Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 4 (1/1/2017 – 12/31/2017)
Waiver Quarter: 2/2017

August 31, 2017
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. Approximately 678,000 members are 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.

As a beginning place for 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 (BCBSNM)
- Molina Healthcare of New Mexico (MHC)
- Presbyterian Health Plan (PHP)
- United Healthcare (UHC)

Section II: Eligibility, Provider Access and Benefits

Eligibility

As noted in Section III of this report, there are 288,580 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment growth of 2,239 from DY4 Q1.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through May 2017. Quarterly data is available through the first 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
BCBSNM	1:39	1:39	1:40
MHC	1:102	1:102	1:102
PHP	1:88	1:88	1:86
UHC	1:30	1:30	1:30

Source: [MCO] PCP Report #53, Q1CY17

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. UHC and PHP met all of the access standards in urban areas. All MCOs did not meet Dermatology, Endocrinology and Neurosurgeons in rural and frontier areas. UHC is very close to meeting access standards for Neurology and Urology in rural areas with 89.5% and 89.3% respectively. Although UHC and MHC did not meet access standards for neurology in frontier areas, both MCOs are very close to meeting access with UHC at 88.6% and MHC at 89.0%. These access gaps are consistent with previous reporting periods as New Mexico continues to experience a shortage of specialty providers throughout the state. Access issues are remedied by providing member transportation to the nearest provider, telemedicine, utilization of border area providers, and single case agreements with out-of-network providers. Please see Attachment B: GeoAccess PH Summary.

Behavioral Health

Statewide there remains continued access which meets standards for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier through Core Service Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient Provider agencies, FQHCs, psychiatrists, psychologists, Suboxone Certified MDs, and other licensed independent behavioral health practitioners.

HSD continues to be aware of the BH services that do not meet the standards due to a limited number of providers in New Mexico, although these valuable services are often critical in transitioning from setting to setting and in following up after discharge. Geo Access for behavioral health providers in rural and frontier areas for Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs, residential treatment programs, both accredited and non-accredited, Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST) remain unmet with limited exceptions. Throughout DY4 Q2 HSD continued collaborating with the MCOs to enhance connections to available providers. HSD provides on-going technical assistance through demonstrations and learning collaboratives of best practice models to both MCOs and providers to continue to enhance and encourage increasing and effective access with the available resources in the state. MCOs continue to show increase in the access of behavioral health services to members in rural and frontier areas through the increasing use of Telehealth services. Please see Attachment C: GeoAccess BH Summary.

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 utilizing care coordinators, family and peer supports and Community Health Workers (CHW). They 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 process inquiries.

Community Health Worker

In DY4 Q2 the Human Services Department (HSD) developed a standardized reporting template for the CHW initiative. Collecting both quantitative and qualitative data, the standardized report allows HSD to continue to track the progress made quarterly with collection of data in the area of workforce development, CHW certification, number of members served, interventions and types, and counties for CHW activities state-wide including rural, frontier, and underserved urban areas.

In the data collected from DY4 Q1, MCOs reported using both employed and contracted CHWs, Peer Support Specialists (PSS), Member Navigators and Paramedics. Data analysis demonstrates an increase in the total number of CHWs employed from 42 CHWs in DY3 Q4 to 56 CHWs in DY4 Q1, including 38 certified CHWs. CHW certification is a voluntary certification process for experienced CHWs offered by the New Mexico Department of Health (DOH). Please see Table 2: Summary of CHW Workforce for each MCO.

Table 2 – Summary of CHW Workforce for each MCO

Quarter 1 Community Health Workers			
	Employed	**Contracted**	**Total**
BCBSNM	13	12	25
MHC	26	0	26
PHP	9	9.5	18.5
UHC	12	0	12
Totals	**60**	**21.5**	**81.5**

Source: [MCO] CHW DSIPT, Q1CY17

In addition, MCOs provide geographical access and the number of unduplicated members served by CHWs and are now reported in the MCO quarterly reports. Table 3 below includes the number of unduplicated members served by CHWs in urban, rural and frontier areas.

Table 3 – Unduplicated members served by CHWs

Quarter 1 Unduplicated Members Served					
	BCBSNM	**MHC**	**PHP**	**UHC**	**Region Totals**
Urban	**857**	**310**	**658**	**1356**	**3181**
Rural	**183**	**548**	**424**	**998**	**2153**
Frontier	**115**	**96**	**89**	**244**	**544**
MCO Total	**1155**	**954**	**1171**	**2598**	**5878**

Source: [MCO] CHW DSIPT, Q1CY17

CHWs also provide MCO educational activities including diabetes and nutritional classes in both English and Spanish. These educational activities are reported and will continue to be tracked by county to allow HSD to track state-wide access to members with a focus on rural, frontier, and underserved urban areas. Please see Table 4: CHW Educational Activities for a comprehensive list of CHW educational activities reported for DY4 Q1.

Table 4 – CHW Educational Activities

Statewide
• Motherhood Matters Prenatal Education provided to Members with car seat incentives 1-2-3 Parent Magic parenting education • Helmet Safety program provides injury prevention information with a free helmet for children/teens • Quit For Life tobacco cessation education and counseling for Members wanting to quit smoking, dipping, etc. • Manage Your Chronic Disease (My CD) program • National Diabetes Prevention Program available • Molina Day events are continually planned to improve important health tests and screenings
Urban
• Day of Dance event with Lovelace for a Healthy Heart 2017 (Bernalillo) • Molina Day Event at Adventure Dental (Bernalillo) • NM Pediatric Town Hall Meeting (Bernalillo) • Car Seat Safety Clinic at Molina Medical Clinic (Bernalillo) • Diabetic Retinal Eye Exam Events with Molina Medical Clinic (Bernalillo) • NM Chronic Disease Prevention Council collaboration (Bernalillo) • New Mexico Council on Asthma collaboration (Bernalillo) • Lovelace Labor of Love program for pregnant Members to provide prenatal education and health education classes (Bernalillo) • Dental Health (Bernalillo) • Blood Pressure (Bernalillo) • Diabetes and Sleep Disorders (Bernalillo) • High Blood Pressure (Bernalillo) • High Blood Pressure (Los Alamos)
Rural
• Nutrition (Sandoval) • Diabetes (McKinley) • Diabetes (Otero)
Frontier
• Nutrition (Mora) • Nutrition Health Fair (Quay) • Nutrition (Mora) • Diabetes/High Blood Pressure (Colfax)

Source: [MCO] CHW DSIPT, Q1CY17

Telemedicine

HSD established a standardized reporting template that captures both quantitative and qualitative data for tracking utilization in MCO telemedicine programs, particularly for specialist care and in rural and frontier counties where access to some provider types is limited. Although telemedicine services in urban areas are not counted towards the Telemedicine Delivery System Improvement Performance Target (DSIPT), HSD collected the data to track and trend overall utilization. During DY4 Q2, HSD reviewed telemedicine utilization data for Q1. Physical

Health utilization data is being validated while the current data reflect that most telemedicine services provided in New Mexico are for behavioral health diagnoses. Additionally, HSD provided technical assistance to the MCOs to clarify parameters for reporting utilization data and to ensure consistent reporting among MCOs. Please see Table 5: Telemedicine Services, which includes geographic access and number of members accessing behavioral health serve through telemedicine.

Table 5 – Telemedicine Services

Telemedicine Services

	Quarter 1		
	Behavioral Health		
	Urban	Rural	Frontier
BCBSNM	238	476	83
MHC	223	827	159
PHP	355	1,065	309
UHC	145	311	57
TOTAL	961	**2,679**	**608**

Source: [MCO] Telemedicine DSIPT, Q1CY17

For DY4 Q1, BCBSNM reports 50% of behavioral health telemedicine visits occurred in Curry and McKinley counties, with the other 50% somewhat evenly distributed amongst various counties. MHC reported 98% of total rural and frontier telemedicine specialty visits were for behavioral health services. PHP reported that the majority of behavioral health telemedicine services occurred in Curry, McKinley, Otero, San Juan, Valencia and San Miguel counties. UHC's geographical distribution shows top areas for member utilization include Otero, Eddy, Luna, San Miguel and Sierra counties.

In light of the Dermatology shortage throughout the state, MHC together with the UNM Center for Telehealth and the UNM Department of Dermatology are collaborating with Vignet Corporation to pilot a Teledermatology program. The Vignet platform carries the endorsement of the American Academy of Dermatology and will allow contracted physicians and providers throughout the state to access the services of board certified UNM Dermatologists through asynchronous/store-and-forward telemedicine technology. In this process referring physicians take photographs of dermatologic conditions which along with relevant history and clinical information are uploaded into a web-based platform specially formatted and secured for the UNM Teledermatology program. The case images and clinical notes are then reviewed by a UNM Dermatologist. The assessment and recommendations for the consult are forwarded within a predetermined timeframe back to the referring physician. This program will expand access to treatment and shorten wait times for patients across the state.

Transportation Member Grievances

Non-emergency medical transportation (NEMT) grievances have consistently represented the highest percentage of total member grievances since the beginning of Centennial Care. As such, analysis of grievance data, intervention strategies and effectiveness, and performance indicators are evaluated by the MCOs and submitted to HSD annually.

In 2015, MCOs were directed by HSD to establish a workgroup to discuss NEMT member grievances and potential improvements. Workgroup focus was to include: standardization of grievance reporting, development of severity levels for transportation grievances, discussion of performance improvement strategies, and confirmation of annual evaluations for sub-delegated entities as required by contract. As reported in DY3 Q2, average year-to-date grievance rates (January through July) by MCO ranged from .06 to 1.92 per 1,000 one-way trips. In subsequent reporting to HSD, average annual grievance rates through December 2015 were .42 to 2.34 per 1,000 one-way trips. (See Attachment D: 2015-2016 NEMT Grievances per 1,000 One-way Trips). These rates are not particularly high when evaluated using a weighted average to allow for comparisons across MCOs. However, HSD recognizes that transportation is a key component for service access. Missed medical appointments and/or inadequate services provision have the potential to adversely affect the health and safety of Centennial Care members.

MCO improvements include, but are not limited to: the beginning of MCO tracking by severity tier levels; HSD Grievance & Appeals Report revisions which are currently in process; and, annual audit submissions by each MCO to HSD for review and evaluation. UHC included performance measures and goals with its 2016 audit materials, developed in partnership with its transportation vendor, and regularly monitored by the MCO. MHC transitioned its transportation vendor during the DY3 Q2 as described in the previous quarterly report. HSD is monitoring member grievances and member line call center volume as early indicators for any needed interventions for a smooth transition of NEMT services for MHC members.

Provider Network

All MCOs actively review and analyze their provider network to ensure the accessibility of Primary Care Physicians (PCPs), specialists, behavioral health providers, and long-term service and support providers. Each MCO has a unique way of monitoring provider networks to include, but not limited to:

- BCBSNM analyzes its provider network on a continual basis. The analysis is then available for Outreach and Enrollment and the Health Care Management Departments throughout the year. Through the use of GeoNetworks software, criteria has been established using ratios of providers to members by zip code, county , and the distribution of all providers by established distances. Other monitoring activities include the Service Quality Improvement Committee which meets every other month to review network issues. Annually, various surveys are reviewed by BCBS's Service Quality Improvement Committee to identify

barriers and opportunities for improvement in the overall network, and in conjunction with the Network Management team to take steps to improve network adequacy and to assure members have timely access to services.

- MHC monitors its provider network by assessing key reports (Availability of Practitioner/Provider Network Annual Report and Provider Access Appointment Availability). MHC collects and performs annual analyses to measure performance against standards. The access reports are presented to the Quality Improvement Committee designed to work with providers and their staff on a number of identified interventions. The access reports are also presented to MHC's Network Operations Committee which oversees the provider network, and development and management plan and activities. MHC continuously monitors the medical community to identify new practices or facilities. In addition, MHC maintains robust networks in other states and can quickly obtain information about available providers who have contracts with other MHC Medicaid plans.
- PHP continuously monitors and manages activities that enable development of the network to ensure sufficient access and availability for all Centennial Care covered services. PHP reviews all covered benefits and services, and considers member enrollment and expected growth. Member location, characteristics, and healthcare utilization needs are also analyzed and considered. In addition, PHP conducts contracting and recruitment efforts that are prioritized on need, continuity of care, capacity, deficiencies, and specialty.
- UHC uses a systematic approach for the development and enhancement of their provider network. With a strong base of multiple-specialty provider types, network adequacy is reviewed on an annual and quarterly basis in accordance with a formalized Network Development Plan. The components of the Network Development Plan are reviewed through multiple venues, with an annual review presented to the appropriate committees for approval.

Service Delivery

Utilization Data

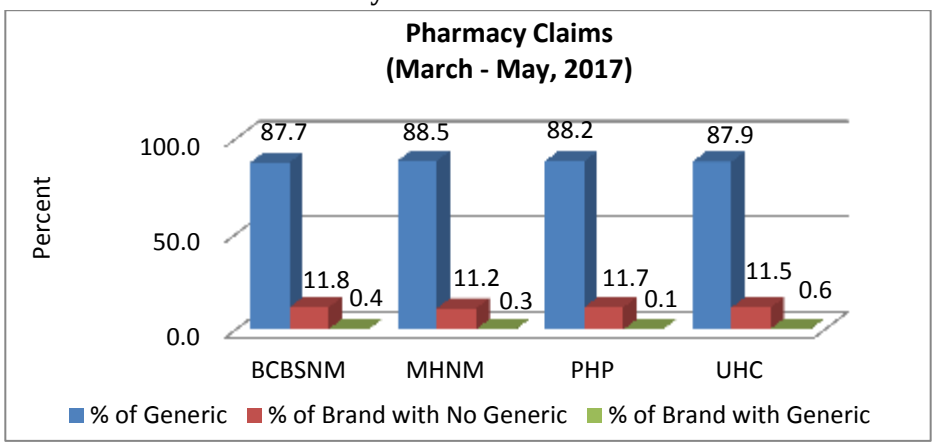
Centennial Care key utilization and cost per unit data by overall programs as well as by a specific program is provided for April 2015 through March 2017. Please see Attachment E: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

HSD monitors key metrics regarding prescription claims for brand and generic drugs. BCBSNM and MHC had a slight decrease in generic drug usage from the previous quarter. PHP and UHC had a slight increase in generic drug usage from the previous quarter with an 88.1% average for all four MCOs. Of the four MCOs, the use of brand with no generic available had a decrease with an average of 11.5% for all MCOs. MHC is the only MCO to have a slight increase of brand with no generic available from the previous quarter. Use of brand with a generic drug available remains at an average of 0.4% for all MCOs. All four MCOs require medical justification for usage of a brand drug when a generic drug is available. HSD has not identified

any concerns at this time and will continue to monitor utilization of generic drug utilization and brand name drug utilization. Please see Table 6: Percent of Pharmacy Claims for each MCO.

Table 6 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M3CY17, M4CY17, M5CY17

Hepatitis C

In DY4 Q2, HSD and the MCOs continue collaborative efforts to increase the number of members treated for Hepatitis C Virus (HCV). The HCV workgroup initiated a *Hepatitis C Screening and Treatment Survey* which was implemented in DY4 Q2. This short survey is directed toward health care providers to identify gaps and opportunities in HCV education, screening, and linkage to care. By participating in this survey, providers are given an opportunity to assist HSD and the MCOs in reducing morbidity and mortality from HCV. In addition, the responses will help the workgroup understand barriers to HCV screening and treatment. The survey has been posted on the MCOs' provider websites. All MCOs are distributing the survey. An update will be provided in DY4 Q3.

In order to successfully achieve the vision of reducing morbidity and mortality by providing evidence-based treatment for all identifiable members with chronic HCV infection by 2020 within the state of New Mexico, MHC has implemented a comprehensive program and innovative approach to Hepatitis C with initiatives to include:

- **Molina HCV Surveillance Database:** MHC uses its claims data to match HCV lab claims with HCV treatment claims and were able to find 200-300 members that have lab claims without treatment claims.
- **Dedicated HCV Care Coordinator team**
- **Collaboration with Chronic Liver Disease Foundation (CLDF) for point of care education and testing:** "Triple C for HCV" – Engagement and Education (of both providers and members), and Eradication (with treatment) by hosting an event at Opioid Treatment Programs.
- **Integration of BH and PH Services:** using PSSs to support medication adherence.

- **Collaboration with University of New Mexico College of Pharmacy (MTM)** to utilize UNM pharmacists to increase HCV education, screening and linkage to care.
- **Metropolitan Detention Center (Molina Care Coordination Project):** Care coordination starts while MHC members are incarcerated. So far, they have 200+ active participants with approximately 10% reported to have HCV (though this is not necessarily confirmed by the lab test results).
- **Incentive Program:** Currently, MHC offers monetary incentives to providers who present/consult a HCV case through Project ECHO.

Nursing Facilities

As previously reported in DY3 Q4, several issues related to MCO processing of Nursing Facilities (NF) claims payments were reported to HSD. In DY4 Q2, HSD continued to monitor the MCOs' efforts to address these issues through regularly scheduled meetings with the MCOs and their NF provider networks to discuss claims payment issues, root causes, and solutions. Significant progress was made in DY4 Q2 as the MCOs analyzed their claims processing procedures and made systemic changes where possible. HSD will continue to monitor NF payment issues to resolution.

Community Interveners

In DY4 Q1, five Centennial Care members received Community Interveners (CI) services as illustrated below.

Table 7 – Community Intervener Services Utilization DY4 Q1

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBSNM	2	142.5	$3,591.00
MHC	0	0	$0
UHC	2	63	$1,673.00
PHP	1	165.75	$4,457.00
Total	**5**	**371.25**	**$9,721.00**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date, 662,824 distinct members, or 72% of all enrollees, have earned at least one reward. Since the launch of Centennial Rewards, members have earned points totaling a value of $46.8 million. Table 8 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.

Table 8 – Healthy Behaviors Rewarded

Eligibility Activities	Activity Completion Reward Value in Points	Activity Completion Reward Value in $	Total Rewards Earned by Activity in $	Total Rewards Redeemed by Activity in $	Redemption Percentage
Asthma Management	600	$60	$ 1,122,770	$ 367,312	32.7%
Bipolar Disorder Management	600	$60	$ 1,290,685	$ 311,279	24.1%
Bone Density Testing	350	$35	$ 57,575	$ 11,486	19.9%
Healthy Smiles Adults	250	$25	$ 9,503,900	$ 1,800,107	18.9%
Healthy Smiles Children	350	$35	$ 22,014,545	$ 5,406,678	24.6%
Diabetes Management	600	$60	$ 5,372,440	$ 1,344,524	25.0%
Healthy Pregnancy	1000	$100	$ 1,327,600	$ 334,709	25.1%
Schizophrenia Management	600	$60	$ 648,940	$ 130,276	20.1%
Health Risk Assessment (HRA)	100	$10	$ 4,393,200	$ 1,034,149	23.5%
Other (Appeals and Adjustments)	N/A	N/A	$ 571,555	$ 330,894	57.9%
Step-Up Challenge	500	$50	$ 535,275	$ 455,869	85.2%
Totals			$ 46,838,485	$ 11,527,283	24.6%

Across all categories, just under 25% of earned rewards have been redeemed. The cumulative redemption rate is nearly one percentage point lower this quarter than it was last quarter. This is primarily due to redemption slowing slightly while the earning trend continued to be similar to last quarter. This slight dip in the redemption rate is typical as we generally see more points being redeemed around the holidays and in the summer months.

The table above shows that members who complete the Step-Up Challenge have the highest likelihood of redeeming the reward they earn. This highlights the fact that the more active a member is in earning a reward, the more likely they are to redeem it.

Finity, the company that administers the Centennial Rewards Program, recently shared some additional data analytics for the program. They compared demographic factors for participants and nonparticipants and found that women participated at a higher rate than men (73% vs. 67%), and children (77%) were more likely to participate than any other age group.

Finity also analyzed how long it takes, on average, for a member to redeem earned points. Interestingly, while members age 26 to 45 were the least likely to participate in the program, they redeemed their points more quickly than any other age group. The overall average time to redeem points is 320 days, but those ages 26 to 45 redeem their points after approximately 285 days.

Lastly, Finity looked at members who have been eligible for the program across multiple years to see how likely they would be to participate year over year. Of members who were eligible (enrolled in managed care) for two consecutive years and who participated in the first of those years, 73% participated again in the second year. And of those members who were eligible for

the program for all three years and participated in the first two, 81% participated in the third year.

Section III: Enrollment

Centennial Care enrollment indicates the largest increase in enrollment continues to be 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 continues to increase each quarter in almost every population.

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 9 – Enrollment DY4 Q2

Demonstration Population	Total Number Demonstration Participants DY4 Q2 Ending June 2017	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**387,788**	**377,261**
FFS	48,875	46,401
Molina	126,259	122,279
Presbyterian	124,454	120,184
United Healthcare	26,509	26,923
Blue Cross Blue Shield	61,691	61,474
Population 2 – SSI and Related – Medicaid Only	**41,965**	**41,807**
FFS	3,311	3,181
Molina	13,098	12,993
Presbyterian	13,599	13,756
United Healthcare	5,219	5,261
Blue Cross Blue Shield	6,738	66,16
Population 3 – SSI and Related – Dual	**37,088**	**40,577**
Molina	7,149	7,658
Presbyterian	6,974	7,597
United Healthcare	16,100	17,723
Blue Cross Blue Shield	6,865	7,599
Population 4 – 217-like Group – Medicaid Only	**430**	**375**
FFS	182	91
Molina	50	56
Presbyterian	55	66
United Healthcare	104	117
Blue Cross Blue Shield	39	45
Population 5 – 217-like Group - Dual	**3,249**	**3,549**
Molina	678	684
Presbyterian	579	630
United Healthcare	1,340	1,509
Blue Cross Blue Shield	652	726
Population 6 – VIII Group (expansion)	**288,580**	**342,794**
FFS	37,888	40,799
Molina	77,281	92,106
Presbyterian	68,810	83,274
United Healthcare	40,689	49,060
Blue Cross Blue Shield	63,912	77,555

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 10 – Disenrollment Counts DY4 Q2

Disenrollments	Total Disenrollments During DY4 Q2
Row Labels	
Population 1 – TANF and Related	**9,032**
FFS	1,223
Molina	2,787
Presbyterian	2,382
United Healthcare	887
Blue Cross Blue Shield	1,753
Population 2 – SSI and Related – Medicaid Only	**744**
FFS	277
Molina	133
Presbyterian	142
United Healthcare	82
Blue Cross Blue Shield	110
Population 3 – SSI and Related – Dual	**852**
Molina	173
Presbyterian	164
United Healthcare	334
Blue Cross Blue Shield	181
Population 4 – 217-like Group – Medicaid Only	**43**
FFS	41
Molina	0
Presbyterian	0
United Healthcare	1
Blue Cross Blue Shield	1
Population 5 – 217-like Group - Dual	**54**
Molina	10
Presbyterian	6
United Healthcare	28
Blue Cross Blue Shield	10
Population 6 – VIII Group (expansion)	**14,352**
FFS	2,403
Molina	3,658
Presbyterian	3,252
United Healthcare	1,966
Blue Cross Blue Shield	3,073

Section IV: Outreach

In DY4 Q2, 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 11 – Schedule of Community Events DY4 Q2

Event Type	Event Location and Date	Audience and Topics
Volunteer-Partner Training	Albuquerque, NM Wednesday April 26, 2017	The NM Aging and Long-Term Services Department, Resource Center requested information/training for the Resource Center Volunteer-Partner program. Information provided was specifically related to the available NM Medicaid categories of eligibility, income guidelines and how and when Medicaid and SSI work with each other.
2017 Mental Health Awareness Day & Community Health Fair	Albuquerque, NM Downtown Civic Plaza Tuesday May 23, 2017	Sponsored by the City of Albuquerque and Bernalillo County. HSD provided Medicaid program information, and answered a variety of Medicaid related questions. Some specific questions were related to Behavioral Health services, Long Term Care services and the Centennial Care Rewards program.
Native American Health Fair	Santo Domingo Health Center, Santo Domingo Pueblo Friday June 9, 2017	Sponsored by the Kewa Pueblo Health Corporation. HSD provided Medicaid program information and answered a variety of Medicaid related questions. Specific questions included Behavioral Health services, Long Term Care services and the Centennial Care Rewards program.
Centennial Care 2.0 Public Input Session	• Albuquerque – June 14, 2017 • Silver City – June 19, 2017 • Farmington – June 21, 2017 • Tribal Consultation – Albuquerque, June 23, 2017 • Roswell – June 26, 2017	HSD obtained a variety of public comments related to the Centennial Care 2.0 1115 waiver renewal.

JUST Health Program

HSD continues to expand facility participation and fine-tune the processes of the Justice-Involved Utilization of State Transitioned Health Care (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 state-certified Presumptive Eligibility Determiners (PEDs) at the correctional facility.

In DY4 Q2, Rio Arriba County and the NM Department of Health Forensics Unit went "live" with the program. With the addition of these entities, the JUST Health program is now active in 26 separate correctional or detention facilities. These entities include 12 New Mexico Department of Corrections facilities, the State of New Mexico Children, Youth and Family Department juvenile detention facilities and adult and juvenile facilities in 6 different counties. Participating counties include some of the most heavily populated counties in the state (Bernalillo, Santa Fe, Dona Ana and Rio Arriba).

The JUST Health program also allows and encourages Centennial Care MCOs to make contact with incarcerated members prior to their release to begin care coordination activities. A pilot project with the Bernalillo County Detention Center and Molina Health is currently underway. Thus far, this pilot has connected 250 Bernalillo County Detention Center detainees to MHC's care coordination program. The Santa Fe County Adult Detention facility is also piloting a similar program with two Centennial Care MCOs (Blue Cross Blue Shield and United Health). The Santa Fe County facility process includes assisting MCO members to contact their respective MCO to conduct a health risk assessment and initiate the process to receive care coordination.

Section V: Collection and Verification of Encounter Data and Enrollment 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 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 address 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 encounter accuracy by comparing encounter submissions to financial reports to ensure completeness. HSD also monitors MCOs' 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.

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

During DY4 Q2, the Centennial Care 2.0 Concept Paper for the renewal of New Mexico's 1115 Waiver was released. The concept paper describes the program's accomplishments and identifies opportunities for targeted improvements and other modifications in the following key areas: care coordination, LTSS, physical and behavioral health integration, payment reform, member responsibility and engagement, refinements to benefits and eligibility, and administrative simplification. Many of the concepts outlined were developed with input from a subcommittee of the Medicaid Advisory Committee (MAC) and the Native American Technical Advisory Committee.

Public input sessions were held throughout the state during the month of June. A comprehensive list of the public meetings is outlined in Table 12 with additional information about other public input opportunities.

Table 12 – Public Meetings

Public Input Opportunities Prior to Development of Concept Paper (before May 2017)	Public Input Meetings on Draft Concept Paper (after May 2017)
Medicaid Advisory Subcommittee: October 14, 2016 – 29 attendees (Santa Fe) November 18, 2016 – 34 attendees (ABQ) December 16, 2016 – 62 attendees (Santa Fe) January 13, 2017 – 55 attendees (ABQ) February 10, 2017 – 50 attendees (Santa Fe) *Public Comment at end of each meeting*	**Statewide Public Input Sessions & Attendees:** **Albuquerque** – June 14, 2017 – 160 attendees **Silver City** – June 19, 2017 – 22 attendees **Farmington** – June 21, 2017 – 41 attendees **Roswell** – June 26, 2017 – 30 attendees
Native American Technical Advisory Committee: December 5, 2016 – NATAC Membership (Santa Fe) January 20, 2017 – NATAC Membership (ABQ) February 10, 2017 – NATAC Membership (Santa Fe) April 10, 2017 – NATAC Membership (ABQ)	**Formal Tribal Consultation** June 23, 2017 – 12 tribal officials/reps & 85 attendees - Albuquerque **Native American Technical Advisory Committee:** July 10, 2017 – NATAC Membership
MAC Meetings with Public Input: November 2016 – 77 attendees (Santa Fe) April 2017 – 55 attendees (Santa Fe)	**MAC Meetings with Public Input:** July 24, 2017 – (Santa Fe)

MCO Trainings

In DY4 Q2, HSD provided a Care Coordination Documentation Training. The training included contract and policy requirements, best practices for documentation, care coordination touchpoints, tips for completion of the Comprehensive Needs Assessment (CNA) and Comprehensive Care Plan (CCP), audit findings, transitions of care, back-up disaster plans, and resources for members.

Contract Compliance

UHC Directed Corrective Action Plan

UHC, at the direction of HSD, implemented policy and process changes in order to: improve oversight of delegated entities; verify claims payment accuracy for ten manually priced claims; improve denial rates for inpatient hospital clean claims; and, report adjudication turnaround times for inpatient hospital clean claims subject to manual processing, based on a high dollar limit. As previously reported, the first two items of the Directed Corrective Action Plan (DCAP), related to delegated-entity oversight, were sufficiently addressed by UHC and closed by HSD in March 2017. UHC contracted with Ernst & Young, LLP (EY) to provide third-party oversight and a report of findings to HSD for the remaining DCAP items. EY's report, along with additional UHC documentation and substantiated improvements were made in all areas. The last remaining DCAP items were closed on August 7, 2017. Official notification to UHC and CMS will be sent within thirty days.

UHC revised its administrative review guidelines to address Myers & Stauffer findings related to high prior authorization/notification denial rates. For inpatient hospital claims, UHC changed its process to deny claims for lack of notification, lack of information, or no notification/prior authorization to instead "pend" these claims, and send letters to providers requesting the required documentation. A standard number of days are allotted for the provider to produce the documentation before a claim is denied. The result of this policy change was seven consecutive months, June 2016 through January 2017, of a positive declining trend for claim denials even when providers exceeded the timeframe to produce the documentation and claims were eventually denied. In addition, the overall denial rate dropped as a result, and cross-over claims are now the most frequent reasons for denial (e.g. Medicaid approved amount paid by Medicare, Coordinated with Medicare/Paid in Full). The "Requires Notification/Plan not notified" denial code now represents 5% of denials for inpatient hospital claims down from 21% in 2015. UHC states that the process reduced the number of provider appeals and generally improved the provider experience. Manually processed inpatient hospital claims, based on high dollar thresholds, were also found to be consistent with what has been reported on the quarterly MCO reports (i.e. meets or exceeds contractual requirements with very few exceptions).

Behavioral Health

Please see Attachment F: Behavioral Health Collaborative CEO Report for an update on Behavioral Health activities.

MCO Initiatives

Blue Cross Blue Shield of New Mexico

- Expansion of CHWs - BCBSNM has been working with culturally and linguistically competent CHWs trusted by the communities they serve. BCBSNM contracts with appropriate community agencies to deploy their CHWs to assist Centennial Care members who utilize emergency department (ED) services frequently. CHWs promote the use of primary care services, as well as, aid members to better manage their often chronic medical conditions. Many of these members are identified as requiring care coordination level 3 support in order to improve or maintain, and manage their health needs effectively. Data has shown this program to be successful in educating members to access primary care medical services instead of ED services. BCBSNM has expanded its efforts by implementing an internal BCBSNM CHW program aimed at increasing the amount of members served in the community by CHWs. Recognizing the profound effect CHWs have on the lives of the members they work with, BCBNM has taken the necessary steps to hire and train CHWs as permanent employees. The development of the internal CHW Program has laid a foundation to integrate CHWs directly into provider practices, clinics, and other facilities. The long-term goal is to "imbed" CHWs full and/or part time in targeted clinics and Emergency Departments.

Molina Healthcare

- Molina Healthcare Prioritized Action-Oriented Care Team (mPACT) - This program focuses interventions on highest risk members. A new tracking system for care coordination was developed to better organize caseload and specific intervention management for these high risk members. DY4 Q2 2017 activities included targeted Care Coordinators receiving alerts regarding 2,250 mPACT members. Additionally, a value-based reimbursement program, Provider mPACT, has been developed and will be offered to providers through the Patient Centered Medical Home program who wish to build their capacity to address mPACT members' needs. Provider mPACT also includes a shared savings component to incentivize providers to deliver quality care more efficiently.
- High Risk Obstetric (HROB) – Neonatal Intensive Care Unit (NICU) Program. This program delivers improved care for MHC pregnant members by 1) pro-active identification of risk factors through bi-weekly claims analysis, 2) enhanced outreach and screening efforts via Care Coordinators, and Case Managers, 3) increased collaboration in the development of members' treatment plans, including evidence –based interventions and coordination between an OB team and the member's provider, and 4) post-discharge care coordination follow up.

United Healthcare

- Las Cruces Store Front Grand Opening - The UHC Store Front is a consumer support center that gives Centennial Care/ Medicaid plan, Dual Special Needs Plan, and Medicare

participants' access to customer service professionals, including bilingual staff, Monday through Friday 8 a.m.-5 p.m. MST. The Las Cruces Store Front had a provider Grand Opening which featured an Open House for area community partners and, in observance of National Safety Month, a Safety Fair for UHC members and the community. The Open House was attended by 23 Las Cruces community providers including Federally Qualified Health Centers, DOH, ALTSD, various Dona Ana County program providers, area hospitals, and personal care providers. There were 50 community members present at the event. During the Safety Fair, in collaboration with Safer Now NM, UHC hosted a child car seat inspection and provided thirteen new car seats to members who needed them.

- Behavioral Health
  - An in-service event at the New Mexico Treatment Center in Espanola provided trainings for Care Coordination and Peer Support Specialists (PSS). Approximately seventy members were assigned to a Care Coordinator and a PSS.
  - A Meet and Greet was held at Santa Fe County Jail and processes were established to complete Health Risk Assessments (HRAs) for inmates and to meet with members in jail to complete assessments.
  - Dona Ana County Peer Support was invited to be involved in the Mayor's task force related to: Law Enforcement Assisted Diversion, Stepping Up, Need for Peer Programs, and working with MCOs for members released from jail.

Fiscal Issues

During DY4 Q2, several reconciliations were completed that resulted in payments for some MEGs and recoupments for others. The Indian Health Service (IHS) and retroactive eligibility reconciliations for the legacy program resulted in payments that affected the PMPMs of MEG 1 for DY1, DY2 and DY3. As for the Other Adult Group (OAG), the risk corridor and retroactive eligibility reconciliations for calendar years 2014 and 2015 resulted in payments and recoupments that affected the PMPM of MEG 6 for DY1 and DY2.

As the state continues to face budget deficits, HSD continues to pursue long term cost containment measures for Medicaid which would be factored into future rate adjustments and developments. HSD is also analyzing and planning for compliance with new CMS requirements related to mental health parity, Department of Labor Fair Standards Act and the managed care rules which will all have fiscal impacts.

Systems Issues

The System issues have stabilized by continuing to run reports on a regular basis and working continually with the MCOs. HSD has processes in place to handle any nursing facility level of care (NFLOC) and setting of care (SOC) 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.

Medicaid Management Information System Replacement

HSD's planning for the replacement of its current legacy Medicaid Management Information System (MMIS) began some time ago, and activity for this effort progressed in DY4 Q2. The replacement MMIS will be an Enterprise system, so HSD has actively engaged its sister agencies, including DOH, Children, Youth and Families (CYFD), and the ALTSD. 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 the MMIS Replacement, the System Integrator, is currently in contract negotiations with the selected vendor.

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

CMS has approved the third module RFP for Quality Assurance. The decision was made to transition two components from the Population Health module and into the Quality Assurance module: Prior Authorization; and Pharmacy Benefits Management (PBM), including rebate services and Drug Utilization Review (DUR). These changes are being discussed with CMS. Once the Financial Services RFP is submitted to CMS, work will commence to update the Quality Assurance RFP prior to its release.

HSD has begun development of the RFP for the fourth module, Financial Services. This RFP involved meetings with all stakeholders, questionnaires to obtain input were distributed and review of other states' procurements and contracts for Financial Services as well as with our current fiscal agent contractor, Conduent (formerly Xerox). The RFP will be sent to CMS in August.

HSD is currently working with Deloitte, our integrated eligibility system vendor to move managed care enrollment from our MMIS to our Eligibility & Enrollment (E&E) system. As a result, the ASPEN eligibility system will become a true E&E system. Deloitte is currently working on the changes to implement managed care enrollment in ASPEN as well as the provisions for Real Time Eligibility (RTE). These changes were previously approved by CMS.

An Implementation Advanced Planning Document Update (IAPD-U) will be submitted to the CMS Regional Office in August 2017 for approval.

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, the MCO grievance and appeals process, and the fair hearing process.

The Aging and Long Term Services Department's, 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 offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions. ALTSD provides quarterly reports to HSD regarding the ADRC Caller Profile Report and Care Transitions Program Data.

The numbers below reflect calls made to the ADRC hotline from April 1, 2017 to June 30, 2017.

Table 13 – ADRC Call Profiler Report

Topic	# of Calls
Home/Community Based Care Waiver Programs	2,412
Long Term Care/Case Management	108
Medicaid Appeals/Complaints	14
Personal Care	154
State Medicaid Managed Care Enrollment Programs	37
Medicaid Information/Counseling	741

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from April 1, 2017 to June 30, 2017.

Table 14 – ADRC Care Transition Program Report

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		165	
Medicaid Education/Outreach	345		
Nursing Home Intakes		93	
*Pre/Post Transition Follow-up Contact	1,697		
**LTSS Short-Term Assistance			31

*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 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 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 staff continues to work directly with the MCOs when facing challenging issues with members. The CTB has worked with the MCOs in explaining the Short Term Assistance referrals and how they can assist the MCOs with their members. This includes assistance with the Income Support Division application, assisting in the eligibility process to identify the reason(s) a client's eligibility has not been established. They also will provide assistance to home bound persons.

Critical Incidents

HSD continues to meet quarterly with the Critical Incident (CI) workgroup in an effort to provide technical assistance to the MCOs. The workgroup supports the Behavioral Health Services Division on the delivery of BH incident reporting protocols to providers. The protocols will be used by BH providers to improve accuracy of information reported and establish guidelines for the types of BH providers who are required to report.

During DY4 Q2, a total of 4,597 critical incident reports (CIRs) were filed for Centennial Care, Behavioral Health and Self-Directed members. 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 Q2, a total of 434 deaths were reported. Of the 434 deaths reported, 394 deaths were reported as natural or expected deaths, 36 deaths were reported as unexpected and four (4) were reported as suicides. 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 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 Q2, Centennial Care, Behavioral Health and Self Directed populations reported a total of 2,910 critical incidents for Emergency Services. Of those Emergency Services reports, 238 were Behavioral Health and 172 were Self-Directed. MCOs continue to identify the use of Emergency Services as the highest critical incident type reported by volume for members with

reportable category of eligibility. All MCOs experienced a decrease in DY4 Q2 for the use of Emergency Services compared to DY4 Q1. MCOs continue to monitor high utilizers of ED use. Reduction initiatives reported include identification of the highest utilizing group, working to effectively coordinate care to reduce ED use and provide education regarding the availability of alternatives to ED use.

Table 15 – Critical Incident Types by MCO – Centennial Care

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	34	0.74%	100	2.18%	88	1.91%	73	1.59%	295	6.42%
Death	96	2.09%	90	1.96%	98	2.13%	150	3.26%	434	9.44%
Natural/Expected	89	1.94%	70	1.52%	92	2.00%	143	3.11%	394	8.57%
Unexpected	7	0.15%	19	0.41%	5	0.11%	5	0.11%	36	0.78%
Suicide	0	0.00%	1	0.02%	1	0.02%	2	0.04%	4	0.10%
Elopement/Missing	7	0.15%	5	0.11%	15	0.33%	4	0.09%	31	0.67%
Emergency Services	651	14.16%	932	20.27%	540	11.75%	787	17.12%	2910	63.30%
Environmental Hazard	8	0.17%	8	0.17%	15	0.33%	28	0.61%	59	1.28%
Exploitation	26	0.57%	34	0.74%	32	0.70%	53	1.15%	145	3.15%
Law Enforcement	19	0.41%	27	0.59%	19	0.41%	31	0.67%	96	2.09%
Neglect	136	2.96%	156	3.39%	155	3.37%	180	3.92%	627	13.64%
Total	977	21.25%	1352	29.41%	962	20.93%	1306	28.41%	4597	100.00%

Table 16 – Critical Incident Types by MCO – Behavioral Health

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	8	1.76%	55	12.09%	19	4.18%	3	0.66%	85	18.68%
Death	0	0.00%	12	2.64%	1	0.22%	3	0.66%	16	3.52%
Natural/Expected	0	0.00%	10	2.20%	1	0.22%	2	0.44%	13	2.86%
Unexpected	0	0.00%	2	0.44%	0	0.00%	1	0.22%	3	0.66%
Suicide	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Elopement/Missing	3	0.66%	2	0.44%	5	1.10%	0	0.00%	10	2.20%
Emergency Services	12	2.64%	186	40.88%	27	5.93%	13	2.86%	238	52.31%
Environmental Hazard	0	0.00%	0	0.00%	1	0.22%	0	0.00%	1	0.22%
Exploitation	1	0.22%	5	1.10%	0	0.00%	0	0.00%	6	1.32%
Law Enforcement	3	0.66%	4	0.88%	0	0.00%	1	0.22%	8	1.76%
Neglect	8	1.76%	69	15.16%	8	1.76%	6	1.32%	91	20.00%
Total	35	7.69%	333	73.19%	61	13.41%	26	5.71%	455	100.00%

Table 17 – Critical Incident Types by MCO – Self Directed

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	3	1.18%	9	3.53%	16	6.27%	2	0.78%	30	11.76%
Death	3	1.18%	4	1.57%	5	1.96%	5	1.96%	17	6.67%
Natural/Expected	3	1.18%	3	1.18%	4	1.57%	4	1.57%	14	5.49%
Unexpected	0	0.00%	1	0.39%	1	0.39%	0	0.00%	2	0.78%
Suicide	0	0.00%	0	0.00%	0	0.00%	1	0.39%	1	0.39%
Elopement/Missing	0	0.00%	0	0.00%	2	0.78%	0	0.00%	2	0.78%
Emergency Services	26	10.19%	31	12.15%	79	30.97%	36	14.12%	172	67.45%
Environmental Hazard	0	0.00%	0	0.00%	1	0.39%	1	0.39%	2	0.78%
Exploitation	2	0.78%	0	0.00%	2	0.78%	3	1.18%	7	2.75%
Law Enforcement	3	1.18%	2	0.78%	4	1.57%	1	0.39%	10	3.92%
Neglect	2	0.78%	0	0.00%	6	2.35%	7	2.74%	15	5.88%
Total	39	15.30%	46	18.04%	115	45.10%	55	21.56%	255	100.00%

Home and Community-Based Services Reporting
HSD received initial CMS approval of the Statewide Transition Plan (STP) in January 2017. HSD, in partnership with the ALTSD, will perform 1115 waiver LTSS provider validation activities in DY4 Q3 and DY4 Q4. HSD is also working to update the STP milestones as required by CMS.

Community Benefit
In DY4 Q2, HSD conducted training on the Community Benefit for the Department of Health's *Advisory Council on Quality Supports for Individuals with Developmental Disabilities and Their Families* (ACQ).

Self-Directed Community Benefit (SDCB)
The mandatory online timesheet requirement for SDCB employees began June 1, 2017. Employers of record (EOR) are now required to approve and submit their employees' timesheets online instead of faxing them to the Fiscal Management Agency (FMA) for manual entry. The MCOs will approve exceptions to the online submission requirement, if members live in an area without internet access, or are unable to submit timesheets online due to their disability.

Electronic Visit Verification
Electronic Visit Verification (EVV) for Personal Care Services (PCS) was fully implemented statewide on November 14, 2016. Effective March 1, 2017, all PCS claims must be submitted to the MCOs through the EVV system.

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. On May 2, 2017, The MCO subcontractor who provides and maintains the tablets for providers presented an update on EVV, answered questions, and responded to provider concerns.

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 99% access to care for Native Americans in rural areas and 99% access to care for Native Americans in frontier areas. For behavioral health there is a 99% access for Native Americans in rural areas and 99% access for Native Americans in frontier areas. This is an improvement from the previous quarter report.

The data shows members are accessing specialty services such as cardiology, orthopedics, ophthalmology, nephrology, and psychology 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. They currently have agreements with Tribal entities for HRA completion, translation, transportation, disease management, and Peer Support Wellness Centers. However, 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 97% of the time for claims being processed and paid within 15 days of receipt and 99% of claims being processed and paid within 30 days of receipt.

Table 18 – Native American Advisory Board (NAAB) meeting for DY4 Q2

MCO	Date of Board Meeting	Issues/Recommendations
BCBSNM	Hernandez Community Center Hernandez, NM 04/26/2017	BCBSNM provided an overview of Blue Cross Community Centennial Care including, virtual visits, home and community based services, hypertension and dental education. They also went over the State Behavioral Health survey results.
MHC	San Ildefonso Pueblo Tewa Center San Ildefonso Pueblo, NM May 16, 2017	Members were encouraged to register for MyMolina.com which allows members to manage their health care online. Members were educated on services and benefits offered by MDLive which includes virtual visits, 24/7 online scheduling, and is available after hours and weekends. The members were also presented with two tips for stress relief – deep breathing and muscle relaxation/contraction exercises. Members were also informed about the prior authorization process and that prior authorizations act as a safety and cost savings measure. The Ombudsman educated members about the Ombudsman's roles and responsibilities. Molina members were informed that the cap for the Traditional Medicine Benefit (TMB) has been met and as a result no other application for TMB will be accepted this year. The new funding cycle begins January 1, 2018.

PHP	Alamo Chapter Magdalena, New Mexico May 11, 2017	PHP began their meeting by talking to individuals and families as they entered the meeting room about PHP. PHP decided to do one to one discussions with people while others had food and looked at information. PHP spoke to about 30 people and explained their Native American Affairs program; the difference between FFS and Centennial Care; described their transportation program with Superior Medical Transportation; described the Presbyterian Financial Assistance Program and how it works for individuals who are not insured or underinsured; and explained the Nurse Advice Line, PresRN.
UHC	Eight Northern Pueblos Espanola, New Mexico June 29, 2017	The Native American Advisory Board meeting was held at the Eight Northern Indian Pueblos meeting room. Attendees voiced appreciation for the UHC Tribal Letters Of Agreement (LOA) which allows them to receive payment for the work of their Peer Support teams, translation, health education and health risk assessment (HRA) completion. UHC also described their prior authorization process. Tribes requested a One Stop Shop approach to prior authorizations. UHC will take it back to leadership to discuss.

HSD's Native American Technical Advisory Committee (NATAC)

The NATAC meeting for this quarter included discussion about:

- The 1115 Waiver renewal known as Centennial Care 2.0;
- An update on the discussions with CMS regarding its reinterpretation of policy for 100% FMAP received through IHS/ITUs and the unique agreement that UNM has with the Albuquerque-Area IHS facility (1952 UNM Agreement);
- The Tribal Consultation regarding the Concept Paper for the Centennial Care 2.0 1115 Waiver Renewal scheduled for June 23, 2017; and
- Proposed language for the MCOs' Contract Amendment #8 regarding the requirement for the utilization of Community Health Representatives (CHRs) for some care coordination activities.

Update on the CMS 100% Federal Medical Assistance Percentage (FMAP)

An email was sent to CMS on August 1, 2017 with two new attachments from UNM Hospital--an "Agreement Regarding Consent to Lease Agreement" and "First Amendment Consent to Lease Agreement" for CMS to review. This additional documentation was submitted to support the state's position that UNM has a unique relationship due to its long standing agreement with IHS that warrants consideration as an IHS-Contracted facility.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment G: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY4 Q2 is the second quarter with the CY 2017 rates that exhibits the full effect of a series of cost containment that began in July 2016. In addition to round one (rate reductions for inpatient and outpatient hospitals, practitioner and dental, and termination of primary care providers enhanced payments) and round two (rate reductions for practitioner reimbursement for both non-radiology and radiology codes), round three of the cost containments went into effect January 1, 2017 with rate reductions for professional fee schedule codes that remain at or above 100% of the Medicare rate to 94% of the Medicare rate. The effects of these costs containments are apparent in the per member per month (PMPM) of DY4 Q2 compared to the PMPM of DY3; The PMPMs of DY4 Q2 are lower than the PMPMs of DY3 for all MEGs (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 DY4 is 29% below the budget neutrality limit (Table 4.4) based two quarters of data.

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 19 – Member Months DY4 Q2

Number of Clients by Population Group and MC	
	2017
Row Labels	**Q2**
Population 1 – TANF and Related	**1,165,097**
FFS	**144,275**
	144,275
MC	**1,020,822**
Molina	380,502
Presbyterian	376,334
United Healthcare	79,055
Blue Cross Blue Shield	184,931
Population 2 – SSI and Related – Medicaid Only	**126,100**
FFS	**9,894**
	9,894
MC	**116,206**
Molina	39,408
Presbyterian	40,799
United Healthcare	15,766
Blue Cross Blue Shield	20,233
Population 3 – SSI and Related – Dual	**109,284**
MC	**109,284**
Molina	21,055
Presbyterian	20,537
United Healthcare	47,608
Blue Cross Blue Shield	20,084
Population 4 – 217-like Group – Medicaid Only	**1,330**
FFS	**554**
	554
MC	**776**
Molina	158
Presbyterian	170
United Healthcare	314
Blue Cross Blue Shield	134
Population 5 – 217-like Group - Dual	**9,444**
MC	**9,444**
Molina	1,991
Presbyterian	1,678
United Healthcare	3,892
Blue Cross Blue Shield	1,883
Population 6 – VIII Group (expansion)	**811,684**
FFS	**104,885**
	104,885
MC	**706,799**
Molina	217,810
Presbyterian	193,395
United Healthcare	115,056
Blue Cross Blue Shield	180,538

Section XII: Consumer Issues – Complaints and Grievances

A total of 1,053 grievances were filed by Centennial Care members in DY4 Q2. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 332 (31.53%) of the total grievances received. The MCOs report they continue to analyze, communicate and meet regularly with their transportation vendors to address identified issues and ensure timely follow up with a resolution. Transportation Member Grievances in Section II of this report provides an analysis of the MCOs' efforts to address transportation grievances under the guidance of HSD.

The second top grievance filed was Other Specialties with a total of 84 grievances (7.98%) which demonstrates a decrease from Q1 (109). Members reported dissatisfaction with balance billing by providers, customer service practices, and quality of care. MCO interventions include member education, provider trending and education, referrals to internal quality department for clinical review, and the development of performance improvement project to track and verify provider billing practices.

There were 637 (60.49%) variable grievances filed during DY4 Q2. 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 Dental. MCO interventions include pharmacy reviews of medication and prior authorization denials, education by member services, and Provider Network Management identifying opportunities for provider outreach and engagement. HSD is monitoring these grievances to identify specific trends.

Table 20 – MCO Grievances DY4 Q2

MCO Grievances DY4 Q2 (April-June 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	183	17.38%	363	34.47%	203	19.28%	304	28.87%	**1053**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	118	11.21%	65	6.17%	48	4.56%	101	9.59%	**332**	31.53%
Other Specialties	0		0		13	1.24%	71	6.74%	**84**	7.98%
Variable Grievances	65	6.17%	298	28.30%	142	13.48%	132	12.54%	**637**	60.49%

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. Analysis of grievance data has the potential to inform network needs, program planning, program evaluation, and resource allocation for staff, provider, and/or vendor technical assistance and training. 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 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 DY4 Q2.

Table 21 – Service Plan Audit DY4 Q2

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

NFLOC

HSD reviews Nursing Facility high LOC denials and community benefit NFLOC denials on a quarterly basis to ensure the denials were appropriate and comply with NFLOC criteria.

Table 22 – Nursing Facility LOC Audit DY4 Q2

MCO High NFLOC denied requests (and downgraded to Low NF)	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**17**	**17**		
BCBSNM	**5**	**5**		
MHC	**3**	**2**		
PHP	**5**	**5**		
UHC	**4**	**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**		
BCBSNM	**5**	**5**		
MHC	**3**	**2**		
PHP	***5***	**5**		
UHC	**4**	**5**		
Percent of MCO level of care determination accuracy	**100%**	**100%**		

Table 23 – Community Benefit NFLOC Audit DY4 Q2

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

HSD was in agreement with all NFLOC decisions; however, one chart submitted for review was outside of the sample criteria. Of the three sample files submitted by MHC for High NF, one did not qualify as a High NF Level of Care request. Per MHC, one of the three files submitted for the HNF universe was incorrectly labeled as a HNF denial, and internal corrections were conducted and staff was re-educated on the importance of correct labeling.

External Quality Review Organization (EQRO) NF LOC

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

Table 24 – EQRO NF LOC Review DY4 Q2

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

The MCO High NF determinations continue to improve with the EQRO in agreement with 89% of the determinations compared to 83% in Q1 and 77% for DY3 total. The Low NF determinations maintain a 97-100% range for EQRO agreement and the Community Based determinations continue to average 99% for EQRO agreement. HSD reviewed NFLOC determination disagreements from EQRO audits from April and May of DY4 Q2 and was in

agreement with all EQRO findings. Issues identified included incomplete supporting documentation and conflicts in documentation. HSD had previously reviewed similar issues that were identified during review of DY3 Q4 with BCBSNM and PHP and discussed strategies to ensure accuracy in determinations and documentation. The strategies implemented by the MCOs have proven to be effective. Additionally, HSD reviewed NFLOC determination disagreements for DY4 Q1, three from UHC and one from MHC, and identified similar issues with documentation. HSD reviewed audit results with both MCOs and discussed their plans to address issues with documentation. UHC provided information to HSD about their internal review process to ensure accurate NFLOC determinations as well as their internal process for completing Requests for Information (RFI) to ensure that all required documentation is present to support NFLOC decisions. MHC provided information to HSD regarding their internal review process to ensure accurate determinations and they also provided a requested care plan to support a HNF factor identified in the audit. HSD will continue to monitor the EQRO audit of MCO NFLOC determinations and identify and address any trends and provide technical assistance as needed.

Care Coordination Monitoring Activities

Care Coordination Audits

In DY4 Q2, HSD continued to focus on analyzing the MCOs' interventions to address areas in need of improvement as a result of previous MCO care coordination audit findings. The MCOs reported they continued to provide training to their care coordinators on documentation, contract and policy requirements. In DY4 Q3, HSD will meet with each MCO to discuss the progress of audit-based changes to care coordination. For DY4, a revised system of quarterly reports and meetings was implemented to track each MCO's internal care coordination audits.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top 35 ED utilizers for each MCO. HSD monitored monthly reports on each MCO's "super utilizer" group, tracking the amount of ED visits, supplemental case information, and care coordination activities to reduce non-emergent ED utilization. Since the project's inception in 2015, MHC, Presbyterian and UHC have demonstrated an overall decline in average ED visits/member, whereas BCBSNM has shown an increase. In May 2017, HSD met with the MCOs to present descriptive data findings on super utilizers and to discuss care coordination best practices for ED reduction. HSD will continue to evaluate the data received from the MCOs to determine if best practices are reducing non-emergent ED utilization for this population.

Care Coordination and EDIE

HSD continues to participate in the statewide "ER is for Emergencies" committee, also known as the EDIE Project. EDIE is a database that shares real time data of member ED utilization among different New Mexico hospitals, EMS agencies, and all four Centennial Care MCOs. This

collaboration will potentially allow for same day care coordination intervention with the member. As of July 1, 2017, 28 of 31 hospitals or medical centers successfully went live.

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. The project focuses on providing incarcerated members with care coordination to address members' immediate healthcare needs upon release. For the members who have participated to date (N=229), the program has continued to demonstrate declines in the reduction of member ED visits, BH claims, PH claims, and pharmacy claims.

Care Coordination Ride-Alongs

HSD continued to conduct "ride-alongs" with MCO care coordinators in June 2017 to observe member assessments in the home setting. HSD staff conducted one ride-along per MCO, observing initial CNAs. Particular emphasis was paid to the utilization by care coordinators of the Community Benefit Services Questionnaire (CBSQ) and the Community Benefit Member Agreement (CBMA), to educate the member on the full array of Community Benefit services and capture acceptance or declination of community benefits. The observed care coordinators adhered and often went beyond all contractual obligations in their assessments.

Section XIV: Managed Care Reporting Requirements

Customer Service

In DY4 Q2 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. Consistent staffing ratios were maintained.

Member calls for an on-going Health and Wellness Campaign were reported as a success by BCBSNM, with over 2,300 calls documented each month in DY4 Q2. The wellness campaign is designed to educate members on yearly check-ups with their PCP, annual dental check-ups and cleanings, and transportation information. All MCOs have agents that are bilingual in English and Spanish. MHC and PHP have agents that speak Navajo. Please see Attachment H: Customer Service Summary.

MCO Reporting Process

In DY4 Q2, HSD continues to see a decline in MCOs report extension requests. Eleven extensions requests were made in DY4 Q1, with no extension requests made in DY4 Q2. Additionally, HSD continues to conduct Technical Assistance (TA) calls and accepts the MCOs' Self-Identified Error Resubmissions, as necessary. Both processes continue to support the quality improvement of the MCO data submissions and analyses submitted to HSD.

Report Revisions

During DY4 Q2, HSD continued to revise reports as necessary. Revision workgroups are developed for each report revision to ensure the needs of all stakeholders are taken into consideration.

Member Appeals

A total of 995 member appeals were filed by Centennial Care members in DY4 Q2. Of those appeals, 914 (91.86%) were standard member appeals and 81 (8.14%) 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 822 (82.61%) of the total appeals received. In this quarter, member appeals included denial of inpatient stay, eligibility criteria for services not met, denial of high tech imaging such as CT scan or MRI, pharmacy, and dental services. MCO interventions include member education, review for trending, assignment of Project Coordinator for Pharmacy Appeals Workgroup, 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 110 (11.05%) 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 and nursing facility level of care.

There were 63 (6.33%) variable appeals in DY4 Q2. 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 25 – Member Appeals DY4 Q2

MCO Appeals DY4 Q2 (April-June 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	64	6.43%	174	17.49%	554	55.68%	122	12.26%	**914**	91.86%
Number of Expedited Member Appeals	16	1.61%	16	1.61%	5	0.50%	44	4.42%	**81**	8.14%
Total	80	8.04%	190	19.10%	559	56.18%	166	16.68%	**995**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	65	6.53%	180	18.09%	464	46.63%	113	11.36%	**822**	82.61%
Reduction of a previously authorized service	3	0.30%	9	0.90%	72	7.24%	26	2.61%	**110**	11.05%
Variable Appeals	12	1.21%	1	0.10%	23	2.31%	27	2.71%	**63**	6.33%
Empty Variables									0	0.00%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues as expected. Throughout DY4 Q2, Deloitte completed major activities for the Centennial Care 1115 Waiver Evaluation including development of the first draft of the Interim Evaluation Report which includes data from DY1 and DY2. Deloitte initiated the data collection and review phase for DY3.

During the development of the DY2 Annual Evaluation Report, HSD communicated that several reports are undergoing revisions in an effort to maintain more consistent and accurate MCO reporting for the remainder of the demonstration. The report revisions will impact several measures and will likely result in re-establishing baseline values under the new reporting methodology. It was determined that the new reporting methodologies would not be finalized prior to the Interim Evaluation Report; therefore, it is likely that report updates and associated measure may be part of the waiver renewal as a change to the Evaluation Design.

Deloitte continues to meet with HSD as needed to further refine the work plan, discuss data and data questions, as well as identify and review any analysis issues or risks.

During the development of the initial Interim Evaluation Report draft, HSD determined that several measures required more up-to-date reports than originally collected and a few additional measures required new data sources. The goal of these revisions was to collect more accurate and consistent data in terms of how the MCOs are reporting. In some instances, this also required retroactive collection of DY1 and DY2 data wherever reporting changes were identified. Due to these data changes, there was a need to re-establish a baseline value for these measures to allow for appropriate analysis of program performance over the term of the evaluation. Deloitte discussed this information with HSD, completed data collection activities, updated baseline values as necessary, and resolved outstanding questions with HSD for all measures.

The Evaluation Model serves as a practical way to organize the data for each measure for longitudinal comparison. The Model presents each measure by baseline and demonstration year with the baseline serving as the benchmark throughout the Evaluation across each demonstration year. This model allows Deloitte to quickly assess the change in a given measure over time.

The Evaluation Model has captured both year-over-year comparisons of measure-specific data as well as annual DY2 performance relative to baseline indicators, including benchmarks as laid out by the STCs. After finalizing all data collection and review for each demonstration year, the final Evaluation Model will be summarized as various Exhibits. The Exhibits will be organized in a way to effectively act as supporting documentation to the analytic review completed within the Evaluation and will be included in the body and appendices of the Interim Evaluation Report.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Monitoring Spreadsheet
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: 2015-2016 NEMT Grievances per 1,000 One-way Trips
Attachment E: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment F: Behavioral Health Collaborative CEO Report
Attachment G: MCO Action Plans
Attachment H: Customer Service Summary

Section XVII: State Contacts

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Section XVIII: Additional Comments

HSD has included success stories from members enrolled with 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
A member who lives in Socorro used a MCO transportation provider to arrange transportation for a specialist appointment in Albuquerque on a Friday. While in Albuquerque, the member suffered a seizure and was taken by ambulance to the emergency room. The member was released close to 5 p.m. Friday evening. The member and the member's spouse did not have transportation or money to get back to Socorro. The member was worried they would not have a place to sleep until Monday without transportation. However, the member contacted a care coordinator and advised the care coordinator of the situation, not being sure if the member could be returned home at this time of day on a Friday. The care coordinator contacted the after-hours number for the MCO's transportation provider and was able to make transportation arrangements for the member and the member's spouse. In addition, the care coordinator called the member that evening and made sure they got home safely. The member was very grateful and thanked the care coordinator for the assistance.

Centennial Care Member Success Story 2
The CHW team was assigned an ED high utilizer. The CHW attempted a home visit, and left an MCO door hanger with the CHW's team contact information to try and engage member. The member within an hour called the CHW and reported the need of psychiatric support. The member was not suicidal or homicidal during the call, but the member reported they needed to be seen. After the CHW staffed with the manager, the CHW worked with superior transport for same day transport for the member. The member was taken to the hospital for same day care.

Centennial Care Member Success Story 3
A care coordinator first began to work with member in April of 2015. When the care coordinator began care coordination with the member, the member was homeless and had arrived on a train from Texas. The member had no natural supports and was not established with any providers. In addition, the member had multiple co-morbidities including: Bipolar Disorder; Substance Abuse Disorder; Morbid obesity; Fibromyalgia; anxiety; and depression. Through care coordination, housing resources and community resources were identified. The member currently resides in senior housing and has maintained this living situation for some time now. The member also has an established PCP and specialty providers including behavioral health providers.

Centennial Care Member Success Story 4
A Peer Support Specialist (PSS) recently began working with a member who had a severe substance abuse disorder and was utilizing the ED up to three times per month. The first encounter occurred while the member was admitted to the hospital after one of these ED visits.

Post-discharge, the PSS and member started meeting weekly at the member's home. It was during the first home visit that the member revealed they had tragically lost one of their adult daughters, three years prior on the member's birthday. There was a large shrine built in the member's small home, covered with pictures and memories. The PSS shared available support groups, including those for addiction and for grief and loss. With the PSS' help, the member set up an appointment with a behavioral health provider. The PSS and member also discussed alternatives to using the ED along with the importance of establishing a relationship with a PCP. The PSS also selected a book to read with the member that they could discuss weekly, similar to their own book club. The member selected a book about grief and loss. During the weekly meetings, the member would share the coping skills described in the book and how apply to the member's life. The PSS and member began to revisit the idea of support groups, including those 12-step based groups. The PSS accompanied the member to an AA meeting and listened as he shared the progress he was making in his life. After this meeting, the member asked the PSS for a list of the grief and loss support groups which they had discussed several times before, stating that the member was finally ready to start attending and move forward.

With the peer support that has been provided, the member reports a start to healing and living again. The member is now calling his PCP instead of going to the ED for non-emergent issues and also practicing self-care and increasing his social supports. The member has expressed gratitude for the role Peer Support played in the member's life.