Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2016 – 12/31/2016)
Waiver Quarter: 3/2016

December 8, 2016
New Mexico Human Services Department

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Section I: Introduction

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 690,000 members are enrolled in the program. Initiatives continuing in the third year of the program (January 2016 – December 2016) include:

Emphasizing Patient-Centered Care

- As of June 30, 88% of members had been reached in order to conduct a health risk assessment (HRA).
- More than 70,000 members are in higher levels of care coordination.
- More than 280,000 members are receiving care in patient-centered medical homes.
- More than 25,000 members are receiving home and community benefits.
- Launched two health home sites for members with complex behavioral health (BH) conditions.
- Identified high cost/high need members and designing programs to reduce inappropriate use of the emergency department (ED), including pilots with community agencies such as Albuquerque Ambulance, Kitchen Angels and Addus Homecare.
- Implemented a justice involved pilot program with county jails to connect incarcerated individuals with care coordination upon release from the facility.

Supporting Provider Capacity

- Maximized Scopes of Practice for Certain Providers.
- Managed care organizations (MCOs) expanded use of telehealth office visits by 45% and launching virtual physician visits, including with BH providers.
- Increased use of Community Health Workers.

Implementing Payment Reform Projects

- MCOs continue to expand value-based purchasing efforts with implementation of bundled payments for episodes of care, shared savings arrangements, pay for performance payments and global capitation with upside risk.

Other initiatives in development during Demonstration Year 3 (DY3)

- Implemented ED diversion strategies, including implementation of ED tracking software to be used by hospitals and MCOs.
- Planned for Certified Community Behavioral Health Clinics and expansion of health homes.
- Collaborated with the MCOs on dually eligible members to align MCO enrollment and better coordinate care.
- Implemented Electronic Visit Verification for members receiving Personal Care Services.

Section II: Eligibility, Provider Access and Benefits

Eligibility

As noted in Section III of this report, there are 272,718 enrollees in the Group VIII (expansion) who are in Centennial Care. Growth in the expansion group shows 6,918 new enrollees for the third quarter of DY3 (DY3 Q3).

Access

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

Network Adequacy

HSD monitors the MCOs' compliance in maintaining an adequate and efficient provider network, tracking new and terminated providers, and transition of members to new providers when a provider or agency is suspended or terminated. Member-to-provider ratios and the number of single case agreements required during the quarter are considered with respect to provider adequacy and the strength of each MCO's network. In July 2016, HSD initiated provider rate reductions; however, all of the MCOs reported their respective provider networks remained stable and rate reductions have not resulted in provider termination during DY3 Q3.

Population Density Designations

Urban counties in New Mexico include: Bernalillo, Los Alamos, Santa Fe and Doña Ana. (4)

Frontier counties in New Mexico include: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. (15)

Rural counties in New Mexico are not frontier or urban and include: Chaves, Curry, Eddy, Grant, Lea, Luna, McKinley, Otero, Rio Arriba, Roosevelt, Sandoval, San Juan, Taos and Valencia. (14)

Primary Care Provider (PCP)-to-Member Ratios

As reflected in the table below, the average PCP-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural and frontier counties from January through June 2016. There are no PCP access concerns at this time.

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June
BCBS	1:56	1:55	1:54	1:55	1:56	1:56
MHC	1:111	1:111	1:111	1:108	1:107	1:105
UHC	1:17	1:17	1:17	1:16	1:16	1:16
PHP	1:83	1:85	1:87	1:88	1:89	1:89
Source [MCO] PCP Report #53, Q2CY16						

Provider Distance Standards

Distance Standard 1 - For PCPs including internal medicine, general practice and family practice provider types and (ii) pharmacies:

- Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.
- Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles.
- Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

Distance Standard 2 - For the providers described in Attachment 8 to the Contract:

- Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.
- Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

Geographic Access

New Mexico's Geographic Access (GeoAccess) report monitors member's geographic access to services and MCO contracted providers across urban, rural and frontier counties. New Mexico also recognizes providers/pharmacies within 100 miles of the border as in-state providers. The GeoAccess report captures forty-nine (49) different provider types as well as out-of-state providers that each MCO is either contracted with or has a single case agreement.

During DY3 Q3, GeoAccess reports continued to be reviewed by HSD to ensure consistent methodology across MCOs. HSD identified discrepancies in an MCO's reporting, including duplication in provider location count and inability to accurately calculate physical location of provider. To ensure consistent methodologies among MCOs, HSD conducted technical assistance (TA) calls with the appropriate MCO to ensure all MCOs report accurate provider location counts and physical location of provider. Please see Attachment B: GeoAccess PH Summary and Attachment C: GeoAccess BH Summary.

GeoAccess Attachments

The GeoAccess attachments to the Q3 report are comparative grids that demonstrate to what degree each MCO "meets" (green), or "does not meet" (orange), the distance standards for each provider type listed. The percentage represents the number of members who have access to a provider divided by the total number of members who reside in the geographic area (urban, rural or frontier counties).

Example: The distance standard for Cardiology (Standard 2 below) is that 90% of urban members shall travel no farther than (30) miles to reach a Cardiologist. Presbyterian (PHP) has 111,782 individual members living in urban counties and who have at least one Cardiologist within 30 miles of their residence. The total number of PHP members in urban counties is 112,872. Therefore, 99% of urban members live within 30 miles of a Cardiologist practice. The cell is green (right of "Cardiology," under urban and PHP), because the percentage or members who have a provider within 30 miles meets or exceeds the distance standard of 90%. The grid facilitates a comparison across MCOs.

In addition, each MCO GeoAccess Report captures detail at the county level; however, HSD submits a higher level summary (by geographic area) for brevity.

Secret Shopper Survey

Medicaid enrolled providers with the State of New Mexico contract with any number of the four Centennial Care MCOs, all of which provide services to members statewide. While MCO GeoAccess Reports measure proximity of members to providers and Network Adequacy Reports measure capacity by MCO, HSD recently conducted a Secret Shopper Survey in order to determine whether the overall Medicaid network of providers are able to offer timely appointments to managed care members across MCOs. HSD provided a script to surveyors that measured time to a new patient appointment, an established patient appointment, and a sick/urgent patient appointment along with other data points including, but not limited to: whether the practice accepted Medicaid for reimbursement, whether the practice was accepting new patients, availability of extended hours, and the MCOs with which the practice was contracted. The script was designed to be conversational and without specific member information provided. Please see Attachment E: HSD Secret Shopper Survey Scripts.

HSD selected primary care physicians (PCPs) and three specialty care provider types from the State's Medicaid Management Information System (MMIS). Providers from the specialty areas of Cardiology, Obstetrics and Gynecology, and Pediatrics were surveyed. (See Attachment F: HSD Secret Shopper Survey Methodology). HSD staff members were trained to ensure consistency and reliability across surveyors. One-to-two attempts were made to reach a provider or practice. Except for new patient Cardiology appointments, the time-to-appointment statistics met or were earlier than the managed care contract standards defined in the Medicaid Managed Care Services Agreement. Additional items of note include: 13% of PCPs offer extended hours (evening or weekend hours or both); 93% of PCPs who were reached accept Medicaid and of

those 88% are contracted with all four MCOs; and only 2% of providers referred members to Urgent Care or an Emergency Room when asked how soon an established patient could be seen for a sick or urgent appointment. On average, established patients who identified as sick or needing an urgent appointment could be seen within one (1) business day. Time to appointment results are as follows.

PCPs

80% *of practices were reached of which* ***87%*** *are accepting new patients.* ***93%*** *accept Medicaid & of those* ***88%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	2 weeks	3-4 days	1 day

Cardiologists

100% *of practices were reached of which* ***93%*** *are accepting new patients.* ***79%*** *accept Medicaid & of those* ***100%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	7 weeks	3-7 days	Same day

Pediatricians

91% *of practices were reached of which* ***98%*** *are accepting new patients.* ***100%*** *accept Medicaid & of those* ***100%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	1 week	2-4 days	Same day-1 day

OB-GYNs

81% *of practices were reached of which* ***90%*** *are accepting new patients.* ***90%*** *accept Medicaid & of those* ***77%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	3 weeks	5 days	Same day-1 day

Transportation

In DY3 Q3, HSD does not have transportation issues to report.

Service Delivery

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program is for April 2016 through June 2016. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

During DY3 Q3, the pharmacy report workgroup continued to meet to review the pharmacy report. The HSD pharmacy workgroup determined additional adjustments were needed to standardize consistent methodologies across MCOs. Revisions to the pharmacy report will include monitoring drugs for the treatment of opioid dependence, alcohol and nicotine dependence, methadone use in pain management, HIV treatment, and utilization of antipsychotic medications in children. The data will include the total number of claims submitted as well as paid claims for unduplicated members and any prior authorization requirements. In addition, reporting of therapeutic classifications will be based on "Generic Product Indicators" to prevent the reporting of high numbers of miscellaneous items. As directed by CMS, elements required for Drug Utilization Review (DUR) reporting will also be included in the report revision. These revisions will reduce variance in reporting among MCOs and ensure a thorough analysis of pharmacy services.

On July 27, 2016, HSD provided the MCOs with an updated Letter of Direction (LOD) regarding the treatment guidance for chronic Hepatitis C virus (HCV) infection. The LOD included a revised Uniform New Mexico HCV Checklist for Centennial Care, provider network education, expanded role of care coordination, treatment criteria expanding screening efforts, and financial changes. It is HSD's goal to lower average drug treatment costs by 25% from the period July 1, 2015 – June 30, 2016 to the period July 1, 2016 – June 30, 2017.

Emergency Department Information Exchange (EDIE)

In July 2016, implementation of the Emergency Department Information Exchange (EDIE) project was launched in an effort to promote appropriate ED utilization. The EDIE project is a collaborative effort by all four MCOs. EDIE enables MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all Emergency Department and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical meta data. As a result of the notification, the provider has information in hand before seeing the patient. This allows the provider to take action and to influence health care outcomes. Furthermore, EDIE will reduce non-emergent visits, so the ER providers have the capacity to rapidly see those with emergent needs as well as reduce the associated costs due to unnecessary ED visits. It is anticipated EDIE will be implemented in December of 2016.

Community Health Workers (CHWs)

CHWs are trusted members of the community who work within the local health care system in rural, frontier, tribal and urban areas. CHWs have been referred to as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives, peer health promoters, peer educators, and community connectors. CHWs are in a unique position to provide interpretation and translation services, culturally appropriate health education, serve as liaisons between the member and the health care system by assisting them in obtaining needed care. CHWs are able to provide informal counseling and guidance on health behaviors while encouraging self-efficacy. CHWs' roles vary from community to community depending on the sector in which they work and the unique needs of their communities.

During DY3 Q3, an MCO conducted a train-the-trainer session on how to teach the diabetes and depression modules to other CHWs. The training included one module on depression and one module on "My Diabetic Plate" and eating healthy by understanding portions and how carbohydrates and how other foods impact blood glucose levels. Throughout Q3, all MCOs continued to cultivate and refine CHW services as needed by the member population served.

Telehealth

Through DY3 Q3, utilization of telehealth for both physical and behavioral health remains strong. Blue Cross Blue Shield of New Mexico (BCBSNM) reports that the majority of equipment funded for practices earlier this year resulted in an increase in behavioral health telemedicine bandwidth. All MCOs have active recruitment initiatives underway to pursue telehealth providers. Molina Health of New Mexico (MHNM) reported recruitment of Behavioral Health medication management providers as well as the purchase of block time services of BH medication management providers through an external vendor among the current priorities. All MCOs continue to provide technical assistance, as needed, to make sure practices understand correct coding.

Contract Amendments

Amended Centennial Care MCO contracts, Amendment 6, went into effect on July 1, 2016. Please see Attachment G: Centennial Care Contract Amendment #6.

Community Interveners (CI)

In DY3 Q3, there were seven 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.

HSD recently approved another provider to provide CI services, All 4 You Home Care Corp. HSD directed the MCOs to provide outreach to this provider for contracting for the CI service.

Table 2 – Community Intervener Services Utilization DY3 Q3

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBSNM	3	837.00	$5,289.75
MHNM	0	0	$0
UHC	3	436.00	$2,791.75
PHP	1	0	$0
Total	**7**	**1,273.00**	**$8,081.50**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date 606,681 distinct members have earned at least one reward, or 70.9% of enrollees. Table 3 shows the healthy behaviors rewarded and each behaviors value. It includes both the point and dollar value of the activity, the total dollars earned and the amount redeemed, and the associated percentage of redemption by activity.

Table 3 – Health 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	$ 907,770	$ 278,959	30.73%
Bipolar Disorder Management	750	$ 75	$ 1,003,845	$ 234,831	23.39%
Bone Density Testing	350	$ 35	$ 37,905	$ 7,906	20.86%
Healthy Smiles Adults	250	$ 25	$ 7,175,375	$ 1,389,435	19.36%
Healthy Smiles Children	350	$ 35	$ 17,089,555	$ 4,216,651	24.67%
Diabetes Management	800	$ 80	$ 4,119,620	$ 1,045,517	25.38%
Healthy Pregnancy	1,000	$ 100	$ 1,038,500	$ 263,194	25.34%
Schizophrenia Management	750	$ 75	$ 494,925	$ 97,707	19.74%
Health Risk Assessment (HRA)	100	$ 10	$ 4,082,300	$ 805,823	19.74%
Other (Appeals and Adjustments)	N/A	N/A	$ 398,210	$ 227,546	57.14%
Step-Up Challenge	500	$ 50	$ 434,075	$ 367,125	84.58%
Totals			**$ 36,782,080**	**$ 8,934,694**	**24.29%**

The table also reflects dental services as having the highest value of rewards earned at $24 million. This may suggest the availability of the rewards has led to the increase in dental visits, as well as the availability of dental coverage under Medicaid.

The Step-Up Challenge shows that members who complete the activity have a high likelihood of redeeming the reward. The Step-Up Challenge is an activity group that individuals have to opt-in to. The other activity groups are based on a health diagnosis.

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 Temporary Assistance for Needy Families (TANF) and Related Medicaid Eligibility Group (MEG) with Group VIII being the next largest group as reflected in Section III of this report. Overall enrollment continues to increase each quarter in almost every population.

The following table outlines all enrollment activity under the demonstration. The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment in each MEG. If members switched MEGs during the quarter, they were counted in the MEG they were enrolled in at the end of the reporting quarter.

Table 4 – Enrollment DY3 Q3

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – September 2016	Current Enrollees (Rolling 12 month period)	Disenrolled in Current Quarter
Population 1 – TANF and Related	384,101	363,815	7,372
Population 2 – SSI and Related – Medicaid Only	41,293	41,574	685
Population 3 – SSI and Related – Dual	37,694	40,264	613
Population 4 – 217-like Group – Medicaid Only	142	208	8
Population 5 – 217-like Group – Dual	2,617	2,910	48
Population 6 – VIII Group (expansion)	272,718	331,302	9,895
Totals	738,565	780,073	18,621

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 top three reasons for disenrollment are attributed to loss of eligibility, incarcerated individuals, 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 slight increase in disenrollment but only in certain populations and is tied to the overall increase in enrollment.

Table 5 – Disenrollment Counts DY3 Q3

Disenrollments	From 2016 Q2 to 2016 Q3		Total Disenrollments During Q3
Last Month Client was Disenrolled	**July 1, 2016**	**August 1, 2016**	
Population 1 – TANF and Related	3,119	4,253	7372
Population 2 – SSI and Related – Medicaid Only	341	344	685
Population 3 – SSI and Related – Dual	303	310	613
Population 4 – 217-like Group – Medicaid Only	5	3	8
Population 5 – 217-like Group - Dual	21	27	48
Population 6 – VIII Group (expansion)	4,404	5,491	9,895
Total Without MEG 7	8,193	10,428	18,621

Section IV: Outreach

In DY3 Q3, HSD continued to provide Centennial Care monthly informational training to staff of the New Mexico Aging and Long-Term Services Department, Adult Protective Services Division and the Aging and Disability Resource Center; Parents Reaching Out; and First Choice Community Healthcare. Other events HSD participated in include Senior Citizen Celebration-Healthy Living Day at the New Mexico State Fair; 38th Annual Conference on Aging Health and Enrichment Fair; and the Local National Recovery Month recovery event.

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

Description of Promising Practices for DY3 Q3

HSD continues to work on implementation of eligibility suspensions for justice-involved individuals. In Q3, automatic electronic interfaces and ASPEN system updates were implemented for the following facilities around the State: New Mexico Department of Corrections (NMDC); Bernalillo County Metropolitan Detention Center; Children, Youth and Families Department (CYFD), Juvenile Justice Division; Sandoval County Detention Center; Santa Fe County adult and juvenile detention centers; Doña Anna County adult and juvenile detention centers; and San Juan County juvenile detention center.

The automatic electronic interfaces and ASPEN system updates allow prison and jail facilities to send their daily booking and release records with no administrative intervention. The ASPEN system updates that were put into place allow HSD to electronically identify all Medicaid-eligible individuals who are incarcerated for more than 30 days. If the individual remains incarcerated for more than 30 days, the system automatically suspends Medicaid; HSD then reactivates Medicaid when the correctional facility informs HSD of the individual's release.

HSD also continues to conduct outreach and training for correctional and county detention center staff. In Q3 HSD conducted four trainings and certified 30 Presumptive Eligibility Determiners (PEDs) in correctional facilities. These PEDs are trained to help the justice-involved population apply for Medicaid while incarcerated when they do not have Medicaid or other health care coverage. The PEDs help justice-involved individuals get connected with their MCO care coordinators and help these individuals access Medicaid-covered services as quickly as possible upon release.

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

The MCOs submit encounters daily and/or weekly to stay current with their encounter submissions. HSD continues to work with the MCOs to respond to questions and address any issues related to encounters. HSD scheduled bi-weekly meetings with the MCOs to address any encounters that have been denied to work through those issues and educate the MCOs of system edits. HSD continues to monitor encounters by comparing encounter submissions to financials to ensure completeness.

Data is extracted on a monthly basis to identify Centennial Care enrollment by MCO and for different 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 and tracking of numbers. HSD continues to monitor enrollment and any anomalies that may arise so they are addressed and resolved timely with each MCO. HSD posts the monthly Medicaid Eligibility Reports to the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx and includes enrollment by MCOs and by county.

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

Program Development

In DY3 Q3, HSD conducted the following trainings:

- ***Care Coordination for Members enrolled in Centennial Care as well as those enrolled in the Developmental Disabilities, Mi Via, and Medically Fragile 1915(c) Waivers.*** The training included guidance on care coordination for members enrolled in the 1915(c) waivers, an overview of the 1915(c) Home and Community-Based Services Waiver Programs, completing a Comprehensive Needs Assessment and Comprehensive Care Plan for these members receiving waiver services, and member transitions from community benefit to a 1915(c) waiver program.

- ***Part II: Nursing Facility Level of Care (NFLOC) and Setting of Care (SOC) Requirements.*** The training covered system requirements for the MCOs when submitting NFLOC and SOC changes for member's who have Appeals, Fair Hearings, and Level of Care Denials.

MCO Initiatives

- Molina Healthcare of New Mexico (MHNM):
  - Maternal Fetal Medicine Initiative to address NICU admissions, low-birth weights, and preterm deliveries;
  - Opioid Reduction Program to address inappropriate opioid utilization which can result in increased ER visits, worsening of medical conditions, and health care costs;
  - Partnership with Central Consolidated School District (CCSD) to sponsor, "Creating Change through Knowledge" and conduct outreach in the community to focus on behavioral health and suicide prevention resources; and
  - Propeller Health Pilot to develop a program for MHNM members to reduce asthma acerbations, improve member asthma medication management, and reduce the number of preventable ER visits and hospitalizations related to Asthma exacerbations.
- Presbyterian Health Plan (PHP):
  - Video Visits – Improve member engagement rates with Disease Management and Care Coordination by improving the following key results:
    - Increased member satisfaction;
    - More personalized service vs. telephonic coaching;
    - Reduction in ED visits for members in Disease Management; and
    - Improved A1C for members in Disease Management.
- Blue Cross Blue Shield of New Mexico (BCBSNM):
  - Created an overall guide to pre-manage ED (EDIE) with other MCOs to be distributed to organizations and emergency rooms across the State;

    - In the process of updating system logic to omit member mailings from being sent to HSD when only the HSD mailing address is provided on the enrollment file. This new process will reduce the number of mailings being sent to HSD; and
    - Successfully managed workgroup for Behavioral Health Provider Critical Incident Reporting Protocol.
- United Healthcare (UHC):
    - Onsite Readiness Review: Community Care – Joint review with HSD to demonstrate new clinical system; and
    - Community Benefit Care Plan Monitoring/Audits by achieving 100% for all three focus areas including:
        - Member record includes a completed CNA, CCP with specific goals and corresponding documentation;
        - Documentation clearly identifying the care coordinator is addressing member specific needs; and
        - Evidence of a completed PCS Allocation Tool that is complete and accurate.

Unreachable Member Campaign

The HSD directed Unreachable Member Campaign concluded on June 30, 2016 and in Q3 results were analyzed. Each MCO had fluctuations in performance as it initiated and refined its strategies and processes. Overall, the MCOs exceeded the established goals. The data reflects that a total of 248,513 previously "unreachable" members were successfully reached by MCOs during the campaign. The percent of Unreachable Members, as compared to enrollment, decreased to 11.6%. In addition, 164,267 total Health Risk Assessments (HRAs) were completed for members who had initially been unreachable. From January 2015 through June 2016, the number of Members Reached can be compared to HRAs Completed for a penetration rate of 73.3%.

Beginning July 1, 2016, an annual Health Risk assessment is no longer required for members who are not in higher levels of care (Care Coordination Levels 2 and 3). Rather, MCOs are required to conduct an initial HRA for members newly enrolled in Centennial Care and a new HRA for members who are identified as having a change in health status. A member can also self-report a change in health status, and the MCO will complete a new HRA to determine the member's appropriate level of care. For the population of members who are not assigned a higher level of care, MCOs will focus on accessing available utilization and claims data, including Emergency Room visits, services and supports history, medications and medication history in order to identify a member's current and emergent needs related to Care Coordination. Care Coordination anticipates members' needs rather than responding to emergencies or exacerbated health conditions.

Electronic Visit Verification (EVV)

In DY3 Q3, HSD extended the date for mandatory full implementation of the EVV system for members receiving Personal Care Services (PCS) to November 14, 2016. This was due to resource issues with the tablet vendor, and an unexpected high demand for tablets. Many "no tech zone" providers have already begun using the tablets and are implementing ahead of the deadline.

Behavioral Health

SAMHSA Monitoring Visit

The Substance Abuse and Mental Health Services Administration (SAMHSA) had selected New Mexico as one of ten sites for a federal fiscal year (FFY) 2016 combined Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant monitoring visit. The visit was conducted on August 2-4 and included staff from the Center for Mental Health Services, the Center for Substance Abuse Prevention, Center for Substance Abuse Treatment, and Office of Financial Resources. The purpose of the visit was to assess New Mexico's compliance with the authorizing legislation and implementing regulations governing the block grants, as well as, SAMHSA's statutory fiscal and financial management policy. In preparation for the visit, BHSD submitted requested pre-site visit materials. SAMHSA visited with staff from HSD and CYFD, OptumHealth and other contractors and stakeholders. Visits were conducted with a variety of behavioral health provider organizations. BHSD received a teleconference debrief roughly four weeks after the onsite visit. Feedback overall was positive but a final report may take as long as a year and a half.

Medical Detoxification

Medically managed inpatient detoxification is a Medicaid reimbursable service if provided in general hospital settings. Standardized evidence-based protocols are available to systematically guided medically managed detoxification, but too often this has not been part of regular practice among general hospitalists and nurses in New Mexico. In order to increase capacity within the New Mexico healthcare system, it is important to disseminate best practices for screening patients who are risk for complicated withdrawal and treatment algorithms for medically managed detoxification.

An educational summit entitled, *Demystifying Hospital and Ambulatory Based Detoxification and Withdrawal* was convened on June 18, 2016 at the University of New Mexico (UNM). It was co-sponsored by UNM Hospitals, UNM Department of Psychiatry and Behavioral Sciences, New Mexico Behavioral Health Collaborative, Presbyterian Health Plan, the New Mexico Hospital Association and UNM Continuing Medical Education & Professional Development. Unfortunately, hospital staff was not well represented. As a result, planning has been initiated to bring this training first to areas served by Certified Community Behavioral Health Clinics (CCBHC) with Las Cruces designated as the first priority. In addition, Dr. Carli Bonham and Dr. Wayne Lindstrom presented on this topic and the ASAM levels of social detox before a

joint meeting of the Taos County Commissioners and the Taos City Council in September 2016. This meeting was followed by a meeting with the leadership at Holy Cross Hospital around the need to make medical detox more available and accessible.

Adolescent Substance Use Reduction Effort (ASURE)

Children Youth and Family Division's (CYFD) – Behavioral Health Division has used the State Youth Treatment Planning Grant (SYT-P) to institute an Interagency Council called the Adolescent Substance Use Reduction Taskforce (ASURT). This taskforce was convened on June 28, 2016 by CYFD Cabinet Secretary Monique Jacobson. ASURT has representation and active collaboration with multiple state agencies, providers, research institutions and other community stakeholders to create a three-year plan to improve behavioral health services for youth and families in New Mexico. This taskforce has formed three subcommittees to focus efforts on the following areas:

1. Behavioral Health Workforce Mapping;
2. Financial Mapping; and
3. Strategic Planning.

Each subcommittee has met and progressed with all three efforts. ASURE received Technical Assistance (TA) from SAMHSA onsite in July. This visit provided the project with feedback from the TA providers and from stakeholders who participated in the visit. The next meeting is scheduled for October 18, 2016 and will provide ASURT with report from the three subcommittees. This meeting will provide another opportunity for stakeholders to provide input into the planning process. Dr. Wayne Lindstrom attended the kick-off meeting on June 28, 2016, and plans to attend a site visit in July.

New Mexico SMVF In-State Policy Academy

Since 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been using the Policy Academy (PA) model to engage interagency teams from states and territories to support the development of strategic plans for strengthening the behavioral health systems for service members, veterans, and their families (SMVF). The SMVF Technical Assistance Center (SMVF TA Center) has been working with state and territory teams providing technical assistance and training to PA graduates and supporting the engagement of new states and territories in the process. The New Mexico In-State Policy Academy was convened by the New Mexico Department of Veterans' Services under the direction of the Governor on June 21-22, 2016. Following the June Leadership Brief, the New Mexico team has started a campaign to identify existing New Mexico resources and assess those that have a mission to help veterans.

The team has also initiated a Memorandum of Understanding (MOU) with the New Mexico Corrections Department to facilitate warm handoff actions for those incarcerated veterans that were under behavioral health clinical supervision. Work is also underway with New Mexico State University to utilize graduate students to analyze large data sets to determine where the

greatest need for behavioral health services for this population is in the State. The team has been aligned into three subcommittees: Administration, Health, and Education. The Policy Academy is constantly providing guidance and best practices from other states to help find solutions to the problems experienced by SMVF. The administrative team will be publishing the Academy's New Mexico Action Plan, which will evolve as services are secured and other initiatives are implemented.

Behavioral Health Strategic Plan

The Implementation Team continues to meet bi-weekly to identify appropriate steps and timeframes for all the activities under the Goals and Objectives, and identify individuals or groups to assume relevant tasks. An 18-month Implementation Plan Matrix was developed which tracks progress on all the goals and activities in the three major goal areas.

A progress report will be presented at each quarterly meeting of the Behavioral Health Collaborative throughout the 18-month implementation period. An evaluation of the Plan will be completed at the conclusion of its implementation.

Some of the accomplishments, during DY3 Q3, are highlighted below:

The Regulations Workgroup Goals:

1) To identify, align and eliminate inconsistencies in behavioral health statutes, regulations, and policies in order to allow for more effective and efficient operation of the publicly-funded service delivery system: Departmental interviews are underway to determine behavioral health-related regulatory barriers; and

2) To increase the adoption of person-centered interventions: The "Treat First" six-month trial period and evaluation were completed. (The "Treat First" section of this report regarding provides more information about this topic.)

The Finance Workgroup Goals:

1) To increase the productivity, efficiency and effectiveness of the current provider network;

2) To implement a value-based purchasing (VBP) system that supports integrated care and reinforces better health outcomes: VBP report was presented to HSD Secretary in July, 2016; and

3) To identify, develop and promote implementation of effective strategies for the State, counties and municipalities to work together to fund the provision of better behavioral health care, especially for high utilizers: In August, a meeting was convened with County behavioral health leadership to explore potential synergies. A special pre-conference day is being planned for the semi-annual Association of Counties meeting in January, 2017 entitled Behavioral Health Innovations by/in Counties to Explore Accomplishments in Innovations Statewide.

The Workforce Workgroup Goal:

1) To support the development of behavioral health practitioners: A survey of behavioral health providers for current behavioral health intern placements has been completed; an inventory of graduate behavioral health programs to determine intern candidates needing placements is underway; a Behavioral Health Clinical Provider Guide is being developed for Fall orientations to students enrolled in behavioral health-related professional programs; and the behavioral health subcommittee of the Health Workforce Committee is reviewing findings on barriers to reciprocity;

2) To build a more multidisciplinary and competent behavioral health workforce; A Medicaid Supplement related to Nursing has been drafted; and a gap analysis on behavioral health EHR adoption has been completed; and

3) To promote the future of excellence in the behavioral health workforce and prepare for integrated care: An Integrated Quality Service Review methodology has been developed and related Clinical Practice Improvement training has been provided to three FQHC's in southern New Mexico.

CareLinkNM – Health Homes

New Mexico's health home project, CareLinkNM, continues to develop. Approximately 350 Medicaid members are enrolled in a CareLinkNM Health Home. The CareLinkNM Health Homes incorporated New Mexico's Treat First Model, allowing a member to be assessed over a period of 4 visits to treat the member's immediate needs and keep the member engaged. The Steering Committee for the project met with the two current health homes sites to identify lessons learned from their experience and areas in which future health home processes can be improved. Some of the areas identified for future improvement include: release of information processes and lack of familiarity with Memoranda of Understanding in small primary care practices, changes to the application process for new health homes, experiences with community liaison and health promotion staff, use of peer support, and a need for more flexibility in staffing. Providers also indicated that integrated care and the relationships with small providers is a culture change and will take time, though some progress in both communities has been made. HSD and the steering committee will review the areas identified for improvement and incorporate necessary changes to the CareLinkNM Policy Manual based on lessons learned.

Behavioral Health Investment Zones (BHIZ)

BHSD received a $1 million allocation in FY16 for the establishment of Behavioral Health Investment Zones. The two counties, Rio Arriba and McKinley Counties have submitted their year 2 plans and budgets for review.

The Rio Arriba County BHIZ convened "Our Enterprise" Table Top Sim Day, October 4, which included approximately 50 representatives from BHIZ partner agencies, MCOs and other community providers. The four-hour Sim Day began with an overview by Rio Arriba County Health and Human Services Director, Lauren Reichelt and health planning consultant, Anne Hays Egan. The large group then divided into two small groups to work on a series of simulation scenarios.

The large group reconvened for further discussion to examine the different options available to someone needing detox resources – both services and gaps. Medical detox is available for a very small percentage of people seeking detox, based upon hospital admitting criteria. Social detox is available through a number of programs in nearby counties. In addition, short-term rehab services are available through the BHIZ network as well as other facilities that are working informally in collaborative relationships with the BHIZ Hub and partner agencies. The challenges which the BHIZ network core agencies will address is facilitating clients in their effort to be admitted to short-term detox or rehab, providing intensive case management support to clients as they access services. They also stressed the importance of intensive case management for clients at risk. BHIZ is using the Pathways outcome-focused system for tracking outcomes, which has been an important national model.

McKinley County BHIZ has redesigned their approach after recognizing the breadth of the challenges that those with behavioral health challenges face. The Gallup McKinley County-BHIZ (GMCK-BHIZ) year two plan includes the following goals:

- Provide direct, intensive services to the "Top 200" chronic, repeat protective custody/public inebriation clients, moving 25% from the abuse/shelter cycle into the path of recovery along the continuum of services, and contribute toward sustenance of core operations of the Gallup NCI Sheltercare & Detox Center.
- Identify the social detox clients with the highest annual rate of utilization of the NCI facility/program.
- Establish a cost basis for providing both standard social detox/sheltercare services and intensive services to the "Top 200" clients.
- Establish cost of "next step" residential treatment services for a pilot sample of 24 (12 %) of the "Top 200" clientele.
- Establish BHIZ contribution to core therapeutic and paramedical operations of the Gallup Sheltercare & Detox Center.
- Continue to develop the GMCK-BHIZ Network.

- Establish of inter-agency agreements and protocols for ensuring continuum of services for BHIZ clients.
- Design and implement case management database for use by the BHIZ Case Manager and case managers representing all participating providers.
- Coordination and support for stakeholder working groups.
- Monitoring and evaluation of the BHIZ program.
- Ongoing strategic planning and funding development for the BHIZ system.

PAX Good Behavior Game

The PAX Good Behavior Game (PAX GBG) has been found to reduce disruptive behaviors, hyperactivity, and emotional symptoms. According to the PAX literature, PAX GBG are found to have long term outcomes that include reduced need for special education, reductions in drug and alcohol addictions, reduction in serious violent crime, suicide contemplations and attempts, reduction in initiation of sexual activity, and an increase in high school graduation rates and college attendance. The most recent cost benefit analysis on the PAX GBG conducted by the Washington State Institute for Public Policy has shown that the program returns $57.53 for every $1 invested.

The final results were reported for the 2016 PAX GBG New Mexico spring pilot across the following participating school districts:

- Bloomfield Public Schools: 62% reduction in disruptive behaviors (as compared to initial report of 41%);
- Espanola Public Schools: 57% reduction in disruptive behaviors (as compared to initial report of 44%); and
- Santa Fe Public Schools: 65% reduction in disruptive behaviors (as compared to initial report of 34%).

During fall 2016, Espanola Public School and Santa Fe Public School districts committed to support the trainings, with approximately 75 new teachers. This resulted in an additional 2,331 students receiving PAX GBG without additional State funding (last year, 3,329 new students received PAX with state funding).

- Espanola Public Schools (EPS) held a two-day PAX GBG teacher training September 30, 2016 with Claire Richardson of PAXIS Institute: New teachers in grades K, 1, 2, 3, and 4, as well as all teachers in grades 5 and 6 participated in the training. There are now 70 elementary teachers trained. At approximately 14 students per classroom, an additional 630 students will be reached. EPS used district funds of $17,445 to cover the training and materials.
- Santa Fe Public Schools (SFPS) worked with Dr. Dennis Embry and PAXIS Institute staff to set up a six-part series of web-based teacher trainings which began October 4, 2016. Thirty new teachers in 10 schools were selected to participate across the district.

This initial training will be followed by five - 90 minutes classes. In these ten schools, 120 teachers are now trained in PAX GBG. This includes both general and special education teachers and 1,171 students participating in PAX GBG. SFPS used $6,000 in district funding to support the trainings.

- Training for principals in SFPS occurred in October 2016 with Dr. Embry: Thirty principals and seven administrators participated in this training.

Lastly, a PAX GBG Community Forum with Dr. Embry and several Farmington and Bloomfield teachers occurred on October 12 at the UNM Dominici Auditorium in Albuquerque, New Mexico. The purpose of the Forum was to educate Albuquerque Public School District administrators and teachers about the opportunity PAX GBG presents to improve student performance and free up teachers' time to what they love most—to teach.

Crisis Triage and Stabilization Centers

Established by HB 212, a Crisis Triage and Stabilization Center is a health facility that is licensed by DOH with programmatic approval by BHSD. These Crisis Triage Centers (CTCs) are not expected to be physically part of an inpatient hospital or included in a hospital's license. CTCs are intended to provide stabilization of behavioral health crises, including short-term residential stabilization. HSD has been working with DOH to establish the new standards for facility licensing and internally to establish the new level of care and program reimbursement mechanisms. Communities will be allowed to choose from a variety of models, including solely outpatient and also detox services that don't exceed medically monitored detox at ASAM level 3.7.

DOH has drafted rules both for facility licensing serving adults. The draft rules are currently under review by HSD. While the initial draft rules focus on adults, CYFD and DOH are expected to collaborate on drafting standards for facilities that would serve adolescents. Collaborative agencies will be notified when rules are available for public input.

Fiscal Issues

Managed care rates effective July 1, 2016 and August 1, 2016 were implemented for all programs. These rates contain the first round of cost containment measures implemented by the HSD. As discussed in the DY3 Q2 report, these measures are restricted to rate reductions for specific providers including inpatient hospitals, outpatient hospital and dental providers.

HSD and its actuary began work on rate development for CY17. As the State continues to face budget deficits, HSD continues to pursue long-term cost containment measures for Medicaid which will be factored into future rate 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.

Systems Issues

HSD continues to run reports to conduct ongoing auditing and analysis of NFLOC assessments to ensure compliance with criteria. HSD conducted another in-depth process training with the MCOs to address issues related to staff turnover and gaps in knowledge. HSD continues to monitor reporting to identify discrepancies that may arise.

Medicaid Management Information System (MMIS) Replacement

HSD began its planning for replacement of its current legacy Medicaid Management Information System (MMIS) some time ago, and activity for this effort progressed in Q3. The selected Independent Verification and Validation (IVV) vendor began work in August 2016. The first module of the State's Framework for MMIS Replacement (the Integration Platform vendor) was approved by CMS and was released in late August. Work on the next module, the Enterprise Data Services RFP, began with stakeholders, including the MCOs, provider associations, tribal and Indian health agencies, multiple agency State staff, and the Medicaid Advisory Committee. The draft RFP has been submitted to CMS for review.

HSD has reviewed the new CMS certification and modularity guidance and has taken steps to ensure that it is in compliance. This includes hiring an employee whose sole responsibility is to ensure compliance with the certification and MITA guidelines. The newly issued guidance on the role and responsibilities of the System Integrator has caused the State to revisit both the IP and Data Services RFPs.

The replacement MMIS will be a true Enterprise system, so the Department has actively engaged the allied departments of Health, Children Youth and Families, and Aging and Long Term Services. These three departments have participated in RFP development and replacement planning.

HSD is working with its two prime existing vendors on matters related to the replacement system. An amendment with Xerox 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 amendment to have the ASPEN system assume responsibility for managed care enrollment of members also includes provisions for Real Time Eligibility. CMS has approved the amendment and plans.

The Implementation Advance Planning Document Update that was submitted to the Regional Office in March with an updated planning document has been approved by CMS for federal fiscal year 2017.

Section VII: Home and Community-Based Services (HCBS)

New Mexico Independent Consumer Support System (NMICSS)

The NMICSS is a system of organizations that provide standardized information to beneficiaries about Centennial Care, LTSS, the MCO grievance and appeals process, and the fair hearing process.

The NMICSS reporting for the quarter is provided by the Aging and Long-Term Services Department (ALTSD), Aging & Disability Resource Center (ADRC). ADRC coordinators provide over the phone counseling in care coordination to resolve issues. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions.

The numbers below reflect calls made to the ADRC hotline from July 1, 2016 to September 30, 2016.

Table 6 – ADRC Call Profiler Report

Topic	# of Calls
Home- and Community-Based Care Waiver Programs	2,618
Long-Term Care/Case Management	198
Medicaid Appeals/Complaints	16
Personal Care	81
State Medicaid Managed Care Enrollment Programs	18
Medicaid Information/Counseling	1,358

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from July 1, 2016 to September 30, 2016.

Table 7 – ADRC Care Transition Program Report

Counseling Services	# of hours	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		125	
Medicaid Education/Outreach	238		
Nursing Home Intakes		66	
*Pre/Post Transition Follow-up Contact			1,263
**LTSS Short-Term Assistance			129

***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 new reporting category. Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed decisions about appropriate LTSS 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) provides assistance to Medicaid beneficiaries enrolled in Centennial Care receiving LTSS (institutional, residential and community-based) in navigating and accessing covered health care services and supports. CTB staff serves as advocates and assists individuals by linking them to both long-term and short-term services and resources within the Medicaid system and outside of that system. CTB staff also monitors to ensure services identified as a need are provided by the MCO, MCO subcontractors and other community provider agencies. Its main purpose is to help consumers identify and understand their needs and to assist them in making informed decisions about appropriate LTSS 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 challenges with member transitions.

Critical Incidents (CI)

HSD continues to work with the CI workgroup in an effort to provide technical assistance to the MCOs. The workgroup supports the Behavioral Health Services Division (BHSD) on the delivery of BH 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. The CI workgroup meetings continue to be held quarterly and the annual Critical Incident Reporting trainings will be held early November 2016.

CIs are reported by each MCO to HSD quarterly. This data is trended and analyzed by HSD.

During Q3, a total of 4,368 CIs were filed. 100% of critical incidents received through the CI web portal are reviewed. All deaths reported through the CI Reporting System are reviewed by HSD and the MCOs.

MCOs identified the use of Emergency Services as the highest CI type reported by volume for members with reportable category of eligibility (COE).

- Emergency Services reports account for 63% of the total CIs reported in Q3 (2,754), which is a slight 0.4% increase compared to Q2 (2,744). No specific reason has been attributed to the slight increase. HSD will continue to monitor any decrease or increases of emergency service reports.

- MCOs have member initiatives underway that include interventions for high utilizers of the Emergency Department that includes education on appropriate use of emergency services and alternative, more appropriate settings of care.

Table 8 – DY3 Q3 Critical Incidents

Critical Incident Types by Population Group						
Critical Incident Types	**Centennial Care**		**Behavioral**		**Self Directed**	
	#	**%**	**#**	**%**	**#**	**%**
Abuse	315	7%	111	21%	24	13%
Death	{422}	10%	{23}	4%	{15)	8%
Natural/Expected	379	9%	17	3%	15	8%
Unexpected	38	1%	5	1%	0	0%
Suicide	5	0%	1	0%	0	0%
Elopement/Missing	34	1%	15	3%	0	0%
Emergency Services	2754	63%	293	57%	118	61%
Enviormental Hazard	86	2%	8	2%	5	3%
Exploitation	129	3%	10	2%	13	7%
Law Enforcement	109	2%	22	4%	5	3%
Neglect	519	12%	35	7%	12	6%
Total	**4368**		**517**		**192**	

Table 9 – Critical Incidents by MCO

Critical Incident Types by MCO - Centennial Care								
Critical Incident Types	**BCBS**		**Molina**		**Presbyterian**		**UHC**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Abuse	37	4%	119	8%	71	11%	88	7%
Death	110	13%	127	8%	67	10%	118	9%
Elopement/Missing	3	0%	11	1%	9	1%	11	1%
Emergency Services	535	63%	1,045	70%	357	54%	817	61%
Environmental Hazard	10	1%	26	2%	26	4%	24	2%
Exploitation	21	2%	32	2%	25	4%	51	4%
Law Enforcement	20	2%	45	3%	17	3%	27	2%
Neglect	115	14%	95	6%	95	14%	214	16%
Total	**851**		**1,500**		**667**		**1,350**	

Critical Incident Types by MCO - Behavioral Health								
Critical Incident Types	BCBS		Molina		Presbyterian		UHC	
	#	%	#	%	#	%	#	%
Abuse	7	26%	69	18%	29	33%	6	21%
Death	2	7%	17	5%	4	5%	0	0%
Elopement/Missing	0	0%	6	2%	8	9%	1	3%
Emergency Services	12	44%	238	64%	26	30%	17	59%
Environmental Hazard	0	0%	4	1%	4	5%	0	0%
Exploitation	1	4%	5	1%	2	2%	2	7%
Law Enforcement	3	11%	14	4%	3	3%	2	7%
Neglect	2	7%	20	5%	12	14%	1	3%
Total	27		373		88		29	

Critical Incident Types by MCO - Self Directed								
Critical Incident Types	BCBS		Molina		Presbyterian		UHC	
	#	%	#	%	#	%	#	%
Abuse	1	4%	10	20%	7	11%	6	11%
Death	3	12%	3	6%	3	5%	6	11%
Elopement/Missing	0	0%	0	0%	0	0%	0	0%
Emergency Services	18	69%	29	58%	40	63%	31	58%
Environmental Hazard	0	0%	1	2%	2	3%	2	4%
Exploitation	4	15%	3	6%	4	6%	2	4%
Law Enforcement	0	0%	1	2%	3	5%	1	2%
Neglect	0	0%	3	6%	4	6%	5	9%
Total	26		50		63		53	

HCBS Reporting

The public comment period for New Mexico's Statewide Transition Plan (STP) ended on September 19, 2016. CMS provided feedback to HSD on the STP Systemic Assessment in September 2016. HSD made the requested changes and will resubmit the entire STP to CMS by the end of October 2016.

Community Benefit

In July 2016, the Community Benefit Services Questionnaire (CBSQ) pilot results were presented to the Long-Term Care (LTC) Workgroup. HSD developed criteria for administering the questionnaire to ensure that it will be an appropriate and effective tool. The CBSQ was finalized in September 2016. HSD will issue detailed direction to the MCOs in October 2016. The MCOs will train their care coordinators in October and fully implement the CBSQ by November 14, 2016. HSD will monitor the implementation through “ride-alongs” with care coordinators.

The LTC Workgroup also focused on implementing the requirements of the HCBS Statewide Transition Plan (STP) for certain services within the Community Benefit package. The MCOs provided feedback on the latest version of the STP prior to submission to CMS. The MCOs plan to create a letter for providers to explain the requirements of the STP.

On August 4, 2016 HSD presented on the Centennial Care personal care and respite services to the New Mexico Association for Home Health and Hospice Care (NMAHHC). On September 1, 2016 HSD provided training to the MCO long-term care and systems staff on proper submission of the NFLOC and Setting of Care data related to denials and closures.

In DY3 Q3, HSD met with one of its MCOs to discuss the alignment of MCO selection for Centennial Care members who are also eligible for Medicare. The discussion involved providing education to members to explain the benefits of aligning their Centennial Care MCO selection with the Medicare plan administered by the same MCO. The MCO will collaborate to develop an effective communication strategy.

Section VIII: AI/AN Reporting

Access to Care

Indian health facilities, Indian Health Service, Tribally operated facility/program, and urban Indian clinics (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 (IHS) and Tribal 638 clinics at any time. The last quarter data from the four Centennial Care MCOs shows there is 96% access to PH care for Native Americans in rural areas and 98% access to PH care for Native Americans in frontier areas.

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. There are formal contract agreements in place for:

- Health Risk Assessment completions;
- Translation services;
- Transportation services;
- Durable Medical Equipment;
- Optometry and Vision services;
- Disease management; and
- Peer Support/Wellness Centers.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements 97% of the time for claims being processed and paid within 15 days of receipt.

Table 10 – Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)

MCO	Date of Board Meeting	Issues/Recommendations
BCBSNM	Zuni Tribal Health Zuni, New Mexico July 29, 2016	There were questions about how the vision benefit works, how to use the member rewards programs, the length of time to receive reimbursement for the traditional healing benefit, how to reach a care coordinator, and if the meetings could be extended to allow for translation. BCBSNM addressed all of the issues with the members and followed up on all requests.

MCO	Date of Board Meeting	Issues/Recommendations
MHNM	Butterfly Healing Center Taos, New Mexico July 7, 2016	MHNM held their advisory board meeting at the adolescent treatment facility at Taos Pueblo. There was a request to simplify the paperwork for the traditional healing benefit. MHNM explained the importance of members completing the HRA.
PHP	Isleta Pueblo, New Mexico September 16, 2016	The question was asked if PHP does criminal background checks for home healthcare companies. The response yes, one is done by the home healthcare agency. If the member has concerns, bring it to the attention of the care coordinator. PHP explained how often a health assessment and comprehensive needs assessment is completed. There was a request for PHP to offer acupuncture as a value added service.
UHC	Dulce Community Center Dulce, New Mexico September 26, 2016	The Vice President of the Jicarilla Apache Nation was present for the NAAB meeting. He expressed concern about substance abuse, PTST among veterans, and correctional system involvement with Tribal members. His administration would like to build strong partnerships and have UHC "come along side". There was discussion about ways the Tribe could be a transportation provider so that there is accessibility for members to get to their medical appointments.

The NATAC meeting for this quarter took place on August 29, 2016. HSD presented on the Access Monitoring Review Plan (Tribal Notification 16-13). HSD also reviewed the State's 2016 General Appropriations Act and provided an update on the work of three Cost Containment Subcommittees, the FY17 Provider Rate Changes, the FY17 Professional Fee Schedule changes, and a list of all the cost-containment Public/Tribal Notifications that have been sent out. There also was an update on work to implement the new federal interpretation of 100% FMAP for services "received through" an IHS/Tribal facility.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment H: MCO Action Plans and Attachment I: Notice to CMS and Directed Corrective Action Plan

Section X: Financial/Budget Neutrality Development/Issues

Attachment A – Budget Neutrality Monitoring, Table 3 "PMPM Summary by Demonstration Year and MEG" shows the immediate impact of cost containment for the most populous MEGs. MEGs 1 and 6 show a declining PMPM in DY3 as compared to DY2.

The reprocessing of the LTSS capitations for the period January 2016 through June 2016 for the new certified rates has yet to occur. The reprocessing will occur in November and December 2016. With the reprocessing, the next quarterly report will have changes to the PMPMs for MEGs 2 through 5.

Section XI: Member Month Reporting

The table below provides the member months for each eligibility group covered in the Centennial Care program for this reporting period.

Table 11 – DY3 Q3 Member Months

Centennial Care MEG Reporting	
Eligibility Group	**Member Months**
Population 1 – TANF and Related	1,162,954
Population 2 – SSI and Related – Medicaid Only	123,735
Population 3 – SSI and Related – Dual	111,164
Population 4 – 217-like Group – Medicaid Only	454
Population 5 – 217-like Group – Dual	7,635
Population 6 – VIII Group (expansion)	770,223
Population 7 – CHIP Group	134,000
Total	2,310,165

Section XII: Consumer Issues (Complaints and Grievances)

A total of 871 grievances were filed by Centennial Care members in DY3 Q3 and involved each MCO equally. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 207 (23.76%) of the total grievances received. All four MCOs report decreases in the number of transportation grievances received in Q3 when compared to 211 in Q2 and 272 in Q1. HSD is developing a process for the MCOs to report their improvement activities related to reoccurring grievances. The MCOs acknowledged the identified trend with transportation grievances and continue to meet regularly with their transportation vendors to address identified issues.

The second top grievance filed, with a total of 138 grievances (15.84%), was regarding other specialties, such as dissatisfaction with payment on services provided. The grievances within this category do not identify a specific trend. MCO staff continues to educate providers in billing issues on a case by case basis.

The third top grievance filed, with a total of 86 grievances (9.87%), was regarding the Centennial Care member's PCP. Specific member grievances relate to dissatisfaction of service, staff member attitudes, prescriptions not being provided and service authorization issues. The MCOs actions include outreach and education to the provider by resolutions analysts.

The remaining 440 (50.51%) grievances filed during Q3 were reported for multiple grievance reasons, such as dental, emergency room and provider specialist issues. Specific reasons include staff member attitudes, billing issues, and quality of service. MCOs are working with internal departments to analyze data and identify opportunities for process improvements.

HSD continues to monitor grievances to identify specific trends.

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 DY3 Q3.

Table 12 – DY3 Q3 Service Plan Audit

Service Plans	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	**120**	**120**	**120**	
Percent of service plans with personalized goals matching identified needs	**100%**	**100%**	**100%**	
Percent of service plans with hours allocated matching needs	**100%**	**100%**	**100%**	

NFLOC

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

Table 13 – DY3 Q3 NFLOC Audit

High NF denied requests (and downgraded to Low NF)	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	10	17	18	
Number of member files that met the appropriate level of care criteria	10	17	18	
Percent of MCO level of care determination accuracy	100%	100%	100%	

Table 14 – DY3 Q3 Community Benefit LOC Audit

Community Benefit denied requests	DY2 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	16	20	20	
Number of member files that met the appropriate level of care criteria determined by the MCO	16	20	20	
Percent of MCO level of care determination accuracy	100%	100%	100%	

The External Quality Review Organization (EQRO) for HSD reviewed a random sample of MCO NFLOC determinations. All reviews by the EQRO that were in disagreement with the MCO determination were then reviewed by HSD. HSD continues to meet with the MCOs regarding these determinations and to provide technical assistance on low and high NFLOC criteria.

Table 15 – EQRO NF LOC Review

Facility Based	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
High NF Determination				
Number of member files audited	**24**	**28**	**26**	
Number of member files the EQRO agreed with the determination	**18**	**20**	**19**	
%	**75%**	**71%**	**73%**	
Low NF Determination				
Number of member files audited	**84**	**80**	**82**	
Number of member files the EQRO agreed with the determination	**83**	**78**	**82**	
%	**99%**	**98%**	**100%**	
Community Based				
Number of member files audited	**156**	**156**	**156**	
Number of member files the EQRO agreed with the determination	**155**	**153**	**154**	
%	**99%**	**98%**	**99%**	

Care Coordination Monitoring Activities

Care Coordination Audits

Evidence from the care coordination audit conducted in November 2015 indicates that training offered by HSD, BHSD and the MCOs resulted in improved quality of documentation and integration practices. However, the audit also identified the MCOs will need to continue to implement procedures in the areas of addressing potential BH needs through more detailed documentation and ensuring updates to assessment, medications, progress on members goals, and a clear backup and disaster plan are properly updated in the member's file. Face-to-face meetings were conducted with the MCOs in July and August 2016 to address their internal action plans approved by HSD. Continued evaluation of monthly MCO plans is ongoing. Additional HSD responses will be sent to the MCOs by December 2016. Development of new HSD care coordination audit criteria shall be completed by December 2016, including review of the implementation of the new standardized Health Risk Assessment (HRA) tool by all MCOs effective July 1, 2016.

HSD continued to provide technical assistance as needed to all of the MCOs as it relates to care coordination. Collaboration with internal HSD staff and MCOs has been provided by way of consultation specific to MCO members who have complex needs, primarily behavioral health, to determine ways to effectively engage members to work with care coordinators directly. Education has been provided to internal HSD staff and to an MCO to utilize required processes with high health risk/high resource utilizers by using "Engagement of Members" policies.

Care Coordination for Super Utilizers

HSD continued to evaluate the progress of the 10 super utilizers of ED services (defined as having greater than four out-patient ED visits in the past 12 months) from each MCO which were reported in the DY2 Q4 report. Each MCO continues to submit monthly reports to HSD on care coordination efforts to engage the identified members and to work with these members on education of appropriate use of the ED. HSD met with each of the MCOs individually in May 2016 to provide technical assistance and further discuss successes and challenges with each of their identified members. HSD expanded the number of members participating in the project to 35 per MCO and enhanced monthly data reporting elements for the project. ED visits have decreased for the initial 40 members by 67% during the time period of July 2015 through July 2016. HSD plans to provide data analysis to date and revised reporting template with instructions to all MCOs individually in November 2016 and to organize an in person meeting with all MCOs in January 2017 to review and share information gleaned from the project and outline effective approaches used to engage members successfully.

Care Coordination and EDIE

HSD began monthly participation in the statewide "ER is for Emergencies" committee in July 2016. Also known as the EDIE (Emergency Department Information Exchange) Project or PreManage ED, this collaborative effort among all of the MCOs is designed to increase care management resources, reduce medically-unnecessary ED readmissions and inappropriate ED utilization, and improve patient outcomes through consistent delivery of care. A Clinical Consensus Group has been formalized and HSD will participate in the development of a statewide standardized care plan accessible to participating emergency room departments and MCO care coordinators. The focus will be on high utilizer members who may need more active management through shared information and collaboration.

Care Coordination for Incarcerated Individuals

HSD continues to provide technical assistance for a pilot project involving a sample population of jail-involved members enrolled with one of the MCOs. This project involves connecting members being released from jail with care coordination, to address members' immediate needs upon release, and ultimately achieve such goals as reducing recidivism and improving public health. Care coordination is provided by the MCO staff in collaboration with detention center staff to members prior to release. Various approaches are being utilized to effectively engage members to participate in care coordination and complete HRAs and Comprehensive Needs Assessments (CNAs), and schedule appointments with appropriate providers. Consultative

review of project reports has been provided to the project since D3Q2 and recommendations for refinement of data collection and care coordination approaches are made by HSD to the MCO and MDC staff regularly.

Care Coordination Software

HSD collaborated with an MCO for the implementation of a new clinical software system migration. This process led by HSD Care Coordination staff included oversight of contract required elements to be included in the new system design and function. A formal onsite readiness review was conducted by HSD and a demonstration was provided by the MCO to HSD staff in September 2016. The new system has improved functionality which allows for more efficient care coordination and auditing. HSD verified that MCO users, including care coordinators, participated in the system design, and has given positive feedback to date.

HSD conducted "ride-a-longs" with MCO care coordinators in July and August 2016 to observe member visits in the home setting. HSD reviewed ride-a-long experiences with the MCOs identifying the need to continue Care Coordination training on assessments and available services. Modifications to assessment tools and technical assistance was provided to the MCOs based on the observations. MCO acknowledged the need for continued training and that the process was helpful to the MCO care coordinators.

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process

During DY3 Q3, HSD's implementation of the Technical Assistance (TA) call process continues to improve the quality of MCO reports and provides them with an opportunity to obtain valuable guidance from HSD Contract Managers. Additionally, HSD continues to evaluate its managed care reporting resubmission processes to make certain they are effective, align with HSD policies and procedures, and subsequently lead to positive outcomes.

Furthermore, HSD subject matter experts (SMEs) consistently perform quality reviews of MCO reports to ensure the data is accurate and adheres to HSD's compliance requirements and performance standards. HSD SMEs are selected to review specific MCO reports based on their level of expertise and ability to identify data trends and patterns. HSD developed a data analytics methodology and tools for SMEs to utilize in conducting a comprehensive analysis of MCO reports.

Customer Service

In June, July, and August 2016, MHNM and UHC, met or exceeded contract standards for all customer service lines (member services, provider services, nurse advice lines and utilization management).

BCBSNM continues to meet contract metrics for all customer services lines except for the provider services line. One hundred percent of voicemails are contractually required to be returned by the next business day. In June, BCBSNM did not meet contractual requirements by returning 94.8% of voicemails by the next business day. As a result, additional staff was trained to ensure all voicemails were returned. In July and August 2016, BCBSNM reported 100% of voicemails were returned by the next business day.

PHP continues to meet contract metrics for all customer service lines except the member services line, provider services line, and UM services line. Calls are contractually required to be answered within 30 seconds 85% of the time. In July, PHP experienced network/telecommunication interruptions, which impacted the ability of call center staff to answer calls in a timely manner. PHP reported 83.6% of calls were answered within 30 seconds for member services line and the provider services line. Additionally, PHP reported 80.1% of calls were answered within 30 seconds for the UM services line. In June and August 2016, PHP met all contract metrics.

Appeals

A total of 1,143 appeals were filed by Centennial Care Members in DY3 Q3. Of the total appeals filed, 731 (64%) were upheld, 374 (33%) were overturned and 14 (1%) were partially overturned. The remaining appeals filed in Q3 were pending resolution, transferred to Fair Hearings, dismissed or were received late in the quarter and were carried over to the following month for resolution.

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues as expected with DY3 Q3 activities generally devoted to data collection, data review, and preparations to complete analysis of received data.

For the DY2 evaluation period, Deloitte Consulting provided HSD with an updated data request that included a summary of files that were required to complete yearly evaluation activities. The data request incorporated a tracking component that allowed the Deloitte team and HSD to have an understanding of what had been received and what was still outstanding at any given time. Further, questions related to the data files from Deloitte Consulting to HSD were tracked in this workbook to consolidate all data related activities into one document for ease of use and to provide each user with a full up to date picture of current data standings.

Due to ongoing data collection activities, the Evaluation Model is currently being updated to reflect DY2 data and adjusted for revised analyses based on lessons learned from DY1 of the Evaluation. After completing all data collection and review, the final Evaluation Model Exhibit will be included as supporting documentation of the analytic review.

The fourth quarter of 2016 will be devoted to completing the collection of all data files, verifying appropriateness and reasonableness of data received and receiving answers to outstanding and new data questions related to received data files. By the end of the fourth quarter, all data analysis should be completed to allow for the DY2 annual report to be finalized by DY4 Q1.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Tables (July 1 – September 30, 2016)
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment E: HSD Secret Shopper Survey Scripts
Attachment F: HSD Secret Shopper Methodology
Attachment G: Centennial Care Contract Amendment #6
Attachment H: MCO Action Plans
Attachment I: Notice to CMS and Directed Corrective Action Plan

Section XVII: State Contacts

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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 member was diagnosed with colon and liver cancer a few months ago. Their local hospital, located in a remote part of the State, informed the member that they were not taking new patients. The member was forced to look for treatment options out of state. However, a few weeks ago, the member's port broke, and a replacement was needed so chemotherapy could be continued. The care coordinator worked with one of the medical directors to intervene with the member's local hospital, explaining that the port replacement was a continuation of service. The port was replaced, and the member was able to continue with chemotherapy. The care coordinator continues to work with the member on their recovery and future service needs.

Centennial Care Member Success Story 2
A care coordinator has a member with physical and BH issues. The member had not seen a Primary Care Physician (PCP) or BH provider in a few years and as a result did not have the appropriate medication. The care coordinator was able to find the member a PCP and a BH provider. The member was very good about attending all PCP appointments, but refused to attend any BH appointments.

The care coordinator suggested to the member and the member's guardian that they try telehealth for the BH appointment. The member and the guardian agreed to try it. The care coordinator went to the member's home, set up telehealth services, and showed them how to make an appointment, even scheduling an appointment for the member for the following day.

A week later, the care coordinator received a phone call from the member's guardian indicating the telehealth appointment went really well. In addition, the BH provider sent a prescription to the pharmacy for the member's BH medication. The member was pleased with the process and is excited to be able to receive the services needed.

Centennial Care Member Success Story 3
A family receiving care coordination has been connected with HELP-NM, a local non-profit organization, for assistance in several situations. HELP-NM will be assisting this family with funding of $300 for car repairs. Although the repairs will exceed the $300 donation, Uptown Auto Clinic is willing to cover the remainder of the cost so their car can be fixed. Additionally, the care coordinator scheduled a meeting to assist with completing a housing application. HELP-NM is trying to help get the family into a home/apartment and is also looking for a service agency to get the family in obtaining ongoing case management services. HELP-NM stated that the family was crying when they received this news. In addition, the husband of the family is scheduled to start his new job.

Centennial Care Member Success Story 4

A member's mother called the Centennial Care Customer Service Center requesting mileage reimbursement from Albuquerque, New Mexico to Denver, Colorado. The member's mother was referred by Superior Medical Transportation. The member's mother was emotional and overwhelmed because of her daughter's illness and the future expenses for their travel to Denver. One of the Centennial Care customer service representatives assisted the member's mother by listening to the mother's concerns. The customer service representative provided outstanding customer service by explaining and offering travel and lodging arrangements. The customer service representative submitted the travel reimbursement request, contacted care coordination, and explained the situation to the member. The member's mother was very impressed by the customer service. In addition, the member's mother did not know that a member has travel and lodging benefits out of the State. The customer service representative was able to sooth the families' financial worries and direct them to their care coordinator for future services.