
# Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2016 – 12/31/2016)
Waiver Quarter: 4/2016

February 28, 2017
New Mexico Human Services Department

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**Section I: Introduction**

On July 12, 2013, the Centers for Medicare and Medicaid Services (CMS) approved New Mexico's Centennial Care Program 1115 Research and Demonstration Waiver. The approval of the waiver was effective from January 1, 2014 through December 31, 2018.

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. Approximately 694,000 members are currently enrolled in the program.

The goals of the Centennial Care Program at implementation included:

- Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most effective settings;
- Ensuring that the care being purchased by the program is measured in terms of its quality and not its quantity;
- Slowing the growth rate of costs or "bending the cost curve" over time without cutting services, changing eligibility or reducing provider rates; and
- Streamlining and modernizing the program.

As a beginning place for the development of a modernized Medicaid program, New Mexico articulated four (4) guiding principles:

1. Developing a comprehensive service delivery system that provides a full array of benefits and services offered through the State's Medicaid program;
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
3. Increasing the emphasis on payment reforms that pay for performance rather than payment for the quantity of services delivered; and
4. Simplifying administration of the program for the State, for providers and for recipients where possible.

These guiding principles continue to steer New Mexico's Medicaid modernization efforts and serve as the foundation for the Section 1115 waiver.

The four Managed Care Organizations contracted with New Mexico to deliver care are:

- Blue Cross Blue Shield of New Mexico (BCBSNM)
- Molina Healthcare of New Mexico (MHNM)
- Presbyterian Health Plan (PHP)
- United Healthcare (UHC)

## Section II: Eligibility, Provider Access and Benefits

### Eligibility

As noted in Section III of this report, there are 276,606 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment growth of 3,888 from DY3 Q3.

### Access

Throughout this report, unless otherwise noted, the most current monthly data available is through November 2016. Quarterly data is available through the third 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.

**Table 1 – PCP-to-Member Ratios by MCO**

| | July | August | September |
|---|---|---|---|
| BCBSNM | 1:54 | 1:56 | 1:42 |
| MHNM | 1:111 | 1:105 | 1:101 |
| UHC | 1:17 | 1:16 | 1:21 |
| PHP | 1:87 | 1:89 | 1:87 |

#### *Geographic Access*

During DY3 Q4, Geographic access (GeoAccess) reports continued to be reviewed by the Human Services Department (HSD) to ensure consistent methodology across MCOs. HSD identified more consistent reporting methodology among all MCOs as they report accurate provider location counts and physical location of the provider. For some specialty and behavioral health providers the MCOs do not meet the distance requirements in which 90% of members shall travel no further than the access standard for their respective provider and county type. There is not a remediation process for not meeting access because there is a shortage of providers throughout New Mexico. HSD implemented provider rate reductions in July 2016; however, throughout Q4 HSD has not identified any access issues related to the provider rate reduction. In addition, MCOs are expanding Telemedicine services in underserved areas. Please see Attachment B: GeoAccess PH Summary and Attachment C: GeoAccess BH Summary.

#### *Telemedicine*

During DY3 Q4, MCOs continued to expand telemedicine services utilizing the following four measures: (1) MCO establishment of or provision of equipment to originating sites, (2) the range of non-emergent medical conditions addressed through each MCO's telemedicine initiatives, (3) incentivization of telemedicine usage of providers through the provision of training for correct coding, and (4) the number of telemedicine visits both as an absolute and as a percentage continues to increase.

MHNM reports they have deployed three originating sites for using the vendor MD Live Breakthrough platform to provide urgent care and behavioral health telemedicine services as follows:

1. Inside Out Wellness Center in Espanola: MHNM has installed a fully-equipped telemedicine unit at this community agency where there is a high rate of substance use, when compared with other areas of the state. Inside Out is staffed by peer support specialists working to support their clients with substance abuse issues. The Inside Out peer support specialists assist MHNM members with creating an email, registering on Breakthrough, and scheduling appointments with MHNM providers using the Breakthrough platform. MHNM plans to expand this model to another Inside Out Wellness Center located in Taos, New Mexico as well as to other wellness centers.
2. La Casa de Buena Salud, Roswell: This BH clinic established an originating site in Q4 using the Breakthrough platform and a MHNM contracted BH provider.
3. Molina Medical Group, Albuquerque: This primary care group has integrated physical health (PH) and behavioral health (BH) services by using the Breakthrough platform. This allows members in the primary care clinic to obtain BH services. Although this is not a rural area, it has served as a model for potential expansion to other areas.

UHC also focused on physical health and developed two specific telemedicine initiatives to improve access to care in rural and frontier communities. The first initiative is to continue to develop a statewide program to improve access to dermatology consults for primary care doctors through Telemedicine technology. The second program is designed to close access to care gaps throughout New Mexico in the form of "virtual visits". The partnership with Doctors on Demand allows our members to "see" a doctor through a tablet, smartphone or computer, 24/7. These providers can also diagnose and treat a wide range of non-emergency medical conditions.

***Transportation***

In DY3 Q4, HSD does not have transportation issues to report.

**Service Delivery**

***Utilization Data***

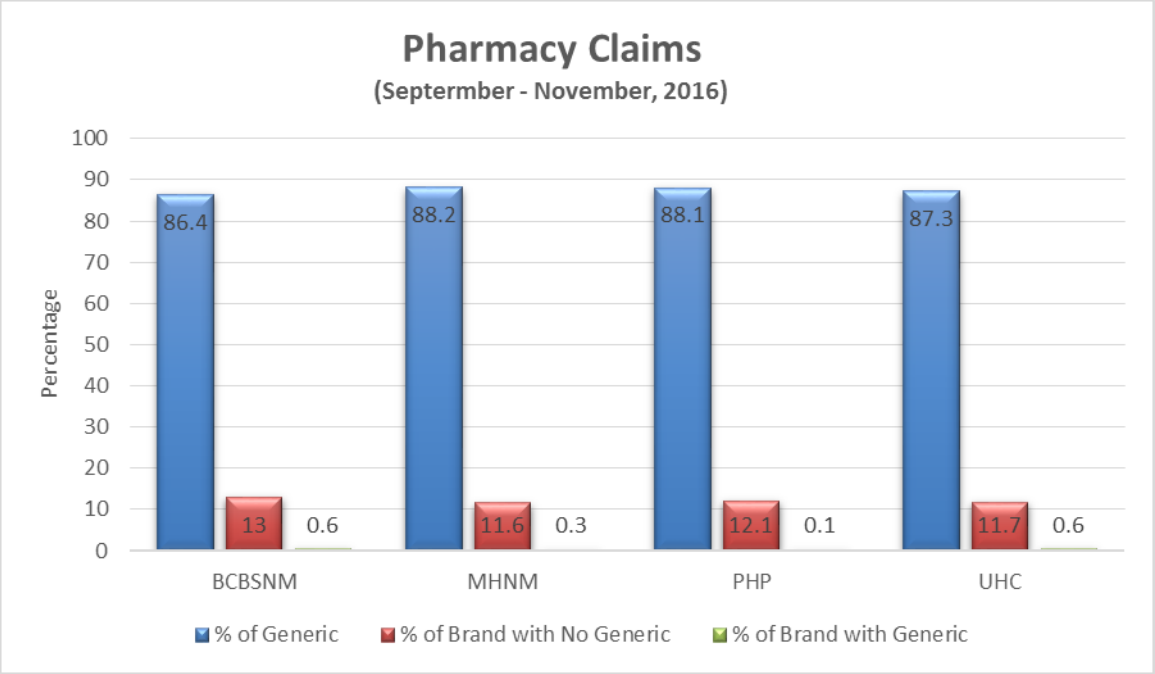
Centennial Care key utilization and cost per unit data by overall program as well as by specific program is provided for 12 months – October 2015 through September 2016. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

***Pharmacy***

The MCO monthly pharmacy report captures key metrics regarding prescription claims for brand and generic drugs. There is a higher use of generic drugs with an 87.5% average for all four MCOs. Use of the brand with no generic available is an average of 12.1% for all MCOs and use of brand with generic drug available is an average of 0.4% for all MCOs. All four MCOs require

medical justification for usage of a brand drug when a generic drug is available. Please see Percent of Pharmacy Claims for each MCO.

**Table 2 – Percent of Pharmacy Claims for Each MCO**




Source: [MCO] Pharmacy Report #44, M9CY16, M10CY16, M11CY16

***Hepatitis C***

During DY3 Q4, HSD continues to see an increase in treatment requests and approvals for Hepatitis C. HSD expects to provide HCV treatment for over 1,000 members by the end of Q4, all data analysis will be provided in the DY3 annual report.

***Community Health Workers (CHWs)***

All MCOs continued CHW initiatives in DY3 Q4 that include coordination of care, health education, health literacy. CHWs provide community support to rural, frontier, and underserved communities in urban regions, across the state of New Mexico. Some CHWs are employed by the MCOs and others are contracted, with a total of sixty-three CHWs.

**Table 3 – Community Health Workers, Employed or Contracted by MCOs DY3 Q4**

| Community Health Workers | | |
|---|---|---|
| | Employed | Contracted |
| BCBSNM | 0 | 12 |
| MHNM | 26 | 0 |
| PHP | 5 | 9 |
| UHC | 11 | 0 |
| Totals | 42 | 21 |

During DY3 Q4, CHWs activities addressed and identified common social determinants to health which include: utilities, food insecurity, employment, transportation, and housing. To address these adverse social determinants of health affecting patients, all MCOs have successfully arranged ongoing local partnerships.

UHC partners with a local non-profit by being on location two days a week to make contact with members. The non-profit focuses on access, education, wellness, and jobs to address the needs of both care coordination level I and II members, along with difficult to engage and unreachable members. This MCO's CHW teams have successfully reached 55% of the persistent super-utilizers (PSU). Out of the 55% reached, 36% have agreed to be followed by a care coordinator.

MHNM has twenty-six CHWs, who live in the communities they serve and share ethnicity, culture, and language, with fluency in Spanish/English and Navajo-English. Native American Members have CHWs that live on tribal lands.

BCBSNM has provided access to food by offering food vouchers through local food banks and delivering food boxes to members, along with utility access, by providing phone numbers of local resources, including LIHEAP and city social services.

UHC implemented an Emergency Room Diversion project and found success by working with local emergency rooms to assist members that are inpatient or recently discharged. This collaboration between the CHWs and care coordination teams has increased the number of members identified as level two care coordination members, and their access to services and supports, including meeting member social determinant needs.

Educational outreach has been accomplished by CHWs working with local partners. PHP had a 37% increase from 239 member educated on diabetic testing in Q3 to 380 members in Q4. PHP also reported that of those members enrolled with CHWs, PCP utilization increased 75%.

***Nursing Facilities (NF)***

In DY3 Q4, several issues related to MCO processing of NF payments were reported to HSD. HSD held meetings with each MCO to discuss issues and root causes. In DY4 Q1, HSD will implement bi-monthly meetings with several of the MCOs and NF billers to discuss improvements. HSD continues to track ongoing issues until they are resolved.

***Community Interveners (CI)***

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

**Table 4 – Community Intervener Services Utilization DY3 Q4**

| MCO | # of Members Receiving CI | Total # of CI Hours Provided | Claims Billed Amount |
|---|---|---|---|
| BCBSNM | 2 | 699 | $4,634.25 |
| MHNM | 0 | 0 | $0 |
| UHC | 3 | 312 | $1,968.00 |
| PHP | 1 | 83 | $506.25 |
| **Total** | **6** | **1,094** | **$7,108.50** |

***Centennial Rewards Program***

All Centennial Care members are eligible for Centennial Rewards and to date 623,581 distinct members have earned at least one reward, or 71.1% of enrollees. Since the inception of Centennial Rewards, the total points are valued at $38.9 million of which 26.4%, or $10.2 million, have been redeemed. Table 5 shows the healthy behaviors rewarded and each behavior's value. It includes both point and dollar values of the activity, the total dollars earned, the amount redeemed, and the associated percentage of redemption by activity.

**Table 5 – Healthy Behaviors Rewarded**

| Eligibility Activities | Activity Completion Reward Value in Points | Activity Completion Reward Value in $ | Total Rewards Earned by Activity in $ | Total Rewards Redeemed by Activity in $ | Redemption Percentage |
|---|---|---|---|---|---|
| Asthma Management | 750 | $ 75 | $ 1,010,325 | $ 327,395 | 32.4% |
| Bipolar Disorder Management | 750 | $ 75 | $ 1,092,525 | $ 269,521 | 24.7% |
| Bone Density Testing | 350 | $ 35 | $ 43,960 | $ 9,656 | 22.0% |
| Healthy Smiles Adults | 250 | $ 25 | $ 7,729,050 | $ 1,610,574 | 20.8% |
| Healthy Smiles Children | 350 | $ 35 | $ 17,832,150 | $ 4,832,361 | 27.1% |
| Diabetes Management | 800 | $ 80 | $ 4,489,040 | $ 1,197,918 | 26.7% |
| Healthy Pregnancy | 1,000 | $ 100 | $ 1,101,300 | $ 294,624 | 26.8% |
| Schizophrenia Management | 750 | $ 75 | $ 537,525 | $ 110,842 | 20.6% |
| Health Risk Assessment (HRA) | 100 | $ 10 | $ 4,196,000 | $ 960,680 | 22.9% |
| Other (Appeals and Adjustments) | N/A | N/A | $ 455,564 | $ 271,607 | 59.6% |
| Step-Up Challenge | 500 | $ 50 | $ 470,625 | $ 407,246 | 86.5% |
| **Totals** | | | **$ 38,958,064** | **$ 10,292,424** | **26.4%** |

Asthma Management offers members an opportunity to earn points for filling the monthly asthma prescription. During DY3 Q4, rewards earned from filing asthma medication increased from the 6$^{th}$ through the 12$^{th}$ month. The same holds true for the bipolar and schizophrenia medication adherence although not to the same levels. The 12$^{th}$ month shows increased adherence for bipolar is 149% and schizophrenia is 121%.

**Table 6 – Medication Adherence**

| Activity Group | CY16 Q1 | CY16 Q4 | Increase/ (Decrease) | % of Change |
|---|---|---|---|---|
| 5th Asthma | 318 | 1,262 | 944 | 297% |
| 6th Asthma | 190 | 1,164 | 974 | 513% |
| 7th Asthma | 154 | 1,079 | 925 | 601% |
| 8th Asthma | 123 | 947 | 824 | 670% |
| 9th Asthma | 111 | 918 | 807 | 727% |
| 10th Asthma | 106 | 881 | 775 | 731% |
| 11th Asthma | 83 | 807 | 724 | 872% |
| 12th Asthma | 83 | 778 | 695 | 837% |
| 12th Bipolar | 446 | 1,109 | 663 | 149% |
| 12th Schizophrenia | 277 | 613 | 336 | 121% |

Increased medication adherence suggests that as members become more aware of the Centennial Rewards program, and aware of the rewards they can earn, they take an active role in managing their chronic conditions.

Effective August 2016, the Rewards Card is no longer available. Based on the redemption data in the table below, members have started to utilize the other redemption categories.

**Table 7 – Centennial Care Reward Expenditures DY3 Q4**

| 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 | $22,687.00 | $10,965.00 | $16,274.00 | $5,317.00 | $20,083.00 | $12,151.00 | $48,825.00 | $10,991.00 | $14,881.00 | $0.00 |
| MOLI | $75,173.00 | $42,473.00 | $47,593.00 | $14,726.00 | $62,562.00 | $37,970.00 | $160,291.00 | $32,790.00 | $44,946.00 | $0.00 |
| PRES | $66,365.00 | $43,025.00 | $46,711.00 | $14,809.00 | $67,632.00 | $42,651.00 | $163,650.00 | $38,340.00 | $47,262.00 | $0.00 |
| UHC | $24,692.00 | $8,783.00 | $11,114.00 | $3,243.00 | $15,076.00 | $10,535.00 | $47,321.00 | $9,741.00 | $16,082.00 | $0.00 |
| **All MCOs** | **$188,917.00** | **$105,246.00** | **$121,692.00** | **$38,095.00** | **$165,353.00** | **$103,307.00** | **$420,087.00** | **$91,862.00** | **$123,171.00** | **$0.00** |
| All MCO's CY16Q3 Redemptions | $82,032.00 | $47,181.00 | $42,240.00 | $0.00 | $85,607.00 | $63,758.00 | $152,007.00 | $50,736.00 | $60,269.00 | $275,520.00 |
| Increased Redemptions from CY16 Q3 to CY16 Q4 | $106,885.00 | $58,065.00 | $79,452.00 | $38,095.00 | $79,746.00 | $39,549.00 | $268,080.00 | $41,126.00 | $62,902.00 | ($275,520.00) |
| Percentage of Increase from Previous Quarter | 130% | 123% | 188% | 100% | 93% | 62% | 176% | 81% | 104% | -100% |
| CY16 Q3 Increase | 59% | 11% | 53% | 0% | 50% | 12% | 20% | 12% | 17% | 6% |

## 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. There were some slight decreases in SSI and Related, both Medicaid Only and Dual but all other groups increased. 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 8 – Enrollment DY3 Q4**

| Demonstration Population | Total Number of Demonstration Participants Quarter Ending – December 2016 | Current Enrollees (Rolling 12 month period) | Disenrolled in Current Quarter |
|---|---|---|---|
| Population 1 – TANF and Related | 385,795 | 366,185 | 9,283 |
| Population 2 – SSI and Related – Medicaid Only | 41,135 | 41,331 | 1,017 |
| Population 3 – SSI and Related – Dual | 37,674 | 40,140 | 718 |
| Population 4 – 217-like Group – Medicaid Only | 307 | 370 | 41 |
| Population 5 – 217-like Group – Dual | 3,046 | 3,325 | 54 |
| Population 6 – VIII Group (expansion) | 276,606 | 334,292 | 12,785 |
| Totals | 744,563 | 785,643 | 23,898 |

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.

**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. Slight increase in disenrollment in certain populations is tied to the overall increase in Medicaid enrollment.

**Table 9 – Disenrollment Counts DY3 Q4**

| Disenrollments | From 2016 Q3 to 2016 Q4 | | Total Disenrollments During Q1 |
|---|---|---|---|
| **Last Month Client was Disenrolled** | **October 1, 2016** | **November 1, 2016** | |
| **Population 1 – TANF and Related** | 3,036 | 2,864 | 9,283 |
| **Population 2 – SSI and Related – Medicaid Only** | 334 | 267 | 1,017 |
| **Population 3 – SSI and Related – Dual** | 340 | 1,209 | 718 |
| **Population 4 – 217-like Group – Medicaid Only** | 5 | 5 | 41 |
| **Population 5 – 217-like Group - Dual** | 30 | 37 | 54 |
| **Population 6 – VIII Group (expansion)** | 4,156 | 4,358 | 12,785 |
| **Total Without MEG 7** | **7,901** | **8,740** | **23,898** |

Beginning in DY4 Q1, HSD will include breakout of enrollment and disenrollment by MCO.

## Section IV: Outreach

In DY3 Q4, HSD continued to provide Centennial Care monthly informational trainings to the New Mexico Aging and Long-Term Services Department (ALTSD), Adult Protective Services Division staff from across the State. HSD also provided Centennial Care informational training to First Choice Community Healthcare. Other events HSD participated in include City of Albuquerque-Taylor Ranch Fun & Wellness Fair and the 2017 annual Southwest Conference on Disability.

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

**Table 10 – Schedule of Community Events DY3Q4**

| Event Type | Event Location and Date | Audience and Topics |
|---|---|---|
| Annual Conference | Southwest Conference on Disability<br>Albuquerque, NM<br><br>October 5-7, 2016 | Set up information table. Spoke with many attendees regarding application and eligibility, benefits and services, and general questions regarding Medicaid coverage. |
| Training and Education | First Choice Community Healthcare<br>Albuquerque, NM<br><br>October 19, 2016 | Presented basic Centennial Care information to agency staff. Topics covered include: Function of Care Coordination Services, Longer-Term Care Services, and Value Added Benefits. |
| Community Health Fair | Taylor Ranch Community Center<br>Albuquerque, NM<br><br>November 6, 2016 | Set up information table. Spoke with many attendees regarding application and eligibility, benefits and services, and general questions regarding Medicaid coverage. |
| Training and Education | NM Aging & Long Term Services Department, Adult Protective Services(APS) Division –<br>Albuquerque, NM<br><br>November 8, 2016 | Presented basic Centennial Care information to new-hires of APS. This is held, at a minimum, on a quarterly basis with APS. Topics covered include: Function of Care Coordination Services, Longer-Term Care Services, and Value Added Benefits. |

## 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 has indicated to the MCOs that meetings can still occur related to encounter issues as needed. HSD continues to monitor encounters by comparing encounter submissions to financial reports 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. 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 October 2016, an 1115 Waiver Renewal Subcommittee of the Medicaid Advisory Committee was convened to provide the Department with input on key areas of focus for the State's waiver renewal. The monthly subcommittee meetings include a comprehensive and diverse group of stakeholders, including primary care and behavioral health providers, advocates, family of Medicaid recipients, the hospital association, the nursing home association, MCOs, Indian Health Services, and Tribal facilities. Stakeholders are given the opportunity to provide input on key areas including:

- Refining care coordination
- Social determinants of health
- Opportunities to enhance long-term service and supports
- BH and PH integration
- Value Based Purchasing initiatives
- Benefit alignment and member responsibility

This input will assist the Department in the development of the concept paper, and focus on key areas relative to the waiver renewal. The subcommittee will continue to meet through DY4 Q1.

### Value Based Purchasing Initiatives

In 2015, the MCOs launched 10 value-based purchasing (VBP) pilot projects that focus on paying for value rather than the volume of services and aim to move the system toward payment for improved healthcare outcomes. These VBP initiatives are aligned with a set of quality and efficiency metrics, such as decreasing inpatient readmission rates. The MCOs implemented:

- Sub-capitated payments for defined populations
- Three-tiered reimbursement rates for Patient Centered Medical Homes (PCMH)
- Bundled payments for episodes of care
- PCMH Shared Savings
- Obstetrics gain sharing

As these projects matured, the MCOs focused on increasing the risk incurred within the arrangements so that providers share some of the risk in caring for their members and achieving better outcomes. In CY17, the MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements.

### Contract Compliance – UHC Directed Corrective Action Plan (DCAP)

UHC, at the direction of HSD, implemented policy and process changes in order to: improve oversight of delegated entities, specifically provider credentialing; verify claims payment accuracy for ten manually priced claims in the audited sample data; and, improve denial rates for inpatient-hospital claims. A primary policy change removed a 24-hour time limit provision for submission of medical necessity documentation for inpatient hospital services. The policy change was implemented in July 2016.

To ensure measurable improvement, and per 7.3.2.6 of the contract, HSD directed UHC to contract with a third-party for review of their claims processing. Ernst & Young, LLP (EY), was successfully contracted by UHC during the quarter. UHC provided historic and current claims data to EY. Results from the EY evaluation, to validate the efficacy of the corrective actions, are due to HSD in DY4 Q1. UHC will also conduct a retrospective review of claims, which had been denied due to the 24-hour provision, and provide its findings to HSD for review.

**Post Award Forum**

The Centennial Care post award forum was held on Monday, November 14, 2016 as part of a regular Medicaid Advisory Committee meeting. Medicaid Director, Nancy Smith-Leslie, introduced the discussion and explained the purpose and the intent of the forum – to hear public comment about the program. A detailed account of the input received from the public forum will be included in the DY3 Annual Report.

**MCO Initiatives**

***All MCOs***

Emergency Department Information Exchange (EDIE) is a collaborative effort among MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full censes of all Emergency Department and inpatient admissions, transfers, observations and discharges. The EDIE project is a web-based communication technology that enables intra- and inter-emergency department communication. PreManage is a complimentary product of EDIE that allows hospital event data to be communicated to the health plan and providers in real time. This type of technological communication will allow MCOs to promote appropriate utilization, and decrease avoidable ED visits. For more information, please reference Care Coordination and EDIE.

***MHNM***

- Dona Ana Wellness Institute Collaboration – On November 3rd, Molina participated in an event at the Domenici Institute as part of the Stepping Up Initiative. The Dona Ana Institute convened stakeholders to share progress with the Center for Health and Justice. This national organization worked with the group to re-define a plan, identify data collection and tracking opportunities, and review policy or system changes that would further their Behavioral Health (BH) Crisis Intervention work. Molina gave a presentation on the Molina/Metropolitan Detention Center Jail Re-Entry Program, a pilot project launched in June 2016 in partnership with the Metropolitan Detention Center in Albuquerque and the Human Services Department to establish a relationship with incarcerated members so that they can receive appropriate care and supports immediately upon release into the community. A workshop followed with the local team and the Center for Health and Justice to share examples of evidence based programs with other counties. The last portion of the event

included a public forum to share efforts with the public and bring awareness to policy changes for policy makers.

- Molina Prioritized Action-Oriented Care Team (mPACT) - The mPACT model is premised on the assumption that a combination of improved complex care management by Molina Care Coordinators, targeted unit-cost interventions (where appropriate), and provider-mediated care coordination interventions can: (1) downwardly manage persistent costs among our highest-cost members; (2) prevent the progression/worsening of disease states and thereby reduce readmissions and high-cost inpatient stays; and (3) generally improve the health and wellbeing of a meaningful proportion of our least healthy/highest-cost members. The program goes live January 1, 2017.

***PHP***

- Benefit Guide - PHP incorporated a Benefit Guide to the annual handbook mailing. The Benefit Guide will be mailed out January 2017 and is intended to be a quick reference to the Centennial Care plan. It highlights benefits and programs as a Presbyterian Centennial Care member. This meets all of the items below:
    - Have an error-free, safe, quality experience
    - Are treated with care, compassion, and respect – and this includes valuing their time
    - Feel known …and have their needs anticipated
    - Are involved in the decisions about their care
    - Have access and choices
    - Are communicated in a matter that they understand those choices
    - Have their experience feel easy and coordinated

***BCBSNM***

- Enhanced Care for Children with Asthma – A collaboration between BCBSNM and the American Lung Association:
    - Based on the results of the program, BCBSNM decided to extend the program for two years in order to reach more clinics.
    - Plans are underway to begin a related program, which will reduce asthma triggers in the homes of asthmatic children with the poorest control of their condition.
- Community Paramedicine/EMTs – A collaboration between BCBSNM Care Coordinators and Community Paramedicine/EMTs:
    - There are 178 members participating.
    - Initiative has reduced ED readmissions by 78%.

***UHC***

- Community Benefit Care Plan Monitoring/Audits - Results reported on UHC performance have been consistently high month-over-month. From September through November 2016, UHC achieved 100% for all three focus areas including: Member record includes a completed Comprehensive Needs Assessment (CNA), Comprehensive Care Plan (CCP) with

specific goals and corresponding documentation; documentation clearly identifying the care coordinator is addressing member specific needs; evidence of a completed Personal Care Service (PCS) Allocation Tool that is complete and accurate.

- Community System Clinical System Migration - On October 1, 2016, UHC successfully migrated from its previous clinical management system to the new system, Community Care. This system brings with it many advances in terms of bi-directional data exchange and communications with providers and members; one integrated member record for dually enrolled members with UHC's Dual Eligible Special Needs Plan (D-SNP) and UHC Centennial Care plans; and further allows the care coordination team members to access claims, utilization, and quality data via one system in the member's single record.

## Behavioral Health

### *Centennial Care Utilization*

Since the onset of Centennial Care on January 1, 2014, there has been a steady increase of New Mexicans accessing behavioral health services. The table below illustrates the annual totals of Centennial Care clients and costs. Although the behavioral health network has changed during the past two years, clients are still able to access services.

**Table 11 – Centennial Care BH Expenditures**

| | CY2015 | CY2016 |
|---|---|---|
| Centennial Care BH Member Count[1] | 613,884 Average Quarterly Count | 666,349 Average Quarterly Count |
| Centennial Care BH Expenditures[2] | $315 million | $322 million |
| Total Centennial Care Expenditures[2] | $3.3 billion | $3.6 billion |

Source: 1. HSD Managed Care Quarterly Enrollment and PMPM for SFY2014-2017 (Omnicaid data through 12/2016)
2. Centennial Care MCO Encounters

### *HEDIS Measures*

The HEDIS measure that requires capturing data on the number of adults diagnosed with major depression who received continuous treatment for 180 days with an antidepressant medication is also known as *Antidepressant Medication Management* (AMM). While the measure's title refers to number of adults with major depression receiving care, the measure definition refers instead to percent of adults diagnosed with major depression receiving continuous treatment for 180 days with an antidepressant medication. For calendar 2016 for two quarters, 4,233 persons received continuous treatment, out of 12,452 diagnosed, for a percentage value of 34%. This is a decrease from the 2015 baseline of 39.40%; however, the number of Centennial Care members identified to receive services increased from 8,569 in 2015 to 12,452 in 2016. That is a 31% increase in the number of members counted in this measure.

***Applied Behavior Analysis Services (ABA)***

On May 1, 2015, the ABA NMAC regulation (8.321.2.10) went into effect. This service available to Centennial Care members identified with Autism Spectrum Disorder (ASD) was new to the array of behavioral health services. A previous service for Centennial Care members identified with ASD limited the service to members under the age of five. The new regulation expanded the age limit from under the age of 5 to under the age of 21.

The ABA services are broken into three stages and in 2015 each stage of the services required a prior authorization. Stage 1 is a service to diagnose, confirm the presence of ASD, and provide direction on all services needed. Stage 2 furthers evaluation to develop as comprehensive plan for treatment. Stage 3 operationalizes the comprehensive plan with direct services. Initially, there were only six approved agencies in two counties statewide to provide these services.

As of January 2017, there are 15 approved agencies in ten counties statewide. The agencies are building a system to provide services at all three stages. The chart below compares the number of approved providers at the start of the services in 2015 and current number of providers.

**Table 12 – ABA Service Providers**

| | Stage 1 Providers | Stages 1, 2 and 3 Providers | Stage 2 and 3 Providers | Total |
|---|---|---|---|---|
| May 2015 | 0 | 1 | 5 | 6 |
| January 2017 | 4 | 4 | 7 | 15 |

Additionally, when the service went live in 2015, approximately 30 children enrolled in Centennial Care transitioned into ABA services. As of the fall of 2016, 195 Centennial Care members access ABA services.

In the fall of 2016, Supplement 16-08 was issued to providers and MCOs. The supplement eliminated the prior authorizations required for Stages 1 and 2 in order to reduce waitlists and allow services to begin quickly. Stage 1 provider types were also expanded to establish the presence of ASD and a complete Stage 1 assessment must be completed in three years. Due to the low number of Stage 1 providers when the ABA services began, members were unable to begin Stage 2 and 3 services and were placed on a waitlist for up to one year. Now, with the expanded provider network, Stage 2 and 3 services can begin immediately.

***Opioid Crisis State Targeted Response Grant (Opioid STR)***

HSD was recently awarded an Opioid STR from the Substance Abuse and Mental Health Services Administration (SAMHSA). These grants are awarded to a Single State Agency (SSA) based on the unmet need for opioid use disorder (OUD) treatment and drug poisoning deaths. New Mexico will be receiving $4.8 million a year for two years. The purpose of the Opioid STR Grant is to:

- Increase access to treatment, reduce unmet treatment need, and reduce opioid overdose-related deaths through the provision of prevention, treatment and recovery activities for OUD (including prescription opioids, as well as, illicit drugs such as heroin);
- Supplement current opioid activities undertaken by the SSA; and
- Support a comprehensive response to the opioid epidemic using a strategic planning process to conduct needs and capacity assessments.

The New Mexico SSA targeted response is meant to supplement current opioid-related activities. The Opioid STR activities are expected to be grounded in epidemiologic data, current research, utilize evidence-based practices to ensure the quality of prevention, treatment and recovery programming.

The award of these funds from SAMHSA will be used to provide an array of prevention, treatment, and recovery support services to address the opioid misuse and overdose epidemic in the state. The funds are also to be used to assess the needs of their tribal communities.

***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 eighteen 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 BH Collaborative through the eighteen-month implementation period. An evaluation of the Plan will be completed at the conclusion of its implementation.

Some of the accomplishments, during the fourth quarter of 2016, are highlighted below:

*The Regulations Workgroup Goal:*

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: The cross-agency Clinical Policy Committee is reviewing all service definitions and is making appropriate policy manual revisions to eliminate conflicts and service barriers. Final product due in February, 2017.
2) To increase the adoption of person-centered interventions: The Treat First model is being expanded to six additional provider locations within the original pilot sites and expand to three new provider organizations in the southern part of the state. (Please see the "Treat First" section of this report regarding Treat First adoption as a standard of practice.)
3) Develop Adult Residential Treatment Center standards to prepare for probable Medicaid coverage and achievement of parity: A "deemed status" directive is being written by HSD to accept national accreditation standards for state-funded Residential Treatment Centers. A similar directive is being drafted for Medicaid consideration.

*The Finance Workgroup Goals:*

1) To increase the productivity, efficiency and effectiveness of the current provider network: Joint meetings are being held between HSD and the Children, Youth, and Families Department (CYFD) to modify/eliminate Comprehensive Community Support Services (CCSS) certification and modify the certification of Community Mental Health Clinics (CMHCs). Final decisions targeted for February, 2017. In addition, more flexibility in the delivery of Recovery Services is under consideration.
2) To implement a value-based purchasing (VBP) system that supports integrated care and reinforces better health outcomes: To continue to advance value-based purchasing initiatives, HSD has included new contractual requirements in its 2017 MCO agreements. In CY17, MCOs are required to spend a minimum of 16 percent of provider payments in VBP arrangements. Within the 16 percent, HSD identified minimums across the spectrum of three VBP levels in order to ensure flexibility for providers that may not have the level of sophistication or resources needed to bear risk while providing opportunities for those providers that do. The MCOs must include behavioral health community providers in its VBP arrangements and must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements.

*The Workforce Workgroup Goal:*

1) To support the development of behavioral health practitioners: A survey of BH providers for current BH intern placements has been completed; an inventory of graduate BH programs to determine intern candidates needing placements is underway; a Behavioral Health Clinical Provider Guide has been developed for orientations to students enrolled in BH-related professional programs; and the BH subcommittee of the Health Care Workforce Committee is reviewing findings on barriers to reciprocity.
2) To build a more multidisciplinary and competent BH workforce: A Medicaid Supplement related to the inclusion of Medication Management Services to be provided by RNs has been completed; and a gap analysis on BH electronic health record adoption has been completed.
3) The Behavioral Health Subcommittee, Health Care Workforce Committee's recommendations include:
    - Expedite professional licensure by endorsement for masters level clinicians;
    - Social workers and counselor should be eligible for New Mexico's Rural Healthcare Practitioner Tax Credits.
    - Funding should be provided for Health Information Exchange and adoption of electronic health records for BH providers.
    - Support Medicaid funding for community-based psychiatry residency programs in Federally Qualified Health Centers (FQHC).
4) 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 FQHCs in southern

New Mexico. Intensive clinical case reviews were conducted in two of three agencies during the early winter. The third agency will be reviewed in January, 2017.

***Behavioral Health Investment Zones (BHIZ)***

HSD received a $1 million allocation in FY16 for the establishment of BH Investment Zones. The two counties, Rio Arriba and McKinley Counties have submitted their year two plans and budgets for review. The counties also provide regular updates on accomplishments.

The Rio Arriba County (RAC) BHIZ hired three case managers dedicated to Opioid Use Reduction (OUR) Network clients, as well as, contracting a LPCC as hub manager. Client data from all RAC clients have been partially transferred from Athena to the Pathways portal; the remaining data will be entered by hand. All RAC staff and staff from seven agencies have been trained in the use of the Pathways portal.

RAC completed a member data transfer from its jail to HSD, and a case manager from the jail has been assigned. A Presumptive Eligibility Medicaid On-Site Application Assistance (PE/MOSSA) certified re-entry specialist has been selected for hire. Given all of these developments, network coordination services, and jail re-entry are on target to go live in January 2017.

Narcan continues to be supplied to the public, law enforcement agencies, and to Espanola High School. Narcan will be distributed to inmates upon release from the jail starting in January 2017.

McKinley County (MC) Behavioral Health Investment Zone continues its aim to provide intensive services to the "top 200" chronic and repeat protective custody and public inebriation clients, and to moving 25 percent from the abuse or shelter cycle into the path of recovery along a continuum of services. With the renovation of the Detox Center, newly established therapeutic and transitional living services are now available.

***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 that the program returns $57.53 for every $1 invested.

A PAX GBG workshop was presented by Dr. Embry and Dr. Lindstrom at the NM School Board Association Annual Conference in December 2016. The purpose of the workshop was to inform school leadership about the benefits of PAX GBG to reduce and prevent mental, emotional,

behavioral and psychiatric disorders among students, which impair academic achievement and dramatically increase special education, security, and staffing costs for school districts. Lastly, a new Request for Applications (RFA) is being developed and will be disseminated to school districts for spring, 2017 implementation. This opportunity is expected to increase the original number of teachers trained (172) and the number of students previously reached (3,329) by the 2016 pilot with an additional 139 elementary school teachers/classrooms and 2500 students. The RFA will target two groups of schools who can apply: higher risk communities and school districts, using data aggregated for CYFD's Early Childhood Investment Zone project; and those districts participating in Phase One of the PAX pilot, Espanola, Santa Fe, Bloomfield, and Farmington.

In addition, as a result of PAX GBG Community Forum that was convened in October, we will be collaborating with Albuquerque, Bernalillo County Governmental Council (ABCGC) on the potential introduction of PAX GBG in community schools.

***Implementation of Crisis Triage and Stabilization Centers***

A Crisis Triage and Stabilization Center (CTC) is a health facility that is licensed by DOH with programmatic approval by the Behavioral Health Services Division (BHSD). These centers are not expected to be physically connected to an inpatient hospital or included in a hospital's license. CTCs are intended to provide stabilization of BH 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 do not exceed medically monitored detox at ASAM level 3.7.

DOH has drafted rules for facility licensing serving adults. The draft rules have been reviewed by HSD. While the initial rules for promulgation focus on adults, CYFD and DOH are expected to collaborate on drafting standards for facilities that would serve adolescents at a joint or separate facility. Collaborative member agencies will be notified when rules are available for public input.

***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 guide 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 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.

The educational summit entitled, *Demystifying Hospital and Ambulatory Based Detoxification and Withdrawal* was convened on June 18, 2016 at UNM. It was co-sponsored by UNM

Hospitals, UNM Department of Psychiatry and Behavioral Sciences, NM Behavioral Health Collaborative, Presbyterian Health Plan, the NM Hospital Association and UNM Continuing Medical Education and Professional Development. Subsequently, Drs. Carli Bonham and Wayne Lindstrom presented on the topic and the ASAM levels of social detox before a joint meeting of the Taos County Commissioners and the Taos City Council which was followed by a meeting with the leadership at Holy Cross Hospital.

The additional trainings have been delivered in Las Cruces and Gallup. Eighteen individuals attended the training in Las Cruces including hospital leadership, physicians, pharmacists, nurses and outpatient clinicians. Fifty individuals attended the training in Gallup including local hospital leadership, pharmacists, physicians, nurses and partners from the Indian Health Services and the Veteran's Administration. These trainings received positive evaluations with participants reporting that they learned new skills, and developed increased confidence in their ability to provide detoxification.

***Opioid Treatment Programs (OTPs)***

There are fifteen Opioid Treatment Programs (OTPs) operating in NM serving approximately 5,090 patients. Of these, nine are located in Albuquerque, including a courtesy dosing clinic at the Metropolitan Detention Center. Clinics are also located in Belen, Santa Fe, Espanola, Farmington, Las Cruces, and Roswell.

There are currently four provider organizations pending approval to operate as an OTP. Location identified for these prospective providers include Espanola, Rio Rancho, Taos, and Gallup. A Central Registry is being created to prevent patients from surreptitiously receiving medication from more than one OTP and can be utilized in the event of an emergency where a clinic may close. Dosing information for patients can be obtained through this system. All existing OTPs have received registry related training and are downloading files to the registry. The Central Registry is expected to be fully operational in January, 2017.

The existing New Mexico Administrative Code (NMAC 7.32.8) Alcohol and Drug Abuse, Opioid Treatment Programs were last revised in 2005. As a result, potential revisions have been drafted to address issues that were not specifically defined in regulation. Planned changes align State regulations with SAMHSA's Federal Guidelines for Opioid Treatment Programs that promote optimal patient care. The regulations are currently under review by HSD before initiating the promulgation process.

***Adolescent Substance Use Reduction Taskforce (ASURT)***

CYFD's BH Division has used the State Youth Treatment Planning Grant (SYT-P) to institute an Interagency Council called the Adolescent Substance Use Reduction Taskforce (ASURT). ASURT will follow the Workforce Training Implementation Plan and the findings from the Workforce Competency survey to develop the workforce throughout the grant. CYFD will offer extensive trainings in the Seven Challenges, Seeking Safety, four MST variations (Externalizing

Behaviors, Child Abuse and Neglect; Substance Use with Contingency Management; MST Emerging Adults), Community Reinforcement and Family Training (CRAFT), Motivational Interviewing, use of the Performance and Outcomes Reporting Tool (PORT) and other tools. The ASURT Workforce Development Subcommittee will align its plan with the Behavioral Health Planning Council (BHPC) - workforce training plan, so that the goals and objective of the Adolescent Substance Use Reduction Effort (ASURE) are fully aligned with the ongoing statewide development plan outlined in the following goals and objectives of the Behavioral Health Collaborative Strategic Plan:

Goal 1: Support the development of BH practitioners;
Goal 2: Build a more multidisciplinary and competent BH workforce;
Goal 3: Promote the future of excellence in the BH workforce and prepare for integrated care; and
Goal 4: Improve the public image of BH professions.

***New Mexico Service Members, Veterans, and Families (SMVF) and In-State Policy Academy***
The SMVF Technical Assistance Center (SMVF TA Center) has been working with state and territory teams providing technical assistance and training to police academy graduates.

One of the main goals of the Policy Academy is to increase access to BH services for veterans. A Memorandum of Understanding (MOU) with the NM Corrections Department is expected to be completed by January 2017. The MOU will support the immediate transition into care for veterans so they do not experience a lapse in treatments. It is anticipated that the MOU will be in place by the end of January 2017.

The Education Subcommittee met to discuss resources needed to implement a pilot project that connect veterans to BH resources. The pilot will employ graduate students in social work who will answer phone calls within their respective University's Veteran Resource Centers. Students will be able to speak with veterans who may be seeking services and can direct them to resources. The students will be supervised by a professor. This initiative is not designed to replace existing state or federal BH call centers, but merely to be another avenue in which veterans can get assistance in securing services in their local communities. New Mexico Department of Veteran Services is working on securing a dedicated phone system that will direct callers to a participating school, based on the callers' locations.

The Policy Academy is constantly seeking guidance about 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.

***Veteran Services***

In 2016, the HSD Veterans Services programs served 1,459 veterans. HSD's Veterans Services programs address the unmet needs of veterans and their families.

The Current Service Providers are:

- National Veterans Wellness and Healing Center in Angel Fire
- Equine Therapeutic Connections
- Horses for Healing, INC.
- Mesilla Valley Community of Hope/ Abode, Inc.
- New Mexico Veterans Integration Centers (VIC)
- Southwest Horsepower
- Goodwill Industries of New Mexico
- Second Judicial District Court

These providers offer programs such as housing, jail diversion and therapeutic support services. Three of the programs offer Equine Therapy. A supplemental program under the Second Judicial District Court is Warrior Canine Connection at Assistance Dogs of the West, providing a service dog to a veteran suffering psychological injuries.

***New Mexico Crisis and Access Line (NMCAL)***

In the fall of 2016, NMCAL answered more than 6,000 calls. This includes 2,393 crisis calls, 399 New Mexico calls from the National Suicide Prevention Lifeline (NSPL), 1,969 calls for the Peer-to-Peer Warm Line, and 1,562 after-hours calls forwarded from New Mexico Core Service Agencies (CSA).

Anxiety, depression, and suicide continue to be the top three presenting reasons for calls. Bernalillo and Dona Ana counties continue to have the highest of access followed by Otero, Santa Fe, and Sandoval counties. The top reported issues of calls to the Peer-to-Peer Warm Line were identified is "mental health", with "relationships" being the next highest reported challenge.

NMCAL continues to report successful stabilization of the caller at an average rate of 95 percent or slightly higher.

***Network of Care (NOC)***

The New Mexico Behavioral Health Network of Care (NMNOC) is operating as the official website for the Behavioral Health Collaborative. This website can be accessed at: http://www.newmexico.networkofcare.org/mh/ .

Development of the Behavioral Health Network of Care (BH NOC) is ongoing. Providers are encouraged to upload information in the Resource Directory, the Job Board, and the Community Calendar. NMCAL continues to use the BH NOC as their resource directory when referring

callers to community providers. NMCAL also collaborates with BHSD in marketing the BH NOC at community events.

In the fall of 2016, total visits to the site was 15,495, approximately 2,000 more than last quarter and total page views. The top five keyword searches were: substance abuse, housing, employment, depression, and inpatient rehabilitation centers. Trilogy continues to support the communities by providing free NOC access and trainings. Trainings in the use of the BH NOC were presented to both the BHIZs and the Albuquerque Police Department (APD).

HSD and Trilogy are also working on the details of launching a bed registry service (dashboard) for all BH inpatient facilities and residential treatment centers (RTC). The registry will allow anyone to search for admission criteria and availability of any inpatient facility or RTC that participates in the bed registry service.

Trilogy has added "Internships" to the Job Bank. This now allows employers to post internships and for job seekers to search for intern possibilities.

The Veterans NOC continues to increase its provider network, as well as, sharing crucial information about services and opportunities with veterans, family members, active-duty personnel, reservists, National Guard, employers, service providers, and the community at large. This site is available at: http://newmexico.networkofcare.org/Veterans/

ALTSD has operationalized NM's 3rd NOC web portal for seniors and People with Disabilities with site.

The NOC site has other portal domains available that include: Autism, Children and Families, Developmental Disabilities, Domestic Violence, Public Health, Prisoner Re-entry and Corrections, and Foster Care.

***Certified Community Behavioral Health Clinics (CCBHC)***

The CCBHC demonstration application was submitted in October 2016. The demonstration application included a program narrative, a description of the Prospective Payment methodology and scope of CCBHC services, and a Criteria Checklist rating NM's readiness to implement the various CCBHC requirements. SAMHSA announced the demonstration States in December and unfortunately, New Mexico was not selected.

In late October, HSD was notified that its request for a No Cost Extension to complete CCBHC planning activities and expend remaining grant funds was approved. The No Cost Extension continues to support the work with stakeholder engagement and finalize the payment rate (including actuarial certification). The CCBHC Ad Hoc Committee will continue to meet through June 30, 2017 and will provide input and guidance as planning activities are completed.

The CCBHC team will also continue to meet with providers through June 2017 who are involved in the year-long process, if the providers express interest in becoming a Health Home.

***CareLinkNM -New Mexico Health Homes***

New Mexico's health homes project - CareLinkNM - is implemented with the two health homes sites. Since New Mexico was not awarded the Certified Community Behavioral Health Clinics (CCBHC) demonstration by SAMHSA, the plan is to evaluate the identified CCBHC sites for possible inclusion as Health Home sites.

***Treat First***

The Treat First model of care is an approach to clinical practice improvement. It has been in a pilot mode within the six provider organizations, and led by BHSD. The organizing principle has been to ensure a timely and effective response to a person's needs as a first priority. It is structured as a way to achieve immediate formation of a therapeutic relationship while gathering needed historical, assessment and treatment planning information over the course of a small number of therapeutic encounters. One of the primary goals has been to decrease the number of members that are "no shows" for the next scheduled appointment because their need was not met upon initial intake.

As reported last quarter, the Treat First pilot was most successful and as a result, it has been extended by nine months to permit further expansion and the adoption of new rules so that Treat First can be recognized as standard clinical practice.

***Integrated Quality Services Reviews (IQSR):***

BHSD has worked with Dr. Ray Foster to adapt the traditional QSR methodology to accommodate quality BH service delivery in integrated treatment environments. This has resulted in the establishment of Integrated Quality Service Review (IQSR) and its related trainings to support local clinical practice improvement across NM.

In SFY 16, close to 200 clinical supervisors, therapists and staff from nine community provider organizations, including four FQHCs, the Navajo Nation, and three State agencies participated in IQSR based training on Clinical Reasoning and Case Formulation and Practice Development in Integrated Care Settings. In SFY17, BHSD will establish cross-practice IQSR Review Teams that are trained to examine clinical practice within respective practice sites. Participating provider organizations will select a sample of their cases to be assessed for the strengths and challenges in their clinical practice. Subsequently, findings will be used to improve their clinical practice processes.

***Prevention "Partnership for Success" (PFS) Grant***

HSD's Office of Substance Abuse Prevention (OSAP) has been awarded a Prevention "Partnership for Success" (PFS) Grant from SAMHSA. The grant of $1.68 annually for five

years ($8 million total) will be used to address underage drinking and youth prescription drug abuse.

All nine PFS 2015 funded providers (Chaves, Cibola, Curry, and Roosevelt counties and the five schools of the Higher Education Prevention Consortium-- NMSU in Las Cruces, NM Tech in Socorro, Santa Fe Community College, San Juan College in Farmington, and UNM in Albuquerque) will attend the 2017 OSAP Recipient Meeting in Albuquerque. Grantees will hear presentations on recent epidemiological data, PMP data, evidence-based opioid overdose prevention strategies, naloxone administration training, and OSAP funded provider program highlights; and receive updates on billing changes and the Prescription Drug Overdose/SPF Rx pilot programs. A PFS 2015 grantee breakout session will be convened to hold discussions on grant deliverables, coalition building, utilizing needs assessment findings, strategic planning, challenges and solutions.

During the fall 2016, the nine grantee sites continued working on coalition building and needs assessment activities; participated in a Prevention Capacity and Readiness training; and took substance abuse prevention courses working toward their Certified Prevention Specialist requirement. They received onsite technical assistance visits in October, November, and December to support the ongoing steps of the Strategic Prevention Framework, submitting Capacity and Readiness Reports in December and sharing the needs assessment findings with their coalitions. A Prevention Evidence Based Practices and Strategic Planning Training will be held in January 2017 with draft strategic plans due in March. The nine project sites are on target to develop a prevention scope of work in spring, with strategy implementation to begin in May 2017.

***National Strategy for Suicide Prevention (NSSP)***

The work of year two of the NSSP grant was dedicated to:

- Building on year one outreach and training efforts;
- Deploying established clinical and professional practices within the pilot sites;
- Expanding clinical and professional practice statewide;
- Utilizing pilot sites to embed and sustain suicide prevention;
- Embedding Zero Suicide practice components within the pilot that include screening, referral, treatment, and follow up;
- Utilizing evaluation data to gauge progress and identify areas for improvement;
- Planning for sustainability beyond the post grant cycle; and
- Documenting and implementing project improvements.

Two counties are now implementing suicide prevention strategies that did not exist prior to this grant. Community steering committees have membership that includes law enforcement, clinicians, non-clinicians advocates, emergency medical services, and community and family members with “lived experience”, hospital staff, CSA staff, and gun shop owners.

Community steering committee members have worked on collaborating suicide prevention and reducing community suicide rates rather than working in a fragmented environment. More clinical and non-clinical staff (medical and behavioral health) is trained on suicide prevention strategies and evidence based practice than before the grant. Zero Suicide gained interest and momentum by organizations outside of the pilot site areas.

Gerald Champion Regional Medical Center (GCRMC) is currently reviewing and revising policy regarding care of suicidal patients in the emergency department (ED) and other units of care. As a result of collaborative grant work, they have created safe rooms in the ED specifically for suicidal individuals and are looking into color coordinated gowns to help with identification of high risk patients. The hospital is improving their system of mental health assessments. Anyone brought into the ED is seen by a BH professional and given an assessment. The hospital staff is increasing staff training on how to better treat suicidal individuals.

The pilot site - Esperanza Guidance Center in Otero County - has a very positive working relationship with GCRMC and continues to work with the hospital to guide the implementation of comprehensive screening, assessment, and treatment in a responsive, recovery oriented fashion. They are working closely together to improve discharge planning, outpatient care, and follow-up. Esperanza continues to develop the referral network in Otero County in order to continue to close the gap in follow-ups and individuals not receiving services upon discharge from the ED or inpatient unit.

As the grant moves ahead the core team and pilot sites will continue to identify opportunities to adapt policies that could nurture an embedded and sustainable suicide prevention model. These opportunities include the allocation of resources, the inclusion of screening in the treatment setting, the training of clinicians and gatekeepers, and the availability of means. The pilot sites continue to engage family members through the use of safety planning and Crisis, Aggression, Limitation and Management (CALM) training. Family members create a trusting environment and allow the suicidal individual to be more open to the idea of involving others, rather than keeping it a secret. As the pilot sites increase public awareness they decrease stigma around suicide and mental health.

The NM Suicide Prevention Program team continues to evaluate the current budget, policies, and workforce needs to accommodate the area of suicide prevention, suicidality, referral, treatment, and follow-up care. Future efforts to establish an all-inclusive model for suicide prevention is dependent on current budgets and projected funding.

***Screening, Brief Intervention, Referral to Treatment***

In August 2013, SAMHSA awarded HSD with a five year, $10 million grant to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT services integrate

primary and behavioral health care within primary care and community health settings. Each medical partner site universally screens adult patients 18 years old or over at least annually to identify those at risk of or have a substance use disorder.

The pre-screen, Healthy Lifestyle Questionnaire (HLQ), includes questions from evidence based tools, such as the AUDIT 10, DAST, and PHQ-9. The HLQ also identifies if an individual is at risk of having or has depression, anxiety, and/or trauma. The HLQ pre-screen score identifies when a patient is considered positive for SBIRT, at risk or having substance misuse and/or a co-occurring disorder. Although the SBIRT grant is specific to addressing substance use, NM SBIRT screening includes anxiety, depression, and trauma questions.

A SBIRT Counselor and Peer Support Worker (PSW) are assigned to each medical partner site. Both practitioner roles actively engage with patients to address their needs. Screening information is entered into the Electronic Health Record (EHR). Each site varies in how a HLQ pre-screen is disseminated and scored; however, the sites maintain fidelity to NM SBIRT model.

There are seven NM SBIRT medical partner sites. These include the following location:

- White Sands Family Medical Practice, Alamogordo;
- Aspen Medical Center, Santa Fe;
- Christus St. Vincent Entrada Contenta, Santa Fe;
- Christus St. Vincent Family Medicine Center, Santa Fe;
- First Nations Community Health Source Zuni Clinic, Albuquerque;
- Santa Fe Indian Hospital, Santa Fe
- UNM Hospital, Albuquerque.

NM SBIRT has made significant progress since the project's inception. Over the course of the grant, a total of 29,979 individuals were screened. Results of the screenings found 17,809 negative screens and 12,171 positive screens. Additionally, NM SBIRT has conducted 4,164 brief interventions, 1,726 mental health brief interventions, served approximately 4,000 individuals with therapy, and approximately 400 individuals were referred to treatment services.

Currently, NM SBIRT is focusing on sustainability measures to ensure services remain operational beyond the life of the grant which expires in August, 2018.

***SAMHSA Grant to Prevent Prescription Drug /Opioid Overdose-Related Deaths (PDO)***

BHSD's Office of Substance Abuse Prevention (OSAP) successfully applied for and received SAMHSA's competitive *Grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO),* winning this $1 million annual award for five years along with ten other states beginning September 2016.

The purpose of the grant is to reduce the number of prescription drug and opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

The PDO Advisory Council met three times in the fall of 2016. The meetings focused on providing guidance for the statewide project and dissemination of information regarding progress and required deliverables. The Department of Health's (DOH) Epidemiology and Response Division contributed substantial data and technical support to the project during this time. Doña Ana County was added to the project scope by recommendation of the Advisory Council, joining Santa Fe, Rio Arriba, and Bernalillo.

The following grant requirements were submitted to SAMHSA during the quarter as required by the terms of the grant award:

- The Needs Assessment Report. It covered the need for naloxone across the state, and provided the justification for adding Doña Ana County. The report was approved and highly commended by the SAMHSA Project Officer.
- The Naloxone Distribution Plan and Training Plan. The plan identified 17 target populations or segments, prioritized by PDO membership through an electronic survey. The SAMHSA Project Officer complemented its comprehensiveness and its reach.

Contracts for implementation in the four counties have been completed. The project will include project coordination, naloxone training, evaluation, media development, social marketing and outreach programs, and interdepartmental agreements for data collection and analysis with the Department of Health, Epidemiology and Response Division.

***SAMHSA Grant Strategic Prevention Framework for Prescription Drugs (SPF Rx)***

BHSD's OSAP also successfully applied for and received SAMHSA's competitive *Strategic Prevention Framework for Prescription Drugs (SPF Rx),* winning this $371,616 award per year for five years along with 24 other states beginning September 2016.

The purpose of the grant is to raise awareness about the dangers of sharing medications and promote collaboration between states and pharmaceutical and medical communities to understand the risks of over-prescribing to youth and adults. SPF Rx will bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and their patients in a targeted community of high need. Lastly, the grant will track reductions in opioid overdoses and promote increased incorporation of Prescription Monitoring Program data into state and community level needs assessments and strategic plans as indicators of program success.

The primary accomplishment of the SPF Rx project has been the finalization of contracts with parties involved in the project, including training and technical assistance, evaluation, data collection, media development and social marketing, infrastructure development with the Prescription Monitoring Program, and a demonstration pilot in Bernalillo County. The Bernalillo County Community Health Council has agreed to facilitate and support a local community coalition to implement the Strategic Prevention Framework and is in the process of hiring staff. In addition, interdepartmental data agreements with the Department of Health's Epidemiology and Response Division are being finalized to coordinate data requirements for DOH's CDC opioid grants and BHSD's SAMHSA opioid grants.

***Naloxone Pharmacy Technical Assistance***

BHSD's OSAP contracted with the Southwest CARE Center in 2016 to provide technical assistance to New Mexico pharmacies reimbursed by Medicaid to dispense naloxone, a medication used to reverse the effects of an opioid overdose. On-site technical assistance focused on increasing patient/customer access to naloxone, increasing the number of pharmacies carrying and dispensing naloxone, reducing pharmacy barriers to dispensing and billing for the medication, and provided pharmacists with CEUs for the training.

OSAP's *A Dose of Rxeality* media campaign worked to coordinate with and supply this project with corresponding media materials. Due to FY17 funding cuts, BHSD was no longer able to fund this initiative. However, a continuation of the project is being explored with the four participating Centennial Care MCOs that support education and training of network staff. In the interim, DOH's Epidemiology and Response Division is currently in the process of finalizing a contract with Southwest Care Center to provide 32 pharmacy trainings paid for with their CDC Prescription Drug Overdose/Prevention for States grant.

***Supportive Housing***

The Collaborative's Housing Leadership Group has begun work on the 2017 New Mexico Supportive Housing Plan with the identification of guiding principles and development of goals in two areas; 1) Increase Affordable Housing; and 2) Improve and Expand Housing Support Services. In addition to updating the 2017 goals, strategies and performance measures are currently being addressed.

The Pueblo of Zuni, Local Lead Agency (LLA) had their first Special Needs Community Stakeholder Meeting to provide information on the newly constructed Low Income Housing Tax Credit 2 (LIHTC2) development. This development will provide two additional special needs units on the pueblo bringing the total number of special needs units to four. The lottery process for these units will begin in late January early February. Local Lead Agency (LLA) training was also provided to the Pueblo of Acoma which will support six new special needs units in early 2018.

The 2016 SAMHSA Projects for Assistance in Transition from Homelessness (PATH) Annual Report was submitted in December. This will be the last year that the report will be submitted into the PATH database manually. Moving forward the report will be generated using data from the Homeless Management Information System (HMIS). The Supportive Housing program is currently working with the current PATH providers, the NM Coalition to End Homelessness (HMIS Administrator) and SAMHSA to ensure all data transition elements are achieved.

The SAMHSA-funded grant program, Housing Supports, Health, and Recovery for Homeless Individuals (HHRHI) completed its first year on September 2016. The program operates in Santa Fe, Bernalillo, and Dona Ana counties and provides permanent supportive housing for chronically homeless individuals with substance use disorders, serious mental illness, or co-occurring disorders. HHRHI service providers met and exceeded their first year benchmarks, providing housing and support services to 125 individuals. HHRHI incorporates the use of peers in the recovery model, and integrates the evidence-based practices of Permanent Supportive Housing, Supported Employment, Seeking Safety, and Motivational Interviewing into project implementation. As HHRHI enters its second year, BHSD continues to work with service and housing providers, the Mortgage Finance Authority (MFA), and New Mexico Coalition to End Homelessness (NMCEH) to support the grant's goal of accessible, effective, comprehensive, coordinated, and sustainable supportive housing services.

**Fiscal Issues**

HSD received final rate documentation from its actuary in December 2016 for rate year CY 2017 for Physical Health, Behavioral Health and Long Term Services and Supports. The CY 2017 rates contain the third round of cost containment measures, a continuous rate reduction for professional services, implemented by HSD. HSD also implemented risk adjusted rates for Physical Health for the base Medicaid population and the Medicaid expansion group for the CY 2017 rate year. (Rate certification documentation was sent to CMS on December 29, 2016.)

As the state continues to face budget deficits, HSD continues to pursue long-term cost containment measures for Medicaid which would be factored into future rate adjustments and developments. HSD is also analyzing and planning for compliance with the CMS mental health parity, home and community-based settings, outpatient drug and new managed care rules which may also have fiscal impacts.

**Systems Issues**

HSD continues to run reports to conduct ongoing auditing and analysis of NFLOC and SOC to identify discrepancies that can be identified and corrected. HSD conducted training with the MCOs to address these concerns and address any questions. HSD conducted a follow-up training to reinforce the initial training and address any new issues. HSD continues to implement reporting to monitor any discrepancies that may arise and continues to work with the MCOs.

***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 Q4. The selected Independent Verification and Validation (IVV) vendor began work in August 2016. 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.

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. However, before any review of proposals began, CMS released revised RFP guidance related to Systems Integrator functions. As a result, HSD cancelled the Integration Platform procurement, and proceeded with development of a System Integrator RFP. This was submitted to CMS for review in early December and was approved. It is to be released in February 2017.

The RFP for the next module of the Framework, the Enterprise Data Services RFP, also had to be revised because of the CMS guidance. It too was submitted to CMS for review in early December and was approved. It is scheduled for release by the end of February.

HSD began development of the RFP for the third module, Quality Assurance, in Q4. This involved extensive meetings with all stakeholders, a public hearing, questionnaires for input and review of other states' procurements and contracts on quality assurance and integrity. This RFP is still in development.

HSD has reviewed the new CMS certification and modularity guidance and has taken steps to ensure that it is in compliance. HSD hired an employee whose sole responsibility is to ensure compliance with the certification and MITA guidelines. HSD also has hired an employee whose sole responsibility is management of the procurement processes for the Framework module RFPs.

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, long-term services and supports (LTSS), the MCO grievance and appeals process, and the fair hearing process.

The Aging & Disability Resource Center (ADRC) is the single point of entry for older adults, people with disabilities, their families, and the general public to access a variety of services, including state and federal benefits, adult protective services, prescription drugs, in-home and community-based care, housing, and caregiver support. The ADRC provides telephonic information, assistance, referrals and advocacy in those areas of daily living that will maximize personal choice and independence for seniors and adults with disabilities throughout New Mexico, as well as for their caregivers.

The ADRC coordinators provide phone counseling in care coordination, which is the process for assisting the client in describing his/her issue. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions. ALTSD provides quarterly reports to HSD regarding the ADRC Caller Profile Report and Care Transitions Program Data.

**The numbers below reflect calls made to the ADRC hotline from October 1, 2016 to December 31, 2016.**

**Table 13 – ADRC Call Profiler Report**

| Topic | # of Calls |
|---|---|
| Home/Community Based Care Waiver Programs | 2,515 |
| Long Term Care/Case Management | 104 |
| Medicaid Appeals/Complaints | 23 |
| Personal Care | 86 |
| State Medicaid Managed Care Enrollment Programs | 127 |
| Medicaid Information/Counseling | 1,069 |

**The numbers below reflect counseling services provided by the ALTSD Care Transition Program from October 1, 2016 to December 31, 2016.**

**Table 14 – ADRC Care Transition Program Report**

| Counseling Services | # of hrs | # of Nursing Home Residents | # of Contacts |
|---|---|---|---|
| Transition Advocacy Support Services | | 230 | |
| Medicaid Education/Outreach | 458 | | |
| Nursing Home Intakes | | 73 | |
| *Pre/Post Transition Follow-up Contact | | | 1145 |
| **LTSS Short-Term Assistance | | | 156 |

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

**This is a newer reporting category. Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed decisions about appropriate long-term services and supports choices in the context of their personal needs, preferences, values and individual circumstances.

As a member of the NMICSS, the ALTSD Care Transition Bureau (CTB) is providing assistance to Medicaid beneficiaries enrolled in Centennial Care and receiving long-term services and supports (institutional, residential and community based) in navigating and accessing covered healthcare services and supports. CTB staff serves as advocates and assist the individual in linking to both long-term and short-term services and resources within the Medicaid system and outside of the system. CTB staff also monitor to ensure that services identified as a need are provided by the MCO, MCO subcontractors and other community provider agencies. The main purpose is to help consumers identify and understand their needs and to assist them in making informed decisions about appropriate long-term services and support choices in the context of their personal needs, preferences, values and individual circumstances.

The CTB staff continue to work directly with the MCOs when facing challenges with member transitions. Trainings are provided to new care coordinators as MCOs bring on new staff. The trainings focus on the advocacy role of the CTS as well as work done in conjunction with the MCO care coordinators.

**Critical Incidents (CI)**

HSD continues to meet quarterly with the CI workgroup in an effort to provide technical assistance to the MCOs. The workgroup supports BHSD on the delivery of BH 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 annual Critical Incident Report (CIR) trainings were held in November 2016 and were presented for the first time via webinar. The trainings were held to ensure providers have an understanding of reporting requirements. Many providers were represented by the 126 individuals that logged into the webinar.

During DY3 Q4, a total of 4000 CIRs were filed for Centennial Care, Behavioral Health and Self-Directed members. One hundred percent of all CIRs received through the HSD CIR web portal are reviewed.

During DY3 Q4, a total of 415 deaths were reported. All deaths reported through the CIR System are reviewed by HSD and the MCOs. Of the 415 deaths reported, 377 critical incidents were reported as natural expected deaths, 36 deaths were reported as unexpected deaths and two (2) deaths were reported as suicides.

All CIRs require follow up and may include a medical record review or request for records from the Office of the Medical Investigator (OMI) to determine a cause of death. MCOs have internal processes to follow up on all deaths.

During DY3 Q4, Centennial Care, Behavioral Health and Self Directed populations reported a total of 2507 (63% of the total reports) critical incidents for Emergency Services. Of those critical incidents, 260 were Behavioral health related and 106 were Self-Directed members. MCOs identified the use of Emergency Services as the highest critical incident type reported by

volume for members with reportable category of eligibility. This is a decrease compared to the 2754 in DY3 Q3, 2744 in DY3 Q2 and 2921 in DY3 Q1. No specific reason has been attributed to the decrease in emergency services reports due to the large volume of emergency service reports submitted. MCOs collaborate on internal and external initiatives to provide education to members with high emergency utilization. HSD will continue to monitor changes in emergency services reports.

**Table 15 – Critical Incident Types by Population Group**

| Critical Incident Types by Population Group | | | | | | |
|---|---|---|---|---|---|---|
| **Critical Incident Types** | **Centennial Care** | | **Behavioral** | | **Self Directed** | |
| | **#** | **%** | **#** | **%** | **#** | **%** |
| **Abuse** | 264 | 7% | 82 | 19% | 16 | 10% |
| **Death** | 415 | 10% | 16 | 4% | 15 | 10% |
| Natural/Expected | {377} | 9% | {12} | 3% | {14} | 9% |
| Unexpected | {36} | 1% | {4} | 1% | {1} | 1% |
| Suicide | {2} | 0% | {0} | 0% | {0} | 0% |
| **Elopement/Missing** | 32 | 1% | 16 | 4% | 1 | 1% |
| **Emergency Services** | 2507 | 63% | 260 | 59% | 106 | 68% |
| **Enviormental Hazard** | 68 | 2% | 2 | 0% | 0 | 0% |
| **Exploitation** | 116 | 3% | 10 | 2% | 7 | 4% |
| **Law Enforcement** | 102 | 3% | 17 | 4% | 0 | 0% |
| **Neglect** | 496 | 12% | 36 | 8% | 12 | 8% |
| **Total** | **4000** | | **439** | | **157** | |

**Table 16 – Critical Incident Types by MCO**

| Critical Incident Types by MCO - Centennial Care | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Critical Incident Types** | **BCBS** | | **Molina** | | **Presbyterian** | | **UHC** | |
| | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** |
| **Abuse** | 33 | 4% | 86 | 6% | 83 | 12% | 62 | 5% |
| **Death** | 98 | 13% | 113 | 8% | 76 | 11% | 128 | 11% |
| **Elopement/Missing** | 1 | 0% | 14 | 1% | 12 | 2% | 5 | 0% |
| **Emergency Services** | 457 | 61% | 1,004 | 73% | 335 | 48% | 711 | 61% |
| **Environmental Hazard** | 11 | 1% | 9 | 1% | 27 | 4% | 21 | 2% |
| **Exploitation** | 20 | 3% | 36 | 3% | 20 | 3% | 40 | 3% |
| **Law Enforcement** | 22 | 3% | 31 | 2% | 22 | 3% | 27 | 2% |
| **Neglect** | 103 | 14% | 91 | 7% | 129 | 18% | 173 | 15% |
| **Total** | **745** | | **1,384** | | **704** | | **1,167** | |

**Table 17 – Critical Incident Types by MCO – Behavioral Health**

| Critical Incident Types by MCO - Behavioral Health | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Critical Incident Types | BCBS | | Molina | | Presbyterian | | UHC | |
| | # | % | # | % | # | % | # | % |
| Abuse | 4 | 18% | 42 | 14% | 33 | 38% | 3 | 12% |
| Death | 1 | 5% | 9 | 3% | 3 | 3% | 3 | 12% |
| Elopement/Missing | 0 | 0% | 9 | 3% | 6 | 7% | 1 | 4% |
| Emergency Services | 13 | 59% | 208 | 68% | 25 | 29% | 14 | 54% |
| Environmental Hazard | 0 | 0% | 1 | 0% | 1 | 1% | 0 | 0% |
| Exploitation | 0 | 0% | 7 | 2% | 2 | 2% | 1 | 4% |
| Law Enforcement | 3 | 14% | 8 | 3% | 5 | 6% | 1 | 4% |
| Neglect | 1 | 5% | 21 | 7% | 11 | 13% | 3 | 12% |
| Total | 22 | | 305 | | 86 | | 26 | |

**Table 18 – Critical Incident Types by MCO – Self Directed**

| Critical Incident Types by MCO - Self Directed | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Critical Incident Types | BCBS | | Molina | | Presbyterian | | UHC | |
| | # | % | # | % | # | % | # | % |
| Abuse | 0 | 0% | 4 | 15% | 7 | 11% | 5 | 14% |
| Death | 1 | 3% | 3 | 11% | 5 | 8% | 6 | 17% |
| Elopement/Missing | 0 | 0% | 0 | 0% | 1 | 2% | 0 | 0% |
| Emergency Services | 22 | 73% | 18 | 67% | 44 | 69% | 22 | 61% |
| Environmental Hazard | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Exploitation | 2 | 7% | 0 | 0% | 2 | 3% | 3 | 8% |
| Law Enforcement | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Neglect | 5 | 17% | 2 | 7% | 5 | 8% | 0 | 0% |
| Total | 30 | | 27 | | 64 | | 36 | |

## HCBS Reporting

HSD submitted the revised Statewide Transition Plan (STP) to CMS at the end of October 2016. CMS responded with a request for a few additional changes in December.

## Community Benefit

In October 2016, a letter of direction (LOD) was issued to the MCOs requiring them to fully implement the Community Benefit Services Questionnaire (CBSQ) in November 2016. The CBSQ is completed by the care coordinator during the CB member's initial assessment and annually thereafter, and informs the member of all available CB services. MCOs provided training to care coordinators to administer the CBSQ. Beginning in December 2016, the MCOs will report the total number of completed CBSQs, along with refusals, to HSD on a monthly basis. HSD will monitor the data, and participate in "ride-alongs" with care coordinators to ensure proper implementation of this directive.

## Electronic Visit Verification (EVV)

EVV was fully implemented statewide on November 14, 2016. HSD continues to work with the MCOs and their contractor to troubleshoot any individual provider issues.

## Section VIII: AI/AN Reporting

### Access to Care

Indian Health Service, Tribally operated facility/programs, and Urban Indian clinics (I/T/Us) are concentrated near or on Tribal land where many Native Americans live and receive services. In DY3 Q4 there are 43,000 Native Americans enrolled in Centennial Care. Of those enrolled, 60% who are accessing physical health services reside in rural areas, and 85% reside in frontier areas. 56% who are accessing behavioral health services reside in rural areas, and 85% reside in frontier areas.

The data is showing members are accessing specialty services such as endocrinology, cardiology, podiatry and oncology outside of I/T/Us.

### *Contracting Between MCOs and I/T/U Providers*

For this quarter there have not been any new contracts (agreements) with I/T/Us. However the MCOs continue to work on developing contracts with I/T/Us.

### *Ensuring Timely Payment for All I/T/U Providers*

The MCOs met timely payment requirements 95% of the time for claims being processed and paid within 15 days of receipt and 95% of claims being processed and paid within 30 days of receipt.

**Table 19 – Native American Advisory Board Meetings**

| MCO | Date of Board Meeting | Issues/Recommendations |
|---|---|---|
| BCBSNM | Gallup Community Service Center<br>Gallup, New Mexico<br><br>November 9, 2016 | There was one microphone shared by presenters. This made it difficult to present information in English then translated into Navajo. In the future BCBS will provide an adequate sound system with multiple microphones. Based on recommendation of attendees, BCBS plans to invite home healthcare agencies to future meetings. |
| MHNM | Upper Fruitland Chapter House<br>Upper Fruitland, New Mexico<br><br>November 4, 2016 | MHNM explained the importance of members completing their HRA and having a care coordinator. Molina explained their MyCD program – a six week peer led community based class for members with chronic conditions, to help them manage their condition and improve their health. Attendees asked about MyCD for PTSD and cancer. They were informed that MyCD is available for anyone with a chronic condition. |
| PHP | Jicarilla Apache Area<br>Dulce, New Mexico<br><br>December 29, 2016 | PHP sent out 33 invitations to its members for their Board meeting in Dulce. The meeting was rescheduled two times due to weather and other community events. No members attended this Native American Advisory Board meeting due to weather and other community events. |
| UHC | Albuquerque Indian Center<br>Albuquerque, New Mexico<br><br>December 15, 2016 | The Native American Advisory Board meeting was held at the Urban Indian Center in Albuquerque to provide benefits information to UHC members in the community. UHC would like to partner with the center to find hard to reach members, complete HRAs, provide information to members, and arrange bus passes for those needing transportation. |

The NATAC meeting for this quarter included discussions about:

- The 1115 Waiver renewal – process & NATAC participation;
- An update on the 100% FMAP – new guidance related to services received outside of an IHS/ITU facility;
- A Tribal notification letter sent out 12/1/16 regarding changes to the Community Benefit rule including new language related to the Statewide Transition Plan; and
- A discussion about Community Health Representative (CHR) roles, responsibilities and reimbursement.

The Department scheduled additional meetings in DY4Q1with the NATAC to assist the Department in the development of the 1115 waiver renewal. These meetings will focus on input from our Native American representatives regarding the key areas identified for the waiver renewal (outlined in Section VI. Program Development).

**Update on implementation of the CMS reinterpretation of 100% Federal Medical Assistance Percentage (FMAP) for Services "Received Through" IHS**

A letter with attachments regarding New Mexico's plan to implement the guidance provided by CMS in SHO #16-002 was sent to CMS on 12/19/2016. It included:

- The State's intent to begin the program as a pilot project with the highest volume of referring providers.
- The State will assist, as requested by IHS, with execution of Care Coordination Agreements (CCAs) between Tribal and non-Tribal providers who serve Native Americans.
- Based on the State's 1952 agreement between UNM Hospital and IHS, the State will claim 100% FMAP for all services provided to Native Americans at UNM Hospital, whether inpatient or outpatient, beginning with effective date of the new CMS guidance.

## Section IX: Action Plans for Addressing Any Issues Identified

See Attachment E: MCO Action Plans

**Section X: Financial/Budget Neutrality Development/Issues**

Attachment A– Budget Neutrality Monitoring, Table 3 "PMPM Summary by Demonstration Year and MEG" shows the impacts of cost containments implemented on July 1st and August 1st of 2016. The impacts are noticeable for MEGs 1, 2, 5 and 6 as they're showing a declining PMPM in demonstration year 3 compared to year 2. On Attachment A – Budget Neutrality Monitoring shows DY3 is 21% below the budget neutrality limit (Table 3.4) with cost containment implementation based on data through quarter 4 of 2016.

## 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 20 – Member Months DY3 Q4**

| **Centennial Care MEG Reporting** | |
|---|---|
| **Eligibility Group** | **Member Months** |
| Population 1 – TANF and Related | 1,164,772 |
| Population 2 – SSI and Related – Medicaid Only | 123,671 |
| Population 3 – SSI and Related – Dual | 110,726 |
| Population 4 – 217-like Group – Medicaid Only | 624 |
| Population 5 – 217-like Group – Dual | 8,277 |
| Population 6 – VIII Group (expansion) | 786,737 |
| Population 7 – CHIP Group | 131,276 |
| Total | 2,326,083 |

## Section XII: Consumer Issues (Complaints and Grievances)

A total of 870 grievances were filed by Centennial Care members in DY3 Q4. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 229 (26.32%) of the total grievances received. The MCOs report the initiation of process improvement initiatives or performance improvement plans to address the continuing transportation issues and continue to meet regularly with their transportation vendors to address identified issues.

The second top grievance filed, with a total of 120 grievances (13.79%), was related to other specialties, such as dissatisfaction with payment on services provided and dissatisfaction with the provider. Other Specialties grievances reported were 138 in Q3, 118 in Q2 and 138 in Q1. The MCOs identified a trend in the provider billing issues for a remaining balance of complaints and grievances. MCO staff continues to educate providers on billing issues on a case by case basis.

The third top grievance filed, with a total of 100 grievances (11.49%), was regarding the Centennial Care member's PCP. PCP grievances reported were 86 in Q3, 98 in Q2 and 126 in Q1. A trend in Member PCP grievances has not been identified. Specific member grievances range from PCPs not filling prescriptions for various medications, health needs or concerns not being met, unprofessionalism of PCP, and long wait times. The MCOs actions include outreach and education to the provider by resolutions analysts.

The remaining 421 (48.39%) grievances filed during Q4 include grievance codes, but not enough information is found to establish a trend. Multiple grievances include complaints about professional staff attitudes, quality of care, and quality of service. MCOs state that communication remains open with internal departments who are involved with grievances in order to analyze the data and to identify opportunities for process improvements, and to perform outreach to the providers. HSD continues to monitor grievances to identify specific trends.

**Table 21 – MCO Grievances DY3 Q4**

| MCO Grievances<br>DY3 Q4 (October – December 2016) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **MCO** | **BCBS** | | **MHC** | | **PHP** | | **UHC** | | **Total** | |
| **Member Grievances** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | % |
| Total Number of Member Grievances Filed | 114 | 13.10% | 259 | 29.77% | 218 | 25.05% | 279 | 32.06% | **870** | |
| Top 3 Member Grievances: | | | | | | | | | | |
| Transportation Ground Non-emergency | 80 | 9.19% | 41 | 4.71% | 41 | 4.71% | 67 | 7.70% | **229** | 26.32% |
| Other Specialties | 5 | 0.57% | 1 | 0.11% | 22 | 2.52% | 92 | 10.57% | **120** | 13.79% |
| Primary Care Physician (PCP) | 1 | 0.11% | 43 | 4.94% | 47 | 5.40% | 9 | 1.03% | **100** | 11.49% |
| | | | | | | | | | | |
| Remaining Grievances | 28 | 3.21% | 174 | 20.00% | 108 | 12.41% | 111 | 12.75% | **421** | 48.39% |

## Section XIII: Quality Assurance/Monitoring Activity

### Service Plans

HSD randomly reviews comprehensive care plans, personal care service hours, and the CNA to ensure the MCOs are allocating hours based on the member's needs. The review also ensures that the member's goals are identified in the care plan. There were no identified concerns in DY3 Q4.

**Table 22 – Service Plan Audit DY3 Q4**

| Member Records | DY3 Q1 | DY3 Q2 | DY3 Q3 | DY3 Q4 |
|---|---|---|---|---|
| Number of member files audited | **120** | **120** | **120** | **120** |
| BCBSNM | | | | 30 |
| MHC | | | | 30 |
| PHP | | | | 30 |
| UHC | | | | 30 |
| Percent of files with personalized goals matching identified needs | **100%** | **100%** | **100%** | **100%** |
| BCBSNM | | | | 100% |
| MHC | | | | 100% |
| PHP | | | | 100% |
| UHC | | | | 100% |
| Percent of service plans with hours allocated matching needs | **100%** | **100%** | **100%** | **100%** |
| BCBSNM | | | | 100% |
| MHC | | | | 100% |
| PHP | | | | 100% |
| UHC | | | | 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 23 – Facility NFLOC Audit DY3 Q4**

| High NFLOC denied requests (and downgraded to Low NF) | DY3 Q1 | DY3 Q2 | DY3 Q3 | DY3 Q4 |
|---|---|---|---|---|
| Number of member files audited | 10 | 17 | 18 | 16 |
| BCBSNM | | | | 5 |
| MHC | | | | 1* |
| PHP | | | | 5 |
| UHC | | | | 5 |
| **High NFLOC denied requests (and downgraded to Low NF)** | **DY3 Q1** | **DY3 Q2** | **DY3 Q3** | **DY3 Q4** |
| Number of member files that met the appropriate level of care criteria | | | | 16 |
| BSBSNM | | | | 5 |
| MHC | | | | 1 |
| PHP | | | | 5 |
| UHC | | | | 5 |
| Percent of MCO level of care determination accuracy | **100%** | **100%** | **100%** | **100%** |

***Of the 5 sample files submitted by MHC, only one qualified as HNF level of care**

**Table 24 – Community Benefit NFLOC Audit DY3 Q4**

| Community Benefit denied requests | DY2 Q1 | DY3 Q2 | DY3 Q3 | DY3 Q4 |
|---|---|---|---|---|
| Number of member files audited | 16 | 20 | 20 | 20 |
| BCBSNM | | | | 5 |
| MHC | | | | 5 |
| PHP | | | | 5 |
| UHC | | | | 5 |
| Number of member files that met the appropriate level of care criteria determined by the MCO | 16 | 20 | 20 | 20 |
| BCBSNM | | | | 5 |
| MHC | | | | 5 |
| PHP | | | | 5 |
| UHC | | | | 5 |
| Percent of MCO level of care determination accuracy | **100%** | **100%** | **100%** | **100%** |

## EQRO NF LOC

The External Quality Review Organization (EQRO) for HSD also reviews a random sample of MCO NFLOC determinations every quarter.

**Table 25 – 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** | **23** |
| BCBSNM | | | | 5 |
| MHC | | | | 3 |
| PHP | | | | 6 |
| UHC | | | | 9 |
| Number of member files the EQRO agreed with the determination | **18** | **20** | **19** | **20** |
| BCBSNM | | | | 3 |
| MHC | | | | 3 |
| PHP | | | | 5 |
| UHC | | | | 9 |
| % | **75%** | **71%** | **73%** | **87%** |
| BCBSNM | | | | 60% |
| MHC | | | | 100% |
| PHP | | | | 83% |
| UHC | | | | 100% |
| **Low NF Determination** | | | | |
| Number of member files audited | **84** | **80** | **82** | **85** |
| BCBSNM | | | | 22 |
| MHC | | | | 24 |
| PHP | | | | 21 |
| UHC | | | | 18 |
| Number of member files the EQRO agreed with the determination | **83** | **78** | **82** | **85** |
| BCBSNM | | | | 22 |
| MHC | | | | 24 |
| PHP | | | | 21 |
| UHC | | | | 18 |
| % | **99%** | **98%** | **100%** | **100%** |
| BCBSNM | | | | 100% |
| MHC | | | | 100% |
| PHP | | | | 100% |
| UHC | | | | 100% |
| **Community Based** | | | | |
| Number of member files audited | **156** | **156** | **156** | **156** |
| BCBSNM | | | | 39 |
| MHC | | | | 39 |
| PHP | | | | 39 |
| UHC | | | | 39 |
| Number of member files the EQRO agreed with the determination | **155** | **153** | **154** | **154** |
| BCBSNM | | | | 39 |
| MHC | | | | 39 |
| PHP | | | | 38 |
| UHC | | | | 38 |
| % | **99%** | **98%** | **99%** | **99%** |
| BCBSNM | | | | 100% |
| MHC | | | | 100% |
| PHP | | | | 97% |
| UHC | | | | 97% |

HSD will continue to monitor the EQRO audit of MCO NFLOC determinations and address any identified trends with the MCOs.

## Care Coordination Monitoring Activities

### *Care Coordination Audits*

In DY3 Q4, HSD continued to focus on analyzing the MCOs interventions to address areas in need of improvement as a result of previous MCO care coordination audit findings. The MCOs reported they continued to provide training on documentation as well as contract and policy requirements to their care coordinators. In DY4, HSD will schedule quarterly meetings with the MCOs to discuss care coordination issues.

### *Care Coordination for Super Utilizers*

HSD continues to evaluate the progress of the targeted care coordination with the top 35 Emergency Department (ED) utilizers for each MCO. In November 2016, a revised template was developed and introduced to the MCOs to track this group of ED utilizer case information, allowing for HSD and MCOs to monitor continued utilization and evaluation for effectiveness of care coordination activities. In March 2017, HSD plans to meet with MCOs to present descriptive data findings on super utilizers and to discuss care coordination best practices for ED reduction**.**

### *Care Coordination and EDIE*

HSD continues to participate in the statewide "ER is for Emergencies" committee, also known as the EDIE (Emergency Department Information Exchange) Project. EDIE is a database that provides real time data of member ED utilization to the MCOs, allowing for same day intervention or connection with the member. Implementation of EDIE is planned for DY4 Q1 by Centennial Care MCOs and partnering hospitals.

### *Care Coordination for Incarcerated Individuals*

HSD continues to provide technical assistance for the care coordination pilot project with one of the MCOs and the Bernalillo County Detention Center. The project focuses on providing incarcerated members with care coordination to address members' immediate needs upon release, potentially bridging gaps in care. In January 2017, the MCO will present data findings for its sample of incarcerated members participating in the pilot project to inform future expansion.

### *Care Coordination Ride-Alongs*

HSD conducted "ride-alongs" with MCO care coordinators in July and August 2016 to observe member assessments in the home setting. HSD reviewed ride-a-long experiences with the MCOs identifying the need to continue Care Coordination training on member assessments and education about available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. In DY3 Q4, HSD developed a process and evaluation tool for DY4 ride-alongs to more thoroughly and

consistently evaluate care coordination activities. The ride-alongs will focus on utilization by care coordinators of the Community Benefit Supplemental Questionnaire (CBSQ). HSD will also be observing the care coordinator's use of the Community Benefit Member Agreement (CBMA), to ensure the member agrees to accept or decline community benefit.

## Section XIV: Managed Care Reporting Requirements

### MCO Reporting Process

During DY3 Q4, the quality improvement initiatives implemented by HSD continues to impact the MCO reporting process. HSD's Contract Managers and Subject Matter Experts (SMEs) report that the collaborative approach HSD developed has proven to be effective in increasing the level of data accuracy in their reports.

Since its inception, the Technical Assistance (TA) Call process allowed MCOs and HSD staff to discuss reporting issues and concerns. The MCOs' understanding of how to report, interpret and qualify their data, continues to be effective and has led to positive outcomes.

In addition, HSD continues to monitor and track MCO reporting results in order to identify data measures that require further analysis. HSD's goal is to ensure the integrity of MCO reports by complying with established performance standards and requirements.

### Customer Service

HSD monitors the MCO call center performance on a monthly basis to ensure member and provider questions are answered in a timely manner. Customer services lines include: member services; nurse advice line; provider services; and a Utilization Management line. All MCOs met performance standards for each customer service line during DY3 Q4. Please see Attachment F: Customer Service Summary.

#### *Call Center Performance Standards*

**Member Services**

- Less than five (5%) percent call abandonment rate
- Eighty-five (85%) percent of calls answered within 30 seconds
- Average wait time for assistance does not exceed two (2) minutes
- 100% of voicemails are returned by the next business day

**Nurse Advice Line**

- Less than five (5%) percent call abandonment rate
- Eighty-five (85%) percent of calls answered within 30 seconds
- Average wait time for assistance does not exceed two (2) minutes

**Provider Services**

- Less than five (5%) percent call abandonment rate
- Eighty-five (85%) percent of calls answered within 30 seconds
- Average wait time for assistance does not exceed two (2) minutes
- 100% of voicemails are returned by the next business day

**UM Line**

- Less than five (5%) percent call abandonment rate
- Eighty-five (85%) percent of calls answered within 30 seconds

- Average wait time for assistance does not exceed two (2) minutes

## Appeals

In addition to member appeals carried over from DY3 Q3, a total of 915 additional appeals were filed by Centennial Care Members in DY3 Q4. 635 were upheld, 6 were partially overturned and 274 were overturned. There were 461 appeals that were either filed late in the quarter or were allocated to the following month for resolution or were transitioned into a Fair Hearing.

**Table 26 – Member Appeals**

| MCO Appeals<br>DY3Q4 (October - December 2016) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **MCO** | **BCBS** | | **MOLINA** | | **PHP** | | **UHC** | | **Total** | |
| **Members Appeals** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** |
| Total Number of Standard Member Appeals | 89 | 9.72% | 141 | 15.40% | 555 | 60.65% | 130 | 14.20% | 915 | 99.97% |
| | | | | | | | | | | |
| Total Number of Member Appeals Carried Over from Previous Reporting Periods | 71 | 12.65% | 35 | 6.23% | 369 | 65.77% | 86 | 15.32% | 561 | 99.97% |
| | | | | | | | | | | |
| Total Number of Appeals Upheld | 11 | 0.74% | 81 | 5.48% | 430 | 29.13% | 113 | 7.65% | 635 | 43.00% |
| Total Number of Appeals Partially Overturned | 0 | 0% | 0 | 0.00% | 4 | 0.27% | 2 | 0.13% | 6 | 0.400% |
| Total Number of Appeals Overturned | 15 | 1.01% | 69 | 4.67% | 158 | 10.70% | 32 | 2.16% | 274 | 18.54% |
| Total Number of Appeals Pending | 34 | 2.30% | 26 | 1.76% | 332 | 22.49% | 69 | 4.67% | 461 | 31.22% |

## Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues as expected. Throughout DY3 Q4, major activities completed under the Centennial Care 1115 Waiver Evaluation consisted of data and report collection efforts for DY2 evaluation purposes, analyzing the DY2 data, and making preparations to begin drafting the DY2 Annual Evaluation Report. An initial outline for the Annual Report was developed; incorporating key feedback from HSD based on a retrospective review of the DY1 work plan and completed activities. In addition, since November 2016, Deloitte Consulting began to collect DY3 reports and data from HSD and has initiated a preliminary review of data.

Each month Deloitte provided HSD with a Data Tracking report by measure. All data files required at this time have been collected for the Annual Report and the Interim Evaluation Report, with the exception of a single revised ad hoc report. Deloitte resolved outstanding questions with HSD for all measures that will pertain to the reports. Deloitte and HSD staff will continue to engage in weekly checkpoint discussions to review data transfers and resolve outstanding data questions in greater detail.

The Evaluation Model is in the process of being finalized as part of the key activities to complete the analysis on the DY2 measure-specific data. The Evaluation Model has captured both year-over-year comparisons of measure-specific data as well as annual DY2 performance relative to baseline indicators, including benchmarks as laid out by the Special Terms and Conditions (STCs). After finalizing all data collection and review, the final Evaluation Model will be summarized as an Exhibit in a way to effectively act as supporting documentation of the analytic review completed within the Evaluation and provided as a supplement to the DY2 Annual Report.

DY4 Q1 activities will prioritize drafting, reviewing, and revising the DY2 Annual Report with HSD. An initial draft of the DY2 Annual Report is scheduled to be provided to HSD at onset of March 2017. Follow-ups with specific HSD personnel may be conducted earlier than this timeframe if warranted by the complexity of the data issues, analyses, or review procedures that arise as the annual report is being drafted.

In this timeframe, Deloitte does not anticipate any new analysis being required to be performed on DY2 measures based on newly acquired data. Instead, DY4 Q1planned activities will be focused on completing the data analyses using sources obtained through the end of calendar year 2016.

**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: MCO Action Plans
Attachment F: Customer Service Summary

## Section XVII: State Contacts

| HSD State Name and Title | Phone | Email Address | Fax |
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| | | | |
| Kari Armijo<br>Deputy Director<br>HSD/Medical Assistance Division | 505-827-1344 | Kari.Armijo@state.nm.us | 505-827-3185 |

## Section XVIII: Additional Comments

HSD has included success stories from members enrolled with Centennial Care MCOs who have had positive experiences with care coordination and other unique aspects of Centennial Care.

### Centennial Care Member Success Story 1

A member was a high utilizer of emergency rooms (ER). A care coordinator from the Behavioral Health Recovery Outreach team and a Community Health Worker (CHW) had both been trying to engage the member since February 2016 when the member's semi-annual CNA was due.

The care coordinator did have brief contact with the member on multiple occasions during outreach at Healthcare for the Homeless, but the member still refused to agree to an appointment for the CNA. The care coordinator once again saw the member at Healthcare for the Homeless and the member finally agreed to the CNA. The CNA was completed and since then, the member's ER usage has decreased considerably.

### Centennial Care Member Success Story 2

A member called the Customer Service Center to inquire about prescribed medications and supplemental medications covered. The medications covered were explained to the member. In addition, the member was also given the MCO's website to view the formulary list for the future. The member also asked if the MCO knew of a database where the member could enter medical history to better understand all the member's medical issues to pursue the right treatment. A care coordinator was then offered. The member had declined care coordination previously, however; the MCO explained the care coordination process and advised the member about the benefit of a care coordinator.

The Customer Service Center received a compliment from this member. "MCO staff was absolutely wonderful. The staff was caring and compassionate, and addressed all my concerns. The best part of the Customer Service Center is they are always so helpful and do it with a smile. It's nice to have a friendly voice on the phone when you are going through a medical crisis."

### Centennial Care Success Story 3

A pediatric member required an out-of-state kidney transplant. Not only did the care coordinator assist the family with making the numerous medical appointments in the months leading up to the transplant, the care coordinator also assisted the family by coordinating their frequent transportation needs as well. This member's parents had been taking turns bringing their child from Gallup to Albuquerque three days per week for dialysis, and a struggle for the family. The member was also frequently hospitalized in Albuquerque, and as the family was based elsewhere, the care coordinator was involved in the logistics of making sure the parents were able to stay in town while their child was an in-patient.

Two months prior to the member's transplant, the care coordinator was engaged with the Albuquerque hospital staff regarding cultural and ethical communication concerns between the hospital and the family. It was appearing as though the transplant may not occur based on these concerns, but the care coordinator and care coordination manager were able to resolve the concerns. In addition, the care coordinator located resources outside of the plan to assist the family financially, as Medicaid would only transport one parent to the transplant state, leaving the other parent and young sibling behind. The member is now recovering out of state, but the care coordinator plans to continue care coordination when the family returns to New Mexico.

**Centennial Care Success Story 4**

Prior to a member meeting with a care coordinator the member was a transient for four years and was in and out of the ER every other day. This member was hard to reach since the member changed numbers all the time. With the help of community programs, the member was able to connect with a care coordinator to complete a CNA. Since the CNA was complete (about 2 months ago), the member has not been back to the ER and continues utilizing other resources. In addition, the member has maintained regular contact with the care coordinator and has been working with a CHW to enroll in a housing program.