Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2018 – 12/31/2018)
Waiver Quarter: 4/2018

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New Mexico Human Services Department

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Section I: Introduction

On July 12, 2013, the Centers for Medicare and Medicaid Services (CMS) approved New Mexico's Centennial Care Program 1115 Research and Demonstration Waiver. The approval of the waiver was effective from January 1, 2014 through December 31, 2018.

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. There are approximately 656,708 members currently enrolled in the program.

The goals of the Centennial Care Program at implementation included:

- Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most effective settings;
- Ensuring that the care being purchased by the program is measured in terms of its quality and not its quantity;
- Slowing the growth rate of costs or "bending the cost curve" over time without cutting services, changing eligibility or reducing provider rates; and
- Streamlining and modernizing the program.

In the development of a modernized Medicaid program, New Mexico articulated four (4) guiding principles:

1. Developing a comprehensive service delivery system that provides a full array of benefits and services offered through the State's Medicaid program;
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
3. Increasing the emphasis on payment reforms that pay for performance rather than payment for the quantity of services delivered; and
4. Simplifying administration of the program for the State, for providers and for recipients where possible.

These guiding principles continue to steer New Mexico's Medicaid modernization efforts and serve as the foundation for the Section 1115 waiver.

The four Managed Care Organizations (MCOs) contracted with New Mexico to deliver care are:

- Blue Cross Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico (MHC)
- Presbyterian Health Plan (PHP)
- UnitedHealthcare (UHC)

Section II: Eligibility, Provider Access and Benefits

Eligibility

As noted in Section III of this report, there are 269,896 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment decrease of 2,269 from DY5 Q3.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through December 31, 2018. Quarterly data is available through the fourth quarter of calendar year 2018.

Primary Care Provider (PCP)-to-Member Ratios

The primary care provider (PCP)-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier areas. Noted in last quarter's progress report, UnitedHealthcare (UHC) members were acquired by and transitioned to Presbyterian Health Plan (PHP) on September 1, 2018. The significant increase in enrollment, approximately 65,500 members, impacted PHP's PCP-to-Member ratio. Still well within the 1:2,000 standard, PHP ensured that transitioning members would seamlessly retain their existing PCPs, or PHP would reach out to the member to assist in selecting an in-network provider. For additional information regarding PHP's primary provider network and the UHC transition, please refer to the Provider Network section of this report.

Because UHC no longer has members, a PCP-to-Member ratio was not calculated beginning in September 2018, and "no data" (nd) or not applicable is an accurate report. Please see Table 1: PCP-to-Member Ratios by MCO.

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
BCBS	1:34	1:36	1:37	1:35	1:36	1:37	1:32	1:33	1:35
MHC	1:91	1:91	1:90	1:87	1:85	1:83	1:83	1:82	1:81
PHP	1:74	1:74	1:74	1:84	1:82	1:74	1:73	1:72	1:97
UHC	1:30	1:29	1:28	1:29	1:29	1:28	1:26	1:26	nd
Source: [MCO] PCP Report #53, Q3CY18									

Geographic Access

Physical Health and Hospitals

Geographic access performance standards require that at least 90% of members reside within defined distances to provider types in urban, rural, and frontier geographic areas. Please see Attachment B –GeoAccess Physical Health (PH) for New Mexico MCOs' geographic access performance.

Also of note, regarding MCO performance for geographic provider access this quarter, are the following points.

- MCO performance for access to general hospitals, PCPs, pharmacies and most specialties in urban, rural and frontier areas were met.
- Geographic access for dermatology, endocrinology, rheumatology, and urology services as well as access to neurosurgeons were, and continue to be, limited due to provider shortages in rural and frontier areas.
- Blue Cross Blue Shield of New Mexico (BCBS) reported 72.9% of urban members have access to dermatology. This is a slight improvement (+0.3%) as compared to last quarter. BCBS was the only MCO not meeting distance requirements for dermatology in urban areas. BCBS met geographic access to "FQHC- PCP Only" for rural members after having dropped below the performance standard last quarter.
- MHNM maintained a significant increase of urban members with access to dermatology services as reported in quarter two (+23%).
- BCBS and PHP met distance requirements for neurology services in frontier areas. MHNM is the only MCO to have met distance requirements for endocrinology (91%) in frontier areas.
- PHP's access percentages fluctuated somewhat during the UHC transition period. PHP established processes to ensure continuity of care and access for existing and transitioning members. For a description of PHP's transition process, please refer to the Provider Network section of the report.

Behavioral Health

In DY5 Q4, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier areas through Core Service Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient provider agencies, psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners. (See Attachment C: GeoAccess Behavioral Health Summary for MCO performance in meeting access to specific provider types.)

Rural and frontier access standards remain unmet with limited exceptions, for the following: Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs. Treatment Foster Care 1 & 2, Behavioral Management Services, Day Treatment Services, Intensive Outpatient Services, Methadone Clinics Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST). Rural access standards for Behavioral Health clinics are not met by the majority of MCOs.

With a few exceptions, none of the urban, rural and frontier access standards were met for non-accredited residential treatment programs, Indian Health Services and Tribal 638s providing BH, Day Treatment Services, and Rural Healthcare Clinics providing BH services.

HSD continues to be aware of the BH services that do not meet the standards due to provider shortages in New Mexico. MCOs continue to work to strengthen their relationships with the existing BH providers in their networks meeting routinely with them and with the State. The efforts to continue to increase accessibility through increased opportunities to expand use of telemedicine, maintain open panels, and expand reimbursement for extended hours have all been collaborated on.

The Interdepartmental Council (IDC), made up of Children, Youth, and Families Department (CYFD) and HSD, has been processing applications and conducting site visits to continue to increase approved Intensive Outpatient Programs (IOP). The addition of CareLink New Mexico (CLNM) Health Homes also increased accessibility for Medicaid beneficiaries with serious mental illness (SMI) for adults and severe emotional disturbance (SED) for children and adolescents.

MCOs individually continue to work to maintain access with the current network while continually striving to build accessibility through efforts to provide innovative service delivery to their members by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available network in ways such as having a Behavioral Health provider service representatives routinely visit providers to validate practice information, respond to claims and other issues. Additionally, MCOs are looking at value-based purchasing to increase access with appointment availability and utilizing High Fidelity Wrap around services to meet member's needs. MCO Network contracting teams monitor the out of network providers from the single case agreement files to recruit additional practitioners to participate in the Behavioral network. Also, ongoing assessments by some MCOs have identified recruitment opportunities with out of state border facilities for Inpatient BH services. It is also notable that MCOs continue to frequently be contracted with the entire available network for some services such as all approved Inpatient Psychiatric Hospitals and General BH Acute Hospitals in New Mexico although access standards are not met. The MCOs utilize additional border resources to provide members with access to services.

Community Health Workers

Centennial Care MCOs reported a 15% increase in members served by Community Health Workers (CHWs) from the previous reporting period. An increase of 21 CHWs was also reported for a total of 144 CHWs, employed or contracted. Please see Table 2 – Summary of CHW Workforce by MCO.

Table 2 – Summary of CHW Workforce by MCO

DY5 Q4			
Community Health Workers			
	Employed	**Contracted**	**Total**
BCBS	34	15	49
MHNM	19	0	19
PHP	40	1	41
UHC	20	15	35
Totals	**113**	**31**	**144**

Source: [MCO] CHW DSIPT, Q3CY18

Housing continues to be the number one social determinate of health need in quarter three, with food access unchanged as the number two request. CHWs are involved in working with members to regain personal documents such as birth certificates and social security cards to assist with applications for housing and other resources.

CHWs also obtain or update HRAs for members who have had an inpatient hospital admission or multiple Emergency Department visits, as well as link members with PCP appointments, prenatal and postpartum care, area wellness centers, detox resources and support in recovery, homeless shelter resources, and behavioral health facilities, including post discharge and follow-up resources. CHW services also focus on Hepatitis C treatment regimen support and follow up. Please see Table 3: Unduplicated Members Served by CHWs.

Table 3-Unduplicated Members Served by CHWs

DY5 Q4 Unduplicated Members Served					
	BCBS	**MHNM**	**PHP**	**UHC**	**Region Totals**
Underserved Urban	9,634	718	1,376	916	**12,644**
Rural	2,569	522	500	1,965	**5,556**
Frontier	643	84	153	704	**1,584**
MCO Totals	**12,846**	**1,324**	**2,029**	**3,585**	**19,784**

Source: [MCO] CHW DSIPT, Q3CY18

Educational outreach in Q3 included:

- NB3-Native American Healthy Foods Healthy Kids
- Head to Toe Healthy Kids Initiative
- American Lung Association-Asthma Basics
- St. Joseph's Children's Program- Parenting Classes
- Trumbull Resource Center-Toddler Safety Seat Education
- Roadrunner Food Bank-Health Foods Classes
- NM Legal Aid-Legal Topics Classes
- Health Education for Native Communities -Jicarilla, Zuni Pueblo, Taos Pueblo, Pine Hill Navajo Tribal 638, Alamo Navajo Tribal 638 & Ohkay Owingeh Pueblo

Telemedicine

MCOs reported increases in telemedicine services for rural and frontier areas of New Mexico in Q4DY5. MCOs reported the following efforts to increase telemedicine utilization.

- BCBS promoted the use of technology during the quarter, providing seven grants to New Mexico behavioral health provider groups ranging from $10,000-$15,000 to increase member access to telemedicine services. Tele-dermatology was made available through a primary care provider group. Promotion of telemedicine services was conducted at New Mexico Behavioral Health Provider Association meetings and a Provider Quick Reference Guide for telemedicine and newsletter was posted to the BCBS provider website.
- Molina Healthcare (MHNM) added Milagro Community Care providers to the Border Area Mental Health provider group increasing access to telemedicine services in the southeast cities of New Mexico, Silver City and Deming, both are located in.
- PHP focused on provider education, technical assistance, and telemedicine specific billing this quarter.
- UHC informed members of telemedicine services available through virtual visit technology and originating site location information.

Most telemedicine services are for members with behavioral health diagnoses. Please see Table 4 – Telemedicine Number of Behavioral Health Visits.

Table 4 - Telemedicine Services

DY5 Q4			
Number of Behavioral Health Visits			
	Urban	Rural	Frontier
BCBS	528	499	149
MHNM	549	1,014	148
PHP	1,938	2,324	1,160
UHC	194	523	135
TOTAL	**3,209**	**4360**	**1592**

Source: [MCO] Telemedicine DSIPT, Q3CY18

*Urban numbers are for data collection only and do not count towards DSIPT goal.

Transportation

To facilitate the ease of access, PHP and its transportation vendor SMT completed a trial run of online scheduling for non-emergency medical transportation for member appointments. PHP asked some of its Consumer Advisory Committee members to be part of the pilot program. Members responded positively to the enhanced scheduling option. Go-live for the program is January 1, 2019, and PHP aims to have utilization information by end of Q1CY19. The option for scheduling by telephone remains available to members as well.

Provider Network

During the last quarter of the year, HSD focused on Centennial Care 2.0 transition planning including member transitions, provider adequacy and network development. While HSD began transition planning in June 2017, with a thorough review and revision of its Transition Management Agreement (TMA), transition monitoring and deliverables continued through the quarter. Documents, due dates, and timelines were closely tracked by HSD to ensure continuity of care and services, facilitating a smooth transition for
New Mexico Medicaid members. Upon Go-Live of Centennial Care 2.0, on January 1, 2019, if a member's provider is determined to be out-of-network, all transition authorizations will be honored for a duration of 60–90 days depending on the service and in accordance with the TMA. In addition, the member's health needs and longevity with the provider will be reviewed by the receiving MCO to explore the potential for a single case agreement, the possibility of contracting with the provider, or assistance with a transition to a new provider as appropriate. To ensure continuity of care for members who do not want to switch providers, when their providers remain out-of-network for the receiving MCO, members will have an opportunity to switch MCOs. HSD monitored the complete list of MCO contracted and re-contracted weekly throughout the quarter and into 2019.

Service Delivery

Utilization Data

Centennial Care key utilization and cost per unit data by programs is provided for October 2016 through September 2018. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

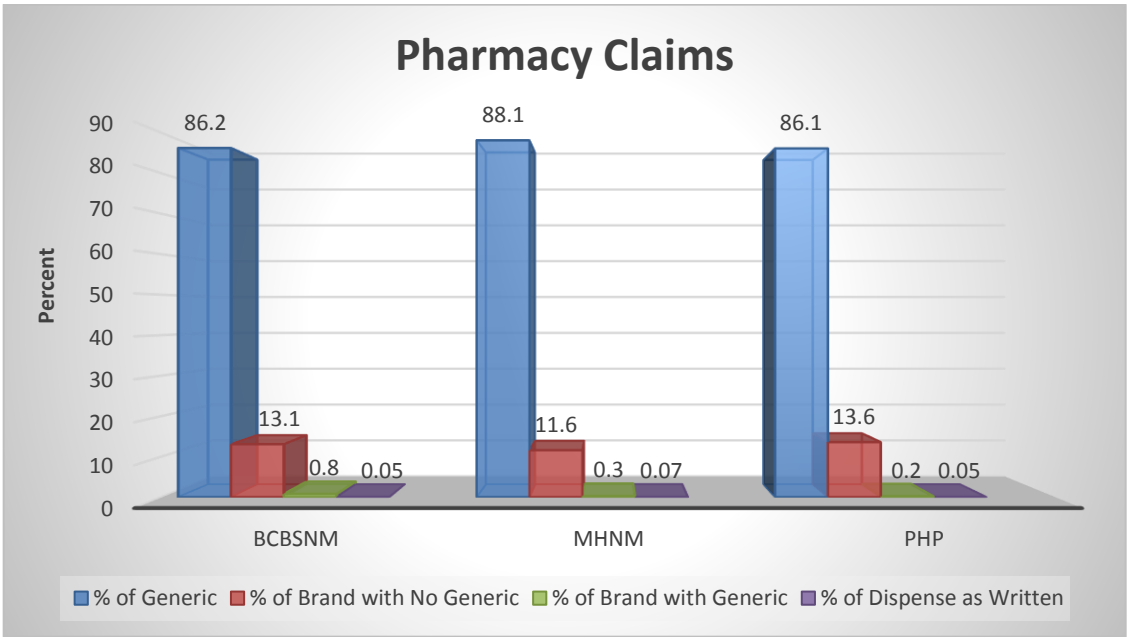
Pharmacy

HSD evaluates monthly MCO pharmacy reports to monitor key metrics regarding prescription claims on brand and generic drugs. Please refer to Table 5 – Percent of Pharmacy Claims for each MCO. This reporting period showed an average generic drug usage for all three MCOs of 87% which is a 1 percentage point decrease from the previous reporting period. In comparison to the last quarter, HSD identified the following:

- All MCOs had a slight decrease in generic drug utilization. BCBS had a 1.5 percentage point decrease, MHNM had a 0.6 percentage point decrease, and PHP had a 1.8 percentage point decrease in generic drug utilization from the previous quarter.

- All MCOs had an increase in usage of brand drugs with no generic available. BCBS had a 1.6 percentage point increase, MHNM had a 0.7 percentage point increase, and PHP had a 1.7 percentage point increase from the previous reporting period.
- The overall usage of brand medication when there was no generic available averaged 12.8 percentage points for the current reporting period with a 1 percentage point increase from the previous reporting period.
- BCBS AND PHP had a slight increase of 0.1 percentage point in the use of brand drugs when there was a generic available; MHNM remained the same. The 0.4% average use of brand drugs when there was a generic available had a slight decrease of 0.1 percentage point from the previous reporting period.
- All MCOs continue to require medical justification for the use of a brand drug when there is a generic available. Dispense as Written (DAW) claims averaged at 0.06% with MHNM having the highest number of DAW claims paid at 0.07%.

Table 5 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M9CY18, M10CY18, M11CY18

Hepatitis C (HCV)

During DY5 Q4, HSD reviewed MCO Q3DY5 data submitted on the HCV delivery system improvement performance target (DSIPT) reporting template. HSD is monitoring the number of unduplicated members requesting HCV treatment for Q3DY5 as well as similar numbers for direct antiviral agent prescription approvals and dispensing by both members' liver fibrosis stages and HCV genotypes.

Each MCO has implemented their own comprehensive plan to expand HCV screening, case finding and develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico. For Q3DY5 the following was reported:

- BCBSNM identified a large provider group which is interested in participating in the incentive program and is working on the finalized details. It is BCBS' intention to include incentives for provider training, starting patients on treatment and ensuring patients complete treatment.
- MHNM's comprehensive plan to expand HCV case finding and screening efforts are multi-faceted and consists of the following: 1) partnering with the Chronic Liver Disease Foundation to host HCV screening events at addiction treatment facilities; 2) establishment of a HCV database that tracks screening results, diagnosis based on laboratory results, and HCV medication treatment; and 3) monthly review of HCV database to identify members who have been screened, but were subsequently lost to follow-up, for outreach by our care coordinator team.

- PHP established a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico, including incentive for receiving Hepatitis C training through UNM Project ECHO; incentives for initiating treatment for Hepatitis C positive members; and incentives for completion of treatments for Hepatitis C positive members.
- UHC implemented a comprehensive plan to expand HCV case finding and screening efforts by engaging shared value-based care (VBC) partners and to other practices throughout the state for member outreach. Care coordinators were also given lists of patients that meet screening recommendations with the expectation that they will outreach to encourage the members to have a Hepatitis C screening test.

Nursing Facilities (NFs)

In DY 5, Q4, HSD received the final audit report from Myers and Stauffer related to claims adjudicated for the period of July 2016 through June 2017 by the Centennial Care MCOs. MCOs were given an opportunity to review the draft report and offer additional documents and feedback. The final report included findings and recommendations for changes to MCO policies and procedures. HSD is working with MCOs to ensure policies and procedures are updated.

Community Interveners

In DY5 Q3, five Centennial Care members received Community Intervener (CI) services as illustrated below. The MCOs provide education to their care coordinators to assist in identifying members that meet the criteria for the CI service. The MCOs provide technical assistance to CI providers when needed regarding billing issues. Please see Table 6 – Community Intervener Services Utilization DY5 Q3.

Table 6 – Community Intervener Services Utilization DY5 Q3

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims paid
BCBSNM	1	6	$38
MHNM	0	0	$0
PHP	3	29	$734
UHC	1	20	$ 125
Total	**5**	**55**	**$897**

Source: [MCO] Utilization Management Report #41, Q3CY18

Centennial Rewards Program

Centennial Care members are eligible for Centennial Rewards and to date, 714,199 distinct members, or 70.7% of all enrollees, have earned at least one reward. Since the launch of

Centennial Rewards, members have earned points totaling a value of $60.3 million. Of that amount $15.4 million have been redeemed for a cumulative redemption rate of about 26.6%. Points expire at the end of the year after the year in which they were earned. The table below shows the healthy behaviors rewarded and each behavior's value. It includes the maximum dollar value available for each activity, the total dollars earned, the amount redeemed, and the associated percentage of redemption by activity. Please see Table 7 – Healthy Behaviors Rewarded.

Table 7 – Healthy Behaviors Rewarded

Eligibility Activities	Reward Value in Points, by Activity	Reward Value in $, by Activity	Total Rewards Earned by Activity in $
Asthma Management	600	$60	$ 20,055
Bipolar Disorder Management	600	$60	$ 26,135
Bone Density Testing	350	$35	$ 1,295
Healthy Smiles Adults	250	$25	$ 306,425
Healthy Smiles Children	350	$35	$ 444,815
Diabetes Management	600	$60	$ 104,400
Healthy Pregnancy	1000	$100	$ 52,400
Schizophrenia Management	600	$60	$ 11,195
Health Risk Assessment (HRA)	100	$10	$ 40
Other (Appeals and Adjustments)	N/A	N/A	$ 43,780
Step-Up Challenge	250	$25	$ 32,075
Totals	**N/A**	**N/A**	**$ 1,042,615**

UnitedHealthcare Community Plan Termination

HSD sent out the Award Notification of the Centennial Care 2.0 RFP process to all the Managed Care Organizations (MCOs) on January 19, 2018. United Healthcare Care (UHC) was not awarded selection in Centennial Care 2.0 and began the transition process. During its transition, UHC entered into an agreement with Presbyterian Health Plan (PHP) and made plans to transition all UHC Centennial Care 1.0 membership to PHP after August 31, 2018. UHC submitted a Centennial Care 1.0 Decommission/Termination Plan to HSD on August 15, 2018 as required by and outlined in section 7.6.8 of the Managed Care Services Agreement and its Centennial Care 1.0 membership was transferred to PHP on September 1, 2018. UHC was advised by HSD regarding its continued contractual obligations for reporting and claims management requirements under the Transition Management Agreements and Transition Management section 7.6.8 of the Managed Care Services Agreement. UHC is current in all transition management requirements and continues to work though claims processing. HSD will continue to work with UHC on its contractual obligations through the remainder of 2019.

Molina Healthcare Plan Termination

HSD sent out the Award Notification of the Centennial Care 2.0 RFP process to all Managed Care Organizations (MCOs) on January 19, 2018. MHNM was not awarded a contract for Centennial Care 2.0 and began the transition process. MHNM entered into Transition Management Agreements with HSD and the selected Centennial Care 2.0 MCOs on May 14, 2018.

MHP submitted a Centennial Care 1.0 Termination Plan to HSD on March 15, 2018 as required by and outlined in section 7.6.8 of the Managed Care Services Agreement. MHP's Centennial Care 1.0 membership was transferred to the 2.0 Centennial Care MCOS on January 1, 2019. MHP was advised by HSD regarding its continued contractual obligations for reporting and claims management requirements under the Transition Management Agreements and Transition Management section 7.6.8 of the Managed Care Services Agreement. MHP is current in all its transition management requirements.

Section III: Enrollment

Centennial Care enrollment indicates a decrease in enrollment in all populations except TANF and Related Dual and 217 Like Group Dual with the Expansion population remaining stable. Most Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in the table below

The following table outlines all enrollment activity under the demonstration. The enrollment counts include unique enrollees, not member months. Please note that these numbers reflect current enrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of the reporting quarter. Since members change eligibility and thus MEGs during the year, the only way to give an unduplicated count for the quarter and YTD is to look at the last month a client was in the MEG within the period. For that reason, the unduplicated total for YTD could be less than a prior quarter. Please see Table 8: Enrollment DY5 Q4.

Table 8 – Enrollment DY5 Q4

Demonstration Population	Total Number Demonstration Participants DY5 Q4 Ending December 2018	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**361,557**	**461,482**
FFS	38,918	61,662
Molina	108,047	141,292
Presbyterian	145,448	173,879
Blue Cross Blue Shield	69,144	80,064
Population 2 – SSI and Related – Medicaid Only	38,260	42,045
FFS	2,445	3,751
Molina	11,138	12,914
Presbyterian	17,414	12,312
Blue Cross Blue Shield	7,283	7,382
Population 3 – SSI and Related – Dual	36,113	38,217
FFS	0	149
Molina	6,998	7,488
Presbyterian	21,517	21,790
Blue Cross Blue Shield	7,598	7,548
Population 4 – 217-like Group – Medicaid Only	310	504
FFS	57	214
Molina	51	58
Presbyterian	137	159
Blue Cross Blue Shield	65	70
Population 5 – 217-like Group - Dual	4,162	4,101
FFS	0	20
Molina	798	863
Presbyterian	2,242	2,136
Blue Cross Blue Shield	1,122	925
Population 6 – VIII Group (expansion)	269,896	287,446
FFS	28,695	38,228
Molina	66,664	70,378
Presbyterian	106,984	99,362
Blue Cross Blue Shield	67,553	65,803

Disenrollments

The definition of disenrollment is when a member was enrolled in Centennial Care at some point in the prior quarter and disenrolled at some point during that same quarter or in the reporting quarter and did not re-enroll at any point in the reporting quarter. Members who switch MEGs are not counted as disenrolled. The majority of disenrollment are attributed to loss of eligibility and death.

HSD continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any potential gaps in enrollment. Any issues that are identified or reported are researched and addressed. Please see Table 9: Disenrollment Counts DY5 Q4.

Table 9 – Disenrollment Counts DY5 Q4

Disenrollments	Total Disenrollments During DY5 Q4
Row Labels	
Population 1 – TANF and Related	**5,063**
FFS	484
Molina	1,509
Presbyterian	1,960
Blue Cross Blue Shield	1,110
Population 2 – SSI and Related – Medicaid Only	**291**
FFS	26
Molina	75
Presbyterian	120
Blue Cross Blue Shield	70
Population 3 – SSI and Related – Dual	**473**
Molina	104
Presbyterian	94
Blue Cross Blue Shield	103
Population 4 – 217-like Group – Medicaid Only	**8**
FFS	2
Molina	1
Presbyterian	3
Blue Cross Blue Shield	2
Population 5 – 217-like Group - Dual	**86**
Molina	9
Presbyterian	55
Blue Cross Blue Shield	22
Population 6 – VIII Group (expansion)	**6,784**
FFS	773
Molina	1,656
Presbyterian	2,720
Blue Cross Blue Shield	1,635
TOTAL	**12,705**

Section IV: Outreach

In DY5 Q4, HSD Outreach and Education staff participated in statewide outreach activities and events:

- Presented Centennial Care 2.0 changes to the New Mexico Aging & Long-Term Services Department's Aging & Disability Resource Center staff from around the state.
- Participated in the Centennial Care 2.0 readiness activities and conducted additional on-site visits for two MCO Member call-centers with a secondary location site and new call-center staff.
- Current MCOs participated in community events across the state providing enrollment opportunities and educating the public about Centennial Care. MCOs attended numerous Medicaid enrollment activities, health fairs and community events comprised of people with disabilities, senior citizens, children and families, Native Americans and other populations.

Please see Table 10: Schedule of Community Events DY5 Q4

Table 10 - Schedule of Community Events DY5 Q4

Event Type	Event Location and Date	Audience and Topics
NM Aging & Long-Term Services Department, Aging &	Santa Fe, NM Wednesday 12/19/2018	NM Aging & Long Term Services Department requested a Centennial Care 2.0 overview presentation for their state-wide Aging & Disability Resource Center staff.

Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's outreach efforts. With over 627 active certified Presumptive Eligibility Determiners (PEDs) state-wide, Medicaid application assistance is available in even the most remote areas of the state.

PEDs are employees of participating hospitals, clinics, FQHCs, IHS Facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some NM State Agencies (NM Department of Health, NM Children Youth and Families Department and the NM Department of Corrections).

In DY5 Q4, HSD PE Program staff updated the PE Certification trainings to reflect the

changes in the PE and on-going YESNM-PE application tool. The changes encompassed eligibility updates and manage care organization changes that were implemented as part of the 1115 waiver effective 01/01/2019.

PEDs continue to provide application assistance state-wide. In DY5Q4, PEDs:

- Granted 636 PE approvals*
- Submitted applications for 4,888 individuals
    - Resulted in 4,076 ongoing Medicaid approvals

*99.9% of all PEs granted in this reporting period also had an ongoing application submitted

JUST Health Program

PEDs who are employees of the NM Department of Corrections and County Jails or Detention Centers participate in the PE Program through the Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) program.

The JUST Health program allows for the automated data transfer of information for Medicaid eligible or enrolled individuals who are incarcerated in New Mexico. Individuals who are Medicaid-enrolled have their benefits suspended after 30 days of incarceration. Benefits are reinstated upon the individual's release from incarceration which allows immediate access to care. Individuals who are not Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply. Application assistance is provided by PEDs at the correctional facilities.

HSD has added enhanced care coordination activities for incarcerated individuals to the 1115 waiver application submitted to CMS. Each MCO will be required to have a dedicated position for justice-involved transitions, including releases that occur on weekends and after hours. Each MCO will be required to work with the facilities to begin care coordination activities prior to an incarcerated individual's release. It is HSD's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, BH appointments, etc.) upon release.

In DY5, Q4, HSD continues the Centennial Care JUST Health workgroup. The workgroup includes representatives from State and County Correctional facilities, Managed Care Organizations, County governments, State agencies, provider organizations and other stakeholders. The goal of the workgroup is to create processes and procedures that can be utilized and adapted to work for all correctional facilities state-wide.

Section V: Collection and Verification of Encounter Data and Enrollment Data

Encounter Data

The MCOs submit encounters daily and/or weekly to stay current with encounter submissions. HSD continues to work with the MCOs to respond to any questions and address any issues related to encounters. HSD works directly with each MCO to address any issues with encounters that have been denied or not accepted. HSD and the MCOs have developed a productive partnership to fix any system edits in either or both systems. HSD meets regularly with the MCOs to address their individual questions and to provide guidance. HSD continues to monitor encounters by comparing encounter submissions to financial reports to ensure completeness. HSD monitors encounters by extracting data on a monthly basis to identify the timeliness and accuracy of encounter submissions. HSD shares this information with the MCOs so they are aware of any potential compliance issues. HSD extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. HSD has seen vast improvements in both the accuracy and timeliness related to encounter data.

Enrollment Data

Data is extracted on a monthly basis to identify Centennial Care enrollment by MCO and for various populations. Any discrepancies that are identified, whether due to systematic or manual error, are immediately addressed. Eligibility and enrollment reports are run on a monthly basis to ensure consistency of numbers. In addition, HSD continues to monitor enrollment and any anomalies that may arise so they are addressed and resolved timely. HSD posts the monthly Medicaid Eligibility Reports to the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx. This report includes enrollment by MCOs and by population.

Section VI: Operational/Policy/Systems/Fiscal Development Issues

Program Development

In preparation for implementation of Centennial Care 2.0, HSD worked with the Managed Care Organizations (MCOs) selected for 2.0 as well as the MCO whose contract would terminate in December 2018. Requirements were developed for the coordination and smooth transition of high-risk members and vulnerable populations. HSD conducted weekly calls with the MCOs to monitor the transition of these members, while ensuring continuity of care, the transfer of member files, care coordinator engagement, and collaboration between the MCOs.

HSD will have staff on-site at the new MCO, Western Sky Community Care (WSCC) for the first week of Centennial Care 2.0 to assist WSCC staff with the transition. HSD will also conduct daily calls with the Centennial Care 2.0 MCOs beginning January 3, 2019, to monitor activities including, but not limited to the following:

- Pharmacy claims and payment;
- Transportation utilization and grievances;
- Call center performance for the member services, provider services, utilization management, and nurse advice lines;
- Member enrollment, including care coordination level assignment and engagement efforts;
- Care coordination timely completion of Comprehensive Needs Assessments (CNAs);
- Nursing Facility Level of Care (NF LOC) determinations;
- Personal Care Service (PCS) claims payment and cash advances; and
- Utilization management (prior authorizations) for physical health, behavioral health, community benefits, durable medical equipment, and pharmacy.

Transition monitoring will continue and Transition Management Agreement (TMA) deliverables will be provided and tracked by HSD into early 2019 to ensure continuity of care and MCO compliance.

In DY5 Q4, HSD finalized Amendment #1 to the CC 2.0 contract. In this amendment, HSD requires new initiatives and worked to clarify definitions and expectations for the Managed Care Organizations (MCOs). Initiatives in the CC 2.0 Amendment #1 include but are not limited to:

- Increased thresholds for many of the Delivery Systems Improvement Performance Targets;
- Increased requirements for nursing facilities and those members meeting a nursing facility level of care;
- Clarified Care Coordination measures for members including but not limited to:
    - Members with co-morbid conditions;
    - Cognitive defects;
    - Poly-pharmaceutical use, defined as use of six or more medications from different drug classes or simultaneous use of three or more medications from the same drug

class;
    - Requiring assistance with two or more activities of daily living;
    - Members classified as difficult to engage.
- Supportive Housing programs targeting an increased population, including but not limited to:
    - Members with serious mental illness;
    - Chronic substance use disorders;
    - High emergency department usage;
    - High inpatient utilization;
    - Crisis stabilization;
    - Funding and direction for School Based Health Centers;
    - Implementation of a Federally Qualified Health Center (FQHC) residency pilot program, to be approved by HSD;
    - New requirements for pharmacy and provider payments and Spread Pricing methodology with required reporting on these initiatives to HSD;
- Initiatives to provide oversight and monitoring of the use of controlled substances including opioids, including but not limited to:
    - Implementation of a task force to develop a standard monitoring program for controlled substance utilization;
    - Monitoring of opioid drug use and poly-drug use in order to detect the potential for drug overdose;
    - Coverage of naloxone without prior authorization or quantity limits;
    - Establishment of a critical incident review committee;
    - Implementing Self-Directed Community Benefit (SDBC) measures to provide assistance and services to those who meet a nursing facility level of care but are able and willing to live in the community
- Quality Assurance initiatives including but not limited to:
    - Value Based Purchasing (VBP) initiatives to reward providers based on quality and improved outcomes rather than volume or services, initiatives require demonstration on how VBP programs improve member outcomes and quality scores;
    - Establishment of a critical incident review committee and reporting on annual dental visits and control of high blood pressure

Behavioral Health

Please refer to Attachment E: Behavioral Health Collaborative CEO Report for an update on Behavioral Health activities.

MCO Initiatives

Blue Cross and Blue Shield of New Mexico
Inpatient Behavioral Health Bundled Case Rates and Value Based Purchasing

BCBSNM has introduced a new reimbursement model to two high volume inpatient behavioral health providers in the state. The new reimbursement model includes paying providers a bundled case rate for each inpatient admission with a primary psychiatric diagnosis. Providers can share savings if the facility reduces their overall readmission rate and percentage of members who have follow-up appointments with a behavioral health provider within seven days of discharge.

The current reimbursement methodology for inpatient psychiatric providers is a negotiated per diem rate, or flat rate that is paid for every day a member is authorized for payment by BCBSNM. This requires the provider and BCBSNM to not only review the medical necessity of the admission, but also to do ongoing concurrent reviews throughout the stay to determine medical necessity. With the change to a bundled case rate, the provider will be paid a flat amount for the inpatient stay, no matter how long or short the stay is (with a stop loss provision if the stay is exceedingly long). The case rate will be slightly higher than the average amount providers are currently getting paid for an admission. With the case rate, the provider is only required to do a medical necessity review upon admission and is no longer required to do concurrent medical necessity reviews. This approach frees up resources for both the provider and BCBSNM to focus on aftercare arrangements and discharge planning.

The bundled case rate approach that allows providers and BCBSNM to focus on setting up strong discharge and aftercare plans are expected to help ensure members are seen soon after discharge, which has proven to be a significant factor in preventing readmissions within 30 days of discharge. Since a reduction of readmissions would have a financial impact on providers, this reimbursement model would share savings with BCBSNM as well from the reduced readmissions. The outcome of this reimbursement model is expected to significantly improve member outcomes while generating moderate savings.

Urgent Care Telemedicine Services in Member Homes

Telemedicine services that members can access from their home have been available for several years to members who have non-urgent healthcare needs and who have access to equipment (e.g., computer or smart phone) that provides real-time audio and visual. This standard telemedicine service can often treat members very effectively and efficiently; however, there are times that members require more of a "hands-on" approach. For example, a telemedicine provider is typically not able to obtain member's vital signs (e.g., blood pressure, pulse, breathing, etc.), and if a provider thinks it's necessary, the member is referred to an urgent care or emergency room. In addition, some members do not have the necessary equipment to access telemedicine services from their home.

BCBSNM has been working with an urgent care provider on a new telemedicine service model that addresses these limitations of the standard telemedicine visit. This urgent care telemedicine model includes sending a paramedic to the member's home. The paramedic would take the member's vital signs and collect other basic information that is typically done by a nurse in an office or urgent care setting. The paramedic then initiates a telemedicine call with the urgent care provider who is at the urgent care center ("distant site") by portable telemedicine equipment, which the paramedic sets up in the home. The member successfully has their telemedicine visit with the urgent care provider.

The urgent care provider is reimbursed for the telemedicine urgent care visit at the same rate as if the member was seen at the urgent care center, plus an additional fee for the telemedicine "originating site" fee. Members can set up these urgent care telemedicine visits either online or by phone. This urgent care telemedicine service will be available for members in the first quarter of 2019.

Difficult to Engage Program

In early 2019, BCBSNM is piloting a new initiative called the Difficult to Engage (DTE) Program with the intention to increase care coordination engagement with the DTE and Unable to Reach (UTR) population. The purpose of the DTE Program is to locate and establish contact with members whom BCBSNM has not been able to reach through traditional channels and engage them in care coordination. BCBSNM recognizes that some DTE/UTR members have mental/behavioral health disorders, substance abuse issues, or a psychosis when left untreated, may lead to a higher risk of self-harm, harm to others, or increase in Emergency Department (ED) and/or Hospitalization utilization. BCBSNM's strategy is to develop a team that has unique training and background to engage with difficult members and develop a relationship in order help move them towards care coordination. This team will consist of DTE care coordinators who will be able to complete assessments and triage any urgent issues before assigning the member to a care coordinator. Once assigned, the care coordinator will resume care coordination activities with the member.

Initially, the project will launch in the Metro and Las Cruces area based on the highest concentration of population, ED/Hospitalization usage, homelessness, and DTE/UTR data. BCBSNM will expand the program and eventually cover all of New Mexico as BCBSNM's capacity increases.

Benefits of the DTE Program include:

- Improving member relationship and participation in care coordination
- Improving treatment outcome
- Reducing unnecessary ED/Hospital utilization
- Improving healthcare utilization
- Decreasing unnecessary medical expense
- Reducing closure rates
- Decreasing unnecessary strain upon health facilities through care coordination

By having a team dedicated to reaching out to these difficult to engage members, BCBSNM is extending its healthcare reach and closing the gap to ensure every member has an opportunity to participate in care coordination and receive the treatment they need.

Molina Healthcare Community Paramedicine

Molina Healthcare partnered with American Medical Response (AMR) and Las Cruces Fire Department (LCFD) with the objective to improve the triple aim of better health, better care and lower costs. Both vendors conducted home visits/outreach to targeted Members providing assessments and education to reduce gaps in care.

Continuous Quality Improvement – Pre and Post-Partum HEDIS

The QI and Population Health Department maintained the Motherhood Matters program, assisting women to obtain the education and services needed for a healthy pregnancy. Services may include prenatal education materials, coordination with social services, and/or case management by a nurse. Expecting mothers can receive 1,000 points ($100) in Centennial Rewards for completion of their maternity screening with a Care Coordinator to identify any additional support or assistance that may be needed. Following delivery, Members who complete their postpartum visit between three (3) and eight (8) weeks after delivery are eligible to receive a reward gift card.

Health Home – CareLink NM

As of 12/31/2018, Molina had 746 members opted-in to Health Homes across the state. The QI and Population Health Department identifies and refers members who qualified for a Health Home.

Quality Improvement PMs – Provider Outreach/Partnerships

- 2 high volume groups participated in a cost-containment program for high risk members (mPACT):
    - Targeted 10% PMPM cost reduction over 12 months;
    - Both provider groups exceeded the targeted reduction;
    - $2.7 M in cost savings was achieved; and
    - 50% of cost savings was shared back to the provider groups.
- Continued to provide education about quality initiatives and health education programs at Member Advisory Board meetings in collaboration with the Member Engagement Department and Native American Affairs.
- Continued to review best practices for improved performance measure rates for targeted Provider Engagement Team (PET) visits at First Choice Community Health Clinic, Clinica la Esperanza, Las Cruces Physician Services, La Clinica de Familia, Presbyterian Medical Services and Lovelace.

Quality Improvement/Member Engagement

Member Engagement hosted **5** Member Advisory Board Meetings in the 4th quarter. The meetings were for Marketplace, Medicare and Centennial Care members and were held in Albuquerque, Upper Fruitland and Las Cruces NM. Topics included self-help tools such as MyMolina Portal and HealthInHand App; other topics included Members' Rights & Responsibilities, Members' Appeals & Grievance process, role and responsibilities of the Ombudsman Care Coordination and Community Benefits. Members were also informed about Health Education Programs such as Quit for Life, Motherhood Matters, National Diabetes Prevention Program, My Chronic Disease and Centennial Rewards. To focus on Behavioral Health, Members were educated about the Peer Support Program and provided with the number for the NM Crisis Line as an additional resource.

Presbyterian Health Plan

PHP finalized an agreement with the Navajo Nation Shiprock Service Unit CHR/Outreach Program to provide community outreach services. The agreement covers the State of New Mexico, part of San Juan County, and the Shiprock Agency.

PHP continues the rollout of their Provider Incentive Program with its next target being the Farmington/Bloomfield area of the state. PHP looks to have this incentive program completed by the end of the first quarter of 2019.

Staff expansion

The Population Health Management Community Health Worker (CHW) team added 8 new CHW FTEs and 4 new Certified Peer Support Worker (CPSW) FTEs and 1 CHW supervisor FTE to the current population health management (PHM) team of 9 CHWs and 1 Manager. The additional staff allows the team to cover a greater number of counties in the southern and northern parts of the state, including the northwest part of New Mexico. The identified member behavioral health needs are addressed more effectively with adding CPSWs to the team. A high percentage of members who are identified with social needs, emergency department (ED) overutilization and physical health care gaps have underlying behavioral health and substance abuse disorders.

Development of Questionnaires & Tools for Care Plans in JIVA

PHP's previous social determinants of health (SDOH) needs questionnaire was updated to reflect evidence-based questions from the "Health Leads Social Needs Screening Toolkit" into the new medical management system, JIVA. Social needs identified during the screening process then trigger a care plan item with suggested goals and interventions based on the Community Health Worker's scope of work as defined by the New Mexico Department of Health Community Health Worker board. Additionally, by identifying needs that require CHW/PSW intervention and documenting the outcome of the intervention in a care plan format, outcomes data can more easily be gathered and measured for future program enhancements.

Fiscal Issues

During DY5 Q4, underwriting gain recoupment for capitation rates for calendar year 2016 reduced the PMPM for MEG 1 of DY 3. The health insurance providers fee payments and recoupments for retroactive eligibility and hepatitis C reconciliations resulted in a higher PMPM for MEG 1 and 6 of DY 4. The health insurance providers fee payment and patient liability reconciliation payments contribute a higher PMPM for MEG 2 of DY 4. For DY 5, the capitation payments reflected the rates update to account for additional programmatic change, changes to the medical and non-medical components to account for material changes in the enrolled populations, and a change to the premium assessments. These changes were identified in the revised rate certification letters dated June 11, 2018 and submitted to CMS on August 17, 2018. The effects of those changes continued to contribute to higher PMPMs for all MEGs in quarter 4 of DY 5 compared to those PMPMs reported for quarter 3 of DY 5.

Systems Issues

HSD continues to implement reporting for analysis and oversight. HSD and the MCOs work together to address any concerns or make any necessary system changes on either side. There is a process in place to identify, track, research and resolve any issues that may arise.

Medicaid Management Information System Replacement

HSD's planning for replacement of its current legacy Medicaid Management Information System (MMIS) began some time ago, and activity for this effort continued to progress in DY5 Q4. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the Department of Health (DOH), Children Youth and Families Department (CYFD), and the Aging and Long-Term Services Department (ALTSD). These three departments have participated in RFP development and replacement planning. For overview and status please reference Table 12: Overview of status for MMSIR Modules.

Table 12 - Overview of status for MMSIR Modules

Module	Description	Status	Date
IV&V	Independent Verification and Validation service (incl. document review, risk assessment, mitigation plan)	Contracted	Aug 2016
System Integrator	Infrastructure for Connectivity, Interoperability, Standards and Security; Enterprise Service Bus, Master Indices, Identity Management, and Legacy Data Conversion; Project Integration Management for all other modules; Data definition and Interface standards	Contracted	March 2018
Data Services	Data Tools and Trainings; Analytics; Reporting; Business Intelligence; Enterprise Data Warehouse	Contracted	Ongoing
Quality Assurance	Program integrity; Third-Party Liability (TPL) Detection, Avoidance and Recovery; Fraud Detection and Reporting Audit and Hearing Coordination; Quality Reporting, RAC	In Procurement	Ongoing
Benefit Management Services	Case/ Care management; Member and provider management; Utilization management; Pharmacy benefits management; Benefit Plan management	Pending release	
Financial Services	Claims processing; payments; financial activities (including account payable, account receivable, financial reporting, budgeting)	Pending release	
Unified Portal Consolidated Customer Service Center	Unified Portal – one stop shop across all programs; Consolidated Customer Service Center – Integrated contact center serving all HSD programs	In Procurement	

Section VII: Home and Community-Based Services

New Mexico Independent Consumer Support System (NMICSS)

The NMICSS is a system of organizations that provide standardized information to beneficiaries about Centennial Care, long-term services and supports (LTSS), the MCO grievance and appeals process, and the fair hearing process.

The NMICSS reporting for the quarter is provided by the Aging and Long-Term Services Department (ALTSD) - Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the general public to access a variety of services, including state and federal benefits, adult protective services, prescription drugs, in-home and community-based care, housing, and caregiver support. The ADRC provides telephonic information, assistance, referrals and advocacy in those areas of daily living that will maximize personal choice and independence for seniors and adults with disabilities throughout New Mexico, as well as for their caregivers.

ADRC Coordinators provide over the phone counseling in care coordination, which is the

process for assisting the client in describing their situation/problem. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions. The ALTSD provides quarterly reports to HSD regarding the ADRC Caller Profile Report and Care Transitions Program Data. Please see Table 11: ARDC Call Profiler Report DY5 Q4 and Table 12: ADRC Care Transition Program Report DY5 Q4.

Table 11 – ADRC Call Profiler Report DY5 Q4

Topic	# of Calls
Home/Community Based Care Waiver Programs	1,927
Long Term Care/Case Management	3
Medicaid Appeals/Complaints	4
Personal Care	226
State Medicaid Managed Care Enrollment Programs	13
Medicaid Information/Counseling	702

Table 12 – ADRC Care Transition Program Report DY5 Q4

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		159	
Medicaid Education/Outreach	3418		
Nursing Home Intakes		72	
**LTSS Short-Term Assistance			160

*Care Transition Specialist team educates residents, surrogate decision makers, and facility staff about Medicaid options available to the resident and assist with enrollment.

**Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed decisions about appropriate long- term services and supports choices in the context of their personal needs, preferences, values and individual circumstances.

As a member of the NMICSS, the ALTSD Care Transition Bureau (CTB) is providing assistance to Medicaid beneficiaries enrolled in Centennial Care receiving long-term services and supports (institutional, residential and community based) in navigating and accessing covered healthcare services and supports. CTB staff serve as advocates and assist the individual in linking to both long-term and short-term services and resources within the Medicaid system and outside of that system. CTB staff also monitors to ensure that services identified as a need are provided by the MCO, MCO subcontractors and other community provider agencies. The main purpose is to help consumers identify and understand their needs and to assist them in making informed decisions about appropriate long-term services and support choices in the context of their personal needs, preferences, values and individual circumstances.

The CTB provides education of the program and transition referrals to new nursing facility staff. The CTB is working closely with the MCOs to identify ways to work collectively to increase referrals and provide advocacy to additional residents in the transition process.

The CTB supervisors and bureau chief met with incoming Medicaid Centennial Care 2.0 MCO, Western Sky Community Care. The meeting provided introductions to discuss programs the ALTSD/ADRC serve and how to work collaboratively with Medicaid recipients in the transition process.

Critical Incidents

HSD continues to meet quarterly with the MCOs' Critical Incident workgroup in an effort to provide technical assistance. The workgroup also supports the Behavioral Health Services Division (BHSD) in the delivery of Behavioral Health (BH) incident reporting protocols to providers. BH protocols have been implemented by HSD/BHSD to improve reporting accuracy as well as establish guidelines for the types of BH providers who are required to report.

United Healthcare (UHC) data is not reflected in the DY5 Q4 report. UHC coordinated with Presbyterian to transfer its Medicaid membership on September 1, 2018. HSD continues to monitor the transition to ensure continuity of care for Medicaid members. UHC provides HSD with a weekly update regarding the single death investigation which currently remains open. This investigation remains open and pending a report from of the Office of the Medical Investigator.

During DY5 Q4, a total of 5,523 Critical Incident Reports (CIRs) were filed for Centennial Care members in the areas of physical health, behavioral health, and self-directed community benefit services. One hundred percent of all CIRs received through the HSD Critical Incident web portal are reviewed. HSD continues to provide technical assistance to the MCOs when providers are non-compliant with reporting requirements.

During DY5 Q4, a total of 494 deaths were reported. Of those deaths reported, 471 were reported as natural or expected deaths while 71 deaths were reported as unexpected and one death was reported as a suicide. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

All CIRs require follow-up and may include a medical record review or a request for records from the Office of the Medical Investigator to determine cause of death. MCOs have internal processes regarding follow-up for all member deaths.

During DY5 Q4, a total of 3,544 critical incidents were categorized as Emergency Services. Of those, 171 were reported by BH providers and 255 were associated with self-directed members. This demonstrates a downward trend in the number of incidents categorized as Emergency Services when compared to DY5 Q3 (3,865), DY5 Q2 (3,797), DY5 Q1 (3,685). MCOs continue to identify the use of Emergency Services as the highest critical incident type reported by volume for members with a reportable category of eligibility. Please see Table 13: Critical Incidents Types by MCO – Centennial Care.

Table 13 – Critical Incident Types by MCO – Centennial Care

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	28	0.58%	74	1.53%	126	2.60%	0	0.00%	228	4.70%
Death	132	2.72%	85	1.75%	277	5.71%	0	0.00%	494	10.19%
Natural/Expected	120		79		233		0		432	
Unexpected	12		6		43		0		61	
Suicide	0		0		1		0		1	
Elopement/Missing	1	0.02%	8	0.16%	8	0.16%	0	0.00%	17	0.35%
Emergency Services	582	12.00%	720	14.85%	1,816	37.44%	0	0.00%	3,118	64.29%
Environmental Hazard	15	0.31%	18	0.37%	44	0.91%	0	0.00%	77	1.59%
Exploitation	13	0.27%	14	0.29%	49	1.01%	0	0.00%	76	1.57%
Law Enforcement	17	0.35%	18	0.37%	31	0.64%	0	0.00%	66	1.36%
Neglect	118	2.43%	123	2.54%	533	10.99%	0	0.00%	774	15.96%
Total	**906**	**18.68%**	**1060**	**21.86%**	**2,884**	**59.46%**	**0**	**0.00%**	**4850**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	4	1.17%	20	5.85%	18	5.26%	0	0.00%	42	12.28%
Death	2	0.58%	8	2.34%	12	3.51%	0	0.00%	22	6.43%
Natural/Expected	2		7		9		0		18	
Unexpected	0		1		3		0		4	
Suicide	0		0		0		0		0	
Elopement/Missing	0	0.00%	3	0.88%	2	0.58%	0	0.00%	5	1.46%
Emergency Services	13	3.80%	111	32.46%	47	13.74%	0	0.00%	171	50.00%
Environmental Hazard	0	0.00%	2	0.58%	2	0.58%	0	0.00%	4	1.17%
Exploitation	1	0.29%	3	0.88%	6	1.75%	0	0.00%	10	2.92%
Law Enforcement	4	1.17%	6	1.75%	11	3.22%	0	0.00%	21	6.14%
Neglect	10	2.92%	23	6.73%	34	9.94%	0	0.00%	67	19.59%
Total	**34**	**9.94%**	**176**	**51.46%**	**132**	**38.60%**	**0**	**0.00%**	**342**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	1	0.30%	5	1.51%	7	2.11%	0	0.00%	13	3.93%
Death	5	1.51%	2	0.60%	20	6.04%	0	0.00%	27	8.16%
Natural/Expected	5		1		15		0		21	
Unexpected	0		1		5		0		6	
Suicide	0		0		0		0		0	
Elopement/Missing	0	0.00%	1	0.30%	0	0.00%	0	0.00%	1	0.30%
Emergency Services	34	10.27%	31	9.37%	190	57.40%	0	0.00%	255	77.04%
Environmental Hazard	0	0.00%	0	0.00%	4	1.21%	0	0.00%	4	1.21%
Exploitation	1	0.30%	2	0.60%	2	0.60%	0	0.00%	5	1.51%
Law Enforcement	3	0.91%	1	0.30%	7	2.11%	0	0.00%	11	3.32%
Neglect	0	0.00%	4	1.21%	11	3.32%	0	0.00%	15	4.53%
Total	**44**	**13.29%**	**46**	**13.90%**	**241**	**72.81%**	**0**	**0.00%**	**331**	**100.00%**

Home and Community-Based Services Reporting

In DY5 Q4, HSD completed its analysis of the on-site validation and participant surveys with Community Benefit providers and members. HSD continues to update the Statewide Transition Plan milestones as required by CMS.

Long-Term Services and Supports (LTSS)

In DY5 Q4, HSD continued to conduct ride-alongs with the MCO care coordinators to observe and monitor care coordination interactions and interviewing practices. For more information regarding the ride-alongs, please see section XIII – Quality Assurance/Monitoring Activities.

HSD continued to hold meetings with PHP to discuss and resolve any transition issues for members who transitioned from UHC as described in the previous quarterly report. PHP resolved all Personal Care Services authorizations related issues, and no new issues were reported during the quarter.

In October 2018, HSD began meeting with each of the MCOs on a weekly basis in anticipation of the implementation of Centennial Care 2.0 and the transition of LTC members between MCOs. In addition, the following long-term care areas were monitored by HSD through weekly reporting from the MCOs:

- LTC service authorization information file transfers amongst MCOs to ensure no break in services occurred with transitioning members;
- Self-Directed member transitions from one MCO to another;
- Development of Western Sky Community Care's LTC provider network; and
- Timely processing of NF LOC determinations.

Self-Directed Community Benefit

In DY5 Q4, HSD met regularly with the SDCB fiscal management agency (FMA) and the MCOs to develop and implement system changes needed for the Centennial Care 2.0 new initiatives such as:

- Start-Up Goods as a new service;
- Increased Respite hour limit from 100-300;
- Limits on certain services for new SDCB members;
- Non-Medical Transportation procedure code changes; and
- Continuous NF LOC.

Electronic Visit Verification

In DY5 Q4, HSD continued planning activities with the MCOs and their EVV Vendor, First Data, for the implementation of EVV for self-directed personal care services. MCOs continued to solicit member input through their regular Member Advisory Board meetings. The SDCB EVV member survey was closed on December 31, 2018, and HSD is analyzing the data that will drive policy decisions in early 2019.

Section VIII: AI/AN Reporting

Access to Care

I/T/Us are concentrated near or on Tribal land where many Native Americans live and receive services. Native Americans in Centennial Care may access services at IHS and Tribal 638 clinics at any time. Approximately 53,891 Native Americans are enrolled in Centennial Care. Data from the MCOs this quarter is consistent with the previous quarter showing:

- 97.5% access to care for Native Americans in rural areas and 98.4% in frontier areas for physical health
- 97.5% access to care for Native Americans in rural areas and 98.4% in frontier areas for behavioral health

Contracting Between MCOs and I/T/U Providers

Since the last quarterly report, UnitedHealthcare members transitioned to Presbyterian Health Plan effective September 1, 2019. The remaining MCOs BCBS, Molina and Presbyterian Health Plan continue to reach out to Indian Health Service (IHS) and Tribal 638 health providers, as well as Tribal programs to develop agreements. Some of the MCOs have contracts with Navajo Area IHS. The MCOs treat the non-contracted I/T/Us as if they are contracted for services rendered to their MCO members. For several of the MCOs, services rendered at any non-contracted I/T/U are considered contracted/in-network for members. There is ongoing outreach to I/T/U programs for reimbursement for telemedicine, peer support recovery programs, Community Health Representative (CHR) services, and non-emergency medical transportation. Several MCOs continue to work with Tribal CHR programs to develop a customized process to reimburse them for their services to MCO members.

Ensuring Timely Payment for All I/T/U Providers

Two of the four MCOs met timely payment requirements for claims processed and paid within 15 days of receipt. The contract standard is for 95% of claims to be processed and paid within 15 days of receipt. For claims processed and paid within 30 days of receipt, none of the MCOs met this standard. The range was 88% to 96% and the contract standard is 99% of claims will be processed and paid within 30 days of receipt. Please see Table 14: Native American Advisory Board (NAAB) meetings for DY5 Q4.

Table 14 – Native American Advisory Board (NAAB) meetings for DY5 Q4

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	PMS Farmington Community Health Center Farmington, New Mexico October 17, 2018	**Issue**: A member asked if all her prescriptions could be sent to the pharmacy. **Response**: BCBS Ombudsman responded that behavioral health prescriptions will be limited. **Issue:** A member asked the difference between home health services and personal care services. **Response:** BCBS stated home health services are for short term acute conditions. Personal Care Services (PCS) are for chronic conditions requiring long-term care. A member needs to qualify for PCS based on Activities of Daily Living (ADL).
MHC	Five Sandoval Indian Pueblos, Inc. Rio Rancho, New Mexico September 12, 2018	There have been some changes to the Motherhood Matters program. One major change Molina informed the group about is a $20 Walmart gift card in lieu of a car seat upon completion of the program. **Issue:** What is the difference between an emergency room (ER) visit and an urgent care visit? **Response:** Molina provided examples of the difference and explained when each one should be used. **Issue:** What is the status of Molina Healthcare in 2019? **Response:** Molina informed members that Molina Healthcare was not selected to be an MCO for Centennial Care 2.0 starting January 1, 2019. Molina Healthcare will continue to provide Medicaid coverage untilthe end of 2018.

PHP	CHR Conference Room Mescalero, New Mexico October 19, 2018	**Issue:** A lot of members don't know anything about care coordination. **Response:** PHP had care coordinators at the meeting who explained what care coordination is andhow care coordinators can help members. It starts with a health risk assessment. **Issue:** PHPs transportation vendor, SMT, does not offer mileage reimbursement. SMT denied member transportation because they needed to find a doctor closer to Ruidoso. **Response:** SMT does not approve or deny transportation. If the travel distance is exceeded, then SMT reaches out to the PHP travel team to give a determination. **Issue:** Diabetic patients are being told they can't eat or drink in the transportation vendor's car. **Response:** For medical issues it is allowed, but the member is asked to bring the meal in a sealed container. There is also a handout for transportation in the packet.
UHC	Farmington Marriott Courtyard Farmington, New Mexico June 7, 2019	The meeting began with UHC informing the group that UHC's bid was denied for Centennial Care 2.0. UHC remains dedicated to its members and the partnerships. They will be operating business as usual. **Issue:** Transport providers are not showing up on time. **Response:** Minutes don't indicate response, but the transportation vendor was at the meeting. **Issue:** What the rules are if a member needs an attendant to assist the member? **Response:** It must be medically necessary and transportation vendor will provide the form.

HSD's Native American Technical Advisory Committee (NATAC) Update
At the NATAC meeting December 10, 2018, the NM Medicaid deputy director presented an update on Centennial Care 2.0 and changes that are effective 01/01/2019.

There was also an update on the federal match for services received through an IHS/Tribal 638 facility. NATAC presented the Native American Data Report which is analyzed quarterly for Native Americans receiving MCO services. There was a Community Health Representative (CHR) update and an Income Support Division (ISD) update.

Update on implementation of the federal reinterpretation of guidance for services received through IHS/Tribal Facilities

- **Albuquerque Area IHS (AAIHS) and the University of NM Hospital (UNMH)**
  UNMH continues to bill for the FMAP for FFS members as well as Native Americans in an MCO referred by IHS. UNMH is in the final stages of having a CCA in place with two Tribal 638 facilities.

- **Navajo Area IHS (NAIHS) and UNMH**
  The CCA between UNMH and Navajo Area IHS was signed 09/26/2018. UNMH began billing for claims 12/01/2018 after a system configuration that was required to process identified claims for the 100% federal match with NAIHS.

- **AAIHS and Presbyterian**
  Presbyterian began claiming the FMAP for services referred by IHS 05/01/2018. Currently they are only identifying claims for FFS members.

- **NAIHS and Presbyterian**
  The CCA discussions were on hold during the federal shutdown since key players with NAIHS were unable to be on the calls. The first conference call between NAIHS and Presbyterian was 01/30/2019. Presbyterianasked NAIHS to research the volume of referrals NAIHS is sending to Presbyterian providers before a second meeting is scheduled.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment F: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY5 Q4 reflects the continued impact of the CY 2018 rate adjustments for programmatic change, changes to the medical and non-medical components to account for material changes in the enrolled populations, and a change to the premium assessments as provided to CMS on August 17, 2018. The PMPM for DY 5 is lower compared to DY 4 for MEGs 1and 2; the PMPM for DY 5 is higher than those of DY 4 for MEGs 3 to 6 (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY 5 is 28.1% below the budget neutrality limit (Table 5.4) based on four quarters of payments.

Section XI: Member Month Reporting

The table below provides the member months for each eligibility group by FFS and MCO covered in the Centennial Care program for this reporting period. Please see Table 15: Member Months DY5 Q4.

Table 15 – Member Months DY5 Q4

Number of client by Population Group and MC	
	2018
	Q4
Population 1 – TANF and Related	**1,081,476**
FFS	112,859
MC	
Molina	327,246
Presbyterian	436,815
Blue Cross Blue Shield	204,556
Population 2 – SSI and Related – Medicaid Only	**114,388**
FFS	7,354
MC	
Molina	33,563
Presbyterian	51,974
Blue Cross Blue Shield	21,497
Population 3 – SSI and Related – Dual	**106,121**
MC	
Molina	20,658
Presbyterian	63,591
Blue Cross Blue Shield	21,872
Population 4 – 217-like Group – Medicaid Only	**996**
FFS	252
MC	
Molina	153
Presbyterian	402
Blue Cross Blue Shield	189
Population 5 – 217-like Group - Dual	**12,014**
MC	
Molina	2,368
Presbyterian	6,519
Blue Cross Blue Shield	3,127
Population 6 – VIII Group (expansion)	**750,077**
FFS	74,318
MC	
Molina	189,286
Presbyterian	298,831
Blue Cross Blue Shield	187,642

Section XII: Consumer Issues – Complaints and Grievances

A total of 763 grievances were filed by Centennial Care members in DY5 Q4. This demonstrates a decrease when compared to member grievances received in DY5 Q3 (1,114). An overall trend cannot be established when compared to DY5 Q2 (850) and DY5 Q1 (891).

Non-emergency ground transportation continues to constitute the largest member grievance code reported. The total number of grievances received was 399. This demonstrates a decrease when compared to 572 in DY5 Q3. An overall trend cannot be established when compared to DY5 Q2 (442) and DY5 Q1(414). Transportation Grievances in Section II of this report provides the MCOs' efforts to address transportation grievances under the guidance of HSD.

Other Specialties was the second top member grievance code filed with a total of 48 grievances reported. This demonstrates a decrease when compared to 72 in DY5 Q3. An overall trend cannot be established when compared to DY5 Q2 (51) and DY5 Q1 (101).

There were 316 variable grievances filed in Q4 of DY5. Of those, each MCO reported unique grievances that do not provide data to establish a trend. HSD is monitoring these grievances to identify specific trends. Please see Table 16: MCO Grievances DY5 Q4.

Table 16 – MCO Grievances DY5 Q4

MCO Grievances DY5 Q4 (October - December 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	277	36.30%	60	7.86%	372	48.76%	54	7.08%	**763**	100.00%
Top Two Prmary Member Grievance Codes										
Transportation Ground Non-Emergency	186	24.38%	20	2.62%	193	25.29%	0	0.00%	**399**	52.29%
Other Specialties	18	2.36%	0	0.00%	7	0.92%	23	3.01%	**48**	6.29%
Variable Grievances	73	9.57%	40	5.24%	172	22.55%	31	4.06%	**316**	41.42%

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD reviews service plans to ensure the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs appropriately allocate and implement the services identified in the member's CNA, and that the member's goals are identified in the care plan. There were no identified concerns in DY5 Q4. Please see Table 17: Service Plan Audit Results DY5 Q4.

Table 17 – Service Plan Audit Results DY5 Q4

Member Records	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	**120**	**120**	**110**	**90**
BCBSNM	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**20**	**N/A**
Percent of files with personalized goals matching identified needs	**100%**	**100%**	**100%**	**100%**
BCBSNM	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**30**	**N/A**
Percent of service plans with hours allocated matching needs	**100%**	**100%**	**100%**	**100%**
BCBSNM	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**20**	**N/A**

NF LOC

HSD reviews Nursing Facility High LOC denials and Community Benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria. Please see Table 18: Nursing Facility LOC Audit Results DY5 Q4 and Table 19: Community Benefit NF LOC Audit DY5 Q4.

Table 18 – Nursing Facility LOC Audit Results DY5 Q4

MCO High NF LOC denied requests (and downgraded to Low NF)	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	15	12	11	10
BCBSNM	5	4	2	5
MHC	0	0	0	0
PHP	5	5	5	5
UHC	5	3	4	N/A
HSD Reviewed Results	**DY5 Q1**	**DY5 Q2**	**DY5 Q3**	**DY5 Q4**
Number of member files that met the appropriate level of care criteria	15	12	11	10
BCBSNM	5	4	2	5
MHC	0	0	0	0
PHP	5	5	5	5
UHC	5	3	4	N/A
Percent of MCO level of care determination accuracy	100%	100%	100%	100%

Table 19 – Community Benefit NF LOC Audit DY5 Q4

Community Benefit denied NF LOC requests	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	25	25	25	17
BCBSNM	5	5	5	5
MHC	10	10	10	7
PHP	5	5	5	5
UHC	5	5	5	N/A
Number of member files that met the appropriate level of care criteria determined by the MCO	25	25	25	16
BCBSNM	5	5	5	4
MHC	10	10	10	7
PHP	5	5	5	5
UHC	5	5	5	N/A
Percent of MCO level of care determination accuracy	100%	100%	100%	94%

HSD agreed with all NFLOC decisions for Quarter 4 for MHC and PHP. HSD agreed with all but one BCBS decision, a Community Benefit NF LOC denial. Documentation in the CNA indicated that member met criteria for LNF; however, the member was denied NF LOC by Utilization Management (UM) staff. HSD followed up with BCBS regarding this discrepancy and BCBS confirmed that decision to deny NF LOC by the UM reviewer was inaccurate. A new CNA was conducted on 1/10/19 and the new determination resulted in the member being approved for PCS. BCBS also noted that the UM reviewer who completed this review had been coached regarding this issue and general reminder will be provided to their NF LOC review team to ensure NF LOC decisions accurately reflect ADL information captured in documentation.

External Quality Review Organization (EQRO) NF LOC

The EQRO for HSD reviews a random sample of MCO NF LOC determinations every quarter. Please see Table 20: EQRO NF LOC Review Results DY5 Q4.

Table 20 – EQRO NF LOC Review Results DY5 Q4

Facility Based	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
High NF Determination				
Number of member files audited	**23**	**22**	**23**	**48**
BCBSNM	4	3	5	16
MHC	7	6	6	15
PHP	7	11	7	17
UHC	5	2	5	-
Number of member files the EQRO agreed with the determination	**22**	**22**	**19**	**37**
BCBSNM	3	3	5	10
MHC	7	6	6	10
PHP	7	11	6	17
UHC	5	2	2	-
%	**96%**	**100%**	**83%**	**77%**
BCBSNM	75%	100%	100%	63%
MHC	100%	100%	100%	67%
PHP	100%	100%	86%	100%
UHC	100%	100%	40%	-
Low NF Determination				
Number of member files audited	**85**	**106**	**134**	**77**
BCBSNM	23	29	41	26
MHC	20	26	36	26
PHP	20	21	35	25
UHC	22	30	22	-
Number of member files the EQRO agreed with the determination	**85**	**102**	**122**	**64**
BCBSNM	23	29	37	22
MHC	20	25	31	20
PHP	20	21	33	22
UHC	22	27	21	-
%	**100%**	**96%**	**91%**	**83%**
BCBSNM	100%	100%	90%	85%
MHC	100%	96%	86%	77%
PHP	100%	100%	94%	88%
UHC	100%	90%	95%	-
Community Based				
Number of member files audited	**156**	**176**	**198**	**156**
BCBSNM	39	44	54	53
MHC	39	44	54	49
PHP	39	44	54	54
UHC	39	44	36	-
Number of member files the EQRO agreed with the determination	**152**	**176**	**192**	**154**
BCBSNM	39	44	51	52
MHC	39	44	51	48
PHP	35	44	54	54
UHC	39	44	36	-
%	**97%**	**100%**	**97%**	**99%**
BCBSNM	100%	100%	94%	98%
MHC	100%	100%	94%	98%
PHP	90%	100%	100%	100%
UHC	100%	100%	100%	-

MCO High NF determinations decreased to 77% in Q4 for EQRO agreement with determinations. The Low NF determinations also decreased from 91% in Q3 to 83% for EQRO agreement in Q4. Community Based determinations increased in Q4 to 99% for EQRO agreement, from 97% in DY5Q3. Issues identified included incomplete supporting documentation and information outside of the expected date range. HSD will follow up with the MCOs regarding the identified cases and will continue to provide technical assistance as needed.

During DY5 Q4, HSD also followed up on EQRO determination disagreements identified in the previous quarter. The EQRO audit in DY5 Q3 indicated three determination disagreements for PHP, seven for BCBS and eight for MHC. HSD requested clarification for discrepancies identified in audit documentation, status updates on the identified members, and plans to improve the accuracy of determinations.

PHP provided clarification for three identified discrepancies. For one file, PHP provided clarification for an initial LNF approval and noted that the updated information was requested from the Nursing Facility after member's discharge. This updated information from the Minimum Data Set (MDS) indicated that member correctly met initial LNF. PHP noted that the member discharged safely to the community and is now accessing self-directed community benefits. For another file, PHP also provided clarification for a HNF approval for therapies and noted that this member had been properly approved for HNF for the certification period. For the last discrepancy, PHP acknowledged that the physician's order utilized for NF LOC approval was not correct and indicated that going forward they would ensure orders are appropriate for the type of NF LOC request. PHP noted that they will submit a communication form as necessary to ensure that all required documentation is current and accurate.

MHC provided clarification for discrepancies in eight audit files. For one file, MHC noted that the CNA was completed by staff at the health home and was not included in the audit packet for review. MHC also provided clarification for two files for the same member, MHC provided clarification for both the initial LNF request and the continued stay request for LNF, identifying additional supporting elements for the member meeting LNF criteria in both files. For another file, clarification was provided regarding member's eligibility and approval period for NF LOC.- MHC also addressed one file which did not have additional documentation supporting a NF LOC decision. MHC notes that, based on the available documentation, LNF should have been denied. For three remaining audit files, MHC provided clarification regarding the physician's orders for NF LOC and provided additional supporting documentation. In response to all the identified discrepancies, MHC noted that new staff had been re-trained regarding correct NF LOC procedures and required documentation needed for review.

BCBS addressed discrepancies identified in seven audit files. For two audit files, BCBS provided corrected and missing documentation from the original submissions. For another file, BCBS provided clarification that the member's file from November 2017 was incorrectly placed in the NF LOC review universe for DY5 Q3. BCBS also addressed documentation that was outside the expected date range for another audit file. For the three remaining audit files, BCBS provided clarification regarding the physician's orders for NF LOC and provided additional supporting documentation. In follow up to all the identified discrepancies, BCBS indicated that UM staff will be retrained around the specific requirements of a complete, accurate and timely NF LOC packet submission. BCBS noted that if the facility fails to submit the required documentation, UM staff will provide technical assistance to the facility and will institute the Communication Form process to obtain the necessary elements; if documentation is not provided within the prescribed timeframe, a NFLOC technical denial will be issued.

HSD will continue to monitor the EQRO audit of MCO NF LOC determinations and identify and address any trends and provide technical assistance as needed.

Care Coordination Monitoring Activities

Care Coordination Audits

HSD continues to evaluate the MCO internal action plans (IAPs). Technical Assistance calls and increased communication between the MCOs and HSD have resulted in high compliance rates for consecutive quarters. In DY5 Q4, HSD completed audits of BCBS, MHC's and PHP's reported IAP audit results. HSD completed audits for BCBS, MHC PHP relating to Behavioral Health needs, Transition of Care plans, care coordination level determinations for 1915 (c) waivers members, care coordination level determinations for Dual Eligible Special Needs (DSNP and high Emergency Department (ED) usage members. HSD revealed that the MCOs had successful completion of 13 of 15 internal audits. HSD has requested BCBS continue to audit two action steps quarterly to comply with contract requirements. HSD added an action step for BCBS related to an EQRO finding related to language in Notice of Adverse Benefits determination letters. HSD will continue to conduct regular care coordination audits and evaluate compliance with current IAPs.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top ED utilizers for each MCO. Originally this project included 35 members from each MCO. Over the past 42 months, some members have lost Medicaid eligibility or are no longer with their original MCO. HSD monitors the efforts by care coordinators to engage members, provide alternatives to excessive ED usage and connect members with needed services. HSD tracks the number of ED visits and reviews next steps to reduce the incidence of ED visits. HSD analyzes how supplemental community assistance can complement the services provided by the care coordinator. DY5 Q4 was the final quarter of the project. HSD began extensive analysis of the final data submitted on project members. Data received monthly by each MCO is validated through HSD's PRISM data base. Due to the claims lag, final ED visit counts for DY5 Q4 cannot be validated until DY6 Q2 therefore HSD will continue to follow the current active participants through claims data through DY6 Q2. Chronic homelessness, substance abuse and behavioral health needs have contributed to high ED utilization. HSD recognizes that all MCOs have gone beyond contract required touchpoints for these members by assisting them with housing, nutritional assistance, treatment center admissions, behavioral health support and collaborating with internal and external partners for member success. HSD has seen a 37% decrease in ED visits, per member per month, since the projects inception in DY2 Q3. Through targeted, consistent outreach by Care Coordinators, Peer Support Specialists and Community Health Workers, members receiving these services have shown substantial decline in ED usage.

Care Coordination and EDIE

The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED admissions, inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient then references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical metadata. Because of the notification, the provider has information in hand before seeing the patient. This allows the provider to act to influence health care outcomes. Due to the increased use of EDIE, MCOs have reported they are gathering data that has allowed them to better assist those members utilizing the ED, rapidly engaging those members with emergent needs and connecting difficult to engage members with care coordinators. Care coordinators participating in the care coordination Super Utilizer Project, have reported building relationships with ER staff that assist them in recognizing those members receiving care coordination. As of DY5 Q4, 33 of 38 hospitals in New Mexico are fully integrated online with the remaining 5 in progress to go live by 2019. The Care Manager User Group was established in 2018 for users within New Mexico to share best practices while promoting increased use of the system. HSD continues to attend the bi-monthly committee meetings to support this collaborative program.

Care Coordination Ride-Alongs

HSD conducted "ride-alongs" with BCBS and PHP care coordinators in October and November 2018 to observe Agency-Based and Self-Directed Community Benefit members' comprehensive needs assessments in the home setting. Over the waiver period, HSD has provided feedback gleaned from the ride-alongs, and observed care coordination improvements by experiencing MCO care coordination efforts first hand. HSD will continue to conduct regular ride-alongs with each of the Centennial Care 2.0 MCOs each quarter to ensure that all MCO requirements are being met.

Care Coordination Member Issue and Technical Assistance Calls

The CCU participates in monthly member issue calls with the MCOs to address issues concerning members with special behavioral or physical health needs. Additionally, the CCU participates in TA calls with the MCOs to discuss various issues related to care coordination. The CCU participated in weekly high utilizer calls with MHC and bi-weekly with PHP in DY5 Q4. Calls focused on warm transfers for members needing highly focused care coordination engagement when changing MCOs.

HSD conducted reviews of care coordination enrollment, engagement and timeliness completion reports submitted by all MCOs throughout DY5. These internal reviews resulted in closer oversight by HSD in all data submitted to the Quality Bureau care coordination unit. Standardized methodology was developed by the unit and discussed at monthly TA calls in DY5 Q4. Items for discussion included HRA and CNA completion, member enrollment, member engagement, and contractual requirements for timeliness. HSD will implement a revised care coordination report in DY6 Q1. HSD will continue to conduct regularly scheduled calls with all the MCOs.

Section XIV: Managed Care Reporting Requirements

Customer Service

In Q4 DY5, all MCOs met call center metrics (abandonment rate, speed of answer and wait time) for customer services lines, member services, provider services, nurse advice line and the utilization management line. The MCOs reported an overall 23% increase in the number of calls received in quarter three due to the transition to Centennial Care 2.0 and questions about changes for enrollment. Please see Attachment X: Customer Service Summary.

MCO Reporting

HSD continued technical assistance (TA) calls with the MCOs regarding report issues and accepting Self-Identified Error Resubmissions (SIERs). These two processes allow HSD and MCO subject matter experts to clarify data requirements and correct any data inaccuracies. Reports from MCOs in Q2 have been timely, and HSD notes minimal report extension requests from MCOs. Four extension requests made for Q4DY5 reports.

Report Revisions

HSD subject matter experts collaborate with Mercer, also an HSD contractor, and MCOs to make report revisions to select reports. There are currently 14 reports that are undergoing the revision process. Three report revisions were completed during Q4DY5. HSD revises reports to streamline data elements, improve monitoring, and incorporate requirements of the managed care final rule.

Member Appeals

A total of 737 member appeals were filed by Centennial Care members in DY5 Q4. This demonstrates a decrease when compared to 780 in DY5 Q3. An overall downward trend is demonstrated when compared to member appeals received in DY5 Q2 (944) and DY5 Q1 (869). Of the 737 appeals filed, 89% were standard member appeals and 11% were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner.

Denial or limited authorization of a requested service remains the top member appeal code reported. The total number of appeals received was 660. This demonstrates a decrease when compared to 681 in DY5 Q3. An overall downward trend is demonstrated when compared to DY5 Q2 (758) and DY5 Q1 (716).

Denial in whole of a payment for a service was the second top member appeal code with a total of 43 member appeals reported. This demonstrates an increase when compared to 34 in DY5 Q3. An overall trend cannot be established when compared to DY5 Q2 (48) and DY5 Q1 (34).

There were 34 variable appeals filed in Q4 of DY5. Of those, each MCO reported unique appeals during the quarter that do not provide enough information to establish a trend. All MCOs have complied with the policies and procedures regarding members' exhaustion of the Grievance and Appeal System prior to requesting a State Fair Hearing. Please see Table 21: Member Appeals DY5 Q4.

Table 21 – Member Appeals DY5 Q4

MCO Appeals DY5 Q4 (October - December 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	123	16.68%	79	10.71%	453	61.47%	1	0.14%	**656**	89.00%
Number of Expedited Member Appeals	76	10.31%	3	0.41%	1	0.14%	1	0.14%	**81**	11.00%
Total	199	27.00%	82	11.13%	454	61.60%	2	0.27%	**737**	100%
Top Two Primary Member Appeal Codes										
Denial or limited authorization of a requested service	172	23.34%	81	10.99%	404	54.81%	3	0.41%	**660**	89.55%
Denial in whole of a payment for a service	9	1.22%	0	0.00%	34	4.61%	0	0.00%	**43**	5.83%
Variable Appeals	18	2.44%	1	0.13%	16	2.17%	-1	-0.13%	**34**	4.61%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continued in DY5 Q4. Deloitte and HSD finalized Amendment 5 of the contract to cover the period January 1, 2019, through June 30, 2019. The activities completed during this quarter were centered around HSD's review of the draft Final Evaluation Report. Discussions were held to address measure-level data changes and clarify report content. Discussions were also held with subject matter experts at HSD to review specific measures, relevant data, and methodology. Deloitte will continue to meet with HSD on a weekly basis to assess Final Report status and gather report content feedback as it becomes available.

Preliminary observations for DY4 indicate the following:

- For both physical health and behavioral health visits, the use of telemedicine has increased from 2,160 in the baseline year to 26,046 in DY4.
- There was a favorable decrease in the ratio of members to providers of 20.4% from DY1 to DY4. This decrease was impacted by the influx of participating providers, which increased by approximately 13,000 from DY1 to DY4.
- Member satisfaction with their personal doctor increased in all three population cohorts from baseline to DY4, increasing 1% for the adult population, 1% for the child general population, and 2% for the children with chronic conditions population. DY4 satisfaction rates exceeded national averages for children with chronic conditions and the child general population, and satisfaction for adults was equivalent to the national average.

Planned activities for DY6 Q1 will focus on the development of the DY5 Annual Report and HSD's approval of the Final Evaluation Report for submission to CMS. This includes review and discussion of the fully assembled Final Evaluation report for HSD leadership as well as discussion and review with Deloitte of the comments on the Final Evaluation Report content.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Monitoring Spreadsheet
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment E: Behavioral Health Collaborative CEO Report
Attachment F: MCO Action Plans
Attachment G: Customer Service Summary

Section XVII: State Contacts

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Section XVIII: Additional Comments

The following are member success stories from the Centennial Care MCOs who have had positive experiences with care coordination and other unique aspects of Centennial Care.

Centennial Care Member Success Story 1

On Friday, December 7, 2018, a PHP Presbyterian Downtown Hospital Emergency Department (ED) based Community Health Worker (CHW) contacted a Certified Peer Support Worker (CPSW) team member regarding a woman he spoke with during an intervention at the ED. She was in the ED for alcohol withdrawals, including delirium tremors. The member was in active withdrawal and experiencing homelessness. The CPSW and ED based CHW spoke with her throughout the day and attempted to find an alternative shelter for her on discharge, rather than returning to Joy Junction, which she stated was "chaotic." The CPSW spoke with Barrett House foundation, and Barrett House located a respite bed available and attempted to get her discharged to them. However, this option was unavailable due to her being in active withdrawal. The CPSW spoke with the Metropolitan Assessment and Treatment (MATS) detox program, and the staff was able to secure her a spot there for further detox. The CPSW and CHW managed to find some funds and paid for an Uber ride to MATS upon discharge. They followed her to MATS in their own vehicles, where they helped her sign in to the facility. The CPSW left the member his business card and requested that she call and keep him informed of her status.

On Monday, December 10, 2018, the member called the CPSW around 11 a.m. to say that MATS had moved her into Turquoise Lodge, which she feels is "much nicer." She was doing well there and expressed a desire to finish the 7-day program, and possibly a 30-day stay after that. The CPSW continued his contact with her during the 7-day program and the member decided to stay for the 30-day program with the encouragement of the CPSW. The member stated that she feels the CHW and CPSW "are miracles" and thanked them for their support. They shared that they want her to succeed and find joy in her life again. As of December 26, 2018, the member remains at Turquoise Lodge and continues to participate in her rehabilitation. The CPSW visits her at the facility at least weekly.

Centennial Care Member Success Story 2

A young member has been in residential treatment three times in the past four years, and in a shelter three times as well. He had a lot of conflict with his mother and was generally not compliant with medication. The Behavioral Health Care Coordinator has been working with him for the past three and a half years, and he has really turned his life around. He has been successfully living independently, is working, going to school, maintaining a better relationship with his mother, and attending behavioral health services regularly. He has been successful and stable enough that he was offered the opportunity to step down from Care Coordination, but he reports that he really appreciates the relationship he has with his Care Coordinator and wants to continue working with her.

Centennial Care Member Success Story 3

Member is a 41-year old female who has been diagnosed with Epilepsy/seizure disorder, osteoarthritis, chronic migraines, vertigo, chronic pain, generalized weakness, chronic fatigue, blood clots, hyperlipidemia, hypothyroidism, hypertension, asthma, depression, anxiety schizoaffective disorder, thrombosis of retinas, and varicose veins of lower extremities. Member lives alone and she has one brother in Las Cruces and doesn't have any other surviving family members. The Care Coordinator (CC) started working with the Member at the end of June 2018 and during the first contact with the member, the CC found out that the member was a high Emergency Department and Behavioral Health inpatient utilizer. This Member had been approved for 25 hours a week of Personal Care Services (PCS) but was not receiving the services due to not being able to keep caregivers. Care Coordinator contacted the PCS Agency, Ambercare, and through collaborated efforts the Member was able to get her brother to become her paid caregiver. She has been utilizing PCS consistently since July and her personal needs are being met. The Member has learned to become more involved in managing her health and is more compliant with medications and medical appointments. Member receives Behavioral Health Care Coordination (BH CC), completes weekly counseling sessions and participates in the Psychosocial Rehabilitation program through La Clinica de Familia. The last Behavioral Health inpatient admission the Member had was on 6/27/2018. Member continues to make progress with the support of her Physical Health Care Coordinator (PH CC), BH CC, counselor and psychiatrist. The Member is becoming more confident and is understanding her conditions and the services and resources available to her.

Centennial Care Member Success Story 4

Member is a 57-year-old male who had a stroke in November 2017. The stroke paralyzed member's left side and his speech. Member had been residing in a nursing facility and CM began to work with member and his family in March, 2018. Through speaking with member's POAs/sisters and visiting member, he expressed a desire to go home and was becoming depressed with being in a nursing facility beyond skilled treatment for rehabilitation. CM began to work with POAs to help navigate and educate member's treatment with providers and general support during member's recovery process.

Member did experience further medical complications related to his stroke and went back to rehabilitation and then more skilled nursing. Once member stabilized medically, CM began to work with member's POAs/sisters to establish community benefits for member and educate the POAs on these benefits. Member needed 24-hour support/monitoring for his ADLs, so his family could work during the day and care for him in the evening.

In November 2018, member was finally ready to return home with his supports in place. CM visited member a month later, when he was back home. Member was extremely happy and grateful to be back in his own home with his family. Member and family expressed gratitude that member was able to qualify for PCS, ERS, Respite, and CTS to make it possible for him to be back at home. When CM was leaving member's home, POA hugged CM and thanked CM for all of the help and support with member and making it possible for him to be home with his family.