision services, including Adult Vision Services, provided by the NM Medicaid program are vital to the health and welfare of the citizens who receive these benefits and we believe these benefits should remain unchanged. Optometrists serving Adult Medicaid populations provide comprehensive eye examination and other primary clinical services that prevent disease, reduce disability, improve quality of life, and promote the adoption of healthy lifestyles, which in turn facilitate lifelong health and reduced Medicaid expenses. Many health issues have important clinical ties to vision and eye health that can be detected by an optometrist during the comprehensive eye exam. Here are a few important reasons to keep the Adult Vision Services in Medicaid: • Eye diseases are common and can go unnoticed for a long time—some have no symptoms at first. A comprehensive dilated eye exam by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective. • During the exam, visual acuity, depth perception, eye alignment, and eye movement are tested. The exam may even spot other conditions such as high blood pressure or diabetes, sometimes before your primary care doctor does. • Early treatment is critically important to prevent some common eye diseases from causing permanent vision loss or blindness:	11/6/17	Mamie Chan Albq. abqmcc@gmail.com

o Cataracts, the leading cause of vision loss in the United States o Diabetic retinopathy, the leading cause of blindness in American adults o Glaucoma o Age-related macular degeneration • Over 14% of the people in New Mexico have diabetes. Of these, an estimated 59,000 don't know it. Diabetic retinopathy is also one of the most preventable causes of vision loss and blindness. Early detection and treatment can prevent or delay blindness due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don't get their eyes examined or are diagnosed too late for effective treatment. • Diabetes is expensive. People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes. Providing Adult Vision Services can save the Medicaid program by lowering the future costs associated with Diabetes. • Providing basic vision correction with glasses to the Adult Medicaid population is one of the most cost-effective ways to improve a person's ability to obtain and maintain employment, attain a higher level of education, and function as a productive member of society. I do not believe the proposed changes to the Adult Vision Services meets the Demonstration Waiver criteria outlined by CMS to included better coverage, better access, better outcomes, and better efficiency. In fact, we believe the changes to the Adult Vision Services in New Mexico fail such criteria, and would weaken the state's waiver request. I also strongly believe the benefit to 19 and 20-year-olds covered under the EPSDT benefit providing comprehensive health care should remain unchanged. The proposed change would be a reduction of benefits for this important age group at a critical time in their lives. As an optometrist providing Medicaid Adult Vision Services I can attest that the program is crucial to keep this population healthy and productive. I ask that you keep the Adult Vision Services in its current form as a benefit without a buy-in premium. Sincerely, Dr. Mamie Chan		
To whom it may concern: Please see my attached individual comments on the proposed Centennial Care 2.0 waiver. Thank you for providing email as a pathway to provide public forum and dialogue Best, Mandisa Bradley	11/6/17	Mandisa Bradley Mandisa Routheni mcroutheni@gmail.com
Our state needs healthy citizens. Medicaid services are vital. Do not reduce coverage.	11/6/17	L Jameson jamesonlr@outlook.com
To whom it may concern: Please find the attached statement from more than 330 agencies and individuals, in response to the Human Services Department's call for public comment on the Centennial Care 2.0 draft application. Thank you, Mandisa Routheni Mandisa Routheni (Bradley) Institute for Policy Studies Healthcare Policy Fellow	11/6/17	Mandisa Routheni (Bradley) Institute for Policy Studies Healthcare Policy Fellow NM Center on Law and Poverty Albuquerque mandisa@nmpovertylaw.org

NM Center on Law and Poverty		
Dear Human Services Department, Please find the attached comments on the behalf of 43 organizations and individuals regarding the Medicaid Centennial Care 2.0 draft application. If you have any questions, please call me at 505-255-2840, or email Sireesha@nmpovertylaw.org. Thank you, Sireesha Sireesha Manne Supervising Attorney, Healthcare NM Center on Law and Poverty	11/6/17	Sireesha Manne Supervising Attorney, Healthcare NM Center on Law and Poverty www.nmpovertylaw.org
To whom it may concern, please find VSP Vision Care's comments to the Human Services Department's proposed modifications to Centennial Care as they relate to eyecare. We appreciate the opportunity to comment. Robert Marcelis, Corporate Counsel	11/6/17	Robert Marcelis, Corporate Counsel VSP Vision Care | Office of the General Counsel | 3333 Quality Drive, Rancho Cordova, CA 95670 robert.marcelis@vsp.com
November 6, 2017 Human Services Department ATTN: HSD Public Comments P.O. Box 2348 Santa Fe, New Mexico RE: New Mexico Centennial Care 2.0 Waiver comments related to Independent Community Pharmacies as providers. The following comments submission is on behalf of the New Mexico Pharmacy Business Council who represents Independent Community Pharmacies across the state. Independents are frontline healthcare providers. Serving those who are insured through The Centennial Care program represent a substantial number of our patients. The ability to provide access to medications, help them understand usage of their medications and support adherence provides benefit not only to them but the system as a whole. The goal of Independent Community Pharmacies is to sustainably continue to provide communities appropriate and reasonable care. Continuance of this goal is greatly impacted by our ability to keep our doors open. It is this intention that is behind our comments. The New Mexico Pharmacy Business Council is in full support of the comments provided by the New Mexico Pharmacists Association and as such are additionally speaking only to two requests. Our first request is that the Centennial Care Managed Care Organizations (MCOs) contractually require their selected Pharmacy Benefit Manger (PBM) be in continued compliance with the New Mexico Pharmacy Benefits Manager Regulation Act. Specific articulation of this requirement will assure there is no confusion as to its applicability. The Act is the legal cornerstone for the professional relationship between all pharmacy types and PBMs. This is most critical in addressing what transpires between Independent Community	11/6/17	Danny Cross R.Ph Owner Southwest Pharmacy Chairman New Mexico Pharmacy Business Council dancross99@gmail.com

Pharmacies and PBMs. Our second request is the serious consideration of expanding National Average Drug Acquisition Cost (NADAC) pricing beyond fee for service and into Centennial Care as a whole. This change could immediately reduce the volatility now experienced in Maximum Allowable Cost (MAC) pricing. We encourage following the recommended Centers for Medicare & Medicaid Services (CMS) dispensing fee of $10.30. A consistent reasonable dispensing fee provides the ability for financial management that is now thwarted by inconsistency in reimbursement by PBMs. The ongoing fluctuation in reimbursed dispensing fees and the medications themselves is operationally unsustainable. Having consistency in the dispensing fee does not wholly solve the systemic reimbursement problem but provides enough certainty to stay in business long enough to get to overarching corrective solutions. We are striving to be strong partners fostering a productive Centennial Care program. Attention to the issues expressed by our organization and the New Mexico Pharmacists Association will provide positive results. In making these requests we are also pledging to truly and actively work with HSD in its Centennial Care 2.0 endeavor. Please reach out to me for more information as you see helpful and appropriate. Thank you for the opportunity to comment. Sincerely, Danny Cross R.Ph		
To: New Mexico Human Services, Medicaid Division From: New Mexico Oral Health Coalition RE: Centennial 2.0 Waiver Application The New Mexico Oral Health Coalition (NMOHC) opposes the changes to adult dental services as proposed Centennial 2.0 Waiver Application. The NMOHC is comprised of a variety of health care professionals and organizations that have a common interest in promoting oral health and increasing access to oral health care services in New Mexico. Adult dental benefits should be an included Medicaid benefit, not an add-on option with premiums. Premiums would be a barrier to accessing care. Eliminating the current dental benefit will only increase Medicaid costs in the long term due to medical complications from untreated dental disease and increased emergency room visits. The U.S. Surgeon's General's report *Oral Health in America* cites numerous studies that identify periodontal disease as a risk factor for many life-altering diseases such as heart disease, diabetes, respiratory disease and prenatal complications. Prevention and early treatment saves lives and critical health care dollars. NMOHC urges you to retain the Medicaid dental benefit. New Mexico cannot afford to jeopardize the health of its citizens. Attached is the letter. Please feel free to contact me, if you have any questions.	11/6/17	Aamna Nayyar Director Dental Department School of Sciences, Health, Engineering and Math Santa Fe Community College Aamna.nayyar@sfcc.edu

Sincerely, Aamna Nayyar		
To Whom It May Concern: My name is Dr. Thomas Kunz and I am an optometrist in Las Cruces, New Mexico. I would like to comment on the importance of Vision Health for all New Mexicans including those adults who receive Medicaid Adult Vision Services. As a Medicaid provider, I believe all vision services, including Adult Vision Services, provided by the NM Medicaid program are vital to the health and welfare of the citizens who receive these benefits and we believe these benefits should remain unchanged. Optometrists serving Adult Medicaid populations provide comprehensive eye examination and other primary clinical services that prevent disease, reduce disability, improve quality of life, and promote the adoption of healthy lifestyles, which in turn facilitate lifelong health and reduced Medicaid expenses. Many health issues have important clinical ties to vision and eye health that can be detected by an optometrist during the comprehensive eye exam. Here are a few important reasons to keep the Adult Vision Services in Medicaid: • Eye diseases are common and can go unnoticed for a long time—some have no symptoms at first. A comprehensive dilated eye exam by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective. • During the exam, visual acuity, depth perception, eye alignment, and eye movement are tested. The exam may even spot other conditions such as high blood pressure or diabetes, sometimes before your primary care doctor does. • Early treatment is critically important to prevent some common eye diseases from causing permanent vision loss or blindness: o Cataracts, the leading cause of vision loss in the United States o Diabetic retinopathy, the leading cause of blindness in American adults o Glaucoma o Age-related macular degeneration • Over 14% of the people in New Mexico have diabetes. Of these, an estimated 59,000 don't know it. Diabetic retinopathy is also one of the most preventable causes of vision loss and blindness. Early detection and treatment can prevent or delay blindness due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don't get their eyes examined or are diagnosed too late for effective treatment. • Diabetes is expensive. People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes. Providing Adult Vision Services can save the Medicaid program by lowering the future costs associated with Diabetes. • Providing basic vision correction with glasses to the Adult Medicaid population is one of	11/6/17	Tom Kunz Las Cruces kunztj@gmail.com

the most cost-effective ways to improve a person's ability to obtain and maintain employment, attain a higher level of education, and function as a productive member of society. I do not believe the proposed changes to the Adult Vision Services meets the Demonstration Waiver criteria outlined by CMS to included better coverage, better access, better outcomes, and better efficiency. In fact, we believe the changes to the Adult Vision Services in New Mexico fail such criteria, and would weaken the state's waiver request. I also strongly believe the benefit to 19 and 20-year-olds covered under the EPSDT benefit providing comprehensive health care should remain unchanged. The proposed change would be a reduction of benefits for this important age group at a critical time in their lives. As an optometrist providing Medicaid Adult Vision Services I can attest that the program is crucial to keep this population healthy and productive. I ask that you keep the Adult Vision Services in its current form as a benefit without a buy-in premium. Sincerely, Dr. Thomas Kunz, OD		
Thank you for considering the comments of the American Occupational Therapy Association (AOTA) on the Centennial Care 2.0 waiver proposal. Our comment letter is attached. If you have any questions about AOTA's comments, please contact Laura Hooper at lhooper@aota.org or (301) 652-2682. Sincerely, Laura Hooper	11/6/17	Laura Broyles Hooper, Manager, Health Policy State Affairs Group American Occupational Therapy Association, Inc. lhooper@aota.org
Please find attached comments from NAVCP concerning Centennial Care 2.0 1115 Demonstration Waiver Renewal Application. Please contact me if you have any questions. Thank you for your consideration. Robert A. Holden	11/6/17	Holden, Robert A. rah@stateside.com
Dear Secretary Brent Earnest, I have significant concerns about the proposed changes to the state's Medicaid program. My main issues of concern are regarding the addition of co-pays to receive care, fees for missed appointments, changes to covered benefits and the elimination of retroactive eligibility. In regards to the addition of co-pays it seems that the department is applying the moral judgement that people need to have "more skin in the game." I think that good public health policy should not be driven by moral judgement but by good research where it exists. There is a wide body of peer-reviewed literature that finds that copays reduce utilization and may have the unintended consequence of people not seeking care or taking medicines when it is urgently necessary. If we want good health care outcomes for New Mexicans we shouldn't put obstacles in the way of the people least able to bear the costs . Anecdotally, I can tell you that I have had patients cancel an appointment because they didn't have a five dollar co-pay. Furthermore, a person with a disability that may use services frequently might have to pay a very high percentage of their income in the first few months of the year before the proposed cap kicks in, which may result in them cutting back on other care or supplies necessary for maintaining their health. The	11/6/17	Pat Bartels pbartels8@comcast.net

strain on providers to collect such fees is also significant. There are many reasons that patients miss appointments and it is a frustration to all health care providers. The reason for missed appointments can be many – inability to get time off of work, child-care issues, lack of reliable transportation or a reliance on public transportation. Surely providers and the state can come up with other ways to get patients to appointments such as multiple-reminder systems, improved medical transportation and an increase in health literacy of New Mexicans. Rehabilitation and Habilitation are important services for helping people attain or retain capability for independence or self-care and is demonstrated to prevent unnecessary hospitalizations or placement into expensive long-term care. The arbitrary cap of specialty services will ensure a lack of supportive therapies that maintain or improve health, result in a lack of continuity of care and poorer health care outcomes. The cost of therapies is small in comparison to a hospital stay or long-term care. Specifically regarding rehabilitation services, hippotherapy (equine movement therapy) is never an isolated treatment and is always part of the clinical tools and strategies that a PT, OT or ST professional uses. There is extensive research in the use of hippotherapy which shows it to be an effective therapy for certain patients with neurological conditions and it's use shouldn't be capped or restricted. Lastly, the elimination of retroactive eligibility for services received in the three months prior applying for Medicaid may result in medical debt and unpaid provider services harming both the families and the health care professionals. Although the state may see a short term financial gain by not paying these costs, there can be long term negative effects in the loss of federal matching funds and an increase in uncompensated costs that is detrimental to the fiscal health of our community's hospitals, clinics and providers. Governor Martinez has repeatedly assured the public that our families would not be "penalized" or asked to "carry the burden" for the state's budget challenges and these proposals seem to be contrary to those stated values. I hope that the department will focus its efforts on innovation and creative strategies in improving Medicaid services over imposing unreasonable costs on the most vulnerable citizens and constraining access to the services that may keep them as active and valued members of their families and their communities. Sincerely, Patricia Bartels, PT		
Re "Medicaid waiver. As a medical microbiologist, I am very concerned about proposed changes that will limit health coverage. Once families drop out, unable to meet premium or co-pay cost, both adults and children will be at risk of infectious disease through loss of necessary vaccinations for childhood ills and routine adult vaccinations (such as for annual flu). This loss of prevention will affect not only those Medicaid/CHIP families but will also result in possible disease transmission to the larger population Leah M. Ingraham, Ph.D	11/6/17	Leah M. Ingraham, Ph.D healthissues@eartlink.net Albuquerque

Please see attached response from NM Pediatric Society. thanks, be NMPS comments on Medicaid waiver final.pdf Brian Etheridge, MD, FAAP	11/6/17	Brian Etheridge, MD, FAAP betheridge@salud.unm.edu Silver City
Good Morning, On behalf of AMERIGROUP Community Care of New Mexico, Inc., I am submitting our comment letter in response to the State of New Mexico's Draft Application for Renewal of Section 1115 Demonstration Waiver, released by the Human Services Department, Medical Assistance Division, as an attachment to this email. If you could please confirm receipt of this email and our response, it would be greatly appreciated. Best Regards, Lauren Fancy, MPH l Strategy and Program Development Director	11/6/17	Lauren Fancy, MPH l Strategy and Program Development Director Business Development l Medicaid Business Unit l Amerigroup l Virginia Beach, VA lauren.fancy@amerigroup.com
Please see attached comment. Thank you! Bill Jordan NM Voices for Children	11/6/17	Bill Jordan BJordan@nmvoices.org
Hello, In working with people experiencing homelessness, I am in strong opposition to the proposed changes in the Centennial Care 2.0 draft waive application. In Santa Fe, I have worked at Christus St. Vincent, La Familia, and Healthcare for the Homeless. I have learned, in depth, about our diverse community, many of whom are low-income, and some with serious medical issues. Health care is a basic human right that needs to be affordable for those who are in serious need. The changes would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Thank you for your time and consideration in this matter. Best, Donna Trainer	11/6/17	Donna Trainer Coordinated Assessment Connection Specialist New Mexico Coalition to End Homelessness donna.nmceh@gmail.com
Here is a letter with our comments. Thank You, Lowell Irby	11/6/17	Daryl Savage dsavage@LowellsPharmacy.onmicrosoft.com
The NM Human Services Department is proposing several changes to the Medicaid program that will harm low income New Mexicans, including: • Implementing co-pays and premiums for Medicaid recipients • Ending retroactive coverage that pays for medical bills incurred in the three months before a person applied for Medicaid • Ending Transitional Medicaid that helps parents have continuous healthcare coverage as they gain employment	11/6/17	Margareta L Martinez luciam@taoscav.org

• Imposing penalties for missed appointments • Reducing health benefits HSD is currently accepting public comment on these proposed changes until Monday, November 6th. You can email comments or leave a recorded message. I agree with these changes, Medicaid must be managed better. Margareta L Martinez		
Dear Secretary Earnest, Attached is the Comment submitted by the Southwest Women's Law Center in response to Medicaid Centennial Care 2.0 Draft Application, for your review and consideration. Pamelya P. Herndon Executive Director Southwest Women's Law Center	11/5/17	Pamelya P. Herndon Executive Director Southwest Women's Law Center pherndon@swwomenslaw.org
On behalf of the New Mexico Dental Hygienists' Association (NMDHA), attached is the position letter of NMDHA on the current NM HSD-Medicaid Issue. Should you have any questions, please do not hesitate to contact us at your earliest convenience. Regards, Elmer E. Gonzalez, RDH, MS, MA, MBA NMDHA President 2017-2018	11/5/17	Elmer E. Gonzalez, RDH, MS, MA, MBA NMDHA President 2017-2018 NMDHA President nmdhadropbox@gmail.com
Dear HSD Secretary, I am writing to you to say that it is a gigantic waste of money to impose premiums and co-pays on Medicaid recipients. As more than 40% of our population is covered by Medicaid and a significant portion of these people would be affected by the proposed changes, it is well known that adding co-pays and premiums adds to staff who aren't doing anything to improve the healthcare of those involved and are costing the medical institutions to pay out more to collect next to nothing for the state but a lot for the patients involved. Just the thought that patients might have to pay something will stop people from seeking care when care can prevent illnesses from deteriorating further and costing more. Asking for an individual just above the poverty line to pay a $10 monthly premium, $5 for an office visit, $50 for hospital stays and $2 per prescription would stop a lot of people who are only getting $1000 a month or a little more. These "small" amounts mean a lot to people paying high rents and for food and transportation not covered by Food Stamps. It is very different for a poor person to pay these things than a person making thousands a month and paying insurance costs. It is prohibitive of taking care of one's health. Also making some people unable to receive full Medicaid benefits, specifically hearing aids and occupational therapy places these people in a position to suffer greatly without them. I have been a social worker working with clients receiving Medicaid and know these proposed changes will significantly damage these people. You don't need to take my word for this, but should listen to Dr. Briane Etheridge, President of NM Pediatric Society who wrote in the Journal on Nov. 1: "Co-pays and premiums for Medicaid patients have been well studied. They burden practitioners,	11/5/17	Joan Robins Albq. 1robins@swcp.com

reduce access to care and do not increase revenues." Do the right thing. Don't punish people for being poor. Joan Robins		
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Nancy Breard	11/5/17	Nancy Breard breardnm@gmail.com
From the beginning of this process the ideas/thoughts of consumers (mental health recipients) were not included except for those who KNEW about this process or where meetings were held at locations consumers knew to attend....that was NOT the case in Las Vegas where, percentage wise, has the greatest number of consumers---discharged into unlicensed, unregulated, without any oversight....other than a cursory visit by Adult Protective Services if/when there is a 'complaint' by a resident...the very same folks who are recipients of the Medicaid program: Centennial Care....the present MCOs are only doing a 'fair' job; many, particularly United do NOT contact consumers when they are discharged from the New Mexico Behavioral Health Institute. Our agency operates a small housing program specifically for consumers discharged from NMBHI and over the years we have seen the lack of interest of all the MCOs in following their 'customers' when they are discharged. However when that occurs and their Care Coordinator does make contact and a plan is followed there has been amazing progress. So often when folks are discharged they have no idea who their MCO is....we have to search this out for them. This is one of the major complaints I hear from consumers....unfortunately they are not given an opportunity to present this to any state official. I read the proposed 'changes' to a number of consumers asking for comments and each person had many 'complaints' starting with the one that they would have liked the opportunity to address them directly to the 'state' but are NEVER given the opportunity....why, they ask, doesn't the 'state' arrange a time and place where they are WELCOME and there are consumers present so they don't have to travel...ie., the clinic, the hospital, a Drop-In Center.... Co-pays for medications, particularly for consumers who are taking a large number of meds, will make it impossible to pay for them...a choice of food or medications...similarly for Seniors...too often folks will only take half of the meds to make them last longer...which of course leads to additional 'ER visits'...charges for ER visits for 'non-emergency' visits would mean impossible choices for folks...in our community all offices close at 5 or 6pm.. the two 'off hours' places closed...now it's only the ER which in our town is AWFUL...they do not treat consumers well...(that is an issue which is being addressed in another format)... A major question which has not been answered: what happens to all the folks who were approved for the Medicaid Expansion???? This state has one of the highest percentages of individuals on Medicaid not only because of a disability but due to poverty...will all of them	11/5/17	Sheila Silverman, Director MHA of NM Las Vegas shelahsilverman@gmail.com

remain on Medicaid?? Or will the state begin to eliminate this program??? I see us going back to the day when the only dental care anyone could get was to have a tooth pulled (if you didn't have the money to get preventive care)...and the only vision care...none...sure if you could afford a pair of 'glasses' from Walmart that helped to see somethings.... New Mexico does not value its' citizens...particularly those who are poor and/or disabled...these changes show a future of how it was in the past...poor health, large numbers of uninsured.... Sheila Silverman, Director MHA of NM		
Good day, I am a pediatrician working at a community clinic and the vast majority of the families that I see have access to medical care due to Medicaid. Their needs are often overwhelming, and the challenges of providing comprehensive health services are many and complicated. I urge you to continue providing the current level of support for families receiving Medicaid. I suspect that requiring co-pays and premiums will reduce the access to needed services, and negatively impact their health. One example: at least a third of the children and youth that come to our clinic are overweight or obese. If this issue is not addressed early on, the cost for later health care, most of which is funded by all of us, is unbelievably high, and unstainable. That's only the cost issue, to say nothing of the human suffering and lost potential for these children and our society. Health benefits must not be reduced for the most vulnerable in our society; they actually need to be made a greater priority. Thank you for your attention to this critical equity issue. Richard Renner, MD Las Cruces	11/5/17	Rich Renner Las Cruces rjrenner50@gmail.com
Please do not punish the most vulnerable of our people. The few dollars saved by the proposed changes will have a ripple effect of undermining many fragile people who lack resources or a safety net. The long term results will be increased crime as desperate people do anything to survive. I know. I used to prosecute some of them. Peter M. Ossorio, J.D. Asst. U.S. Atty (retired)	11/4/17	PETER OSSORIO peterossorio@centurylink.net
These cuts should not happen. It's ridiculous to even think this is acceptable. 40% of New Mexicans r covered.	11/4/17	George Apodaca rucadr2@yahoo.com
Please do not institute the following proposed changes to the Medicaid Program. • Implementing co-pays and premiums for Medicaid recipients • Ending retroactive coverage that pays for medical bills incurred in the three months before a person applied for Medicaid • Ending Transitional Medicaid that helps parents have continuous healthcare coverage as they gain employment	11/4/17	Sharon Thomas Las Cruces SKTHOMAS_10@msn.com

• Imposing penalties for missed appointments • Reducing health benefits I have worked on several programs throughout the rural areas of Dona Ana County and I know that many people rely on Medicaid. Most of these people cannot afford the changes being proposed, which means that they will no longer have access to health care. Why is it that the United States is the ONLY industrialized nation that does not provide health care for its citizens? Who benefits from this situation? Certainly not the average citizen. Please reconsider. Medicaid is an important lifeline in a country whose medical programs already leave too many without care. Sharon Thomas Former city councilor, Las Cruces New Mexico Associate Professor (retired), Michigan State University		
To Whom It May Concern: Please do not implement these changes that will adversely affect our most vulnerable populations! Sincerely, Jim R. Moore	11/3/17	Jim R. Moore Las Cruces jimndean@yahoo.com
On behalf of the New Mexico Dental Hygienists' Association (NMDHA), attached is the position letter of NMDHA on the current NM HSD-Medicaid Issue. Should you have any questions, please do not hesitate to contact us at your earliest convenience. Regards, Elmer E. Gonzalez, RDH, MS, MA, MBA NMDHA President 2017-2018	11/5/17	Elmer E. Gonzalez, RDH, MS, MA, MBA NMDHA President 2017-2018 NMDHA President nmdhadropbox@gmail.com
> Medicaid Action Alert > The NM Human Services > Department is proposing several changes to the Medicaid program that > will harm low income New Mexicans, including: > Implementing co-pays > and premiums for Medicaid recipients Ending retroactive coverage that > pays for medical bills incurred in the three months before a person > applied for Medicaid Ending Transitional Medicaid that helps parents > have continuous healthcare coverage as they gain employment Imposing > penalties for missed appointments Reducing health benefits > HSD is currently > accepting public comment on these proposed changes until Monday, > November 6th. You can email comments or leave a recorded message. > Please call 505-827-1337 > or email HSD-PublicComment@state.nm.us by 5:00pm on Monday, November > 6th with this message: > I oppose the proposed changes in the	11/3/17	Annette Strom annetterstrom@yahoo.com

> Centennial Care 2.0 draft waive application that would impose co-pays > and premiums, end retroactive coverage and transitional Medicaid, that > would impose penalties for missed appointments and that reduce health > benefits. These changes will harm New Mexicans who rely on Medicaid. > Then, send us a quick email letting us know you recorded or emailed a > message. NMCEH, Santa Fe		
Issues of concern: 1. I feel strongly that charging monthly charge premiums for insurance coverage for people who may be above the federal poverty level, but still are poor, will cause these people to drop off or not enroll in Medicaid because they can't afford to pay. Food, rent, utilities, costs for transportation and other critical costs for living are so expensive now, and keep going up, so it is hard for the poor to also have something left for health insurance. Locking people out of coverage is punitive and cruel. 2. Denying coverage for dental services and instead requiring the payment of these services is short sided and just not smart financially on the long term. Poor dental health is not only linked to periodontal disease, oral infections and tooth decay, but also associated with stroke, diabetes, and heart disease. Endocarditis, infection of the inner lining of the heart, is also linked to poor dental health, as is premature birth and low birth weight. Preventing dental services because people can't afford them due to poverty will lead to higher hospitalizations and physicians costs. 3. Denying coverage for vision services and requiring payment for these services for those who cannot afford it is also short sided. When people have eye infections or worse concerns such as glaucoma that will be missed due to no vision care, future costs to the system will be much increased, and in the long run much more expensive to the system. People not getting vision services will not have up to date prescriptions for glasses, and in particular, those people with severe eye issues will be prone to tripping and falling, or having hand injuries, leading to other increased issues and costs to the system, that could be prevented otherwise. Regards, Stevenson Bass	11/3/17	Stevie Bass redcloud@newmex.com
Good afternoon; The recommendations below would move the state forward in services and supports to individuals with Autism Spectrum Disorder: • The new Centennial Care contracts should include Applied Behavior Analysis (ABA) as a behavioral health benefit for adults with Autism Spectrum Disorder. • The Centennial Care contracts should require that the MCO's only use residential treatment centers that use evidence based practices in their treatment of children with ASD. All the centers should have a behavioral analytic approach, and a behavior analyst	11/3/17	Gay Finlayson Albuquerque GFinlayson@salud.unm.edu

should develop the child's treatment plan, and the plan carried out by staff who are registered behavioral technicians. • Care coordination for individuals with serious problem behaviors should be ASD informed, proactive, and provided at an appropriate level. • Travel reimbursements for families visiting children or adults in residential treatment should be issued in the name of the parent visiting, and not in the child's name. Checks issued to the individual in care must be reported to the IRS as income and could impact SSI benefits. An explanation that reimbursement checks to parents will not be reported to the IRS as income is necessary, as families are concerned about filling out a W-9. • MCOs should accept surrogate health decision maker documents when parents are on waiting lists to obtain guardianship. • MCOs should be encouraged to contract with providers with ASD expertise for BMS, CCSS, PCS, and behavioral health respite. Families are currently unable to access these services because providers issue denials based on lack of expertise. Thanks for the opportunity to share these ideas! Gay Finlayson		
Hello, I am writing to say that as a citizen as well as a community services professional in Domestic/sexual violence prevention I strongly oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums; end retroactive coverage and transitional Medicaid; impose penalties for missed appointments, and reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Thank you, Lorenne Gavish	11/3/17	Lorenne Gavish Early Childhood Community Educator Community Against Violence 945 Salazar Rd Taos
I support the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes make perfect sense and it is time to start cutting back on an already bankrupt system. Gary Clute	11/3/17	Gary Clute La Mesa, NM gclute@zianet.com
There has not been a successful implementation of copayments in any state Medicaid program. The only thing co-payments due is restrict access to care to America's poorest individuals. It's not enforceable and an enormous burden on providers who carry the burden of collection and turning away patients in need. I've worked in area that had imposed Medicaid co-payments on prescription drugs and the result was my pharmacy parking lot full of sick children with their parents asking for a dollar to fill the prescription for these babies. It's unconscionable. Let's try what most states do when they can't budget for their neediest constituents and tax non-essential items. It does work. Another terrible idea is eliminating retroactive eligibility. People who can afford medical	11/3/17	Nancy Klukas nanklukas@gmail.com Albuquerque

insurance and care do not generally apply for Medicaid. To deny retroactive eligibility results in medical debt for the recipients and non-collectible debt for providers. Providers unable or unwilling to accept pending Medicaid recipients will simple deny or restrict care. Once again, reducing access to medically necessary services for many. People's lives can change for the worse in a minute. An accident can leave a family without medical coverage. A catastrophic illness can result in loss of employer sponsored insurance for an entire family. Who provides the newly impoverished family with care when services are needed? No one and that result will be in lost lives. Fees for missed appointments even when the consumer has no control over the circumstances (such as the medical transport vehicle is late or doesn't show at all) they will be assessed penalties or a fee. Who has to try to collect that? Unenforceable. Take a look at NM's population and come up with some reasonable solutions to the budget woes. Do not attempt make up shortsightedness and misappropriation at the State level by hindering or denying access to services for NM's most vulnerable citizens. Nancy Klukas		
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Micah Herold	11/3/17	Micah Herold micah.herold@gmail.com
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Nicole Martinez, Executive Director Mesilla Valley Community of Hope/ Abode, Inc.	11/3/17	Nicole Martinez Executive Director Mesilla Valley Community of Hope/ Abode, Inc. Las Cruces
Human Services Department – Thank you for the opportunity to provide public comments regarding Centennial Care. Electronic Visit Verification We encourage the state to review the use of Electronic Visit Verification (EVV) in the delivery of personal care services and encourage the adoption of an "Open Model" EVV system in which the provider agency has the ability to use any EVV system, subject to a set of uniform standards, at the point of care – the client's home. In an Open Model, the provider agency system is required to upload EVV data to a repository, or aggregation system, maintained by the state, or in states with MLTSS, the Managed Care Organization (MCO). This aggregation system fulfills the needs of the MCO and the state, such as claims editing, and still provides one platform to review and report on an individual provider's performance.	11/3/17	Darby Anderson *EVP & Chief Development Officer* Downers Grove, IL danderson@addus.com

In the Open Model, provider agencies have access to the EVV data for the purposes of generating payroll, do not have to input employee schedules into multiple systems, and can improve and innovate within their systems to improve quality and consistency of care. Our agency has considerable experience with both Open and Closed Model EVV implementations. In all cases, the Closed Model resulted in higher costs and more difficulty in implementation. In addition, adoption of and compliance with the EVV system from direct care employees was significantly better in Open Model implementations. The Open Model solution is supported by the Partnership for Medicaid Home Care (PMHC), the National Association for Home Care (NAHC), and virtually all state Home Care Trade Associations. More information on the benefits of an Open Model of EVV can be found on the Partnership for Medicaid Home Care website: http://www.medicaidpartners.org/evv-mandate/ Gross Receipts Tax Centennial Care managed care organizations should be required to have a uniform method of reimbursement factoring New Mexico's Gross Receipts Tax (GRT). Currently each MCO has establishes its own methodology and addresses GRT in negotiations of provider contracts. As you are aware, GRT is variable on a percentage rate basis by New Mexico County. Some MCO's pay providers specific to the GRT rate in the County where the client served resides. Others have contracted at a set or "blended" rate across the state which leaves providers footing the bill for GRT given a shift in client mix in counties with a higher GRT rate. Our recommendation is for all MCOs to pay providers the GRT rate above the contracted rate for services for the specific county where the client served resides. Municipal/County Wage Ordinances Santa Fe City, Santa Fe County, Albuquerque, Bernalillo County, and Las Cruces municipalities and counties have passed ordinances requiring the payment of minimum wages above the state or federal minimum wage rate. New Mexico Medicaid and Managed Care Organizations have continually failed to address these regional cost variances when setting reimbursement rates for personal care services. Our recommendation is for a regional rate variance be set under Medicaid in all counties and municipalities where minimum wages above the state minimum wage is required to be paid. MCOs would also be required to negotiate rates with providers that factor the additional minimum wage cost on those localities. Thank you again for the opportunity and please feel free to contact me should you have any questions. Darby Anderson *EVP & Chief Development Officer* Addus Home Care		
Letter with comments from Kenneth Corazza, Medicine Chest Pharmacy.	11/3/17	Kenneth Corazza, RPh Albq
I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would	11/3/17	Kellie Tillerson, BS | Director of Employment

impose co-pays and premiums, end retroactive coverage and transitional Medicaid, that would impose penalties for missed appointments and that reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Kellie Tillerson, BS | Director of Employment Services St. Martin's HopeWorks | Hope Center		Services St. Martin's HopeWorks | Hope Center ktillerson@hopeworksnm.org
Good Morning, This email is to state that, I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums; end retroactive coverage and transitional Medicaid; impose penalties for missed appointments, and reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Thank you, *Sarah Tafoya* NNMCAC Advocate Community Against Violence	11/3/17	*Sarah Tafoya* NNMCAC Advocate Community Against Violence Taos saraht@taoscav.org
Good Morning, This email is to state that, I oppose the proposed changes in the Centennial Care 2.0 draft waive application that would impose co-pays and premiums; end retroactive coverage and transitional Medicaid; impose penalties for missed appointments, and reduce health benefits. These changes will harm New Mexicans who rely on Medicaid. Rose Bernal, Grant Manager Community Against Violence Inc. (CAV)	11/3/17	Rose Bernal Grant Manager Community Against Violence Inc. (CAV) Taos RoseB@taoscav.org
Letter from the American Speech-Language Hearing Association (ASHA). Laurie Alban Havens Director, Private Health Plans and Medicaid Advocacy American Speech-Language-Hearing Association (ASHA)	11/3/17	Laurie Alban Havens Director, Private Health Plans and Medicaid Advocacy American Speech-Language-Hearing Association (ASHA) lalbanhavens@asha.org
Recently the Human Services Department has proposed changes to Centennial care for Physical Therapy, Occupational Therapy, and Speech Therapy. The proposal is to eliminate all therapy habilitation services for individuals covered under the Alternative Benefit Plan (ABP). The ABP covers the vast majority of adults on Medicaid who are not considered "medically frail" or whom qualify for Long Term Services. Our experience informs us that this change will lead to negative and potentially expensive outcomes for the small number of people who receive this service currently. To help clarify these changes it is important to differentiate between rehabilitative and habilitative services. Normally rehabilitative services are used after a medical incident (Stroke, broken bones, Traumatic Brain injury, etc.). Habilitative services are usually longer term and not always associated with a medical incident. In most instances Habilitative Therapy Services already require a Physician to review appropriateness and write a prescription for them. In addition, Habilitative services must already pass a secondary review by the medical HMO for appropriateness. We feel these 2 steps are more	11/3/17	Tracy Perry Las Cruces tracy3perry@icloud.com

than adequate to monitor the appropriate use of these habilitative services. I would like to give a few examples of individuals that would be harmed by these changes: 1) A person has a neurological disorder that habilitative services can help treat and delay the effects of. Habilitative services will help keep the person independent, at a lower level of care, employed, and resulting in reduced medical costs. 2) A person gets a high-tech communication devices (Like Steven Hawking uses) costing $12,000+ to Medicaid. These devices are very complex and requires hours of training to use and set up. The device would most likely go unused without habilitative services. This device could lead to increased independence and decreased program costs. 3) A person with physical limitations gets a new job; however, they are unable to get Occupational Therapy modifications and training needed to be successful at the job. The person is required to give up an employment unnecessarily without habilitative services. 4) A person gets a $100,000 cochlear implant to increase or restore hearing paid for by Medicaid. Without intensive habilitative services the benefits of the device would most likely never be realized. 5) A person lives with chronic pain that habilitative Physical Therapy helps control. Without these habilitative services the person could lose their job, physical functioning, and end up on a higher level of care. Our experience suggests these services are rarely used and when they are used they greatly benefit the recipients while reducing overall medical costs. We request these changes are not part of the new Centennial Care program. <u>Additional comments below</u>: * Monthly premiums for some people with incomes above the federal poverty level (FPL), which this year is $12,060 for an individual and $24,600 for a household of four. Medicaid doesn't currently charge premiums (monthly charges for insurance coverage). The charges for one person would range from $10 to $25 a month in 2019 and could increase to $20 to $50 a month in later years. The household rate would be double the individual rate, regardless of the number of people in the household, so those charges would range from $20 to $50 a month in 2019, and $40 to $100 a month in later years. Not paying the required premium would result in loss of Medicaid coverage after a 90-day grace period to catch up on the payments. A person who loses coverage would be "locked out" and not permitted to re-enroll in Medicaid for three months. Experience in other states has shown that even small premiums cause many people to drop off or not to enroll in Medicaid because they can't afford to pay. Although HSD says premiums would promote personal responsibility and reduce program costs by shifting those cost to recipients,		

savings to the state will come primarily from people losing coverage because they can't afford the premium. Locking people out of coverage is purely punitive and serves no proper Medicaid purpose. * Co-pays when services are received. Earlier this year, HSD had proposed to add co-pays for many Medicaid recipients, but it dropped those plans and now intends to begin charging co-pays when the waiver renewal begins in 2019. Co-pays are problematic because they discourage people from getting the services they need. HSD also proposes to change the way the cap on the amount of co-pays someone has to pay is calculated. The cap would remain unchanged at no more than 5% of income, but HSD proposes to calculate the cap on an annual basis. That means that someone who uses services frequently – as many people with disabilities must do – might have to pay a very high percentage of their income in the first few months of the year before the cap on these charges kicks in. * Fees for missed appointments. The department proposes to let providers charge a fee when a recipient misses three or more appointments, but gives few details on how this would work – apparently, those decisions will be left to the managed care organizations. It appears that even when there's a good reason the appointment was missed (like the van not picking a person up as scheduled), it could be counted and could subject the person to a penalty. It's not clear what the consequences of not paying the fee would be. * Changes to covered benefits. HSD proposes to reduce or even eliminate some Medicaid benefits. Habilitation services for adults are specifically mentioned as a service to be eliminated. The department also proposes to drop EPSDT coverage for 19- and 20-year-olds, other than those considered "medically frail". And it may in the future end the limited current coverage for dental and vision services for adults and instead make this coverage available to purchase by paying an added premium. HSD also proposes to limit the allowable amounts for some services in the self-directed community benefit (SDCB) – related goods and services would be capped at $2,000/year, non-medical transportation at $1000, and specialized therapies such as acupuncture, chiropractic, hippotherapy and massage therapy at $2,000. * Eliminate retroactive eligibility that covers medical bills for health care services received in the three months before a person applies for Medicaid. It's a long-standing rule of Medicaid that the program pays for services in the three months before applying for Medicaid – eliminating this will leave individuals with medical debt and providers with unpaid bills. <u>Positive elements of the proposal</u>: * Streamlined renewal of eligibility for "nursing facility level of care" (NFLOC) in some cases. NFLOC is the standard used to determine eligibility for home- and community-based services as well as facility care. We've argued to HSD for years that full annual reassessments of NFLOC for persons whose condition won't change or improve is personally burdensome for the individual and an unnecessary administrative burden for the state. We're pleased that the		

department has finally come to see that this change in procedure makes sense. * Increased focus on social factors that affect health, such as housing, nutrition, etc. There's little detail on how this would actually work but HSD's recognition of the importance of addressing these issues is welcome. * Promoting use of peer support and community health workers. * Increasing the number of hours of respite for caregivers, from 100 hours a year to 300 hours. HSD had previously proposed this increase for people caring for kids with special needs, but now proposes to allow it for all who are receiving long-term services and supports through the Community Benefit (adults as well as children). * Providing a one-time allowance of up to $2,000 for start-up goods when a person moves to the self-directed community benefit (SDCB) from the agency-based model (ABCB), to cover things like a computer and printer that are needed to self-direct successfully. * Improving care for justice-involved individuals by starting care coordination 30 days before the person is released from jail or prison, to ensure a smooth transition to care upon release. Many of these individuals have mental health or other chronic conditions and making sure they have prompt access to services upon release is important. * Streamlining income eligibility determinations by using information already available to the state rather than putting the full burden on the individual to prove their income. This also will reduce administrative burdens for the state.		
Some notes from a concerned citizen who believes that good healthcare is a human right as well as need: I believe that many of the proposed change to Centennial Care 2 penalize and target the recipients of the Centennial services. The primary stakeholders, from whom you have received feedback, are the businesses that provide services. Of course they will encourage more fees and less services. In general increased payments and premiums or copayments will encourage people to not receive care. The removal of eye and dental services are particularly serious for human beings who will inevitably need them.. Eyes are critical to functionality. Teeth often lead to other more serious disease such as bone and cardiovascular infection. As far as the ER hospital visits, education is a much better tool to help. Either proactively beforehand or working with a person after an "unnecessary" visit, showing them their options and encouraging them to receive regular health care with a primary provider will reinforce to clients that going to the ER for a cold is like using an airplane to go to the store a mile away. It is expensive, time consuming, sometimes dangerous (other germs to catch) and unnecessary. Part of good health care creates a healthy environment of competition between providers (keeps them honest/ more aware that they are not the only choice for clients). Another part of good health care is honoring that right of clients. Under your Centennial 2, that safety provision of choice is proposed to be removed under your plan. Your "updates" do not show care or respect	11/3/17	Alicia Da Silva alicitamaria@hotmail.com

towards the people for whom Centennial Care was designed. This "update" would make Centennial Care an extension of the will of the medical corporations within New Mexico. We are one of the poorest States in the US. We already have great need and are already debilitated. Apart from limiting choices, much of Centennial 2 is not geared towards the clients who need medical services. When you recognized you needed or wanted changes to the system as it stands now, who was the leader that said: "We need to update this?" Yes better prenatal care is excellent. Streamlining redundant bureaucratic practices is less cumbersome and opens up clearer communication, which is vital to providing healthcare. Also forcing people to use one drug company for a medicine can allow that company to become sloppy, as they know that their generic drug is the only choice. I'm not saying that people should use the more expensive drugs as a rule, but if doctors and patients see that there are differences between generic and a named drug, they should be allowed to prescribe what actually works for their clients. A healthy system encourages accountability by all parties involved. If everyone who were to receive Centennial care had to go through some kind of education process each year as to how this care works, what is self care and proactive self care, what do they see as possible changes or needs the way the system is designed, what do they not understand about it, what support do they need and how do they find it even if they don't have a computer at home—Engaging with people as human beings, not as statistics, could help create a much more fluid and effective program. Encouraging people who use this system to educate their neighbors (a volunteer program within Centennial care?) will create more trust and access to your services as well. Where I don't see any real effort by this "upgrade" of the Centennial Care plan is inclusion of the people who receive healthcare or the communities within our state to be part of designing and tailoring Centennial work in our state. We actually are intelligent and care about peoples well being. The 21st century seems to be a time where disease is normalized and drug issues prevail. Yet so many simple tools exist that promote health care. Education, good nutrition, stress reducing protocols, preventative/proactive health awareness and care. How could the Centennial Plan be part of our State's changing that story? Alicia Da Silva		
To whom it may concern, Below are some of the issues with cutting Medicaid. We have to take care of our people in a way that is humanitarian. With the proposals the poor will suffer more. I really hope this does not happen. Thank you for taking the time to consider my wishes. • Charging new fees for low-income patients, including monthly premiums that must be paid to stay enrolled in Medicaid as well as co-pays at the time of service that will most heavily impact children in CHIP, the working disabled and low-income adults living just	11/3/17	Cathy Swedlund cathy.swedlund@yahoo.com

above the poverty line. These fees will cause thousands of people to lose coverage and/or be unable to get needed healthcare; • Eliminating retroactive coverage protection that pays for the past medical bills that a person had in the three months before applying for Medicaid, leaving families exposed to massive financial debt; • Ending a "transitional Medicaid" program that will result in coverage loss for the lowest income families, penalizing them for entering a new job or accepting a raise that places them just above the income cutoff for Medicaid; and • Reducing important healthcare benefits for very low-income adults with dependent children, eliminating coverage protections for children who are 19 and 20 years old, and giving the HSD secretary broad authority to cut benefits drastically in the future. Sincerely, Cathy Swedlund (packet attached)		
Dear Committee members, As an Optometry provider for this plan, I think it is important for you to be aware of a situation that I have been trying to understand for quite some time. The payment arrangement between Presbyterian and VSP and the Optometric providers is not following the state guidelines. New Mexico has set the reimbursement for a comprehensive eye exam CPT code 92004 at roughly $130 which is in line with Medicare. But, somehow because of contract language the provider only receives $60 for this service when billed through VSP. The other managed care entities such as March Vision pay the whole amount ($130) to the provider. Why do Presbyterian and VSP get to keep more than half of the contracted amount? Respectfully, Daniel Dieterichs, OD	11/3/17	Daniel Dieterichs, OD drdieterichs@hotmail.com
Dear Secretary Brent Earnest, I am joining with professional colleagues and concerned families to comment on the proposed 1115 Medicaid Waiver program. This proposal would negatively affect many New Mexicans. • I am not in support of proposed changes to charge our state's most vulnerable population a copay to receive care. • I am not in support of limiting rehabilitation services to people receiving Medicaid. Contrary to some beliefs, rehabilitation is a key service helping people attain or retain capability for independence or self-care. It is demonstrated to prevent unnecessary hospitalizations or placement into expensive long-term care. • I am opposed to eliminating habilitation services for adults. These services for adult persons are provided to assist the individual realize and maintain a skill or function that was never learned or acquired and is due to a disabling condition. There are many people transitioning into adult life who will need habilitative services, for example adults with cerebral palsy or developmental disabilities learning or struggling to maintain independent living skills and individuals with psychiatric illnesses who often go unserved	11/2/17	Margaret P. Horan, Speech-Language Pathologist Albuquerque maggieh@edua.com

and struggle in their home communities to name a few. Lastly, I am against changes in the waiver that would alter the essential health benefits of people insured under Medicaid. Sincerely, Margaret P. Horan, Speech-Language Pathologist		
To Whom It May Concern: My name is Dr. Robert Ratzlaff, and I am an optometrist practicing in Taos, New Mexico. I would like to comment on the importance of Vision Health for all New Mexicans including those adults who receive Medicaid Adult Vision Services. As a Medicaid provider, I believe all vision services, including Adult Vision Services, provided by the NM Medicaid program are vital to the health and welfare of the citizens who receive these benefits and we believe these benefits should remain unchanged. Optometrists serving Adult Medicaid populations provide comprehensive eye examination and other primary clinical services that prevent disease, reduce disability, improve quality of life, and promote the adoption of healthy lifestyles, which in turn facilitate lifelong health and reduced Medicaid expenses. Many health issues have important clinical ties to vision and eye health that can be detected by an optometrist during the comprehensive eye exam. Here are a few important reasons to keep the Adult Vision Services in Medicaid: ▪ Eye diseases are common and can go unnoticed for a long time—some have no symptoms at first. A comprehensive dilated eye exam by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective. ▪ During the exam, visual acuity, depth perception, eye alignment, and eye movement are tested. The exam may even spot other conditions such as high blood pressure or diabetes, sometimes before your primary care doctor does. ▪ Early treatment is critically important to prevent some common eye diseases from causing permanent vision loss or blindness: o Cataracts, the leading cause of vision loss in the United States o Diabetic retinopathy, the leading cause of blindness in American adults o Glaucoma o Age-related macular degeneration ▪ Over 14% of the people in New Mexico have diabetes. Of these, an estimated 59,000 don't know it. Diabetic retinopathy is also one of the most preventable causes of vision loss and blindness. Early detection and treatment can prevent or delay blindness due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don't get their eyes examined or are diagnosed too late for effective treatment. ▪ Diabetes is expensive. People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes. Providing Adult Vision Services can	11/2/17	Dr. Robert Ratzlaff RealEyes Taos DrRatzlaff@realeyestaos.com

save the Medicaid program by lowering the future costs associated with Diabetes. ▪ Providing basic vision correction with glasses to the Adult Medicaid population is one of the most cost-effective ways to improve a person's ability to obtain and maintain employment, attain a higher level of education, and function as a productive member of society. I do not believe the proposed changes to the Adult Vision Services meets the Demonstration Waiver criteria outlined by CMS to included better coverage, better access, better outcomes, and better efficiency. In fact, we believe the changes to the Adult Vision Services in New Mexico fail such criteria, and would weaken the state's waiver request. I also strongly believe the benefit to 19 and 20-year-olds covered under the EPSDT benefit providing comprehensive health care should remain unchanged. The proposed change would be a reduction of benefits for this important age group at a critical time in their lives. As an optometrist providing Medicaid Adult Vision Services I can attest that the program is crucial to keep this population healthy and productive. I ask that you keep the Adult Vision Services in its current form as a benefit without a buy-in premium. Sincerely, Dr. Robert Ratzlaff		
I know that you are going to get nothing but negative comments about the purposed Medicaid changes but I see the changes as a benefit to our state. People need to have some responsibility. Making them pay a small office visit fee and/or copay will make them think twice about going to the ER for a runny nose (I see it all the time). This could free up resources for those that are truly in need of the ER and save the state a lot of money! All our society does is enable the use and abuse of tax payer dollar and this will force people to take on some of the responsibility, be it very little, it's a start. Thank you.	11/1/17	(name not given) Farmington
Letter with comments on pharmacy issues and MCO contracts.	11/1/17	Ashley Seyfarth, PharmD Bloomfield karedrug@hotmail.com
Indian Health Service (HIS) Albq: Here are our comments from the consultation: • The Albuquerque Area IHS is supportive of the State's efforts to allow Indian Managed Care Entities (IMCE), but does not anticipate that this would negate the need for a Fee For Service Program in the State of New Mexico. The Albuquerque Area IHS assumes that the language in the draft waiver request does not include a mandate for Native Americans to join any IMCE that is established. • The Albuquerque Area IHS supports the comment that was made during the recent tribal consultation regarding pre-authorizations for Native Americans enrolled in an MCO. Under the new 100% FMAP interpretation, these referrals will be paid 100% by CMS when the referral is made by an IHS or Tribal site, and the requirement for IHS or Tribal sites to obtain a prior authorization should not be allowed by the MCOs. This	11/2/17	Sandra Winfrey, IHS Abq, Sandra.Winfrey@ihs.gov

process can be burdensome and will not increase costs for the State of New Mexico Medicaid program. • The Albuquerque Area IHS recommends that the exemption from the three month retroactive removal be written to cover anyone that is not required to have insurance coverage under the ACA. Below is the language from the ACA.. I think this would cover non-natives pregnant with a native child, etc. • American Indians and Alaska Natives (AI/ANs) and other people eligible for services through the Indian Health Service, tribal programs, or urban Indian programs (like the spouse or child of an eligible Indian) don't have to pay the fee for not having health coverage. This is called having an Indian health coverage exemption.		
Letter from Barbara Kim (member).	11/2/17	Barbara Kim bbkim@juno.com Las Cruces
To whom it may concern: I have read the proposal that's suggests that individuals pay co-pays and other stipulations in order to maintain their insurance coverage. I work in the behavioral health field and know first hand how limited our members to become is and how much they need their services. For example, even if their co-pay is low as $5.00 and they see a therapist weekly and their Psychiatrist monthly would cost them $25 out of their already fixed and limited income. That is not to include their other physical health needs, pain management, dental, vision, etc.. In addition, penalties for not keeping all their appointments is outrageous. Speaking as a mother of an adult child with mental illness, I know that she has many bad days in a month and occasionally misses appointments due to her mental illness. Penalizing individuals for being themselves is a violation of their rights. By imposing co-pays the state takes a risk of individuals not seeking appropriate care. Therefore spending money in other areas; such as using law enforcement to answer more behavioral health calls if a member puts off setting their medication management appointment to save a few bucks. Delia Munoz, Concerned parent and behavioral health provider.	11/1/17	Delia Munoz munozdelia3@gmail.com
My wife is covered under a brain injury waiver program, once called "MiVia". She is able to live at home and manage her own services and purchasing of necessary things through this program. I believe the program brings her needed coverage without the overhead and inflexibility that comes with the intervention of an agency, as had been the case before the waiver. She has heard that this program will be altered or cut under the proposed changes. In particular, there will be drastic caps in benefits covering certain types of therapy, dietary supplements, and other items (under a "T1999" category in her budget) that have been helpful or essential for her continued care. Instead, she will be left with only certain types of caregiver services. The MiVia - brain injury waiver has allowed my wife, and others suffering from brain injury, to live	11/1/17	Daniel Kim danyhkim2@juno.com Las Cruces

independently, while saving the state considerable overhead costs. For those persons who can meet the requirements for self-management, it fills the gap between no affordable care and institutional care. Please reconsider the changes proposed for the brain injury waiver programs. Daniel Kim		
To whom it may concern: Please, do not increase co-pays and premiums for children in CHIP, the working disable and low-income adults living just above the poverty line. Do not end "transitional Medicaid" programs that would penalize our lowest income families, penalizing the for entering a new job or accepting a raise that places them above eligibility threshold for Medicaid. Do not reduce benefits for very low income adults with dependent children. Do not give the secretary broader authority to make more drastic cuts in the future. If you need more tax money to cover health care for the most needy, then LEGALIZE MARIJUANA AND TAX IT. LEGALIZE THE GROWING OF HEMP. RAISE TAXES ON THE PRODUCTION OF NUCLEAR POWER AND WASTE THAT IS CONTAMINATING OUR STATE. RAISE TAXES ON THE *THE LARGEST SECURITY FIRM* IN THE COUNTRY IN ESPANOLA, NEW MEXICO. RAISE TAXES ON *ALCOHOL AND CIGARETTES*. RAISE TAXES ON THE MILITARY BASES IN OUR STATE. THEY SHOULD SUPPORT US, NOT US SUPPORT THEM. RAISE TAXES ON GAS AND OIL USE AND PRODUCTION. Wake up! Get creative and start working for us!!! Thank you very much. Sincerely, Dorothy Moloney	11/1/17	Dorothy Moloney djmoloney@earthlink.net
This is an amazing plan! I am a pharmacist and I see abuse of the system happen on a daily basis. Medicaid patients will drive up in new cars and be the first to complain if it's not free or if it takes longer than 5 minutes! Young people that should be working are, instead going to the doctor or ER for the sniffles, just because they can. Then, they will have the narcotic filled and trash the antibiotic. There needs to be partial responsibility and I think the purposed plan will do just that. It's not about "being in-humane" as the ABQ Journal said, it's about partial responsibility. I watch my elderly patients who worked their entire lives pay copay's and young people who should be working, enabled by the system not to work, getting Starbucks and tattoos with no copay's on anything! I am completely and 100% for the purposed changes to the Medicaid system. You may actually see a huge amount of savings, more than anticipated, when patients effected by this stop over using the healthcare system just because its free!	11/1/17	(name not given) Farmington
Letter from Dr Daniel Mayes, NM optometric Association.	11/1/17	Richard Montoya New Mexico Optometric Association

		Richard Montoya <newmexicooptometry@gmail.com>
I feel that the proposed changes are warranted and necessary. I have worked with the Medicaid population for over 7 years and have seen first hand the abuse and over use this program encourages. The thought that "It's Free' really adds to the over use of the ER system. Nothing is free and New Mexico's middle class can no longer pick up the tab for those who pay nothing. I have seen my commercial insurance rates rise and increase and has put a burden on my family. It is only fair that everyone pay their fair share, even is this means a $50 premium. Me and my husband pay $500 a month and we do not misuse the system. This is not fair. Those on Medicaid will have to budget health care just like the Middle Class. Entitlements such as Medicaid are killing NM's middle class and it needs to stop before it gets any worse. Bottom line, everyone needs to pay their fair share. Nothing is ever free and those who misuse the system need accountability. Thank you.	11/1/17	(name not given) Las Cruces
To Whom It May Concern: My name is Dr. Ashley Pulis and I am an optometrist in Albuquerque, New Mexico. I would like to comment on the importance of Vision Health for all New Mexicans including those adults who receive Medicaid Adult Vision Services. As a Medicaid provider, I believe all vision services, including Adult Vision Services, provided by the NM Medicaid program are vital to the health and welfare of the citizens who receive these benefits and we believe these benefits should remain unchanged. Optometrists serving Adult Medicaid populations provide comprehensive eye examination and other primary clinical services that prevent disease, reduce disability, improve quality of life, and promote the adoption of healthy lifestyles, which in turn facilitate lifelong health and reduced Medicaid expenses. Many health issues have important clinical ties to vision and eye health that can be detected by an optometrist during the comprehensive eye exam. Here are a few important reasons to keep the Adult Vision Services in Medicaid: • Eye diseases are common and can go unnoticed for a long time—some have no symptoms at first. A comprehensive dilated eye exam by an optometrist or ophthalmologist is necessary to find eye diseases in the early stages when treatment to prevent vision loss is most effective. • During the exam, visual acuity, depth perception, eye alignment, and eye movement are tested. The exam may even spot other conditions such as high blood pressure or diabetes, sometimes before your primary care doctor does. • Early treatment is critically important to prevent some common eye diseases from causing permanent vision loss or blindness: • Cataracts, the leading cause of vision loss in the United States	10/31/17	Dr. Ashley Pulis Albuquerque ashleypulis.od@gmail.com

• Diabetic retinopathy, the leading cause of blindness in American adults • Glaucoma • Age-related macular degeneration • Over 14% of the people in New Mexico have diabetes. Of these, an estimated 59,000 don't know it. Diabetic retinopathy is also one of the most preventable causes of vision loss and blindness. Early detection and treatment can prevent or delay blindness due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don't get their eyes examined or are diagnosed too late for effective treatment. • Diabetes is expensive. People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes. Providing Adult Vision Services can save the Medicaid program by lowering the future costs associated with Diabetes. • Providing basic vision correction with glasses to the Adult Medicaid population is one of the most cost-effective ways to improve a person's ability to obtain and maintain employment, attain a higher level of education, and function as a productive member of society. I do not believe the proposed changes to the Adult Vision Services meets the Demonstration Waiver criteria outlined by CMS to include better coverage, better access, better outcomes, and better efficiency. In fact, we believe the changes to the Adult Vision Services in New Mexico fail such criteria, and would weaken the state's waiver request. I also strongly believe the benefit to 19 and 20-year-olds covered under the EPSDT benefit providing comprehensive health care should remain unchanged. The proposed change would be a reduction of benefits for this important age group at a critical time in their lives. As an optometrist providing Medicaid Adult Vision Services I can attest that the program is crucial to keep this population healthy and productive. I ask that you keep the Adult Vision Services in its current form as a benefit without a buy-in premium. Sincerely, Dr. Ashley Pulis		
To Whom It May Concern: I am writing to you about the serious impact proposed changes to Medicaid would have on my family. I am a single mother of 3 children. Two of those children are disabled, they have autism. Just one of them has 5 specialist visits a week, in the form of intensive ABA therapy. My other child has between 4-7 specialist visits per week. Adding copays to those visits would devastate my family. I would have to make impossible choices between feeding my family and keeping the lights on in our home versus therapy that has a significant, measurable, impact on their future lives. Remember, children are not children forever and one day they will be adult members of Albuquerque society. Why not give them what they need now so they can actively participate in our society? Therapy costs are just the tip of our iceberg. They also take multiple medications that they need to be able to function on a daily basis. All of this adds up and adding copays to these	10/31/17	Lynda Griego, RN lyndarenee@msn.com

sorts of things will bury my family financially. Please don't mistake me for a lazy parent either. I work hard to give my children what they need but because of their disabilities and therapy demands I'm only able to work part time. As a Registered Nurse here in NM I see patients on a regular basis for whom Medicaid is a lifeline. Please don't give us additional barriers for the care that should be a HUMAN RIGHT. Sincerely, Lynda Griego, RN		
I am writing to express my opposition to the proposed changes to Medicaid entitled "Centennial Care 2.0" This plan includes too many changes that will hurt the health and well-being of far too many of the most vulnerable New Mexicans. First, the plan will have a negative impact on low-income participants. Unfortunately, by charging excessive patient fees, in the form of co-pays and monthly premiums, to 3 highly disadvantaged groups (CHIP children, low-income adults just above the FPL, and the working disabled), thousands of deserving people are likely to lose their Medicaid coverage or otherwise unable be to afford necessary health care. Second, it is just wrong to eliminate retroactive coverage protection that pays for the prior medical bills (in the 3 months prior to applying for Medicaid), because there are too many cases where the disadvantaged simply do not know that medical insurance is available. Third, ending the transitional Medicaid program will result in loss of healthcare coverage for the lowest income families and will also penalize them for taking a new job (or raise) that puts them just above the eligibility threshold for Medicaid. Finally, reducing benefits for very low-income adults with dependent children will cause untold hardship for New Mexican children. And it is shortsighted to give the Secretary of HSD overly broad authority to drastically slash benefits in the future without further scrutiny and evaluation. In short, I urge the HSD to cease consideration of the proposed changes to Medicaid known as "Centennial Care 2.0". However, I have one further suggestion: Any future proposals to change Medicaid should first be subjected to a comprehensive GAO-style assessment of costs and consequences. I make this suggestion because is impossible to legislate wisely and prudently without a detailed and reliable evidence base, including probable outcomes. Such an assessment will allow both legislators and the public to fully understand the economic, social and healthcare costs and consequences of any proposed changes to the NM Medicaid program. Thank you for listening to my concerns. Sincerely yours, John Ely, M.P.H., Ph.D. Epidemiologist	10/31/17	John Ely, M.P.H., Ph.D. Epidemiologist Alamogordo, NM john10ely@gmail.com
The waiver proposal as presented last evening at the Hispanic Cultural Center is inimical to the health of New Mexico in many ways. It also seems designed to trip-up eligible recipients via	10/31/17	Jay Johnson Albuquerque

monthly charges and co-pays which one would REASONABLY expect would lower participation and "Lock Out" (your words) many of the eligible families because for whatever reason, they could not come up with what seems to many to be insignificant amounts cash to maintain their eligibility and cost-sharing. I know that throughout the hearing process, you have become informed of the dangers to our most vulnerable posed by this part of the proposal. I strongly suspect that you cynically designed the monthly premium schedule to provide a bureaucratic trap door that many eligible recipients would fall through and thus be denied their needed coverage. I know, and you know that people living with very limited resources will often choose to use their last few dollars on immediate needs (food, gas, utility, rent, rather than a "premium" that they might imagine they will pay later. That is the reality of poverty! There is no surplus! I oppose the imposition of several of the measures proposed not only because they will not work to benefit New Mexico or our New Mexico children, but also because they are clearly mean-spirited, cruel, punitive, and hostile to the population needing Medicaid services. Specifically: Co-pays Monthly Premiums Abolishing the 3-month retroactive qualification process Fines for missed appointments Restricting or refusing to cover proven treatment modalities In conclusion, I would hope (and pray) that the emphatic and thoughtful input generated in the hearings would touch the heart of the five responsible public servants at the hearing and the others in our state who are tasked with formulating policy. I further hope that the whispers of think tanks and in-state and out-of-state political donors with their self-serving agendas will not completely cancel out the concerns of the PEOPLE OF NEW MEXICO. Jay Johnson		jayjojohn@yahoo.com
I believe that your plan to begin charging increased premiums and co-pays to people with an income as low as 101% of the poverty level is a mistake. The federal poverty level is far lower than what is actually required to live on, especially if you are in a community with high rental housing costs (Albuquerque, Santa Fe, and Los Alamos) or rely primarily on seasonal work to generate that "annual" income. This proposal could easily force low-income families to choose between food and health care, which is precisely what Medicaid is supposed to prevent. I believe that you should consider other options to raise money. One option, of course, is a small tax increase. Another would be to investigate the possibility of working towards a state-level Medicare for all plan that eliminates for-profit insurance and puts all of us into one pool where we can subsidize each other. Rebecca Sherry	10/30/17	Rebecca Sherry rebeccas42@yahoo.com ALBUQUERQUE
Hello, My name is Daryl Smith and I reside at 1359 San Lorenzo Ave., NW in Albuquerque, New Mexico. In having reviewed your draft application to renew Centennial Care 2.0, I would like to	10/30/17	Daryl T. Smith 1359 San Lorenzo Ave., NW Albuquerque

express the following comments: I am a public health professional and have spent more than the past 2 decades living and working with low income populations both along the New Mexico-Mexico border region, and in Bernalillo County. Currently I am the program manager for a large community-based program called Pathways to a Healthy Bernalillo County, administered out of the UNM Health Sciences Center. I have had the privilege of working with Community Health Workers (Pathways Navigators) over the past nine years and have learned so much from them about the incredible hardships that many of the individuals and families that they work with endure on a daily basis. These navigators are out there on the front lines and many have shared their concerns with me about how their clients are the ones that would be most adversely impacted by the proposed changes being made in your renewal application. HSD's proposal includes harmful and costly cuts to Medicaid, which would seriously diminish the gains that we have made here in New Mexico with the passage of the Affordable Care Act. Many individuals that have finally received health care coverage for the first time in their adult lives would be at serious risk of losing this coverage, thus creating financial difficulties, increasing medical debt for the people that can least afford it, driving up long term costs for the state's healthcare system, and resulting in the loss of significant federal matching funds for Medicaid that help sustain jobs and our economy in New Mexico. The proposed changes would charge new fees for low-income patients, including monthly premiums that would be required to stay enrolled in Medicaid, AND co-pays at the time of service. This alone will result in many families losing their ability to access healthcare and will most heavily impact children in CHIP, the working disabled, and low-income adults living just above the poverty line - in other words, some of the most vulnerable populations living in New Mexico. The proposed changes would also end the "transitional Medicaid" program that will result in coverage loss for the lowest income families, penalizing them for entering a new job or accepting a raise that places them just above the income cutoff for Medicaid; it would end retroactive coverage that protects patients from debt by paying for the past medical bills that a person incurred over the three months prior to applying for Medicaid, and three months before applying for Medicaid, and it would provide the Secretary of HSD much more authority to cut even more benefits in the future. The proposed changes, if implemented, would take New Mexico a giant step backwards after all of the gains that it has made. Somehow when budgets get tight, the burden always seems to fall on the individuals and families that already struggle to feed their families and make ends meet. These proposed changes are heartless and cruel and low-income New Mexicans can ill afford to be forced to decide between feeding their families or accessing health care. That is exactly what will happen to so many families if these changes go through. Rather than scaling back, the plan should work on further improving access to health care. There are dozens of evidence-based public health practices that go far upstream and prevent		optimisticgrouch@yahoo.com

adverse occurrences from happening, including, but not limited to: home visitation programs, care coordination (including Pathways), increasing health literacy, utilizing Community Health Workers to help people navigate our extremely complex systems, working with returning citizens coming out of incarceration, and the list goes on. I remember a couple years ago when HSD participated in the yearlong Systems Innovation Model (SIM) planning that was spearheaded by the NM Department of Health, your sister agency. There was a great deal of input from experts from around the state and I would bet that none of the recommendations that resulted from those discussions were anywhere close to what is being proposed in this renewal application. It might be beneficial if HSD went back to review the reports that came out of that planning process, solicited more feedback from community stakeholders, and re-visited and changed these destructive changes that are being proposed in this draft. New Mexico ranks near the bottom of so many categories and this is a perfect example of why. It is HSD's obligation as a state agency, funded by public tax dollars, to look out in the best interests of the residents of New Mexico. These proposed changes clearly contradict HSD's mission statement, which is: "To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance. You can and should, do much better. Thank you for providing the opportunity for public comment. Sincerely, Daryl T. Smith (attachment)		
Secretary Brent Earnest – I am commenting on the proposed 1115 Medicaid Waiver program. I am not in support of proposed changes to charge our state's most vulnerable population a copay to receive care. Second, I am not in support of limiting rehabilitation services to people receiving Medicaid. Rehabilitation is a key service helping people attain or retain capability for independence or self-care and is demonstrated to prevent unnecessary hospitalizations or placement into expensive long-term care. Third, I am opposed to eliminating habilitation services for adults. Habilitative services for adult persons are provided to assist the individual attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. There are many people transitioning into adult life who will need habilitative services, for example adults receiving cochlear implants to treat hearing loss, those with psychiatric illnesses and substance abuse disorders, and adults with cerebral palsy or developmental disabilities learning independent living skills. Lastly, I am against any changes in the waiver that would alter the essential health benefits of people insured under Medicaid. Cathy Binger, PhD, CCC-SLP Associate Professor of Speech-Language Pathology, University of New Mexico	10/30/17	Cathy Binger, PhD, CCC-SLP Associate Professor of Speech-Language Pathology University of New Mexico cbinger@unm.edu
Letter with comments on Waiver Renewal. Good afternoon. I have submitted the comments from our board of directors.	10/30/17	Alicia Shields, MSN,RN Chief Nursing Officer Fort Defiance Indian Hospital Board, Inc

Please let me know if you have any questions. Thank you! Alicia Shields, MSN, RN, Chief Nursing Officer Fort Defiance Indian Hospital Board, Inc		Fort Defiance, AZ Alicia.Shields@fdihb.org
Letter with comments on Waiver Renewal.	10/30/17	John Victor Castillo Albuquerque
Letter with comments on Waiver Renewal.	10/30/17	Kenneth L Corazza medicinejeffe@gmail.com Albuquerque
Letter with comments on Waiver Renewal: The National Alliance on Mental Illness New Mexico disagrees with any Medicaid proposal that reduces access to care for our very vulnerable constituents. People with a mental health condition are often under-employed or unemployed. They simply cannot afford increased costs for services. There are already too many New Mexican's that aren't getting the help they need when it comes to behavioral health. Medicaid proposals should be increasing access to services and that is done by lowering barriers to care, and that includes reducing the costs to patients of receiving that care. David A Gonzales, Executive Director National Alliance on Mental Illness (NAMI) New Mexico	10/30/17	David A Gonzales, Executive Director National Alliance on Mental Illness (NAMI) New Mexico, Albuquerque naminm@aol.com
To whom it may concern: The proposed Medicaid plan is not good for those most vulnerable in our state. The proposed cuts to Medicaid will ultimately result in greater harm and increased cost. As the poorest state in the union, how can you in good conscience endorse a plan the will actually create financial hardships for families, drive up long term costs for the state's already fragile health care system, and lose significant federal matching funds for Medicaid that help sustain jobs and our economy in New Mexico? In addition to the plan that proposes patient fees to families already experiencing poverty, to end retroactive coverage, to end a transitional Medicaid program, reduces health benefits for parents living in deep poverty, it also proposes to end dental benefits for adults. Dental benefits for adults not only improves overall health (numerous studies indicate the association of poor dental health with diabetes, cardiovascular disease, preterm births, and increased mortality from aspirational pneumonia among elders), but can also increase the ability to obtain and sustain employment. I ask that you reject the proposed Centennial Care 2.0 plan, and provide one that focuses on improving access to care! Mary M. Altenberg, MS, CHES, Executive Director Community Dental Services, Inc.	10/30/17	Mary M. Altenberg, MS, CHES Executive Director Community Dental Services, Inc. Albuquerque, MAltenberg@cdsabq.org
Letter from AARP NM on waiver renewal.	10/27/17	Gene Varela, State Director, AARP NM,

		Santa Fe, evarela@aarp.org
Human Services Department ATTN: Public Comments PO Box 2348 Santa Fe, NM 87504-2348 Dear Ladies and Gentlemen: I would like to protest the proposed cuts to Medicaid and Medicare and CHIP recipients in Centennial Care 2.0. We were very disappointed that a recent meeting in Las Vegas discussing these changes was virtually an after-thought and was cut short. This seems like an intentional way to avoid negative comments from the most affected areas in the state. If another meeting could be scheduled and action postponed until adequate time is allowed to inform those most affected about these changes, it would be both fair and welcome. With or without further feedback, I would like you to know I live in one of the two poorest counties in the state in arguably the poorest state in the Union. I find it outrageous that the state's administration is trying to pay for tax cuts for the rich or following the less than compassionate conservative principles of the administration by adding to the costs for the needy. It demonstrates a contempt for poor people by presuming that they should be able to pay more or should be penalized because they are poor and powerless. Because the number of needy individuals and families are so many and the number of wealthy are so few, the logic seems to be that raising the costs for the many who are poor, young and elderly is justified so that the rich and powerful few do not have to pay for what they do not receive nor need. Obviously, the Republican Congress and White House have messed with the Affordable Care Act so much that insurance companies are reacting with larger and larger premiums, but we do not have to exacerbate the problems put upon the poor by the federal government and insurance companies. We can eliminate the proposals to charge more for Medicaid, co-pays at the time of service, and other programs which lock out many "on the edge" working poor, disabled, handicapped, and children. We should allow access for essential healthcare services for these needy individuals and families. And we do not need to impose new fees for those who can barely pay to begin with. Of particular importance are all those proposals that affect children because New Mexico has such shameful rankings in terms of child poverty and hunger. The CHIP program is in trouble in terms of the federal government reauthorization, but New Mexico could take the lead and not penalize children's parents with fees and increases in payments and demands on them such as the suspension of "transitional Medicaid" and demands for payment of co-pays at time of service. Please consider building upon some of the good parts of the Centennial 2.0 proposal that lead to helping participants become better informed about health care and providing help for children of those in detention centers. If only these changes were not accompanied by increased premiums and fees from those least likely to be able to pay. Sincerely, Ruth Elizabeth Orem	10/26/17	Ruth Elizabeth Orem Las Vegas relizabethorem@gmail.com

Comments from October 30 public meeting in Albuquerque		
Letter submitted Good afternoon, please find comments for submission on behalf of Consumer Direct Care Network. Thank you. Kelly Jepson | Policy Analyst Consumer Direct Care Network | Government Relations	10/25/17	Kelly Jepson KellyJ@consumerdirectcare.com
My son lives with a diagnosis of schizophrenia and it is imperative that he has medical coverage to pay for his medications and possible hospitalizations. He lives on a fixed income and could NEVER afford to pay for his care on his own. My son is on Medicare Part A,B, that means that he will not be eligible for the Expansion. This is devastating for individuals like my son and others who have a serious mental illness. Please don't do this to the most vulnerable. It is already so difficult for them and their families. Mary Lou Shaw	10/25/17	Mary Lou Shaw lujjshaw3@gmail.com Santa Fe
Dear Secretary Brent Earnest, I am commenting on the proposed 1115 Medicaid Waiver program. I am not in support of proposed changes to charge our state's most vulnerable population a copay to receive care. Second, I am not in support of limiting rehabilitation services to people receiving Medicaid. Rehabilitation is a key service helping people attain or retain capability for independence or self-care and is demonstrated to prevent unnecessary hospitalizations or placement into expensive long-term care. Third, I am opposed to eliminating habilitation services for adults. Habilitative services for adult persons are provided to assist the individual attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. There are many people transitioning into adult life who will need habilitative services, for example adults receiving cochlear implants to treat hearing loss, those with psychiatric illnesses and substance abuse disorders, and adults with cerebral palsy or developmental disabilities learning independent living skills. Lastly, I am against any changes in the waiver that would alter the essential health benefits of people insured under Medicaid. Sincerely, Gail A. Stockman MS, OTR/L	10/25/17	Gail A. Stockman MS, OTR/L gstockman@comcast.net
Dear Mr. Earnest: I am commenting on the proposed 1115 Medicaid Waiver program. I am not in support of proposed changes to charge our state's most vulnerable population a copay to receive care. Second, I am not in support of limiting rehabilitation services to people receiving Medicaid. Rehabilitation is a key service helping people attain or retain capability for independence or self-care and is demonstrated to prevent unnecessary hospitalizations or placement into expensive long-term care. Third, I am opposed to eliminating habilitation services for adults. Habilitative services for adult persons are provided to assist the individual attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. There are many people transitioning into adult life who will need habilitative services, for example adults	10/24/17	Dr, Michael Kaplan Speech Pathologist stachemannm@aol.com

receiving cochlear implants to treat hearing loss, those with psychiatric illnesses and substance abuse disorders, and adults with cerebral palsy or developmental disabilities learning independent living skills. Lastly, I am against any changes in the waiver that would alter the essential health benefits of people insured under Medicaid. Dr. Michael Kaplan, Speech-Language Pathologist		
Dear NM Legislators, I am voicing my concern over the proposed changes to the NM Medicare program via the Century Care 2.0 act. In particular euphemistic "Value-based purchasing (VBP)" arrangements will jeopardized the poor, those who need healthcare the most. Not ensuring healthcare for all, regardless of income, ultimately detriments all of us. It increases visits to emergency centers, increasing overall costs in care, medicine and insurance. Medicaid was the vision of our better leaders, going as far back as Teddy Roosevelt, and championed by Franklin Roosevelt, Harry Truman, John F Kennedy and ultimately put into law by Lyndon B Johnson, calling for the creation of a national health insurance fund, open to all Americans, regardless of social status. Forcing participants to co-pay or pay a premium to participate is not only unethical, but goes against our very principles as a people the vision of a great America. Melora Palmer Albuquerque, 87108	10/24/17	Melora Palmer Albuquerque melora_palmer@hotmail.com
I want to commend the people who are actually addressing the problem with Medicaid! I was born in Albuquerque and 58 years later, I cannot believe that there are people who pay nothing for health insurance, child care, groceries, etc. We have created a society of enablers. We enable people not to work, not to pay bills, not to help with their child's education nor pay for any visit to a health facility. I believe that if every person had to pay some copay for any service such as health care visit, child care-$5 or $10 we would have millions of dollars coming in because these people have been paying zero dollars. If everyone who goes to see a doctor has to pay a $5 or $10 copay per visit, there would be millions of dollars into the health care system and maybe people would not abuse the system if they had to pay and maybe people would take better care of themselves and their children. I disagree with the proposal if a person misses over 3 appts. they would have to pay a $5 fee. They should have to pay when they miss the first appt. My daughter missed an appt. in Kansas and did not call. They billed her for $50. I explained to her that she needed to call them as someone else could have got the appt. and the doctor was counting on the appt. I paid the $50. We have allowed people to get away with so much, no responsibility, no consequences, no personal damage. This change in Medicaid could change New Mexico and hopefully if other states do this, it could change the world. We need to change things now because those of us paying taxes cannot continue to support the people who have to do nothing for themselves or their family and totally live off the system. It is like a parasite that lives off another living being or thing. It needs to stop now. Thank you, Donna Fletcher	10/23/17	Donna Fletcher downcare@comcast.net

I am writing in support of the proposed alterations to the Medicaid program. If left unchanged, Medicaid spending will continue to increase and will swamp the state budget. It's not unreasonable for recipients to have to pay a nominal amount for their healthcare. There is not enough wealth in New Mexico to provide totally free health care to everyone who meets the qualifications. James Boyd	10/23/17	James Boyd jaboyd@pga.com
Medicaid fix. I would like to make a suggestion to Medicaid fix for New Mexico. Are partnerships with Goodwill Industries a possibility? I have an extended family member who is middle aged but goes to numerous doctors for ailments but is in the Medicaid system. It seems to me she can work, perhaps part-time, to get herself reintegrate in the workforce & help herself.	10/22/17	Melissa Stroud randallkenkel@gmail.com
As a very grateful Medicaid recipient I would like to state that my family and I have become healthier and at peace knowing we have healthcare. I believe co-pays and premiums would be difficult for us, but we will do it if needed. Please do not think all Medicaid recipients are irresponsible or ungrateful. Thank you, Kerry Radecki	10/22/17	kerryradecki kerryradecki@yahoo.com
Letter with Waiver Renewal comments from NM/So. Colo. Community Health Reps.	10/20/17	Jean Pino Rio Rancho jpino@fsipinc.org
Letter with Waiver Renewal comments from Canoncito Band of Navajos Health Center.	10/20/17	Maria Clark, COO CBNHC To'Hajiilee
Letter with Waiver Renewal comments from NM Association of Counties.	10/20/17	awebb@nmcounties.org Santa Fe
Letter with Waiver Renewal comments from NM Hospital Association. Secretary Earnest and Medicaid Director Smith-Leslie, Attached please find the New Mexico Hospital Association's comments on your updated draft Section 1115 Waiver application, aka Centennial Care 2.0 Our CEO Jeff Dye looks forward to discussing NMHA's comments with you in more depth. Regards, Beth Landon Director of Policy, New Mexico Hospital Association	10/20/17	Beth Landon Director of Policy New Mexico Hospital Association blandon@nmhsc.com
Dear HSD Representative: I am writing to submit comments regarding the proposed changes to the Centennial Care Medicaid program. I am writing as a concerned citizen who is not a Medicaid recipient. Although I do not benefit from Medicaid personally, I am a strong supporter of the program and am opposed to the changes your Department has proposed. I am especially concerned about the proposal that Medicaid recipients be required to pay copays. Although a copay may not seem like a burden to some, Medicaid recipients often struggle to make ends meet and do not have the resources to pay such fees.	10/19/17	Shelley Walden Albuquerque shelleywalden@gmail.com

According to Abuko Estrada, a lawyer for the New Mexico Center on Law and Poverty, these fees will not save the state money, as, "the administrative costs are simply too high to justify charging copays." These administrative costs are likely to decrease the number of providers willing to accept Medicaid.[1] As Estrada said, "For low-income New Mexicans, these changes are going to be devastating. States that have implemented copays and premiums in the past have seen significant reductions in health care coverage, or individuals losing access to much-needed health care."[2] I second these and all of the other concerns expressed by the New Mexico Center on Law and Poverty about your proposed changes. These include: • "Eliminating retroactive coverage protection that pays for Medicaid applicants' past medical bills, from three months prior to applying for Medicaid, putting New Mexico's families in severe medical debt and leaving healthcare providers with uncompensated care costs; • Ending a transitional Medicaid program that will result in coverage loss for families that have been living in deep poverty, creating financial hardships and interrupting health coverage when they enter new jobs or accept raises that place them just above the eligibility threshold for Medicaid; and • Reducing important health benefits for very low-income adults with dependent children, eliminating Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) protections for children who are 19 and 20 year olds, and opening the door for the HSD secretary to make drastic cuts to more benefits in the future."[3] I believe that healthcare is a basic right and should be made available to all, especially those who cannot afford it. The proposed changes jeopardize this right and have the potential to harm many impoverished New Mexicans. I therefore request that you abandon your proposed changes to the Centennial Care program. Sincerely, Shelley Walden		
To whom it may concern, I am opposed to the Medicaid waiver proposals to change essential health care services. Gaylene	10/19/17	Gaylene Tool OTS, COTA/L Occupational Therapy Graduate Program, UNM gmtool@salud.unm.edu
Comments from October 18 public meeting in Las Vegas		
Letter with Waiver Renewal comments from NM Pharmacists Association.	10/18/17	Dale Tinker dtinker@nmpharmacy.org Albuquerque
I don't like the idea of eliminating dental/vision coverage. I feel marginalized enough as it, without the Governor wanting to further dismiss poverty-stricken people. Also, this notion of "personal responsibility" sounds awfully familiar, i.e. Congress said the same thing and those bills did not	10/18/17	(unknown) Albuquerque

survive. Don't understand why Martinez can't support her statement of the state "not being able to afford a growing Medicaid bill". She chose to expand it. To ask people on Medicaid to fork over a co-pay is ludicrous. Does she know why people are on Medicaid in the first place?		
Letter with Waiver Renewal comments from UNM Hospitals.	10/18/17	Rodney McNease rmcnease@salud.unm.edu Albuquerque
Hello my name is Marie. I am glad I have the opportunity to comment on the proposed medical cuts taking place. These medical cuts will be devastating to families already in need. I have two disabled brothers that depend on medical coverage to live and my parents struggle to pay for necessary monthly prescriptions. My family has come together to help but because of the medical cost we are all affected. I work in a community healthcare facility and see many families who depend on centennial care. Cutting back on medical care will only disable the community of their healthcare and they will not be able to afford treatment in getting better. I know change is going to come but there are thousands across the nation who benefit from these programs. This issue is very important to me and I hope my opinion is heard. Thank you for your time.	10/18/17	Maria Aranda maria_aranda@fcch.com
I believe everyone regardless of income should pay either a small monthly premium &/or copay for the medical services they receive. I advocate for an elderly man who receives approx. $9,000 per year in SSI. He is in good health but goes to the doctors for minor complaints because it doesn't cost him anything. Even a small fee would make him think twice about running to the doctor for every little ache or pain. I am also against the upper 3 tiers of service (240%, 250%, 300%). Our state simply cannot afford such generous benefits. We need to reserve our funds for those that truly need it.	10/17/17	JACK/LYNNE SCOTT jakalyn@msn.com
Comments from October 16 public meeting in Santa Fe		
Good Morning- My name is Monica Briones and I am the Assistant Medical Director of First Choice Community Healthcare (FCCH) which is a Federally Qualified Health Center. I practice as a Family Medicine Physician at the FCCH Clinic in Edgewood, New Mexico. I am writing because I am greatly concerned about the proposed changes to Medicaid as they will greatly affect many of my patients and those that FCCH serves. In the rural setting in which I practice, the proposed cuts would significantly affect our patient population that is already burdened by extreme poverty, health issues, and lack of access to care. My patients sometimes do not come to a much-needed doctor's appointment due to lack of transportation, lack of gas money, or other financial issues that create an obstacle to their appropriate health care. My concern is that adding additional financial or systemic burdens to an already fragile portion of our population will be even more detrimental to their poor health outcomes and further perpetuate the cycle of poverty, malnutrition, and overall decreased quality of life for these many New Mexicans. I ask that you reject the proposed Medicaid cuts for these reasons.	10/16/17	Monica E. Briones, M.D. Assistant Medical Director First Choice Community Healthcare Edgewood Center Edgewood, NM monica_briones@fcch.com

Sincerely, Monica E. Briones, M.D., Assistant Medical Director First Choice Community Healthcare, Edgewood Center, Edgewood, NM		
Please DON'T! We're all in this boat together and it's our moral obligation to help each other. Please don't cut the Medicaid program. If I can help feed violent criminals in prison, I can sure afford to help feed those who really need Medicaid help. Thank you for your time and consideration, cmeyer Los Lunas, NM	10/16/17	Cindy Meyer Los Lunas cindy_meyer@fcch.com
Hello - My name is Dr. Emily Cohen. I am a family physician practicing at First Choice Community Healthcare in the South Valley of Albuquerque. I am writing to express my opposition to the proposed Medicaid cuts that would require patients to pay premiums, increase copays, and lose essential services. I care for Medicaid patients every day and I see the frequent complications and difficulties present in their lives. I fear that placing this restrictions on their access will result in patients losing Medicaid coverage for failure to pay, missing doctor's appointments for inability to pay, and on the whole this will create an environment that is toxic for those living on the lowest incomes. Studies have shown that the kind of environmental stresses our population experiences harm individuals' and communities' health. Why would we add to that toxic burden? Please, let Medicaid remain the safety net that it is. At a time when other public benefits are being cut dramatically, our population deserves at the very least to have access to medical care without restrictions. I firmly believe (and the available scientific evidence supports my belief) that increasing out of pocket expenses for families on Medicaid will result in poorer health for our population. Thank you for your consideration and please feel free to contact me with any questions. Best, Dr. Emily Cohen, Board-Certified Family Physician First Choice Community Healthcare, Albuquerque, NM	10/16/17	Dr. Emily Cohen, Board-Certified Family Physician First Choice Community Healthcare, Albuquerque, NM emily_cohen@fcch.com
To Whom It May Concern: Attached are public comments regarding Centennial Care 2.0 on behalf of the team working on the Integrated Primary Care and Community Support (I-PaCS) initiative, a collaborative between the Medicaid Assistance Division, the University of New Mexico, and Southwest Center for Health Innovation. Sincerely, Arthur Kaufman, MD, Distinguished Professor Vice Chancellor for Community Health University of New Mexico Health Sciences Center (letter attached to email)	10/16/17	Arthur Kaufman, MD, Distinguished Professor Vice Chancellor for Community Health University of New Mexico Health Sciences Center, Albuquerque AKaufman@salud.unm.edu
Regarding the state's proposal to make changes to Medicaid payments for its customers, I would like to comment.	10/16/17	Laura Wall Licensed Speech-Language Pathologist

I am a New Mexico health care provider. I work with numerous families whose children benefit from Medicaid enrollment. Health insurance for my clients is not a matter of "personal responsibility." Children suffering from medical conditions, such as cerebral palsy, Down syndrome & other genetic syndromes, congenital heart conditions, autism, or any other of a host of possible medical issues that can affect young children, did not demonstrate any lapse in personal responsibility. Our state, poor as it is, needs to support these children and their families by continuing to provide healthcare access and insurance through Medicaid. We should not be charging co-pays to these families. Studies show that healthcare outcomes are best when families access preventative services such as vaccinations and well-child check ups. Complicating these with even minimal co-pays is cruel and will likely result in less frequent access of preventative services, followed by a predictable rise in costly emergency room visits. Healthcare also impacts educational attainment as a healthy populace is better able to become a well-educated citizenry. We must keep our children healthy during their crucial developmental years so they are best able to learn and perform well in school. Later this will pay dividends as they become tax-paying workers in our economy. Please do not change Medicaid for the worse. Keep our families healthy, and promote a good future in NM, by supporting continued full funding of Medicaid. Thank you, Laura Wall, Licensed Speech-Language Pathologist Albuquerque, New Mexico		Albuquerque, New Mexico adobewall@comcast.net
Dear Human Services Department Leadership: Thank you for the opportunity to comment and provide feedback on New Mexico's Centennial Care 2.0 Draft Plan. Attached are comments provided to you by the New Mexico Primary Care Training Consortium. (letter attached to email)	10/16/17	Lori Ann Loera, MJ – Health Law Network Operations Program Manager New Mexico Primary Care Training Consortium Silver City lloera@swchi.org
New Mexico HSD Medicaid Review Committee: I will address the merits of the proposed changes to New Mexico's Medicaid program momentarily, but let me say from the outset that, from a national level, every citizen and permanent resident should be granted comprehensive medical insurance, not necessarily free for everyone, but at costs appropriate to one's income level. The above mention aside, and given the US does not have a comprehensive national health care plan that covers everyone, the changes New Mexico is considering implementing for Medicaid are, by and large, reasonable. I myself am on Medicaid momentarily (hopefully), and have felt uncomfortable not having any sort of out of pocket expenses to contribute to the system - as small as they may be even given my very small income.. New Premiums: While many countries have free health care for their citizens, I do not think it unreasonable for citizens to at least be responsible for some portion of medical services rendered - depending on income level, of course. The $10-$20/month suggested is quite reasonable for the $12,100-	10/15/17	Rhett Zyla rzyla@rocketmail.com

$18,100. The $20-$40 premium for a family of three just above the poverty line is also very reasonable. However, I think for individuals making over $36,200 a year, the $25 suggested premium can be increased closer to $50. I do have issue with native Americans being exempt regardless of income; I think a certain level of responsibility is warranted for all citizens - irrespective of background. Copays: In addition to reasonable premiums as mentioned above, so too are reasonable copays. The numbers you have indicated seem reasonable for the low-end of the poverty level, but perhaps should be indexed with income and family size as you suggest for premiums. I am a huge supporter of preventive services (such visits reduce long term chronic illnesses and costs associated with problems that develop to later term prognosis due to lack of earlier preventive care). That said, a copay for a preventive visit is still not unreasonable, but I would not object to keeping such visits free of charge in the interest of encouraging illness prevention. As with New Premiums mentioned above, I do not believe Native Americans should be excluded from copays. Anything that can be done to foster self-responsibility - irrespective of background - is a positive step for the individual, and for society. Dental, Vision: I am weary of your intention to do away with dental and vision benefits. Perhaps you can charge a separate - but reasonable - premium for these services. I myself unfortunately have had to use dental benefits while on Medicaid, beyond basic services. Do not make this a service out of financial reach for our citizens. Retroactive Benefits: If removing this feature does not preclude individuals from still obtaining Medicaid coverage retroactively as you suggest through "presumptive eligibility on site", then this option may not be unreasonable. It would seem, however, that such a safety net is pragmatic to keep in place. My concern would be for those individuals who chose not to sign up for health care benefits only until something significant appears. In other words, everyone should pay into the system, healthy or ill. The healthy individuals obviously support the health care system; to make use of the system "for free" only when one is ill is counterproductive, exploitative, and opportunistic. Missed Visits: I fully support a charge for missed visits without notification; however, such a charge should be assessed for any visits missed - not just until the third offense has been committed. I think the $5 assessment is a little too forgiving: increase to $10. Added Benefits: As with dental coverage, I believe vision coverage, irrespective of income level, is pertinent. Perhaps a small separate premium, but vision is no less critical than other categories of coverage. Loss of vision reduces or eliminates one's ability to work (and therefore a loss of tax revenue to the state and federal government), and other governmental services may be required to assist the		

individual with sight problems if left unchecked. The latter also adds to the costs in the private and public health care sector. Best to avoid chronic, long-term issues than can be avoided with regular checkups. Regarding the purported figure that 72% of births in New Mexico are covered by Medicaid... This is a stickier subject to address. Ultimately the safe and healthy delivery of a baby is paramount. However, what Medicaid has likely exacerbated is reckless and irresponsible procreation by those who are too young themselves to have children, without the financial means to raise children, and lack of foresight in ballooning an unsustainable population in which global resources are clearly limited. I'm not sure exactly what the solution is to counter this unfortunate side effect, but perhaps a limit on the number of children/pregnancies covered by Medicaid can be set to discourage such behavior. To my knowledge there is no state policy (and surely no federal policy) anywhere in the US addressing this issue. I think this an important enough issue to mention even with the exceedingly unlikely scenario that such a concern will pragmatically be addressed at the governmental level. Thank you for the opportunity to comment and consideration of the aforementioned remarks. Rhett Zyla		
I could not read all of the Journal article. I became too angry. People on Medicaid get a free pass on skipped appointments and no surcharges for name brand drugs vs. generics, eh? All of it is as bad as I suspected. People make their "job" out of going to free health appointments, and they can't even show up for that. Meantime paying folks wait socialized-medicine time frames for appointments, and God forbid they need to reschedule: "The next available spot is this many months out." I need to go to the hearings to make sure every non-profit group does not flood the meetings with an unbalanced voice to make politics and vote-getting usurp reasonable policy, once again.	10/15/17	Dave Mitchell Bosque Farms davematastillero@gmail.com
RE Public Comment on Centennial 2.0 as presented in the Sunday Journal: I fully support having low income people have more skin in the game, except the emergency room charge of $8 for non-emergencies needs to be significantly increased. I had need of an emergency room but waited too long because of the myriad non-emergencies clogging the intake. With co-insurance my visit was $1000 out of pocket ...with health insurance. There needs to be incentives to stay healthy, eat better and look into preventative care. If unfortunately, the only means is to start charging something for services, and relieve the potential of more tax and insurance increases on those not below one of the many poverty lines, then it has to start happening. The current system is totally financially unsustainable. Health insurance is not insurance anymore. If it were then premiums regardless of income would be set based upon a health exam like my next life insurance policy. Including a driving record review. David Mitchell Bosque Farms	10/15/17	David Mitchell Bosque Farms davematastillero@gmail.com
I would like to suggest that co-pays are a horrible idea. The co-pays are so small that it will NOT be possible for a physician or clinic to bill for the amount of the co-pay. In general the co-pay will	10/15/17	Joel Saland, MD Pediatrician, Albuquerque

be uncollectable! In some cases even a small co-pay will prevent a patient from seeking medical care when he/she needs it but in most cases the patient will be seen by a doctor who WILL NOT BE REIMBURSED. If co-pays are required, the STATE WILL BE BETTING THAT DOCTORS WHO ARE BY NATURE "KIND HEARTED" WILL NOT TURN AWAY PATIENTS BUT WILL SEE THEM WITHOUT A CO-PAY. In fact not seeing a non-paying patient is illegal under Federal guidelines. Having copays will probably save the State money but at the expense of doctors and clinics who will not collect the copay and just have a lower reimbursement. Some Medicaid patients already have co-pays and in general these have not been collected. The patients usually have forgotten to take their checkbook or wallet but really need the care. Of course this does not happen in grocery stores or Walmart but those people will not give services without money whereas doctors do. Please do not impose co-pays. Joel Saland, MD Pediatrician, Albuquerque		jsaland2@gmail.com
I can understand the new changes for adults, but little children should be able to receive care under the same guidelines that are in use now. Do we want parents deciding that their child does not need to see a doctor when the child is running a high fever? Please don't change the income requirements that allow children to receive health insurance, even when their parents do not qualify for themselves. My grandchild broke her elbow and my daughter would not have been able to afford the medical bill even though she has worked full time for the State of New Mexico for over ten years and pays medical insurance for herself. Having our little ones insured is beneficial for our state. Able bodied adults who choose not to work and are on Medicaid should pay something for their care.	10/14/17	R. Reed cabintre@yahoo.com
Dear HSD, I hope this email finds you in good health and with a positive outlook. I am emailing to say that I strongly oppose the plan to cut Medicaid (Centennial Care 2.0). It looks like more than 800,000 citizens of our state will be harmed by the planned cuts. The cuts will risk federal matching funding, too. I think that we need to support the most vulnerable people in our communities, and Medicaid/Centennial Care 2.0 is a wonderful way to do just that. Our beloved elders in particular need the support which Medicaid can provide. Therefore, I respectfully and firmly urge you NOT to enact the cuts to Medicaid. Thank you for your time and work. May you find restful moments in each day. Gregory Corning	10/14/17	Gregory Corning Pojoaque cogreg@gmail.com
To whom it may concern; I am writing this in response to the "Proposed Cuts to Medicaid" that have been proposed for NM. As a full time working parent I am personally impacted by this. As you know New Mexico is among one of the lowest income states in our country. My husband and I do the best week can working full time (myself in healthcare and my husband	10/13/17	Alisha Cordova alishancordova@gmail.com

as a mechanic) and we have 3 small children. I am paid bi-weekly and my husband is paid PRN due to work flow. My employer does offer healthcare coverage but it is very expensive, coverage of services is limited and not to mention it is a big expense to pay for all 5 of us to be covered. Not to mention the cost of the coverage is a big amount out of my paycheck for just myself. If I had myself, my spouse and our children on the health plan that my employer offers it would cost me $204.38 per pay period (every 2 weeks) which is a huge deduction as I only make $800 every pay check. Not to mention the cost of living expenses, bills (daycare, electric, gas, trash, water, fuel for vehicles, vehicle insurance, home insurance, mortgage, etc..) With the cuts to Medicaid we are naturally concerned because this will impact our family tremendously. If there are high co-pays how will we be able to take our children to the doctor when they need it. It will be an issue of can we afford it vs. do they need the care? This will put children and families in danger. It should not be that way. Minimum wage in NM is also not that great which affects us both, luckily our children qualified for Medicaid due to our income. My husband and I are able to receive Medicaid right now (with limited coverage), but if my paycheck is ever slightly higher than the average $800 that I bring home then I am kicked off of it for "making too much". Which is easier said than proven. How can someone be told that they are "making too much" when their bills are not taken into account in the ratio and they cannot afford the health coverage on their own. Our only choice is Medicaid, once that is gone we will either go uninsured and pay the penalty at the end of the year come tax time or scavenge to pay for health coverage. Honestly, going uninsured is more affordable. Why can't something be done to make us have universal healthcare?!? It is scary to think that the future for not only us but for our children will be harsh living due to all these changes that have been discussed. Children and adults who need vaccinations to stay healthy, medications to manage their health conditions, treatment to stay alive... Have any of these things been taken into account? My husband and I have looked at all of our options and if these cuts are approved we will have no choice but to move to a different state so that we can provide for ourselves and our children. Thank you for your time but know that our family, as born and raised New Mexicans- are in complete disapproval (not to mention disgust) of these Medicaid cuts. Sincerely, Alisha		
10/12/2017 To whom it may concern, I attended the Public Hearing today in Las Cruces, NM – Thursday, October 12, 2017 for Centennial Care 2.0. I have a few concerns after reflecting on the presentation given. A comment that resonated with me was "passing the cost on to low income families is not the answer." My daughter is a recipient of CHIP Medicaid; a monthly premium would cause a strain on my family's already tight financial budget. I also recognize that personal responsibly is important, I think paying a $5 copayment for my daughter rare sick visit would be much more reasonable. I do	10/13/17	Kaily Guerra kguerra101@gmail.com Las Cruces

recognize that I am very blessed that my child is very healthy, therefore I lean more towards copayments if a charge to recipients must be implemented. I also think that charging both a monthly premium and copayment is not reasonable; it will greatly affect the ability of New Mexicans to access necessary health care. I do think that a charge for non-emergency use of the ER would be acceptable. I do not agree with coverage starting the following month. If I am unable to get a P.E. Determination at the time of service I will be responsible for that expense. Also if I do not have the $40-$50 premium by the first of the following month what am I to do? I feel as a consumer that cuts should be made to programs like Centennial rewards, or not adding new programs like Home Visiting. I have benefited from the Centennial Rewards program by receiving a car seat for my youngest child using my available points for attending my prenatal visits. It is a very nice program, but if costs can be offset by ending this program I feel it would be preferable to charging premiums and copayments to already stressed and strained families. Thank you for your time in reading my comments, Sincerely, Kaily Guerra		
As a nurse I am absolutely blown away that anyone, including government officials would think that it is ok to institute these changes that may in the end cause some of our most poverty stricken people to lose their only means for obtaining healthcare. These people already have a very difficult time living within the means of a very poor support system and for those who really need it this is a disgrace. For I have seen many families who abuse this system and do not really need the support, or receive support for many children in the family and yet live a better life than me and my family even though I work. Because I work I am not able to go to the hearings. however I know first hand how this is going to affect many. My daughter is disabled with a young child and she gets minimal assistance from the state and her disability. She only goes to the doctor and only takes her son to the doctor when necessary and for well child checks. Our system is broken and it blows me away that our government officials who are making a substantial amount of money and living very comfortably think they can make calls to decrease services and monies for people who live in poverty every day not sure how they are going to make it to the next month. This includes our elderly who many have worked very hard their entire lives, maybe in jobs which didn't provide benefits, and now have to make the decision whether to eat or pay for their medications they must take. These decisions are not being made by those who have lived this life, but by those who have no idea what it is to live in poverty and try to pay all the bills on a low subsidized income and yet provide for children and still pay co pays for their doctor visits and their prescriptions, as well as pay for housing and utilities and everything else that one needs on a daily basis. I appreciate your attention to this matter. Anna Gurule PO Box 242 Bosque, NM 87006	10/13/17	Anna Gurule Bosque, NM GuruleA@beleneagles.org
Comments from October 12 public meeting in Las Cruces		
To whom it may concern: I am a nurse in a low income community and every day my patient's tell me how difficult	10/12/17	Jon Helm, RN Nurse Flow Manager First Choice Community Healthcare –

navigating Medicaid can be. They discuss with me that they have had 3 doctors in 4 years as plans are constantly changing. In the low income clinic in which I work there are also patients with too much pride to apply for Medicaid. They do not want to take from others. Health care is not an economic issue, it is not a pride issue, it is a human issue. It is an issue of compassion. Please make every effort to protect every element of Medicaid for New Mexico families. Thank you, Jon Jon Helm, RN Nurse Flow Manager First Choice Community Healthcare – Alameda Albuquerque, NM		Alameda Albuquerque, NM jon_helm@fcch.com
I am a New Mexico resident. I am not on Medicaid, nor is anyone in my family. However, many in my community live either in or very close to poverty. These include families with small children, the elderly, and students who are trying hard to uplift their lives and those of their families through education. Some progress is being made, but it is very very hard. Please do not make matters so much worse by threatening to remove or reduce the federal support this state needs to serve people who have lived here all of their lives and by removing healthcare benefits that keep many alive. These are not lazy people - they are simply the working poor, the elderly, the children, not to mention the people who simply dared to get sick. With all of the wealth a small percentage in this country enjoy, please don't threaten the very people this Administration campaigned for with the promise that "everyone will have the best healthcare ever..." Does that include removing pre-natal care from pregnant women? Who is the genius who suggested that??? This has nothing to do with the ridiculous title "Obamacare." Forget that retaliation against the past does not serve the country NOW and does not uplift the public image of our current President in any way. This has everything to do with the threat this newest version of TRUMPCARE promises. Let him make a POSITIVE difference by actually supporting the people of this state. Don't make this another example of the big disconnect with REAL PEOPLE who are in the majority here. Let our President truly create a good picture of himself because he might actually make life better for many, and at the very least, not worse! Thank you. Bonnie Schranz Las Cruces, NM	10/12/17	Bonnie Schranz Las Cruces, NM bonnie.schranz@gmail.com
As someone who believes in shared responsibility, I do not think that the proposed premiums are not out of line. I agree with the Medicaid expansion, I agree with the rules of the ACA. I also agree that all people have a responsibility to participate in their healthcare	10/12/17	Cathy Salazar cms2869@gmail.com
I am writing to you to tell you, if Medicaid is cut for my husband & I, we will be getting bills that we cannot pay. We are trying to survive on Social Security as our only income, & this would devastate us. PLEASE DON'T CUT OUR MEDICAID! Sincerely, Mr. & Mrs. Frank Sides Roswell, NM	10/12/17	Mr. & Mrs. Frank Sides Roswell, NM Lee Sides leesds1984@gmail.com
To whom it may concern:	10/12/17	Chelsie Montano MAIII/ Super User/ Mentor

The proposed cuts to Medicaid is a huge deviset on millions of individuals, myself included. I have had my family on Medicaid since 2000. I currently have a good job that does offer benefits however I do not make enough to be able to afford coverage for my family. I make an average of $1600 a month but if I were to have to pay through my employer for full family coverage that would take $600 a month out of pocket which does not leave a lot of room for rent, utilities and food. not to mention if an EMERGANCY happens! what would happen if my car broke down? what would happen if I had to pay extra medical cost not covered by my employer insurance for myself or my family due to a severe illness or injury. These changes proposed will only create more issues for families you will have more families not trying to work because their health concerns and coverage are more important than anything else, you will see an increase in homelessness on families that now have to work with less money in their home because they have to pay more coverage. relook at cases where people are working and are trying to improve their lives and help them get over the hump of getting out of low income and into a comfortable living situation, instead of dropping them the second they make a little over the poverty line. I myself am on the edge already I have been stripped down to Family planning which does nothing for me as I have had a hysterectomy, maybe look into age range, current medical needs. I am currently paying $100 through my employer to only have myself covered that doesn't even include vision and dental is only covered if I go to my works locations. $100 would be really helpful for other things like FOOD. so not only did I get dropped from medical coverage at that same time my food stamps dropped and I do not get enough to cover the month I get enough that last a week. so basically I'm not doing any better than I was before having a decent job. Relook at cases that families keep getting larger, but don't make an effort to find or keep a job. Get more help to young parents to get into school programs to better their lives. Resources and people who truly help them use those resources. this needs to be revisited instead of just making cuts make life changes for people. Chelsie Montano MAIII/ Super User/ Mentor Edgewood, NM 87015		Edgewood, chelsie_montano@fcch.com
Hi there, I'm Nathan Bertelsen and I just wanted to say a few things Medicaid recipients are a very vulnerable community, the changes being considered harm a lot people that are already in a precarious position. retroactive coverage is important in facing the realities of uncertainty in how these situations unfold. excess fees become undue burdens. much of the actions considered have a net negative outcome, this seems a very poor approach. Think of the most vulnerable that depend on Medicaid and do the right thing. thank you for your consideration	10/12/17	nathan bertelsen sleepyknightbob@gmail.com
I'd like to make a public comment about the proposed Medicaid Changes. Medicaid enables people who are indigent, elderly and disabled to receive regular and preventive medical care. This is so important and cost effective. As a society we need to have a safety net for people that are living at or below poverty that includes health care. Excessive copays or premiums as well	10/11/17	LeeAnn Meadows Las Cruces NM lehona@hotmail.com

as ending the retroactive coverage program will cause problems with access. Many people living at or near poverty often move frequently and their mail doesn't always follow them. They might miss and important forms that causes them to lose benefits and while they can reapply, they will still need services while the paperwork is going through The transitional Medicaid is helpful in situations with people beginning new jobs with a waiting period for insurance. Some people with chronic illness like diabetes that is so common on the border, might not be able to get a job if it means they are without medical services for 3 months. I'm asking you to consider the consequences of the proposed changes which may cause people to become more ill and create an even greater burden on society when emergency care is needed on conditions that could have been managed. Most people are an accident or illness away from bankruptcy. I know I receive benefit through Medicare from chronic illnesses that prevent me from working. Before I was unable to work, I was a physical therapist and worked with many children with disabilities that received Medicare. It breaks my heart to think that we are not caring for the most fragile and giving them the best opportunities for their futures. Warm Regards, LeeAnn Meadows Las Cruces NM		
Medicaid is an important part of the social safety net. Many poor people are unable to afford care without it. We do not mandate that companies provide health insurance, so it falls on the State to assist their citizens when they suffer a health issue. In many cases, they are unable to work due to the health issue, so it is catch 22. They need to work so they have health care, but they are unable to work because of a health issue. We need to make sure that this program is maintained and strengthened. Our providers also depend on this program. The poor and indigent will still come to the hospital and the law requires the provider to care for them. This is extremely expensive and providing Medicaid coverage to be able to see a provider in a less-expensive care setting. The Governor has already destroyed the Medicaid Mental health system. This forces these unfortunate people into the criminal justice system that is more expensive and provides no treatment. We need to get mental health re-established and get these people the help they need. If we are to set ourselves above the animals on this planet, we need to prove that being human is superior by taking care of those less fortunate than we are. Virtually all religions call for taking care of the sick. If we feel we need to implement other religious restrictions, then we need to implement and maintain this one as well. Sincerely, Berton Stevens Las Cruces, NM 88012	10/11/17	Berton Stevens Las Cruces, NM blslcnm@comcast.net
Good Morning, I am an enrollment counselor for a small rural clinic in Ft Sumner NM, The majority of our community are low income families who would be greatly affected by these new changes, we are very lucky to have a school based health clinic and adding a copay for children would definitely affect the health and well-being of our children in our small community please reconsider these	10/11/17	Liz S lizstant@plateautel.net

new changes, for low income families our clinic is a vital part of the community as our nearest hospital is 45 miles away and many of the community do not have transportation or the money to travel and pay premiums and copays. Many of our community live pay check to pay check please don't make it where they have to decide between paying the electric bill or seeing a doctor. Thank you		
Thank you. Are you able to confirm whether or not the state is seeking a waiver of non-emergency medical transportation? The draft waiver application says they are proposing eliminating the benefit but there is no waiver request on the "Waiver List" on page 36	10/4/17	Michael Massiwer mmassiwer@mjsimonandcompany.com
When is the comment deadline for the Draft application for renewal of section 1115 demonstration waiver for Centennial Care 2.0. Is it 10/18 or 10/30?	10/4/17	Michael Massiwer mmassiwer@mjsimonandcompany.com
I am a family physician working with a community health center in Albuquerque. I have worked in community health centers in 4 different states and I have always been impressed by the way New Mexico takes care of their own, much better than Colorado or Washington state. The proposed cuts to Medicaid however will devastate my patient population and their families. The gains that we have made the last few years under the ACA, will be wiped out immediately by adding co pays and premiums. For people living on a nominal fixed income or living with hourly wages that change at the whim of their employers, monthly premiums are untenable. I can give countless examples of patients that would not seek any care or seek it only in an emergency if they had a 2$ co pay, as that may be there food money for the day. We all know that there are abusers of the system and those who get benefits that should not, but the vast majority are truly needy and depend on the good of the state to help them get the care that we need. On behalf of the people of New Mexico, please do not cut Medicaid or any of its benefits. Thank you, Jennifer Pentecost, M.D., Family Physician	9/27/17	Jennifer Pentecost, MD jennifer_pentecost@fcch.com
Letter submitted by AIPC (Tribal group)	9/26/17	E. Paul Torres, Chairman, All Indian Council of Governors
I oppose cuts to Transitional Medicaid that leave anyone on Medicaid attempting to accept a job or raise, vulnerable to having no medical coverage between the time they begin a job or get a raise & actually are either covered by the new workplace Group Insurance or the raise is equivalent to the avg. cost of working adult Medicaid Co-pays for 3-6 month- wean them, don't cut them off. This is a dangerous practice & a CLEAR dis- incentive to take the job or raise & thus incur loss of Medicaid… we wean horses, don't we? I oppose any kind of co-pay or deductibles for 100% Medical/Mental Disability entitled New Mexicans, Dual Medicaid/Medicare-eligible New Mexicans or for New Mexican Children on Medicaid. They are especially vulnerable more so than simple poverty alone, can inflict. They can't usually	9/25/17	Linda Finkelstein, linda_finkelstein@fcch.com

up their income- they are locked in poverty with no escape by actions they can take. They are too young or too old to work or too ill/injured to work. They are stuck. They will be penalized with receiving NO CARE when they may need it, based upon an extremely limited, low income over which they have no control. They are our most vulnerable of the vulnerable. They are much worse-off then a working adult or student adult whose family size or low income creates an eligibility for Medicaid …they can exercise some control over their finances by accepting more work hours or controlling the births they produce… & so impact positively, their income. They can make choices to allow them to save some small amount/mo. for a low co-pay. This select group on Medicaid, should be incentivized to judiciously access services, raise fewer children, work more than part-time & so hang-on to a $5.00 bill for a LOW co-pay if they need it. In this way, they can afford to pick-up a $5.00 co-pay, but this is just not true for the totally disabled or children- they can't control their financial situations.		
To Whom It May Concern, As a parent who had a child receiving Medicaid and an employee in a community healthcare clinic, I am writing to oppose any cuts to Medicaid. In a climate where there is the threat of repealing the Affordable Care Act, our state must not contribute to any cuts to Medicaid. Any cuts to Medicaid will have drastic financial and health implications for members of our community. Increased fees may prevent individuals and families from seeking healthcare due to the inability to cover the costs. I encourage you to support the health of our state by denying any cuts to Medicaid. Sincerely, Jessica Jespersen Chavez	9/25/17	Jessica Jespersen Chavez, jessjc2@hotmail.com
Please help us not to have any changes in Medicaid Thank You, Ammie Mendoza , MA	9/21/17	Ammie Mendoza, Albq, ammie_mendoza@fcch.com
Hello- I am unable to attend any of the public hearings regarding HSD's Centennial Care 2.0 waiver proposal, but as a primary care provider in Albuquerque's South Valley I am horrified at the proposed changes and the impact the would have on my patients. As physicians we practice evidence-based medicine, and the overwhelming evidence shows that changes such as reducing Medicaid benefits, adding premiums and/or co-pays, ending transitional assistance and eliminating retroactive coverage will have extremely adverse effects on the health and well-being of thousands of New Mexican families. I strongly urge all our state's leaders and policymakers to reconsider the proposed changes and to prioritize policies that promote health. Jesse Barnes, MD Albuquerque, NM	9/19/17	Jesse Barnes, MD Albuquerque, NM jbarnes1980@gmail.com
To whom it may concern. I am writing in response to the HSD proposed changes to New Mexico Centennial Care program	9/19/17	Stephen Ratcliff, MA, LPCC President

titled Centennial Care 2.0. I strongly oppose these changes because I see them as further limiting services to many of the most at risk citizens of New Mexico. Stephen Ratcliff, MA, LPCC President, Families First Therapy, LLC		Families First Therapy, LLC Albuquerque, NM www.familiesfirsttherapy.org
Good morning, I am unable to attend any of the public hearings scheduled regarding proposed changes to Medicaid coverage in New Mexico but I wanted to share my thoughts. I am currently a community health worker for a non-profit community health agency in Albuquerque and work directly with a lot of patients who will be affected by the proposed changes. Prior to my current position I worked for Income Support Division / HSD for 7 years processing Medicaid, SNAP and TANF cases. I feel my background allows me a unique perspective on the proposed changes. The one proposed change that made me pause is the proposal to do away with the transitional full-coverage Medicaid that families usually receive when income rises above a certain limit. With healthcare costs rising and the high number of families in poverty, this proposed change will actually discourage parents from seeking better paying jobs or working at all, especially those parents who are chronically ill or in the midst of treatment. The reason I know this is because dozens of families over the years expressed this sentiment to me when I would process their Medicaid/SNAP/TANF re-certifications. Any gain in income would be wiped-out by extra medical costs without the transitional full-coverage Medicaid. Granted, children could be covered under other Medicaid categories with higher income levels, but the parents would be at a disadvantage. Without the full coverage transitional Medicaid, parents would most likely be put on a Family Planning Medicaid which wouldn't cover maintenance medications or being seen for illnesses or chronic diseases. Many families would prefer lower income with full Medicaid coverage to slightly higher income with reduced coverage and being forced to decide between paying for the gas bill and expensive medications. If the budget simply doesn't allow for keeping the transitional Medicaid in its current form (12 months of full-coverage transitional Medicaid), perhaps a compromise could be found to keep the transitional Medicaid open for 6 months. This would at least give recipients time to come up with a plan and to budget accordingly for when the full coverage ends. Regarding the other proposed changes in general, we see high levels of poverty, inadequate education and poor nutrition and health throughout New Mexico, especially in rural areas. We need to improve patient access to care and affordability of care, not chop patients off at the knees, so to speak, when they are trying to make strides forward. Thank you, John Schmidt, Community Health Worker First Choice Community Healthcare	9/19/17	John Schmidt Community Health Worker First Choice Community Healthcare Albuquerque, NM john_schmidt@fcch.com

Hello HSD, Thank you for giving the public the opportunity to comment on your proposed changes to Medicaid in NM. Our son Marceliano receives numerous medical health services through the Mi Via Waiver and Presbyterian Centennial Health Insurance to maintain his health and quality of life with quadriplegic Cerebral Palsy and related issues. We have read through the proposed changes to Medicaid and want to share our concerns. It is our understanding that Medicaid was created to address the special needs of people like our son, who have ongoing, intensive healthcare needs. Modifying the program in ways which diminish the efficacy of meeting the needs of these especially vulnerable populations directly diminishes the health and lives of the people Medicaid was created to support. 1. Please reconsider the proposed addition of copays for 'routine' and emergency medical services. The financial impact of requiring co-pays for the numerous services received by our son would ultimately require the elimination of some of his services. Please understand that we are talking about a minimum of three copays a week for sustaining therapies (PT, SLP for communication and OT). These therapies reduce the incidence of Marcel's medical visits by maintaining range of motion, strengthening, etc (PT), increasing safety and connection in community (SLP) and working toward increased independence (OT). They are not luxury services, but rather support his well being, quality of life and reduce his need for other medical intervention. Even with a $10 copay, that means an extra $120/month!! In addition, doctor's visits, specialists and scheduled surgeries (he had 2 surgeries this summer, for example) would amount to way more than what we can afford. So we would be forced to reduce his preventative and maintenance healthcare, which would result WITHOUT A DOUBT in increased emergency interventions. This reduces his well being and quality of life, in addition to putting additional strain on ERs and increasing the severity and expense of medical interventions that WILL be needed. 2. We already privately cover a number of medically necessary items excluded by the current Medicaid program. Excuse me for talking personal hygiene, but this example illustrates our situation well. Marceliano is incontinent, and briefs are very expensive. Because Medicaid will not cover two different kinds of briefs monthly, we cover the night briefs ourselves. Why? Because our son is 17, with a 17-year old bladder capacity. Daytime briefs, which he uses while sitting up in his wheelchair, are changed every for 2-3 hours, and have one particular capacity and catchment design. At night, when he is lying down for 7-8 hours without changing, the brief must have a MUCH greater capacity and different design to meet that need. So we buy them ourselves to maintain his skin integrity, dignity, and to avoid the need to wash the bedding every day. This is just one example of 'covered' Medicaid benefits which are crucial to us, but are already only covering part of our son's need. 3. Please do not reduce the age-out age for EPSDT! As a 17 year old senior in High school,	9/14/17	Stephanie Varoz, The Varoz Family, peace2u@comcast.net

Marceliano is preparing to 'transition' into a completely new life situation, without the support of school. Removing EPSDT services from 19 and 20 year olds who are trying to figure out how to live a quality life in our community pulls the rug out from them at a very vulnerable time! Trying to maintain health, secure supports like health aides and gain access to programs for work, school and daytime activity is so complex for people with special needs! Reducing services at this time threatens to make even more difficult an already very complex and challenging situation. While Marceliano's typical peers will be graduating and going on to work or school or programs of their choice, Marceliano has to choose from a very narrow menu of possibilities. He also has much less room for mistakes, changes and adjustments. Very few 18 year olds make perfect choices which require no changes or adjustments—his typical peers will have much more freedom to adjust to 'adulthood' than will Marceliano. This is because his special needs place rigorous requirements on his time and require a lot of efforts to maintain his body and well being. Removing EPSDT supports from him during this period would make it even harder for our son to succeed! Please consider our concerns, and the concerns of other who rely on Medicaid for their health and well being. For some of us, this truly is life or death. We all deserve dignity and respect, and we believe that NM can do better than cutting services to the people who rely on them so heavily for a quality life. Thank you, The Varoz Family		
Leaders, Perhaps the most important thing that has happened to support the needs of limited income families and individuals in the past ten years in New Mexico was Medicaid expansion. It has made a huge difference to their physical and financial well-being. To now modify the access and affordability provisions of the expansion, is not to just stop but reverse the trends toward stabilizing families, improving their health, their family cohesiveness and functioning, and their abilities to be productive workers and learners. It is this kind of decision making that keeps New Mexico attached to the high end of every negative measure and the low end of every positive one. We have no problem socializing costs when we want to build a new transmission line or to support economic development models that repeatedly fail to produce the results they promise. Why then the outrage or "impossible to do" narrative about socializing costs for people who suffer grievously when we refuse to invest in needs so basic as medical care. The proposed "structural reforms" are a euphemism for a crushing, cost shifting scheme from the state to our most vulnerable populations, and must be retracted. Best, Ona Porter President and CEO, Prosperity Works	9/13/17	Ona Porter President and CEO, Prosperity Works ona@prosperityworks.net
Hello, I just want to say, I am not voting for government elected officials that support this highly discriminatory rationing & burdening the poorest amongst us to "save" taxes from those of us	9/11/17	Linda Finkelstein, Health Care Manager, Edgewood, New Mexico linda_finkelstein@fcch.com

that are much better off. You are dis-incentivizing seeking employment without Transitional coverage since companies can withhold coverage for 3 months before they allow an employee full benefit eligibility or use. Not a smart decision in my view. Our ER's & hospitals will again, begin to handle the poor, with increased costs to taxpayers as they deal with delayed care complications that are much more expensive to manage. Your plan is not sound nor is it sustainable. Very short-sighted decisions on your part. Linda Finkelstein, Health Care Manager, Edgewood, New Mexico		
Sirs I can't believe I am reading that you are going ahead with these cuts to Medicaid. After our meeting with your people who came to Silver City it appeared they understood what catastrophic effects these changes would have on our most vulnerable citizens as well as the rest of the community. They even said that some of these proposals had already been taken off the table. As a retired Human Services Department employee I have witnessed the improvement of outcomes since the addition of these programs. The "conservative" agenda to push expenses back onto local communities to give the appearance of cost cutting will actually cost lives. None of these cuts will reduce ANY costs. They simply shift the burden to smaller entities, again ignoring the very reason for the State and Feds establishing this program in the first place, because the larger entity spreads the costs over a larger population creating a less expensive insurance system. Eliminating the retroactive coverage will not only hurt people who will be caught with the highest of the bills that tend to occur at the onset of illness or just after an accident, but will require the local hospitals and County indigent funds to absorb much of those costs. I have not forgotten and do you even know why this coverage was added in the first place. Knowing that those initial expenses would be covered has allowed Doctors and Hospitals to more aggressively treat issues and actually reduce the long term expenses, thus the retro-coverage has reduced total cost. Ending the Transitional Medicaid period takes the insurance away from the very people who have done the work to turn their lives away from public assistance. This is short term insurance coverage that can mean the difference between making it out of poverty and falling back into complete State support. Then, of course, the meanest of these proposals it to charge poor people who are already struggling to balance feeding their children with school costs, housing costs, transportation and other costs of trying to work, additional fees to be able to get medical care for those children. *The statistics are clear*! Postponing treatment creates higher costs and worse outcomes. You may be able to point to "saved dollars" on your budget ledger but the long term costs will certainly increase and the citizens will not be fooled as those costs are shifted to our local communities. It took years of budget wrangling in the Legislatures to determine the funding for	9/10/17	Linda Pafford, Silver City, NM ruinrat@gmail.com

these programs and they were only established because they were in the best interest of the entire population. These mean spirited cuts can be seen as nothing but Political pandering to some entities that do not live in the real world of our communities. To make these recommendations to the Governor is simply irresponsible and I would hope you would also present the real-life effects that she doesn't want to hear. *Linda Pafford*, *Silver City, NM*		

NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

QUALITY STRATEGY

September 2017 Update

TABLE OF CONTENTS

Section I: Introduction:

CMS requirement CFR §438.340(a)

General rule. Each State contracting with a MCO must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO.

Program History

CMS requirement CFR §438.340

Include a brief history of the state's Medicaid (and CHIP, if applicable) managed care programs.

Prior to 1997, New Mexico Medicaid members received their care through a Fee-For-Service (FFS) model. The New Mexico Legislature mandated that the Human Services Department, Medical Assistance Division (HSD/MAD) implement a managed care program. A proposal was submitted under section 1915(b) of the Social Security Act to provide comprehensive medical and social services to the State's Medicaid population.

On July 1, 1997, New Mexico implemented the Salud! program, a managed care program for physical health services. The program was designed to improve quality of care and access to care while making cost-effective use of state and federal funds. During that period, approximately 65% of Medicaid eligible members were participants in Salud!.
In addition, the Medicaid safety net programs for children, including the Children's Health Insurance Program (CHIP) were combined into one program known as New Mexikids.

In 1999, HSD/MAD implemented the Personal Care Option (PCO) as a state plan service to meet the needs of Medicaid members in need of long-term services and who met a Nursing Facility Level of Care (NF LOC). PCO was developed to allow members to receive care in their home rather than being placed in a Nursing Facility.

In August 2002, A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by the Centers for Medicare & Medicaid Services (CMS). The waiver program utilized unspent CHIP funds to provide basic health benefits for New Mexicans with incomes up to 200 percent of the federal poverty level through an employer based buy-in insurance plan.

In 2004, the Interagency Behavioral Health Purchasing Collaborative (The Collaborative) was established as a pioneering effort in the behavioral health system transformation. The Collaborative had the authority to contract for behavioral health services and make decisions regarding the administration, direction and management of state-funded behavioral healthcare services in New Mexico. Optum Health, was selected as the Statewide Entity charged with the oversight of behavioral healthcare services for Medicaid recipients in Salud!.

On March 18, 2005, Governor Bill Richardson signed the State Coverage Insurance Program (SCI) into law. SCI was an innovative insurance product, combining features of Medicaid and a basic commercial health plan. Support from the federal government provided the flexibility to offer coverage to the adults most in need throughout the state.

In 2008, the Coordination of Long-Term Services (CoLTS) program was implemented as the state's first managed long-term care program for Medicaid members who met a NF LOC. This 1915 (b) (c) concurrent program covered members residing in nursing facilities, participants of the Disabled & Elderly (D&E) waiver, Personal Care Option (PCO) members, dual eligible members and members with a qualified brain injury (BI). The program was an interagency collaboration between HSD/MAD and the New Mexico Aging and Long-Term Services Department (ALTSD). All acute, preventative and long-term care services were provided through contracted MCOs. The primary goal of the program was to mitigate the array of problems resulting from the fragmentation of services provided to Medicare and Medicaid dual eligibles.

Centennial Care

In 2013, of the two million citizens in the state of New Mexico, approximately 520,000 people received their healthcare through the Medicaid program. The Medicaid program operated 12 separate waivers as well as a FFS program. Seventy percent of the Medicaid enrollees were in a managed care setting. Seven different health plans administered the various delivery systems. Services were provided under an umbrella of programs for eligible individuals in more than 40 eligibility categories.

In 2014, New Mexico embarked on a new path to deliver integrated care to the Medicaid population through a Section 1115 Demonstration Waiver known as Centennial Care. The 1115 Demonstration Waiver consolidated all previous federal waivers, with the exception of the Medically Fragile Waiver (MFW), the Developmentally Disabled Waiver, and the Mi Via ICF/IID Waiver. Similarly, the MCO contracts were reduced from seven to four.

The Section 1115 Demonstration Waiver, Centennial Care, was approved by CMS for a 5 year period, beginning in January 2014 through December 2018. Centennial Care modernizes the Medicaid program by improving the efficiency and effectiveness of healthcare delivery; integrating physical health, behavioral health and long-term services and supports (LTSS); advancing person-centered models of care; and slowing the rate of growth in program costs. Guiding principles for Centennial Care include:

- Developing a comprehensive service delivery system;
- Increasing personal responsibility;
- Encouraging active engagement of members in their health care;

- Emphasizing payment reforms to incentivize quality versus quantity of services; and
- Maximizing opportunities to achieve administrative simplification.

Today, four MCOs administer the full array of services in an integrated model of care. The care coordination infrastructure is an integral focus of Centennial Care and promotes a person-centered approach to care with more than 900 care coordinators ensuring members receive services in the right place when they need them. Centennial Care increased access to LTSS for people who previously needed a waiver allocation to receive such services by allowing any Medicaid member who meets a NF LOC to access home and community based services (HCBS). As a result, New Mexico experienced an increase of 11.4% individuals receiving HCBS between 2014 and 2016.

Also in 2014, New Mexico became an expansion state under the Affordable Care Act. The total enrollment in the Medicaid program has grown 8.5% per year since 2014 while the per capita costs have decreased by 1.5% between 2014 and 2016. Centennial Care demonstrated improved utilization of health care services and cost-effectiveness despite significant enrollment growth.

In 2016, New Mexico launched two Health Homes sites targeting individuals with serious mental illness or severe emotional disturbance. The Medicaid program continues to see an increase in members participating in a patient centered medical home (PCMH) with over 300,000 members to date.

In November 2017, HSD/MAD will submit the Centennial Care 1115 Waiver renewal. In the renewal application, New Mexico has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system through the implementation of Centennial Care 2.0; therefore, building on the many successes and accomplishments achieved since implementation of the program.

Quality Management Structure

Include an overview of the quality management structure that is in place at the state level.

The Quality Bureau (QB) within HSD/MAD currently consists of 14 positions plus a bureau chief. The QB is structured with three units: Care Coordination Unit (CCU); Performance Measure Unit (PMU); and the Critical Incident Unit (CIU). The CCU conducts oversight and monitoring activities related to MCO care coordination requirements. The PMU conducts oversight of MCO quality performance and improvement initiatives and manages both the External Quality Review Organization and the 1115 Demonstration evaluation activities. The CIU conducts oversight of the reporting of critical incidents by MCOs and provider monitoring to ensure the health and welfare of members for 14 categories of eligibility (COE). All units operate in accordance within applicable state and federal regulations as well as MCO contract and policy requirements.

The QB is responsible for directing the Division's Quality Program and coordinating existing quality improvement and future health reform initiatives with contracted MCOs. The bureau

oversees all aspects of performance measurement for Centennial Care including quality improvement projects, performance measures and performance evaluation and reporting. The State retains ultimate authority and accountability for ensuring the quality initiatives of Centennial Care are accomplished, although several internal and external collaborations/partnerships are utilized to address specific initiatives and/or issues. Administrative authority for the Quality Strategy lies within the HSD/MAD Director's Office and is delegated to the QB for development, revision, evaluation, and reporting.

Section II: State Standards:

Quality and Appropriateness of Care Standards

CMS requirement CFR §438.340(b)

Summarize the procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO contracts, and to individuals with special health care needs.

Quality Management and Quality Improvement Standards:

MCOs are required to comply with state and federal standards for quality management and quality improvement (QM/QI) and shall adhere to the following:

- Establish a QM/QI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria;
- Recognize the opportunities for improvement are continual;
- Ensure the QM/QI process is data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements;
- Require re-measurement of effectiveness and continuing development and implementation of improvements as appropriate;
- Reflect member and Contract Provider input;
- Develop a QM/QI annual program description that includes goals, objectives, structure, and policies and procedures that result in continuous quality improvement;
- Review outcome data at least quarterly for performance improvement, recommendations and interventions;
- Establish a mechanism to detect under and over utilization of services;
- Have access to, and the ability to collect, manage and report to the State data necessary to support the QM/QI activities;
- Establish a committee to oversee and implement all policies and procedures;
- Ensure that the ultimate responsibility for QM/QI is with the MCO and shall not be delegated to subcontractors;

- Develop an annual QM/QI work plan to be submitted at the beginning of each year and include, at a minimum, immediate objectives for each year and long-term objectives for the entire term of the contract;
- Implement Performance Improvement Projects (PIPs) identified internally by the MCO and as directed by HSD;
- Design sound quality studies, apply statistical analysis to data and derive meaning from the statistical analysis; and
- Submit an annual QM/QI written evaluation to HSD that includes, but is not limited to:
    - A description of ongoing and completed QM/QI activities;
    - Inclusion of measures that are trended to assess performance;
    - Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;
    - Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;
    - Demonstration that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention's effectiveness;
    - Demonstration that the results of QM/QI projects and reviews are incorporated in the QM/QI program;
    - Incorporation of annual HEDIS results in the following year's plan as applicable to HSD specific programs;
    - Communication with appropriate Contract Providers about the results of QM/QI activities and opportunities for provider to review and use this information to improve their performance, including technical assistance, corrective action plans, and follow-up activities as necessary; and
    - Upon request, present about Behavioral Health aspects of the MCOs' annual QM/QI work plan during a quarterly meeting of the Collaborative.

Utilization Management Standards:

HSD/MAD requires that the MCOs establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) UM standards and

promotes quality of care, adherence to standards of care, and efficient use of resources, member choice, and the identification of service gaps within the service system. The MCO UM system must:

- Ensure members receive services based on their current conditions and effectiveness of previous treatment;
- Ensure services are based on the history of the problem/illness, its context and desired outcomes;
- Assist members and/or their representatives in choosing among providers and available treatments and services;
- Emphasize relapse and crisis prevention, not just crisis intervention;
- Detect over and underutilization of services to assess quality and appropriateness of care furnished to members with special health care needs; and
- Accept the uniform prior authorization form for prescriptions drug benefits and respond to prior authorization request within three (3) business days.

MCO Accreditation Standards:

The MCO shall be either (i) National Committee for Quality Assurance (NCQA) accredited in the State of New Mexico or (ii) accredited in another state where the MCO provided Medicaid services and achieved New Mexico NCQA accreditation by 1/01/16.

Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the MCO contract with the State. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract.

CMS requirement CFR §438.340(b)(9)
Describe the mechanisms implemented by the State to identify persons who need long-term services and supports or persons with special health care needs. (This must include the state's definition of special health care needs.)

Care Coordination Standards:

A comprehensive care coordination model fosters the goal of ensuring that Medicaid recipients receive the right care, at the right time, and in the right place. MCOs establish levels of care coordination for members based on an assessment to determine the level of support that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to reassess the individual and, as appropriate, make the corresponding changes in their care coordination level of support.

HSD/MAD requires the MCOs to conduct a standardized health risk assessment (HRA) on each member to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a Comprehensive Care Plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members assigned to

care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs are required to routinely monitor claims and utilization data for all members (including members who are not assigned to care coordination levels 2 or 3) to identify changes in health status and high-risk members in need of a higher level of care coordination.

Additional components of care coordination includes:

- Assessing each member's physical, behavioral, functional and psychosocial needs;
- Identifying the specific medical, behavioral, LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet the member's needs;
- Assessing members for LTSS. This applies to members of all ages who have functional limitations and/or chronic illnesses. The primary purpose is to support the ability of the beneficiary to receive services in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or institutional setting;
- Identifying members with special health care needs. The state defines members with special health care needs as those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally;
- Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare.

Access and Network Adequacy Standards

CMS requirement CFR §438.340(b)(1)

Define the network adequacy and availability of service standards for MCOs required by §438.68 and §438.206. Include examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.

New Mexico must ensure the delivery of all covered benefits to all Medicaid beneficiaries. Services must be delivered in a culturally competent manner and require that the MCO coordinate health care services and maintain a provider network sufficient to provide timely access to covered services for all of its members.

The MCO must have written policies and procedures that align with the Network Adequacy Standards detailed in the MCO contract and the Centennial Care policy manual. The policies and procedures must describe how access to services will be available including prior authorization and referral requirements for medical and surgical services; emergency room services; behavioral health services; and long-term care services.

The MCO must establish a mechanism to monitor adherence with Network Adequacy Standards and shall submit a Network Adequacy Report as directed by HSD/MAD to ensure compliance with the following:

- Access Standards
    - Member caseload of any PCP should not exceed two-thousand (2,000)
    - Members have adequate access to specialty providers
- Distance Requirements for PCPs (including internal medicine, general practice, and family practice types), and pharmacies
    - Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles
    - Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles
    - Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles
- Distance Requirements for Behavioral Health Providers practitioners and Specialty
    - Ninety Percent (90%) of Urban members shall travel no farther than thirty (30) miles
    - Ninety Percent (90%) of Rural members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the State
    - Ninety Percent (90 %) of Frontier members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved ty the State
- Timeliness requirements
    - No more than thirty (30) Calendar Days, for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care
    - No more than sixty (60) Calendar Days, for routine, asymptomatic member-initiated dental appointments.
    - No more than fourteen (14) calendar Days for routine, symptomatic member-initiated, outpatient appointments for non-urgent primary medical, behavioral health and dental care
    - Within twenty four (24) hours for Primary medical, behavioral health and dental care outpatient appointments for urgent conditions
    - Consistent with clinical urgency but no more than twenty-one (21) calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health
    - Consistent with clinical urgency but no more than fourteen (14) calendar days for routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments
    - Consistent with the severity of the clinical need, walk-in rather than an appointment, for outpatient diagnostic laboratory, diagnostic imaging and other testing

- Consistent with clinical urgency, but no longer than forty-eight (48) hours for urgent outpatient diagnostic laboratory, diagnostic imaging and other testing
- No longer than forty (40) minutes for the in-person prescription fill time (ready for pickup). A prescription called in by a practitioner shall be filled within ninety (90) minutes
- Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners
- Within two (2) hours for face-to-face Behavioral Health crisis services

Provider Standards:
The MCO must have the appropriate licenses in the State to do risk-based contracting through a managed care network of health care providers. The MCO is required by the state to employ a full-time staff person responsible for provider services and provider relations, including all network management issues, provider payment issues and provider education.

The MCO must develop written policies and procedures that meet NCQA standards and State and federal regulations for credentialing and re-credentialing of contracted providers. The document should include but not be limited to: defining the scope of providers covered; the criteria and the primary source verification of information used to meet the criteria; the process used to make decisions that shall not be discriminatory; and the extent of delegated credentialing and re-credentialing arrangements.

MCO network providers are obligated to abide by all federal, state and local laws, rules and regulations, including but not limited to those laws, regulation, and rules applicable to providers of services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by the State.

All health care providers rendering services to Medicaid beneficiaries must render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief or source of payment.

Evidenced-Based Clinical Practice Guideline (CPGs) from the MCOs include examples from their QM/QI plan such as Asthma, Diabetes, ADHD (Attention Deficit Hyperactive Disorder)/ADD (Attention Deficit Disorder), Depression, and Obesity. CPGs are updated every two years and analyzed for relevant member population and practitioner/specialists and disseminated to providers. Typically, measurements (i.e. Healthcare Effectiveness Data and Information Set [HEDIS]) are established and evaluated through MCO Quality Committees, NCQA, and HSD/MAD.

CMS requirement CFR §438.340(b)(6)

Detail the State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO at the time of enrollment.

Health Disparities

In New Mexico many factors contribute to health disparities, including access to health care, behavioral choices, genetic predisposition, geographic location, poverty, environmental and occupational conditions, language barriers and social and cultural factors.

HSD/MAD enlists a variety of methodologies and resources, including enrollment files delivered daily to the MCOs, to identify, evaluate, reduce and overcome any barriers that limit access to appropriate care for the State's Medicaid beneficiaries. Resources include, but are not limited to:

- Stratified data tracking and monitoring of targeted populations, illness or chronic conditions to identify at risk Medicaid beneficiaries;
- State directed interventions and oversight and monitoring of MCO directed interventions developed to address specific health care needs unique to Medicaid beneficiaries;
- Requiring that the MCOs maintain an adequate provider network that adheres to the State's provider participation standards;
- Establishment of a Care Coordination infrastructure to assess member needs;
- Member rewards program to encourage member engagement with preventive services and follow up care by incentivizing beneficiaries to pursue healthy behaviors;
- Peer support program to provide formalized support and practical assistance to people who have or are receiving services to help regain control over their lives in their own unique recovery process; and
- Requiring the MCO to develop a Cultural Competence and Sensitivity Plan to ensure that covered services provided to members are culturally competent and include provisions for monitoring and evaluating disparities in membership, especially as related to Native Americans.

Transition of Care Standards:

CMS requirement CFR §438.340(b)(5)

Must include a description of the State's transition of care policy.

The State is committed to providing the necessary supports to assist Medicaid beneficiaries and requires the MCOs to establish policies and procedures that adhere to the standards defined by the State in the Managed Care Policy Manual and MCO contract.

The MCOs shall facilitate and ensure a timely and seamless transition for all Medicaid members transitioning to new services or service providers without any disruptions in services.

The MCOs must identify and facilitate coordination of care for all members during various transitions including, but not limited to:

- From an institutional facility into the community;
- For members turning twenty-one (21) years of age;
- From higher levels of care to lower levels of care. (e.g. acute inpatient, residential treatment centers social detoxification programs, treatment foster care, etc.);
- For members changing MCOs (e.g. while hospitalized, during major organ and tissue transplantation, or while receiving outpatient treatment for significant medical conditions); and
- For members with special conditions, circumstances, treatment needs or ongoing needs such as (e.g. pregnancy, chronic illness, significant behavioral health conditions, chemotherapy, dialysis or durable medical equipment).

Monitoring and Compliance Standards:

CMS requirement CFR §438.340(b)(2)

Detail the State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO.

New Mexico's Quality Strategy utilizes a Continuous Quality Improvement (CQI) model to achieve goals and objectives outlined for the Centennial Care program.

Centennial Care is driven by the following goals:

1. Assuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting;
2. Ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity;
3. Slowing the growth of rate of costs, or "bending the cost curve" over time without cutting benefits or services, changing eligibility, or reducing provider rates; and
4. Streamlining and modernizing the Medicaid program in the State.

Centennial Care objectives include:

1. Develop a quality framework consistent with, and pertinent to all Medicaid programs;
2. Continue use of nationally recognized protocols, standards of care and benchmarks;
3. Continue use of a system of rewards for physicians, in collaboration with MCOs, based on clinical best practices and outcomes;
4. Develop collaborative strategies and initiatives with state agencies and other external partners;
5. Build upon prevention efforts and health maintenance/management to improve health status through targeted medical management;
6. Assure the effective medical management of at risk and vulnerable populations; and
7. Build capacity in rural, frontier and underserved areas.

HSD/MAD, through the QM/QM standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement in the health status of the population served by the MCOs. The State conducts an annual review of each MCO's QM/QI program that includes a Work Plan and Evaluation by an integrated team from the QB, the Behavioral Health Services Division (BHSD) and the Centennial Care Contracts Bureau.

HSD/MAD monitors provider access and network adequacy in a variety of ways and through various reports submitted by the MCOs. The following outlines the various methods utilized to monitor MCO provider access and network adequacy:

- Provider Satisfaction Survey
- Member Satisfaction Survey
- Secret Shopper Survey
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
- External Quality Review Organization (EQRO) Reviews
- MCO Call Center Reports
- Grievance & Appeals Reports
- PCP Report
- Geo Access Report
- Network Adequacy Report
- Ad Hoc Reports
- Primary Care Physician to member ratio report

In addition, the State evaluates achievement through analysis of the quality and appropriateness of care and services delivered to members by the MCOs based on member needs and the level of contract compliance of MCOs by comprehensively monitoring MCO activities on an on-going basis. The State requires monthly, quarterly, and annual reports, including Ad Hoc reports reflective of all MCO service delivery activities. Various reports evaluate structure, process, and outcome measures.

Sanctions

CMS requirement CFR §438.340(b)(7)

Detail the appropriate use of the intermediate sanctions for MCOs.

HSD/MAD has established sanctions for the failure to meet certain contract requirements by the MCO, affiliate, parent or subcontractor, and if a party fails to comply with the contract, HSD/MAD may impose sanctions.

HSD/MAD has the option to apply Corrective Action Plans (CAPs) if HSD /MAD determines that the MCO is not in compliance with one or more requirements. HSD/MAD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a CAP or an HSD/MAD Directed Corrective Action Plan (DCAP). A notice from HSD/MAD of noncompliance that directs a CAP or DCAP may also serve as a notice of sanction in the event HSD/MAD determines that sanctions are also necessary.

HSD/MAD may impose any or all of the non-monetary sanctions and monetary penalties to the

extent authorized by federal and state law. Non-monetary intermediate sanctions may include:

- Suspension of auto-assignment of members in a MCO;
- Suspension of enrollment in the MCO;
- Notification to members of their right to terminate enrollment with the MCO without cause;
- Disenrollment of members by HSD;
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
- Rescission of Marketing consent and suspension of the MCO's marketing efforts;
- Appointment of temporary management on any portion thereof for a MCO and the MCO shall pay for any costs associated with the imposition of temporary management; and
- Additional sanctions permitted under federal or state stature or regulations that address areas of noncompliance.

The State has established monetary penalties that may include:

- Actual damages incurred by HSD and/or members resulting from the MCO's non-performance of obligations;
- Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a member in the event of the MCO's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the MCO and the rates paid to the replacement health plan. HSD may withhold payment to the MCO for damages until such damages are paid in full;
- Civil monetary penalties;
- Monetary penalties up to five percent (5%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed;
- HSD reserves the right to assess a general monetary penalty of five hundred dollars ($500) per occurrence with any notice of deficiency; and
- Other monetary penalties for failure to perform specific responsibilities or requirements.

PROGRAM ISSUES	PENALTY
Failure to comply with Claims processing as described in Section 4.19 of the contract	2% of the monthly capitation payment per month, for each month that the HSD determines that the MCO is not in compliance with the requirements of Section 4.19 of the contract

Failure to comply with Encounter submission as described in Section 4.19 of the contract	Monetary penalties up to two percent (2%) of the MCO's Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
Failure to comply with the timeframes for a Comprehensive Needs Assessment for care coordination level 2 and level 3	$1,000 per member where the MCO fails to comply with the timeframes for that member.
Failure to complete or comply with CAPs/DCAPs	.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
Failure to obtain approval of member Materials as required by Section 4.14.1 of the contract	$5,000 per day for each Calendar Day that HSD determines the MCO has provided member Material that has not been approved by HSD. The $5,000 per day damage amounts will double every ten (10) Calendar Days.
Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of the contract	$1,000 per occurrence where the MCO fails to comply with the timeframes.
For every report that meets the definition for "Failure to Report" in accordance with Section 4.21 of the contract	$5,000 per report, per occurrence With the exception of the cure period: $1,000 per report, per Calendar Day. The $1,000 per day damage amounts will double every ten (10) Calendar days.
Failure to submit timely Summary of Evidence in accordance with Section 4.16 of the contract	$1,000 per occurrence.
Failure to have legal counsel appear in accordance with Section 4.16 of the contract	$10,000 per occurrence.
Failure to meet targets for the performance measures described in Section 4.12.8 of the contract	A monetary penalty based on 2% of the total capitation paid to the MCO for the contract/ agreement year, divided by the number of performance measures specified in the contract/agreement year.

HSD can modify and assess any monetary penalty if the MCO engages in a pattern of behavior that constitutes a violation of this contract/agreement or, involves a significant risk of harm to members or to the integrity of Centennial Care. This may include, but is not limited to the following: Reporting metrics not met; failure to complete care coordination activities by the timeframes specified; failure to report on required data elements in report submissions; for a report that has been rejected by and resubmitted by the MCO up to three times and the report still meets the definition of for "Failure to Report" in accordance with Section 4.21 of the contract; etc.	Monetary penalties up to five percent (5.0%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity of the infraction, taking into consideration factors reasonably related to the nature and severity of the infraction.

Below is a total by year of HSD imposed monetary penalties:

- 2014: $3,212,744.66
- 2015: $3,271,585.54
- 2016: $0

Section III: Development, Evaluation and Revision of the Quality Strategy:

(This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.)

Development

CMS requirement CFR §438.340(c)

(This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.)

CMS requirement CFR §438.340(c)(1)

Include a description of how the state made (or plans to make) the Quality Strategy available for public comment.

CMS requirement CFR §438.340(c)(1)(i)

Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input from the Medical Advisory Committee, beneficiaries and other stakeholders in the development of the quality strategy.

CMS requirement CFR §438.340(c)(1)(ii)

Include a description of how the state obtained the input of the Native American Advisory Committee in accordance with the State's Tribal consultation policy.

HSD/MAD retains the ultimate authority, management, direction and oversight of the Quality Strategy and has organized a Quality Strategy work group within the QB that is responsible for the development, evaluation, and revision of the Quality Strategy.

The work group's focus was to develop the Quality Strategy in alignment with the goals and objectives identified by HSD/MAD to provide the right amount of care, delivered at the right time, and in the right setting to all Medicaid beneficiaries. HSD/MAD believes that by driving improvements in quality, many of the goals of Centennial Care are accomplished.

New Mexico's Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement. The Quality Strategy was designed to ensure that services provided to the States Medicaid beneficiaries meet or exceed the established standards for access to care, clinical quality of care and quality of services to achieve the delivery of high-quality and high value healthcare.

The key traits of high-quality, high value healthcare include:

- Effectiveness that concentrates on the appropriateness of care (care that is indicated, given the clinical condition of the member);
- Efficient and coordinated care over time that addresses the underlying variation in resource utilization, overuse, misuse, and duplication in the system and the associated costs. The system should be safe for all members, in all processes, in all programs, at all times;
- Member-Centered to encompass respect for members' values, preferences, and expressed needs; coordination and integration of care; information, communication and involvement of family and friends;
- Timeliness to address access issues with the underlying principle that care be provided in a timely manner;
- Equality of appropriate care that is based on an individual's needs, not on personal characteristics that are unrelated to the member's condition or to the reason for seeking care, such as gender, race, geographical location, disability, or insurance status; and
- Prevention and early detection to provide treatment early in the causal chain of disease, with resulting slower disease progression and to reduce the need for long-term care.

HSD/MAD developed the Quality Strategy with input from the Medicaid Advisory Committee (MAC), a diverse and comprehensive group of stakeholders and providers, including Native American Advisory Boards (NAAB) and the Native American Technical Advisory Committee (NATAC). The MAC serves as an advisory body to the Secretary of the Human Services

Department and the Medical Assistance Division Director on policy development and program administration for the Medicaid services provided to New Mexicans. The MAC encourages participation of health professionals, consumers and consumer groups, advocates, and public health entities concerned or involved with the NM Medicaid program. Additionally, quality review committees representing the various populations meet periodically to discuss quality of care issues and performance measure outcomes with the intention of improving health outcomes and safety.

HSD/MAD solicited input and recommendations regarding content and direction of the Quality Strategy from a variety of sources including;

- Medicaid beneficiaries
- The public
- Stakeholders
- Managed Care Organizations
- EQRO
- Behavioral Health Collaborative

The Quality Strategy was published on the New Mexico Human Services Department website for approximately 5 weeks prior to finalizing the document to allow all interested parties to provide feedback and public comment. The comments and feedback provided were considered and/or incorporated into the Quality Strategy as deemed applicable to the goals and objectives established by HSD/MAD.

Evaluation

CMS requirement CFR §438.340(c)(2)

Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).

CMS requirement CFR §438.340(c)(2)(i)

Review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.

HSD/MAD will continue to utilize a CQI model to evaluate and assess the effectiveness of the Quality Strategy. HSD/MAD will review the Quality Strategy annually to ensure alignment with reported outcomes from EQR technical reporting, MCO audited HEDIS reports, CAHPS survey, 1115 waiver evaluation design plan and CMS Special Terms and Conditions (STCs), reported findings from HSD internal audits and State required MCO reports, including QM/QI programs. The outcomes will be utilized to gauge effectiveness of the Quality Strategy and to determine if any necessary changes or updates to the Quality Strategy are warranted.

CMS requirement CFR §438.340(c)(2)(iii)

Updates to the quality strategy must take into consideration the recommendations for improving the quality of health care service furnished by the MCO including how the State can target goals

and objectives in the quality strategy to better support improvement in the quality timeliness and access to health care services furnished to Medicaid beneficiaries. Include a timeline for modifying or updating the Quality Strategy. (If this is based on an assessment of "significant changes")

CMS requirement CFR §438.340(c)(3)(ii)

Submit to CMS a copy of the revised quality strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's Medicaid Program.

CMS requirement CFR §438.340(c)(2)(ii)

The State must make the results of the review available on the Website.

HSD/MAD received approval for the Quality Strategy from CMS in May 2014. The Quality Strategy was reassessed in September 2017 and revised to address the program outcomes through calendar year 2016. New Mexico will continue to assess quality outcomes to determine the need for modifications to the Quality Strategy. Upon approval of the 1115 Demonstration Waiver renewal in 2018, HSD/MAD will revise the Quality Strategy to include additional goals, objectives, and outcome measures.

All aspects of the Quality Strategy will be assessed for effectiveness to determine areas of needed improvement. The review will include an evaluation of improvements implemented from the previous year's assessment and address any significant changes made to the Quality Strategy as a result of the assessment. The State defines significant change as changes that materially affect the actual quality of information collected or analyzed. Minor changes in timeframes, reporting dates, or format are not considered significant changes. With Centennial Care 2.0 the performance measures will focus on areas that show improved member outcome with the right care at the right time and the right place as well as the integration of physical, behavioral, and long-term services and supports. The State will submit a final draft of the Quality Strategy to (CMS) for comment and feedback.

Any updates to the Quality Strategy based on "significant changes" shall be developed, reviewed, and submitted to CMS for review and feedback and will be posted on the HSD website once approved.

Section IV: Assessment

CMS requirement CFR §438.340(b)(8)

Describe how the State will assess the performance and quality outcomes achieved by each MCO.

Quality Metrics

CMS requirement CFR §438.340(b)(3)

The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported. The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required. The performance improvement projects to be implemented. Include a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO

HSD/MAD defined specific Performance Measures (PMs) and targets, Performance Improvement Projects (PIPs), quality metrics for Tracking Measures (TMs), and performance targets to ensure access, quality, or timeliness of care for all Medicaid beneficiaries. The QB monitors, analyzes, trends and provides feedback and technical assistance to the MCOs to improve access, quality, and timeliness of care to all Medicaid beneficiaries.

HSD/MAD's QB and the contracted MCOs have formed a Quality Workgroup which meets quarterly to discuss quality outcomes and performance. The group was established to promote a collaboration of those responsible for ensuring quality of care and improved outcomes. The Workgroup provides an arena for discussion on gaps in care, interventions, barriers, and best practices. QB is also able to provide feedback on performance, direction and technical assistance in a group setting which encourages the collaborative effort. The group focuses on the key quality metrics defined by the State to assess performance and encourage positive outcomes.

HSD/MAD selects PMs and PIPS utilizing data that identifies the strengths and opportunities for improvement specific to the Medicaid population. PMs, PIPs and performance targets are reasonable and based on industry standards and consistent with CMS EQR Protocols. An annual review of PMs and PIPs is conducted by the EQRO and the final technical report with findings and recommendations are posted on the HSD website.

Performance Measures (PMs)

PMs and performance targets are based on HEDIS technical specification for the current reporting year. The MCO is required to follow relevant and current NCQA HEDIS standards for reporting. HSD/MAD requires the MCOs to meet the established performance targets. HSD/MAD considered calendar year 2014 and calendar year 2015 to be noncompetitive baseline years for PM thresholds and for setting PM targets.

The performance targets listed in the MCO contracts requires: 1) a two (2) percentage point improvement above the MCO's NCQA audited HEDIS rates; or 2) achievement of the Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass, or the State's determined target.

Failure to meet the established performance targets will result in monetary penalties as detailed in the MCO Medicaid contract.

HSD/MAD directed the MCOs to focus on eight (8) clinical initiatives to drive improved quality outcomes. The table below reflects the aggregate percentage by calendar year of the annual HEDIS results reported to HSD by the four (4) contracted MCOs.

Performance Measures	**2014**	**2015**	**2016**
PM#1 Annual Dental Visits	57.50%	61.50%	63.75%

PM#2 **Use of Appropriate Medication for People with Asthma**	51.75%	55.75%	56%
PM#3 **Controlling High Blood Pressure**	52.75%	53.5%	54.5%
PM#4 **Comprehensive Diabetes Care**			
HbA1C testing	85%	84.25%	83.5%
HbA1C >9%	47.5%	50%	47.5%
Retinal Eye Exam	56%	53%	56%
Nephropathy Screening	80.75%	87.5%	88.75%
PM#5 **Prenatal/Postpartum Visits**			
Prenatal visits within first trimester or within 42 days of enrollment	73%	70.5%	76.5%
Postpartum visit on or before 21 & 56 days after delivery	55%	50.75%	57.75%
PM#6 **Frequency of on-going prenatal care**	52%	44.75%	55.75%
PM#7 **Antidepressant Medication Management**			
Acute Phase 84 days	52%	53.75%	50.75%
Continuous Phase 180 days	43.5%	38.25%	35.5%
PM#8 **Follow up after hospitalization for Mental illness**			
7 days	65.75%	62%	64.75%
30 days	44.74%	39.25%	42.75%

Performance Improvement Projects (PIPs)

HSD/MAD directed the MCOs to implement PIPs designed to meet the unique needs of its members. The PIPs were developed to ensure sustainable improvements and interventions with a focus on quality improvement. The 2014 Centennial Care Managed Care Contract directed the MCOs to implement PIPs in the following areas: one (1) on Long-Term Care Services, one (1) on services to children, one (1) on Behavioral Health, and one (1) on women's health.

In January 2013, New Mexico was awarded the Adult Medicaid Quality Grant (AMQG) by CMS. The grant was designed to support the development of staff capacity to collect, report, and analyze data for adults enrolled in Medicaid. HSD/MAD developed Quality Improvement Projects (QIPs) in accordance with the Initial Adult Core Set Technical Specification and selected Diabetes: Prevention and Enhanced Disease Management, and Behavioral Health: Screening and Management for Clinical Depression. The AMQG ended in December of 2015, and in an effort to promote sustainability of the projects associated with the AMQG, the MCO contract was amended in 2015 directing the MCOs to incorporate the ongoing QIPs as PIPs.

The MCO contract continues to direct the MCOs to, at a minimum, implement the following PIPs:

- One (1) on Long-Term Care
- One (1) on Services to Children
- One (1) on Diabetes Prevention and Management
- One (1) on Screening and Management for Clinical Depression

Tracking Measures

HSD/MAD directed the MCOs to report on tracking measures (TMs) that focus on a specific target populations. TMs are areas for the MCOs to evaluate and make improvements, if necessary. The MCOs are required to submit quarterly reports to HSD/MAD using the QB developed reporting template which applies HEDIS, CMS Adult Core Set, or HSD defined technical specifications. The report is analyzed by the QB to identify performance trends, best practices, gaps and interventions reported by the MCOs.

Currently, these measures do not have associated sanctions. Feedback is shared and discussed with the MCOs during the quarterly quality workgroup meetings. Below is a timeline, description and measure of the TMs implemented:

Date of Direction	Tracking Measure	Description of Target Population or Topic	2014	2015	2016
March 2014	Fall Risk Management	The Percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 Months and who received fall risk intervention from their current practitioner.	12%	8%	12%
August 2015	Diabetes, Short-Term Complications Admission Rate	The number of inpatient discharges with a principal diagnosis code for diabetes short-term complications for Medicaid enrollees.			
		18 to 64 years of age	22%	17%	19%
		65 + years of age	88%	95%	60%

August 2015	Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid enrollees screened for clinical depression using a standardized depression screening tool and if positive a follow-up plan is documented on the date of the positive screen.	NR		
		18 to 64 years of age	0.02%	0.07%	0.12%
		65+ years of age	0.04%	0.24%	0.26%
May 2016	Well-Child Visits in the First 15 Months of Life	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life	NR	NR	58%
May 2016	Children and Adolescents' Access to Primary Care Practitioners (PCP)	The percentage of members 12 months – 19 years of age who had a visit with a PCP.	NR	NR	61%
October 2016	Long Acting Reversible Contraceptive (LARC)	The use of LARC among members age 15 -19 years of age.	NR	NR	3106
October 2016	Smoking Cessation	The monitoring of smoking cessations products: Cost utilization	NR	NR	$1,146,190
		The monitoring of counseling: Products and Services (Total Units) utilization			7609

Child and Adult Core Set Quality Measures

HSD/MAD reports on CMS determined Child Core Set and Adult Core Set Quality Measures through the Medicaid and CHIP Program (MACPro) systems data entry portal. The CMS defined Core Set of Quality Measures provides New Mexico with a nationally recognized set of core quality measures to track performance and identify areas needing improvement. Reporting on these performance measures will assist HSD/MAD to further enhance the quality of health care for both Children and Adults within the States Medicaid program.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HSD/MAD incorporates the CAHPS 5.0H Survey required by NCQA for accreditation as part of the required MCO annual report submissions. CAHPS 5.0H allows for inclusion of state specific questions and provides information on New Mexico's Medicaid beneficiaries and their experiences with the services provided. Below is a table with the Supplemental questions and results for 2015 and 2016.

CAHPS Supplemental Questions *CCC-Children with Chronic Conditions *N/A- Not Reported	Year	BCBS		MHC		PHP		UHC	
Child Care Coordination									
1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% answering Yes)	2015	27%	43% CCC	64%	71% CCC	52%	60% CCC	N/A	
	2016	28%	28% CCC	27%	44% CCC	14%	29% CCC	56%	51% CCC
2. In the last 6 months, who helped to coordinate your child's care?									
Someone from your child's health plan	2015	4%	8% CCC	13%	14% CCC	4%	9% CCC	N/A	
	2016	6%	6% CCC	5%	6% CCC	13%	20% CCC	5%	10% CCC
Someone from your child's doctor's office or clinic	2015	19%	22% CCC	55%	48% CCC	48%	50% CCC	N/A	
	2016	22%	22% CCC	24%	31% CCC	63%	57% CCC	29%	35% CCC
Someone from another organization	2015	1%	4% CCC	6%	10% CCC	6%	7% CCC	N/A	
	2016	3%	3% CCC	2%	4% CCC	0%	6% CCC	2%	6% CCC
A friend or family member	2015	5%	6% CCC	1%	1% CCC	3%	3% CCC	N/A	
	2016	4%	4% CCC	5%	3% CCC	9%	3% CCC	6%	3% CCC
You	2015	71%	60% CCC	25%	27% CCC	39%	31% CCC	N/A	
	2016	65%	65% CCC	64%	56% CCC	16%	14% CCC	59%	46% CCC
3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?									
Satisfied or Very Satisfied	2015	81%	74% CCC	86%	87% CCC	91%	88% CCC	N/A	
	2016	77%	77% CCC	90%	86% CCC	86%	87% CCC	84%	77% CCC
Adult Care Coordination									
4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (% answering Yes)	2015	33%		24%		27%		N/A	
	2016	38%		30%		29%		37%	
5. In the last 6 months, who helped to coordinate your care?									
Someone from your health plan	2015	9%		19%		17%		N/A	
	2016	14%		12%		34%		12%	
Someone from your doctor's office or clinic	2015	25%		48%		47%		N/A	
	2016	26%		23%		48%		21%	
Someone from another organization	2015	2%		3%		4%		N/A	
	2016	4%		1%		1%		5%	
A friend or family member	2015	14%		16%		13%		N/A	

	2016	14%	11%	8%	23%
You	2015	50%	16%	19%	N/A
	2016	43%	53%	9%	39%
6. How satisfied are you with the help you received to coordinate your care in the last 6 months?					
Satisfied or Very Satisfied	2015	80%	87%	88%	N/A
	2016	74%	81%	94%	79%
Member Education					
7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% answering Yes)	2015	58%	59%	62%	N/A
	2016	73%	57%	63%	67%
8. In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% answering Yes)	2015	50%	48%	50%	N/A
	2016	60%	54%	51%	59%
Care Plan					
9. Did your care coordinator sit down with you and create a plan of care? (% answering Yes)	2015	24%	24%	64%	N/A
	2016	28%	25%	54%	35%
10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?					
Satisfied or Very Satisfied	2015	70%	71%	N/A	N/A
	2016	70%	83%	84%	71%
Fall Risk					
11. A fall is when your body goes to the ground without being pushed. In the last 6 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? (% answering Yes)	2015	22% (12 mo.)	18%	22%	N/A
	2016	23% (12 mo.)	17%	57%	29%
12. Did you Fall in the past 6 months? (% answering Yes)	2015	19%	18%	17%	N/A
	2016	21%	15%	52%	25%
13. In the past 6 months, have you had a problem with balance or walking? (% answering Yes)	2015	27%	24%	25%	N/A
	2016	26%	20%	21%	40%
14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (% answering Yes)	2015	23%	23%	26%	N/A
	2016	26%	21%	58%	38%

External Quality Review

CMS requirement CFR §438.340(b)(4)

Detail the arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO.

HSD/MAD, in accordance with 42 CFR 438.354, has retained the services of an External Quality Review Organization (EQRO), HealthInsight New Mexico, to provide External Quality Review (EQR). The EQRO will conduct all mandatory and optional EQR reviews to assess quality

outcomes and timeliness of, and access to, the services provided to Medicaid beneficiaries and covered under each MCO.

The EQRO will follow CMS protocols that set forth the parameters that must be followed in conducting the EQR for the following activities:

- Compliance Monitoring, an annual review designed to determine the MCO compliance with State and Federal Medicaid regulations and applicable elements of the contract between the MCO and State. As an extension of Compliance Monitoring, the EQRO has conducted numerous educational sessions for the MCOs regarding Transition of Care 2015 and 2016 requirements;
- Validation of PMs, an annual review designed to evaluate the accuracy of the State defined performance measures reported by the MCOs;
- Validation of PIPs, an annual review designed to verify the projects developed by the MCO were designed, conducted and reported in a methodically sound manner and address the target population defined by the State;
- Validation of Encounter Data, a review conducted every three (3) years as an independent validation to measure the consistency between submitted encounter data and corresponding health record entries;
- Independent Assessment, a review conducted every three (3) years to assess the State's activities and efforts to monitor the MCOs' access to services, quality of services and cost effectiveness; and
- Audit of the MCO NFLOC determinations every quarter. HSD monitors the EQRO audit of MCO NFLOC determinations and addresses trends identified.

The MCOs are required to cooperate fully with the EQRO and demonstrate compliance with New Mexico's managed care regulations and quality standards as set forth in federal regulation and State policy.

The EQRO reports findings and recommendations to the State.

CMS requirement CFR §438.340(b)(10)

Describe how the state will ensure non-duplication of EQR **activities.**

To ensure non-duplication of EQR activities, HSD/MAD has a designated Contract Administrator authorized to represent HSD/MAD in all matters related to EQR. The Contract Administrator utilizes tracking sheets to monitor scope of work activities with relevant contractors within the division.

HSD conducts internal quality review activities such as:

- NF LOC audits by the HSD/MAD Nurse Auditor for review of service plan reduction determinations by the MCOs;

- NF LOC audits by the HSD/MAD Nurse Auditor for review of high NF LOC and low NF LOC denials on a quarterly basis to ensure the denials are appropriate and based on NF LOC criteria;
- Service Plan audits by the HSD/MAD Nurse Contractor to review service plans ensuring that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and the member's goals are identified in the care plan;
- Care coordination audits evaluating and monitoring MCO care coordination activities. HSD/MAD monitors monthly progress reports from the MCOs outlining the MCOs' efforts to improve care coordination practices according to HSD/MAD's findings that required follow-up to recommendations and action steps;
- "Ride-alongs" by HSD/MAD staff were conducted with MCO care coordinators in 2015, 2016 and 2017 to observe member visits in the home setting. HSD/MAD ride-along experiences with the MCOs identified the need to continue care coordination trainings for member assessments and available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. The ride-alongs focus on application by care coordinators of the Community Benefit Services Questionnaire (CBSQ), a tool developed collaboratively by HSD/MAD and the MCOs to educate members about available home and community based services. HSD/MAD observes the care coordinator's use of the Community Benefit Member Agreement (CBMA), to document if the member agrees to accept or decline available services;
- Monitoring MCO continued expansion of the PCMH model by engaging PCMH providers to conduct care coordination activities for their attributed members through value based purchasing (VBP) arrangements. Centennial Care 2.0 seeks to expand of this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model). Monitoring activities shall occur through MCO reporting to HSD and verification of VBP initiatives.
- Delivery System Improvement Performance Targets (DSIPTs) allow MCOs to be recognized for their quality improvements in specific areas. In 2014 and 2015, HSD required four target areas for DSIPTs. In 2016, HSD expanded target areas by adding emphasis on five specific areas. Below is a description of DSIPTs target areas by year:

Delivery System Improvement Targets		
2014	**2015**	**2016**
HIE/HIT Increase the use of electronic health records by Contract Providers and increase the number of Contract Providers who participate in the exchange of electronic health information.	**Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in Urban regions of the State.	**Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in Urban regions of the State.
Telehealth A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telehealth** A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telemedicine** A minimum of a 15% increase in telemedicine "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**
PCMH A minimum of a 5% of members served by PCMHs.	**PCMH** A minimum of a 5% increase in members served by PCMHs.	**PCMH** A minimum of a 5% increase of members being served by PCMHs, maintaining a minimum of 40% of membership being served by PCHMs.
ER Diversion A minimum of a 10% reduction of non-emergent use of the ER.	**ER Diversion** A minimum of a 10% reduction in the per capita use of emergency room.	**Behavioral Health** Percent of 7-day follow-up visits into community-based BH care for child and adult members released from inpatient psychiatric hospitalizations stays of 4 or more days.
		Hepatitis C Treat at least 50% of Hepatitis C drug treatments included in the capitated rate during the contract period.

Centennial Care Summary

Accomplishments for Centennial Care, now in its fourth year of operation, include the following:

- Streamlined program administration by consolidating a myriad of federal waivers that segregate the care of populations. Four MCOs administer the full array of services in an integrated model of care, serving approximately 700,000 Medicaid members;
- Built a care coordination infrastructure that promotes a person-centered approach to care. More than 900 care coordinators ensure members receive services when they need them;
- Increased access to long-term services and supports (LTSS) for people who previously needed a waiver allocation to receive such services. More than 29,750 individuals are

receiving home- and community-based services (HCBS) which represents an increase of 11.4% per year between 2014 and 2016;

- Continue to be a leader in the nation in spending more of its LTSS dollars to maintain the number of members receiving services in their homes and in community settings rather than in institutional settings;
- Advanced payment reforms in partnership with the MCOs and, in 2017, requiring VBP arrangements for at least 16% of all medical payments to providers; and
- Demonstrated improved utilization of health care services and cost-effectiveness of the program despite significant enrollment growth. Total enrollment in the Medicaid program has grown 8.5% per year since 2014 while per capita costs have decreased by 1.5% between 2014 and 2016.

NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

Summary of

External Quality Review Organization

Reports

October 2017

This report is a summarization by HSD of External Quality Review (EQRO) reports. The New Mexico Human Services Department (HSD) created this summary based upon reports supplied by HealthInsight New Mexico, the contracted EQRO for New Mexico.

HSD staff involved in the development of this document included:

- Megan Pfeffer, RN, Quality Bureau Chief
- Kathy Leyba, BSBA, Quality Bureau Staff Manager
- Marvin Martinez, RN, Quality Bureau Nurse Manager
- Reina Guillen, Quality Bureau Staff Manager

The reports upon which this summarization was created were prepared by HealthInsight New Mexico Staff under the internal direction of:

- Margy Wienbar, MS, Executive Director
- Herb Koffler, MD, MS, FAAP, External Quality Review Medical Director
- John Seibel, MD, HealthInsight New Mexico Medical Director
- Margaret White, RN, MSHA, BSN, EQRO Director
- Allen Buice, MA, CHPQ, PMP, EQRP Project Manager

Other EQRO staff members who provided information included with this summary:

- Debi Peterman, MSN, RN, Project Manager
- Angela Baca, Project Coordinator
- Alison Fredericksen, Project Coordinator
- Andrea (Andy) Romero, RHIT, CCS, CPC, Project Manager

HealthInsight New Mexico staff who provided additional support:

- Bob Walsh, Senior Database Analyst
- Marie Sorce, BFA, Senior Communications Specialist

Table of Contents

How to Use This Report

This report, provided by HSD, contains summarization of the external quality reviews (EQRs) of Centennial Care managed care organizations (MCOs) in New Mexico. To get a complete, detailed understanding of the projects, refer to the original, published reports available on the HSD website. As a summary, the precise wording may vary from the original report.

The reports covered in this summary include:

1. Compliance reports Calendar Year (CY) 2014 and CY 2015
2. Performance Measurements and Performance Improvement Projects for CY 2014 and CY 2015
3. Initial Encounter Reconciliation Report dated April 7, 2017 for the Encounter Data Validation (EDV) Project CY 2014
4. Independent Assessment (IA) performed for CY 2014

The summary includes scores and recommendations. Recommendations indicate the actionable items for the organizations under review.

The MCOs reviewed for all of these projects are the four MCOs contracted for provision of Medicaid Managed Care services under Centennial Care and are:

- Blue Cross and Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico (MHP)
- Presbyterian Health Plan, Inc. (PHP)
- United Healthcare of New Mexico, Inc. (UHC)

For reference, a glossary is provided at the end of this report that defines acronyms and other terms specific to these reviews.

1.0 Compliance Report CY 2014 and 2015

1.1. Compliance Report Comparison Executive Summary

During the annual compliance review projects, the MCOs were assessed for compliance with federal and state regulations. This report covers data gathered during CY 2014 and CY 2015, which were the first two years of Centennial Care.

Both assessments were conducted according to EQR Protocol 1, published by Centers for Medicare & Medicaid Services (CMS), and included an evaluation of each MCOs' policies, procedures and other documentation; and an examination of medical records and case files. The Human Services Department (HSD) determined the topics for assessment and approved the assessment methodology. The original, approved versions of this report are available on the HSD website at http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

Table 1 shows the overall results for each MCO included in this review.

Table 1: Overall Compliance Scores by MCO				
MCO	CY 2014 Scores	CY 2015 Scores	Percentage Point Change from 2014 to 2015	Compliance Levels
BCBS	97.80%	92.15%	-5.65	Full
MHP	98.89%	96.96%	-1.93	Full
PHP	96.91%	95.46%[1]	-1.45	Full
UHC	95.55%	94.47%	-1.08	Full
Compliance Levels By Defined Score Range				
Full Compliance: 90% - 100%	Moderate Compliance: 80% - 89%	Minimal Compliance: 50% - 79%	Non-Compliance: <50%	

While MCOs do fall below the threshold for full compliance for individual sections, the EQRO has not identified a MCO that fell below the threshold for overall compliance. The scores above reflect the final scores after all zero scores and timeliness/accuracy penalties have been deducted.

[1] This score was revised due to a rounding function used by the Excel spreadsheet to generate the score and the change in the Care Coordination score. The previous score was 95.89 percent.

1.2. Compliance Scores

Table 2 shows the scores by review subject for each MCO and compares the scores between CY 2014 and CY 2015. These scores are based on weighted averages. For more information on the details of the weighting structure, refer to the full State Fiscal Year (SFY) 15 or SFY 16 Compliance Reports posted to the HSD website at http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

Table 2: MCO Score by Subject Annual Comparison

Review Subject	CY 2014 BCBS Scores	CY 2015 BCBS Scores	CY 2014 MHP Scores	CY 2015 MHP Scores	CY 2014 PHP Scores	CY 2015 PHP Scores	CY 2014 UHC Scores	CY 2015 UHC Scores
Enrollment/Disenrollment	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%
Member Handbook	100.00%	N/A	100.00%	N/A	100.00%	N/A	100.00%	N/A
Member Materials	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Member Services	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Program Integrity	95.80%	95.00%	94.40%	98.40%	100.00%	100.00%	98.60%	95.00%
Provider Network	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Provider Services	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Reporting Requirements	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Self-Directed Community Benefit	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Care Coordination	87.40%	73.10%	96.70%	93.10%	99.00%	80.76%[2]	96.00%	89.70%
Transition of Care	100.00%	62.20%	100.00%	90.80%	100.00%	81.50%	100.00%	84.70%
Grievances and Appeals	99.30%	99.50%	99.60%	99.60%	99.30%	99.60%	99.46%	97.60%
Medical Records	96.78%	97.00%	95.78%	96.56%	96.22%	97.44%	92.00%	96.89%
Primary Care Provider (PCP) and Pharmacy Lock-ins	100.00%	100.00%	100.00%	100.00%	78.75%	94.44%	62.60%	100.00%
Adverse Determinations (Denials)	99.67%	91.00%	97.67%	100.00%	96.00%	100.00%	100.00%	100.00%
Approvals	91.00%	N/A	100.00%	N/A	78.72%	N/A	100.00%	N/A
Scores	97.80%	92.15%	98.89%	96.96%	96.91%	95.46%	95.55%	94.47%

The Member Handbook subject was merged into the Member Materials section for the CY 2015 review, therefore the score for Member Handbook for CY 2015 is reported as "N/A." In the CY 2014 review for Transitions of Care, HSD elected to remove the file review portion from the scores due to the need for

[2] This score was revised based on the clarification responses. The previous score was 77.78 percent.

clarifying language from HSD in the Managed Care Policy Manual. The file review scores were included for the CY 2015 review, therefore accounting for the noticeable drop in scores. The subject 'approvals' was removed for the CY 2015 report so that the EQRO could look more closely at adverse determinations (denials).

1.3. Compliance Recommendations

The section below details MCO specific recommendations in each category of review for the CY 2014 and CY 2015 compliance reports. The CY 2014 recommendations are given first and the CY 2015 recommendations immediately follow for each MCO. Recommendations listed in CY 2014 that are not repeated in CY 2015 indicates the MCO addressed the recommendation from the previous year's review. Recommendations listed in CY 2015 that were not specified in CY 2014 indicates a new finding upon subsequent review. Such a change does not imply a change in requirements, only that the review identified something that had not been previously identified. Parenthetical to the subject names listed below is the Citation of Authority from which that subject is drawn. The Citation of Authority is the official source from which the EQRO developed the list of questions reviewers asked the MCOs. The Citation of Authority is generally one of four items:

1. The contract between the MCOs and HSD
2. The HSD Managed Care Policy Manual
3. The federal language found in the Code of Federal Regulations (CFR)
4. New Mexico Administrative Code (NMAC)

Blue Cross and Blue Shield of New Mexico

BCBS Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that BCBS:

- Update its policies and procedures to establish a 60-day timeframe for self-reporting of overpayments, as required by NMAC 8.308.22.9.
- Update its policies and procedures to include how often the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System will be checked for providers that are excluded from participation in the Medicaid program.
- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.

In CY 2015, the EQRO recommended that BCBS:

- Amend its policies and procedures to include checking all the listed databases upon enrollment and re-enrollment for contracted providers and those with an ownership or controlling interest or who are an agent or managing employee. Enrollment for atypical providers appears to be addressed but not reenrollment for the other persons. Additionally, the MCO should amend its policies and procedures to indicate that the Office of the Inspector General's List of Excluded Individuals (LEI) and Excluded Parties List System (EPLS) are checked monthly for all applicable persons, not just atypical providers.
- Conduct a review to identify contract providers and any person with an ownership and controlling interest or who is an agent or managing employee, as identified by the provider enrollment documents, to ensure that all applicable persons have been checked.

BCBS Care Coordination (MCO/HSD Contract Section 4.4)

For CY 2014, the EQRO recommended that BCBS:

- Continue to assess and improve its care coordination processes to meet all federal and state requirements.

- Develop a method of retaining data from employee laptops when the employee leaves the organization so that documentation of care coordination efforts can be efficiently maintained.

For CY 2015, the EQRO recommended that BCBS:

- Complete all health risk assessments (HRAs) and comprehensive needs assessment (CNAs) within required timeframes and document their completion.
- Provide member notifications within required timeframes and document that activity.
- Conduct a root cause analysis to determine why such a high percentage (46.67 percent) of sampled members refused care coordination.

BCBS Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that BCBS:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual, Section 5, Transitions of Care.

In CY 2015, the EQRO recommended that BCBS:

- Create, document, and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from nursing facilities to community settings.
- Update policies to reflect the need to develop and implement specific, individual transition plans.

BCBS Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that BCBS:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that BCBS:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

BCBS Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2015, the EQRO recommended that BCBS:

- Adopt the practice of having medical directors write a “plain language” summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.

BCBS Information Systems Capability Assessment (ISCA) (CMS EQR Protocol 5)

In CY 2015, the EQRO recommended that BCBS:

- Formally document its process for handling erroneous or rejected claims.
- Develop and implement a method for calculating defect rates within its systems.

Molina Healthcare of New Mexico

MHP Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that MHP:

- Update its policies and procedures to include regular checks of the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System for providers who are excluded from participation in the Medicaid program.
- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.
- Require primary business addresses and post office boxes on the Disclosure of Ownership and Control Interest form for providers and fiscal agents.
- Update its policies and procedures to specify that the documentation of any significant business transactions between the provider and any subcontractor must cover the most recent five years.

In CY 2015, the EQRO recommended that MHP:

- Add the requisite language from 42 CFR 422.13 regarding not infringing on the legal rights of persons involved and affording due process of law in the course of conducting an investigation.

MHP Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that MHP:

- Document the timing of the HRAs and CNAs clearly and consistently and monitor them for completion.
- Determine the best method for recording that the member and/or the member's representative participated in care plan development.

MHP Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that MHP:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual, Section 5, Transitions of Care.

In CY 2015, the EQRO recommended that MHP:

- Institute corrective action to create, document, and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from nursing facilities to home.

MHP Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that MHP:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that MHP:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

MHP Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2015, the EQRO recommended that MHP:

- Adopt the practice of having medical directors write a "plain language" summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.

Presbyterian Health Plan, Inc.

PHP Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that PHP:

- Document the timing of the HRAs and CNAs clearly and consistently and monitor them for completion.
- Add text to the phone script or other HRA-related member education material provided at the time of the HRA that informs the member that she or he has the right to request a higher level of care coordination. Additionally, appropriately document that this notification has occurred.
- Update relevant policies and procedures to include a statement clearly defining how PHP will communicate to the member the care coordination unit contact Information and when to expect contact regarding scheduling a CNA.

PHP Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that PHP:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual, Section 5, Transitions of Care.

In CY 2015, the EQRO recommended that PHP:

- Create, document, and implement specific, individual Transition Plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from nursing facilities to community settings.

PHP Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that PHP:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that PHP:

- Direct providers to develop and implement a process that can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

PHP Approvals (MCO/HSD Contract Section 4.12.10)

In CY 2014, the EQRO recommended that PHP:

- Develop and implement a method of documenting the approved criteria (e.g. Milliman) and the clinical information used to approve provider requests (from providers outside of the PHS provider partners system) in each member's file beyond what is stated in the Member Handbook.

- Improve internal processes to meet the timeliness requirements for making the prior authorization determination and communicating that information to the member and the requesting provider consistently.

PHP Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2014, the EQRO recommended that PHP:

- Document that PHP informed the requester of the qualifications of the staff member at the health plan who made the determination and advised the requester that the staff member is available by phone for consultation.
- Develop and implement a method of documenting the criteria used to make the determination, including a citation of the regulation used beyond what is stated in the Member Handbook.

In CY 2015, the EQRO recommended that PHP:

- Adopt the practice of having medical directors write a "plain language" summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.
- Have medical directors review administrative adverse determinations (denials) as required by the contract. If this is being conducted already, discuss ways to provide documentation of this activity for review.

PHP PCP and Pharmacy Lock-Ins (MCO/HSD Contract Section 4.22.2-3)

In CY 2014, the EQRO recommended that PHP:

- Establish and maintain contact with all members who have a Pharmacy Lock-In in place. Members also need to be educated as to what behavior is necessary for release from the lock-in.

United Healthcare of New Mexico, Inc.

UHC Enrollment/Disenrollment (MCO/HSD Contract Section 4.2-4.3)

In CY 2015, the EQRO recommended that UHC:

- Update the related policies to include contract required language:

  > *The [MCO] shall not request disenrollment because of a change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members. (HSD/MCO Contract 4.3.1)*

UHC Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that UHC:

- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.

In CY 2015, the EQRO recommended that UHC:

- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.

UHC Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that UHC:

- Update its policies and procedures for care coordination to reflect how the member will be informed of the timeframe expectations for the CNA completion.

UHC Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that UHC:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual Section 5 Transitions of Care.

In CY 2015, the EQRO recommended that UHC:

- Develop and implement a consistent way of documenting Transition Plans for members that is retained in one place to facilitate care coordinator management of the transition process and follow-up.

UHC Grievances and Appeals (MCO/HSD Contract Section 4.16)

In CY 2015, for member appeals, the EQRO recommended that UHC:

- Provide a process whereby members can present evidence in support of their appeal in person.

In CY 2015, for provider appeals, the EQRO recommended that UHC:

- Provide a letter to the provider of the findings and conclusions in every provider appeal, whether or not it is resolved in the provider's favor.

UHC Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that UHC:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that UHC:

- Direct providers to develop and implement a process that can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

UHC PCP and Pharmacy Lock-In (MCO/HSD Contract Section 4.22.2-3)

In CY 2014, the EQRO recommended that UHC:

- Implement policies and procedures to identify, monitor and communicate with members requiring a PCP or Pharmacy Lock-In.

UHC Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2015, the EQRO recommended that UHC:

- Work with its dental vendors to update the dental service denial letters to more closely mirror those issued by UHC.
- Adopt the practice of having medical directors write a "plain language" summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required in the denial.

UHC ISCA (CMS EQRO Protocol 5)

In CY 2015, an ISCA was conducted and the EQRO recommended that UHC:

- Include the timeliness requirements in its policy regarding adjudication of pended claims.
- Develop a policy or procedure that describes how claims are tracked when they are sent for manual review and that they are processed timely.

- Develop and provide evidence of its processes for oversight and auditing of vendors that submit data used to report performance measures.
- Add material to its training program for federal and state reporting that addresses how coding affects the data management process.

1.4. HSD Monitoring Activities

- HSD evaluated MCO care coordination records to identify and address any areas of concern during the first six months of Centennial Care in July 2014. The universal finding was the need for additional care coordination training to meet contractual obligations. HSD attended all of the care coordination trainings performed by the MCOs and determined accuracy of trainings.
- In December 2014, HSD reviewed the MCO care coordination records to evaluate the efficacy of the MCOs' additional care coordination training. The evaluation identified specific areas for each MCO to address and improve care coordination activities. MCOs were directed to respond to action plans developed by HSD to address the findings. HSD reviewed the interventions and activities performed by the MCOs and provided feedback and/or technical assistance as necessary. The action plans were closed upon completion of activities.
- In November 2015, HSD reviewed the MCO care coordination records from CY 2015 to evaluate the second year of care coordination in Centennial Care. HSD again developed action plans for care coordination documentation and other care coordination activities in need of improvement.
- HSD developed care coordination training specific to documentation requirements and conducted a training for all of the MCOs in June 2016.
- Throughout 2016 and 2017, MCOs continued to provide interventions and actions to improve care coordination activities in their action plans. The MCOs performed internal auditing of their action items and provided qualitative and quantitative data for HSD's review on a quarterly basis.
- HSD continued to meet with MCOs and provide feedback to action plans. In October 2017, HSD began the process to close MCO action plans that had shown positive internal audit results. HSD will perform audits on the MCO care coordination records to ensure the closed action plans continue to show improved care coordination activities.
- HSD monitors care coordination contractual obligations through monthly MCO reporting of care coordination activities, including assessments performed and required member visits.
- In August 2015, HSD researched the top 10 members at each MCO with high emergency room (ER) utilization and met with the MCOs' key care coordination personnel to establish a framework for increasing care coordination efforts with the identified top 10 high ER utilizers. The MCOs reported monthly on their activities with the high ER utilizers, showing their progress with member engagement and reduction in ER utilization.
- In April 2016, HSD added 25 more members with high ER utilization. The MCOs continue to report on proven interventions to provide adequate care coordination with their top 35 high ER utilizers.
- Beginning in 2016, HSD conducted ride-alongs with the care coordinators to monitor accurate and consistent implementation of the CNA. Recommendations were provided to each MCO.
- HSD conducts a qualitative and quantitative analysis of the MCOs' Grievances and Appeals report submitted monthly by the MCOs to observe for trends and the need for corrective action.

2.0 Performance Measurement Program/Performance Improvement Projects CY 2014 and CY 2015

2.1. Performance Measurement Program (PMP) and Performance Improvement Projects (PIPs) Executive Summary

During the annual PMP and PIP review projects, the MCOs were assessed for compliance with federal and state regulations. This report contains data gathered during CY 2014and CY 2015, which were the first and second years of Centennial Care.

Both assessments were conducted according to CMS EQR Protocols 2 and 3; included an evaluation of each MCO's policies, procedures and other documentation; and included an examination of medical records and case files. HSD determined the topics for assessment and approved the assessment methodology. The original, approved versions of these reports are available on the HSD website.

The EQRO rated each MCOs' quality improvement program as fully compliant with Centennial Care contractual and regulatory requirements. The EQRO validated the accuracy and reliability of the PMs and PIPs reported to HSD by each MCO.

In CY 2014, HSD directed the MCOs to submit four (4) PIPs: one (1) on Long-Term Care Services; one (1) on services to children; one (1) on Behavioral Health; and one (1) on Women's Health.

For CY 2014 and CY 2015 HSD directed the EQRO review and score the MCO submitted PIPs for Long-Term Services and Supports (LTSS) and Services to Children.

For the purposes of reporting, PIP #1 is the Services to Children measure and PIP #2 is the LTSS measure. Since the MCOs can select their own PIPs, submissions varied by MCO; therefore, the scores for CY 2014 may differ than those for CY 2015. For example, in CY 2014, MHP submitted a PIP for dental health for children, whereas in CY 2015, MHP submitted a PIP for diabetes prevention in youth. For this reason, the scores are reported separately.

Table 3 shows the overall PMP and PIP results for each MCO for CY 2014.

Table 3: PMP and PIPs Scores and Compliance Levels for CY 2014						
MCO	PMP Score	PMP Compliance	PIP #1 Score	PIP #1 Compliance	PIP #2 Score	PIP # 2 Compliance
BCBS	100.00%	Full	100.00%	Full	100.00%	Full
MHP	100.00%	Full	100.00%	Full	100.00%	Full
PHP	100.00%	Full	100.00%	Full	100.00%	Full
UHC	100.00%	Full	100.00%	Full	96.84%	Full
Compliance Levels By Defined Score Range						
Full Compliance: Score 90% - 100%		Moderate Compliance: 80% - 89%		Minimal Compliance: 50% - 79%		Non-compliance: <50%

Table 4 shows the scores for the PMP and PIP review for CY 2015.

Table 4: PMP and PIPs Scores and Compliance Levels for CY 2015						
MCO	PMP Score	PMP Compliance	PIP# 1 Score	PIP #1 Compliance	PIP #2 Score	PIP #2 Compliance
BCBS	100.00%	Full	100.00%	Full	100.00%	Full
MHP	100.00%	Full	61.25%	Minimal	100.00%	Full
PHP	100.00%	Full	100.00%	Full	100.00%	Full
UHC	100.00%	Full	100.00%	Full	100.00%	Full
Compliance Levels By Defined Score Range						
Full Compliance: 90% - 100%		Moderate Compliance: 80% - 89%		Minimal Compliance: 50% - 79%		Non-compliance: <50%

PM Rates

Table 5 lists BCBS's Healthcare Effectiveness Data and Information Set (HEDIS®[3]) certified PM rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A PM rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best PM rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 5: BCBS PM Rates and Historical Comparisons

BCBS PMs	CY 2014 PM Rate	CY 2015 PM Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	57.46%	59.63%	2.17	60.65%	-1.02
Medication management for people with asthma[4]					
Medication compliance 50%	N/A	51.09%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	51.66%	56.99%	5.33	43.53%	+13.46
Comprehensive diabetes care					
Eye Exam	54.23%	47.76%	-6.47	44.99%	+2.77
HbA1c Testing	83.42%	80.43%	-2.99	83.25%	-2.82
Nephropathy	78.61%	85.07%	6.46	90.26%	-5.19
Poor HbA1c Control *(lower is better)	47.26%	52.90%	5.64	59.90%	-7.00*
Prenatal and postpartum care					
Prenatal care (timeliness)	73.08%	72.61%	-0.47	81.64%	-9.03
Postpartum visit (frequency)	54.52%	57.91%	3.39	59.84%	-1.93
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	55.20%	50.56%	-4.64	60.65%	-10.09
Antidepressant medication management					
Acute treatment	59.97%	54.80%	-5.17	54.58%	+0.22
Continuation treatment	47.77%	39.40%	-8.37	39.58%	-0.18
Follow-up After Hospitalization for Mental Illness					
7-days after discharge	39.00%	34.27%	-4.73	40.79%	-6.52

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

30-days after discharge	58.49%	55.10%	-3.39	61.46%	-6.36

Table 6 lists MHP's HEDIS certified performance measurement rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A performance measurement rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best performance measurement rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 6: MHP PM Rates and Historical Comparisons

MHP PMs	CY 2014 PM Rate	CY 2015 PM Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	62.75%	70.07%	7.32	60.65%	+9.42
Medication management for people with asthma[5]					
Medication compliance 50%	N/A	49.38%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	49.88%	51.38%	1.50	43.53%	+7.85
Comprehensive diabetes care					
Eye exam	56.51%	54.53%	-1.98	44.99%	+9.54
HbA1c testing	85.65%	88.08%	2.43	83.25%	+4.83
Nephropathy	74.83%	88.08%	13.25	90.26%	-2.18
Poor HbA1c control *(lower is better)	49.89%	45.03%	-4.86	59.9%	-14.87*
Prenatal and postpartum care					
Prenatal care (timeliness)	76.80%	75.97%	-0.83	81.64%	-5.67
Postpartum visit (frequency)	54.50%	51.49%	-3.01	59.84%	-8.35
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	61.04%	55.38%	-5.66	60.65%	-5.27
Antidepressant medication management					
Acute treatment	53.50%	49.55%	-3.95	54.58%	-5.03
Continuation treatment	38.63%	34.67%	-3.96	39.58%	-4.91
Follow-up after hospitalization for mental illness					
7-days after discharge	41.80%	34.64%	-7.16	40.79%	-6.15

[5] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

30-days after discharge	64.80%	59.76%	-5.04	61.46%	-1.70

Table 7 lists PHP's HEDIS certified performance measurement rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A performance measurement rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best performance measurement rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 7: PHP PM Rates and Historical Comparison

PHP PMs	CY 2014 Performance Measurement Rate	CY 2015 Performance Measurement Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	68.14%	66.43%	-1.71	60.65%	+5.78
Medication management for people with asthma[6]					
Medication Compliance 50%	N/A	54.57%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	55.95%	56.42%	0.47	43.53%	+12.89
Comprehensive diabetes care					
Eye exam	47.75%	46.07%	-1.68	44.99%	+1.08
HbA1c testing	86.52%	84.64%	-1.88	83.25%	+1.39
Nephropathy	79.53%	86.91%	7.38	90.26%	-3.35
Poor HbA1c control *(lower is better)	43.93%	48.34%	4.41	59.9%	-11.56*
Prenatal and postpartum care					
Prenatal care (timeliness)	77.88%	66.36%	-11.52	81.64%	-15.28
Postpartum visit (frequency)	61.88%	53.13%	-8.75	59.84%	-6.71
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	48.71%	42.92%	-5.79	60.65%	-17.73
Antidepressant medication management					
Acute treatment	53.94%	53.36%	-0.58	54.58%	-1.22
Continuation treatment	38.97%	36.24%	-2.73	39.58%	-3.34
Follow-up after hospitalization for mental illness					

[6] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

7-days after discharge	43.14%	32.56%	-10.58	40.79%	-8.23
30-days after discharge	67.88%	59.75%	-8.13	61.46%	-1.71

Table 8 lists UHC's HEDIS certified performance measurement rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A performance measurement rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best performance measurement rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 8: UHC PM Rates and Historical Comparisons					
UHC PMs	CY 2014 Performance Measurement Rate	CY 2015 Performance Measurement Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	41.52%	49.88%	8.36	60.65%	-10.77
Medication Management for people with asthma[7]					
Medication compliance 50%	N/A	56.28%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	53.04%	49.88%	-3.16	43.53%	+6.35
Comprehensive diabetes care					
Eye exam	65.21%	62.53%	-2.68	44.99%	+17.54
HbA1c testing	84.43%	84.43%	0.00	83.25%	+1.18
Nephropathy	83.70%	90.27%	6.57	90.26%	+0.01
Poor HbA1c control *(lower is better)	49.15%	52.55%	3.40	59.90%	-7.35*
Prenatal and postpartum care					
Prenatal care (timeliness)	63.75%	67.40%	3.65	81.64%	-14.24
Postpartum visit (frequency)	48.18%	41.36%	-6.82	59.84%	-18.48
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	42.58%	34.06%	-8.52	60.65%	-26.59
Antidepressant medication management					
Acute treatment	62.50%	56.62%	-5.88	54.58%	+2.04
Continuation treatment	48.34%	42.89%	-5.45	39.58%	+3.31

[7] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

Follow-up after hospitalization for mental illness					
7-days after discharge	55.16%	54.96%	-0.2	40.79%	+14.17
30-days after discharge	71.00%	73.08%	2.08	61.46%	+11.62

2.2. PMP and PIP Recommendations

Blue Cross and Blue Shield of New Mexico

BCBS PMP Recommendations

In CY 2015, for the PMP, the EQRO recommended that BCBS:

- Implement alternative methods and/or new settings to increase the rates of follow-up for member who are hospitalized for mental illness.

BCBS PIP Recommendations

In CY 2015, for the PIPs, the EQRO recommended that BCBS:

- Implement alternative methods and/or new settings to increase the number of diabetic members in the LTC program who receive screening for retinopathy.

Molina Healthcare of New Mexico

MHP PIP Recommendations

In CY 2015, for PIP #1, the EQRO recommended that MHP:

- Submit evidence that MHP has researched and analyzed its unique population for the following characteristics: 1) the incidence and/or prevalence of the need or issue; 2) the impact to the enrollee target population; 3) the estimate of enrollees eligible for the PIP; and 4) if the study topic reflects high volume or high-risk enrollees.
- Explain why the study topic was prioritized, including consideration given to the high risk of the population and the feasibility of performing the PIP.
- Show how the study topic has the potential to affect enrollee health, functional status or satisfaction significantly.
- Provide supporting documentation of the rationale behind its choice of this PIP, the location for the population and how the PIP could reasonably be expected to improve the processes and outcomes of health care provided by MHP.
- Submit a clear definition of enrollee characteristics that were used to determine that the interventions chosen were appropriate for the population to be studied.
- Identify and describe the sampling methodology prior to implementing the PIP.
- Report the inclusion criteria and the exclusion criteria for the study population along with associated definitions, data sources, calculation methodology and codes.
- Develop a robust plan for collecting and analyzing data in order to answer the study question(s).
- Identify any threats to the internal or external validity of the study results. Plan to measure again after the baseline period has ended and after the intervention has taken place. Additionally, MHP needs to consider and report factors that might compromise internal and/or external validity (e.g., project's history, maturation, sample size, effects of selection bias, statistical regression, study group composition, matriculation, and other educational experiences).
- Provide supporting documentation of the rationale behind its choice of the PIP and the location for the population and how the PIP could reasonably be expected to improve the indicator.

In CY 2015, for PIP #2, the EQRO recommended that MHP:

- Include a fall risk assessment on the CNA for those transferring from nursing facilities to home.

- Complete the fall risk assessment for its long-term services PIP for 100 percent of members who are identified as having a high risk for falls.
- Implement at least one intervention to be undertaken with all members identified as having a high risk for falls.

Presbyterian Health Plan, Inc.

PHP PIP Recommendations

In CY 2015, for PIP #1, the EQRO recommended that PHP:

- Analyze available data further to see how many of the 476 scheduled appointments for annual dental visits were actually completed.

United Healthcare of New Mexico, Inc.

UHC PIP Recommendations

In CY 2015 for PIP #2, the EQRO recommended that UHC:

- Rephrase the study question to be more precisely defined so that it can be more accurately measured according to CMS EQR Protocol requirements.

2.3 HSD PM and PIP Initiatives for CY 2016

HSD considered CY 2014 and CY 2015 to be noncompetitive baseline years for PM thresholds and for setting PM targets. For CY 2016, HSD established performance measure targets, which required; 1) a two percentage (2%) point improvement above the MCOs' NCQA audited HEDIS rates; or 2) achievement of the Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass, or HSD's determined target.

HSD formed a Quality Workgroup, which meets quarterly to discuss issues related to Quality Assurance. The Workgroup promotes a collaboration between the MCOs and HSD to evaluate quality of care and improve outcomes. During these meetings, HSD provides feedback on Performance outcomes; direction on contractual requirements related to PMs, tracking measures (TMs) and PIPs; and technical assistance to support the MCOs' understanding of HSD's expectations and achievement of improved performance outcomes.

3.0 Encounter Data Validation

3.1. Encounter Data Validation Executive Summary

The New Mexico Human Services Department contracted with HealthInsight New Mexico as the EQRO for this project. Myers and Stauffer, LC (Myers and Stauffer) is subcontracted and under the direction of HealthInsight New Mexico for the encounter data validation (EDV) project. This project covers the review period of January 1, 2014 through April 30, 2016.

HSD requires that each MCO submit encounter data to HSD's fiscal agent (FA), Conduent, Inc., known as Xerox Health Solutions prior to January 2017. As part of the EQR Protocol 4 process, Myers and Stauffer analyzed Medicaid encounter data for CY 2014 that had been submitted by the MCOs to the FA, Conduent, Inc., and completed a comparison of the encounters to the accounting system data (ASD) provided by each MCO.

Validated encounter data have many uses in rate setting analyses by actuaries, as well as fulfilling the federal reporting requirements related to the Medicaid Managed Care Final Rule, in providing program management and oversight and other ad hoc analyses.

This encounter reconciliation will help fulfill part of the work requirements set forth in Activity Number 3 of the CMS EQR Protocol 4, which requires a determination of the completeness, accuracy and quality of the encounter data submitted by each MCO. CMS EQR Protocol 4 is a way to assess whether the encounter data can be used to determine program effectiveness, accurately evaluate utilization, identify service gaps and make management decisions. In addition, the Protocol requires an evaluation of both departmental policies, as well as the policies, procedures and systems of the MCOs to identify strengths and opportunities to enhance oversight.

CY 2014 was the implementation year for the Centennial Care program. Based on Myers and Stauffer LC's experience in other states, multiple issues typically arise with the processing, submission and acceptance of encounter data during the implementation year that are generally resolved as the program matures. Recommendations are based on the on-site interviews, documentation and data provided for this validation. Recommendations are specific to the validation period (CY 2014); are based on correct coding standards, Health Insurance Portability and Accountability Act (HIPAA) rules and regulations and industry best practices; and may not reflect the current status of the Centennial Care encounter data if subsequent modifications have been made.

Below are recommendations for Conduent and HSD. MCO-specific sections in the main report present detailed findings and recommendations for each MCO and is available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

HSD and Conduent acknowledge these findings and recommendations and have implemented, or are in the process of implementing, system changes to address the concerns identified during this validation period (CY 2014). HSD and Conduent meet with the MCOs at least monthly to discuss concerns and issues, such as attestations, provider affiliation, Systems Manual updates and encounter completeness.

3.2. Recommendations

HSD encounter submission standards in some instances are generally stated and could potentially be subject to interpretation. Developing more specific encounter data submission standards could assist in improving the quality of the encounter data and generating the accuracy and completeness required for HSD oversight and other analyses performed using the encounter data. Therefore, HealthInsight and Myers and Stauffer LC make the following recommendations related to the State's requirements.

HSD might consider:

1. Reviewing the provider registration process to ensure that it is working efficiently and not causing delays or the inability of the MCOs to submit certain encounters to Conduent. During the on-site visits, the MCOs stated that certain providers' encounters would be rejected by Conduent because the providers had multiple taxonomy codes and the services they submitted on the encounters were not allowed with the submitted taxonomy code. HSD may need to consider exploring aligning provider taxonomy codes used in the State's registration process with the provider-registered taxonomy codes in the National Provider Identifier (NPI) registry.
2. Evaluating the effectiveness of the affiliation process. Providers who submit claims to the MCOs for payment must be registered with the State with the taxonomy code indicated on the claim. In addition, the MCO must be affiliated with the provider in order for the MCO to submit the encounter to Conduent. Based on the experience of Myers and Stauffer LC in other states, the affiliation process and the provider registration is unique and appears to be causing some delays with the submitting of encounters.
3. Increasing the 30-day encounter submission requirement in the MCO contract (Section 4.19.2.2.11) to 95 percent, based on best practice.

4. Accepting MCO denied encounter data submissions. As of the time of the on-site visits, the MCOs were not required to submit denied encounters. The MCO denied claims would provide a more complete picture of the services being provided to the members. Additionally, we recommend that special consideration be given to encounters with both paid and denied lines.
5. Implementing an on-going measurement of the completeness and accuracy of encounters to comply with the Medicaid Managed Care Final Rule (Mega Rule, 42 CFR 438.602(E)), as directed by CMS, such as the encounter reconciliation, which is part of this analysis.

HSD and Conduent might consider:
6. Requiring the MCOs to attest to all encounter data submissions. It is best practice to require an attestation by the MCOs related to the accuracy and completeness of each of the encounter data submissions.
7. A review of the operations of the Self-Directed Community Benefit (SDCB) program to ensure the MCOs have the ability to adequately oversee its members.

Conduent might consider:
8. Updating its data dictionary to include a list of the code set(s) and the descriptions of each code. A code set is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, medical procedure codes, three-digit provider type codes, three-digit provider specialty codes, or two-digit place of service codes.
9. Adding MCO training regarding the resources available for accessing control totals for the enrollment files. Control totals are used to verify the accuracy of transmitted data files, so that the MCOs can ensure that it has the complete file before processing it into its enrollment and claims system and its subcontractor vendor's claims systems.
10. Increasing the amount and frequency of updates to system companion guides and provide advance communication about system changes to ensure the MCOs have adequate time to account for the changes. Keeping these documents up to date and giving advance notification to the MCOs would allow for upfront adjustments to its claims processing systems and help protect the MCOs against spikes in rejected encounters after the implementation of new exception codes and edits.
11. Reviewing the adequacy of the advance notice provided to the MCOs, related to system changes, to ensure the MCOs have ample time to adjust the claims processing system to account for the changes.
12. Implementing additional reviews or edits to ensure the Medicaid management information system (MMIS) is capturing and retaining all encounter data submitted, is reflective of the encounter data submitted by the MCO, remains as submitted by the provider of service and values are in the appropriate field(s).

4.0 Independent Assessment

4.1. Introduction

This report contains details of the tri-annual independent assessment (IA) of HSD's activities and efforts to monitor the performance of New Mexico MCOs. It fulfills federal and state requirements for oversight of the Medicaid MCOs. The information reviewed was collected from HSD for CY 2014 (January 1 through December 31, 2014). This was the first year of implementation of New Mexico's redesigned Medicaid Managed Care program, Centennial Care. HealthInsight New Mexico was chosen by HSD to perform this IA to fulfill the requirements of the Medicaid waiver.

HealthInsight New Mexico conducted the review according to the following:

- The scope of work provided in the EQRO, contract identified as PSC #15-630-8000-0015 A2.
- Guidance to State Medicaid directors published by the Department of Health and Human Services Centers (DHHS) in December 1998, entitled "Section 1915(b) Waiver Program Independent Assessments: Guidance to States."

4.2. Purpose

As HSD's EQRO, HealthInsight New Mexico performed an in-depth analysis of quantitative and qualitative information obtained regarding the MCOs and the Centennial Care waiver program as a whole. The areas of specific focus were Access to Care, Quality of Care and Cost-effectiveness.

The findings of the analysis for each section are summarized below. A full description of the analysis is provided in the full report posted on the HSD website under SFY15 Independent Assessment at: http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

This IA is designed to identify opportunities for improvement by HSD in oversight activities related to each of the managed care contracts. These improvements would better serve Medicaid members in New Mexico through access to care, quality of care and cost-effectiveness of care.

4.3. Independent Assessment Access Findings Summary

All four MCOs experienced a significant increase in their membership subsequent to the rollout of the Centennial Care program and in response to expansion of Medicaid in 2014 under the Patient Protection and Affordable Care Act of 2010 (ACA). Despite this growth, the analysis of the information provided indicates that overall, the MCOs have met the standards for access. Specifically, all MCOs met the standards for access to PCPs in urban areas. There is continued progress in establishing and maintaining an adequate number of providers, in particular for specialists in the rural and frontier areas; however, it has been a challenge for the MCOs. Some specialist categories in the rural and frontier areas that did not meet standards are dermatology, neurosurgery, rheumatology, endocrinology and some behavioral health (BH) services.

Primary care physicians are allowed a maximum of 2,000 assigned Medicaid members to enable members to receive appropriate care and services. The provider-to-member ratio averaged 64 members per PCP for Centennial Care, thereby meeting the standard.

MCO call center answering timeliness and call abandonment rates were examined as a measure of customer satisfaction and access. The standard is that 90.0 percent of all calls be answered within 30 seconds and no more than 5.0 percent of the calls waiting would be abandoned. The scores ranged from 76.2 percent to 99.1 percent among the MCOs for call answering timeliness and, on average, all four MCOs met the standard. All four MCOs also had less than a 5.0 percent abandonment rate and so met the standard.

There are opportunities to improve the reports that manage and monitor access to healthcare that would in turn be advantageous for monitoring the program. Consistency and standardization in both data quality and report formats would improve the ability to monitor the contract and waiver.
As is stated in Amendment 1 of the MCO contract – the contract version guiding the MCOs during CY 2014 – it is critical that reports be submitted by the MCOs in a timely manner and in proper format (4.21.1.7). If there are revisions requested, then it is imperative that the revised reports also be submitted in a timely fashion and with a title that clearly tracks the revision number and the revised date of the report. Report templates and specifications are important elements in keeping the reports consistent in format and containing the same data quality across all four MCOs. Amendment 1 requires that reports include data summaries and a brief analysis of the report data compared to previous reports (4.21.1.5 and 4.21.1.8). Both of these elements are critical when synthesizing and analyzing data.

Quality Findings

HealthInsight New Mexico examined the following in assessing the quality of care:

- Quality Management/Quality Improvement
- EQRO Audits
- Performance Measures
- Performance Improvement Projects
- Grievances and Appeals
- National Committee for Quality Assurance (NCQA) Ratings
- Call Center Dropped Call Rates
- Accuracy of claims
- Member Satisfaction Surveys

HealthInsight New Mexico noted that each MCO had a comprehensive Quality Management/Quality Improvement (QM/QI) Program Description and a QM/QI Plan that was evaluated annually. In addition, the MCOs have a variety of plans to address the cultural diversity of their members. In support of continuous improvement, the MCOs are tracking the HSD-specified HEDIS®[8] PMs. In support of results from these PMs, the MCOs have all selected PIPs to address gaps in performance per contractual requirements. All MCOs were audited by NCQA in SFY 2014 and each earned an accreditation rating of either accredited or commendable. Further evidence of a functioning system was the completion of an external quality review by the EQRO, as required by CMS. Each MCO earned a rating of Full Compliance for program compliance, PM, PIPs, and ISCA audits.
The MCOs are tracking member satisfaction by reporting of grievances and appeals. Results in the first year of Centennial Care showed an increase in reporting but also showed patterns of responsiveness and improvement by some MCOs. These results are further supported by satisfaction levels using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[9]) 5.0H Medicaid Survey for both adults and children, which indicated acceptable performance. The MCOs submitted CY 2014 provider satisfaction reports to HSD; however, there was no report template and consequently the reports were not consistent in content or usable for evaluation. HSD identified the problem and revised the report instructions in order to provide the MCOs a clear understanding of the report expectations. HSD expects that these will be completed in following years.
All MCOs provided evidence of satisfactory claims accuracy. The EQRO noted areas of variation, specifically, with MHP where consistent high performance was indicated across all claim types.

[8] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[9] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Overall, HealthInsight New Mexico found evidence, based on its review of documents provided, that HSD is providing oversight of the Centennial Care quality programs in compliance with the regulations under which it operates.

Cost-effectiveness Findings

The overall financial status was evaluated by considering the following:

- Financial reports
- Bank statements
- Insurance forms
- Independent audit reports
- Medicaid-specific audit reports

After review of available financial reports, and comparing the data to national reports and benchmarks where available, the Centennial Care MCOs appeared to be cost effective for CY 2014. The MCOs demonstrated fiscal responsibility through maintenance of financial viability and stability for CY 2014. The operational summary report discussed in the Cost-effectiveness Section 9.0 showed an overall operating gain of 6.5 percent. Annual costs per consumer in CY 2014 averaged $244.63 per person, while the allowable per person rate was an average of $257.45. This demonstrated that the Centennial Care program was being fiscally responsible with State funds. Please note that calculations were done for MCOs individually, and then aggregated and/or averaged to look at the program as a whole. Examination of short term cost trends by program (BH, LTSS, and PH) by MCO show an overall pattern for three of the MCOs of the lowest cost in the 4th quarter of CY 2014. Comparison of National Medicaid spending trends show that the rate of spending in New Mexico was 0.2 percent lower than the national average (Federal FY 2010 – FY 2014). In addition, New Mexico paid 15 percent less for its share of federal funds than most states for Federal FY 2014.

Overall Findings

The findings of this assessment are that the Centennial Care program met the requirements for access, quality of care, and cost-effectiveness as outlined in the CFR, NMAC regulations and the HSD/MCO contracts, based upon review and analysis of the available data.

Overall Summary of Findings and Conclusions

Despite some challenges in the first year of the Centennial Care program, access and quality of care were provided to its members in a cost efficient manner. HSD standards have been met and plans and processes are in place that aim to improve in all three categories of access, quality and cost effectiveness. HSD has shown good management of HSD's Medicaid Managed Care system on the items assessed in this report. In writing and revision of this report, HSD communicated that there are processes being implemented to cover any identified gaps. Issues have been identified and HSD has provided the MCOs with technical assistance in order to improve processes. It is anticipated that HSD will continue to maintain and improve the access and quality of care to the members and increase the cost-effectiveness of the overall Medicaid Managed Care system by addressing any weaknesses and building on the strengths revealed through further analysis.

4.4. Independent Assessment Recommendations

One possible approach to evaluate performance is adoption of balanced scorecard methodology. Balanced scorecards are performance and quality management tools that support simple evaluation of company or program performance by identifying key measures across four critical areas. Typically, the measures are limited to about 20 at the macro level. In full balanced scorecard deployment, secondary measures that should be correlated to the high level measures support analysis at a cause-and-effect level. For example, if results are not as expected at the scorecard level, then the structure allows for a "drill-down" into the secondary measures to identify causes. With HSD's wealth of detailed reports, these balance scorecards would be the secondary measures that would support higher-level measures on the summary scorecard.

Another approach that HealthInsight New Mexico used extensively in preparing this report is comparisons between the MCOs. While HealthInsight New Mexico did not assess the way in which HSD uses the reports, other than to note that reviewers are assigned by functional areas, it could be that HSD would identify developing performance issues among the MCOs or possible performance improvement opportunities if this comparison approach is performed on a consistent basis.

In addition, common among fully deployed measurement systems is an annual review of the measures themselves. If the measures and the supporting reporting system are meeting the needs of the program. Such a system helps maintain a flexible, agile reporting structure that meets the evolving needs of the program. It also would help identify and remove underutilized reports and identify reporting gaps. It is unclear for this assessment how HSD maintains the currency of their reporting structure. HealthInsight did observe that the Letter of Direction process allows HSD to modify its reporting needs to current requirements.

5.0 Glossary

Term	Definition
ADL	Activities of Daily Living: The things we normally do in daily living including any daily activity we perform for self-care such as feeding, bathing, dressing, grooming, work and homemaking. If a member is identified as needing help with these activities, then care coordination processes may be implemented by an MCO to provide additional care for the member.
ASD	Accounting System data: This is data extracted by the MCOs as evidence of monies paid out for services rendered by providers. This data was required as part of the Encounter Data Validation review.
BCBS	Blue Cross and Blue Shield of New Mexico: One of the four Medicaid Managed Care organizations in New Mexico.
BH	Behavioral Health: The service by which behavioral healthcare services are provided and monitored by HSD, EQR and the managed care organizations. While administered by the same Medicaid Managed Care organizations, behavioral health is considered distinct from physical health and long-term support services.
BHSD	Behavioral Health Services Division: The division within State government tasked with overseeing the provision of behavioral healthcare services for Medicaid members.
CAP	Corrective Action Plan: A plan that is implemented to correct serious issues that were identified either internally by the managed care organization or by an external review. A managed care organization can implement a corrective action plan internally or may be placed on one by HSD if the managed care organization's EQR score falls below a predefined threshold.
CCP	Comprehensive Care Plans: Plans developed by the managed care organizations in collaboration with the member and the member's family to coordinate care for members who have complex medical cases or need additional help managing their healthcare.
Centennial Care	Centennial Care: The name given to the Medicaid Managed Care program administered by HSD effective January 1, 2014. It replaced the previous system, which had Salud!, State Coverage Insurance, coordination of long-term services, and behavioral health all administered as separate programs.
CAHPS	Consumer Assessment of Health Plans: CAHPS surveys ask consumers and patients to report on and evaluate their health care experiences. Each CAHPS survey is designed to assess patient experience in a specific health care setting.
CFR	Code of Federal Regulations: The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the federal government. It is divided into 50 titles. Title 42 deals with public health.

Term	Definition
Citation of Authority	Citation of Authority: The official source from which the EQRO developed a question for the MCOs. The citation of authority is generally one of four items: 1) the contract between the MCOs and HSD; 2) The HSD Managed Care Policy Manual; 3) the federal language found in the CFR; or 4) New Mexico Administrative Code (NMAC).
CMS	Centers for Medicare & Medicaid Services: A department within the United States Department of Health and Human Services that oversees the implementation of the Medicare and Medicaid programs.
CNA	Comprehensive Needs Assessment: This is part of the care coordination process used under Centennial Care. If a member's Health Risk Assessment identifies the need for further assessment for care coordination needs, this is the tool used to conduct that assessment.
CY	Contract Year: The year as defined in a contract. This year may or may not be concurrent with the calendar year. It is not to be confused with Fiscal Year or Measurement Year as defined elsewhere in this document.
EQR	External Quality Review: The analysis and evaluation by an External Quality Review Organization (EQRO) of information on quality, timeliness and access to the healthcare services that an MCO or its contractors furnish to Medicaid members.
EQRO	External Quality Review Organization: An organization contracted with HSD to conduct reviews of the contracted Medicaid Managed Care organizations. The External Quality Review Organization also writes reports of findings and recommendations for improvement to HSD. The contracted External Quality Review Organization that developed this report is HealthInsight New Mexico.
FY	Fiscal Year: The year as defined for accounting purposes. It may or may not be concurrent with the calendar year. As of this writing, HSD Fiscal Year is July 1-June 30. This is not to be confused with Measurement Year or Contract Year, as defined elsewhere in this document.
FA	Fiscal Agent: The organization contracted with HSD to oversee Medicaid data management fiscal agent (FA), Conduent, Inc. (formerly known as Xerox).
FWA	Fraud, Waste and Abuse: The federal government monitors, investigates, and prosecutes cases of fraud, waste, or abuse against the Medicaid program as a function of the Program Integrity program.
HCBS	Home and Community-Based Services: When members transition from a nursing facility, needed medical services can be provided by various agencies in either the member's home or other settings outside of the nursing facility. These are part of the Nursing Facility Level of Care (NF LOC) review.

Term	Definition
HEDIS	Healthcare Effectiveness Data and Information Set: A tool used by the National Committee for Quality Assurance (NCQA) to measure health plan compliance with a wide array of performance measures. The results of annual HEDIS audits are published in the Quality Compass, available for purchase from NCQA.
HSD	State of New Mexico Human Services Department, Medical Assistance Division: The agency of State government responsible for administering a portfolio of programs, including Medicaid.
HRA	Health Risk Assessment: A part of the care coordination process used under Centennial Care. This is a basic assessment to determine if a member requires further assessment for care coordination needs.
IRR	Inter-rater Reliability: A metric used to determine the extent to which two or more reviewers agree on a scored item. It is an indicator of the consistency of the implementation of a rating system. It is also an indicator of the accuracy and quality of a review or review process.
LTSS	Long-term Support Services: Services provided by the contracted managed care organizations for members who need long-term care. What care is needed is determined through a series of assessments. This care may be provided in a variety of settings.
MCO	Managed Care Organizations: Organizations contracted with HSD Human Services Department to provide Medicaid Managed Care services. As of this writing (2017) the four currently contracted Medicaid Managed Care organizations are Blue Cross and Blue Shield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Health Plan, Inc. and United Healthcare of New Mexico, Inc.
MDS	Minimum Data Set: is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.
MHP	Molina Healthcare of New Mexico: One of the four Medicaid Managed Care organizations in New Mexico.

MY	Measurement Year: The year defined as criteria for measurement of a quality indicator or other metric. It may or may not be concurrent with the calendar year. It is not to be confused with Fiscal Year or Contract Year as defined elsewhere in this document.
NCQA	National Committee for Quality Assurance: An independent nonprofit organization that works to improve healthcare quality through evidence-based standards, measures, programs and accreditation. One of the assessment tools developed and used by NCQA is the Healthcare Effectiveness Data and Information Set (HEDIS).
NF LOC	Nursing Facility Level of Care: The EQRO was tasked by HSD to ensure NF LOC criteria and instructions, outlined in HSD of New Mexico Medical Assistance Program Manual Supplement Number 13-06, are being applied consistently and equitably across the New Mexico Medicaid program. Level of Care assessments are performed by MCOs to determine if the member qualifies for a specific level of care. This determination is made based on the number of Activities of Daily Living (ADLs) with which the member needs assistance.
NOD	Notice of Direction: Notices issued by HSD to HealthInsight New Mexico, outlining the areas to be reviewed and deliverables to be completed as part of external quality review audits and reviews. A separate Notice of Direction is issued for each review or review conducted.
NMAC	New Mexico Administrative Code: The official compilation of current rules filed by State agencies.
PDF	Portable Document Format File: PDF is a file format used to present and exchange documents reliably, independent of software, hardware, or operating system.
PCP	Primary Care Physician: A member's primary physician, who should serve as the member's primary point of contact with the healthcare system. Typically, a PCP is a general practice or family practice doctor or nurse practitioner.
PH	Physical Health: The process by which physical healthcare services are provided and monitored by HSD, external quality review and the managed care organizations. While administered by the same Medicaid Managed Care organizations, physical health is considered distinct from behavioral health and long-term support services.
PHP	Presbyterian Health Plan, Inc.: One of the four Medicaid Managed Care organizations in New Mexico.
PMP	Performance Measurement Program: This is a way to refer to all seven of the MCO/HSD contract-defined Performance Measures as a discrete unit since they are scored together unlike the PIPs, which are scored individually.
QM/QI	Quality Management and Quality Improvement programs.

SFY	State Fiscal Year: HSD's budget year that runs from July 1 to June 30 of the following.
TAT	Turn Around Time: The amount of time it takes to make changes and get the document returned.
UHC	United Healthcare of New Mexico, Inc.: One of the four Medicaid Managed Care organizations in New Mexico.
UM	Utilization Management: UM is the evaluation of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called utilization review.

MYERS AND STAUFFER LC
1977 - 2017
CERTIFIED PUBLIC ACCOUNTANTS

NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Analysis of Current Uncompensated Care Pools

Final Report: November 9, 2017

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Table of Contents

Executive Summary

The purpose of this report is to address the request of the Centers for Medicare & Medicaid Services (CMS) for the New Mexico Human Services Department (HSD), to provide an independent analysis of the state's uncompensated care (UC) pool. As indicated in the letter from CMS requesting analysis, there are three principles CMS utilizes in reviewing state UC requests. Following each principle is a summary analysis that will be discussed in more detail throughout the report.

1. Coverage is the best way to assure beneficiary access to health care for low income individuals. UC pool funding should not pay for costs that would otherwise be covered in a Medicaid expansion.

   Summary: HSD expanded Medicaid eligibility through the Affordable Care Act (ACA) and has experienced a growth of 355,000 enrollees from 2014 through 2017. Currently, roughly 40 percent of the population of New Mexico is enrolled in Medicaid (889,692 unique enrollees as of July 2017, with a total estimated population of 2,081,015 per the U.S. Census Bureau).

2. Medicaid payments should support the provision of services to Medicaid and low-income uninsured individuals.

   Summary: HSD has significantly raised reimbursement levels in the past several years, particularly with the safety net care pool (SNCP) and teaching hospitals. As a result of the number of enrollees increasing substantially, there has been an overall reduction in total UC.

3. Provider payment rates must be sufficient to promote provider participation and access. They should also support plans in managing and coordinating care.

   Summary: Access requirements to hospital services are being met by all of the participating managed care organizations (MCOs). In addition, the SNCP payments provide support to the plans in maintaining access in the rural and frontier areas of the state. These payments promote and incentivize quality improvement as well as population-focused improvements.

The letter goes on to request that the analysis "*specifically review the impact of the uncompensated care pool on:*"

- *Financing overall UC in the state.*
- *Medicaid provider payment rates.*
- *Beneficiary access to Medicaid services.*
- *Financing providers that play a significant role in serving the Medicaid population and the low-income uninsured.*
- *Support of managed care plans in managing care.*
- *Any state-specific circumstances for CMS to take into account as it reviews the UC pool.*
- *Whether and, the extent to which, similar issues exist in the state's hospital quality improvement incentive pool.*

The following report will address each of these principles and review points as they relate to payments authorized under Section XII of the special terms and conditions (STCs) related to Centennial Care. Based on the data available, it appears that New Mexico has made significant progress in reducing UC in the state through increased reimbursement rates, and expansion of Medicaid, but significant UC remains.

As illustrated throughout the report, the focus of the SNCP within Centennial Care was on the smallest rural hospitals in the state. The SNCP program focuses the resources on those hospitals that have demonstrated the need. While the effects of the increased reimbursement rates and Medicaid expansion have aided in reducing the UC of these hospitals, it is important to note that even amounts of UC that may appear to be small are difficult for these facilities to address. Current policy direction from CMS has indicated that they intend to emphasize the use of S-10 from the Medicare report in identifying allowable UC costs in the future. Some of the potential issues associated with S-10 and the potential impact on the pools, particularly the smaller pools, is discussed in greater detail in the body of the report. The state has met the STCs of the Centennial Care waiver but additional need remains to ensure that the progress can continue.

Historical Perspective

Beginning in 1989, the majority of hospital providers in the state of New Mexico were reimbursed for inpatient hospital services based on prospectively-determined reimbursement rates. The exception to those hospitals would have been for inpatient rehabilitation and specialty hospitals or Medicare-prospective payment system (PPS) exempt distinct part units within hospitals which were reimbursed under the Tax Equity and Finance Reduction Act (TEFRA) provisions.

In July of 1997, Medicaid managed care in New Mexico was introduced through the Salud! program. While the majority of the coverage was provided through the Salud! program, there remained fee-for-service (FFS) populations that continued to be paid on a cost basis. In addition, while behavioral health services were originally included within the Salud! program, when the contracts were signed in 2005 these services were transitioned out of Salud! to a separate program. Beginning in 2008, individuals that were in need of nursing home level of care, personal care options, and/or disabled and elderly home and community-based services (HCBS) waiver, were phased into the Coordination of Long Term Services (CoLTS) waiver.

In addition to their standard inpatient and outpatient reimbursement, certain hospitals were also eligible to receive supplemental payments for indirect medical education (IME), graduate medical education (GME), disproportionate share hospital (DSH) payments, and sole-community hospital adjustments. Outpatient hospital services were also traditionally paid under a cost-based FFS arrangement, however, in 2010, HSD implemented an outpatient PPS system utilizing an ambulatory payment classification (APC) methodology.

With the implementation of the Centennial Care demonstration waiver, HSD was able to enroll most New Mexico Medicaid and Children's Health Insurance Program (CHIP) beneficiaries in managed care for a full range of services. Centennial Care consolidated 12 existing delivery system waivers into a single comprehensive managed care product.

With the transition of services into Centennial Care, HSD agreed within the STCs to remove the sole-community payments from their state plan and replace it with the SNCP payments within

Centennial Care. These payments were effectively broken into three pools for calculation and distribution. The initial "pool" of funds was used to increase overall reimbursement rates for hospital services as specified in STC 105 and referenced in attachment F of the waiver. This was accomplished through increases to base rates being paid to the hospitals. The available "supplemental" funding was broken into two pools, with the first being the UC pool which was designed to defray the actual UC of inpatient and outpatient hospital services provided to Medicaid eligible or uninsured individuals. The second pool is the Hospital Quality Improvement Incentive (HQII). This pool is designed to provide incentives for hospitals to improve the health and quality of care they provide to the Medicaid and uninsured individuals they serve.

Financing Overall Uncompensated Care in the State

The financing of UC in New Mexico has been accomplished in several ways. The primary way is through payment rates for the Medicaid population that reimburse providers at or near the cost of providing services to the Medicaid population. The second factor in financing overall UC is through Medicaid expansion.

New Mexico expanded their Medicaid program in response to the ACA, and have subsequently seen their Medicaid enrollment climb from approximately 535,000 individuals in 2014 to nearly 890,000 currently, or roughly 40 percent of the population in the state. Prior to the ACA expansion childless, non-disabled adults were ineligible for Medicaid services. Through Medicaid expansion, these groups with incomes up to 138 percent of the federal poverty level were now able to enroll and receive Medicaid services. This expansion assisted in reducing the overall UC of hospitals in New Mexico.

In total, the UC of those SNCP hospitals that experienced net UC was reduced by approximately 35 percent between 2014 Demonstration Year (DY)1 and 2015 DY2. This reduction was possible due to the expansion efforts as well as an overall hospital base rate increase to the SNCP hospitals of approximately forty-two percent from state fiscal year (SFY) 2014 through 2017. This was accomplished with a significant increase in the last half of SFY 2014 and SFY 2015 of approximately 62 percent over prior reimbursement rates, however slower than anticipated recovery from the recession resulted in cost containment measures in SFY 2017 that reduced the increase to 49.5 percent. Fortunately, the UC pool and DSH program assist in offsetting the burden of these cost containment measures passed on to hospitals. It is likely that the 2016 DY3 reconciliation, which will be completed in April of 2018, will result in less significant UC reductions than those experienced in 2015.

In addition to the traditional claims-based payments for services, New Mexico's DSH program provides approximately $30 million in funding through DSH payments. The federal criteria governing DSH allotments to states have identified New Mexico as a "Low DSH" state. A "Low DSH" state was initially characterized as a state with DSH expenditures greater than zero percent and less than 3 percent of total Medicaid spending in fiscal year (FY) 2000. For the non-"Low DSH" states, their annual allotments are limited by 12 percent of their total Medicaid expenditures. This creates a wide disparity in DSH allotments that is largely based on the DSH spending of states in 1992 prior to the federal limits being established. Based on the preliminary 2017 DSH allotment calculations, New Mexico has the second lowest DSH allotment as a percentage of their total computable Medicaid

expenditures net of DSH. The following data is from the 2017 preliminary DSH allotment table provided by CMS.

Low DSH States from 2017 Preliminary Allotment Spreadsheet				
State	**Column G* FY 2017 TC MAP Exp. Net of DSH**	**Column J* FY 2017 DSH Allotment**	**Calculated Not in Allotment Table Column (J / G)**	**Calculated Not in Allotment Table Rank**
Nebraska	$ 2,124,979,000	$ 31,061,430	1.462%	1
South Dakota	$ 905,405,000	$ 12,123,113	1.339%	2
Wisconsin	$ 8,759,791,000	$ 103,763,574	1.185%	3
Alaska	$ 2,495,854,000	$ 22,358,712	.896%	4
Iowa	$ 4,842,615,000	$ 43,226,550	.893%	5
Idaho	$ 2,048,318,000	$ 18,042,558	.881%	6
Utah	$ 2,605,160,000	$ 21,533,602	.827%	7
Montana	$ 1,662,835,000	$ 12,459,133	.749%	8
North Dakota	$ 1,304,404,000	$ 10,484,694	.804%	9
Oklahoma	$ 5,228,463,000	$ 39,748,819	.760%	10
Arkansas	$ 6,440,178,000	$ 47,350,016	.735%	11
Minnesota	$ 12,074,536,000	$ 81,981,945	.679%	12
Oregon	$ 9,733,104,000	$ 49,686,028	.510%	13
Delaware	$ 1,968,900,00	$ 9,937,205	.505%	14
Hawaii	$ 2,264,951,000	$ 10,697,430	.472%	15
New Mexico	$ 5,497,332,000	$ 22,358,712	.407%	16
Wyoming	$ 600,508,000	$ 248,430	.041%	17

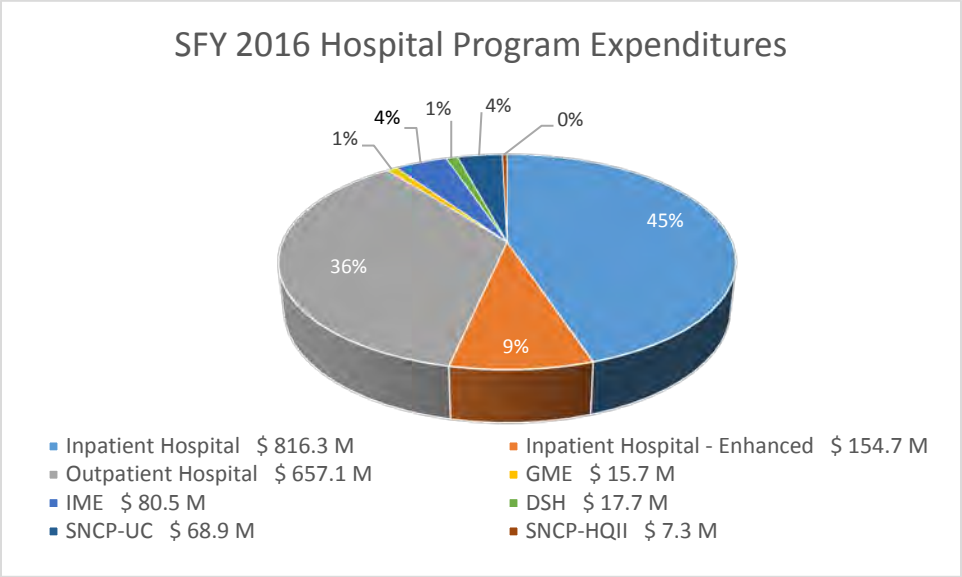
*** - These columns are from the preliminary DSH allotment table for 2017 provided by CMS**.

The table above only reflects the values for those states designated as “low-DSH” under federal regulation. For the non-“low DSH” states, the average percentage is 2.717 percent of total expenditures, with a high of 9.143 percent, and the low being .709 percent. The discrepancy in DSH funding available is apparent when compared to the low DSH states represented above which have an average percentage of DSH allotment to total expenditures of only .773 percent with a high of 1.462 percent and a low of .041 percent.

Prior to Centennial Care, the state also made supplemental payments to sole-community hospitals and the state teaching hospital based on Medicare upper payment limit (UPL) criteria. These payments were designed to assist these facilities, primarily the small rural providers, in covering their UC. With Centennial Care, the majority of these funds were rolled into the SNCP to avoid disrupting the funding of these critical providers in the rural and frontier areas of New Mexico.

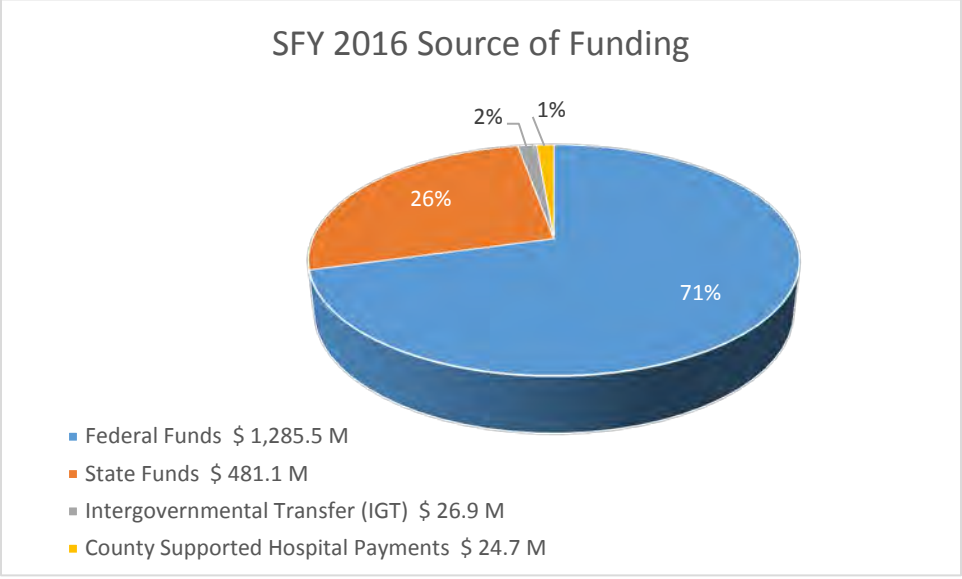
The financing of Medicaid payments in New Mexico is accomplished primarily through state and federal dollars. In 2016, the normal federal medical assistance percentage (FMAP) was 70.37 percent, which requires a state share of 29.63 percent. The non-federal or state share of the expenditure can be obtained from several sources, including state general funds, transfers from local government units or providers (IGTs), certified public expenditures (CPEs), or through permissible

provider taxes. Most states use some combination of these sources to make up the non-federal share of the Medicaid expenditures. The following chart illustrates the various payments made to hospitals in New Mexico in SFY 2016.



Note: *Expenditure amounts for MCO services were obtained from Annual Financial Reports submitted by the MCO's to HSD. The FFS payments were obtained from upper payment limit calculations.*

As the chart above indicates nearly 90 percent of the funds received by hospitals are for direct inpatient and outpatient care. The remaining non-claims based payments are to support the medical education programs in the state through IME and GME payments, provide compensation for hospitals' UC through DSH and UC payments, and promote quality improvement goals within the industry. The source of these funds, as illustrated in the chart below, is primarily federal matching and state general fund dollars, with these two accounting for 97 percent of the total expenditures.



Medicaid Provider Payment Rates

With the implementation of Centennial Care, the majority of the Medicaid population was enrolled with one of the four participating MCOs. As of July 31, 2017, there were approximately 889,000 individuals covered by the New Mexico Medicaid program with 686,000 enrolled through one of the participating plans. Within the hospital reimbursement system, HSD has implemented multiple rate increases over the last several years as well as a small reduction in 2016. The net effect of these changes have increased diagnosis-related group (DRG) base rates to SNCP hospitals by approximately 42 percent. While this increase directly impacts the FFS reimbursement to these hospitals, similar increases have been provided to the MCOs to build into their payment structure.

The second principle utilized by CMS to review states' UC pool requests is:

> *Medicaid payments should support the provision of services to Medicaid and low income uninsured individuals.*

To evaluate overall Medicaid reimbursement, we looked at the Annual Reporting Requirements schedule from the state's most recent two years of DSH audits, covering the Medicaid state plan rate year (SPRY) 2012 and 2013. It should be noted that the hospitals eligible for DSH are not necessarily the same hospitals that participate in the SNCP reimbursement. However, there is overlap within the two groups and when reviewing Medicaid cost coverage within the state it provides a reasonable basis. The following is a statewide summary of the DSH hospitals from the 2012 and 2013 DSH audit reports (included as *Appendix A: 2012 Final DSH Examination Report* and *Appendix B: 2013 Final DSH Examination Report*).

Statewide Summary of DSH Hospitals		
	SPRY 2012	**SPRY 2013**
Total Cost of Care I/P and O/P Medicaid Services (Note A)	$ 603,710,497	$ 715,02,722
Total Medicaid I/P and O/P Payments (Excluding Supplemental)	$ 521,094,959	$ 621,017,559
Percentage of Cost Coverage	86.32%	86.85%

(*Note A) – Would include FFS and MCO volume, would also include cross-over claims and out-of-state Medicaid as required by the DSH audit criteria.*

As mentioned above, HSD has implemented multiple rate increases over the past several years that are not fully reflected in the above numbers. In a recent brief published by the Medicaid and CHIP Payment and Access Commission (MACPAC) in April of 2017, they performed an analysis to compare FFS inpatient hospital payments across states. The data they utilized was from 2010, and a national average payment index was calculated and adjusted for such things as case mix and wage differences. A payment index of 1.0 would indicate that the state was at the national average. The calculated indexes ranged from a value of .49 to 1.69. The index for New Mexico was right at the 1.0 national average.

In reviewing the UC costs of the SNCP facilities, we also pulled data from the Medicare 2252-10 cost reports schedule S-10. The most recent cost reports available for all providers were their 2015 and

2016 reports. A summary of this data by hospital is provided in *Appendix C: 2015 and 2016 Summary of 2552-10 Schedule S-10 Data for SNCP Hospitals*.

2015 Schedule S-10 Data

Unreimbursed Uncompensated Costs

SNCP Group of Hospitals	Medicaid Unreimbursed Costs	CHIP	Other State and Local Indigent Care	Charity Care – Uninsured	Charity Care - Insured	Non-M'Care and Non-Reimb Bad Debt	Total Unreimbursed Uncompensated Care
Smallest	$9,453,555	$74,739	$374,578	$2,340,146	$1,073,455	$10,926,713	$24,243,186
Small	$2,875,403	0	$480,800	$2,567,770	$997,131	$10,426,569	$17,347,673
Medium	$25,758,271	$263	$42,454	$8,046,657	$321,262	$13,942,080	$48,110,987
Large	0	0	$2,436,658	$13,198,455	$478,581	$8,538,544	$24,652,238
Largest	$0	0	0	$17,499,027	$18,431,498	$26,783,685	$62,714,210
Total	**$38,087,229**	**$75,002**	**$3,334,490**	**$43,652,055**	**$21,301,927**	**$70,617,591**	**$177,068,294**

2016 Schedule S-10 Data

Unreimbursed Uncompensated Costs

SNCP Group of Hospitals	Medicaid Unreimbursed Costs	CHIP	Other State and Local Indigent Care	Charity Care – Uninsured	Charity Care - Insured	Non-M'Care and Non-Reimb Bad Debt	Total Unreimbursed Uncompensated Care
Smallest	$12,481,794	$35,487	$516,883	$2,574,053	$2,315,701	$13,403,618	$31,327,536
Small	$6,122,346	$22,865	$546,906	$3,116,425	$1,379,235	$10,830,473	$22,018,250
Medium	$2,342,653	$548	$45,408	$5,498,509	$254,727	$13,979,767	$22,121,612
Large	$11,902	$0	$0	$5,871,095	$168,411	$9,464,356	$15,515,764
Largest	$0	$0	$515,008	$6,861,650	$14,373,313	$22,651,797	$44,401,768
Total	**$20,958,695**	**$58,900**	**$1,624,205**	**$23,921,732**	**$18,491,387**	**$70,330,011**	**$135,384,930**

This data would indicate that the smallest, small, and medium hospitals in the state account for roughly 56 percent of the total UC costs in the state based on the 2016 S-10 data. Due to their size and volume of services provided, they have little opportunity to make up these shortfalls without the assistance of supplemental payments. The programs and payments implemented by HSD have resulted in a significant improvement in the unreimbursed Medicaid and uninsured costs, but the need for these types of programs appears to remain.

In Myers and Stauffer's discussions with other states regarding their waiver applications, CMS has discussed utilizing S-10 data as its source for measuring uncompensated care. Specifically, there has been discussion around only allowing the costs associated with Charity Care – Uninsured in the UC calculation. There are several issues for consideration in this area:

- ***Charity Care*** *– By definition, charity care is based on each individual hospital's policy regarding charity care, also referred to as the hospital's financial assistance policy (FAP). Since it is up to the discretion of each hospital to define their FAP, the variance among*

hospitals can be substantial leading to data that is potentially not comparable, or does not provide a complete picture.

- ***Redistribution of UC*** *- The summary table provided below compares total uninsured costs from the UC reconciliation process to the cost of charity care provided to uninsured patients from S-10. In total, the S-10 data will result in approximately a 42 percent reduction in uninsured costs. The other factor that makes this more concerning for the SNCP program is that it will shift the dollars toward the larger facilities. As indicated in the chart, the S-10 charity care uninsured is approximately 24 percent of the total uninsured in the smallest category. That percentage increases to 31 percent for the small, 62 percent for the medium, and 91 percent for the large hospitals.*

- ***Data Quality*** *– The S-10 report has typically not been utilized or tied to reimbursement activity and has received very little scrutiny from the Medicare Administrative Contractors (MACs). CMS has provided hospitals with some additional guidance and modified the S-10 schedule recently allowing hospitals an opportunity to reopen their cost reports and refile this schedule, if necessary. In addition, there are indications that the S-10 will be the focus of some additional review by the MACs, but this data will not be available for some time.*

2015 Comparison of UC Uninsured to S-10 Charity-Uninsured Costs

SNCP Group of Hospitals	UC Uninsured Costs	S-10 Charity Uninsured Costs	S-10 Charity Uninsured as % of UC-Uninsured
Smallest	$ 9,595,577	$ 2,340,146	24.39%
Small	$ 8,217,694	$ 2,567,770	31.25%
Medium	$13,053,250	$ 8,046,657	61.34%
Large	$ 14,576,775	$ 13,198,455	90.54%
Total	$ 45,443,295	$ 26,153,028	57.55%

The current UC calculation process utilizes a much more detailed analysis of uncompensated care and follows the guidance provided through the DSH rules to define UC. This recognizes the net loss, or gain in some instances, on providing services to all individuals who are eligible for Medicaid services as well as those that are uninsured. The UC schedules collect days and charge information from the hospitals for each eligibility category by Medicare cost center and calculate total cost of providing services based on Medicare cost finding principles. Payments received by the hospital for each eligibility category are used to reduce that cost to the unreimbursed cost. The use of one component of the S-10 will minimize the impact of UC whereas the current UC calculation includes the total cost of UC. Based on the data provided in *Appendix D: 2015 Comparison of Uninsured from UC Reconciliation to S-10 Data* the uninsured portion of the UC calculation of some of the smallest hospitals in the state have significant differences between the uninsured data reported for UC and what is on the S-10. For example, Guadalupe County which is in the smallest category had uninsured costs for UC purposes of $581,363, while the uninsured charity portion of S-10 only identified $27,547.

As displayed above, if only the uninsured individuals who were designated as meeting the hospitals charity care policy were included in the calculation, the uninsured costs for the smallest hospitals

would be reduced by more than 75.61 percent. The same data indicates that the large hospitals uninsured costs would be reduced by only 9.5 percent. While the charity care policies of the smallest and small hospitals may not be as robust as the larger hospitals, they are still providing a much needed and valued service to the rural areas they serve by caring for individuals with no source of third party coverage, regardless of their charity care policy. If the UC was limited to only the charity care portion of the uninsured, it would effectively transfer available UC funding from the small hospitals that the program was intended to assist, to the larger hospitals.

Beneficiary Access to Medicaid Services

The SNCPs are designed to address the unique needs of beneficiaries in the state of New Mexico, which is geographically a large state with small areas of dense population, leaving many rural communities. According to the 2010 U.S. Census Bureau data, the population per square mile of the United States is 87.4. The state of New Mexico's population per square mile is 17, ranking it the 6th lowest in the United States.

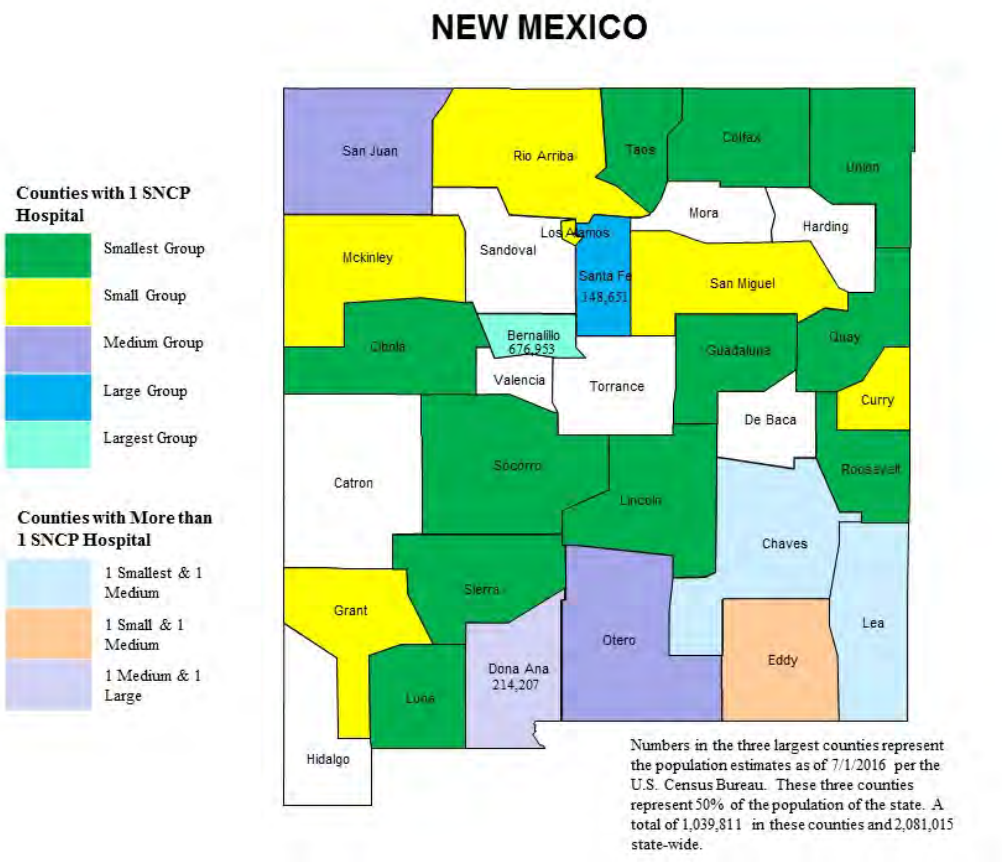
State/Area	Population per Square Mile*
United States	87.4
Alaska	1.2
Wyoming	5.8
Montana	6.8
North Dakota	9.7
South Dakota	10.7
New Mexico	17

**Source: US Census Data 2010 (https://www.census.gov/2010census/data/approtionment-dens-text.php)*

As the map on the following page indicates, of the 33 counties in the state of New Mexico, the three most populated counties make up half of the population. The map (*Figure 1*), illustrates the counties where the SNCP payment-eligible hospitals are located. These counties are color coded based on the location of the hospitals in each SNCP group. As defined in the approved STCs, the UC portion of the payment that is made is first allocated to the smallest, small, and medium facilities. These percentages are indicated on the table below.

UC Group	Bed Size of Hospital	Percent of Available UC Funding
Smallest	30 or Fewer	60%
Small	31 – 100	30%
Medium	101 – 200	10%
Large	201 – 300	0%
Largest	More than 301	0%

Figure 1 – Map of SNCP Eligible Hospitals by Group



The design of the SNCP program enables HSD to target payments to the smaller rural hospitals first. These payments assist the rural hospitals transition into Centennial Care and to ensure that they were able to meet their obligations and remain open to serve the beneficiaries in the rural areas. Payments to an individual hospital were limited to their total UC as defined in the special terms and conditions. If the hospitals in a particular group did not have sufficient UC to receive all of the allotted funds to that group, the excess funds would flow to the next group of larger hospitals. Among the hospitals in each group, the available funding was allocated based on their UC as a percent of the total UC of the group.

The STCs resulted in two types of SNCP funding; the first as described above was the UC funding, the second level of funding was provided for the HQII pool. Under Centennial Care, the total UC funding level was set at $68,889,323 for all five of the demonstration years. The HQII pool funding was set at a percentage of the available UC pool for each year, and gradually increased through the demonstration years as illustrated in the table on the following page.

	DY 1 (CY 2014)	DY 2 (CY 2015)	DY 3 (CY 2016)	DY 4 (CY 2017)	DY 5 (CY 2018)	Total
UC Pool	$68,889,323	$68,889,323	$68,889,323	$68,889,323	$68,889,323	**$344,446,615**
HQII Pool	0	$2,824,462	$5,764,727	$8,825,544	$12,011,853	**$29,426,586**
% UC	100%	96%	92%	89%	85%	**92%**
% HQII	N/A	4%	8%	11%	15%	**8%**
Total	**$ 68,889,323**	**$71,713,785**	**$74,654,050**	**$77,714,867**	**$80,901,176**	**$373,873,201**

As illustrated in *Appendix E: Medicaid Enrollment by County of Residence – July 2017*, as of July 31, 2017, there were a total of 889,692 unique enrollees in the Medicaid program. Of that total, 48 percent of the enrollees (427,749) are in the three most populous counties of Bernalillo, Santa Fe, and Dona Ana. Access to care in these heavily-populated areas is less of an issue, which creates increased demand and increased access to care. The remaining 461,943 enrollees reside in the other 30 counties within the state. The small, smallest, and medium groups of providers identified in the UC payment protocol provide access to hospital care to these individuals in the smaller rural areas of the state.

Included as *Appendix F: Access Reporting from DY3 Annual Report*, are several tables that were included in HSDs Demonstration Year (DY) 3 (January 1, 2016 through December 31, 2016) annual report. These reports summarize by each MCO, their ability to meet the access criteria contained in their contracts for the four quarters in FY15, as well as the first three quarters of FY16. The reports break down the evaluation of the access criteria into three specific areas: Urban, Rural, and Frontier. As the reports indicate, with the exception of one plan (PHP), all plans met the standard for all seven quarters displayed in all three geographic areas. The one plan that did not was only below in the Rural and Frontier areas for one quarter out of the seven.

Financing Providers that Play a Significant Role in Serving the Medicaid Population and the Low-Income Uninsured

All providers in the state of New Mexico play a significant role in serving the Medicaid population and the low-income uninsured. These providers are compensated within program limitations through the DSH payment and SNCP mechanisms. With total available DSH funding (Allotments) to states scheduled to be reduced starting in FY 2018, additional pressures will be placed on overall reimbursement. While final rules on the proposed reductions and allocation of those reductions to individual states have not been made available, the illustrative example provided with the proposed rule would reduce DSH funding in the state of New Mexico by a little over two percent in the first year.

As discussed above, the state of New Mexico participated in Medicaid expansion and has seen a significant increase in the enrolled beneficiaries as a result. Currently, approximately 40 percent of the population of New Mexico are enrolled in the Medicaid program. In addition to expanding Medicaid, overall HSD increased Medicaid reimbursement levels in recent years, which has aided in lowering the overall UC of the state. The S-10 data reviewed above indicated a 23 percent decrease in the total UC from the 2015 to the 2016 cost reports.

Those hospitals that continue to be the most at-risk appear to be the smallest and small hospitals in terms of UC per bed. Based on the S-10 data from the 2016 cost reports, the average UC costs per bed were approximately $100,000 for the "smallest" group of providers in the UC pool. The "small" group was approximately $49,000, with the "medium" and "large" groups around $25,000 per bed. The other hospital that plays a significant role in serving the Medicaid population and the low-income uninsured is the University of New Mexico (UNM). As with the other SNCP hospitals, the Medicaid reimbursement rates for UNM have also been adjusted in recent years resulting in a net increase, which have reduced their requests for funding through the DSH and UC programs.

Support of Managed Care Plans in Managing Care

The rate increases that were previously discussed were also built into the managed care rates allowing them to also increase hospital provider payments. In addition, through the provision of the UC payments and the HQII pool payment, HSD is able to provide critical funding to primarily the small rural hospitals in the state that have limited resources to make up for UC. With this funding, they are able to remain open and provide the needed access to beneficiaries in the rural and frontier areas of the state.

As indicated in the STCs, the available UC funding pool is allocated at 60 percent to the smallest hospitals, 30 percent to the small, and the final 10 percent to the medium group. If the allocated funds cause a group to exceed their allowable funding level (100 percent of their UC costs), the remaining funds would flow to the next larger group of hospitals. In the 2015 reconciliation of UC payments, the cascading of funds was utilized and all eligible providers in the smallest, small, medium, and large groups were able to receive payments up to their UC.

The design of the current mechanism allows for the funding to flow to the smallest and most at-risk hospital provider group first, and then flow down to the larger hospitals if additional funding is available. The ability to assist these hospitals in meeting their obligations and remaining a viable provider within the smaller communities provides the managed care plans with the necessary access to effectively manage care.

The other portion of the SNCP program is the HQII pool. This pool, which was approved as an increasing percentage of the available UC pool, was designed to provide financial incentives for hospitals to meaningfully improve the health and quality of their patients. The HQII pool of payments was further divided into two domains for payment purposes:

> *Domain 1 – Urgent Improvements in Care.* Critical patient safety and quality measures for areas of widespread need where there are opportunities to achieve better care for individuals within five years and "raise the floor" for all participating hospitals.
>
> *Domain 2 – Population-focused Improvements*. Measures of prevention and improved care delivery for the highest burden conditions in the Medicaid and uninsured population where there are opportunities to achieve better health for the population and lower cost through improvement at select hospitals that elect to "raise the bar" by selecting additional HQII outcome measures.

The goals of the HQII program are designed to have an impact on the CMS triple aims:

- *Better care for individuals (including access to care, quality of care, and health outcomes).*
- *Better health for the population.*
- *Lower cost through improvement (without any harm whatsoever to individuals, families, or communities).*

All of these goals are consistent with supporting the managed care plans in managing care. By creating incentives for providers to focus on quality (including access and outcomes), and overall better health for the population in their geographic areas, which helps shift the focus from getting paid for volume of care provided towards quality. With the continuation of these programs, the goal is to reduce overall program costs through improved outcomes and better overall health.

The initial implementation of the HQII program has brought attention to application of consistent definitions for performance measures, and the need to accurately report outcomes. While this attention is desirable, the process needs time to continue to develop and make these measures and the data gathered a routine part of managing care in the communities. In transitioning to Centennial Care 2.0, HSD is proposing to increase the funding levels for the HQII program. This would create a greater incentive to participate and comply. In addition, it would require participating hospitals to be a network provider with each Centennial Care MCO in order to participate in the HQII funding.

State-Specific Circumstances for CMS to take Into Account as it Reviews the Uncompensated Care Pool

These circumstances have been addressed above, within the various applicable areas, but the primary circumstances in New Mexico that make the SNCP reimbursement a vital part of total Medicaid payments to these providers includes:

- *The rural nature of the state relies upon many smaller hospitals to provide the necessary access to required care.*
    - *New Mexico's population density of 17 per square mile is the 6th lowest in the United States.*
    - *Three of the 33 counties have roughly half of the population.*
- *The smallest, small, and medium hospitals included in the SNCP account for 56 percent of the UC need.*
- *The DSH allotment for New Mexico ranks next to last in the country in terms of DSH dollars available per total Medicaid expenditures at .406 percent.*
- *New Mexico is ranked among the top five poorest states in the country.*

As HSD looks to continue their progress of transitioning from a volume-based purchasing arrangement with the Medicaid providers to a quality and value-based arrangement, the funding provided through the SNCP will be necessary to aid these smaller hospitals in that transition.

Whether and, the Extent to Which, Similar Issues Exist in the State's Hospital Quality Improvement Incentive Pool

The issues or facts outlined above apply to the HQII pool as well, since the hospitals eligible to participate in the UC pool are also eligible for the HQII pool. As illustrated above, the recent UC payments have been adequate to reimburse the UC of the smallest, small, and medium providers with some of the remaining funding going to the large group. Moving forward, HSD is planning on a proposal which would shift some of the available dollars from the UC pool to the HQII pool. These available dollars would further their goal in promoting payments for quality and improved outcomes over simply volume of services provided.

The HQII program has two parts to it as well, with the initial focus of the program being on the urgent improvements in care, and the second being a focus on population-focused improvements. As the focus of the HQII program transitions from urgent improvements in care to the population-focused improvements, increased funding of the HQII program will likely be required to make a meaningful improvement in many of these areas.

Summary of Conclusions

The state of New Mexico has made significant strides in creating a more streamlined and efficient health care delivery model. As described in greater detail above, there are significant challenges within the state including a predominantly rural and frontier population which presents unique challenges when addressing adequate access to care. It is imperative that the small rural hospitals that are identified as SNCP facilities remain open to provide that critical access to the residents in remote areas of the state.

In addition to the rural population, New Mexico also has a significant portion of their population enrolled in the Medicaid program. New Mexico addressed the needs of their population through Medicaid expansion as provided for in the ACA. This provided additional access to care to those individuals who were likely previously uninsured. The expansion did assist in reducing the overall UC of the hospitals, but even with this additional funding these hospitals continue to experience significant amounts of UC. Even amounts of UC that may appear to be small, when incurred by a rural hospital provider, there are limited options in making up that loss. As discussed above, if the UC pools were limited to only the charity care portion of uninsured, as currently reported on Schedule S-10, this could have a significant and disproportionate impact on the small rural providers this program was designed to assist.

The payments provided through the SNCP provide that additional funding to assist in filling those gaps. Without that funding there is added pressure on the hospitals to remain open and viable to provide access to the residents in their area. In addition to providing UC funding, the SNCP program operated by the state of New Mexico currently includes the HQII payments as well, which are designed to first provide better care for individuals, and to also improve the overall health of the population. In moving forward, the initial plans of HSD are to increase the funding of the HQII pool to further promote the quality programs that have been started, and to leverage the gains that have already been made to improve the overall health of the population which in turn results in lowering health care spending per beneficiary.

Appendix

Appendix A – 2012 Final DSH Examination Report

Report on Disproportionate Share Hospital Verifications
(With Independent Accountant's Report Thereon)

State of New Mexico
Human Services Department
Medical Assistance Division
2025 South Pacheco Ark Plaza
Santa Fe, New Mexico 87504

DSH Year Ended June 30, 2012

Prepared by:

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Independent Accountant's Report
and
Report on DSH Verifications

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

State of New Mexico
Human Services Department
Medical Assistance Division
Santa Fe, New Mexico

Independent Accountant's Report

We have examined the state of New Mexico's compliance with Disproportionate Share Hospitals (DSH) payment requirements listed in the Report on DSH Verifications as required by 42 CFR §455.301 and §455.304(d) for the year ending June 30, 2012. The state of New Mexico is responsible for compliance with federal Medicaid DSH program requirements. Our responsibility is to express an opinion on the state of New Mexico's compliance with federal Medicaid DSH program requirements based on our examination.

Except as discussed in the Schedule of Data Caveats Relating to the DSH Verifications, we conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants, and General DSH Audit and Reporting Protocol as required by 42 CFR §455.301 and §455.304(d). Based on these standards, our examination included examining, on a test basis, evidence about the state of New Mexico's compliance with those requirements and performing such other procedures we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination of the state of New Mexico's compliance with federal Medicaid DSH requirements.

Our examination was conducted for the purpose of forming an opinion on the state of New Mexico's compliance with federal Medicaid DSH program requirements included in the Report on DSH Verifications. The Schedule of Annual Reporting Requirements provided in accordance with 42 CFR §447.299 is presented for purposes of additional analysis and is not a required part of the Report on DSH Verifications. Such information has not been subjected to the procedures applied in the examination of the Report on DSH Verifications, and, accordingly, we express no opinion on it.

In our opinion, except for the effect of the items addressed in the Schedule of Data Caveats Relating to the DSH Verifications, the Report on DSH Verifications presents fairly, in all material respects, the state of New Mexico's compliance with federal Medicaid DSH program requirements addressed by the DSH verifications for the year ending June 30, 2012.

This report is intended solely for the information and use of the New Mexico Human Services Department - Medical Assistance Division, the State Legislature, hospitals participating in the State DSH program and the Centers for Medicare and Medicaid Services (CMS) and is not intended to be, and should not be, used by anyone other than these specified parties.

Myers and Stauffer LC

Myers and Stauffer LC

December 29, 2015

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

4906 Alameda Blvd NE, Ste B | Albuquerque, NM 87113
PH 505.243.3486 | PH 877.828.0253 | FX 505.247.2154
www.mslc.com

State of New Mexico Disproportionate Share Hospital (DSH)
Report on DSH Verifications
For the Year Ended June 30, 2012

As required by 42 CFR §455.304(d) the state of New Mexico must provide an annual independent certified examination report verifying the following items with respect to its disproportionate share hospital (DSH) program.

Verification 1: Each hospital that qualifies for a DSH payment in the State was allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

Findings: The results of testing performed related to this verification are summarized in the Report on DSH Verifications (table) included with this report.

Verification 2: The DSH payments made in the Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same Medicaid State plan rate year. The actual uncompensated care costs for the Medicaid State plan rate year have been calculated and compared to the DSH payments made. Uncompensated care costs for the Medicaid State plan rate year were calculated in accordance with Federal Register/Vol. 73, No. 245, December 19, 2008 and Federal Register/Vol. 79, No. 232, December 3, 2014.

Findings: The results of testing performed related to this verification are summarized in the Report on DSH Verifications (table) included with this report.

Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923 (g)(1)(A) of the Act.

Findings: The total uncompensated care costs reflected in the Report on DSH Verifications (table) reflects the uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services received.

Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

Findings: In calculating the hospital-specific DSH limit represented in the Report on DSH Verifications (table), if a hospital had total Medicaid payments in excess of the calculated Medicaid cost, the excess was used to reduce the total uncompensated care costs.

Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section have been separately documented and retained by the State.

Findings: The state of New Mexico has retained documentation of costs and payments associated with calculating the hospital-specific DSH limits contained in this report. The state retains cost data through the collection of cost reports; Medicaid expenditure data through the MMIS and other documentation; and uninsured data through the DSH payment calculations and DSH examination.

Verification 6: The information specified in verification 5 above includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient services they received.

Findings: The documentation retained related to the calculation of the hospital-specific DSH limits contained in this report includes a description of the methodology used to calculate each hospital's DSH limit under Section 1923(g)(1) of the Act. For DSH payment purposes, the state defines the hospitals' payment limits in accordance with its state plan. For purposes of this examination, the state defines the hospitals' payment limits in accordance with 42 CFR §455.304.

State of New Mexico
Report on DSH Verifications (table)
For the Medicaid State Plan Rate Year Ended June 30, 2012

Hospital	Verification #1	Verification #2			Verification #3	Verification #4	Verification #5	Verification #6
	Was Hospital Allowed to Retain DSH Payment?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under or <Over> Total Uncompensated Care Costs (UCC)	O/P Hospital Costs to Medicaid eligible and Uninsured Included in UCC?	Payments were in excess of Medicaid cost was the Total UCC reduced by this amount?	expenditures and payments for Medicaid and Uninsured been documented and	documentation include a description of the methodology used to calculate the
University of New Mexico Hospital	Yes	22,695,211	83,354,642	60,659,431	Yes	Yes	Yes	Yes
Alta Vista Regional Hospital	Yes	143,548	3,967,077	3,823,529	Yes	Yes	Yes	Yes
Eastern New Mexico Medical Center	Yes	298,512	7,579,295	7,280,783	Yes	Yes	Yes	Yes
Espanola Hospital	Yes	154,159	1,802,960	1,648,801	Yes	Yes	Yes	Yes
Holy Cross Hospital	Yes	197,725	(64,156)	(197,725)	Yes	Yes	Yes	Yes
Gila Regional Medical Center	Yes	178,364	(9,985,119)	(178,364)	Yes	Yes	Yes	Yes
Lovelace Women's Hospital	Yes	852,608	(30,953)	(852,608)	Yes	Yes	Yes	Yes
Memorial Medical Center	Yes	887,677	(14,750,964)	(887,677)	Yes	Yes	Yes	Yes
Presbyterian Hospital Center	Yes	1,956,298	40,063,393	38,107,095	Yes	Yes	Yes	Yes
Plains Regional Medical Center - Clo	Yes	476,428	5,762,490	5,286,062	Yes	Yes	Yes	Yes
Rehoboth McKinley Christian Hospi	Yes	203,160	410,485	207,325	Yes	Yes	Yes	Yes
Carlsbad Medical Center	Yes	233,165	314,728	81,563	Yes	Yes	Yes	Yes
Lea Regional Hospital	Yes	405,726	3,977,048	3,571,322	Yes	Yes	Yes	Yes
Lovelace Regional Hospital - Roswel	Yes	315,108	2,380,673	2,065,565	Yes	Yes	Yes	Yes
Socorro General Hospital	Yes	67,737	(1,448,689)	(67,737)	Yes	Yes	Yes	Yes
Lincoln County Medical Center	Yes	119,679	(695,596)	(119,679)	Yes	Yes	Yes	Yes
Cibola General Hospital	Yes	71,948	(6,608,171)	(71,948)	Yes	Yes	Yes	Yes
Mimbres Memorial Hospital	Yes	157,136	2,397,292	2,240,156	Yes	Yes	Yes	Yes
New Mexico Rehabilitation Center	Yes	447,932	1,502,207	1,054,275	Yes	Yes	Yes	Yes

State of New Mexico Disproportionate Share Hospital (DSH)
Schedule of Data Caveats Relating to the DSH Verifications
For the Year Ended June 30, 2012

During the course of the engagement, the following data issues or other caveats were identified and are being reported in accordance with the requirements of 42 CFR 455.301.

(1) The signed Certification Statement was not received after multiple requests.
    a. Lea Regional Hospital

(2) Exhibit B documentation does not include insured patient payments.
    a. Lovelace Women's Hospital
    b. Cibola General Hospital
    c. Espanola Hospital
    d. Presbyterian Hospital Center
    e. Plains Regional Medical Center
    f. Socorro General Hospital
    g. Lincoln County Medical Center

(3) Uninsured payment scope limitation (not a full year of cash based payments)
    a. Lovelace Regional Hospital – Roswell

(4) Scope limitation (estimated payments) for the following: Uninsured payments, Medicaid MCO payments, FFS-Crossover payments, and Other Medicaid Eligible payments.
    a. Lovelace Regional Hospital – Roswell

(5) Scope limitation (no revenue codes at patient level) for the following: Uninsured charges, Medicaid MCO charges, FFS –Crossover charges, Other Medicaid Eligible charges, Out-of-State charges.
    a. Lovelace Regional Hospital – Roswell

Schedule of Annual Reporting Requirements

State of New Mexico
Schedule of Annual Reporting Requirements (table)
For the Medicaid State Plan Rate Year Ended June 30, 2012

Definition of Uncompensated Care: The definition of uncompensated care was based on guidance published by CMS in the 73 Fed. Reg. 77904 dated December 19, 2008 and the 79 Fed. Reg. 71679 dated December 3, 2014. The calculated uncompensated care costs (UCC) represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services received. The UCC for these patient groups was calculated using Medicare cost reporting methods, and utilized the Medicare cost report, Medicaid Paid Claims Summaries, and Hospital-Provided Data. Total uncompensated care costs represents the net uncompensated care costs of providing inpatient and outpatient hospital services to patients that fall into one of the following Medicaid in-State and out-of-State payment categories: Fee-for-Service Medicaid primary, Fee-for-Service Crossovers, Managed Care Medicaid primary, Managed Care Medicaid Crossover, and Uninsured individuals with no source of third party coverage for the inpatient and outpatient hospital services received. The cost of services for each of these payment categories was calculated using the appropriate per diems or cost-to-charge ratios from each hospital's Medicare Cost Report. These costs were then reduced by the total payments received for the services provided, including any supplemental Medicaid payments and Section 1011 payments where applicable.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid I/P Utilization Rate	Low-Income Utilization Rate	State-Defined Eligibility Statistic*	Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Supplemental / Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Medicaid Payments (F+G+H)	Total Medicaid Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care Costs (J-I)	Total IP/OP Indigent Care/Self-Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Costs (N-M-L)	Total Eligible Uncompensated Care Costs (K+O)	Total In-State DSH Payments Received	Total Out-of-State DSH Payments Received	Medicaid Provider Number	Medicare Provider Number	Total Hospital Cost
University of New Mexico Hospital	83,354,642	50.91%	54.30%	0	92,976,830	96,044,451	78,202,799	267,224,080	227,653,754	(39,570,326)	1,810,648	910,136	125,645,752	122,924,968	83,354,642	22,695,211	0	67	320001	666,417,217
Alta Vista Regional Hospital	3,967,077	48.88%	24.05%	0	5,197,855	6,354,287	0	11,552,142	13,312,633	1,760,491	13,821	0	2,220,407	2,206,586	3,967,077	143,548	0	76546	320003	28,845,014
Eastern New Mexico Medical Center	7,579,295	25.41%	12.69%	0	4,246,447	10,077,939	0	14,324,386	15,197,829	873,443	195,562	0	6,901,414	6,705,852	7,579,295	298,512	0	B2978	320006	72,766,997
Espanola Hospital	1,802,960	22.38%	33.66%	0	1,427,223	5,594,214	3,810,898	10,832,335	8,174,056	(2,658,279)	244,309	122,578	4,828,126	4,461,239	1,802,960	154,159	0	265	320011	36,826,259
Holy Cross Hospital	(64,156)	26.44%	31.27%	0	2,478,202	4,026,377	6,546,393	13,050,972	9,235,247	(3,815,725)	385,361	0	4,136,930	3,751,569	(64,156)	197,725	0	760	320013	43,741,532
Gila Regional Medical Center	(9,985,119)	34.42%	35.68%	0	5,743,330	5,739,131	17,583,225	29,065,686	15,337,490	(13,728,196)	268,662	0	4,011,739	3,743,077	(9,985,119)	178,364	0	570	320016	56,578,463
Lovelace Women's Hospital	(30,953)	58.02%	26.27%	0	10,897,353	25,724,067	63,512	36,684,932	33,976,161	(2,708,771)	544,034	0	3,221,852	2,677,818	(30,953)	852,608	0	73824062	320017	84,128,068
Memorial Medical Center	(14,750,964)	24.77%	26.94%	0	25,120,564	28,186,326	39,544,860	92,851,750	60,273,352	(32,578,398)	862,744	0	18,690,178	17,827,434	(14,750,964)	887,677	0	67939864	320018	277,863,368
Presbyterian Hospital Center	40,063,393	26.88%	13.24%	0	22,720,849	87,719,633	0	110,440,482	125,225,773	14,785,291	3,228,440	331,121	28,837,663	25,278,102	40,063,393	1,956,298	0	109	320021	690,759,829
Plains Regional Medical Center - Clovis	5,762,490	29.86%	20.63%	0	2,183,341	12,614,045	1,575,767	16,373,153	16,154,146	(219,007)	558,087	63,892	6,603,476	5,981,497	5,762,490	476,428	0	224	320022	68,690,691
Rehoboth McKinley Christian Hospital	410,485	87.72%	41.22%	0	10,760,732	2,580,426	8,369,095	21,710,253	19,539,977	(2,170,276)	207,392	0	2,788,153	2,580,761	410,485	203,160	0	331	320038	45,823,609
Carlsbad Medical Center	314,728	31.65%	13.73%	0	5,377,130	8,272,077	2,634,902	16,284,109	13,242,831	(3,041,278)	559,801	0	3,915,807	3,356,006	314,728	233,165	0	B3186	320063	48,823,253
Lea Regional Hospital	3,977,048	30.21%	11.58%	0	7,644,440	2,333,464	0	9,977,904	10,338,309	360,405	752,731	0	4,369,374	3,616,643	3,977,048	405,726	0	B3139	320065	41,955,019
Lovelace Regional Hospital - Roswell	2,380,673	34.22%	14.73%	0	1,473,907	3,847,541	652,742	5,974,190	7,234,161	1,259,971	290,840	0	1,411,542	1,120,702	2,380,673	315,108	0	97950084	320086	31,827,447
Socorro General Hospital	(1,448,689)	40.99%	41.47%	0	1,440,895	3,295,112	3,683,159	8,419,166	5,566,466	(2,852,700)	174,831	31,542	1,610,384	1,404,011	(1,448,689)	67,737	0	695	321301	16,688,733
Lincoln County Medical Center	(695,596)	25.75%	29.80%	0	1,561,865	2,674,828	4,018,696	8,255,389	5,071,341	(3,184,048)	384,519	18,729	2,891,700	2,488,452	(695,596)	119,679	0	521	321306	27,440,232
Cibola General Hospital	(6,608,171)	44.59%	70.37%	0	4,366,050	1,975,580	9,100,474	15,442,104	7,075,056	(8,367,048)	85,511	0	1,844,388	1,758,877	(6,608,171)	71,948	0	729	321308	14,491,295
Mimbres Memorial Hospital	2,397,292	43.79%	29.91%	0	4,341,564	3,609,766	1,535,834	9,487,164	10,274,271	787,107	297,502	0	1,907,687	1,610,185	2,397,292	157,136	0	B2113	321309	27,956,468
New Mexico Rehabilitation Center	1,502,207	22.84%	27.40%	0	439,593	27,525	0	467,118	827,644	360,526	7,799	0	1,149,480	1,141,681	1,502,207	447,932	0	273	323026	3,153,350
Institute for Mental Disease																				
N/A																				
Out-of-State DSH Hospitals																				
N/A																				

*The New Mexico DSH Eligibility is determined by hospitals with "a MAD inpatient utilization rate greater than the mean MAD inpatient utilization rate for hospitals receiving MAD payments in the state; or a low-income utilization rate exceeding 25 percent;" NMAC 8.311.3.13 A(3)(a).

Independence Declaration

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

To Whom it May Concern:

Myers and Stauffer LC declares it is independent of the state of New Mexico and its DSH hospitals for the Medicaid State plan rate year ending June 30, 2012.

Myers and Stauffer LC

December 29, 2015

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

4906 Alameda Blvd NE, Ste B | Albuquerque, NM 87113
PH 505.243.3486 | PH 877.828.0253 | FX 505.247.2154
www.mslc.com

Appendix B – 2013 Final DSH Examination Report

Report on Disproportionate Share Hospital Verifications
(With Independent Accountant's Report Thereon)

State of New Mexico
Human Services Department
Medical Assistance Division
2025 South Pacheco Ark Plaza
Santa Fe, New Mexico 87504

DSH Year Ended June 30, 2013

Prepared by:

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Independent Accountant's Report
and
Report on DSH Verifications

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

State of New Mexico
Human Services Department
Medical Assistance Division
Santa Fe, New Mexico

Independent Accountant's Report

We have examined the state of New Mexico's compliance with Disproportionate Share Hospitals (DSH) payment requirements listed in the Report on DSH Verifications as required by 42 CFR §455.301 and §455.304(d) for the year ending June 30, 2013. The state of New Mexico is responsible for compliance with federal Medicaid DSH program requirements. Our responsibility is to express an opinion on the state of New Mexico's compliance with federal Medicaid DSH program requirements based on our examination.

Except as discussed in the Schedule of Data Caveats Relating to the DSH Verifications, we conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants, and General DSH Audit and Reporting Protocol as required by 42 CFR §455.301 and §455.304(d). Based on these standards, our examination included examining, on a test basis, evidence about the state of New Mexico's compliance with those requirements and performing such other procedures we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination of the state of New Mexico's compliance with federal Medicaid DSH requirements.

Our examination was conducted for the purpose of forming an opinion on the state of New Mexico's compliance with federal Medicaid DSH program requirements included in the Report on DSH Verifications. The Schedule of Annual Reporting Requirements provided in accordance with 42 CFR §447.299 is presented for purposes of additional analysis and is not a required part of the Report on DSH Verifications. Such information has not been subjected to the procedures applied in the examination of the Report on DSH Verifications, and, accordingly, we express no opinion on it.

In our opinion, except for the effect of the items addressed in the Schedule of Data Caveats Relating to the DSH Verifications, the Report on DSH Verifications presents fairly, in all material respects, the state of New Mexico's compliance with federal Medicaid DSH program requirements addressed by the DSH verifications for the year ending June 30, 2013.

This report is intended solely for the information and use of the New Mexico Human Services Department – Medical Assistance Division, the State Legislature, hospitals participating in the State DSH program, and the Centers for Medicare and Medicaid Services (CMS) as required under 42 CFR §455.304 and is not intended to be, and should not be, used by anyone other than these specified parties and for the specified purpose contained in 42 CFR §455.304.

Myers and Stauffer LC
December 22, 2016

4906 Alameda Blvd NE, Ste B | Albuquerque, NM 87113
PH 505.243.3486 | PH 877.828.0253 | FX 505.247.2154
www.mslc.com

State of New Mexico Disproportionate Share Hospital (DSH)
Report on DSH Verifications
For the Year Ended June 30, 2013

As required by 42 CFR §455.304(d) the state of New Mexico must provide an annual independent certified examination report verifying the following items with respect to its disproportionate share hospital (DSH) program.

Verification 1: Each hospital that qualifies for a DSH payment in the State was allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

Findings: The results of testing performed related to this verification are summarized in the Report on DSH Verifications (table) included with this report.

Verification 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. The DSH payments made in the Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same Medicaid State plan rate year. The actual uncompensated care costs for the Medicaid State plan rate year have been calculated and compared to the DSH payments made. Uncompensated care costs for the Medicaid State plan rate year were calculated in accordance with Federal Register/Vol. 73, No. 245, December 19, 2008 and Federal Register/Vol. 79, No. 232, December 3, 2014.

Findings: The results of testing performed related to this verification are summarized in the Report on DSH Verifications (table) included with this report.

Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923 (g)(1)(A) of the Act.

Findings: The total uncompensated care costs reflected in the Report on DSH Verifications (table) reflects the uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services received.

Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

Findings: In calculating the hospital-specific DSH limit represented in the Report on DSH Verifications (table), if a hospital had total Medicaid payments in excess of the calculated Medicaid cost, the excess was used to reduce the total uncompensated care costs.

Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section have been separately documented and retained by the State.

Findings: The state of New Mexico has retained documentation of costs and payments associated with calculating the hospital-specific DSH limits contained in this report. The state retains cost data through the collection of cost reports; Medicaid expenditure data through the MMIS and other documentation; and uninsured data through the DSH payment calculations and DSH examination.

Verification 6: The information specified in verification 5 above includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient services they received.

Findings: The documentation retained related to the calculation of the hospital-specific DSH limits contained in this report includes a description of the methodology used to calculate each hospital's DSH limit under Section 1923(g)(1) of the Act. For DSH payment purposes, the state defines the hospitals' payment limits in accordance with its state plan. For purposes of this examination, the state defines the hospitals' payment limits in accordance with 42 CFR §455.304.

State of New Mexico
Report on DSH Verifications (table)
For the Medicaid State Plan Rate Year Ended June 30, 2013

	Verification #1	Verification #2				Verification #3	Verification #4	Verification #5	Verification #6
Hospital	Was Hospital Allowed to Retain DSH Payment?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State) *	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under or <Over> Total Uncompensated Care Costs (UCC)	DSH Payment Complies with the Hospital-Specific DSH Limit	Were only I/P and O/P Hospital Costs to Medicaid eligible and Uninsured Included in UCC?	If Medicaid Payments were in excess of Medicaid cost was the Total UCC reduced by this amount?	Have all claimed expenditures and payments for Medicaid and Uninsured been documented and retained?	Does the retained documentation include a description of the methodology used to calculate the UCC?
University Hospital	Yes	23,583,077	46,936,953	23,353,876	Yes	Yes	Yes	Yes	Yes
Alta Vista Regional Hospital	Yes	92,231	5,635,872	5,543,641	Yes	Yes	Yes	Yes	Yes
San Juan Regional Medical Center	Yes	0	(3,742,124)	0	No	Yes	Yes	Yes	Yes
Eastern New Mexico Medical Center	Yes	100,421	3,314,433	3,214,012	Yes	Yes	Yes	Yes	Yes
Espanola Hospital	Yes	55,333	2,553,895	2,498,562	Yes	Yes	Yes	Yes	Yes
Holy Cross Hospital	Yes	81,631	4,794,449	4,712,818	Yes	Yes	Yes	Yes	Yes
Gila Regional Medical Center	Yes	75,824	2,559,272	2,483,448	Yes	Yes	Yes	Yes	Yes
Lovelace Women's Hospital	Yes	0	(1,698,933)	0	No	Yes	Yes	Yes	Yes
Memorial Medical Center	Yes	255,687	6,262,299	6,006,612	Yes	Yes	Yes	Yes	Yes
Presbyterian Hospital	Yes	2,200,288	42,783,728	40,583,440	Yes	Yes	Yes	Yes	Yes
Plains Regional Medical Center	Yes	163,217	6,279,952	6,116,735	Yes	Yes	Yes	Yes	Yes
Rehoboth McKinley Christian Hospital	Yes	87,022	1,544,547	1,457,525	Yes	Yes	Yes	Yes	Yes
Carlsbad Medical Center	Yes	72,115	1,435,856	1,363,741	Yes	Yes	Yes	Yes	Yes
Lea Regional Hospital	Yes	126,364	4,904,242	4,777,878	Yes	Yes	Yes	Yes	Yes
Lovelace Regional Hospital Roswell	Yes	91,556	1,270,999	1,179,443	Yes	Yes	Yes	Yes	Yes
Socorro General Hospital	Yes	0	(61,866)	0	No	Yes	Yes	Yes	Yes
Lincoln County Medical Center	Yes	45,235	1,923,698	1,878,463	Yes	Yes	Yes	Yes	Yes
Cibola General Hospital	Yes	0	(1,498,673)	0	No	Yes	Yes	Yes	Yes
Mimbres Memorial Hospital	Yes	47,014	1,438,680	1,391,666	Yes	Yes	Yes	Yes	Yes
New Mexico Rehabilitation Center	Yes	472,323	1,650,806	1,178,483	Yes	Yes	Yes	Yes	Yes
Guadalupe County Hospital **	Yes	0	0	0	N/A	N/A	N/A	N/A	N/A

This report is intended solely for the information and use of the New Mexico Human Services Department - Medical Assistance Division, the State Legislature, hospitals participating in the State DSH program, and the Centers for Medicare and Medicaid Services (CMS) as required under 42 CFR §455.304 and is not intended to be, and should not be, used by anyone other than these specified parties and for the specified purpose contained in 42 CFR §455.304.

* DSH Payment reflects the redistribution of refunded DSH Payments.

** The provider elected to not complete a DSH survey because the cost of doing so is greater then the DSH payments received.

See Independent Accountant's Report

State of New Mexico Disproportionate Share Hospital (DSH)
Schedule of Data Caveats Relating to the DSH Verifications
For the Year Ended June 30, 2013

During the course of the engagement, the following data issues or other caveats were identified and are being reported in accordance with the requirements of 42 CFR 455.301.

(1) **Exhibit B documentation does not include insured patient payments**

a. Espanola Hospital
b. Presbyterian Hospital
c. Plains Regional Medical Center
d. Socorro General Hospital

Schedule of Annual Reporting Requirements

State of New Mexico
Schedule of Annual Reporting Requirements (table)
For the Medicaid State Plan Rate Year Ended June 30, 2013

Definition of Uncompensated Care: The definition of uncompensated care was based on guidance published by CMS in the 73 Fed. Reg. 77904 dated December 19, 2008 and the 79 Fed. Reg. 71679 dated December 3, 2014. The calculated uncompensated care costs (UCC) represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services received. The UCC for these patient groups was calculated using Medicare cost reporting methods, and utilized the Medicare cost report, Medicaid Paid Claims Summaries, and Hospital-Provided Data. Total uncompensated care costs represents the net uncompensated care costs of providing inpatient and outpatient hospital services to patients that fall into one of the following Medicaid in-State and out-of-State payment categories: Fee-for-Service Medicaid primary, Fee-for-Service Crossovers, Managed Care Medicaid primary, Managed Care Medicaid Crossover, and Uninsured individuals with no source of third party coverage for the inpatient and outpatient hospital services receiv The cost of services for each of these payment categories was calculated using the appropriate per diems or cost-to-charge ratios from each hospital's Medicare Cost Report. These costs were then reduced by the total payments received for the services provided, including any supplemental Medicaid payments and Section 1011 payments where applicable.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid I/P Utilization Rate *	Low-Income Utilization Rate *	State-Defined Eligibility Statistic *	Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Supplemental / Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Medicaid Payments (F+G+H)	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care Costs (J-I)	Total IP/OP Indigent Care/Self Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Costs (N-M-L)	Total Eligible Uncompensated Care Costs (K+O)	Total In-State DSH Payments Received ***	Total Out-of-State DSH Payments Received	Medicaid Provider Number	Medicare Provider Number	Total Hospital Cost
University Hospital	46,936,953	57.96%	72.28%	25%	114,630,758	118,210,236	76,153,651	308,994,645	273,195,545	(35,799,100)	2,506,814	0	85,242,867	82,736,053	46,936,953	23,583,077	0	67	32-0001	680,919,299
Alta Vista Regional Hospita	5,635,872	54.98%	22.43%	25%	5,453,183	6,629,214	360,062	12,442,459	16,077,018	3,634,559	140,764	0	2,142,077	2,001,313	5,635,872	92,231	0	76546	32-0003	31,130,479
San Juan Regional Medical Center	(3,742,124)	28.84%	21.72%	25%	33,922,161	7,249,995	14,647,088	55,819,244	43,143,808	(12,675,436)	2,757,843	0	11,691,155	8,933,312	(3,742,124)	0	0	299	32-0005	164,528,533
Eastern New Mexico Medical Center	3,314,433	27.99%	15.15%	25%	4,419,036	9,434,667	3,169,742	17,023,445	14,241,290	(2,782,155)	193,351	0	6,289,939	6,096,588	3,314,433	100,421	0	B-2978	32-0006	65,493,004
Espanola Hospital	2,553,895	25.18%	32.07%	25%	2,251,860	6,004,377	2,702,187	10,958,424	9,390,618	(1,567,806)	344,028	0	4,465,729	4,121,701	2,553,895	55,333	0	265	32-0011	39,722,425
Holy Cross Hospital	4,794,449	36.57%	50.73%	25%	5,095,744	3,747,256	2,516,869	11,359,869	12,488,611	1,128,742	282,774	0	3,948,481	3,665,707	4,794,449	81,631	0	760	32-0013	42,482,523
Gila Regional Medical Center	2,559,272	25.68%	27.45%	25%	5,172,890	4,306,076	8,298,931	17,777,897	15,750,725	(2,027,172)	209,326	0	4,795,770	4,586,444	2,559,272	75,824	0	570	32-0016	56,719,061
Lovelace Women's Hospital	(1,698,933)	56.54%	21.72%	25%	11,981,702	24,303,592	55,328	36,340,622	32,535,602	(3,805,020)	339,024	0	2,445,111	2,106,087	(1,698,933)	0	0	73824062	32-0017	84,303,836
Memorial Medical Center	6,262,299	45.71%	33.53%	25%	24,841,822	26,504,504	17,006,557	68,352,883	57,881,435	(10,471,448)	773,766	0	17,507,513	16,733,747	6,262,299	255,687	0	67939864	32-0018	153,601,867
Presbyterian Hospital	42,783,728	28.44%	12.98%	25%	32,471,710	90,460,200	0	122,931,910	139,394,522	16,462,612	2,967,936	0	29,289,052	26,321,116	42,783,728	2,200,288	0	109	32-0021	721,061,785
Plains Regional Medical Center	6,279,952	31.52%	23.29%	25%	3,597,680	11,746,019	2,721,348	18,065,047	18,188,139	123,092	514,570	0	6,671,430	6,156,860	6,279,952	163,217	0	224	32-0022	69,422,432
Rehoboth McKinley Christian Hospita	1,544,547	90.36%	34.63%	25%	10,769,472	2,145,495	5,365,083	18,280,050	17,255,030	(1,025,020)	134,431	0	2,703,998	2,569,567	1,544,547	87,022	0	331	32-0038	39,444,122
Carlsbad Medical Center	1,435,856	31.29%	18.27%	25%	5,282,601	7,903,840	4,080,311	17,266,752	14,405,464	(2,861,288)	594,451	0	4,891,595	4,297,144	1,435,856	72,115	0	B-3186	32-0063	46,977,921
Lea Regional Hospital	4,904,242	35.30%	13.94%	25%	6,023,123	5,007,679	2,042,564	13,073,366	13,010,637	(62,729)	810,468	0	5,777,439	4,966,971	4,904,242	126,364	0	B-3139	32-0065	45,179,103
Lovelace Regional Hospital Roswel	1,270,999	36.46%	13.92%	25%	1,964,289	3,432,362	1,372,498	6,769,149	6,837,551	68,402	233,415	0	1,436,012	1,202,597	1,270,999	91,556	0	97950084	32-0086	23,239,633
Socorro General Hospital	(61,866)	45.44%	37.45%	25%	1,914,493	2,865,034	2,627,983	7,407,510	6,018,519	(1,388,991)	180,777	0	1,507,902	1,327,125	(61,866)	0	0	695	32-1301	16,940,166
Lincoln County Medical Center	1,923,698	25.67%	25.65%	25%	1,967,512	2,564,195	1,592,891	6,124,598	5,363,272	(761,326)	409,888	0	3,094,912	2,685,024	1,923,698	45,235	0	521	32-1306	27,002,593
Cibola General Hospital	(1,498,673)	55.31%	39.04%	25%	5,398,752	2,930,734	4,201,038	12,530,524	9,160,736	(3,369,788)	73,684	0	1,944,799	1,871,115	(1,498,673)	0	0	729	32-1308	19,147,404
Mimbres Memorial Hospita	1,438,680	42.24%	24.01%	25%	4,160,463	3,808,534	2,267,656	10,236,653	9,854,168	(382,485)	319,469	0	2,140,634	1,821,165	1,438,680	47,014	0	B-2113	32-1309	24,959,171
New Mexico Rehabilitation Center	1,650,806	23.51%	20.30%	25%	380,760	63,539	0	444,299	820,032	375,733	0	0	1,275,073	1,275,073	1,650,806	472,323	0	273	32-3026	3,876,484
Guadalupe County Hospital **	0	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A

* The State-Defined Eligibility Statistic consists of two ratios. 1) the MIUR which compared to the mean MIUR of the entire state population. The data above does not represent the entire state hospital population and 2) the LIUR which must be greater then 25% if the provider is not eligible based on the MIUR.
** The provider elected to not complete a DSH survey because the cost of doing so is greater then the DSH payments receive
*** DSH Payment reflects the redistribution of refunded DSH payment

Independence Declaration

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

To Whom it May Concern:

Myers and Stauffer LC declares it is independent of the state of New Mexico and its DSH hospitals for the Medicaid State plan rate year ending June 30, 2013.

Myers and Stauffer LC

December 22, 2016

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

4906 Alameda Blvd NE, Ste B | Albuquerque, NM 87113
PH 505.243.3486 | PH 877.828.0253 | FX 505.247.2154
www.mslc.com

Appendix C – 2015 and 2016 Summary of 2552-10 Schedule S-10 Data for SNCP Hospitals

Summary HCRIS Data Extract from 2552-10 Cost Reports

Facility Name	Medicare #	2015 S-10 Data: Medicaid Unreimbursed Costs	CHIP Unreimbursed Costs	Other State and Local Government Indigent Care	Cost of Charity Care - Uninsured Patients	Cost of Charity Care - Insured Patients	Non-Medicare and Non-Reimbursable Medicare Bad Debt	Total Unreimbursed Uncompensated Care Per 2015 S-10
Smallest Group (30 or Less Beds)								
Guadalupe County Hospital	32-0067	-	-	-	27,547	-	224,951	252,498
Roosevelt General Hospital	32-0084	1,719,919	-	-	421,940	-	6,273	2,148,132
Socorro General Hospital	32-1301	-	5,504	169,614	374,712	264,898	347,302	1,162,030
Cibola General Hospital	32-1308	-	-	-	314,398	-	1,173,210	1,487,608
Dan C Trigg Memorial Hospital	32-1302	-	3,346	76,421	201,131	200,123	297,481	778,502
Lincoln County MC	32-1306	-	6,291	84,937	318,318	322,364	726,364	1,458,274
Mimbres Memorial Hospital	32-1309	-	-	43,606	21,930	3,899	487,785	557,220
Miners' Colfax MC	32-1307	1,351,271	59,598	-	-	-	653,843	2,064,712
Nor-Lea General Hospital	32-1305	3,478,008	-	-	92,771	-	3,004,407	6,575,186
Sierra Vista Hospital	32-1300	-	-	-	84,792	26,323	1,315,964	1,427,079
Union County General Hospital	32-1304	-	-	-	277,524	-	904,907	1,182,431
Lovelace Regional Hospital - Roswell	32-0086	-	-	-	12,881	45,569	665,218	723,668
Holy Cross Hospital	32-0013	2,904,357	-	-	192,202	210,279	1,119,008	4,425,846
Sub-Total		9,453,555	74,739	374,578	2,340,146	1,073,455	10,926,713	24,243,186
Small Group (31-100 Beds)								
Los Alamos Medical Center	32-0033	107,527	-	383,656	17,167	-	(262)	508,088
Artesia General Hospital	32-0030	-	-	-	68,856	-	3,515,913	3,584,769
Alta Vista Regional Hospital	32-0003	2,767,876	-	424	84,948	(1,082)	301,600	3,153,766
Rehoboth McKinley Christian HC	32-0038	-	-	-	246,638	-	1,641,936	1,888,574
Gila Regional Medical Center	32-0016	-	-	-	811,834	-	2,449,626	3,261,460
PHS Espanola Hospital	32-0011	-	-	33,113	426,388	444,811	1,096,059	2,000,371
Plains Regional MC	32-0022	-	-	63,607	911,939	553,402	1,421,697	2,950,645
Sub-Total		2,875,403	-	480,800	2,567,770	997,131	10,426,569	17,347,673
Medium Group (101 - 200 Beds)								
Carlsbad MC	32-0063	635,767	-	-	111,397	16,314	1,078,027	1,841,505
Gerald Champion Regional MC	32-0004	3,083,753	-	-	177,815	260,885	1,878,556	5,401,009
Eastern NM MC	32-0006	21,589,071	263	-	25,364	-	1,708,739	23,323,437
Mountain View Regional MC	32-0085	-	-	42,454	1,160,625	9,700	768,837	1,981,616
Lea Regional Hospital	32-0065	449,680	-	-	56,907	34,363	1,773,695	2,314,645
San Juan Regional MC	32-0005	-	-	-	6,514,549	-	6,734,226	13,248,775
Sub-Total		25,758,271	263	42,454	8,046,657	321,262	13,942,080	48,110,987
Large Group (201 - 300 Beds)								
St. Vincent Regional MC	32-0002	-	-	452	12,591,403	478,581	3,220,226	16,290,662
Memorial MC	32-0018	-	-	2,436,206	607,052	-	5,318,318	8,361,576
Sub-Total		-	-	2,436,658	13,198,455	478,581	8,538,544	24,652,238
Largest Group (301 or More)								
University of NM Hospital	32-0001	-	-	-	17,499,027	18,431,498	26,783,685	62,714,210
Sub-Total		-	-	-	17,499,027	18,431,498	26,783,685	62,714,210
Total		38,087,229	75,002	3,334,490	43,652,055	21,301,927	70,617,591	177,068,294

Summary HCRIS Data Extract from 2552-10 Cost Reports

Facility Name	Medicare #	2016 S-10 Data: Medicaid Unreimbursed Costs	CHIP Unreimbursed Costs	Other State and Local Government Indigent Care	Cost of Charity Care - Uninsured Patients	Cost of Charity Care - Insured Patients	Non-Medicare and Non-Reimbursable Medicare Bad Debt	Total Unreimbursed Uncompensated Care Per 2016 S-10
Smallest Group (30 or Less Beds)								
Guadalupe County Hospital	32-0067	99,636	-	-	20,821	-	239,399	359,856
Roosevelt General Hospital	32-0084	2,174,843	-	-	189,186	-	1,566,606	3,930,635
Socorro General Hospital	32-1301	-	4,471	344,771	340,525	186,828	183,835	1,060,430
Cibola General Hospital	32-1308	817,739	-	-	497,607	-	1,036,437	2,351,783
Dan C Trigg Memorial Hospital	32-1302	3,214,180	11,494	66,442	439,954	456,341	400,731	4,589,142
Lincoln County MC	32-1306	-	5,173	70,711	272,505	277,535	705,976	1,331,900
Mimbres Memorial Hospital	32-1309	-	14,349	-	4,163	16,415	364,593	399,520
Miners' Colfax MC	32-1307	-	-	34,959	34,959	-	600,682	670,600
Nor-Lea General Hospital	32-1305	2,501,884	-	-	332,313	-	3,546,382	6,380,579
Sierra Vista Hospital	32-1300	-	-	-	124,029	5,805	1,844,911	1,974,745
Union County General Hospital	32-1304	-	-	-	177,439	1,069,792	874,746	2,121,977
Lovelace Regional Hospital - Roswell	32-0086	1,217,806	-	-	13,250	23,101	512,393	1,766,550
Holy Cross Hospital	32-0013	2,455,706	-	-	127,302	279,884	1,526,927	4,389,819
Sub-Total		12,481,794	35,487	516,883	2,574,053	2,315,701	13,403,618	31,327,536
Small Group (31-100 Beds)								
Los Alamos Medical Center	32-0033	-	-	438,233	(8,365)	-	509,117	938,985
Artesia General Hospital	32-0030	2,394,152	-	-	1,041,297	-	5,945,209	9,380,658
Alta Vista Regional Hospital	32-0003	3,280,379	-	-	-	1,883	290,674	3,572,936
Rehoboth McKinley Christian HC	32-0038	-	-	-	568,943	87,190	862,244	1,518,377
Gila Regional Medical Center	32-0016	-	-	-	(22,715)	-	1,479,736	1,457,021
PHS Espanola Hospital	32-0011	447,815	16,314	-	488,581	596,644	616,222	2,165,576
Plains Regional MC	32-0022	-	6,551	108,673	1,048,684	693,518	1,127,271	2,984,697
Sub-Total		6,122,346	22,865	546,906	3,116,425	1,379,235	10,830,473	22,018,250
Medium Group (101 - 200 Beds)								
Carlsbad MC	32-0063	572,265	548	-	19,962	169	2,390,667	2,983,611
Gerald Champion Regional MC	32-0004	1,770,388	-	-	229,007	219,747	1,141,518	3,360,660
Eastern NM MC	32-0006	-	-	-	4,421	-	2,135,223	2,139,644
Mountain View Regional MC	32-0085	-	-	45,408	590,237	32,846	629,698	1,298,189
Lea Regional Hospital	32-0065	-	-	-	44,916	1,965	2,780,804	2,827,685
San Juan Regional MC	32-0005	-	-	-	4,609,966	-	4,901,857	9,511,823
Sub-Total		2,342,653	548	45,408	5,498,509	254,727	13,979,767	22,121,612
Large Group (201 - 300 Beds)								
St. Vincent Regional MC	32-0002	11,902	-	-	5,671,802	168,411	5,293,465	11,145,580
Memorial MC	32-0018	-	-	-	199,293	-	4,170,891	4,370,184
Sub-Total		11,902	-	-	5,871,095	168,411	9,464,356	15,515,764
Largest Group (301 or More)								
University of NM Hospital	32-0001	-	-	515,008	6,861,650	14,373,313	22,651,797	44,401,768
Sub-Total		-	-	515,008	6,861,650	14,373,313	22,651,797	44,401,768
Total		20,958,695	58,900	1,624,205	23,921,732	18,491,387	70,330,011	135,384,930

Appendix D – 2015 Comparison of Uninsured from UC Reconciliation to S-10 Data

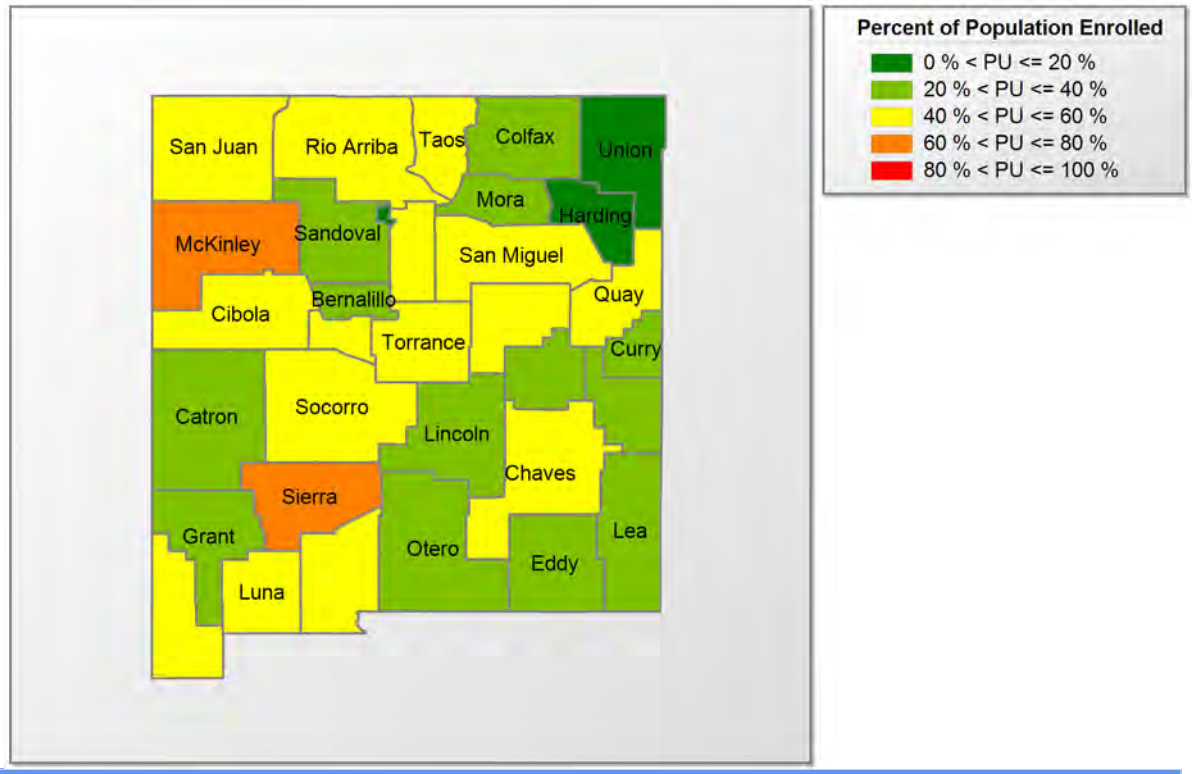
Comparison of Uninsured from UC Reconciliation to S-10 Data
(2015 Reconciliation to 2015 S-10 Data)

		From 2015 UC Reconciliation			From 2015 S-10 Schedule	
		Uninsured IP Costs	Uninsured OP Costs	Total	Cost of Charity Care - Uninsured Patients	% of Uninsured from UC Reconciliation
Cibola General Hospital	Smallest	247,382	427,560	674,942	314,398	
Dan Trigg Memorial Hospital	Smallest	74,619	390,039	464,658	201,131	
Guadalupe County Hospital	Smallest	64,037	517,326	581,363	27,547	
Holy Cross Hospital	Smallest	275,557	691,038	966,596	192,202	
Lincoln County Medical Center	Smallest	197,640	612,634	810,275	318,318	
Lovelace Regional Hospital Roswell	Smallest	202,664	432,152	634,816	12,881	
Mimbres Memorial Hospital	Smallest	649,768	510,314	1,160,082	21,930	
Miners' Colfax Medical Center	Smallest	149,987	383,365	533,352	-	
Nor-Lea General Hospital	Smallest	170,716	1,490,888	1,661,603	92,771	
Roosevelt General Hospital	Smallest	135,116	447,755	582,871	421,940	
Sierra Vista Hospital	Smallest	37,156	365,254	402,410	84,792	
Socorro General Hospital	Smallest	123,362	310,168	433,530	374,712	
Union County General Hospital	Smallest	208,150	480,929	689,080	277,524	
			Sub-Total	9,595,577	2,340,146	24.39%
Alta Vista	Small	122,203	257,980	380,183	84,948	
Artesia General Hospital	Small	517,226	872,530	1,389,756	68,856	
Espanola Hospital	Small	663,795	630,100	1,293,895	426,388	
Gila Regional Medical Center	Small	355,837	467,607	823,444	811,834	
Los Alamos Medical Center	Small	202,265	597,418	799,683	17,167	
Plains Regional Medical Center	Small	1,121,676	1,293,284	2,414,960	911,939	
Rehoboth McKinley Christian Health Care S	Small	543,015	572,758	1,115,772	246,638	
			Sub-Total	8,217,694	2,567,770	31.25%
Carlsbad	Medium	1,141,286	1,147,975	2,289,261	111,397	
Eastern New Mexico Medical Center	Medium	775,998	1,459,611	2,235,608	25,364	
Gerald Champion Regional Medical Center	Medium	271,156	865,914	1,137,070	177,815	
LEA REGIONAL HOSPITAL	Medium	1,283,332	1,383,150	2,666,482	56,907	
Mountain View Regional Medical Center	Medium	1,200,386	756,861	1,957,248	1,160,625	
San Juan Regional MC	Medium	1,681,022	1,086,559	2,767,581	6,514,549	
			Sub-Total	13,053,250	8,046,657	61.64%
Memorial Medical Center	Large	2,696,965	2,887,447	5,584,412	607,052	
St. Vincent Hospital	Large	5,340,274	3,652,089	8,992,363	12,591,403	
			Sub-Total	14,576,775	13,198,455	90.54%

Appendix E – Medicaid Enrollment by County of Residence – July 2017

From HSD Website:
https://webapp.hsd.state.nm.us/MERReport/RunReport.aspx?Report=Medicaid%20Enrollment%20by%20County%20of%20Residence.rdl

Medicaid Enrollment by County of Residence as of 7/31/2017



Search Criteria	
Selected Month	July 2017
Managed Care Organizations	BLUE CROSS BLUE SHIELD OF NM, MOLINA HEALTHCARE, PRESBYTERIAN HEALTH PLAN, UNITEDHEALTHCARE COMMUNITY PLAN, FFS - Full Benefit, FFS - Partial Benefit
Race	American Indian and Alaskan Native, Asian, Asian or Pacific Islander, Black or African American, Hispanic, Native Hawaiian or Other Pacific Islander, Some Other Race, Two or More Races, Unknown, White
Display	Adults and Children

# of Unique Enrollees	Breast and Cervical Cancer	Children, including CHIP and not in another category	CYFD Children	Developmentally Disabled	Family Planning	Home & Community Based Waiver	Institutional Care	Medicare Premium Only (SLIMB & QI)	Other Adult Group/Expansion	Parents and Caretakers (Non Expansion Adults)	Pregnant Women	Qualified Medicare Beneficiary	Refugees and Repatriates	Supplemental Security Income Related	Transitional Medicaid	Working Disabled	Total
Bernalillo	50	93,931	1,931	1,845	23,110	1,128	1,294	3,291	73,017	17,854	1,795	9,847		17,780	475	734	248,082
Catron		235	13	3	63	3	3	30	275	58	1	103		67	2	1	857

Chaves	4	12,750	313	167	2,541	146	154	436	7,548	2,379	235	1,463		2,195	40	76	30,447
Cibola	4	5,472	100	48	776	59	59	166	4,003	1,475	87	485		886	12	20	13,652
Colfax		1,903	41	10	505	23	52	60	1,518	426	42	287		436	3	21	5,327
Curry	3	8,185	112	133	1,406	103	116	187	4,543	1,586	152	607		1,549	20	54	18,756
De Baca		264	1	1	66	7		12	178	52	4	41		85	1		712
Dona Ana	27	43,206	447	502	8,295	440	239	927	31,224	7,869	800	4,648	1	8,266	842	222	107,955
Eddy	5	9,365	209	65	1,911	83	170	221	5,411	2,277	188	917		1,302	59	68	22,251
Grant	2	3,901	146	76	742	62	143	247	3,456	1,084	70	637		893	11	21	11,491
Guadalupe	1	788	19	7	188	29	2	32	684	147	13	141		228	7	6	2,292
Harding		26			16	2	1	3	28	3		8		16		1	104
Hidalgo		677	10	1	138	10	25	31	603	155	11	105		195	6	2	1,969
Lea	2	13,814	231	89	2,077	126	120	203	6,564	2,723	212	938	1	1,591	78	44	28,813
Lincoln	2	2,782	58	27	815	15	25	133	2,354	644	56	419		373	22	11	7,736
Los Alamos		338	31	22	93	6	19	10	325	67	5	35		61	2	6	1,020
Luna		6,156	72	24	1,070	41	28	183	4,346	1,393	72	899		1,486	29	11	15,810
McKinley	8	17,170	133	153	2,870	116	101	283	11,928	4,924	252	1,261		4,651	74	77	44,001
Mora	1	473	24	8	126	13	7	41	496	116	2	126		269	2	15	1,719
Otero	5	7,928	173	94	1,902	74	111	288	7,029	1,785	172	941		1,451	68	42	22,063
Quay		1,465	41	13	354	34	7	73	1,219	336	25	308		396		16	4,287
Rio Arriba	3	8,410	185	98	1,727	167	83	311	6,436	1,996	145	1,154		1,887	51	66	22,719
Roosevelt	1	3,180	90	42	565	30	38	65	1,966	570	69	307		588	7	23	7,541
San Juan	14	24,420	305	159	4,604	203	256	510	16,196	6,215	324	1,789		4,329	140	204	59,668
San Miguel	2	4,113	91	81	879	101	144	232	4,103	1,035	91	723		1,863	17	94	13,569
Sandoval	7	19,418	330	242	4,436	202	142	556	12,855	4,092	370	1,625		2,774	90	162	47,301
Santa Fe	12	22,293	299	247	5,183	195	191	641	30,100	5,115	521	2,413		4,204	113	185	71,712
Sierra		2,277	25	10	419	59	88	211	2,371	565	38	522		721	5	41	7,352
Socorro		2,943	60	31	574	35	45	112	2,464	710	49	413		993	15	23	8,467
Taos	7	4,924	126	56	1,334	99	60	257	5,470	1,225	89	974		1,105	20	80	15,826
Torrance	4	3,520	66	45	877	37	10	187	2,864	878	60	570		666	20	45	9,849
Union		237	21	2	66	4	15	13	161	41	2	38		100		2	702
Valencia	12	13,080	313	286	2,755	177	82	447	9,757	2,747	231	1,588	1	2,486	47	100	34,109
Unknown		347	669	2	45	1		14	219	94	8	45		81	8		1,533
Total	176	339,991	6,685	4,589	72,528	3,830	3,830	10,413	261,711	72,636	6,191	36,377	3	65,973	2,286	2,473	889,692

Population data obtained from the the Bureau of Business and Economic Research (BBER) at the University of New Mexico, http://bber.unm.edu/

Appendix F – Access Reporting from DY3 Annual Report

BCBNM 2015 - 2016

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.8%	92.0%	99.9%	99.8%	99.9%	99.8%	99.8%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacies	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%		100.0%	100.0%	100.0%	99.9%	99.9%	99.9%	99.9%		99.1%	100.0%	99.1%	99.1%	99.2%	99.2%	99.2%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		91.7%	91.7%	91.7%	91.7%	91.3%	91.1%	90.9%		99.0%	97.3%	97.2%	97.2%	97.3%	97.4%	97.4%	
PH - Standard 2																								
Cardiology	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		98.5%	98.5%	98.5%	98.5%	99.7%	99.7%	99.7%		100.0%	99.6%	99.6%	99.6%	99.8%	99.8%	99.8%	
Certified Nurse Practitioner	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.9%	99.9%	99.9%	99.9%	99.9%	99.7%	99.8%		99.7%	99.7%	99.8%	99.8%	99.8%	99.8%	99.8%	
Certified Midwives	94.6%	94.6%	94.8%	99.2%	99.2%	99.1%	99.2%		91.3%	91.3%	91.5%	91.4%	91.1%	90.9%	90.9%		96.6%	96.6%	99.6%	96.5%	96.5%	96.6%	96.6%	
Dermatology	71.7%	71.7%	71.8%	71.7%	71.8%	71.7%	72.0%		57.6%	57.6%	57.1%	57.0%	57.4%	57.7%	57.4%		74.8%	74.8%	74.9%	74.7%	74.3%	74.3%	74.2%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Endocrinology	94.6%	94.6%	94.7%	94.7%	94.7%	94.8%	94.7%		44.0%	37.6%	64.4%	72.4%	72.9%	73.2%	73.3%		78.1%	78.1%	79.1%	76.1%	76.1%	76.4%	76.3%	
ENT	99.1%	99.1%	99.1%	99.1%	99.2%	99.1%	99.1%		98.1%	98.1%	98.2%	98.3%	98.3%	90.7%	90.4%		96.2%	96.2%	96.1%	96.1%	96.1%	94.8%	94.7%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	
Hematology/Oncology	99.1%	99.1%	99.1%	99.1%	99.2%	99.1%	99.1%		71.4%	71.4%	98.5%	98.5%	98.6%	99.7%	99.3%		99.2%	99.2%	99.0%	99.1%	99.1%	99.3%	99.4%	
Neurology	98.6%	98.6%	99.1%	99.1%	99.2%	99.1%	99.1%		83.0%	83.0%	97.5%	98.4%	98.5%	98.5%	98.6%		90.4%	90.4%	91.3%	91.2%	91.4%	91.6%	91.5%	
Neurosurgeons	99.1%	99.1%	99.1%	99.2%	99.2%	99.1%	99.1%		31.1%	31.1%	30.9%	39.2%	39.4%	39.3%	39.2%		70.4%	70.4%	70.2%	70.1%	69.7%	69.8%	69.6%	
OB/Gyn	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.7%	99.7%	99.7%	99.7%	99.7%	99.9%	99.9%		99.7%	99.7%	99.6%	99.6%	99.7%	99.7%	99.8%	
Orthopedics	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%		97.2%	96.4%	96.5%	96.4%	96.4%	96.6%	96.5%	
Pediatrics	99.2%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%		99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.8%		92.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.3%	99.3%	99.4%	99.4%	99.9%	99.9%	99.9%		99.7%	99.7%	99.7%	99.7%	99.8%	99.8%	99.8%	
Rheumatology	99.1%	99.1%	99.1%	99.1%	99.2%	99.1%	92.9%		50.7%	50.7%	78.0%	78.0%	77.9%	77.8%	77.0%		80.6%	80.6%	81.8%	81.8%	81.8%	82.1%	81.9%	
Surgeons	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%		99.7%	99.7%	99.7%	99.7%	99.8%	99.8%	99.8%	
Urology	94.6%	94.6%	94.7%	94.7%	99.2%	99.1%	99.1%		90.8%	91.4%	91.2%	91.2%	91.3%	82.3%	81.9%		91.9%	92.7%	92.5%	92.6%	92.5%	92.6%	92.4%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	99.1%	99.1%	99.1%	99.2%	99.2%	99.2%	99.2%		99.1%	99.4%	99.4%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Personal Care Service Agencies (PCS) - directed	99.2%	99.1%	99.1%	99.2%	99.2%	99.2%	99.2%		99.4%	99.4%	99.4%	99.0%	99.0%	99.0%	99.0%		99.8%	99.8%	99.8%	99.7%	99.8%	99.8%	99.8%	
Nursing Facilities	94.7%	94.7%	94.8%	94.8%	94.8%	94.9%	94.9%		99.4%	99.4%	99.4%	99.5%	99.4%	99.5%	99.4%		99.9%	99.9%	99.8%	99.8%	99.8%	99.9%	99.9%	
General Hospitals	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.8%	99.8%	99.8%	99.8%	99.8%	99.7%	99.7%		96.8%	100.0%	100.0%	100.0%	100.0%	99.8%	99.8%	
Transportation	99.1%	99.1%	99.1%	100.0%	100.0%	100.0%	100.0%		91.1%	98.7%	98.7%	99.6%	99.6%	99.6%	99.6%		99.1%	99.1%	99.0%	100.0%	100.0%	100.0%	100.0%	

Source: BCBSNM, GeoAccess Report #55, Q1CY15 - Q3CY16

MHNM 2015 - 2016

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.0%	100.0%	100.0%	100.0%	99.0%	99.0%	99.0%	
FQHC - PCP	100.0%	100.0%	ND	100.0%	100.0%	100.0%	100.0%		93.0%	93.0%	93.0%	93.0%	92.0%	93.0%	100.0%		99.0%	99.0%	98.0%	99.0%	99.0%	98.0%	99.0%	
PH - Standard 2																								
Cardiology	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Certified Nurse Practitioner	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Certified Midwives	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		88.0%	88.0%	88.0%	87.0%	82.0%	93.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.0%	97.0%	100.0%	
Dermatology	77.0%	77.0%	77.0%	77.0%	75.0%	76.0%	76.0%		65.0%	65.0%	65.0%	64.0%	63.0%	83.0%	64.0%		91.0%	91.0%	91.0%	91.0%	88.0%	87.0%	87.0%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Endocrinology	99.0%	98.0%	99.0%	99.0%	98.0%	98.0%	98.0%		54.0%	54.0%	71.0%	69.0%	68.0%	68.0%	68.0%		89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	88.0%	
ENT	99.0%	98.0%	99.0%	99.0%	98.0%	98.0%	98.0%		99.0%	99.0%	99.0%	99.0%	99.0%	98.0%	92.0%		100.0%	99.0%	98.0%	98.0%	95.0%	98.0%	91.0%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Hematology/Oncology	99.0%	99.0%	99.0%	99.0%	98.0%	98.0%	98.0%		99.0%	99.0%	99.0%	99.0%	98.0%	98.0%	98.0%		96.0%	95.0%	94.0%	94.0%	93.0%	94.0%	93.0%	
Neurology	99.0%	99.0%	99.0%	99.0%	99.0%	98.0%	98.0%		95.0%	94.0%	95.0%	95.0%	93.0%	94.0%	95.0%		89.0%	90.0%	91.0%	91.0%	89.0%	89.0%	89.0%	
Neurosurgeons	99.0%	99.0%	99.0%	99.0%	98.0%	98.0%	98.0%		50.0%	53.0%	49.0%	49.0%	47.0%	47.0%	49.0%		72.0%	72.0%	72.0%	72.0%	69.0%	71.0%	68.0%	
OB/Gyn	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Orthopedics	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.0%	98.0%	100.0%	99.0%	98.0%	98.0%	98.0%	
Pediatrics	99.0%	99.0%	99.0%	99.0%	98.0%	98.0%	98.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	99.0%	99.0%	99.0%	99.0%		95.0%	95.0%	95.0%	95.0%	94.0%	95.0%	94.0%	
Rheumatology	99.0%	98.0%	99.0%	99.0%	98.0%	98.0%	98.0%		99.0%	82.0%	86.0%	85.0%	80.0%	98.0%	98.0%		94.0%	88.0%	87.0%	88.0%	84.0%	90.0%	90.0%	
Surgeons	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Urology	99.0%	99.0%	98.0%	98.0%	98.0%	98.0%	98.0%		95.0%	95.0%	95.0%	95.0%	94.0%	94.0%	94.0%		97.0%	97.0%	97.0%	97.0%	94.0%	93.0%	93.0%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Personal Care Service Agencies (PCS) - directed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nursing Facilities	96.0%	96.0%	95.0%	95.0%	92.0%	93.0%	94.0%		94.0%	94.0%	92.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
General Hospitals	99.0%	99.0%	99.0%	99.0%	99.0%	98.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Transportation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Source: MHNM, GeoAccess Report #55, Q1CY15 - Q3CY16

PHP 2015 - 2016

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.9%	100.0%	99.9%	99.9%	99.9%	99.9%	99.9%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	100.0%	
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	99.9%	99.9%	99.9%	99.8%	99.8%	99.8%		99.9%	99.5%	99.5%	99.8%	99.7%	99.7%	99.6%	
FQHC - PCP Only	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.0%	99.0%	95.1%	94.2%	99.7%	99.6%	99.5%		92.3%	86.3%	86.4%	92.8%	99.0%	98.9%	98.9%	
PH - Standard 2																								
Cardiology	99.0%	99.1%	99.1%	99.1%	99.1%	99.0%	99.1%		92.0%	92.2%	92.6%	92.7%	99.6%	99.6%	99.6%		97.6%	97.5%	97.5%	97.6%	99.9%	99.9%	99.9%	
Certified Nurse Practitioner	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Certified Midwives	96.7%	96.7%	96.7%	96.8%	96.7%	96.7%	96.7%		94.1%	94.0%	93.8%	93.7%	98.9%	92.8%	92.8%		98.9%	98.9%	98.9%	98.9%	98.8%	98.8%	98.7%	
Dermatology	85.8%	85.5%	85.3%	85.2%	85.3%	85.2%	99.0%		70.7%	70.7%	70.3%	70.3%	69.9%	69.7%	69.8%		78.5%	78.7%	78.5%	78.6%	78.5%	78.3%	78.1%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Endocrinology	98.8%	99.1%	99.1%	99.1%	99.1%	99.0%	99.1%		75.5%	76.8%	69.4%	69.4%	68.9%	68.6%	68.7%		79.9%	81.3%	86.7%	86.8%	86.8%	86.5%	86.6%	
ENT	99.0%	99.0%	99.1%	99.1%	99.1%	99.0%	99.1%		98.7%	98.7%	98.8%	98.6%	98.5%	98.5%	94.4%		98.6%	98.5%	98.4%	98.6%	98.3%	98.3%	95.7%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Hematology/Oncology	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		97.0%	97.2%	98.7%	98.9%	98.9%	98.9%	98.9%		98.0%	98.1%	99.8%	99.7%	99.7%	99.7%	99.6%	
Neurology	98.8%	99.1%	99.1%	99.1%	99.1%	99.0%	99.1%		89.4%	91.1%	91.6%	91.8%	91.6%	91.7%	91.7%		88.1%	89.6%	90.3%	90.3%	90.3%	90.5%	90.5%	
Neurosurgeons	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		59.8%	59.6%	59.3%	59.3%	59.0%	58.8%	58.4%		75.3%	75.5%	75.1%	75.1%	75.1%	74.9%	74.9%	
OB/Gyn	99.1%	99.1%	99.2%	99.2%	99.2%	99.1%	99.1%		99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	
Orthopedics	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.2%		99.3%	99.4%	99.5%	99.6%	99.6%	99.6%	99.6%		96.7%	98.9%	98.9%	98.9%	98.8%	98.8%	98.7%	
Pediatrics	99.3%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%		99.5%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.1%	99.1%	99.2%	99.3%	99.3%	99.2%	99.2%		99.3%	99.3%	99.3%	99.3%	99.3%	100.0%	100.0%		99.9%	99.9%	99.9%	99.9%	99.9%	98.9%	99.9%	
Rheumatology	99.1%	99.1%	99.1%	99.1%	99.1%	99.0%	99.1%		88.2%	88.1%	89.0%	89.0%	88.9%	89.1%	89.1%		86.8%	86.8%	87.1%	87.4%	87.2%	87.3%	87.7%	
Surgeons	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		95.0%	94.8%	99.6%	99.6%	99.6%	99.6%	99.6%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	
Urology	99.1%	99.1%	99.1%	99.1%	99.1%	99.0%	99.1%		97.6%	94.5%	95.2%	97.9%	98.0%	98.0%	98.1%		96.1%	95.9%	95.9%	96.0%	95.9%	95.9%	96.1%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.5%	99.6%	99.6%	99.7%	99.5%	99.6%	99.7%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Personal Care Service Agencies (PCS) - directed	99.3%	99.2%	99.3%	99.2%	99.1%	99.3%	99.3%		98.9%	99.1%	99.0%	99.7%	99.5%	99.6%	99.7%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nursing Facilities	96.3%	96.9%	97.1%	97.1%	97.0%	97.1%	96.8%		97.1%	96.4%	96.4%	98.2%	98.2%	98.6%	98.8%		100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	
General Hospitals	99.2%	99.2%	99.9%	99.2%	99.2%	99.1%	96.3%		99.3%	99.3%	98.4%	99.4%	99.4%	99.4%	84.8%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	82.0%	
Transportation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Source: PHP, GeoAccess Report #55, Q1CY15 - Q3CY16

UHC 2015 - 2016

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY1**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY1**	**Q3FY16**	**Q4FY16**	**Q1FY15**	**Q2FY15**	**Q3FY15**	**Q4FY15**	**Q1FY16**	**Q2FY1**	**Q3FY16**	**Q4FY16**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	99.7%	
Pharmacies	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%		99.5%	99.4%	99.4%	99.4%	99.0%	99.4%	99.4%	
FQHC	nd	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		nd	100.0%	nd	99.1%	100.0%	99.1%	99.1%		nd	100.0%	nd	98.0%	100.0%	98.1%	98.2%	
PH - Standard 2																								
Cardiology	99.0%	99.1%	99.1%	99.1%	99.0%	99.1%	99.1%		99.5%	99.5%	99.5%	99.3%	99.0%	99.5%	99.5%		99.8%	99.8%	99.8%	99.8%	100.0%	99.8%	99.8%	
Certified Nurse Practitioner	100.0%	nd	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	nd	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	nd	100.0%	100.0%	100.0%	99.9%	100.0%	
Certified Midwives	96.2%	nd	96.2%	96.2%	96.0%	100.0%	100.0%		92.1%	nd	91.3%	91.0%	91.0%	90.7%	99.8%		97.6%	nd	97.7%	97.7%	98.0%	97.9%	97.8%	
Dermatology	95.0%	94.9%	95.0%	95.0%	95.0%	95.2%	94.0%		68.5%	62.9%	62.9%	62.7%	68.0%	67.2%	61.3%		88.1%	88.3%	88.2%	88.0%	88.0%	88.2%	87.4%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	
Endocrinology	95.2%	95.1%	95.2%	95.2%	95.0%	99.1%	94.0%		89.7%	66.6%	66.6%	90.1%	73.0%	90.0%	82.6%		93.8%	93.9%	93.7%	93.6%	94.0%	91.0%	85.5%	
ENT	99.0%	99.0%	99.1%	99.0%	99.0%	99.1%	99.1%		92.9%	93.0%	93.1%	93.2%	93.0%	93.0%	93.1%		92.8%	92.9%	92.8%	93.1%	93.0%	93.2%	97.4%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.2%	99.1%	99.1%	100.0%	100.0%	100.0%	100.0%		97.9%	97.9%	91.9%	100.0%	100.0%	100.0%	100.0%	
Hematology/Oncology	99.0%	99.0%	99.1%	99.0%	99.0%	99.0%	99.1%		97.6%	99.2%	97.8%	98.0%	98.0%	99.1%	99.3%		99.8%	99.8%	99.8%	99.8%	100.0%	99.8%	99.7%	
Neurology	95.2%	95.2%	95.2%	95.2%	95.0%	99.1%	99.1%		89.1%	89.2%	89.4%	89.5%	89.0%	89.4%	89.8%		85.1%	85.4%	87.8%	88.5%	89.0%	88.6%	93.7%	
Neurosurgeons	98.7%	98.8%	98.8%	98.8%	99.0%	98.8%	99.1%		40.3%	40.0%	40.1%	40.0%	40.0%	43.1%	42.8%		69.3%	69.6%	69.2%	68.9%	69.0%	74.2%	73.4%	
OB/Gyn	99.0%	99.0%	99.1%	99.1%	99.0%	99.1%	99.1%		99.7%	99.7%	99.7%	99.8%	100.0%	99.8%	99.8%		99.7%	99.7%	99.7%	99.8%	100.0%	99.8%	99.8%	
Orthopedics	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.7%	99.7%	99.7%	99.6%	100.0%	99.8%	99.8%		97.0%	97.4%	97.4%	99.7%	100.0%	97.7%	97.6%	
Pediatrics	99.0%	99.0%	99.1%	100.0%	100.0%	99.1%	99.1%		99.5%	99.5%	99.5%	99.5%	100.0%	99.3%	99.9%		97.8%	97.9%	97.9%	97.9%	98.0%	98.0%	98.1%	
Physician Assistant	96.2%	N/A	100.0%	96.2%	96.0%	96.3%	94.9%		100.0%	N/A	100.0%	100.0%	100.0%	99.3%	99.8%		100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.0%	99.0%	99.1%	99.0%	99.0%	99.1%	99.1%		99.5%	99.5%	99.5%	99.3%	99.0%	99.3%	98.9%		99.9%	99.9%	99.9%	99.9%	100.0%	99.9%	100.0%	
Rheumatology	95.2%	95.1%	95.2%	95.2%	95.0%	95.3%	94.0%		73.2%	73.8%	74.0%	74.1%	74.0%	73.8%	93.1%		84.4%	84.5%	84.1%	83.8%	84.0%	83.9%	92.5%	
Surgeons	99.0%	99.1%	99.1%	99.1%	99.0%	99.1%	99.1%		99.2%	99.2%	99.2%	99.3%	99.0%	99.3%	99.8%		99.8%	99.8%	99.8%	99.8%	100.0%	99.8%	99.8%	
Urology	99.0%	99.0%	99.1%	99.0%	99.0%	99.0%	99.1%		97.6%	97.8%	97.8%	97.8%	98.0%	98.0%	97.9%		94.1%	94.4%	94.3%	94.3%	95.0%	94.7%	94.5%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	99.1%	99.1%	99.2%	99.2%	99.0%	100.0%	99.1%		96.3%	95.4%	95.5%	95.6%	95.0%	99.4%	98.4%		99.8%	99.7%	99.7%	99.7%	100.0%	100.0%	100.0%	
Personal Care Service Agencies (PCS) - directed	99.1%	99.1%	99.2%	99.2%	99.0%	100.0%	99.1%		91.1%	90.2%	90.4%	90.6%	90.0%	99.4%	98.4%		97.6%	97.5%	97.5%	97.6%	98.0%	100.0%	100.0%	
Nursing Facilities	99.2%	99.2%	99.2%	99.2%	99.0%	99.3%	99.3%		98.0%	98.2%	98.3%	98.3%	98.0%	98.0%	97.7%		99.9%	99.9%	99.9%	99.9%	100.0%	97.7%	97.7%	
General Hospitals	95.0%	95.2%	95.3%	95.3%	95.0%	95.3%	99.1%		97.0%	96.7%	96.6%	96.6%	96.0%	96.6%	99.5%		99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.8%	
Transportation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.8%	99.8%	99.8%	99.8%	100.0%	99.8%	99.1%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Source: UHC, GeoAccess Report #55, Q1CY15 - Q3CY16