Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2016 – 12/31/2016)
Waiver Quarter: 2/2016

September 7, 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 640,000 members are enrolled in the program. Initiatives continuing in the third year of the program (January 2016 – December 2016) include:

Emphasizing Patient-Centered Care

- Completed health risk assessments (HRA) for 70% of members;
- More than 70,000 members in higher levels of care coordination;
- More than 280,000 members receiving care in patient-centered medical homes;
- More than 25,000 members receiving home and community benefits;
- Launching two health home sites for members with complex behavioral health (BH) conditions;
- Identifying 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; and
- Piloting a program with Bernalillo Detention Center to connect incarcerated individuals with care coordination upon release from the facility.

Supporting Provider Capacity

- Maximizing Scopes of Practice for Certain Providers;
- Managed care organizations (MCOs) expanding use of telehealth office visits by 45% and launching virtual physician visits, including with BH providers; and
- Increasing 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) include:

- ED diversion strategies, including implementation of ED tracking software to be used by hospitals and MCOs;
- Planning for Certified Community Behavioral Health Clinics and expansion of health homes; and
- Continued expansion of value-based purchasing strategies.

Section II: Enrollment and Benefits

Eligibility

As noted in Section III of this report, there are 265,800 enrollees in the Group VIII (expansion) who are in Centennial Care. Growth in the expansion group shows 3,179 new enrollees for the second quarter of DY3 (DY3 Q2).

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.

Disenrollment

The New Mexico Human Services Department (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 it is tied to the overall increase in enrollment.

Access

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

Primary Care Provider (PCP)-to-Member Ratios

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

Physical Health (PH) and Hospitals

Geographic access (GeoAccess) reports were reviewed by HSD to ensure consistent methodology across MCOs. HSD identified a discrepancy between MCOs reporting point-to-point distance measurements versus actual mileage. To ensure consistent methodologies among MCOs, HSD conducted technical assistance (TA) calls with the appropriate MCO to ensure all MCOs report actual mileage to travel to the nearest provider. (See Section XIV: Managed Care Reporting Requirements for TA call process). No significant changes to MCO networks have been reported in the quarter. Please see Attachment B: GeoAccess PH Summary and Attachment C: GeoAccess BH Summary.

Transportation

In DY3 Q2, HSD has nothing new 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 January 2016 through March 2016. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

During DY3 Q2, HSD convened a workgroup to review the pharmacy report. The workgroup determined adjustments to the pharmacy report are needed to standardize methodologies across MCOs. Standardizing methodologies will allow HSD to ensure consistent reporting among MCOs and an effective HSD analysis. To standardize methodologies, adjustments to the pharmacy report will include: therapeutic classifications; monitoring of antipsychotic drug use in children and Drug Utilization Review (DUR); and requirements with program standards to ensure prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical issues. These adjustments will result in a revision of the pharmacy report and an update will be presented in DY3 Q3.

Centennial Care is experiencing a rapid increase in members who are being treated for Hepatitis C. After a comprehensive review of policies and processes, and in collaboration with our MCOs, we expanded directly acting antiviral coverage from two of the seven stages of Hepatitis C (F3 and F4) to the five stages for which there is medical evidence indicating the benefit of treatment (F2, F3, F4, decompensated cirrhosis, hepatocellular carcinoma).

The results of the change in benefit plan, combined with an intensive collaborative process improvement effort with the MCOs, have resulted in a dramatic increase in the treatment of our Hepatitis C members. We have worked closely with the Hepatitis C Coalition, our state advocacy group, and have co-developed a Strategic Plan that includes the further expansion of treatment coverage. The below excerpt from the Strategic Plan is included as an example of the level of collaboration we feel we have achieved:

> New Mexico has taken the lead in responding to HCV in a progressive and inclusive fashion. In particular, New Mexico's Medicaid Program has been reviewing the epidemiology and needs for persons living with HCV for several years to identify mechanisms for expanding access to treatment. Their work has been both innovative and strategic in complying with and going beyond federal guidance. The Medicaid Program strived to establish evidence-based policies regarding access that would meet the program's goals, including ensuring broader access and removing restrictive barriers that had no scientific basis.

In addition, we believe we have "turned the tide" in our provider community, and the number of Hepatitis C related complaints has dropped precipitously since the announcement of our expanded coverage.

The Medical Assistance Division's medical director currently meets quarterly with our four health plan contractors/partners to review current guidelines, investigate new therapies and processes to ensure members complete their course of treatment, explore new and lower cost treatments that would allow us to provide more affordable therapy, and agree on revisions to our approach to ensure our benefit plan is administered uniformly.

Last, we have fully joined the more recent effort called Eliminate HCV in New Mexico, and hope to assist in the development of a five to ten year plan for the elimination of HCV in our State.

Provider Network

United Healthcare (UHC), the University of New Mexico Hospital (UNMH) and University of New Mexico Medical Group (UNM MG) were in contract negotiations during the quarter. The Medicaid contract was not renewed and transition plans were submitted by UHC identifying members who were paneled with UNM MG PCPs, members with complex cases, and members who had accessed services within the preceding six months. The transition did not affect members receiving BH or pharmacy services as those services are covered under separate agreements. In addition, UHC demonstrated in its transition plan documents that members were transitioned to new PCPs appropriately and timely. Alternatively, members requesting continuity of care with their existing providers were able to request a switch to another MCO outside of the open-enrollment period.

Community Health Workers (CHWs)

Through DY3 Q2 MCOs remained focused on CHW initiatives that promote service delivery to encourage and facilitate greater coordination of care, health education, health literacy, and community support linkages in rural, frontier, and underserved communities across the State. Two MCOs completed the State Fiscal Year 2016 fourth quarter (April 1, 2016 – June 30, 2016) of a CHW pilot project in partnership with the University of New Mexico Health Sciences Center, Office for Community Health (UNMHSC/OCH). The Integrated Primary Care and Community Support (I-PaCS) model used in the pilot integrated CHWs into care teams in the primary care setting to screen for and address the adverse social determinants of health affecting patients.

Telehealth

All MCOs are implementing telehealth initiatives for both PH and BH. During DY3 Q2, one MCO has reportedly helped with the acquisition of audio-visual equipment for several practice sites so they can start to provide telehealth services to their patients. As MCOs strive to meet the goal of increasing member utilization by 15% over DY2 goals, they continue to provide support, as needed, to make sure practices understand correct coding for telehealth services to ensure utilization is properly captured.

Community Interveners (CI)

In DY3 Q2, there were seven Centennial Care members receiving Community Intervener services. The MCOs will continue to provide training and education to Care Coordinators to identify potential members who could benefit from CI services.

Table #1 – Community Intervener Services Utilization DY3 Q2

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBSNM	3	894.00	$5,689.25
MHNM	0	0	$0
UHC	3	381.00	$2,531.75
PHP	1	8.00	$50.00
Total	**7**	**1,283.00**	**$8,271.00**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date 573,826 distinct members have earned at least one reward, or 69% of enrollees. Since the inception of Centennial Rewards, the total points are valued at $32.8 million of which 24.6%, or $8 million, have been redeemed. Table 1 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 #2 – 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 $	Percentage of Redeemed Rewards by Activity
Asthma Management	750	$ 75	$ 800,475	$ 247,134	30.87%
Bipolar Disorder Management	750	$ 75	$ 903,075	$ 210,571	23.32%
Bone Density Testing	350	$ 35	$ 34,125	$ 7,271	21.31%
Healthy Smiles Adults	250	$ 25	$ 6,268,925	$ 1,282,037	20.45%
Healthy Smiles Children	350	$ 35	$ 15,128,225	$ 3,834,415	25.35%
Diabetes Management	800	$ 80	$ 3,778,860	$ 954,493	25.26%
Healthy Pregnancy	1,000	$ 100	$ 960,100	$ 240,879	25.09%
Schizophrenia Management	750	$ 75	$ 440,250	$ 86,357	19.62%
Health Risk Assessment (HRA)	100	$ 10	$ 3,829,370	$ 698,837	18.25%
Other (Appeals and Adjustments)	N/A	N/A	$ 300,474	$ 190,260	63.32%
Step-Up Challenge	500	$ 50	$ 376,700	$ 323,090	85.77%
Totals			**$ 32,820,579**	**$ 8,075,344**	**24.60%**

DY3 Q2 shows an increase in rewards earned and rewards redeemed for all activity categories.

Table #3 – Rewards Card Accounts

MCO	Total Dollar Value of Accessories Expenditures	Total Dollar Value of Athletics Expenditures	Total Dollar Value of Baby Expenditures	Total Dollar Value of Children's Activities Expenditures	Total Dollar Value of Education & Learning Expenditures	Total Dollar Value of Healthy Kit Expenditures	Total Dollar Value of Healthy Lifestyle Expenditures	Total Dollar Value of Movement & Fitness Expenditures	Total Dollar Value of Wellbeing Expenditures	Total Dollar Value of Reward Card Expenditures
BCBS	$12,549	$40,818	$9,512	$26,478	$17,113	$54,617	$78,497	$45,143	$36,850	$508,157
MOLI	$46,062	$168,041	$28,667	$85,220	$61,628	$185,072	$260,489	$140,773	$110,349	$1,847,393
PRES	$63,326	$209,769	$31,314	$104,705	$78,668	$232,722	$344,530	$209,419	$160,534	$2,026,618
UHC	$16,821	$28,132	$9,629	$17,295	$12,402	$44,241	$80,121	$37,599	$38,314	$565,757
All MCOs Total Redemptions	**$138,758**	**$446,760**	**$79,122**	**$233,698**	**$169,811**	**$516,652**	**$763,637**	**$432,934**	**$346,047**	**$4,947,925**
All MCOS CY16 Q1 Redemptions	$112,796	$395,076	$59,251	$213,332	$129,668	$461,010	$641,646	$375,595	$287,339	$3,856,554
Increased Redemptions from CY16 Q1 to CY16 Q2	$25,962	$51,684	$19,871	$20,366	$40,143	$55,642	$121,991	$57,339	$58,708	$1,091,371
Percentage of Increase from Previous Quarter	23%	13%	34%	10%	31%	12%	19%	15%	20%	28%

The following is an excerpt that an MCO stated in its calendar year 2015 (CY15) Annual Supplement analysis:

> *We continue to see a general upward trend in Dental expenses, which has been growing through the year. We suspect that this may be a reflection of the outreach for Dental services related to the Centennial Rewards. Even though Orthodontic services are not rewarded, it is likely that as some of these children are receiving more routine dental care they are able to identify if there are orthodontic needs.*

Based on Table 3, dental services have the highest value of rewards earned at $21 million. This may suggest the availability of the rewards is a factor in the increased dental visits, as well as the availability of dental coverage under Medicaid.

Table #4 – Earned Rewards

Eligibility Activities	Earned Rewards	Redeemed Rewards	Redemption Percentage
Asthma Management	$ 800,475	$ 247,134	30.87%
Bipolar Disorder Management	$ 903,075	$ 210,571	23.32%
Bone Density Testing	$ 34,125	$ 7,271	21.31%
Healthy Smiles Adults	$ 6,268,925	$ 1,282,037	20.45%
Healthy Smiles Children	$ 15,128,225	$ 3,834,415	25.35%
Diabetes Management	$ 3,778,860	$ 954,493	25.26%
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Health Risk Assessment (HRA)	$ 3,829,370	$ 698,837	18.25%
Other (Appeals and Adjustments)	$ 300,474	$ 190,260	63.32%
Step-Up Challenge	$ 376,700	$ 323,090	85.77%
Totals	**$ 32,820,579**	**$ 8,075,344**	24.60%

The Step-Up Challenge, in Table 3, shows that members who complete the activity have a high likelihood of redeeming the reward. The Step-Up Challenge is an activity group individuals opt-in to. The other activity groups are based on a health diagnosis.

MCO Initiatives

All MCOs implemented a Text4Baby prenatal care program in which MCOs have the ability to send text messages to members to provide information regarding prenatal care, development, nutrition, safety, and also to send urgent alerts. Text4Baby is a free service for pregnant women through the first year of the baby's life. Please find a list of example text messages alerts the Text4Baby service provides to members:

- Reminders for well-baby visits, prenatal, and postpartum doctor appointments;
- Alerts on what to expect at the various stages of pregnancy; and
- Alerts on what to expect during the baby's first year of life.

Additionally, an MCO received an award to Multicultural Health Care Distinction by the National Committee for Quality Assurance (NCQA). The MCO was recognized for its efforts to provide members who are traditionally underserved with access to quality health care. The Multicultural Health Care program evaluated New Mexico Medicaid on how well the MCO meets requirements in the following: collection of race/ethnicity and language data; provision of language assistance; cultural responsiveness; quality improvement of culturally and linguistically appropriate services; and reduction of health care disparities.

Section III: Enrollment Counts

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 #5 – Enrollment DY3 Q2

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – June 2016	Current Enrollees (Rolling 12 month period)	Disenrolled in Current Quarter
Population 1 – TANF and Related	376,882	359,386	6,488
Population 2 – SSI and Related – Medicaid Only	41,147	41,685	647
Population 3 – SSI and Related – Dual	36,368	40,172	715
Population 4 – 217-like Group – Medicaid Only	171	181	70
Population 5 – 217-like Group – Dual	2,460	2,758	58
Population 6 – VIII Group (expansion)	265,800	325,105	9,144
Totals	723,828	769,287	17,122

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.

Table #6 – Disenrollment Counts DY3 Q2

Disenrollments	From 2016 Q1 to 2016 Q2		Total Disenrollments During Q2
Last Month Client was Disenrolled	**April 1, 2016**	**May 1, 2016**	
Population 1 – TANF and Related	3,066	3,422	6,488
Population 2 – SSI and Related – Medicaid Only	318	329	647
Population 3 – SSI and Related – Dual	343	372	715
Population 4 – 217-like Group – Medicaid Only	12	58	70
Population 5 – 217-like Group - Dual	24	34	58
Population 6 – VIII Group (expansion)	4,264	4,880	9,144
Total Without MEG 7	8,003	9,061	17,122

Section IV: Outreach

In DY3 Q2, HSD provided a Centennial Care informational training to the New Mexico Aging and Long-Term Services Department staff and Adult Protective Services Division staff from across the State. Other events HSD participated in included a Senior Citizen conference with the Alzheimer's Association; St. Elizabeth's Shelter and Supportive Housing event; Alcohol and Substance Abuse Treatment Conference; Psychosocial Rehabilitation Association of New Mexico conference; New Mexico Highlands University; and Department of Health, Development Disabilities Support Division.

All four MCOs participated in a variety of community events across the state, providing enrollment opportunities and educating the public about Centennial Care. They attended Medicaid enrollment events, health fairs and community events comprised of senior citizens, children and families, Native American members and other community members. The MCOs also held events with the Advancement of Latino Professional for America and local chambers of commerce organizations.

Description of Promising Practices for DY3 Q2

As part of implementing the Medicaid for Incarcerated Individuals Program (MIIP), HSD has been working with state and county correctional facilities and their representatives. MIIP allows Medicaid recipients to maintain their Medicaid eligibility while in prison or jail. Their Medicaid benefits are temporarily suspended until released from incarceration, at which time, HSD reactivates their Medicaid benefits. MIIP also allows for Medicaid eligibility determinations of inmates while incarcerated. HSD has implemented MIIP with the New Mexico Corrections Department and Bernalillo County Detention Center in Albuquerque, and conducted several outreach and training activities to educate correctional officers about the Medicaid Program. HSD is in the process of implementing MIIP with 27 county detention facilities, 11 juvenile detention centers and other state-run adult and juvenile jails, and continues to extensively conduct outreach and training activities for correctional staff.

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 has also scheduled 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.

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.

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

Program Development

In DY3 Q2, HSD conducted Brain Injury 101 and Care Coordination Documentation trainings in an effort to continue collaboration and enhance the education of staff within the MCOs. The Brain Injury 101 training educated attendees on resources for individuals with brain injuries as well as resources for their family members and caregivers. In addition, the Brain Injury 101 provided guidance for care coordinators and provided tips and techniques on how to support an individual living with a brain injury. The Care Coordination Documentation Training provided guidance on best practices for maintenance of member care coordination records, including core elements of care coordination documentation. It also identified areas in need of better documentation in order to ensure quality outcomes. Additional trainings will be conducted in DY3 Q3.

MCO Initiatives

- Molina HealthCare
    - Partnering with Metropolitan Detention Center in Bernalillo County to conduct health risk assessments in the facility for members released from being incarcerated
    - Kitchen Angels value added service provides up to 42 home delivered meals per calendar year to homebound members after hospital discharge
- Presbyterian Health Plan
    - Partnership with Highlands University – Internship program for Social Workers
    - Partnership with Albuquerque Air Ambulance for ED diversion project
    - Wellness Referral Center – Partnership with Adelante that services the areas of PMG Isleta, San Mateo, First Choice South Valley and First Nations
- Blue Cross Blue Shield
    - Enhanced Care for Children with Asthma – a collaboration between BCBSNM and the American Lung Association
        - Data from the initial 12 clinics in New Mexico showed:
            - An 80% reduction in ER visits for asthma
            - An 80% reduction in hospitalizations for asthma
    - Community Paramedicine
        - Designed to interact with and educate members identified as high ED utilizers and recent hospital discharges with high risk of readmission
- United HealthCare
    - Letters of Agreement with Tribal governments for compensation. Services vary by Tribal government, and include translation, health risk assessment completion, and mileage reimbursement for non-emergency medical transportation
    - Opened a Resource Center in Shiprock, which provides a variety of services including health literacy education, virtual visits, and assistance with other social services

Unreachable Member Campaign

In July 2014, HSD directed all four MCOs to initiate unique and innovative campaigns in order to connect with their unreachable members in need of completing a health risk assessment (HRA) and/or a comprehensive needs assessment (CNA). These assessments assist in determining the appropriate care coordination level (CCL) of the member. Care coordination is fundamental to the demonstration for coordinating care at a level appropriate to each member's needs. The Unreachable Member Campaign demonstrated the MCOs' progress in decreasing the number of unreachable members enrolled in managed care over time.

To track progress, a baseline was established each month which removed members who had been reached during the month and either completed an assessment, declined an assessment, or who had been disenrolled. New members were added to the baseline. Table 7 below represents the last reporting of the campaign which ended June 30, 2016. When comparing the July 2014 baseline for all MCOs to the ending baseline in June 2016, the MCOs collectively reduced the net percentage of unreachable members by 63.5% (214,253 unreachable members to 78,130 unreachable members). When considering all the members who had been reached at the end of each month, rather than the change in the baseline, over 248,000 unreachable members had eventually been reached by the MCOs during the campaign. Collectively, the MCOs reduced the percent of unreachable members to 11.62% of the total members enrolled in managed care at the end of June 2016.

During the campaign, HSD identified an additional member group not defined in the contract, or otherwise predicted by the program, as the member who is "difficult to engage" (DTE). The DTE member is a member who has been reached but has not followed through with completing an HRA or has declined the assessment at the time of contact. Based on data observations to date, HSD predicts that while unreachable member rates are likely to remain stable, the number of DTE members, and members who decline an HRA, are likely to increase. This is because healthy members in care coordination level 1 (CCL1) may not want to repeat annual HRAs year after year. It is important to note that members who are determined to be unreachable, who are DTE, or who have declined an HRA, do not lose Medicaid eligibility as a result of not completing an HRA.

Table #7 – Unreachable Member Campaign DY3 Q2

	Apr-16				May-16				Jun-16				6/30/2016
	Baseline	5% Target	Reached	Percent Reached	Baseline	5% Target	Reached	Percent Reached	Baseline	5% Target	Reached	Percent Reached	New Baseline
BCBSNM	7,317	366	511	6.98%	6,409	320	427	6.66%	5,888	294	471	8.00%	5,607
UHC	11,711	586	842	7.19%	11,702	585	842	7.20%	11,475	574	1,044	9.10%	11,076
MHNM	24,318	1,216	1,509	6.21%	22,825	1,141	1,296	5.68%	22,391	1,120	1,087	4.85%	21,766
PHP	44,281	2,214	2,491	5.63%	43,931	2,197	2,282	5.19%	42,612	2,131	2,154	5.05%	39,681
Source: MCO monthly reporting													

Electronic Visit Verification (EVV)

In DY3 Q2 HSD moved forward with mandatory full implementation of the EVV system for members receiving Personal Care Services (PCS). The MCOs developed a series of Frequently Asked Questions (FAQs) for the PCS Agencies and caregivers to fully explain the implementation of the three options for EVV:

1. Utilization of the member's landline or cell phone, if the member agrees.
2. Utilization of the caregiver's smartphone. The caregiver receives a monthly stipend for utilization of their smartphone.
3. Utilization of a tablet that is issued by the MCO to the PCS agency for the caregiver.

All MCOs are working with Verizon and Mobility Exchange to provide the tablets for caregivers who are unable to use the member's landline/cell phone or their smartphone. The tablets will be distributed in August 2016. All PCS billing will be submitted through the EVV system after October 1, 2016. The MCOs continue to collaborate with PCS Agencies to ensure a smooth implementation of EVV statewide.

Behavioral Health

Strategic Planning

During the quarter, the Implementation Team met bi-weekly to identify appropriate steps and timeframes for all the activities under the Goals and Objectives, and identifying individuals or groups to assume relevant tasks. An eighteen month Implementation Plan Matrix has been developed that tracks progress on all the goals and activities in the three major goal areas.

Some of the accomplishments during DY3 Q2 are highlighted below:

The Regulations Workgroup Goals:

- To identify, align and eliminate inconsistencies in BH statutes, regulations, and policies in order to allow for more effective and efficient operation of the publicly-funded service delivery system; and
- To increase the adoption of person-centered interventions such as Treat First.

The Finance Workgroup Goals:

- To increase the productivity, efficiency and effectiveness of the current provider network;
- To implement a value-based purchasing system that supports integrated care and reinforces better health outcomes; and

- To identify, develop and promote implementation of effective strategies for state, counties and municipalities to work together to fund the provision of better BH care, especially for high utilizers.

The Workforce Workgroup Goals:

- To support the development of BH practitioners; Objective: Survey Providers for current BH intern placements;
- To build a more multidisciplinary and competent BH workforce; Objective: Medicaid Supplement related to Nursing; and Objective: Gap analysis on BH- EHR adoption.
- To promote the future of excellence in the BH workforce and prepare for integrated care; and,
- To improve the public image of BH professions, raise awareness of its impact on the population and promote the effectiveness of the service delivery system.

CareLink NM: Health Homes

In CY3 Q2, the HSD launched the Health Home initiative in New Mexico. This system innovation is intended to enhance integration and coordination of primary, acute, BH, and long-term care services and supports for persons with chronic conditions across the lifespan. CareLink NM Health Homes involves a multi-disciplinary team that partners with enrolled members to develop and implement a service plan designed to meet all the person's behavioral, social, and health needs. This is a patient-centered approach within which care coordination will occur at the community level for both Centennial Care enrollees and fee-for-service (FFS). The State Plan Amendment for this program received approval from the Centers for Medicare & Medicaid Services (CMS) and the initial roll-out of CareLink NM occurred April 1, 2016 in San Juan County under the auspices of Presbyterian Medical Services (PMS) and in Curry County by Mental Health Resources (MHR).

The total number of members currently enrolled and receiving services from the two CareLink NM locations are as follows:

- MHR: 510 referred; 173 opted in; 321 opted out (62.97% opted out); 16 not addressed
- PMS: 357 referred; 153 opted in; 204 opted out (57.14% opted out)

The HSD and the MCOs formed a Steering Committee to address issues related to the implementation of CareLink NM.

Agave Health's Termination of BH Services

On April 1, 2016, Agave Heath issued a 90 day notice of contract termination. Agave Health has operated 12 locations in 10 counties and reported to serving 3,170 Centennial Care members. Nine of the locations delivered children's services, two delivered adult services, and one delivered services to both adults and children.

The MCOs and OptumHealth NM initially reviewed the last 90 days claims data to gather

information on members who would require transitioning to a new provider. On April 4, 2016 the MCOs created a team to create an application process for new providers whom would cover the services previously delivered by Agave Health. The team developed a Request For Information (RFI) application and disseminated it to their BH network providers. The goal was to select providers who were credentialed and able to assume Agave Health's services in designated areas. The providers were reviewed and prioritized in terms of readiness (e.g., licensing, provider type, etc.).

Eleven providers responded to the RFI and four were selected as either primary or secondary providers.

Each week the Transition Team with representation from the MCOs, Optum, HSD, and CYFD convened to plan for each stage of the transition. Agave Health provided information on staffing at each location, which made it possible for the new providers to hire its staff at respective service locations. Agave Health also provided information on the medical records each provider would need during the transition and a contact to be used after July 1, 2016.

All children in treatment foster care were transitioned to new providers in June. By mid-July, the MCOs were able to report that 50% to 75% of all members had appointments with the new providers.

Applied Behavior Analysis (ABA)

On May 1, 2015, ABA went into effect providing an array of services for Centennial Care members identified with Autism Spectrum Disorder (ASD).The new regulation expanded the age limit for services from under the age of 5 to under the age of 21.

Last year, the service launched with only one Stage 1 provider and six Stage 2 and Stage 3 agencies available to serve Centennial Care members. This quarter, the number of agencies with Stage 1 providers increased to six agencies and there are 10 agencies with Stage 2 and Stage 3 services.

Behavioral Health Investment Zones (BHIZ)

HSD received a $1 million allocation in fiscal year 2016 (FY16) for the establishment of BHIZ. Rio Arriba and McKinley counties were identified as the two counties in New Mexico with the highest levels of combined incidence of mortality related to alcohol use, drug overdose and suicide. HSD established an application process for designation of BHIZ and qualified the approved county for $500,000 to implement a plan that best addresses the needs in the priority zones. Both counties submitted their respective applications, which have been approved.

Rio Arriba County has established a coalition know as Opioid Use Reductions (OUR) as the BHIZ collaboration structure. The partners include: the lead agency, Rio Arriba County Health and Human Service Department, El Centro Family Health, Presbyterian Medical Services, Hoy Recovery Program, Espanola Presbyterian Hospital, Rio Arriba County Detention Center, La

Clinica del Pueblo de Rio Arriba, Espanola Public Health Office, Espanola Valley School District, , Las Cumbres Community Service, Inside Out, Valle del Sol of New Mexico, Santa Fe Mountain Center, North Central Community-Based Services, Honor of Our Pueblo Existence, Rio Arriba County Substance Treatment, Outreach and Prevention Program, and Rio Arriba Youth Service Providers. Accomplishments include:

- Purchase of 232 complete Narcan kits for distribution through network members;
- Santa Fe Mountain Center is providing data collection system for tracking Narcan doses and is training the outreach network in all aspects of implementation;
- Eleven staff participating in the outreach network has been certified as Harm Prevention Specialists;
- Pre-sentencing jail diversion pilot for five referrals from magistrate court and five from district court commencing in August 2016;
- Purchase of 40 full use and 40 limited use 27-month licenses for the Pathways Care Coordination System;
- Forty-five case managers from at least 10 provider organizations have been trained on the Pathways Care Coordination system;
- Purchase of 65 tablets for distribution to provider organizations for use by their case managers;
- Through the Detox Task Force, eight beds have been established at Hoy for social detox, filling a gap in services; and
- A re-entry specialist has been placed in the Rio Arriba County Jail.

McKinley County has developed a BHIZ oversight board that includes the City of Gallup as the local lead Agency, and the following authorities: McKinley County, Northwest New Mexico COG, Navajo Nation, and Zuni Pueblo. The Implementation Team includes Rehoboth McKinley Christian Health Care Services (RMCHCS), the Northwest New Mexico Council of Governments, Navajo Nation, Pueblo of Zuni, Na'nfzhoozhf Center, Inc., Western New Mexico University, Health Alliance, Gallup Police Department, Gallup Fire and Rescue, and Gallup Share & Care Coalition. Accomplishments include:

- Five provider hubs are working together to coordinate services;
- The Gallup Detox Center is undergoing renovations to meet compliance with local building and safety codes;
- RMCHCS has hired a BHIZ Coordinator and case manager to implement the goals of the BHIZ; and
- Two BHIZ Summits have been convened to continue the implementation of BHIZ goals.

PAX Good Behavior Game

The PAX Good Behavior Game (PAX GBG) has been found to reduce disruptive behaviors, hyperactivity, and emotional symptoms. Its long term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, and initiation of sexual activity with increases 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 the

program returns $57.53 for every $1 invested.

Beginning in March 2016, three school districts participated in the PAX GBG pilot program. Santa Fe, Espanola, and Bloomfield received training between March 2016 and May 2016. The table below illustrates the number of schools, teachers, and administrators who participated, and the number of students the PAX GBG would affect.

Table #8 – PAX GBG Pilot Program

District	# of Schools participating	# of Teachers Trained	# of Admin & Support	# of Students PAX GBG will effect
Bloomfield	1	10	8	364
Espanola	12	73	2	1,326
Santa Fe	20	89	17	1,639
Totals	**33**	**172**	**27**	**3,329**

Preliminary data on the PAX GBG pilot across the following three school districts with just six weeks of implementation demonstrates the following:

- Bloomfield: 41% reduction in disruptive behaviors;
- Espanola: 44% reduction in disruptive behaviors; and
- Santa Fe: 34% reduction in disruptive behaviors.

Certified Community Behavioral Health Clinics (CCBHCs)

New Mexico is one of 24 states selected by the Substance Abuse and Mental Health Services Administration (SAMHSA) to receive planning grant funds to establish CCBHCs. Each planning state is expected to certify at least two community BH clinics, secure ongoing, meaningful input from stakeholders to guide development of the CCBHC program, and develop a prospective payment system for reimbursable CCBHC services. Each planning state will prepare an application to participate in a CCBHC demonstration program. Eight of the planning grant states will be selected for the two-year demonstration program beginning in 2017. CCBHCs presents an opportunity for New Mexico to advance to the next stage of integration with PH care, to assimilate and utilize evidence-based practices on a more consistent basis, to improve access to high quality services, and to improve outcomes for those with complex health needs while lowering costs.

CCBHCs are required to provide nine services including crisis BH services, outpatient mental health and substance use services, targeted case management, and psychiatric rehabilitation services. A team of clinical experts developed guidance for clinics to use in order to project anticipated costs for expansion of services and necessary staffing. The clinical team is expected to continue to refine the CCBHC clinical design to clarify the scope of services and assist clinics in preparing their Certification Application and Plan.

The CCBHC Implementation Team has completed Readiness Assessments with 8 prospective CCBHCs. Prospective CCBHCs were asked to review their level of readiness, current licensing and certification standing, and the requirements of the clinical design. Based on their review, each prospective CCBHC decided whether or not to apply for certification. As of June 30, 2016, six clinics will apply for certification. The Team will continue working closely with these sites to assist them in addressing gaps in their level of readiness, current licensing and certification standing, and the requirements of the clinical design.

The CCBHC Implementation Team secures ongoing input from stakeholders through an Ad Hoc Committee and direct outreach. Made up of relevant State agencies, providers, and consumers, the Ad Hoc Committee provides ongoing guidance to the CCBHC Implementation Team. The Committee also provides input on how best to design and implement the NM CCBHC program. It has met four times and will continue to meet each month through September 2016 when it will review the demonstration program proposal. The CCBHC Project Director, Teresa Gomez, secures input from other key stakeholders by providing regular updates to the Behavioral Health Planning Council, Sub-Committees and some of the Local Collaboratives.

In order to develop the Prospective Payment System (PPS), each clinic is completing a cost report that includes allowable CCBHC costs and visits (both current and anticipated).This information is used to establish a clinic-specific PPS rate that reflects all the services provided to a client in a single day. REDW, a New Mexico accounting firm, was contracted to provide cost reporting TA and support to each prospective CCBHC. As of June 30, 2016, six clinics have completed preliminary cost reports with final reports expected to be completed by July 30, 2016. A PPS Work Group has convened to address other PPS design elements and will meet every other week through mid-August when the demonstration program proposal will be written.

UNM serves as the evaluator of this grant, and has taken the lead on gathering readiness assessment data, designing a statewide needs and gaps analysis, and ensuring timely data entry into the SAMHSA TRAC database on a quarterly basis. UNM is also working with BHSD to analyze Medicaid claim data to inform the needs assessment for each agency and for statewide planning. In addition, UNM is working with Falling Colors Technology to develop the data infrastructure necessary for the CCBHC demonstration project. The statewide Behavioral Health Treatment Gaps Analysis Survey (Needs Assessment) has been reviewed and vetted by various stakeholder groups. A team from UNM will administer, collect, and analyze the statewide Needs Assessment, which will be used to inform the CCBHC demonstration proposal.

Network of Care (NOC)

The NOC is now the official website for the Behavioral Health Collaborative. The intent is for this website to be the one-stop-shop for BH in New Mexico. Key features of the NOC include a BH learning center, designed to educate, inform, and provide access to relevant BH information; a user-friendly client interface that enables NOC partners to easily display local content throughout the site; an advanced Social Networking platform, which is designed to promote collaboration and coordination across diverse groups; and a HIPAA- and HL7-compliant, Personal Health Record that stores valuable medical and legal information and documents. This portal can be accessed at: http://www.newmexico.networkofcare.org/mh/

Forums, blog links, and job postings are available for providers and consumers. Other available portal domains include: Seniors and People with Disabilities, Children and Families, Developmental Disabilities, Domestic Violence, Public Health, Prisoner Re-entry and Corrections, Autism, and Foster.

Prevention "Partnership for Success" (PFS) Grant

HSD's Office of Substance Abuse Prevention (OSAP) has been awarded this SAMHSA grant of $1.68 annually for five years ($8 million total) to address underage drinking and youth prescription drug abuse. The counties receiving funding through the new grant are Chaves, Cibola, Curry, and Roosevelt. These counties were selected using a data-driven analysis of risk factors and need, including youth use of alcohol and prescription drugs. Each county's coalition is undergoing a rigorous needs assessment, capacity building, and planning process to ensure prevention strategies implemented through the new grant are successful in reducing underage drinking and prescription drug misuse in their respective communities.

The new sub-grantees attended an OSAP Recipient Meeting and New Grantee Orientation Meeting in Albuquerque in February 2016 where they received information on substance abuse epidemiological data, community level data collection, New Mexico ATODA Prevention Workforce Trainings, the Strategic Prevention Framework process, training on Synar tobacco prevention activities, and PFS 2015 grant requirements, timelines, and expectations. Technical assistance visits for the new counties were conducted in February 2016 and a Coalition Development Training was held in March 2016.

FY16 Withdrawn Behavioral Health Initiatives due to State Budget Crisis

- Prescription drug collection boxes, which would have provided a monitored source of disposal for many unused and improperly stored prescription opiates often sitting in home medicine cabinets;
- Prescription drug incinerators would have provided local communities and law enforcement agencies with a means to collect prescription painkillers and dispose of them without problems associated with bio contamination, theft, transportation and transfer;
- Mobile Crisis Response Teams that were planned for McKinley and Rio Arriba Counties, would have diverted those in BH crisis from psychiatric hospitalization, would have

linked suicidal individuals discharged from the ED and hospitals to community-based services; and would have also provided diversion from arrest and subsequent jailing;

- New Mexico Supported Employment BH Center of Excellence would have built a supported employment service capacity in New Mexico using an evidence-based best practice;
- New Mexico Peer Empowerment Center would have been peer managed and operated to serve the recovery needs of youth, family, and peers whether veterans, first responders, law enforcement, corrections, or ED staff who require recovery supports for PTSD and other related conditions;
- Behavioral Health Planning Council (BHPC) was slated to receive additional funding to develop and implement an orientation and mentorship program that would have included an orientation manual for new members; and a small portion of this additional funding was to be used to support the designated BHPC members who review and analyze the Block Grant Application and other reports;
- Local Collaborative Alliance (LCA) was also slated for additional funding to match its resource development achievements to support capacity-building and infrastructure development; and
- Mesilla Valley Hospital Addiction Recovery Center would have supported the expansion of services to include partial hospitalization, residential, and intensive outpatient treatment.

Fiscal Issues

HSD received final Long-Term Services and Supports (LTSS) rate documentation from its actuary in the month of June 2016. This occurred after HSD and its actuary concluded the review of financial reports to assure the development of sound base LTSS rates for the period January 1, 2016 through December 2016. (Rate certification documentation was sent to CMS on July 5, 2016.)

During the month of June, new rate documentation was developed for rates effective July 1, 2016 for all programs. As discussed in the DY3 Q1 report, HSD has been working with the New Mexico Medicaid Advisory Committee and internally to propose and implement immediate and long-term measures to curb Medicaid costs in light of the overall state budget environment. The rates effective July 1, 2016 contain the first round of cost containment measures implemented by the State. These measures are restricted to rate reductions for specific providers including hospitals, physicians and dental providers. Additional rate reductions were discussed in June 2016 with additional impact analysis conducted in June. These further rate reductions are anticipated to be implemented on August 1, 2016. (Rate certification documentation was sent to CMS on August 16, 2016.)

Systems Issues

HSD continues to conduct ongoing auditing and analysis of Nursing Facility Level of Care (NF LOC) and setting of care (SOC) assessments to identify discrepancies in documentation. HSD conducted training with the MCOs to address concerns and remediate systemic issues. HSD will conduct another session in the upcoming months as a follow up on the training that was

conducted and to address new issues. HSD continues to implement reporting requirements to monitor any discrepancies that may arise.

Medicaid Management Information System (MMIS) Replacement

HSD began its planning for replacement of its current legacy MMIS some time ago, and activity for this effort progressed in the quarter. The RFP for an Independent Verification and Validation (IVV) vendor was released, a finalist has been selected, and the contract received CMS approval. Information on the upcoming procurement for the first module of the State's Framework for MMIS Replacement (the Integration Platform/System Integrator) was submitted to CMS and has subsequently been approved. Work on the next module, the Enterprise Data Services RFP, has begun with all stakeholders, including the MCOs, provider associations, Tribal and Indian health agencies, multiple agency State staff, and the Medicaid Advisory Committee. This draft RFP is to be submitted to CMS for review by the end of August 2016.

HSD has reviewed the new CMS certification and modularity guidance and has taken steps to ensure it is in compliance. This includes hiring an employee whose sole responsibility is to ensure compliance with the certification and Medicaid Information Technology Architecture guidelines.

HSD is working with its two prime vendors on matters related to the replacement system. An amendment with Xerox addressing conversion matters is about to be executed, and with Deloitte, our integrated eligibility system vendor, we completed the definitional work to be done 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 was submitted to CMS in June 2016, and has subsequently been approved.

An Implementation Advance Planning Document Update was submitted to the Regional Office in March 2016, and an updated planning document was submitted to the Regional Office for federal fiscal year 2017.

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

New Mexico Independent Consumer Support System (NMICSS)

The NMICSS continues to recruit and establish a system of organizations that provides 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 April 1, 2016 to June 30, 2016.

Table #9 – ADRC Call Profiler Report

Topic	# of Calls
Home- and Community-Based Care Waiver Programs	2,506
Long-Term Care/Case Management	40
Medicaid Appeals/Complaints	15
Personal Care	104
State Medicaid Managed Care Enrollment Programs	260
Medicaid Information/Counseling	1,347

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

Table #10 – ADRC Care Transition Program Report

Counseling Services	# of hours	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		222	
Medicaid Education/Outreach	2,055		
*Medicaid Options/Enrollment	230		
**Pre/Post Transition Follow-up Contact			2,335
***LTSS Short-Term Assistance			167

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

****76% of the contacts are pre-transition contacts and the remaining 24% are post transition contacts. These numbers are resident specific and situation dependent.**

*****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 Behavioral Health Services Division (BHSD) to monitor CI reports. The CI workgroup and the BHSD CI sub-workgroup are meeting to revise protocols and forms for BH providers. The BH protocols to be used by BH providers will improve accuracy of information reported and establish guidelines for the types of BH providers who are required to report.

The CI unit is engaged in monitoring activities during DY3 Q2 with respect to the performance oversight of the MCOs and their provider agencies. The CI workgroup meetings continue to be held quarterly.

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

During DY3 Q2, a total of 4,220 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 65% of the total CIs reported in DY3 Q2, which is a decrease of 6% compared to DY3 Q1. All MCOs reported a slight decrease in Emergency Services in DY3 Q2.
- MCOs have member initiatives underway that include interventions for high utilizers of the ED that includes education on appropriate use of emergency services and alternative, more appropriate settings of care.

Table #11 – DY3 Q2 Critical Incidents

Critical Incident Types by Population Group						
Critical Incident Types	**Centennial Care**		**Behavioral**		**Self Directed**	
	#	**%**	**#**	**%**	**#**	**%**
Abuse	323	8%	111	21%	22	13%
Death	{413}		{31}		{11}	
Natural/Expected	376	9%	25	5%	10	6%
Unexpected	35	1%	4	1%	1	0%
Suicide	2	0%	2	0%	0	0%
Elopment/Missing	31	1%	7	1%	0	0%
Emergency Services	2744	65%	300	58%	108	65%
Enviormental Hazard	68	2%	4	1%	0	0%
Exploitation	115	3%	7	1%	9	5%
Law Enforcement	107	3%	27	5%	7	4%
Neglect	419	10%	30	6%	8	5%
Total	**4220**		**517**		**165**	

HSD has broken out CIs by MCO and included the non-Centennial Care (FFS) data in the table below, although the FFS population is not included in any other section of this report since it is not a covered population under the Section 1115 demonstration waiver.

Table #12 – Critical Incidents by MCO and FFS

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	**BCBS**		**Molina**		**Presbyterian**		**UHC**		**FFS/HSD**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Abuse	49	6%	95	7%	78	12%	101	7%	0	0%
Death	118	14%	109	8%	68	11%	117	8%	1	33%
Elopement/Missing	4	0%	9	1%	6	1%	11	1%	1	33%
Emergency Services	529	64%	1,019	74%	336	56%	859	62%	1	33%
Environmental Hazard	8	1%	11	1%	14	2%	35	3%	0	0%
Exploitation	19	2%	23	2%	24	4%	49	4%	0	0%
Law Enforcement	14	2%	30	2%	30	5%	33	2%	0	0%
Neglect	80	10%	88	6%	79	12%	172	12%	0	0%
Total	**821**		**1,384**		**635**		**1,377**		**3**	

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	7	28%	58	16%	39	44%	7	17%	0	0%
Death	0	0%	28	8%	1	1%	2	5%	0	0%
Elopement/Missing	0	0%	5	1%	1	1%	1	2%	0	0%
Emergency Services	13	52%	236	65%	28	32%	23	56%	0	0%
Environmental Hazard	0	0%	2	0%	2	2%	0	0%	0	0%
Exploitation	0	0%	4	1%	2	2%	1	2%	0	0%
Law Enforcement	1	4%	13	4%	10	11%	3	7%	0	0%
Neglect	4	16%	17	5%	5	6%	4	10%	0	0%
Total	25		363		88		41		0	

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	3	20%	9	19%	4	9%	6	11%	0	0%
Death	1	7%	2	4%	3	7%	5	9%	0	0%
Elopement/Missing	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Services	9	6%	32	67%	28	61%	39	70%	0	0%
Environmental Hazard	0	0%	0	0%	0	0%	0	0%	0	0%
Exploitation	0	0%	3	6%	3	7%	3	5%	0	0%
Law Enforcement	0	0%	1	2%	4	9%	2	4%	0	0%
Neglect	2	13%	1	2%	4	9%	1	2%	0	0%
Total	15		48		46		56		0	

HCBS Reporting

In April 2016, HSD received feedback on its draft statewide transition plan (STP) for the HCBS Setting Rule from CMS. HSD has revised its plan accordingly and is currently in the tribal comment period. HSD plans to submit the revised version of the STP to CMS in the Fall of 2016.

In DY3 Q2, HSD participated in a STP TA group with other states. There were four TA calls that were extremely informative for New Mexico to meet the compliance requirements of the CMS Settings Rule.

Community Benefit

In June 2016, the MCOs piloted the Community Benefit Services Questionnaire (CBSQ) that was created by the HSD and MCO Long-Term Care (LTC) Workgroup. The CBSQ will:

- Ensure that care coordinators explain all available Community Benefit Services to members;
- Become part of the member's Comprehensive Needs Assessment (CNA).

Additionally, the HSD and MCOs created a member brochure that explains each of the Community Benefit Services within Centennial Care.

5% of each of the MCO's LTC members with assessments conducted in June 2016 were included in the targeted pilot population. These members were either due for an annual renewal of their NF LOC or were newly eligible to receive Community Benefits. The LTC Workgroup will meet in DY3 Q3 to review the questionnaire results, share lessons learned during the pilot, review feedback from members and care coordinators, make any necessary changes to the CBSQ, and move toward full implementation.

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 88% access to PH care for Native Americans in frontier areas and 98.1% access to PH care for Native Americans in rural areas and 95% 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, LTSS, and transportation services.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements 96% of the time for claims being processed and paid within 15 days of receipt and 99% of the time for claims being processed and paid timely within 30 days of receipt.

Table #13 – 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	Shiprock Charter House Shiprock, New Mexico May 27, 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 travel and whether the Nurse Advice Line can be used when a member is out of state.
MHP	Gallup, New Mexico May 6, 2016	Molina had approximately 100 members attend this meeting. It was suggested to hold another meeting in Gallup before the end of the year.
PHP	Nenahnezad Chapter House Fruitland, New Mexico June 10, 2016	Add language on transportation benefit in the new Native American Member Guide. There was a suggestion for same day transportation for urgent care. Plan a collaborative meeting between Northern Navajo Medical Center and local Presbyterian Care Coordination team to discuss discharge and case management issues.
UHC	Shiprock Chapter House April 7, 2016	Someone requested information about the Medically Frail exemption to receive full Medicaid benefits. Patients asked for information about Centennial Care and UHC services.

The NATAC meeting for this quarter took place on May 23, 2016. HSD presented on the FY17 Medicaid budget projection and the cost containment measures being implemented by the State including proposed provider payment reductions.

HSD provided an update on the meetings being held between HSD, IHS and Tribal representatives regarding the enhanced federal funding for services received through an IHS/Tribal facility for services outside of an IHS/Tribal facility. HSD reported they will continue to work with IHS and Tribal representatives to implement this new opportunity for additional funding and develop a proposal for CMS.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment E: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

The year-to-date per member per months (PMPMs) in DY3 continue to track normally. With the implementation of cost containment, the PMPMs in Q3 will show a steady decrease.
Attachment A – Budget Neutrality Monitoring continues to show DY2 holding at 13% below the budget neutrality limit (Table 2.4.)

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 #14 – DY3 Q2 Member Months

Centennial Care MEG Reporting	
Eligibility Group	**Member Months**
Population 1 – TANF and Related	1,141,292
Population 2 – SSI and Related – Medicaid Only	123,271
Population 3 – SSI and Related – Dual	109,811
Population 4 – 217-like Group – Medicaid Only	470
Population 5 – 217-like Group – Dual	7,135
Population 6 – VIII Group (expansion)	750,427
Population 7 – CHIP Group	138,830
Total	2,271,236

Section XII: Consumer Issues (Complaints and Grievances)

A total of 933 grievances were filed by Centennial Care members in DY3 Q2. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 211 (22.61%) of the total grievances received. All four MCOs report decreases in the number of transportation grievances received in Q2 when compared to 272 in Q1of 2016. 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 118 grievances (12.64%), was regarding other specialties, such as dissatisfaction with payment on services provided and general dissatisfaction with specialty provider types. 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 98 grievances (10.50%), was regarding the Centennial Care member's PCP. Specific member grievances relate to dissatisfaction of service, staff member attitudes and prescriptions not being provided. The MCOs actions include Peer-to-Peer review, concern referrals to Clinic Managers, MCO Quality Management team, and MCO Provider Network Management.

The remaining 506 (54.23%) grievances filed during Q2 were reported for multiple grievance reasons, such as provider specialist and dental. Of those grievances, 56 (11%) were dental issues. The issues include cancelled appointments, dissatisfaction of service, and payment of services being provided. The MCOs report that dental issues are being reviewed to determine possible trends with dental providers.

HSD continues to monitor grievances to identify specific trends.

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

The HSD/Medical Assistance Division (MAD) Quality Bureau (QB) randomly reviews service plans to ensure the MCOs use 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 Q2.

Table #15 – DY3 Q2 Service Plan Audit

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

NF LOC

QB reviews high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria.

Table #16 – DY3 Q2 NF LOC 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		
Number of member files that met the appropriate level of care criteria	10	17		
Percent of MCO level of care determination accuracy	100%	100%		

Table #17 – DY3 Q2 Community Benefit LOC Audit

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

The External Quality Review Organization (EQRO) for HSD/MAD has reviewed a random sample of MCO NF LOC determinations. All reviews by the EQRO that were in disagreement with the MCO determination were then reviewed by HSD/MAD QB. HSD/MAD QB continues to meet with the MCOs regarding these determinations and to provide TA on Low and High NF LOC criteria.

Table #18 – EQRO NF LOC Review

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

Care Coordination Monitoring Activities

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 and progress on members goals are clearly documented as newly updated information to the records.

In June 20106, HSD provided additional training on documentation best practices and expectations to the MCOs' care coordinators, trainers, managers and auditors. Areas addressed included aligning PH and BH needs identified from the CNA with the Comprehensive Care Plan goals, enhancing falls documentation, individualizing and updating backup and disaster plans, effectively capturing on-going care coordination activity and ways to capture member input through response, feedback and concerns expressed.

HSD continued to provide TA as needed to all the MCOs as it relates to care coordination. Assistance has been provided throughout the quarter as needed to successfully implement the State standardized HRA tool by July 1, 2016. Care Coordination TA from HSD focused on: providing case consultation for coordination of member's care for complex member issues; ways to further educate and engage members in reducing high ED utilization; and developing guidelines for coordination of care for jail involved members being released and for members transitioning to and between waivers (1115 and 1915(c)).

HSD continued to evaluate the progress of the 10 super utilizers of ED services (defined as having greater than four outpatient 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. In May 2016, the HSD met with each of the MCOs to:

- Provide TA and discuss their successes and challenges with each of their identified members;
- Expand the number of members in the project to 35 per MCO; and

- Enhance monthly data reporting elements for the project.

HSD will meet with the MCOs in August 2016 to jointly review and share information gleaned from the project and outline best practices used to engage members successfully.

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process

HSD continues to streamline the managed care reporting process by developing new tools in an effort to increase the effectiveness of the TA call process, HSD directed report resubmission processes, and the self-identified error resubmission process. Feedback provided by the MCOs indicated several benefits from the three processes enhanced the ability to collaborate with MCOs on questions or concerns; logistical training support; and effective exchange of information and communication. Because the managed care reporting process continues to evolve, HSD continues quality improvement initiatives to ensure effective monitoring and tracking of managed care reports.

Customer Service

All call center metrics (abandonment rate, speed of answer and wait time) for all customer services lines (member services, provider services, nurse advice and the utilization management) were met by each MCO during the quarter.

Appeals

A total of 1,264 appeals were filed by Centennial Care Members in DY3 Q2. Of the total appeals filed, 835 (66%) were upheld, 391 (31%) were overturned and 9 (1%) were partially overturned. The remaining appeals filed in Q2 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 work plan continues as expected with quarter activities generally devoted to collecting data and preparing for year two of the waiver evaluation. Deloitte Consulting worked collaboratively with HSD to assess lessons learned from the first year of the evaluation and develop a process to streamline and simplify collecting, evaluating and reporting on available data provided by HSD. Deloitte Consulting continues to meet with HSD on conference calls to further refine the work plan, discuss data and analysis issues and review materials produced for HSD leadership.

Data Identification and Acquisition

As previously discussed, Deloitte Consulting reviewed hundreds of reports and data files received from HSD to identify the appropriate data to be used for the upcoming interim report submission to CMS. Based on this effort, DY2 data collection should be more streamlined as the majority of the required data sources and data summaries to be produced are clearly defined. For measures where data was not readily available or may not become available, HSD is initiating conversations with CMS to request adjustments to the evaluation plan to ensure the evaluation plan aligns with available data in order to effectively evaluate the waiver.

Evaluation Model

The Evaluation Model continues to serve as a practical way to organize the data collected for the evaluation for year-over-year comparison and analysis. The Model uses Excel and presents each measure by Baseline and Demonstration Year with the Baseline serving as the benchmark. The current Evaluation Model shows the Baseline and Demonstration Year 1 calculations utilized in the DY1 Annual data collection along with the data source used, and the year of the data. Deloitte Consulting will initiate updates to the evaluation model for DY2 in coming months to populate with updated data as it is received as well as identify adjustments required to further extract useful information from the data that has been summarized.

DY3 Q3 Planned Activities

The primary efforts in Q3 will be to collect the vast majority of the data required to conduct the evaluation for DY2 and update the evaluation model. Adjustments to the evaluation model will include populating with the new data, adjusting as needed to account for any differences between the DY1 and DY2 data, or adjusting for revisions to the evaluation plan based on discussions between HSD and CMS.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Tables (April 1, 2016 – June 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: MCO Action Plans

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 CHW recently worked with a member who was initially difficult to engage. The member was homeless for over five years, living on the streets or staying with friends. The CHW was touched by the member's story and positive attitude. The CHW was able to connect the member with local resources who helped secure an apartment for the member. After the member moved in, she contacted the CHW to find out about available assistance in obtaining some basic household goods, as the member had nothing of their own. The member was touched by the CHW's efforts in helping the member get established in a home of their own.

Centennial Care Member Success Story 2

A member was born with Phelan-McDermid Syndrome, a rare genetic disorder that causes pervasive development delays. About 400 people worldwide are known to have this health condition. The member's family was told the member might never be able to walk or talk. The member is now six years old and exhibits many delays, is non-verbal and has autistic-like behaviors associated with the syndrome. Due to the consistent therapy the member receives and the dedication of the medical team, the member has made great strides and was videoed taking unassisted steps while at school. The video of the member walking was posted online by the member's mother. The video garnered so much attention that a local TV station decided to run a story on the member. The care coordinator said it is an honor to be a part of the member's success and growth.

Centennial Care Member Success Story 3

A member was hospitalized at NM Behavioral Health Institute (NMBHI). A care coordinator was involved with a social worker with regards to discharge planning and finding placement for the member. The initial visit was somewhat difficult because the member would not speak to the care coordinator. Ultimately, the care coordinator was able to find a common ground with member around music. The care coordinator would play music on a cell phone during each visit, which opened the member to speaking more. During the course of several visits, the CNA was competed after several visits due to the member refusing to speak at times. During the final visit, the care coordinator explored reasons for the member's numerous readmissions and discussed the importance and benefits of remaining in the community. The member was very adamant about returning to NMBHI because of lack of any support. However, by end of the visit the care coordinator was able to stress the benefits of being in the community and explained the supports and boarding home placements that could be provided to the member. Since the beginning of April 2016, the member has been successful in maintaining boarding home placement.

Centennial Care Member Success Story 4

A care coordinator initially met with the member when the member was inpatient at Turquoise Lodge Hospital this past May. The member was being treated for alcoholism and was to be discharged soon. However, the member did not know where to go or what to do upon release. The member is from a small town and did not want to return there for fear it would be easy to start drinking again, so the care coordinator provided the member with a list of Oxford Homes (sober living homes) in Albuquerque as well as alcohol treatment programs. The care coordinator followed up with the member one month after the member was released. The member was able to get into one of the Oxford Homes and is doing very well. The member has two jobs and has remained sober. The member gets along with others in the home and they all support each other. The member is grateful for the care coordinator's assistance and on the road to recovery.