Centennial Care Waiver Demonstration

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

May 31, 2017
New Mexico Human Services Department

Table of Contents

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 694,000 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 (MHNM)
- 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 286,341 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment growth of 9,735 from DY3 Q4.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through February 2017. Quarterly data is available through the fourth quarter of 2016.

Primary Care Provider (PCP)-to-Member Ratios

All MCOs continue to meet the PCP-to-member ratio standard of 1:2,000 in urban, rural, and frontier counties. There are no PCP access concerns at this time.

Table 1 – PCP-to-Member Ratios by MCO

	October	November	December
BCBSNM	1:40	1:40	1:41
MHNM	1:117	1:117	1:117
UHC	1:21	1:21	1:21
PHP	1:88	1:87	1:88

Geographic Access

During DY4 Q1, the Human Services Department (HSD) reviewed and ensured a consistent methodology for the Geographic access (GeoAccess) reports among all the MCOs. Distance requirements state that 90% of members shall travel no further than the access standard for their respective provider and county type. 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. Specialty provider shortages are consistent across MCOs and occur primarily in rural and frontier areas. There is one exception, dermatology, where there is a shortage in all geographic areas including urban. HSD is currently focusing on those outliers where all but one MCO met distance standards for specific provider types in geographic areas. These outliers include: Urology, Rheumatology, and Neurology in rural and frontier areas. Please see Attachment B: GeoAccess PH Summary, Attachment C: GeoAccess BH Summary, Attachment D: 2016 GeoAccess PH – BCBSNM, Attachment E: 2016 GeoAccess PH – MHNM, Attachment F: 2016 GeoAccess PH – PHP, and Attachment G: 2016 GeoAccess PH – UHC.

Community Health Worker

All MCOs continued to use Community Health Workers (CHWs) to provide care coordination activities, health education, health literacy and translation services in DY4 Q1. Areas of focus include high-utilizing members of emergency department (ED) services in Care Coordination Levels 2 and 3, diabetic members with two or more admissions for diabetic primary issues in the

last twelve months, Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD), members with two or more hospital admissions, prenatal members, members with hypertension, and members with substance abuse and smoking cessation needs.

Assessments for social determinates of health needs, completed by CHWs, provide important indicators for the types of CHW interventions that will benefit a member. These assessments indicate that access to food and utilities are often two of the most prevalent barriers to care, along with housing and transportation.

HSD developed a reporting template for the CHW initiative for DY4 that will provide both quantitative and qualitative data to better assess the effectiveness of the CHW interventions and aid in addressing the barriers for access to care. Education activities and events will be tracked by counties. An update will be reported in DY4 Q2.

Telemedicine

During DY4 Q1 HSD established a standardized reporting template that will capture both quantitative and qualitative data for tracking utilization in MCO telemedicine programs, particularly for specialist care and increased use in rural and frontier counties where access is limited to certain provider types. HSD is working collaboratively with the MCOs to further define parameters for reporting data utilization. An update will be reported in DY4 Q2.

Transportation

All MCOs met the geographic distance standards for urban, rural and frontier areas this quarter. The number of grievances per 1,000 trips has not been unreasonable based on volume alone. HSD recognizes that missed medical appointments and/or inadequate service provision by transportation vendor(s) has the potential to adversely affect the health, welfare and/or safety of Centennial Care members. In 2015, HSD directed the MCOs to create a Transportation Workgroup with the goal to improve oversight of transportation services and reduce member grievances. HSD is currently aggregating data to provide a trend analysis since the time that the workgroup convened. HSD is also reviewing the oversite documentation provided by each MCO.

Preliminary findings show that at least two MCOs utilize severity levels to address member complaints. One MCO reports severity levels in Report 37 – Grievances and Appeals, while the other MCOs monitor internally and meets with its vendor monthly to review performance. One MCO elected to change its transportation vendor altogether. The MCO reported that in spite of an increase in its subcontractor's capitated rate, the change was a result of continued concerns with the vendor's solvency and its ability to pay transportation vendors and reimburse members for personal vehicle use on a timely basis. At least two MCOs use performance measures to proactively monitor performance. HSD will develop direction based on its analysis of the MCO annual audit materials and the transportation vendors' performance results.

Provider Network

To enhance HSD's efforts of effective provider monitoring, HSD implemented a new policy to ensure monitoring for both expected and unexpected changes in the network. The new policy includes, but is not limited to: MCOs must submit a written request to HSD regarding significant changes in the MCO's provider network; the request must be submitted at least sixty (60) calendar days prior to the MCO's intended action; the request must include the justification for the closure or reduction of the specific provider network as well as a completed Transition Notification. The Notification form provides information regarding the potential number of members impacted and the types of services that may be eliminated. Additionally, the MCO must submit a current GeoAccess report demonstrating member access and include the accessibility overview, map, and analysis of provider network; and, at HSD's discretion, the MCO may be required to submit all transition plan documents. HSD will review and then provide the MCO with written approval or denial.

Secret Shopper Survey

Beginning with contract amendment #7 that was effective January 1, 2017, MCOs are required to conduct Secret Shopper Surveys bi-annually to ensure contract standards are met or exceeded. Submissions are due to HSD in January and July each year. To provide adequate time to implement the surveys, HSD accepted surveys that the MCOs had in progress for the January 2017 submission. Not all of the existing surveys had been anonymous. Beginning with the July 2017 submission, each MCO survey will be conducted in an anonymous format. As an oversight activity, HSD also conducts Secret Shopper Surveys and will determine if results are comparable with those provided by the MCOs. Analysis will be conducted in the third quarter and reported in the annual report.

Service Delivery

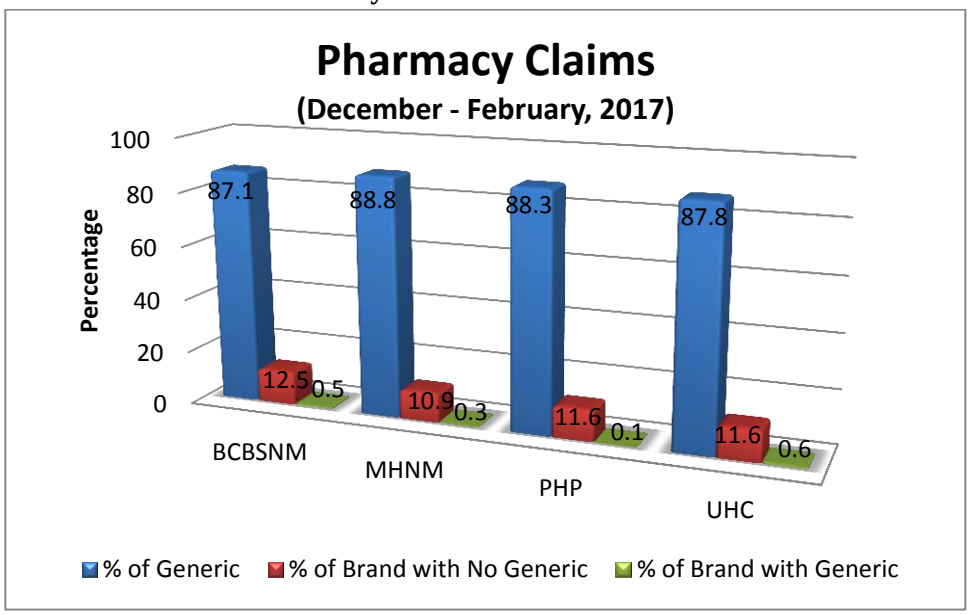
Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program is provided for CY15 to CY16. Please see Attachment H: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

The HSD pharmacy report workgroup is finalizing report revisions to standardize reporting methodologies across the MCOs. In addition, HSD continues to monitor key metrics regarding prescription claims for brand and generic drugs. Generic drug use remains at an 88% average for all four MCOs. Use of brand, with no generic available, is an average of 11.7% and use of brand with generic drug available is an average of 0.2% for all MCOs. All MCOs require medical justification for usage of a brand drug when a generic drug is available. Please see Table 2 - Percent of Pharmacy Claims for each MCO.

Table 2 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M12CY16, M1CY17, M2CY17

Hepatitis C

During DY4 Q1 HSD continued to meet quarterly with the MCO workgroup to address Hepatitis C (HCV) treatment. Two MCO subgroups were convened to develop provider recruitment and education tools to ease the process of treating Hepatitis C and to ensure uniform MCO outreach efforts. Additionally, possible options to reduce HCV treatment costs were analyzed, including possible use of 340B drugs. HSD is working with epidemiologists from the NM Department of Health (DOH) and other state partners to refer identified cases to MCOs for treatment.

Nursing Facilities (NF)

In DY3 Q4, several issues related to MCO processing of Nursing Facilities (NF) claims payments were reported to HSD. HSD coordinated conference calls with the specific MCOs and their NF provider network to discuss claims payment issues, root causes, and solutions. The MCOs analyzed their claims processing procedures and are making systemic changes as needed. Significant progress has been made in DY4 Q1 to resolve issues. HSD continues to participate in these calls and to track ongoing issues to resolution.

Community Interveners

In DY3 Q4, there were six Centennial Care members receiving Community Intervener (CI) services. The MCOs will continue to provide training and education to care coordinators to identify potential members who could benefit from CI services.

Table 3 – Community Intervener Services Utilization DY3 Q4

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBSNM	1	167.75	$4,193.75
MHNM	0	0	$0
UHC	3	102.5	$2,397.00
PHP	1	47	$1,267.25
Total	**5**	**317.25**	**$7,858.00**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date 647,250 distinct members, or 72% of enrollees, have earned at least one reward. Since the inception of Centennial Rewards, total points earned are valued at $42.6 million; $10.8 million have been redeemed. Table 4 shows the healthy behaviors rewarded and each behavior's value. It includes both point and dollar values for each activity, the total dollars earned, the amount redeemed, and the associated percentage of redemption by activity.

Table 4 – 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	750	$ 75	$ 1,066,625	$ 347,903	32.6%
Bipolar Disorder Management	750	$ 75	$ 1,184,360	$ 288,142	24.3%
Bone Density Testing	350	$ 35	$ 51,310	$ 10,566	20.6%
Healthy Smiles Adults	250	$ 25	$ 8,556,300	$ 1,695,426	19.8%
Healthy Smiles Children	350	$ 35	$ 19,634,720	$ 5,068,476	25.8%
Diabetes Management	800	$ 80	$ 4,956,860	$ 1,268,329	25.6%
Healthy Pregnancy	1,000	$ 100	$ 1,190,900	$ 309,677	26.0%
Schizophrenia Management	750	$ 75	$ 591,740	$ 119,874	20.3%
Health Risk Assessment (HRA)	100	$ 10	$ 4,392,120	$ 997,817	22.7%
Other (Appeals and Adjustments)	N/A	N/A	$ 514,525	$ 301,412	58.6%
Step-Up Challenge	500	$ 50	$ 505,125	$ 429,936	85.1%
Totals			**$ 42,644,585**	**$ 10,837,558**	**25.4%**

Across all categories, 25.4% of earned rewards have been redeemed. The Step-Up Challenge, in the table above, shows that members who complete the activity have a highest likelihood of redeeming the reward. The other activity groups are based on a health diagnosis.

Rewards redemptions decreased from CY16 Q4 to CY17 Q1. The decrease can be explained by seasonality. CY16 Q4 includes the holiday season, which historically sees an increase in rewards redemptions.

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. There is a change in this quarterly report to reflect the enrollments by MCO and fee-for-service (FFS).

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 5 – Enrollment DY4 Q1

Demonstration Population	Total Number Demonstration Participants DY4 Q1 Ending March 2017	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**389,950**	**376,585**
FFS	45,036	43,424
Molina	128,605	123,151
Presbyterian	126,929	121,365
United Healthcare	26,754	26,951
Blue Cross Blue Shield	62,626	61,694
Population 2 – SSI and Related – Medicaid Only	**41,509**	**41,637**
FFS	2,831	2,922
Molina	13,120	12,979
Presbyterian	13,668	13,825
United Healthcare	5,241	5,313
Blue Cross Blue Shield	6,649	6,598
Population 3 – SSI and Related – Dual	**37,198**	**40,570**
Molina	7,031	7,510
Presbyterian	6,969	7,565
United Healthcare	16,353	17,930
Blue Cross Blue Shield	6,845	7,565
Population 4 – 217-like Group – Medicaid Only	**335**	**381**
FFS	66	93
Molina	52	53
Presbyterian	60	65
United Healthcare	112	123
Blue Cross Blue Shield	45	47
Population 5 – 217-like Group - Dual	**3,243**	**3,526**
Molina	665	678
Presbyterian	570	599
United Healthcare	1,371	1,538
Blue Cross Blue Shield	637	711
Population 6 – VIII Group (expansion)	**286,341**	**338,101**
FFS	33,003	36,679
Molina	77,745	91,660
Presbyterian	69,381	82,850
United Healthcare	41,370	49,304
Blue Cross Blue Shield	64,842	77,608

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. There is a change in this quarterly report to reflect the disenrollments by MCO and FFS.

Table 6 – Disenrollment Counts DY4 Q1

Disenrollments	Total Disenrollments During DY4 Q1
Row Labels	
Population 1 – TANF and Related	**7030**
FFS	1086
Molina	2066
Presbyterian	1936
United Healthcare	644
Blue Cross Blue Shield	1298
Population 2 – SSI and Related – Medicaid Only	**947**
FFS	545
Molina	134
Presbyterian	127
United Healthcare	61
Blue Cross Blue Shield	80
Population 3 – SSI and Related – Dual	**1652**
Molina	371
Presbyterian	327
United Healthcare	638
Blue Cross Blue Shield	316
Population 4 – 217-like Group – Medicaid Only	**50**
FFS	49
Molina	1
Presbyterian	0
United Healthcare	0
Population 5 – 217-like Group - Dual	**48**
Molina	7
Presbyterian	6
United Healthcare	26
Blue Cross Blue Shield	9
Population 6 – VIII Group (expansion)	**11106**
FFS	2216
Molina	2644
Presbyterian	2503
United Healthcare	1408
Blue Cross Blue Shield	2335

Section IV: Outreach

In DY4 Q1, HSD participated in the annual KOB TV4 Health and Wellness Fair. Over 7,000 health-conscience New Mexicans attended this event, which is New Mexico's largest health and wellness fair. HSD also participated in the annual Behavior Health Collaborative – Behavior Health Day providing Centennial Care information as it related to behavior health needs and issues.

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.

Grant writers, Capacity Builders Inc. (CBI), was recently approved for a 2-year Covering Kids grant with the objective of assisting citizens of San Juan County in the completion of NM Medicaid applications. CBI's goal is to increase children's Medicaid enrollment in the County. To that end, HSD has been working to assist CBI staff to be certified as Presumptive Eligibility Determiners (PEDs). As PEDs, CBI will be allowed to complete and submit NM Medicaid applications via the NM Medicaid web portal known as YESNM-PE.

Table 7 – Schedule of Community Events DY4 Q1

Event Type	Event Location and Date	Audience and Topics
Annual Health and Wellness Fair	Lujan Exhibit Hall at Expo NM Albuquerque, NM January 28-29, 2017	Sponsored by KOB TV4. Set up informational table. Assisted many attendees with Medicaid application and eligibility questions for Centennial Care. Topics also covered included: Function of Care Coordination Services, Long-Term Care Services, and Value Added Benefits.
Annual Behavior Health Day Event	The Lodge Santa Fe, NM February 14, 2017	Sponsored by the NM Behavior Health Collaborative Planning Council. Set up informational table. Assisted many attendees with Medicaid application and eligibility questions for Centennial Care. Topics also covered included: Function of Care Coordination Services, Long-Term Care Services, and Value Added Benefits.

Description of Promising Practices for the Quarter

In DY4 Q1, HSD continued to make significant progress with Medicaid coverage through the Presumptive Eligibility (PE) program for justice-involved individuals as well through the regular PE program.

Processes and procedures for the justice-involved program, Justice-Involved Utilization of State-Transitioned Health Care, (JUST Health), have been implemented to ensure quality workflows among HSD staff, the state fiscal agent and participating correctional facilities. In DY4 Q1, electronic data interfaces with ASPEN, NM's eligibility system, were implemented for the NM

Corrections Department, the NM Children, Youth & Families Department (CYFD) and several county correctional facilities.

In DY4 Q1, system and data transfer updates were implemented that made the process more efficient, which has allowed HSD to expand the JUST Health program to more entities. Although the new entities did not go "live" in Q1, General Service Agreements (GSA) and system data transfer testing have occurred between HSD, the DOH Forensic Unit, and Rio Arriba County. Facilities operated by these entities are scheduled to begin program participation in May 2017.

To ensure ease of participation for organizations involved in the JUST Health program, HSD continues to conduct outreach and training sessions for correctional and county detention center staff. In DY4 Q1 HSD conducted four (4) trainings and certified thirty-nine (39) PEDs in correctional facilities. PEDs trained to assist justice-involved individuals in the Medicaid application process are able to submit applications for these individuals while they're still incarcerated. Upon release, individuals approved for coverage have immediate access to Medicaid-covered services, including substance abuse treatment and MCO care coordination services.

Further application assistance to individuals across New Mexico is available to non-incarcerated individuals through HSD's regular PE program. To ensure the continued success of this program, HSD continues to offer monthly trainings to new PEDs. HSD held three (3) regular PED trainings in DY4 Q1. Thirty PEDs were certified at these trainings. HSD also offers monthly on-line webinars that demonstrate the use of HSD's electronic application system, YES-NM for PEDs, which was developed exclusively for use by PEDs.

In DY3, PEDs (for both incarcerated and non-incarcerated individuals) granted 3,221 PEs. Of those, 3,112 (or 96.62%) also had an application for ongoing eligibility submitted. Of all individuals who applied for Medicaid coverage, only 4.31% were denied ongoing eligibility.

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 any questions and address any issues related to encounters. HSD works directly with each MCO to address any issues with encounters that have been denied. HSD and the MCOs have developed a productive partnership to fix any system edits in either or both systems. HSD meets regularly with the MCOs to address their individual questions and to provide guidance. HSD continues to monitor encounters by comparing encounter submissions to financial reports to ensure completeness. HSD monitors encounters by extracting data on a monthly basis to identify the timeliness and accuracy of encounter submissions. HSD shares this information with the MCOs so they are aware of any potential compliance issues.

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

1115 Waiver Renewal Subcommittee Update

In DY4 Q1, the 1115 Waiver Renewal Subcommittee of the Medicaid Advisory Committee concluded their monthly meetings. Stakeholders were given the opportunity to give HSD input on key areas of focus for the State's waiver renewal included below.

- Refining care coordination
- Social determinants of health
- Opportunities to enhance long-term service and supports
- BH and PH integration
- Value Based Purchasing Expansion
- Benefit & Eligibility Alignment and
- Member Engagement and Personal Responsibility

The Department provided the Subcommittee with a timeline of next steps that include:

- Release of Draft Concept Paper
- Statewide Public Input Sessions
- Formal Tribal Consultation
- Release of Draft 1115 Waiver Application
- Public Hearings
- Formal Tribal Consultation
- Submission of Waiver Application to CMS

MCO Trainings

HSD identified program areas for which MCOs would benefit from enhanced trainings. In DY4 Q1, HSD provided a Financial Reporting Training to the MCOs. The training included the following topics: Report 1 – Schedule of Revenues and Expenses by Category, Report 2 – Schedule of Expense Detail, Report 5A through 5Q – Electronic Lag, Report 6 – Encounter Comparison, Report 7 – Individual High Cost Claims, and Report 12B – Copays.

Contract Amendments

The Centennial Care MCO contract, Amendment #7, went into effect on January 1, 2017 and can be found on the HSD website at http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx.

Contract Compliance

UHC Directed Corrective Action Plan (DCAP)

UHC, at the direction of HSD, implemented policy and process changes in order to improve: oversight of delegated entities, specifically provider credentialing; verification of claims

payment accuracy for ten manually priced claims in the audited sample data; denial rates for inpatient-hospital claims; and report adjudication turnaround for inpatient hospital clean claims, subject to manual pricing, based on a high dollar limit. As reported in the DY3 Q4 report, as well as in the annual DY3 report, the first two items of the DCAP, related to delegated-entity oversight, were sufficiently addressed by UHC and closed by HSD. UHC contracted with Ernst & Young, LLP (EY) to provide third-party reporting and oversight for the four remaining DCAP items related to claims processing. While the reports from EY were projected to be final at the end of March 2017, an extension was granted to UHC until May 10, 2017. This was to ensure that an accurate sample was provided to EY, as defined by HSD, and was based on the same criteria used during the original audit. HSD will provide an analysis of the findings in the next quarterly report.

Behavioral Health

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

MCO Initiatives

BlueCross and BlueShield of New Mexico (BCBSNM)

- Implementation of MDLIVE - BCBSNM implemented virtual physician visits effective January 1, 2017 for all covered members on the Blue Cross Community Centennial Care plan. Whether at home or on the road, members now have access to a board-certified doctor, psychiatrist, or licensed therapist. Access is available 24 hours a day, seven days a week. With MDLIVE's virtual visits, members can speak to a doctor quickly or make an appointment based on their availability. The average wait time is less than 10 minutes. Behavioral health consultations with a psychiatrist or licensed therapist are available by appointment only, via secure video. Virtual visits may be a better choice for members than going to the emergency room or urgent care center. MDLIVE's board-certified doctors and psychiatrists or licensed therapists can help treat conditions such as allergies, asthma, cough, anxiety, and several other conditions.

Molina Healthcare of New Mexico (MHNM)

- Implemented an Intensive Care Coordination Program (ICCP) to target members who have had multiple inpatient psychiatric hospitalizations and/or emergency room visits with co-occurring disorders.
    - The ICCP includes weekly face-to-face touch points and additional phone calls throughout the week with members as needed.
    - The ICCP's Personal Service Coordinators operate from a "whatever it takes" philosophy to engage with members and to connect them to community services and supports to facilitate positive health and wellness outcomes.
- Santa Fe Detention Center Collaboration

- Finalizing a workflow with the Detention Center's Clinical Directors.
- Targeting June 1, 2017 to begin the program to provide Care Coordination to incarcerated members prior to release.

Presbyterian Health Plan (PHP)

- Previously reported initiatives are still ongoing.
- PHP is working closely with Collective Medical Technologies (CMT) and the other MCOs on the New Mexico ER for Emergencies Steering Committee, also known as EDIE (Emergency Department Information Exchange). EDIE is a web-based communication technology that enables intra- and inter-emergency department communication by aggregating a full census of ED and inpatient admissions, transfers, observations, and discharges. PHP has signed its contract with CMT and successfully facilitated signed contracts between CMT and all eight Presbyterian Delivery System (PDS) hospitals. Go-Live is scheduled for 6/1/17.
    - It is anticipated that EDIE and its complimentary product, PreManage, will increase the impact of existing care coordination resources. PHP has identified specific profiles---for example, two or more ED visits within the last six months----that will result in care coordination review at the time the member presents to the ED.

United Healthcare (UHC)

- Expanded two Quality initiatives in DY4 Q1.
    - Community Benefit Care Plan Monitoring Audits: These audits are briefly described in Attachment J: MCO Actions Plans. The overarching initiative has three focus areas including: complete member records with a current comprehensive needs assessment (CNA) and comprehensive care plan (CCP) identifying specific measureable goals; documentation that the Care Coordinator is addressing member specific needs; and, evidence of a complete and accurate Personal Care Services (PCS) Allocation Tool. To this end, UHC is utilizing its new clinical care system functionality to enhance performance. One example is to use system generated care goals, based on medication and service utilization records and other data as a starting point to tailor an individualized care plan with engagement from the member. Audit results, based on a checklist of 48 items, have been consistently high month-over-month with the most recent score aggregate score of 96% for audited files in the first quarter. In-depth staff training for the purpose of maximizing CommunityCare functionality continued through the quarter.
    - Behavioral Health HEDIS and PHQ-9 Training: Staff training on the Healthcare Effectiveness Data and Information Set (HEDIS) and the Patient Health Questionnaire (PHQ-9) used for screening, diagnosing, monitoring and measuring the severity of depression to promote positive health outcomes. The training was developed in quarter one and rolled out at the end of the quarter. After the PHQ-9 training, UHC intends to audit Care Coordination files for members with a diagnosis

of depression to determine if the PHQ-9 screening was completed and is documented in CommunityCare. UHC is developing an audit tool to determine whether Care Coordinators are utilizing the PHQ-9 (i.e. identifying health improvement opportunities) and following up with members for appropriate interventions and using measurable goals to quantify progress toward improved health outcomes. The audit is projected to be completed in quarter two with results and feedback to staff early in quarter three. This is a continuous quality improvement process and UHC is establishing a baseline with performance results expected to increase over time.

Fiscal Issues

During DY4 Q1, several reconciliations were completed that resulted in payments for some MEGs and recoupments for others. The Indian Health Service (IHS), Hepatitis C and retroactive eligibility reconciliations, and the cost settlement with the schools for the legacy program resulted in payments that affected the per member per month (PMPMs) of MEG1 for DY2 and DY3. On the other hand, the risk corridor and retroactive eligibility reconciliations for the Other Adult Group (OAG) for calendar years 2014, 2015 and 2016 resulted in recoupments and mostly responsible for the reduction of the PMPM for MEG6 for DY 1, DY 2 and DY 3 compared to the previous report.

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 the CMS mental health parity and managed care rules which may also have fiscal impacts.

Delivery System Improvement Performance Fund

As stated in the DY3 report, HSD evaluated the MCO results for the 2016 Delivery System Improvement Performance Fund (DSIPF) targets. The five target areas were:

1. Increase the use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages in rural, frontier, and underserved communities in urban regions of the State.
2. A minimum of a 15 percent increase in telemedicine “office” visits with specialists, including Behavioral Health providers, for members in rural and frontier areas. At least 5 percent of the increase must be visits with BH providers.
3. A minimum of 5 percent increase of members being served by Patient-Centered Medical Homes (PCMH) (including both PCMHs that have achieved NCQA accreditation and those that have not) or maintain a minimum of 40 percent.
4. Percent of seven-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalization stays of four or more days. Due to claims lag a final target ranging between 10 – 15 percent improvement will be established in consultation with MCOs and national standards after submission of the annual report.

5. MCOs must treat at least 50% of members estimated to need Hepatitis C drug treatments for the combined Physical Health, Medicaid Only LTSS, and OAG populations during the contract period.

All targets were met with the exception of the Hepatitis C target in which one MCO did not meet the target.

Systems Issues

HSD continues to run reports to conduct ongoing auditing and analysis of nursing facility level of care (NFLOC) and setting of care (SOC) to identify discrepancies that can be identified and corrected. HSD has issued guidance to the MCOs and made additional system changes to enhance editing. HSD continues to implement reporting to monitor any discrepancies that may arise and continues to work with the MCOs. HSD continues to see progress with the MCOs.

Medicaid Management Information System Replacement

HSD's planning for replacement of its current legacy Medicaid Management Information System (MMIS) began some time ago, and activity for this effort progressed in Q1. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the allied departments of DOH, CYFD, and the Aging and Long-Term Services Department (ALTSD). These three departments have participated in RFP development and replacement planning. HSD is currently in the process of drafting GSAs with these agencies for qualifying activities to receive MMISR funding.

The first module of the State's Framework for MMIS Replacement, the System Integrator, was released February 16, 2017. Proposals were received on April 19, 2017; a decision is expected to be made at the end of May 2017.

The RFP for the next module of the Framework, the Enterprise Data Services RFP, was released on April 17, 2017. Proposals are scheduled to come in on June 21, 2017.

HSD has begun development of the RFP for the fourth module, Financial Services. This RFP also will involve meetings with all stakeholders, questionnaires for input and review of other states' procurements and contracts on Financial Services as well as with our current fiscal agent contractor, Conduent (formerly Xerox).

HSD is working with its two existing vendors on matters related to the replacement system. A contract amendment with Conduent addressing conversion matters has been executed, and with Deloitte, our integrated eligibility system vendor, we completed the definitional work to have the ASPEN eligibility system become a true Eligibility and Enrollment system. The contract amendment to have the ASPEN system assume responsibility for managed care enrollment of members also includes provisions for Real Time Eligibility (RTE). CMS has approved the amendment and plans for RTE.

An Implementation Advance Planning Document Update was submitted to the CMS Regional Office in early April 2017 for approval.

Pertinent Legislation or Litigation

The following legislation, pertinent to the demonstration, was passed during the 2017 legislative session and signed into law.

House Bill 15 Data Breach Notification Act

Creates the Data Breach Notification Act as a consumer protection measure. Provides that notice be given to persons who are affected by a security breach involving their personal identity information. The measure is directed at the use or breach of information (a) without the approval or direction of the card issuer; (b) that results in the compromised security and confidentiality of access device data; and (c) that creates a material risk of harm or actual harm to a cardholder.

House Bill 58 Rulemaking Requirements

Amends the New Mexico State Rules Act to change requirements for proposing, adopting, amending or repealing rules. Applies to all executive branch agencies, boards, commissions, departments, institutions or officers. Proposed rules must be provided to the Legislative Council for distribution to appropriate interim and standing committees. Includes updates to accommodate the electronic transfer and posting of notices and rule publication.

House Bill 122 Ban Certain Pharmacy Fees

Provides a new section of the Pharmacy Benefits Manager Regulation Act to prohibit a pharmacy benefits manager—either at the time of claim adjudication or any time before or after—from charging or holding a pharmacist or pharmacy responsible for a fee for any step or component of the adjudication of a claim.

House Bill 138 Lactation Consultant Practice Act

Creates the Lactation Consultant Practice Act. Provides for licensure of lactation consultants by the Board of Nursing and establishes a scope of practice for licensed lactation consultants, defines qualifications and requirements for licensure, and provides for disciplinary proceedings.

House Bill 274 Immunizations for Certain Senior Citizens

Makes offering of influenza or pneumococcal immunizations to senior citizens mandatory upon release from a hospital.

House Bill 370 Opioid Overdose Education

Requires opioid treatment center agencies operating a federally certified program to dispense methadone or another narcotic replacement for detoxification or maintenance treatment to provide each patient with opioid overdose education, two doses of naloxone and a prescription for naloxone.

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 & 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 January 1, 2017 to March 31, 2017.

Table 8 – ADRC Call Profiler Report

Topic	# of Calls
Home/Community Based Care Waiver Programs	2,799
Long Term Care/Case Management	98
Medicaid Appeals/Complaints	11
Personal Care	150
State Medicaid Managed Care Enrollment Programs	37
Medicaid Information/Counseling	882

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from January 1, 2017 to March 31, 2017.

Table 9 – ADRC Care Transition Program Report

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		263	
Medicaid Education/Outreach	395		
Nursing Home Intakes		66	
*Pre/Post Transition Follow-up Contact	2,073		
**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.

**This is a newer reporting category. 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 serves 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 CTB staff continue to work directly with the MCOs when facing challenges with members. This includes assistance with the Income Support Division (ISD) Application, assisting to identify the reason(s) a client's eligibility has not been established.

Critical Incidents (CI)

HSD continues to meet quarterly with the CI workgroup in an effort to provide technical assistance to the MCOs. The workgroup supports BHSD 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.

Daily review of incident reports is conducted by the MCOs and HSD CI unit. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.

During DY4 Q1, a total of 4,804 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.

During DY4 Q1, a total of 477 deaths were reported. Of the 477 deaths reported, 434 deaths were reported as natural/expected deaths, 39 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 Q1, Centennial Care, Behavioral Health and Self Directed populations reported a total of 3,172 critical incidents for Emergency Services. Of those Emergency Services reports, 296 were Behavioral Health and 155 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. MCOs are monitoring 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. HSD will continue to monitor any decreases or increases of emergency services reports.

Table 10 – Critical Incident Types by MCO – Centennial Care

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	33	0.69%	87	1.81%	86	1.79%	74	1.54%	280	5.83%
Death	{104}	2.16%	{118}	2.46%	{79}	1.64%	{176}	3.66%	{477}	9.92%
Natural/Expected	92	1.92%	105	2.19%	69	1.43%	168	3.49%	434	9.03%
Unexpected	12	0.24%	11	0.23%	8	0.17%	8	0.17%	39	0.81%
Suicide	0	0.00%	2	0.04%	2	0.04%	0	0.00%	4	0.08%
Elopement/Missing	6	0.12%	8	0.17%	9	0.19%	5	0.10%	28	0.58%
Emergency Services	586	12.20%	1147	23.88%	543	11.30%	896	18.65%	3172	66.03%
Environmental Hazard	6	0.12%	12	0.25%	11	0.23%	30	0.62%	59	1.22%
Exploitation	20	0.42%	36	0.75%	24	0.50%	51	1.06%	131	2.73%
Law Enforcement	17	0.35%	33	0.69%	16	0.33%	17	0.35%	83	1.72%
Neglect	80	1.67%	117	2.44%	155	3.23%	222	4.62%	574	11.96%
Total	**852**	**17.74%**	**1558**	**32.43%**	**923**	**19.21%**	**1471**	**30.62%**	**4804**	**100.00%**

Table 11 – Critical Incident Types by MCO – Behavioral Health

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	8	1.68%	44	9.24%	14	2.94%	2	0.42%	68	14.00%
Death	{1}	0.21%	{10}	2.10%	{3}	0.63%	{0}	0.00%	{14}	2.94%
Natural/Expected	0	0.00%	6	1.26%	0	0.00%	0	0.00%	6	1.26%
Unexpected	1	0.21%	3	0.63%	1	0.21%	0	0.00%	5	1.05%
Suicide	0	0.00%	1	0.21%	2	0.42%	0	0.00%	3	0.63%
Elopement/Missing	5	1.05%	4	0.84%	5	1.05%	0	0.00%	14	2.94%
Emergency Services	20	4.20%	241	50.63%	22	4.62%	13	2.73%	296	62.18%
Environmental Hazard	1	0.21%	1	0.21%	2	0.42%	0	0.00%	4	0.84%
Exploitation	0	0.00%	7	1.47%	0	0.00%	0	0.00%	7	1.47%
Law Enforcement	2	0.42%	8	1.68%	5	1.05%	0	0.00%	15	3.15%
Neglect	3	0.63%	36	7.56%	9	1.89%	10	2.10%	58	12.18%
Total	**40**	**8.40%**	**351**	**73.74%**	**60**	**12.61%**	**25**	**5.25%**	**476**	**100.00%**

Table 12 – Critical Incident Types by MCO – Self Directed

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	6	2.90%	2	0.97%	7	3.38%	3	1.45%	18	8.70%
Death	{2}	0.97%	{1}	0.48%	{4}	1.93%	{2}	0.97%	{9}	4.35%
Natural/Expected	2	0.97%	1	0.48%	3	1.45%	2	0.97%	8	3.87%
Unexpected	0	0.00%	0	0.00%	1	0.48%	0	0.00%	1	0.48%
Suicide	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Elopement/Missing	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Emergency Services	25	12.08%	23	11.11%	73	35.27%	34	16.43%	155	74.87%
Environmental Hazard	0	0.00%	0	0.00%	0	0.00%	2	0.97%	2	0.96%
Exploitation	2	0.97%	3	1.45%	2	0.97%	4	1.93%	11	5.31%
Law Enforcement	1	0.48%	0	0.00%	1	0.48%	0	0.00%	2	0.96%
Neglect	1	0.48%	1	0.48%	5	2.42%	3	1.45%	10	4.83%
Total	**37**	**17.88%**	**30**	**14.49%**	**92**	**44.44%**	**48**	**23.19%**	**207**	**100.00%**

Home and Community-Based Services Reporting
HSD received initial CMS approval of its Statewide Transition Plan (STP) in January 2017.

HSD, in partnership with the ALTSD, will perform provider validation activities in DY4 Q2 and Q3 and will update the STP for submission to CMS for final approval.

Community Benefit
HSD began "ride-alongs" with care coordinators to assess care coordinators' administration of the Community Benefit Services Questionnaire (CBSQ) that was implemented in October 2016. The MCOs began reporting of the total number of completed CBSQs to HSD in December 2016.

HSD conducted Community Benefit (CB) training ALTSD Aging and Disability Resource Center staff on March 29, 2017. The training focused on the process for allocating persons who are not otherwise Medicaid eligible to receive community benefits.

The Community Benefit rule (NMAC 8.308.12) was revised effective March 1, 2017. Changes included adding language to comply with the HCBS Final Rule, clarifying the definition of respite services, and implementing a $100 monthly limit for cell-phone services. The Centennial Care Managed Care Policy Manual was also revised effective March 1, 2017 to align with the full implementation of Electronic Visit Verification (EVV) and with changes made to the rule as stated above.

Self-Directed Community Benefit
In DY4 Q1, the MCOs began to work with Conduent to roll out the implementation of mandatory online timesheets for SDCB employees. Effective June 1, 2017, members and employers of record (EORs) will be required to approve and submit their employees' timesheets online instead of faxing them to the FMA for manual entry. A member may be approved for an exception if he/she lives in an area without internet access, or is unable to submit timesheets online due to his/her disability.

Electronic Visit Verification
EVV was fully implemented with most providers participating in November 2016. However, claims for PCS were still allowed to be billed outside of the EVV system until March 1, 2017, when the MCOs required all PCS claims to be billed through the EVV system. The MCOs and their subcontractors continue to provide assistance to PCS agencies with the EVV system and billing as needed.

HSD and the MCOs partner with the New Mexico Association for Home Health and Hospice Care (NMAHHC) to provide information on the EVV system to PCS providers at its quarterly conferences. On March 2, 2017, a panel that included the MCOs and their EVV subcontractor, First Data, presented an update on EVV, answered questions, and responded to provider concerns.

Section VIII: AI/AN Reporting

Access to Care

I/T/Us are concentrated near or on Tribal land where many Native Americans live and receive services. Native Americans in Centennial Care may access services at Indian Health Service (HIS) and Tribal 638 clinics at any time. Approximately 44,000 Native Americans are enrolled in Centennial Care. Data from the MCOs shows:

- 93% access to care for Native Americans in rural and frontier areas for physical health
- 93% access to care for Native Americans in rural and frontier areas for behavioral health

Contracting Between MCOs and I/T/U Providers

The MCOs continue to reach out to IHS and Tribal 638 health providers, as well as Tribal programs to develop agreements. Some of the MCOs have contracts with Navajo Area IHS. The MCOs treat the non- contracted I/T/Us as if they are contracted for services rendered to their MCO members.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements for claims processed and paid within 15 days of receipt at 96% but not for claims processed and paid timely within 30 days of receipt at 96%.

Native American Advisory Board (NAAB) meeting for DY4 Q1

MCO	Date of Board Meeting	Issues/Recommendations
BCBSNM	Lovelace Women's Hospital Albuquerque, NM 2/23/17	**Issue**: The facility had several entrances which may have confused attendees. There was no microphone so it was hard to hear speaker. **Response**: Have sound system at meetings. Have info table at entrance to guide people to room. Provide copy of presentation to attendees. Have a traditional healer present.
MHNM	Zuni Wellness Center Zuni Pueblo, NM 2/22/17 Native American Community Academy Albuquerque, NM 3/10/17	Molina held two Advisory Board meetings this quarter in Tribal programs. Molina uses input from the NAAB meetings to evaluate how well the plan is meeting the needs of its members. The Traditional Medicine Benefit (TMB) is now exclusive to Native Americans age 12 and older and has increased from $100 to $200 dollars per calendar year. Members were encouraged to seek professional help or stay after the meeting to speak to a Molina team member if they were suffering from depression, thoughts of suicide or addiction problems. The Zuni meeting provided translation in the Zuni language. **Issue**: How will changes in the Affordable Care Act affect Medicaid Benefits? **Response**: Molina has served the Medicaid population for 30 years. If there are changes, members will be quickly notified.
PHP	The Cooper Center Albuquerque, NM 3/10/17	**Issue**: PHP provided clarification that for Native Americans in their MCO, PHP will automatically assign them to IHS as their primary care provider. **Response**: If the member wants to change to a PCO outside of IHS, they can do so. **Issue**: HME Specialists is the preferred DME vendor for PHP. **Response**: HME will drop off equipment as IHS facilities if the member prefers to pick them up at IHS.
UHC	Mescalero Tribal Office Mescalero, NM 3/14/17	**Issue**: The MCOs need to be more culturally sensitive on how Tribal members take care of each other in Tribal communities. **Response**: A recommendation is for members to have a companion go with them to their appointments, especially to assist with the language and cultural needs.

HSD's Native American Technical Advisory Committee (NATAC)

A subcommittee of the NATAC met in January and February 2017 to provide the Department with recommendations related to the upcoming 1115 waiver renewal. During these meetings, the subcommittee was provided with the areas of focus for the waiver renewal and were given the opportunity to provide input to the Department. The Department will utilize this feedback during the development of the waiver concept paper.

100% FMAP – CMS Guidance

During DY4 Q1, New Mexico implemented the CMS guidance through a unique partnership between the University of New Mexico Hospital and Albuquerque Area Indian Health Services (AAIHS) for FFS claims for Native American Medicaid members. A Care Coordination Agreement (CCA) is in place between these parties and New Mexico is awaiting further guidance from CMS. New Mexico Medicaid also began discussions with other partners, including AAIHS and Presbyterian Healthcare Services, to develop a CCA. A draft CCA is under review by both parties.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment J: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY4 Q1 is the first quarter with the CY 2017 rates that exhibits the full effect of a series of cost containments that started 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 PMPM of DY4 Q1 compared to the PMPM of DY3; The PMPMs of DY4 Q1 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 35% below the budget neutrality limit (Table 4.4) based one quarter 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 13 – Member Months DY4 Q1

Number of Clients by Population Group and MC	
	2017
Row Labels	**1**
Population 1 – TANF and Related	**1,185,137**
FFS	**145,170**
	145,170
MC	**1,039,967**
Molina	387,798
Presbyterian	385,187
United Healthcare	79,308
Blue Cross Blue Shield	187,674
Population 2 – SSI and Related – Medicaid Only	**125,612**
FFS	**9,545**
	9,545
MC	**116,067**
Molina	39,353
Presbyterian	40,937
United Healthcare	15,789
Blue Cross Blue Shield	19,988
Population 3 – SSI and Related – Dual	**109,740**
MC	**109,740**
Molina	20,674
Presbyterian	20,508
United Healthcare	48,424
Blue Cross Blue Shield	20,134
Population 4 – 217-like Group – Medicaid Only	**1,381**
FFS	**560**
	560
MC	**821**
Molina	160
Presbyterian	178
United Healthcare	345
Blue Cross Blue Shield	138
Population 5 – 217-like Group - Dual	**9,461**
MC	**9,461**
Molina	1,966
Presbyterian	1,648
United Healthcare	3,992
Blue Cross Blue Shield	1,855
Population 6 – VIII Group (expansion)	**824,058**
FFS	**105,404**
	105,404
MC	**718,654**
Molina	220,931
Presbyterian	195,970
United Healthcare	117,726
Blue Cross Blue Shield	184,027

Section XII: Consumer Issues (Complaints and Grievances)

A total of 969 grievances were filed by Centennial Care members in DY4 Q1. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 274 (28.28%) of the total grievances received. The MCOs report they continue to investigate, communicate and meet regularly with their transportation vendors to address identified issues.

The second top grievance filed was Other Specialties with a total of 109 grievances (11.25%). The dissatisfaction reported was the provider billing the member for a remaining balance after a Medicaid payment was made. MCOs continue to investigate and review data that will determine what has caused the increase.

There were 586 (60.48%) variable grievances filed during Q1. Of those, each MCO reported unique grievances during the quarter that does not provide data to establish a trend. Quarter one examples among the MCOs include Pharmacy; Primary Care Physician; and Durable Medical Equipment. HSD is monitoring these grievances to identify specific trends.

Table 14 – MCO Grievances DY4 Q1

MCO Grievances DY4 Q1 (January – March 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	144	14.86%	336	34.67%	190	19.61%	299	30.86%	**969**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	87	8.98%	63	6.50%	38	3.92%	86	8.88%	**274**	28.28%
Other Specialties	11	1.14%	0	0.00%	19	1.96%	79	8.15%	**109**	11.25%
Variable Grievances	46	4.75%	273	28.17%	133	13.73%	134	13.83%	**586**	60.48%

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 Q1.

Table 15 – Service Plan Audit DY4 Q1

Member Records	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**120**			
BCBSNM	**30**			
MHC	**30**			
PHP	**30**			
UHC	**30**			
Percent of files with personalized goals matching identified needs	**100%**			
BCBSNM	**30**			
MHC	**30**			
PHP	**30**			
UHC	**30**			
Percent of service plans with hours allocated matching needs	**100%**			
BCBSNM	**30**			
MHC	**30**			
PHP	**30**			
UHC	**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 16 – Nursing Facility LOC Audit DY4 Q1

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

Table 17 – Community Benefit NFLOC Audit DY4 Q1

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

HSD was in agreement with all NFLOC decisions; however, three charts submitted for review were outside of the sample criteria. Of the five sample files submitted by UHC for High NF, one did not qualify as a High NF Level of Care request. Of the five sample files submitted by BCBS for Community Benefit, two did not qualify as denials. HSD will follow up with the MCOs to ensure that selected samples match requested criteria for future audits.

EQRO NF LOC

HSD reviewed NFLOC determination disagreements from EQRO audits from January and February of DY4 Q1 and was in agreement with all of EQRO findings.

Table 18 – EQRO NF LOC Review DY4 Q1

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

Issues identified included incomplete supporting documentation and supporting documentation dated outside the required time period. HSD will address these issues with the MCOs and discuss strategies to ensure accuracy in determinations and documentation. BCBS outlined their current process for improving HNF Level of Care determinations and included a timeline of additional training sessions as well as a description of their internal review process. Per BCBS, all HNF reviews would require the final review/check-off by the Unit Manager. In addition, BCBS implemented a step to their audit file submission process to confirm inclusion of all necessary documents prior to submission for review. PHP informed HSD that additional training would be provided internally. PHP will also reach out to facilities and provide training to ensure required documentation is complete when submitted and will provide an update to HSD regarding the status of this process. 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 Q1, 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 on documentation as well as contract and policy requirements to their care coordinators. In February 2017, HSD met 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, UHC and Presbyterian have demonstrated an overall decline in average ED visits/member, whereas BCBS and MHC levels have remained relatively stable. In May 2017, HSD plans to meet with MCOs to present descriptive data findings on super utilizers and to discuss care coordination best practices for ED reduction**.**

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 between 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. During DY4 Q1, eight sites began using EDIE, while another 31 hospitals or medical centers are projected to go live by 7/1/2017.

Care Coordination for Incarcerated Individuals

HSD continues to provide technical assistance for a care coordination pilot project with MHC and the Bernalillo County 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=195), the program has demonstrated significant declines in the reduction of member ED visits, BH claims, PH claims, and pharmacy claims. Most notably, the recidivism rate within one year of release for participating members is 20%, which is less than half of the national average (56.7%).

Care Coordination Ride-Alongs

HSD continued to conduct "ride-alongs" with MCO care coordinators in March 2017 to observe member assessments in the home setting. HSD staff conducted one ride-along per MCO, observing initial and follow-up CNAs. Particular emphasis was paid to the utilization by care coordinators of the CBSQ and the Community Benefit Member Agreement (CBMA), to ensure the member agrees to accept or decline 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 Q1 all call center metrics (abandonment rate, speed of answer and wait time) for all customer services lines for member services, provider services, nurse advice line and the utilization management line were met by each MCO, including consistent staffing ratios. All MCOs have agents that are bilingual in English and Spanish. Please see Attachment K: Customer Service Summary.

MCO Reporting Process

In the DY4 Q1 utilization phase, the MCOs continued the Technical Assistance (TA) Calls and the Self-Identified Error Resubmission. These two processes allow HSD and MCO Subject Matter Experts (SMEs) to clarify data requirements and correct data inaccuracies. Reports from MCOs in Q1 have been timely with few extensions requests, which have produced positive outcomes for report completion.

Report Revisions

HSD continues to revise reports, as necessary, through a formal written process in which HSD and MCOs request needed changes to data reporting. This process is intended to streamline managed care reporting, perform contract oversight, and monitor MCO performance. A revision workgroup to include SMEs is developed for each report revision to ensure the needs of all stakeholders are considered. HSD revises reports to streamline elements from various reports, improve monitoring of MCO performance, and incorporate requirements of the managed care final rule, etc.

Member Appeals

A total of 1,021 member appeals were filed by Centennial Care members in DY4 Q1. Of those appeals 944 (92.46%) were standard member appeals and 77 (7.54%) 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 873 (85.50 %) of the total appeals received. In this quarter, member appeals included denial of inpatient stay, eligibility criteria for services not met and denial of personal care service hours. The second top appeal filed was reduction of a previously authorized service with a total of 81 (7.93%) member appeals.

There were 67 (6.56%) variable appeals filed during Q1. Of those, each MCO reported unique appeals during the quarter that does not provide data to establish a trend. Quarter one examples among the MCOs include Denial in whole of payment for a service; Termination of a previously authorized service; and Denial in part of a payment for a service. HSD continues to monitor appeals to identify specific trends.

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 19 – Member Appeals DY4 Q1

MCO Appeals DY4 Q1 (January – March 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	108	10.58%	124	12.14%	574	56.22%	138	13.52%	**944**	92.46%
Number of Expedited Member Appeals	19	1.86%	15	1.47%	10	0.98%	33	3.23%	**77**	7.54%
Total	127	12.44%	139	13.61%	584	57.20%	171	16.75%	**1021**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	118	11.56%	134	13.12%	523	51.22%	98	9.60%	**873**	85.50%
Reduction of a previously authorized service	4	0.39%	5	0.49%	27	2.64%	45	4.41%	**81**	7.93%
Variable Appeals	5	0.49%	0	0.00%	24	2.35%	28	2.74%	**57**	5.58%
Empty Variables									**10**	0.98%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues as expected. Throughout DY4 Q1, major activities completed under the Centennial Care 1115 Waiver Evaluation consisted of finalizing data analysis and reporting for the DY2 Annual Evaluation Report. Deloitte is preparing to draft the Interim Evaluation Report and to collect DY3 data.

The DY2 Annual Report, developed by Deloitte, highlights approximately 20 measures in detail that illustrate progress under the Centennial Care 1115 waiver in terms of cost, quality, and access. A high-level commentary on the overall results was included to support evaluation of each research question.

Deloitte continues to update and maintain the DY2 data and questions tracker in order to effectively monitor the status of all data items received including identification, timing, and resolution. Deloitte meets 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 DY2 Annual Evaluation Report, HSD communicated that several reports are undergoing revisions in reporting criteria 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 reestablishing baseline values under the new reporting methodology.

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 in a way to effectively act as supporting documentation of the analytic review completed within the Evaluation and included in the appendix of the DY2 Annual Report.

DY4 Q2 activities will focus around the interim report required with the submission of New Mexico's 1115 waiver renewal. These activities include:

- Drafting an example outline of the report format for discussion with HSD
- Continuing to collect and assess DY3 information as applicable
- Continuing discussions with HSD on reporting methodology updates and impacted measures, as well as data questions as they arise

For the Interim Evaluation Report due to HSD on September 15, 2017, Deloitte will produce a detailed and comprehensive report of progress and performance of the waiver's experience against the full range of evaluation measures where appropriate data is available. However, the body of the report will focus on the results of the analyses for each measure and detail on the data sources and methodology will be contained in the appendices.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Tables
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: 2016 GeoAccess PH – BCBSNM
Attachment E: 2016 GeoAccess PH – MHNM
Attachment F: 2016 GeoAccess PH – PHP
Attachment G: 2016 GeoAccess PH - UHC
Attachment H: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment I: Behavioral Health Collaborative CEO Report
Attachment J: MCO Action Plans
Attachment K: Customer Service Summary

Section XVII: State Contacts

HSD State Name and Title	Phone	Email Address	Fax
Nancy Smith-Leslie Director HSD/Medical Assistance Division	505-827-7704	Nancy.Smith-Leslie@state.nm.us	505-827-3185
Angela Medrano Deputy Director HSD/Medical Assistance Division	505-827-6213	Angela.Medrano@state.nm.us	505-827-3185
Jason Sanchez Deputy Director HSD/Medical Assistance Division	505-827-6234	JasonS.Sanchez@state.nm.us	505-827-3185
Kari Armijo Deputy Director HSD/Medical Assistance Division	505-827-1344	Kari.Armijo@state.nm.us	505-827-3185

Section XVIII: Additional Comments

HSD has included success stories from members enrolled with 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 care coordinator successfully assisted a 28-year old female who suffers from diabetes, status post stroke with total blindness, and is paralyzed. The care coordinator assisted the member in reintegrating the member out of a nursing facility into the community. The member is thriving out of the nursing facility and has not had any emergency room visits or hospitalizations since discharging to a home. This has allowed the member to bond with their 8-year-old son. In addition, the member is able to live in the community with her father and with the assistance of personal care services.

Centennial Care Member Success Story 2
A member was abruptly kicked off of Medicaid when she became eligible for Social Security and Medicare. The care coordinator advised the member to obtain a waiver, which she did. The member and care coordinator continued to work together to get PSC reinstated. The member was then accidentally assigned to a different MCO when the waiver was approved, but she contacted HSD that she wanted to stay with her original MCO, and to continue to have the same care coordinator. At the six month face to face visit, the member expressed her gratitude for the help extended to her. The member is very happy with the services in place again and has completed most goals on her care plan.

Centennial Care Success Story 3
A care coordinator was assigned a member who had just been released from prison. During six years of incarceration, the member had little or no access to health care. In addition, the member had epilepsy, Hepatitis C, nerve pain, post-traumatic stress disorder (PTSD), and a history of substance abuse. The member would suffer a seizure once every other month and the Hepatitis C and PTSD remained untreated. The nerve damage also caused the member to be bedridden for several days out of the week. Upon meeting with the member, the care coordinator educated the member on the importance of having a PCP and the dangers of not treating the various conditions. The care coordinator helped the member find a PCP, a neurologist, and a behavioral health provider. Currently, the member is actively engaged in all levels of care, sees the PCP on a regular basis, and takes all necessary medications. The member has been seizure-free for the last six months and has completed all Hepatitis C treatments. In addition, the member's nerve pain is under control, allowing the member to be active and pain free. Lastly, the member is also receiving therapy for PTSD.

Centennial Care Success Story 4
A member was first enrolled into care coordination when he was inpatient at Rust Medical Center due to alcohol induced hepatitis. When the care coordinator walked into the room the care

coordinator was taken back by how frail and jaundiced the member was. Throughout the assessment, the care coordinator found out the member had been given months to live due to liver failure caused by his alcohol consumption. After talking with the member and the member's family, the care coordinator was able to develop a discharge plan that the member seemed eager to follow. Within the discharge plan, the member would attend Intensive Outpatient Program (IOP) at Four Winds Behavioral Health and would consider attending Alcoholics Anonymous (AA), the member would also continue to follow up with his physical health providers. The member's family was very supportive throughout the entire process. The care coordinator met with the member three months later for the required in person visit and was once again was taken back by his appearance. The member looked like a healthy 26-year old with ease of movement and rosy cheeks. The member has been attending IOP three times per week along with AA. In addition, the member was successfully discharged from physical therapy and recently received a letter from his Gastroenterologist (GI) stating the member's liver function is almost back to normal. The care coordinator and member discussed the member's plans for the future, which include eventually moving out of the member's parents' home and getting a job. The member was also very open in discussing how close he came to dying and the choices that led him to that place. The member's mind is now set on sobriety and living a healthy active life.