Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 4 (1/1/2017 – 12/31/2017)
Waiver Quarter: 4/2017

March 2, 2018
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 669,000 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 271,084 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment decrease of 4,046 from DY4 Q3.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through November 2017. Quarterly data is available through the third quarter of 2017.

Primary Care Provider (PCP)-to-Member Ratios

The PCP-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties. There are no PCP access concerns at this time.

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	April	May	**Jun**	July	Aug	Sep
BCBS	1:39	1:39	1:40	1:38	1:38	1:38	1:35	1:35	1:36
MHC	1:102	1:102	1:102	1:100	1:99	1:99	1:98	1:96	1:94
PHP	1:88	1:88	1:86	1:87	1:86	1:84	1:83	1:81	1:82
UHC	1:30	1:30	1:30	1:29	1:29	1:29	1:28	1:28	1:27
Source: [MCO] PCP Report #53, Q3CY17									

Geographic Access

Physical Health and Hospitals

Geographic access standards were met by all MCOs for general hospitals, federally qualified health centers (FQHCs), PCPs, pharmacies and most specialties in urban, rural and frontier counties. New Mexico continues to experience a shortage of specialty providers throughout the state. In DY4 Q4, none of the MCOs met access standards for dermatology and endocrinology in rural areas as well as neurosurgeons in both rural and frontier areas. In rural areas, three of the four MCOs did not meet access for rheumatology and urology. In frontier areas, three of the four MCOs did not meet access for dermatology, endocrinology, and neurology. BCBS and PHP did not meet access standards for rheumatology in frontier areas; a gap that can be attributed to both MCOs having less contracted rheumatology providers as well as a greater frontier membership than their counterparts. As addressed last quarter, BCBS and MHC did not meet access standards for dermatology in urban areas.

HSD continues to focus on those outliers where all but one MCO met distance standards for specific provider types in geographic areas. This reporting period, PHP is close to meeting access standards in rural areas for Certified Nurse Midwives (88.8%) and Neurology (85.1%) as well as access standards in frontier areas for Ears, Nose and Throat (ENT) specialist (86.5%). In the previous quarter, PHP met the access standards for the noted specialties; however, in DY4 Q4 these gaps can be attributed to a decrease in the number of providers. Access issues may be

remedied by transportation to the nearest provider, telemedicine, and single case agreements with out-of-network providers.

Of note this quarter, MHC successfully met access standards for dermatology with 90% and endocrinology 91% in frontier areas. In the previous quarter, MHC was close to meeting access standards for both specialties with 87%. Please see Attachment B: GeoAccess PH Summary.

Behavioral Health

In DY4 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.

However, 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 Federally Qualified Health Centers (FQHCs) are not met by the majority of MCOs.

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

HSD continues to be aware of the BH services that do not meet the standards due provider shortages in New Mexico. HSD continues to work with MCOs to strengthen their relationships with providers and to increase accessibility to areas not meeting access standards through increased opportunities to expand use of telemedicine and Project ECHO.

MCOs individually work to maintain access with the current network while continually striving to build accessibility through efforts to provide innovative service delivery to their members and 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 vist providers to validate practice information, respond to claims and other issues. Please see Attachment C: GeoAccess BH Summary.

Community Health Worker

The CHW initiative for improving health outcomes in New Mexico continues to focus on the development of the workforce, interventions, and education and outreach activities. HSD evaluated the summary of DY4 Q3 CHWs employed and contracted with MCOs. There was a

total of 89 CHWs in the MCO workforce, an increase of three CHWs from the previous quarter. Please see Table 2 – Summary of CHW Workforce.

Table 2 – Summary of CHW Workforce for each MCO

DY4 Q3 Community Health Workers			
	Employed	**Contracted**	**Total**
BCBS	13	15	28
MHC	22	0	22
PHP	12	4	16
UHC	11	12	23
Totals	**58**	**31**	**89**

Source: [MCO] CHW DSIPT, Q3CY17

The MCOs continue to develop and provide on-going training for the CHW workforce. The training includes an emphasis on how to assist members return home after a hospital stay, who have excessive emergency room usage, and how to improve maternal-child health. The CHWs work to address barriers to care through their knowledge of their communities and providing linkages to community supports that address social determinants of health such as housing, food insecurity, and transportation. MHC reports the creation of an internal triage team that makes calls to match members with CHWs and thereby optimize the workforce. .

The New Mexico Department of Health (DOH) continues to offer CHW certification as a voluntary process for experienced CHWs and also to work with the Integrated Primary Care and Community Support (I-PaCS) to develop job-specific training for the New Mexico CHW initiative. I-PaCS is a collaboration between the University of New Mexico, Health Sciences Center - Office for Community Health, the Southwest Center for Health Innovation and HSD. HSD provides technical assistance to the MCOs for the CHW initiative.

HSD requires MCO reporting for each member that is served by a CHW for the purpose of tracking the development of this initiative in urban, rural, and frontier areas. A member is counted one time per year. This count is independent of how many interventions or supports a member receives as a result of contact with a CHW. Some members receive one intervention, but most members receive five or more according to MCO reporting. Setting up Primary Care Physician (PCP) appointments, food assistance, transportation to medical appointments and pharmacies remain among the top types of interventions for members. Please see Table 3 – Unduplicated Members Served by CHWs.

Table 3 – Unduplicated Members Served by CHWs

DY4 Q3 Unduplicated Members Served					
	BCBS	**MHC**	**PHP**	**UHC**	**Region Totals**
Underserved Urban	9,640	794	1,193	655	12,282
Rural	1,343	853	664	541	3,401
Frontier	251	136	147	85	619
MCO Total	**11,234**	**1,783**	**2,004**	**1,281**	**16,302**

Source: [MCO] CHW DSIPT, Q3CY17

Assessing for behavioral health needs is included in the CHW initiative for New Mexico, particularly for the social determinants of health. MCOs reported completion of 3,648 social determination of needs assessments in Q3. A portion of the CHW outreach includes providing services at the time of discharge from behavioral health facilities in urban, frontier, and rural areas including Bernalillo, Dona Ana, San Miguel and San Juan counties. CHWs also work with Medicaid eligible incarcerated individuals being released from prisons and jails. The following is a list of specific types of interventions reported for DY4 Q3:

- Locate member
- Educate member on the role of care coordination
- Complete health risk assessment with member
- Refer member for further assessments
- Assist member when a higher level of care coordination is needed
- Educate member on Emergency Room versus Urgent Care utilization
- Educate member on primary care physician (PCP) role
- Educate member on use of the Nurse Advise Line
- Assist member to connect with a PCP
- Durable Medical Equipment Medication adherence
- Attend Alcoholics Anonymous (AA) & Narcotics Anonymous (NA) recovery meetings
- Assist member with referrals for care
- Provide community resources
- Assist with food resources
- Assist with housing resources
- Assist with financial resources
- Assist with employment resources
- Assist with legal resources

Telemedicine

In DY4 Q4, HSD reviewed telemedicine utilization data for Q3.Consistent with previous reporting periods, the data indicates that most telemedicine services provided in New Mexico are for behavioral health diagnoses. All MCOs continue to promote use of technology to allow members to have access to telemedicine services and provide technical assistance to providers for accurate coding of telemedicine services. Please see Table 4 – Telemedicine Services.

Table 4 – Telemedicine Services

DY4 Q3			
Behavioral Health			
	Urban	Rural	Frontier
BCBS	198	367	73
MHC	396	854	155
PHP	598	704	421
UHC	358	833	151
TOTAL	1,550	**2,758**	**800**

Source: [MCO] Telemedicine DSIPT, Q3CY17

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

Transportation

HSD closely monitors the administration of the non-emergency medical transportation benefit provided under managed care to ensure recipients have freedom of choice. MCOs monitor adequate access to safe and timely transportation services while ensuring the benefit is appropriately utilized for medically necessary services. In an effort to better monitor the MCOs' subcontracting process for transportation services, in DY4 Q4, HSD requested that the MCOs submit documentation supporting methods of monitoring and ensuring contractor compliance. MCOs provide consistent oversight of transportation contractors via monthly reporting, grievance reports, call center audits, joint operational meetings, and corrective action. MCOs maintain quality assurance and compliance standards for non-emergency medical transportation providers including timely pickup and drop off for health care appointments, complaint resolution, verification of member eligibility and services, cost containment, and over-utilization. For transportation grievances please see Section XII: Consumer Issues – Complaints and Grievances.

Provider Network

New Mexico continues to experience a provider shortage; however, the overall provider network remained consistent with previous quarters. During DY4 Q4, HSD monitored MCOs' compliance in maintaining an adequate and efficient provider network by: tracking and trending new and terminated providers, member-to-provider ratios, the number of providers with panels and/or practices that are open and closed to new members, the number of single case agreements,

and the transition of members to new providers when a provider or agency was suspended or terminated.

Service Delivery

Utilization Data

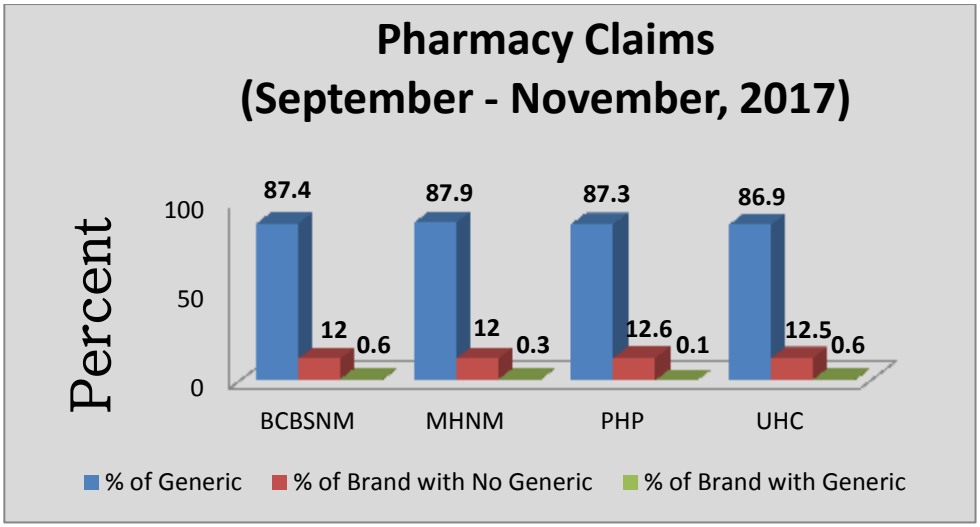
Centennial Care key utilization and cost per unit data by overall programs as well as by a specific program is provided for October 2015 through September 2017. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

HSD reviews the monthly MCO pharmacy report to identify trends in prescription claims for brand and generic drugs (Please see Table 5 – Percent of Pharmacy Claims for each MCO). For this reporting period, the average generic drug usage for all four MCOs was 87.4%, a decrease from 87.9% in the previous reporting period. In comparison to the last quarter, HSD identified the following:

- All MCOs had a slight decrease in generic drug utilization and usage of brand drugs when no generic is available from the previous quarter.
- For usage of brand drugs when there is no generic available, three of the MCOs had the same utilization while BCBSNM had an increase of 0.1%.
- The overall usage of brand medication when there was no generic available averaged 12.3% for the quarter.
- Use of brand drugs when there was a generic drug available remained at an average of 0.4% for all MCOs.
- All four MCOs continue to require medical justification for usage of a brand drug when there is a generic drug available.

Table 5 – Percent of Pharmacy Claims for Each MCO



Hepatitis C (HCV)

During DY4 Q4, HSD issued a Letter of Direction (LOD) to MCOs to expand the treatment criteria for members with active Hepatitis C infection and to all members with active HCV infection for three months. Effective December 15, 2017, the MCOs are to expedite the handling of all treatment requests using the 2017-revised "Uniform New Mexico HCV Checklist for Centennial Care," and to approve properly requested treatments for all members over age 17 infected with all HCV genotypes. MCOs were further directed to develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico. Provider incentives include training for the treatment of chronic HCV infection, initiating treatment in the practice, and a per member treatment incentive. MCOs are granted the option to expand their treatment criteria beyond the guidelines provided in the LOD (e.g., to members 17 years of age and under) with advance notice to and approval by HSD.

Nursing Facilities

In DY4 Q4, HSD continued to monitor the MCOs' efforts to address nursing facility (NF) claims issues through regularly scheduled meetings with the MCOs and their NF provider network. No new billing issues have been presented, but the MCOs continue to explore ways to automate claims processing wherever possible.

HSD along with our contractor, Myers and Stauffer, worked to establish audit objectives to audit MCOs' claims payments to NFs. Audit activities began in October 2017. The audit will focus on the MCO processing of crossover claims, denial of payment for preauthorized services, and accuracy of payment rates for retroactive rate changes.

Community Interveners

In DY4 Q3, five Centennial Care members received Community Interveners (CI) services as illustrated below.

Table 6 – Community Intervener Services Utilization DY4 Q3

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBS	1	257	$1,630.25
MHC	0	0	$0
UHC	3	52.50	$822.75
PHP	1	23	$581
Total	**5**	**332.5**	**$3,034**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date, 685,460 distinct members, or 72% of all enrollees, have earned at least one incentive or reward. With the program just completing its fourth full year, members have earned points totaling a value of $51 million. Of that amount $13.7 million in points have been redeemed. Table 7 shows the healthy behaviors rewarded and each activity's value in dollars. 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.

Table 7 – Healthy Behaviors Rewarded

Eligibility Activities	Reward Value in Points, by Activity	Maximum Reward Value in $	Total Rewards Earned in $	Total Rewards Redeemed in $
Asthma Management	600	$60	$1,221,510	$429,717
Bipolar Disorder Management	600	$60	$1,438,670	$375,033
Bone Density Testing	350	$35	$66,465	$14,894
Healthy Smiles Adults	250	$25	$10,597,350	$2,173,727
Healthy Smiles Children	350	$35	$23,941,855	$6,538,226
Diabetes Management	60	$60	$5,826,440	$1,600,772
Healthy Pregnancy	1000	$100	$1,530,200	$395,224
Schizophrenia Management	600	$60	$721,615	$161,520
Health Risk Assessment*	10	$10	$4,394,170	$1,125,253
Other (Appeals and Adjustments)	N/A	N/A	$646,548	$409,493
Step-Up Challenge	500	$50	$580,025	$511,450
Totals			**$50,964,848**	**$13,735,309**

***HRA completion was discontinued as a rewardable activity at the end of CY2016**

The table above shows that members who complete the Step-Up Challenge have the highest likelihood of redeeming the reward they earn, and the Challenge remains one of more popular components of the Centennial Rewards program. Over 90,000 members have registered for the Challenge and logged their steps. Step-Up Challenge participants continue to show lower costs and improved quality.

Centennial Rewards program participation remains remarkably strong and is likely the highest participation rate for a program of this kind in the nation. Since the beginning of the program, there have been over one million visits to the Centennial Rewards member portal. Most importantly, member satisfaction has remained exceptionally high, with the percentage of people reporting satisfaction with the program and who say that the program has helped them stay healthier in the mid- to upper-90s.

Section III: Enrollment

Centennial Care enrollment indicates a decrease in enrollment in TANF, SSI and Group VIII. The majority of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in the table below. Overall, enrollment indicates a decrease in each population, other than the 217-Like populations.

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.

Table 8 – Enrollment DY4 Q4

Demonstration Population	Total Number Demonstration Participants DY4 Q4 Ending December 2017	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**373,808**	**475,332**
FFS	46,193	67,125
Molina	121,548	152,127
Presbyterian	118,995	146,951
UnitedHealthcare	26,972	33,695
Blue Cross Blue Shield	60,100	75,434
Population 2 – SSI and Related – Medicaid Only	**39,238**	**45,586**
FFS	2,925	4,845
Molina	12,335	13,724
Presbyterian	12,598	13,752
UnitedHealthcare	5,023	5,949
Blue Cross Blue Shield	6,357	7,316
Population 3 – SSI and Related – Dual	**35,984**	**38,305**
FFS	0	300
Molina	7,142	7,453
Presbyterian	6,797	7,091
UnitedHealthcare	15,387	16,450
Blue Cross Blue Shield	6,658	7,011
Population 4 – 217-like Group – Medicaid Only	**371**	**717**
FFS	122	443
Molina	50	60
Presbyterian	53	58
UnitedHealthcare	104	108
Blue Cross Blue Shield	42	48
Population 5 – 217-like Group - Dual	**3,461**	**3,137**
FFS		42
Molina	740	682
Presbyterian	629	547
UnitedHealthcare	1,362	1,245
Blue Cross Blue Shield	730	621
Population 6 – VIII Group (expansion)	**271,084**	**287,246**
FFS	32,824	40,907
Molina	74,019	76,068
Presbyterian	66,077	64,692
UnitedHealthcare	38,399	42,250
Blue Cross Blue Shield	59,765	63,329

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 disenrollments 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.

Table 9 – Disenrollment Counts DY4 Q4

Disenrollments	Total Disenrollments During DY4 Q4
Row Labels	
Population 1 – TANF and Related	**5,215**
FFS	641
Molina	1,630
Presbyterian	1,506
UnitedHealthcare	440
Blue Cross Blue Shield	998
Population 2 – SSI and Related – Medicaid Only	**413**
FFS	66
Molina	132
Presbyterian	93
UnitedHealthcare	55
Blue Cross Blue Shield	67
Population 3 – SSI and Related – Dual	**528**
Molina	121
Presbyterian	105
UnitedHealthcare	175
Blue Cross Blue Shield	127
Population 4 – 217-like Group – Medicaid Only	**18**
FFS	9
Molina	2
Presbyterian	2
UnitedHealthcare	3
Blue Cross Blue Shield	2
Population 5 – 217-like Group - Dual	**152**
Molina	26
Presbyterian	23
UnitedHealthcare	62
Blue Cross Blue Shield	41
Population 6 – VIII Group (expansion)	**7,107**
FFS	926
Molina	1,856
Presbyterian	1,761
UnitedHealthcare	942
Blue Cross Blue Shield	1,622

Section IV: Outreach

In DY4 Q4, –MAD staff presented Centennial Care information to the University of New Mexico, Center for Development and Disability, Leadership Education in Neurodevelopmental and Related Disabilities Program staff. Discussion centered on timelines related to applications, services, and benefits for children enrolled in Centennial Care.

In October 2017, HSD Medicaid Outreach staff provided technical and administrative support to the Director's office with the five (5) public hearings held to record public comments about the Centennial Care 1115 Demonstration waiver renewal.

All four MCOs participated in a wide variety of community events across the state providing enrollment opportunities and educating the public about Centennial Care. MCOs attended numerous Medicaid enrollment events, health fairs and community events comprised of people with disabilities, senior citizens, children and families, Native Americans and other populations.

Table 10 – Schedule of Community Events DY4 Q4

Event Type	Event Location and Date	Audience and Topics
NM Medicaid – Centennial Care Informational Training	Albuquerque, NM October 6, 2017	University of New Mexico, Center for Development and Disability, Leadership Education in Neurodevelopmental and Related Disabilities Program staff. Timelines related to applications, services, and benefits for children enrolled in NM Medicaid-Centennial Care.
NM Medicaid-Centennial Care 2.0 Public Hearings	Las Cruces, NM October 12, 2017 Santa Fe, NM October 15, 2017 Las Vegas, NM October 18, 2017 Native American Advisory Committee Santa Fe, NM October 20, 2017 Albuquerque, NM October 30, 2017	HSD Outreach staff provided technical and administrative support to the Director's office for all 1115 Demonstration waiver renewal public hearings.

Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's outreach efforts. Presumptive Eligibility determiners (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 (DOH, NM Children Youth and Families Department (CYFD) and the NM Department of Corrections). With over 635 active certified PEDs state-wide, Medicaid application assistance is available in even the most remote areas of the state.

To coincide with the system changes that moved managed care enrollment from the state's MMIS system to the state's eligibility system, HSD also made updates to YESNM-PE (Your Eligibility System NM for Presumptive Eligibility Determiners). To prepare PEDs for this change, MAD's PE Program staff conducted training sessions on the new PE Enrollment process. These sessions were held October 26- December 31, 2017. Attendance at a training session was required for all PEDs to retain their certification.

In DY4Q4, PEDs:

Granted PE Approvals:	670
Medicaid Applications Submitted:	5,924
Ongoing Medicaid Approvals:	4,984

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 programs allows for the automated data transfer of information regarding the incarceration status of individuals 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.

Seven of the thirty-eight PED enrollment training sessions that occurred October through December were held exclusively for JUST Health participating PEDs. Currently, there are 117 active JUST Health PEDs in the state.

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 its specific issues with encounters that have been denied or not accepted. HSD and the MCOs have developed a productive partnership to fix system edits in 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 has achieved 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 errors, 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

During DY4 Q4, HSD conducted public hearings in Las Cruces, Las Vegas, Santa Fe, and Albuquerque as well as a formal Tribal Consultation in Santa Fe, to obtain public feedback about changes to the Centennial Care program as a part of the renewal of the Centennial Care 1115 demonstration waiver renewal. Centennial Care 2.0 was designed to build on successes achieved during the past four years. Improvements and reforms are intended to facilitate sustainability of the program while preserving comprehensive services. Areas of focus for Centennial Care 2.0 are care coordination, benefit and delivery system modifications, payment reform, member engagement and personal responsibility, and administrative simplification through refinements to eligibility. The 1115 draft waiver renewal application was released on September 5, 2017 (revised on October 6, 2017), and public comments were accepted through November 6, 2017. The final waiver application was submitted to CMS on December 6, 2017.

Behavioral Health

Please refer to the following attachments for an update on Behavioral Health activities:

- Attachment E: Behavioral Health Collaborative CEO Report

MCO Initiatives

Blue Cross and Blue Shield of New Mexico

The Blue Cross and Blue Shield of New Mexico (BCBSNM) Encounters Team identified numerous opportunities to improve encounter performance. The BCBSNM Encounters Team diligently coordinated work efforts with numerous BCBSNM operational areas including IT, Claims, Medicaid Operations as well as delegated entities in support of several work efforts, which included:

- enhancing system capabilities to remediate identified defects;
- completing reconciliation of state exceptions from a denied to accepted status;
- developing a process flow to map all data processing points from claims processing, encounter submission, and State acceptance; and
- working with delegated entities on reconciliation of State exceptions.

As a result of these BCBSNM interventions, all encounter accuracy contractual metrics were met for Q4 DY17.

Molina Healthcare

- Santa Fe Fire Department Pilot Program - This collaboration with paramedics targets members with complex care coordination needs who are also high utilizers of 911 services. The objective is to engage these members, who could not be contacted by other means, and establish relationships with care coordinators. The desired outcomes include

increased utilization of appropriate physical health and behavioral health services and reduction of non-emergent emergency room visits.

Presbyterian Health Plan

- PHP began offering support broker services for community benefit self-directed members during this quarter. Members now have the option of selecting PHP as a support broker or choosing from one of two contracted support brokers.
- PHP implemented its "Pre-Managed" reports that documents when care coordinators receive near real-time notification about a member who is accessing the emergency department. These reports afford an opportunity to rapidly identify members who require follow up. In some cases, PHP has been able to make contact with members who are difficult to engage by deploying care coordinators to the emergency department when the member presents.
- PHP has care coordinators who are embedded in a pediatric primary care provider office that sees a high-volume of high risk pediatric members. This has enhanced collaboration and communication between high-volume primary care providers and the care coordination department.
- PHP continues to partner with CYFD and All Faiths to develop and initiate a High Fidelity Wrap program for high needs adolescents and youth. This program has been successful in keeping members in the community, returning members from out-of-state RTC placements, and reducing cost of care.
- The HELP (Helping to Engage and Link to Providers) team was developed to engage members in care coordination and connect to clinically appropriate services and providers. An Engagement Specialist conducts outreach to previously difficult to engage members and connects them to services in the community.
- PHP's Emergency Department (ED) Diversion project utilizes peer support specialists. Upon review of its frequent ED utilizers, PHP assigns a peer support specialist to conduct intensive outreach with the member. Of the 147 identified, 99 were able to be connected to a peer support specialist. A comparison of ED utilization indicates that those engaging with peer support showed a 70% reduction in ED utilization.
- PHP has a specific maternal child health team who works solely with members considered to be high-risk during pregnancy. PHP partners with the Milagro program for this population and is planning to expand the program. PHP intends to further strengthen its collaboration through delegation of care coordination for these members.
- PHP's Facility Incentive Program is designed to provide a framework for leveraging provider profiling data to engage facilities to increase quality, improve efficiencies, and manage medical costs. This program targets high-volume inpatient facilities and has demonstrated improvement in a variety of metrics including follow up after hospitalization and readmission rates for participating facilities.

UnitedHealthcare

- Outreach and Education Community Initiatives – UHC focused on supporting community initiatives by collaborating with the Navajo Nation, Shiprock Chapter House to provide a Winter Family Festival. This is the third year UHC collaborated on such an event with over 800 attendees. UHC sponsored firewood distribution (300 vehicles loaded with firewood), warm holiday meals, recovery songs and poetry performances, arts and crafts for children, and community resources at information tables. Additionally, UHC collaborated with the Albuquerque Indian Center to provide the community with flu shots, warm meals, coats, scarves, gloves and hats, community resources and information. There were over 400 attendees at this event.

Fiscal Issues

During DY4 Q4, retroactive reconciliations, hepatitis C reconciliations and a recoupment associated with a HEDIS performance measure penalty for CY 2016 resulted in a reduction of expenditures. This reduction in expenditures affected the PMPM of MEG 1 of DY 3. For the Other Adult Group (OAG), a revised risk corridor reconciliation and recoupment associated with retroactive reconciliations for calendar year 2016 resulted in an increase of expenditures. The increase in expenditures is apparent in the PMPM for MEG 6 of DY 3 compared to the PMPM from DY 4 Q3 report.

Systems Issues

HSD continues to implement reporting for analysis and oversight. HSD and the MCOs continue to work together to address any concerns or make any necessary system changes on either side. Enrollment was transitioned from our MMIS to our Eligibility and Enrollment (E&E) as a requirement to make our ASPEN system a true E&E system. In addition, this transition of enrollment served as our first phase of replacing our MMIS as part of our MMISR project. This allowed HSD to implement one piece of the MMISR while gaining some valuable lessons learned as the replacement project progresses. With the transition of enrollment from the MMIS to the E&E system, some issues were identified that are being researched and worked. 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 legacy MMIS began some time ago, and activity for this effort progressed in DY4 Q4. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the DOH, CYFD, and the Aging and Long-Term Services Department (ALTSD) to assist in the planning and implementation efforts. These three departments have participated in RFP development and replacement planning. HSD is currently in the process of drafting GSAs with CYFD and ALTSD for qualifying activities to receive MMISR funding; the GSA with DOH has been approved.

The first module of the State's Framework for MMIS Replacement, the System Integrator, is in the procurement process and the contract has been approved by CMS. The contract is routing through the approval and signature process for finalization.

The RFP for the next module of the Framework, the Enterprise Data Services RFP, was released on April 17, 2017. Proposals came in on June 21, 2017, and HSD is currently in an active procurement process. Contract negotiations have begun for Data Services.

CMS has approved the third module RFP for Quality Assurance. The Quality Assurance RFP is being routed and reviewed internally prior to release.

HSD has begun development of the RFP for the fourth module, Benefit Management Services. This RFP involved meetings with all stakeholders, questionnaires for input, review of other states' procurements and contracts, as well as information from the current fiscal agent contract. Information is being gathered for requirements development and will be vetted through the stakeholder review process for comment prior to submission to CMS.

Once the Benefit Management Services RFP is submitted to CMS for review, work will continue with the development of the RFP for the fifth module, Financial Services. Some work with stakeholders, questionnaires, and requirements gathering from other states has already been started.

The module previously referenced as Population Health has been renamed Outcomes Based Management. The components that were part of the Population Health module have been transitioned to better align with the other modules.

HSD moved managed care enrollment from our MMIS to our E&E system to make our ASPEN eligibility system a true E&E system. Deloitte is currently working on the changes to implement the provisions for Real Time Eligibility (RTE). These changes were previously approved by CMS.

An Implementation Advanced Planning Document Update (IAPD-U) was submitted and approved by CMS.

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 ALTSD Aging & Disability Resource Center (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.

The ADRC coordinators provide phone counseling in care coordination, which is the process for assisting the client in describing his/her issue. ADRC staff offer options, coordinate New Mexico's aging and disability service systems, provide objective information and assistance, and empower people to make informed decisions.

As a lead partner of the NMICSS, the ALTSD Care Transition Bureau (CTB) provides assistance to Medicaid beneficiaries enrolled in Centennial Care and 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 the system. CTB staff also monitor to ensure that identified services are provided by the MCO, MCO subcontractors and other community provider agencies. The main purpose of the CTB 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 preferences, values and individual circumstances.

ALTSD provides quarterly reports to HSD including the ADRC Caller Profile Report and Care Transitions Program Data.

Table 11 – ADRC Call Profiler Report DY4 Q4

Topic	# of Calls
Home/Community Based Care Waiver Programs	2,874
Long Term Care/Case Management	128
Medicaid Appeals/Complaints	19
Personal Care	159
State Medicaid Managed Care Enrollment Programs	589
Medicaid Information/Counseling	583

Table 12 – ADRC Care Transition Program Report DY4 Q4

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		186	
Medicaid Education/Outreach	1,471		
Nursing Home Intakes		76	
*Pre/Post Transition Follow-up Contact	2,015		
**LTSS Short-Term Assistance			156

*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.

CTB participated in scheduled meetings with BCBS. The meetings occur monthly and specific transition cases are discussed. The cases brought to these meetings involve client issues, delaying the transition of the client to the community. The issues vary and include financial eligibility questions related to the transition goods and services and their eligibility for the benefits. The purpose of the meeting is to address and remedy the issues and allow the client to transition.

CTB and Short Term Assistance (STA) Regional Counseling Program met with Presbyterian Health Plan to discuss ways to connect members to Medicaid benefits and to generate more care transition referrals in the NW and NE Region of the State to enhance supports provided to NM residents in nursing facilities.

Critical Incidents

HSD continues to meet quarterly with the MCOs' Critical Incident (CI) workgroup in an effort to provide technical assistance. The workgroup supports the Behavioral Health Services Division in the delivery of BH incident reporting protocols to providers. The protocols will be used by BH providers to improve accuracy of information reported and to establish guidelines for the types of BH providers who are required to report. The annual Critical Incident Report (CIR) trainings were held in November 2017 to ensure providers have an understanding of reporting requirements.

During DY4 Q4, a total of 4,094 CIRs were filed for Centennial Care members which includes physical health, behavioral health and, community benefit self-directed. One hundred percent of all CIRs received through the HSD CI web portal are reviewed. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.

During DY4 Q4, a total of 420 deaths were reported. Of the 420 deaths reported, 384 deaths were reported as natural or expected deaths, 36 deaths were reported as unexpected and no suicides were reported. 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 (OMI) to determine a cause of death. MCOs have internal processes on follow-up for all member deaths.

During DY4 Q4, a total of 2,690 critical incidents were reported for Emergency Services. Of those Emergency Services reports, 184 were reported by Behavioral Health providers and 200 were associated with Self-Directed members. 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. This quarter demonstrated an overall decrease in the use of Emergency Services when compared to DY4 Q3 (2,692), DY4 Q2 (2,910) and DY4 Q1 (3,172). MCOs continue to monitor high utilizers of the emergency department (ED).

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	25	0.61%	76	1.86%	55	1.34%	74	1.81%	230	5.62%
Death	103	2.52%	106	2.59%	90	2.20%	121	2.96%	420	10.26%
Natural/Expected	96		96		76		116		384	
Unexpected	7		10		14		5		36	
Suicide	0		0		0		0		0	
Elopement/Missing	2	0.05%	4	0.10%	6	0.15%	4	0.10%	16	0.39%
Emergency Services	548	13.39%	710	17.34%	726	17.73%	706	17.24%	2690	65.71%
Environmental	13	0.32%	14	0.34%	34	0.83%	30	0.73%	91	2.22%
Exploitation	21	0.51%	26	0.64%	20	0.49%	44	1.07%	111	2.71%
Law Enforcement	10	0.24%	21	0.51%	17	0.42%	17	0.42%	65	1.59%
Neglect	83	2.03%	114	2.78%	121	2.96%	153	3.74%	471	11.50%
Total	**805**	**19.66%**	**1071**	**26.16%**	**1069**	26.11%	**1149**	**28.07%**	**4094**	**100.00%**

Table 14 – Critical Incident Types by MCO – Behavioral Health

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	4	1.20%	28	8.43%	20	6.02%	4	1.20%	56	16.87%
Death	3	0.90%	20	6.02%	1	0.30%	1	0.30%	25	7.53%
Natural/Expected	1		19		0		1		21	
Unexpected	2		1		1		0		4	
Suicide	0		0		0		0		0	
Elopement/Missing	1	0.30%	1	0.30%	1	0.30%	0	0.00%	3	0.90%
Emergency Services	6	1.81%	146	43.98%	24	7.23%	8	2.41%	184	55.42%
Environmental	1	0.30%	0	0.00%	2	0.60%	0	0.00%	3	0.90%
Exploitation	2	0.60%	2	0.60%	1	0.30%	0	0.00%	5	1.51%
Law Enforcement	1	0.30%	4	1.20%	2	0.60%	0	0.00%	7	2.11%
Neglect	4	1.20%	30	9.04%	10	3.01%	5	1.51%	49	14.76%
Total	**22**	**6.63%**	**231**	**69.58%**	**61**	**18.37%**	**18**	**5.42%**	**332**	**100.00%**

Table 15 – Critical Incident Types by MCO – Self Directed

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	0	0.00%	3	1.17%	9	3.52%	2	0.78%	14	5.47%
Death	6	2.34%	2	0.78%	9	3.52%	4	1.56%	21	8.20%
Natural/Expected	6		2		7		4		19	
Unexpected	0		0		2		0		2	
Suicide	0		0		0		0		0	
Elopement/Missing	0	0.00%	1	0.39%	0	0.00%	0	0.00%	1	0.39%
Emergency Services	28	10.94%	27	10.55%	114	44.53%	31	12.11%	200	78.13%
Environmental	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Exploitation	1	0.39%	4	1.56%	4	1.56%	1	0.39%	10	3.91%
Law Enforcement	1	0.39%	0	0.00%	1	0.39%	0	0.00%	2	0.78%
Neglect	1	0.39%	1	0.39%	5	1.95%	1	0.39%	8	3.13%
Total	37	14.45%	38	14.84%	142	55.47%	39	15.23%	256	100.00%

Home and Community-Based Services Reporting

In order to comply with statewide requirements for the HCBS Settings Final Rule, HSD, in partnership with the ALTSD, completed on-site provider validation and participant surveys in October 2017. HSD will begin compiling and analyzing the results of the survey in DY5 Q1. HSD is also continuing to update the Statewide Transition Plan (STP) milestones as required by CMS.

Self-Directed Community Benefit

As described in the DY4 Q3 report, effective in Q4, PHP transitioned SDCB members to either its in-house Support Brokers (SB) or to one of the two contracted external SB agencies. PHP and HSD continued to have weekly meetings to monitor and discuss member transitions.

Electronic Visit Verification

In DY4 Q4, HSD began planning for the implementation of EVV for the SDCB program. HSD expects to fully implement EVV within the required timeframes of the federal Cures Act. HSD and the MCOs partner with the New Mexico Association for Home Health and Hospice (NMAHHC) to provide information on the EVV system to providers at its quarterly conferences. At the November 2017 conference, the MCOs presented EVV information to the PCS providers on what is working, ongoing challenges and next steps. The information was well received by the PCS agencies and the MCOs continue to deploy targeted on-site technical assistance to specific PCS agencies as needed.

Section VIII: AI/AN Reporting

Access to Care

Indian Health Service, Tribally operated facility/programs, and Urban Indian clinics (I/T/Us) are concentrated near or on Tribal land where many Native Americans live and receive services. The last quarter data from the four Centennial Care MCOs shows for physical health there is 97.4% access to care for Native Americans in rural areas and 98.5% access to care for Native Americans in frontier areas. For behavioral health there is a 97.3% access for Native Americans in rural areas and 98.5% access for Native Americans in frontier areas. This is a slight improvement from the previous quarterly report.

The data is showing members are accessing specialty services such as psychiatry, ophthalmology, orthopedics and cardiology outside of I/T/Us.

Contracting Between MCOs and I/T/U Providers

For this quarter there have not been any new contracts (agreements) with I/T/Us. Several agreements are pending review of IHS or Tribal leadership. The MCOs currently have agreements with Tribal entities for HRA completion, translation, transportation, health education, audiology, optical, extended hour services, tribal behavioral health services, recovery services, and Wellness Centers. The MCOs were notified that one of the Tribal facilities received their NPI number and are open to negotiating and contracting with the MCOs. The MCOs continue to work on developing contracts with I/T/Us.

Ensuring Timely Payment for All I/T/U Providers

The MCOs met timely payment requirements 95.1% of the time for claims being processed and paid within 15 days of receipt and 94.7% of claims being processed and paid within 30 days of receipt. Both figures are down from the previous reporting period.

Table 16 – Native American Advisory Board (NAAB) meetings for DY4 Q4

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Crownpoint Chapter House Crownpoint, NM October 25, 2017	BCBS shared their participation in community events in the Crownpoint area - the employee sponsored fundraisers for school supplies, Kaboom playground equipment, and scholarship/grant programs. All individuals in attendance were new attendees. Navajo translation was provided. BCBS presented on the Alternative Benefits Plan (ABP) including covered services. BCBS outlined their Value Added Services (VAS) such as the Traditional Healing benefit. The BCBS Ombudsman was introduced and he explained what services he provides for members. Many audience members had questions which BCBS staff answered during and after the meeting.

MHNM	Tribal Administrative Bldg. Acoma Pueblo, NM November 3, 2017	Molina members were informed of the purpose of the Native American Advisory Board (NAAB) meetings, which included an opportunity for members to provide feedback. There were questions about personal care services and transportation. Molina answered the questions and referred members to the Ombudsman as needed.
PHP	Mescalero Tribal Offices Mescalero, NM October 13, 2017	Presbyterian stated the purpose of the NAAB meetings is to get feedback from their Centennial Care members. PHP told their audience that if they need referrals to see specialists outside of IHS, PHP can help with this as well as the transportation piece, if needed. Several individuals in the audience asked how members can get home modifications, grab bars, a ramp, etc. PHP explained that the care coordinator will need to come in and do an assessment. Other questions were answered during the meeting or after the meeting.
UHC	Hilton Garden Inn Gallup, NM December 1, 2017	The UHC team discussed the UHC benefits for Native Americans and how to get prior authorizations for specialty referrals. They also informed members where to go to resolve billing issues, if they come up.

HSD's Native American Technical Advisory Committee (NATAC) Update

In place of the October NATAC meeting, a formal Tribal consultation on the 1115 demonstration waiver renewal was held in Santa Fe. NATAC members, Tribal leadership, and I/T/Us were present for the consultation. HSD utilized the feedback from the Tribal consultation to inform its 1115 waiver renewal application.

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

Albuquerque Area IHS and UNM continue to meet to finalize the process for the referral, scheduling and documentation sharing of services provided. Testing of the new process will take place in DY5 Q1.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment F: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY4 Q4 reflects the CY 2017 rates that exhibit the full effect of a series of cost containment that started in July 2016. Round one (rate reductions for inpatient and outpatient hospitals, practitioner and dental, and termination of primary care providers enhanced payments), round two (rate reductions for practitioner reimbursement for both non-radiology and radiology codes), and round three of the cost containments went into effect January 1, 2017 (rate reductions for professional fee schedule codes that remain at or above 100% of the Medicare rate to 94% of the Medicare rate) are reflected. The effects of these costs containments are apparent in the per member per month (PMPM) of DY4 Q4 compared to the PMPM of DY 3; the PMPMs of DY4 Q4 are lower than the PMPMs of DY 3 for MEGs 1, 2, 3 and 5 (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 4 is 26.5% below the budget neutrality limit (Table 4.4).

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.

Table 17 – Member Months DY4 Q4

Number of Clients by Population Group and MC	
	2017
Row Labels	**Q4**
Population 1 – TANF and Related	**1,121,156**
FFS	**135,559**
MC	**985,597**
Molina	366,940
Presbyterian	359,090
UnitedHealthcare	80,049
Blue Cross Blue Shield	179,518
Population 2 – SSI and Related – Medicaid Only	**117,287**
FFS	**8,826**
MC	**108,461**
Molina	36,844
Presbyterian	37,582
UnitedHealthcare	15,067
Blue Cross Blue Shield	18,968
Population 3 – SSI and Related – Dual	**105,472**
MC	**105,472**
Molina	20,858
Presbyterian	19,850
UnitedHealthcare	45,355
Blue Cross Blue Shield	19,409
Population 4 – 217-like Group – Medicaid Only	**1,152**
FFS	**431**
MC	**721**
Molina	144
Presbyterian	152
UnitedHealthcare	301
Blue Cross Blue Shield	124
Population 5 – 217-like Group - Dual	**9,866**
MC	**9,866**
Molina	2,156
Presbyterian	1,778
UnitedHealthcare	3,871
Blue Cross Blue Shield	2,061
Population 6 – VIII Group (expansion)	**755,981**
FFS	**86,701**
MC	**669,280**
Molina	207,827
Presbyterian	184,711
UnitedHealthcare	108,398
Blue Cross Blue Shield	168,344

Section XII: Consumer Issues – Complaints and Grievances

A total of 871 grievances were filed by Centennial Care members in DY4 Q4. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 414 (47.53%) of the total grievances received. The MCOs report they continue to communicate and meet regularly with their transportation vendors to address identified issues that involve transportation vendors and the appropriate service levels. Transportation Grievances in Section II of this report provides MCOs' efforts to address transportation grievances under the guidance of HSD.

The second top grievance filed was "Other Specialties" with a total of 45 grievances (5.17%) which demonstrates a downward trend from Q3 (61), Q2 (84) and Q1 (109). Members reported dissatisfaction with services not provided and customer service practices. MCO interventions include regular communication with providers and outreach by the provider advocates.

There were 412 (47.30%) variable grievances filed during DY4 Q4. Of those, each MCO reported unique grievances that do not provide data to establish a trend. Examples of variable grievances include Pharmacy, Primary Care Physician, and Durable Medical Equipment/Supply (DME). MCO interventions include member education by member services, continued communication with internal management to resolve issues at the lowest level, and the Appeals and Grievance department working with members to ensure that their concerns are addressed. HSD is monitoring these grievances to identify specific trends.

Table 18 – MCO Grievances DY4 Q4

MCO Grievances DY4 Q4 (October - December 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	180	20.67%	275	31.57%	192	22.04%	224	25.72%	**871**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	106	12.17%	131	15.04%	62	7.12%	115	13.20%	**414**	47.53%
Other Specialties	0	0.00%	0	0.00%	22	2.53%	23	2.64%	**45**	5.17%
Variable Grievances	74	8.50%	144	16.53%	108	12.40%	86	9.87%	**412**	47.30%

While MCOs work toward optimizing member satisfaction, it should be noted that grievance reporting is generally encouraged to ensure adequate member protections across grievance types, quantification and identification of concerns, and appropriate and effective interventions.
It is important to note that categories, which consistently reflect the highest percentages of total grievances, are not necessarily indicators of poor performance. Several performance measures, such as grievances per service units and severity levels, must be taken into consideration when evaluating performance and needed improvements.

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD randomly reviews service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures that the MCOs appropriately allocate and implement the services identified in the member's Comprehensive Needs Assessment (CNA), and that the member's goals are identified in the care plan. There were no identified concerns in DY4 Q4.

Table 19 – Service Plan Audit DY4 Q4

Member Records	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**120**	**120**	**120**	**120**
BCBS	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**30**	**30**
Percent of files with personalized goals matching identified needs	**100%**	**100%**	**100%**	**100%**
BCBS	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**30**	**30**
Percent of service plans with hours allocated matching needs	**100%**	**100%**	**100%**	**100%**
BCBS	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**30**	**30**

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.

Table 20 – Nursing Facility LOC Audit DY4 Q4

MCO High NF LOC denied requests (downgraded to Low NF)	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**17**	**17**	**17**	**15**
BCBS	**5**	**5**	**5**	**5**
MHC	**3**	**2**	**2**	**0**
PHP	**5**	**5**	**5**	**5**
UHC	**4**	**5**	**5**	**5**
HSD Reviewed Results	**DY4 Q1**	**DY4 Q2**	**DY4 Q3**	**DY4 Q4**
Number of member files that met the appropriate level of care criteria	**17**	**17**	**17**	**15**
BCBS	**5**	**5**	**5**	**5**
MHC	**3**	**2**	**2**	**0**
PHP	***5***	**5**	**5**	**5**
UHC	**4**	**5**	**5**	**5**
Percent of MCO level of care determination accuracy	**100%**	**100%**	**100%**	**100%**

Table 21 – Community Benefit NF LOC Audit DY4 Q4

Community Benefit denied NF LOC requests	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**20**	**22**	**22**	**25**
BCBS	**3**	**5**	**5**	**5**
MHC	**7**	**7**	**7**	**10**
PHP	**5**	**5**	**5**	**5**
UHC	**5**	**5**	**5**	**5**
Number of member files that met the appropriate level of care criteria determined by the MCO	**20**	**22**	**22**	**25**
BCBS	**3**	**5**	**5**	**5**
MHC	**7**	**7**	**7**	**10**
PHP	**5**	**5**	**5**	**5**
UHC	**5**	**5**	**5**	**5**
Percent of MCO level of care determination accuracy	**100%**	**100%**	**100%**	**100%**

HSD was in agreement with all NF LOC decisions for DY4 Q4. MHC did not have any HNF denials in Q4 and an additional 5 files for Community Benefit were reviewed. All NF LOC decisions were appropriate and complied with NF LOC criteria.

External Quality Review Organization (EQRO) NF LOC

The EQRO for HSD reviews a random sample of MCO NF LOC determinations every quarter.

Table 22 – EQRO NF LOC Review DY4 Q4

Facility Based	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
High NF Determination				
Number of member files audited	**29**	**27**	**23**	**28**
BCBS	7	2	5	6
MHC	5	8	3	4
PHP	8	7	9	8
UHC	9	10	6	10
Number of member files the EQRO agreed with the determination	**24**	**24**	**22**	**27**
BCBS	6	2	5	6
MHC	5	6	3	4
PHP	6	6	9	8
UHC	7	10	5	9
%	**83%**	**89%**	**96%**	**96%**
BCBS	86%	100%	100%	100%
MHC	100%	75%	100%	100%
PHP	75%	86%	100%	100%
UHC	78%	100%	83%	90%
Low NF Determination				
Number of member files audited	**79**	**81**	**85**	**80**
BCBS	20	25	22	21
MHC	22	19	24	23
PHP	19	20	18	19
UHC	18	17	21	17
Number of member files the EQRO agreed with the determination	**77**	**81**	**85**	**78**
BCBS	20	25	22	21
MHC	22	19	24	22
PHP	19	20	18	18
UHC	16	17	21	17
%	**97%**	**100%**	**100%**	**98%**
BCBS	100%	100%	100%	100%
MHC	100%	100%	100%	96%
PHP	100%	100%	100%	95%
UHC	89%	100%	100%	100%
Community Based				
Number of member files audited	**156**	**156**	**156**	**156**
BCBS	39	39	39	39
MHC	39	39	39	39
PHP	39	39	39	39
UHC	39	39	39	39
Number of member files the EQRO agreed with the determination	**155**	**154**	**153**	**153**
BCBS	39	39	39	37
MHC	39	39	39	39
PHP	38	37	37	38
UHC	39	39	38	39
%	**99%**	**99%**	**98%**	**98%**
BCBS	100%	100%	100%	95%
MHC	100%	100%	100%	100%
PHP	97%	95%	95%	97%
UHC	100%	100%	97%	100%

The MCO High NF determinations continue to average 96% in Q4 for EQRO agreement of determinations. The Low NF determinations decreased slightly in Q4 to 98% from an average of 100% in Q3 for EQRO agreement. Community Based determinations continue to average 98%

for EQRO agreement. HSD reviewed the six NF LOC determination disagreements from EQRO audits from for DY4 Q4 and was in agreement with all EQRO findings. Issues identified included conflicts in documentation and incomplete documentation. HSD noted that the number of denial determinations from the MCOs increased slightly in Q4 with all four MCOs having at least one denial determination. HSD will follow up with the MCOs regarding the identified cases and will continue to provide technical assistance as needed.

Additionally, HSD reviewed the four NF LOC determination disagreements for DY4Q3 with the MCOs, two for PHP and two for UHC. HSD requested clarification for discrepancies identified in audit documentation, status updates on the identified members, and plans moving forward to improve the accuracy of determinations. PHP provided additional information justifying NF LOC approval for one member and acknowledged an incorrect entry for the other file. PHP also provided status updates for the identified members and reported that they have initiated the implementation of Audit Tools to be reviewed monthly for each staff member. Additionally, PHP reports that Long Term Care Utilization Management Unit conducts monthly trainings that include Medical Director staffing and presenting cases across all Long Term Care Reviews to ensure that PHP is consistent with all criteria and regulations.

UHC also provided clarification for the identified discrepancies. UHC provided additional information justifying NF LOC approval for one member. For the other file, UHC acknowledged an incorrect entry in documentation and noted that supporting documentation was mistakenly not included in this audit file when it was submitted to the EQRO for review. UHC provided status updates for both members and noted that the state NFLOC criteria including descriptors of ADLs/IADLs were reviewed with Care Coordinators, Secondary Reviewers, and Medical Director to ensure consistency in the application of criteria. Additionally, UHC states that they will strive to complete accurate and timely NF LOC determinations by completing: Annual IRR competencies, Monthly Secondary Review Team and Medical Director NF LOC discussions, Monthly NF LOC criteria and eligibility review by a Secondary Review Team, ongoing and consistent review of UHC NF LOC Policy and Procedures, NMAC regulations, Managed Care Policy Manual, NF LOC Criteria and Instructions, and internal quarterly auditing of NF LOC determinations and criteria. 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 has continued to target specific deficiencies identified with the MCO audits. HSD continues to evaluate the MCOs' internal action plans and has documented improvement in several areas, which has prompted HSD to close those particular deficiencies. UHC was successful in areas such as updating Member action lists and milestones, providing updated Member medication lists in CNAs and CCPs and implementing procedures to improve documentation of member appointments. MHC has shown improvement in assuring that

Emergency and Disaster plans, as well as member back-up plans, are member-centric and up to date. Based on a transition of care audit, HSD initiated new recommendations and action steps for the MCOs' internal action plans. The HSD audit identified that the MCOs were not consistent with their documentation and processes regarding members transitioning from a facility to the community. HSD will continue to monitor the MCOs' internal action plans in DY5 Q1 with specific attention to the Transition of Care Action Steps.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top 35 Emergency Department (ED) utilizers for each MCO. HSD monitors this group on a monthly basis, tracks the number of ED visits, reviews what steps are being taken by care coordinators to reduce the incidence of ED visits by their members and how supplemental community assistance can complement the services provided by the care coordinator. Community Health Workers, Housing Specialists and Peer Support staffs have all contributed to a higher level of success for reducing avoidable ED visits. Data from DY4 Q2 and DY4 Q3 have shown decreasing ED use among active BCBS members from 3.12 visits per month at the start of the project to 1.72 currently. MHC has seen the number of ED visits fall to 1.63, UHC experienced a decrease to 1.81 per month, and PHP's current data reflected an average of 2.18 ED visits per month. HSD will meet with the MCOs in DY5 Q1 to review the data, discuss best practices and what steps can be taken going forward to continue reducing avoidable ED visits.

Care Coordination and EDIE

HSD continues to participate in the statewide "ER is for Emergencies" PreManage ED committee, also known as the EDIE project. EDIE is a database that is able to share real time data of member ED utilization when the member is accessing services among participating New Mexico hospitals. This collaboration will potentially allow for same day care coordination intervention with the member. There are currently 39 hospitals participating in the EDIE project across the state. Targeted training of staff is being scheduled with some participating agencies and specific technical issues are being worked on with others. A standardized care plan is being considered for this project. HSD and all participants are confident that as more sites are launched, training is completed and standardized care plans implemented, more agencies will see the benefits of EDIE.

Care Coordination for Incarcerated Individuals

HSD continues to provide technical assistance for a care coordination pilot project with MHC and the Bernalillo County Metropolitan Detention Center (BCMDC). The project focuses on providing incarcerated members with care coordination to address members' immediate healthcare needs upon release. HSD attends monthly meetings with BCMDC and MHC focusing on care coordination activities and member outcomes. Currently there are 366 members who have agreed to participate in this program which is an increase from DY4 Q3. MHC has worked closely with BCMDC to lower the number of participants who are missed due to early release.

Connecting with participants who are released and then difficult to engage has continued to be a priority for MHC. Care Coordinators have been connecting with pharmacies and providers for updated participant information. MHC has engaged more community connectors to locate members and identify and address any social determinants as a way to reengage members in care coordination services. A current challenge is understaffing at the BCMDC which is placing a temporary hold on new referrals to the project. HSD is also collaborating with the Santa Fe County Jail in their efforts to assist incarcerated individuals in obtaining care coordination before their release. The jail currently coordinates with BCBS and UHC in this collaboration. Current goals of the jail are to enroll incarcerated individuals into short term, presumptive eligibility Medicaid and ongoing Medicaid when appropriate and to reinstate Medicaid in an effort to make their transition from incarceration to the community as seamless as possible. HSD will be requesting a meeting with the jail to discuss their process, recidivism, successes with coordinating PCPs or specialists and to determine their interest in presenting to HSD and the other MCOs.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY4 Q4 ride-alongs were conducted with MHC and BCBS with staff observing initial CNA assessments in the members' home. Currently, HSD has conducted ride-alongs specifically with new care coordinators but have widened that scope to allow care coordinators that have been on staff for a year or more. HSD realizes that over time a care coordinator can improve their motivational interviewing skills when conducting a CNA as well as increase their knowledge of current policies and procedures. HSD found that the care coordinator's activities were in compliance with contract requirements, including the administration of the Community Benefit Services Questionnaire (CBSQ) and the CNA.

Section XIV: Managed Care Reporting Requirements

Customer Service

In DY4 Q4, all MCOs met call center metrics (abandonment rate, speed of answer and wait time) for all customer services lines, member services, provider services, nurse advice line and the utilization management line.

Medicaid cards, eligibility, and benefits were the three highest call types for Member calls received by the MCOs for this reporting period. All MCOs continue to have agents who are bilingual in English and Spanish. PHP also has agents that speak Dine, a Navajo language. Please see Attachment G: Customer Service Summary.

MCO Reporting

HSD utilizes MCO reports to monitor contract compliance. Contract provisions include requirements for accuracy and completeness as well as penalties for errors, which are an incentive for MCOs to submit accurate data. The data received is used for a variety of analyses including state budget, legislative reports, and external stakeholder meetings. The need for reliable data provides an opportunity for HSD to maintain quality checks on the data. HSD is dedicated to improving the quality of the data and achieving uniformity in data collection and reporting by providing regular technical assistance to MCOs. In the DY4 Q4, HSD continued technical assistance calls with the MCOs regarding report issues and accepting self-identified error resubmissions. These two processes allow HSD and MCO subject matter experts to clarify data requirements and correct data inaccuracies. HSD continues to see a decline in MCOs report extension requests, with one extension request made in DY4 Q4.

Report Revisions

HSD revises reports as necessary. A revision workgroup that includes subject matter experts is developed for each report revision to ensure the needs of all stakeholders are considered. HSD revises reports to streamline elements, improve monitoring, and incorporate requirements of the managed care final rule. During DY4 Q4, HSD conducted reviews of the final draft of the pharmacy report to ensure a thorough analysis of pharmacy services. The revised pharmacy report will provide a broader overview of utilization across the MCOs and focuses on monitoring drugs for the treatment of opioid dependence, alcohol and nicotine dependence, methadone use in pain management, HIV treatment, and utilization of antipsychotic medications in children.

Member Appeals

A total of 876 member appeals were filed by Centennial Care members in DY4 Q4. Of those appeals, 793 (90.53%) were standard member appeals and 83 (9.47%) were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner. Denial or limited authorization of a requested service constitutes the largest number of appeals reported with 697 (79.57%) of the total appeals received. Member appeals included criteria for services not met and denial of personal care service hours. MCO interventions include member education and

referrals to Medical Directors and Clinical Operations Directors for continued ways to improve processes.

The second top reason for appeals was the reduction of a previously authorized service with a total of 54 (6.16%) member appeals. Issues for member appeals included dissatisfaction with reduction in personal care service hours or home health services, and denied requests for long term care.

There were 125 (14.27%) variable appeals in DY4 Q4. 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.

Table 23 – Member Appeals DY4 Q4

MCO Appeals DY4 Q4 (October - December 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member	78	8.90%	172	19.63%	387	44.18%	156	17.81%	**793**	90.53%
Number of Expedited Member	27	3.08%	22	2.51%	3	0.34%	31	3.54%	**83**	9.47%
Total	105	11.99%	194	22.15%	390	44.52%	187	21.35%	**876**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	76	8.68%	178	20.32%	338	38.58%	105	11.99%	**697**	79.57%
Reduction of a previously authorized service	0	0.00%	5	0.57%	28	3.20%	21	2.40%	**54**	6.16%
Variable Appeals	29	3.31%	11	1.26%	24	2.74%	61	6.96%	**125**	14.27%
Empty Variables									**0**	0.00%

Section XV: Demonstration Evaluation

Throughout DY4 Q4, Deloitte completed major activities for the Centennial Care 1115 Waiver Evaluation including the finalization and submission of the Interim Evaluation Report. Continued activities centered on the collection of outstanding DY3 data as well as initiating the data collection process for DY4. Deloitte and HSD discussions focused on the development of timelines and deliverables for DY4, reporting activities, and report content and structure of the Final Evaluation Report.

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

Often times, members' most immediate needs are not healthcare related. In December, one Centennial Care MCO received an urgent referral for an 8-month old member. The child's mother contacted the MCO because the 8-month old had been admitted to a local medical center a few days prior for respiratory syncytial virus (RSV) and two other viruses. Along with this stressor, the mother was unable to cover rent, had been given an eviction notice, and was on the verge of becoming homeless. While the child's mother stayed with her 8-month old at the hospital, her fiancée who was also the primary income-earner for the household had been unable to work in order to stay home with their other three boys. To say the least, the mother was beyond overwhelmed and worried for her family.

The MCO immediately assigned the member's case to a registered nurse with experience in pediatrics for care coordination. Due to the emergent housing needs, the member's care coordinator also reached out to one of the MCO's community health workers (CHW) for assistance. By that afternoon, the CHW met with the mother. The CHW worked quickly with local churches and resources and was able to get the rent covered, so there was no longer an immediate threat of eviction. In addition, the CHW learned that due to financial hardships, the family did not have Christmas presents for the children or birthday presents for one of the children whose birthday was on Christmas. The care coordinator and CHW again worked with local churches and resources and were able to provide gifts for all of the children. The care coordinator and the CHW kept in contact with the mother during the 8-month old's discharge to ensure that he transitioned home with everything that was needed. The care coordinator will be completing a comprehensive needs assessment in order to continue care coordination and assist the mother with managing her son's needs and educating her on RSV aftercare.

Centennial Care Member Success Story 2

A newborn member had been admitted to the pediatric intensive care unit shortly after birth at the Children's Hospital in El Paso. At two months of age, the child was then transferred to the Children's Hospital of Colorado (CHC) due to his complex cardiac conditions. Since then, the member has had several cardiac procedures and a recent urology procedure requiring coordination for the out-of-state visits. The member's parents reported having difficulty navigating the health care system and expressed concerns about prior authorizations being approved.

A care coordinator assisted the member's parents with managing his out-of-state visits, certifying that prior authorizations were complete and educating them on the process. The member's parents have become more confident in understanding their son's complex conditions. The care

coordinator communicates with the Utilization Department regularly to follow-up on the status of all prior authorization reviews. The care coordinator has also assisted with transportation, lodging and meal reimbursements to ensure the member is still able to see out-of-state providers.

The member's parents have expressed their gratitude for the assistance the care coordinator has provided. The care coordinator received a call from a Nurse Practitioner at the CHC to express her appreciation and admiration for her involvement and making sure the member receives the necessary medical services.

Centennial Care Member Success Story 3

A member was able to access Long Term Care services through Centennial Care. The member was given care giver support, and environmental modifications. The environmental modifications were completed in the member's bathroom. However, the member resides in an older adobe home in Pecos that is in need of repair. In particular, the member had some windows missing. Because the member heats the home with a wood stove, the member was not able to keep the home adequately warm. The care coordinator reached out to the Garfield Foundation with member's permission and was able to secure the funding to get the windows replaced and installed. The work will be completed, which will ensure member stays warm and safe in the member's home.

Centennial Care Member Success Story 4

A care coordinator has been working with a member for years. This member struggles with Post Traumatic Stress Disorder, Traumatic Brain Injury, and was a victim of abuse by her ex-husband. Most recently, our member had a moderate stroke which affected mobility. This member has never had family support, and a close friend took care of the member after the stroke. However, the member's friend was diagnosed with a brain tumor and had to move out of state to live with family. Before moving, the friend called the member's care coordinator to thank her for everything she had done for the member. The member's friend also told the care coordinator that she was the anchor the member needed and with her in the picture, the friend felt confident to move away, knowing that the member's needs would still be met.