Centennial Care Reporting Instructions
Native American Members – Report #1

Report Objective

To ensure Native American members have access to care and are receiving needed services. Native American members are identified by the "Race Code" field on the 834 file. The "Race Code" for Native Americans must be equal to "3," or "D," or "E."

General Instructions

The managed care organization (MCO) is required to submit the Native American Members report on a quarterly basis. This report is due on April 30, July 30, October 30, and January 30 of each year. If a report due date falls on a weekend or a State of New Mexico holiday, receipt of the report the next business day is acceptable. An annual supplement is also required for this report. The annual supplement is a restatement of all four quarterly report submissions related to the reporting periods within the particular calendar year. The restated reports are to reflect data as of March 30 of the following year, thus benefiting from the additional paid claims run out. Please adhere to the following reporting periods and due dates.

Quarter	Reporting Period	Report Due Date
1	January 1 – March 31	April 30
2	April 1 – June 30	July 30
3	July 1 – September 30	October 30
4	October 1 – December 31	January 30
Annual Supplement	January 1 – December 31	April 30 (following year)

An Excel workbook is provided as a separate attachment for submission. Quantitative data and any qualitative data **must** be entered in the Excel workbook. The MCO must ensure that data is entered in all fields. The report will be considered incomplete if any field is left blank. Use "ND" if there is no data available to report. Use "N/A" if the data field is not applicable. All formulas provided in the workbook shall not be altered by the MCO. An electronic version of the report in Excel must be submitted to the New Mexico Human Services Department (HSD) by the report due date listed above. The report shall be submitted via the State's secure DMZ FTP site. The date of receipt of the electronic version will serve as the date of receipt for the report.

To assist MCOs with the use of the template, all cells within the template are viewable. This allows the user to move the cursor into any cell of the template and enables the user to see the formulas in the cells that calculate automatically. Although certain cells are locked and protected, the user's ability to view the formulas should assist in the MCO's understanding of the template and calculations performed. It is important to note that when populating the templates with data, users are not to use the "cut and paste" function in Excel, as this may cause errors to the cell formulas. Additionally, certain cells have been shaded and locked to prevent data entry where data is not applicable to the particular item or category.

Please note that the majority of this report captures information based on paid claims with dates of service within the quarterly reporting period. For sections of this report that capture data for multiple reporting periods, the MCO is required to restate previously submitted data unless

instructed otherwise. Reporting data in this manner will take advantage of the most recent look at the claims paid data and other information outside the MCO's claims processing system necessary for completing this report, thus benefiting from the additional months of claims paid run out and reporting lag. Amounts entered into this report are to be based on actual data and exclude any estimates or accruals.

Each time the report is submitted, the MCO shall use the same template that was submitted in previous quarters. For example, the report due on July 30 will include data for the 1st and 2nd quarters. The reporting period for the report would be 1/1/19 through 6/30/19.

The MCO shall submit the electronic version of the report using the following file labeling format: MCO.HSD1.Q#CY##.v#. The "MCO" part of the labeling should be the MCO's acronym for their business name. With each report submission, change the quarter reference (Q# - e.g., Q1), the calendar year (CY## - e.g., CY19), and the version number (v# - e.g., v1), as appropriate. The version number should be "1" unless the MCO is required to resubmit a report for a specified quarter. In those instances, the MCO will use "2" and so on for each resubmission.

The Reporting Period, MCO Name, and Report Run Date must be entered in the fields provided at the very top left corner of the first worksheet in the Report. Using the format illustrated below, enter the start and end dates for the Reporting Period. The MCO Name should be the MCO's full business name. Using the format illustrated below, enter the Report Run Date. The Report Run Date refers to the date that the data was retrieved from the MCO's system. All dates and the MCO name entered on the first worksheet will automatically populate the top of all other worksheets in the report.

Reporting Period	MM/DD/YYYY	through	MM/DD/YYYY
MCO Name	MCO's Full Name		
Report Run Date	MM/DD/YYYY		

Attestation and Penalties

The MCO shall ensure that all data is accurate and appropriately formatted in each of the tabs prior to submitting the Report. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit accurate reports and/or failure to submit properly formatted reports may result in monetary penalties of $5,000 per report, per occurrence.

The MCO shall include a signed Centennial Care Report Attestation Form with each Report submitted. Failure to submit a signed attestation form by the Report due date will result in the entire Report being late. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit timely reports may result in monetary penalties of $1,000 per report, per calendar day. The $1,000 per calendar day damage amounts will double every ten calendar days.

Related Contract and Regulatory Requirements

1. Section 4.4 – Care Coordination
2. Section 4.7 – Value Added Services
3. Section 4.21 – Reporting Requirements
4. Section 7.3 – Failure to Meet Agreement Requirements

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Definitions

Care Coordination Level 2 (CCL2)	Members who were assigned to CCL2 based on the CNA (as outlined in contract section 4.4.6).
Care Coordination Level 3 (CCL3)	Members who were assigned to CCL3 based on the CNA (as outlined in contract section 4.4.7).
Category of Eligibility (COE)	The Medicaid eligibility categories as defined under Centennial Care.
Comprehensive Care Plan (CCP)	A CCP is a comprehensive plan of services that meets the Member's physical, behavioral and long-term care needs. CCPs will be developed and implemented for Members in CCL2 and CCL3. Refer to Section 4.4.9 of the contract for more information.
Comprehensive Needs Assessment (CNA)	The CNA is an assessment of the Member's physical, behavioral health, and long-term care needs; it will identify potential risks and provide social and cultural information. The results of the CNA will be used to create the CCP, which is based on the Member's assessed needs. The CNA may also include a functional assessment, if applicable. Refer to Section 4.4.5 of the contract for more information.
Current Procedural Terminology (CPT)	A numeric coding system maintained by the American Medical Association. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.
Difficult to Engage (DTE)	Members who were categorized as DTE (as outlined in contract section 4.4.2.6.2). A Member may be categorized as "difficult to engage" (DTE), if reached at least once, with an additional two attempts to contact documented by the CONTRACTOR.
Full Delegation Model	In the Full Delegation Model, the MCO delegates the full set of care coordination functions to the provider/health system (the delegate) for an attributable Membership and only retains oversight and monitoring functions. Refer to Section 4.4.19.1 of the contract for more information.
Health Risk Assessment (HRA)	The HSD Standardized HRA is an assessment conducted on all Members who are (1) newly enrolled in Centennial Care and (2) who are not in CCL2 or CCL3 and who have a change in health condition that requires a higher level of care coordination. The HRA is conducted for the purpose of (i) introducing the CONTRACTOR to the Member, (ii) obtaining basic health and demographic information about the Member, and (iii) confirming the need for a CNA. Refer to Section 4.4.2 of the contract for more information.
Healthcare Common Procedure Coding System (HCPCS)	The Healthcare Common procedure Coding System is divided into principal subsystems, referred to as level 1 and level 2 of the HCPCS.

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HCPCS Level 2	Level 2 of the HCPCS is a standardized coding system that is used primarily to identify products, supplies and services not included in the CPT-4 code, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.
Inpatient Psychiatric Facility/Unit (IPF) – Discharges and Follow-Up Evaluations	Includes psychiatric units in general hospitals and freestanding psychiatric hospitals. For the purposes of tracking discharges and follow-ups, claims data should be used.
Non-Emergent Conditions	Conditions that do not meet the criteria of emergency medical conditions. Per the Centennial Care Contract, emergency medical conditions means a medical or behavioral health condition manifesting itself through acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the members' health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) serious disfigurement to the member.
Refused Care Coordination	Members who refused to participate in care coordination (as outlined in contract section 4.4.1.5).
Residential Treatment Center (RTC) – Discharges and Follow-Up Evaluations	For the purposes of tracking RTC discharges and follow-ups, authorization data and claims data should be used, where applicable.
Shared Functions Model	In the Shared Functions Model, the MCO retains some care coordination functions and allows other care coordination activities to be conducted by a partner. Refer to Section 4.4.19.2.1 of the contract for more information.
Treatment Foster Care (TFC) – Discharges and Follow-Up Evaluations	For the purposes of tracking TFC discharges and follow-ups, authorization and claims data should be used, where applicable.
Unreachable	Members who were categorized as Unreachable (as outlined in contract section 4.4.2.6.1).
Value Added Service	Any service offered by the MCO that is not a Medicaid covered benefit under the Centennial Care Contract or provided in lieu of the MCO offered service or setting.

Section I: Care Outside of I/T/U

Before entering data in the workbook, ensure that the "Care Outside of ITU" tab is selected. This section of the report captures information regarding Native American members who have accessed care outside of the Indian Health Service, Tribal health providers, and Urban Indian providers, including facilities that are operated by a Native American/Alaskan Indian tribe. Note that completing this section of the report

requires the MCO to use multiple data sources (e.g., enrollment data and claims data). Please refer to Addendum A for a list of provider codes to assist with reporting provider counts.

Row Header	Row Number	Description
Count of Newly Enrolled Non-Dual Native American MCO Members	7	The number of unduplicated new non-dual Native American members enrolled in the MCO during the reporting period. Count members who meet all of the following criteria: (1) with race code = "3," "D," or "E"; (2) without Medicare; (3) enrollment effective date within the last month of the reporting period; and (4) not enrolled in a Centennial Care MCO in the month preceding the month of the enrollment effective date.
Total Count of Non-Dual Native American MCO Members	8	The total number of unduplicated non-dual Native American members enrolled in the MCO during the reporting period (includes the number reported in Row 7). Count members who meet all of the following criteria: (1) with race code = "3," "D," or "E"; (2) without Medicare; and (3) actively enrolled in the MCO during the particular reporting period.
Total Count of Unduplicated Native American Members who went Outside of ITU to Visit Specialty Provider(s)	9	The unduplicated count of Native American members who received services during the reporting period outside of an I/T/U facility from any of the provider types listed in Rows 10 through 22. Note that the value reported in this field is not a sum of Rows 10 through 22. Please count each member one time even if he/she visited multiple providers within the reporting period.
Cardiology Endocrinology Hem/Oncology Nephrology Nutrition Counseling Ophthalmologist Orthopedics Podiatry Pulmonologist Licensed Alcohol and Drug Abuse Counselor Licensed Professional Clinical Counselor Psychiatrist Psychologist	10 through 22	The unduplicated count of Native American members who received services outside of an I/T/U facility from any of the provider types listed in Column A. Count Native American members who had a paid claim with date of service within the particular reporting period where the provider (billing, rendering, or attending) was not an I/T/U facility. Refer to the provider type codes listed in Addendum A. Please count each member one time for each reporting period and applicable provider type associated with the service, even if he/she visited the same provider multiple times within the particular reporting period. A member who received services from more than one provider type during the particular reporting period is to be counted once within each row associated with the applicable provider types.

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Section II: High Behavioral Health Utilization

Before entering data in the workbook, ensure that the "High BH Utilization" tab is selected. This section of the report captures behavioral health services most utilized by Native American members and the names of the top ten providers that rendered those services (based on number of paid claims with dates of service within the applicable quarter). The provider type of the billing provider listed on the claim is to be used to identify claims to use when reporting utilization of behavioral health services.

Note that the behavioral health (BH) services applicable to this section can be obtained by the Native American member either at an I/T/U facility or at a non-I/T/U facility.

Completing this section of the report requires three steps:

(i) List the ten most utilized behavioral health services for the reporting period based on the number of paid claims with dates of service within the applicable reporting period;

(ii) List the ten most utilized behavioral health services for the reporting period based on dollar amount of paid claims with dates of service within the applicable reporting period; and

(iii) List the top ten rendering/attending providers based on the number of paid claims with dates of service within the applicable reporting period) that performed each behavioral health service.

Top 10 Behavioral Health Services Based on Number of Paid Claims and Dollar Amount of Paid Claims

In Rows 6 through 17, the MCO is required to identify the ten behavioral health services most utilized by Native American members for the reporting period based on paid claims with dates of service within the applicable reporting period. The MCO must also list the ten most utilized services based on dollar amount of paid claims with dates of service within the quarterly reporting period. The CPT or HCPCS codes for the ten most utilized behavioral health services must be sorted in descending order by number of paid claims and by dollar amount of paid claims (Columns D and I, respectively).

Column Header	Column	Description
CPT/HCPCS Code	B, G	The CPT/HCPCS code for each service listed.
Service Classification	C, H	Enter a short and concise service classification (e.g., inpatient stay at psych facility) that corresponds to the CPT/HCPCS code in Columns B and G.
Number of Paid Claims	D	The number of paid claims for the CPT/HCPCS codes in Column B with dates of service within the reporting period.
Dollar Amount of Paid Claims	I	The dollar amount of paid claims for the CPT/HCPCS codes in Column G with dates of service within the reporting period.

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Top 10 Rendering/Attending Providers of Most Utilized Behavioral Health Services Based on Number of Paid Claims

In Rows 20 through 47, for each of the ten most utilized behavioral health services listed in Cells B8 through B17, list the top ten rendering/attending providers according to the number of paid claims. Entries are to be made in descending order according to the number of paid claims. Claims are to be limited to those paid claims with dates of service within the applicable reporting period. If a provider has more than one location, combine the data to ensure a provider is unduplicated. In the column next to the provider's name, enter the number of corresponding paid claims associated with the particular service. Behavioral health service CPT/HCPCS codes in Rows 21 and 36 will automatically populate each section of the table using the data entered in Cells B8 through B17. Data entry is not required in these fields.

Section III: Inpatient Statistics

Before entering data in the workbook, ensure that the "Inpatient Stats" tab is selected. This section of the report captures inpatient statistics for Native American members. Please report based on paid claims with dates of service within the applicable reporting period.

For each of the four inpatient categories (medical, surgical, maternity, and NICU), provide the following information:

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Row Header	Row Number	Description
Admits / 1000 members	8, 13, 18, 22	The number of inpatient admissions per 1,000 Native American members. Numerator: Number of inpatient admissions that occurred in the particular reporting period Denominator: Number of Native American members enrolled in the MCO for the particular reporting period Rate = (numerator/denominator)*1,000
Average Length of Stay (ALOS)	9, 14, 19, 23	The average number of days a Native American member was in the hospital for an inpatient admission. Numerator: Number of days of inpatient stays. Days are calculated as the number of days between admit and discharge date, excluding the date of discharge and any days that are denied. If dates are equal, the inpatient day is counted as one. Days counted should be all paid days of service for each admission that occurred in the particular reporting period. If the admission and discharge do not occur in the same reporting period, all days are to be counted as occurring in the reporting period in which the admission occurs. Denominator: Number of inpatient admissions associated with a Native American member that occurred in the particular reporting period.
Days / 1000 members	10, 15, 20, 24	The number of days a Native American member was in the hospital for an inpatient admission. Numerator: Number of days of inpatient stays. Days are calculated as the number of days between admit and discharge date, excluding the date of discharge and any days that are denied. If dates are equal, the inpatient day is counted as one. Days counted should be all paid days of service for each admission that occurred in the particular reporting period. If the admission and discharge do not occur in the same reporting period, all days are to be counted as occurring in the reporting period in which the admission occurs. Denominator: Number of inpatient admissions associated with a Native American member that occurred in the particular reporting period Rate = (numerator/denominator)*1,000
Number of Inpatients w/ LOS > 10 Days	11, 16	The number of inpatient admissions in the particular reporting period where the length of stay was greater than 10 days.

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Section IV: High Emergency Room (ER) Utilization for Non-Emergent Conditions

Before entering data in the workbook, ensure that the "High ER Utilization" tab is selected. This section of the report captures emergency room utilization for Native American members with an emergency room visit for non-emergent condition(s). This is any Native American member who presents at an emergency room, a claim is submitted, and the condition is non-emergent. Report based on paid claims with dates of service within the applicable reporting period.

Data must be provided based on the member's care coordination category as of the last day of the applicable reporting period. Members are to be counted in only one of the five care coordination categories within each applicable reporting period.

Emergency Room (ER) Utilization for Non-Emergent Conditions

This section of the worksheet (Rows 6 through 30) captures the total number of unduplicated Native American members per care coordination category, the number of unduplicated Native American members for each category with an emergency room visit during the reporting period, and of those Native American members with an emergency room visit, the number with non-emergent condition(s) associated with the emergency room visit. Data is to be limited to paid claims with dates of service within the applicable reporting period.

Data in this section of the report must be restated each time the report is submitted (e.g., when submitting the 3rd quarter report, data for 1st and 2nd quarters must be restated).

Percent Calculations:

- Unduplicated Native American Members with an ER Visit: Unduplicated Native American members with an ER visit relative to the total number of unduplicated Native American members.

- Unduplicated Native American Members with an ER Visit for Non-Emergent Conditions: Unduplicated Native American members with an ER visit for a non-emergent condition relative to the number of unduplicated Native American members with an ER visit.

Top 10 Diagnoses for Non-Emergent Conditions in an ER

This section of the worksheet (Rows 33 through 44) captures the most frequent ICD codes for the reporting period based on paid claims with dates of service within the applicable reporting period for Native American members with non-emergent emergency room visits. The MCO is required to identify the ten most frequent ICD codes for Native American members with non-emergent emergency room visits during the quarterly reporting period.

The ICD codes for the ten most frequent non-emergent conditions treated in the emergency room must be listed in Column B and sorted in descending order by number of instances (Column H). For each ICD code listed in Column B, enter a short and concise description of the diagnosis in Column C. In Column H, enter the number of times the ICD code appeared on paid claims for non-emergent ER visits.

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Top 10 Utilized Emergency Room Diagnoses for Non-Emergent Conditions by Care Coordination Category

For each of the ten most utilized ICD codes identified in the previous section of this report, identify the number of instances of each diagnosis for Native American members, broken down by care coordination category. The data in this section must pertain to the current quarterly reporting period. Refer to Rows 47 through 54 of this section.

Please note that the top ten ICD codes from the previous section are automatically populated in Columns D through M of Row 48. The codes are listed from left to right in descending order by number of instances of ICD code as entered in the table described in the previous section (Top 10 Emergency Room Diagnoses for Non-Emergent Conditions Based on Number of ICD Codes). Please note that the Number of Instances of ICD Codes for each ICD code under the section "Top 10 Emergency Room Diagnoses for Non-Emergent Conditions Based on Number of ICD Codes" must match the quarter totals (Row 54) of this section.

Unduplicated Count of Native American Members with Non-Emergent Emergency Room Visits

This section of the worksheet (Rows 57 through 64) captures the frequency of emergency room visits that occurred in the reporting period for those Native American members with non-emergent conditions. Emergency room visits are to be reported by the care coordination category of the respective member as of the last day of the reporting period and by the frequency of visits (1, 2-3, or 4+ visits). Members are to be assigned to only one care coordination category at any given time. Visit counts are to be mutually exclusive by each care coordination category and frequency grouping.

Section V: Facility Readmissions

Before entering data in the workbook, ensure that the "Facility Readmissions" tab is selected. This section of the report captures facility follow-up and readmission rates for Native American members within 7 and 30 calendar days following discharge using a rolling quarter format. Using the rolling quarter format where sections of this report capture data for multiple reporting periods (both current and prior quarters), the MCO is required to restate previously submitted data.

Please note that counts captured in this section are to be based on paid claims with dates of service within each of the quarterly periods specified in Row 6. With each submission, the MCO is required to restate quarterly data from previous submissions with updated data as necessary. Reporting data in this manner will take advantage of the most recent look at the claims paid data and other information necessary (i.e., authorization data) for completing this report, thus benefiting from the additional months of claims paid run out and reporting lag. Amounts entered into this report are to be based on actual data and exclude any estimates or accruals. The MCO is required to enter the applicable reporting periods in the template (Row 6) with each submission of the report.

Rolling Quarters

With each report submission the MCO is required to enter data for the current reporting period, as well as the three previous reporting periods noted in Row 6 of the report.

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Columns Q – U: Enter data for the **current** reporting period. For example, if the report is submitted for the fourth quarter on January 30. The MCO is required to enter data for the current reporting period and label the header Q4CY19 in Row 6.

Columns L – P: Enter data for the **previous** report submission. For example, if the current report is submitted for the fourth quarter, the MCO is required to enter data for the third quarter in these columns and label it as Q3CY19 in Row 6.

Columns G – K: Enter data for 2 quarters back. For example, if the current report is submitted for the fourth quarter, the MCO is required to enter data for the second quarter in these columns and label it as Q2CY19 in Row 6.

Columns B – F: Enter data for 3 quarters back. For example, if the current report is submitted for the fourth quarter, the MCO is required to enter data for the first quarter and label it as Q1CY19 in Row 6.

Data Fields

Note: Follow-up evaluation counts and facility readmission counts are to be reported within the particular reporting period in which the associated discharge is reported.

Each discharge and readmission must be counted and reported.

Columns B, G, L, and Q capture the number of members under the age of 18 at time of discharge. Columns C, H, M, and R capture the number of members between the ages of 18 through 20 at time of discharge. Columns D, I, N, S capture the number of members between the ages of 21 through 64. Columns E, J, O, and T capture the number of members 65 or older at the time of discharge.

Data for members 21 and over must not be reported for RTCs and TFCs.

Columns F, K, P, and U capture the quarterly total for each row outlined below; the MCO is required to enter and update data in these columns with each submission.

Column V captures the four-quarter total for the quarterly periods displayed in Row 6; data entry is not required in this column.

Note: Each time a member is discharged from a facility, the MCO must restart the count of days from discharge to the follow-up visit. For members with multiple discharges, use the most recent discharge date to determine the number of days from discharge to a follow-up visit.

Row Header	Row	Description
Inpatient Psychiatric Facility/Unit (IPF)	8	This is a row header; data entry is not required in this field.
IPF Discharges	9	The number of Native American members discharged from an IPF during the applicable reporting period.

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Row Header	Row	Description
Number of Native American Members Seen for Follow-Up within 7 Days of Discharge from IPF	10	Of the number of Native American members discharged from an IPF during the applicable reporting period, enter the number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 7 calendar days of discharge from the IPF. Note: The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.
Percent of Native American Members Seen for Follow-Up within 7 Days of Discharge from IPF	11	The number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 7 calendar days of discharge from an IPF divided by the number of Native American members discharged from an IPF during the applicable reporting period. Data entry is not required in this field.
Number of Native American Members Seen for Follow-Up within 30 Days of Discharge from IPF	12	Of the number of Native American members discharged from an IPF during the applicable reporting period, enter the number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 30 calendar days of discharge from the IPF. This count must also include the counts reported in Row 10 for Native American members seen for follow-up within 7 calendar days of discharge. Note: The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.
Percent of Native American Members Seen for Follow-Up within 30 Days of Discharge from IPF	13	The number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 30 calendar days of discharge from an IPF divided by the number of Native American members discharged from an IPF during the applicable reporting period. Data entry is not required in this field.
Total Number of Readmissions to an IPF within 30 Days of Discharge from IPF	14	Of the number of Native American members discharged from an IPF during the applicable reporting period, enter the total number of Native American members who were readmitted to an IPF within 30 calendar days of being discharged from an IPF.
Percent of IPF Readmissions within 30 Days of Discharge from IPF	15	The total number of Native American members readmitted to an IPF within 30 calendar days of discharge divided by the number of Native American members discharged from an IPF during the applicable reporting period. Data entry is not required in this field.
Residential Treatment Center (RTC)	17	This is a row header; data entry is not required in this field.
RTC Discharges	18	The number of Native American members discharged from an RTC during the applicable reporting period.

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Row Header	Row	Description
Number of Native American Members Seen for Follow-Up within 7 Days of Discharge from RTC	19	Of the number of Native American members discharged from an RTC during the applicable reporting period, enter the number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 7 calendar days of discharge from the RTC. Note: The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.
Percent of Native American Members Seen for Follow-Up within 7 Days of Discharge from RTC	20	The number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 7 calendar days of discharge from an RTC divided by the number of Native American members discharged from an RTC during the applicable reporting period. Data entry is not required in this field.
Number of Native American Members Seen for Follow-Up within 30 Days of Discharge from RTC	21	Of the number of Native American members discharged from an RTC during the applicable reporting period, enter the number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 30 calendar days of discharge from the RTC. This count must also include the counts reported in Row 19 for Native American members seen for follow-up within 7 calendar days of discharge. Note: The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.
Percent of Native American Members Seen for Follow-Up within 30 Days of Discharge from RTC	22	The number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 30 calendar days of discharge from an RTC divided by the number of Native American members discharged from an RTC during the applicable reporting period. Data entry is not required in this field.
Total Number of Readmissions to an RTC within 30 Days of Discharge from RTC	23	Of the number of Native American members discharged from an RTC during the applicable reporting period, enter the total number of Native American members who were readmitted to an RTC within 30 calendar days of being discharged from an RTC.
Percent of RTC Readmissions within 30 Days of Discharge from RTC	24	The total number of Native American members readmitted to an RTC within 30 calendar days of discharge divided by the number of Native American members discharged from an RTC during the applicable reporting period. Data entry is not required in this field.

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Row Header	Row	Description
Total Number of Admissions to an IPF within 30 Days of Discharge from RTC	25	Of the number of Native American members discharged from an RTC during the applicable reporting period, enter the number of Native American members admitted to an IPF within 30 calendar days of discharge from an RTC.
Percent of IPF Admissions within 30 Days of Discharge from RTC	26	The total number of Native American members admitted to an IPF within 30 calendar days of discharge from an RTC divided by the number of Native American members discharged from an RTC during the applicable reporting period. Data entry is not required in this field.
Treatment Foster Care (TFC)	28	This is a row header; data entry is not required in this field.
TFC Discharges	29	The number of Native American members discharged from a TFC during the applicable reporting period.
Number of Native American Members Seen for Follow-Up within 7 Days of Discharge from TFC	30	Of the number of Native American members discharged from a TFC during the applicable reporting period, enter the number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 7 calendar days of discharge from the TFC. Note: The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.
Percent of Native American Members Seen for Follow-Up within 7 Days of Discharge from TFC	31	The number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 7 calendar days of discharge from a TFC divided by the number of Native American members discharged from a TFC during the applicable reporting period. Data entry is not required in this field.
Number of Native American Members Seen for Follow-Up within 30 Days of Discharge from TFC	32	Of the number of Native American members discharged from a TFC during the applicable reporting period, enter the number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 30 calendar days of discharge from the TFC. This count must also include the counts reported in Row 30 for Native American members seen for follow-up within 7 calendar days of discharge. Note: The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.
Percent of Native American Members Seen for Follow-Up within 30 Days of Discharge from TFC	33	The number of Native American members who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within 30 calendar days of discharge from a TFC divided by the number of Native American members discharged from a TFC during the applicable reporting period. Data entry is not required in this field.

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Row Header	Row	Description
Total Number of Readmissions to a TFC within 30 Days of Discharge from TFC	34	Of the number of Native American members discharged from a TFC during the applicable reporting period, enter the total number of Native American members who were readmitted to a TFC within 30 calendar days of being discharged from a TFC.
Percent of TFC Readmissions within 30 Days of Discharge from TFC	35	The total number of Native American members readmitted to a TFC within 30 calendar days of discharge divided by the number of Native American members discharged from a TFC during the applicable reporting period. Data entry is not required in this field.
Total Number of Admissions to an IPF within 30 Days of Discharge from TFC	36	Of the number of Native American members discharged from a TFC during the applicable reporting period, enter the number of Native American members admitted to an IPF within 30 calendar days of discharge from a TFC.
Percent of IPF Admissions within 30 Days of Discharge from TFC	37	The total number of Native American members admitted to an IPF within 30 calendar days of discharge from a TFC divided by the number of Native American members discharged from a TFC during the applicable reporting period. Data entry is not required in this field.

Section VI: Long Term Care

Before entering data in the workbook, ensure that the "Long Term Care" tab is selected. This section of the report captures information regarding Native Americans that reside in a nursing facility and those who receive community benefits (i.e., agency-based or self-directed community benefit). This section of the report is based on paid claims with dates of service within the applicable reporting period.

Row Header	Row	Description
Native Americans in a Nursing Facility	7	The count of unique members who reside in a nursing facility.
Native Americans Receiving Community Benefits	8	The count of unique members who received self-directed or agency-based community benefit.
Native Americans Receiving Self-Directed Community Benefits	9	The count of unique members who received any self-directed community benefit.

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Row Header	Row	Description
Self-Directed Community Benefits	10-24	The count of unique members who received each of the self-directed community benefits listed below. 1. Behavior Support Consultation 2. Customized Community Supports 3. Emergency Response Services 4. Employment Supports 5. Environmental Modifications 6. Home Health Aide 7. Nutritional Counseling 8. Private Duty Nursing for Adults 9. Related Goods 10. Respite 11. Self-Directed Personal Care 12. Skilled Maintenance Therapies 13. Specialized Therapies 14. Start Up Goods 15. Transportation
Native Americans Receiving Agency-Based Community Benefits	25	The count of unique members who received any agency-based community benefit.
Agency-Based Community Benefits	26-38	The count of unique members who received each of the agency-based community benefits listed below. 1. Adult Day Health 2. Assisted Living 3. Behavior Support Consultation 4. Community Transition Services 5. Emergency Response Services 6. Employment Supports 7. Environmental Modifications 8. Home Health Aide 9. Nutritional Counseling 10. Personal Care 11. Private Duty Nursing for Adults 12. Respite 13. Skilled Maintenance Therapies

Section VII: Value Added Services Summary

Before entering data in the workbook, ensure that the "Value Added Services" tab is selected. This section of the report captures summary information on the value added services offered by the MCO and the number of requests for the service that were denied and rendered (approved). The MCO must report based on the date of service of paid claims. Note that only those value added services that are accessible by the Native American population (whether by IHS or another means) should be reported.

Column Header	Column	Description
Name of Value Added Service or Product	A	The name of the value added service rendered or product provided to Native American MCO members.

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Column Header	Column	Description
Type of Value Added Service	B	Behavioral Health (BH), Physical Health (PH) or Long-Term Services and Supports (LTSS).
Procedure/Revenue Code	C	If applicable, list all procedure and revenue codes assigned to the value added service. If there is no procedure or revenue code for the value added service, enter "N/A".
Total Number of Requested Services	D	The number of requests received for value added services or products.
Number of Services Rendered	E	The number of requests for the value added services that were rendered (approved).
Number of Service Requests Denied	F	The number of requests for the value added services that were denied.
Number of Denial Notifications Sent to Native American Members	G	Of the number of requests for the value added service, the number of denial notifications sent to Native American members for the value added service.

Section VIII: Care Coordination – Enrollment

Before entering data in the workbook, ensure that the "Care Coordination Enrollment" tab is selected. This section of the report captures information related to care coordination assignments for all Native American Members.

Note that the content and methodology in this section is also used in the Native American Member sections of Report #6 – Care Coordination. Because the reporting periods and report due dates are the same for this report and Report #6, care coordination data for Native American Members in both reports is expected to match for each quarterly submission.

Data in this section will be entered by the MCO for each month of the quarterly reporting period as of the last day of each month. In each quarterly column, data will be auto-populated for each quarter of the quarterly reporting period as of the last day of each quarter. The data reported is a "snapshot" of the last day of the month or the last day of the quarter.

Note: Each monthly entry is a "snapshot" as of the last day of each month and previous monthly/quarterly data are not to be refreshed.

The MCOs shall NOT "reset" or "refresh" enrollment data including Members who are Unreachable, DTE or Refuse Care Coordination.

If a Member is deceased, changed MCOs or lost Medicaid eligibility during the month, they are not active as of the last day of the month and should **not** be counted in this section.

Native American Members who are assigned to a Health Home will **not** be included in any of the counts in this section, with the exception of Row 11, "Total Native American MCO Population".

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Due to reporting methodology differences between Section IV and Sections VIII & IX, it's possible that Native American Member counts will differ across these sections.

Enrollment

Row Header	Row	Description	Methodology
Total Native American MCO population	11	The total number of Native American Members enrolled with the MCO.	Report the total Native American Membership as of the last day of the month. • Remove Native American Members who are/have: o Changed MCOs o Deceased o Lost Medicaid eligibility • Include Native American Members who are: o Assigned to Full or Shared Functions Model o Assigned to a Health Home o CCL2 o CCL3 o DD Waiver Recipients o DTE, Unreachable or Refused Care Coordination o In a Nursing Facility o In a PCMH o Medically Fragile Waiver Recipients Include **ALL active** Members as of the last day of the month.

Native American Care Coordination Assignments

In rows 21-30, Members **may only be counted in one** of the following five categories: CCL2, CCL3, Unreachable, DTE or refused care coordination. For example, a Member who is counted in Row 21, "Number of CCL2 Members", may **not** be counted in Row 25, "Number of Unreachable Members". A Member who is counted in Row 29, "Number of Members who refused care coordination after an HRA and prior to a Care Coordination Assignment Notification", may **not** be counted in Row 27, "Number of Difficult to Engage (DTE) Members".

Row Header	Row	Description	Methodology
Number of Native American CCL2 Members	21	The total number of **unduplicated** Native American Members who were assigned to CCL2 based on CNA completion.	Of the total Native American Membership reported in Row 11, report the number of Members who are assigned to, and/or categorized as, CCL2 on, or as of, the last day of the month. • Remove Members who are/have: o Assigned to a Health Home o CCL3 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination o Lost Medicaid eligibility • Include Members who are: o Assigned to Full or Shared Functions Model

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Row Header	Row	Description	Methodology
			o CCL2 o DD Waiver Recipients o In a Nursing Facility o In a PCMH o Medically Fragile Waiver Recipients Report the **unduplicated** Members as of the last day of the month
Native American CCL2 percentage of total Native American MCO population	22	This is an auto-calculated field. The percentage of Native American Members assigned to CCL2.	
Number of Native American CCL3 Members	23	The total number of **unduplicated** Native American Members who were assigned to CCL3 based on CNA completion.	Of the total Native American Membership reported in Row 11, report the number of Native American Members who are assigned to, and/or categorized as, CCL3 on, or as of, the last day of the month. • Remove Members who are/have: o Assigned to a Health Home o CCL2 o Changed MCOs o DTE, Unreachable or Refused Care Coordination o Deceased o Lost Medicaid eligibility • Include Members who are: o Assigned to Full or Shared Functions Model o CCL3 o DD Waiver Recipients o In a Nursing Facility o In a PCMH o Medically Fragile Waiver Recipients Report the **unduplicated** Members as of the last day of the month
Native American CCL3 percentage of total Native American MCO population	24	This is an auto-calculated field. The percentage of Native American Members assigned to CCL3.	
Number of Native American Unreachable Members	25	The total number of **unduplicated** Native American Members who were categorized as Unreachable (per "Unreachable" definition in "Definitions" section of these instructions).	Of the total Native American Membership reported in Row 11, report the number of Members who have the appropriate documentation in their file to categorize them as Unreachable (per contract) on, or as of, the last day of the month. • Remove Members who are/have: o Assigned to a Health Home o CCL2 o CCL3 o Changed MCOs o Deceased o DTE o Lost Medicaid eligibility

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Row Header	Row	Description	Methodology
			o Refused care coordination • Include Members who are: o Assigned to Full or Shared Functions Model o DD Waiver Recipients o In a Nursing Facility o In a PCMH o Medically Fragile Waiver Recipients o Unreachable Report all **unduplicated** Members categorized as Unreachable as of the last day of the month
Native American Unreachable percentage of total Native American MCO population	26	This is an auto-calculated field. The percentage of Native American Members who were categorized as Unreachable.	
Number of Native American Difficult to Engage (DTE) Members	27	The total number of **unduplicated** Native American Members who were categorized as DTE (per "Difficult to Engage (DTE)" definition in "Definitions" section of these instructions) as of the last day of the month.	Of the total Native American Membership reported in Row 11, report the number of Members who have the appropriate documentation in their file to categorize them as DTE (per contract) on or as of the last day of the month. • Remove Members who are/have: o Assigned to a Health Home o CCL2 o CCL3 o Changed MCOs o Deceased o Lost Medicaid eligibility o Refused care coordination o Unreachable • Include Members who are: o Assigned to Full or Shared Functions Model o DD Waiver Recipients o Difficult to Engage o In a Nursing Facility o In a PCMH o Medically Fragile Waiver Recipients Report all the **unduplicated** Members categorized as DTE as of the last day of the month
Native American DTE percentage of total Native American MCO population	28	This is an auto-calculated field. The percentage of Native American Members who were categorized as DTE.	
Number of Native American Members who refused care coordination during or after an HRA and/or prior to a Care Coordination	29	The total number of **unduplicated** Native American Members who refused Care Coordination during or after an HRA and/or prior to a Care Coordination	Of the total Native American Membership reported in Row 11, report the number of Members who have the appropriate documentation in their file that they have refused care coordination during or after an HRA and/or prior to a care coordination assignment notification, on or as of the last day of the month. • Remove Members who are/have: o Assigned to a Health Home

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Row Header	Row	Description	Methodology
Assignment Notification		Assignment Notification (per "Refused care coordination" definition in "Definitions" section of these instructions) as of the last day of the month.	o CCL2 o CCL3 o Changed MCOs o Deceased o DTE o Lost Medicaid eligibility o Refused care coordination during or after completion of a CNA o Unreachable • Include Members who are: o Assigned to Full or Shared Functions Model o DD Waiver Recipients o In a Nursing Facility o In a PCMH o Medically Fragile Waiver Recipients o Refused care coordination during or after and HRA Report all the **unduplicated** Members who refused care coordination during or after an HRA and/or prior to a Care Coordination Assignment Notification as of the last day of the month.
Number of Native American Members who refused care coordination during, or after completion of, a CNA	30	The total number of **unduplicated** Native American Members who refused Care Coordination during, or after completion of, a CNA (per "Refused care coordination" definition in "Definitions" section of these instructions) as of the last day of the month. (contract reference 4.4.1.5)	Of the total Native American Membership reported in Row 11, report the number of Members who have the appropriate documentation in their file including a care coordination declination form, that they have refused care coordination during, or after completion of, a CNA, on or as of the last day of the month. • Remove Members who are/have: o Assigned to a Health Home o CCL2 o CCL3 o Changed MCOs o Deceased o DTE o Lost Medicaid eligibility o Refused care coordination during or after an HRA and/or prior to a care coordination assignment notification o Unreachable • Include Members who are: o Assigned to Full or Shared Functions Model o DD Waiver Recipients o In a Nursing Facility o In a PCMH o Medically Fragile Waiver Recipients o Refused care coordination Report all the **unduplicated** Members who refused care coordination during or after completion of a CNA as of the last day of the month.

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Row Header	Row	Description	Methodology
Total number of Native American Members who refused Care Coordination	31	This is an auto-calculated field. The number of Native American Members who refused care coordination during or after an HRA and during or after a CNA.	

Section IX: Care Coordination – Timeliness and Engagement

Before entering data in the workbook, ensure that the "Care Coordination Timeliness" tab is selected. This section of the report captures information related to assessment, timeliness, and engagement requirements of Centennial Care for all Native American Members.

Note that the content and methodology in this section is also used in the Native American Member sections of Report #6 – Care Coordination. Because the reporting periods and report due dates are the same for this report and Report #6, care coordination data for Native American Members in both reports is expected to match for each quarterly submission.

Data in this section shall be entered for each month of the quarterly reporting period as of the last day of each month. In each quarterly column, data will be auto-calculated for each quarter as of the last day of the quarter. The data is a "snapshot" of the last day of the month and the last day of the quarter.

This tab will **not** include measures for Members who are:

- Assigned to a Health Home
- Receiving care coordination through the Full Delegation Model

Assessments and touchpoints for Native American Members who are categorized as DTE, Unreachable or Refused Care Coordination (DUR) will NOT be counted in any of the timeliness measures in this section. Per contract, a Member may be classified as Difficult to Engage in relation to the HRA or CNA. Per HSD Policy, if the Member is categorized as a care coordination level 2 or level 3, based on the most recent CNA, but fails to engage in 2 consecutive contract required touchpoints (telephonic or in-person), the Member is then categorized as DTE, with appropriate documentation in the Member file. The MCO will continue attempts to reach the Member quarterly or until the Member has signed, or has documentation of refusing to sign, the care coordination declination form.

The data in this section refer to those measures due and completed within contract timeframes. Measures may only be counted as completed timely when completed by the due date.

If a Native American Member is deceased, changed MCOs or lost Medicaid eligibility during the month, but the listed measure was due in the month; their due touchpoint **will** be included in the counts in this section. The exception to this is if the Member became deceased, changed MCOs or lost Medicaid eligibility prior to the date the touchpoint was due.

Example: A Member's touchpoint is due 1/15/19. The touchpoint was completed on 1/13/19. The touchpoint was Due and Completed in the reporting month of January. The Member then was deceased on 1/22/19. The Member is NOT counted in enrollment for 1/31/19 but the Member's touchpoint is.

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Example: A Member's touchpoint is due 1/25/19. The Member is deceased on 1/5/19. The Member's touchpoint is NOT counted in the 1/31/19 report because the Member has passed away **prior** to the touchpoint being due. The Member is NOT counted in enrollment on the 1/31/19 report because the Member passed away and is not enrolled on 1/31/19.

Assessments, touchpoints and notifications that have a due date that falls in the next month will not be included in the current month.

Example: A CNA is due 3/15/19. It is completed on 2/26/19, before its due date. The CNA is to be counted as Due and Completed in March and not in February.

Note: Each monthly entry is a "snapshot" as of the last day of the month or the last day of the quarter and previous monthly/quarterly data are not to be refreshed or reset.

The methodology for each line is outlined at the right side of that line. The MCO shall be aware that each timeliness and engagement tab has specific inclusions/exclusions required for the submitted data.

Native American Health Risk Assessments (HRAs)

Row Header	Row	Description	Methodology
Number of HRAs due for Native American Members newly enrolled in Centennial Care	10	Report the total number of HRAs due for Native American Members newly enrolled in Centennial Care. (per contract reference 4.4.2)	Report the total number of HRAs due for Native American Members who are newly enrolled in Centennial Care and whose contract required due date falls in the reporting period. • Remove HRAs due for Members who are/have: o A change in health condition o Assigned to Full Delegation Model o Assigned to a Health Home o CCL2 o CCL3 o Changed MCOs o DD Waiver Recipients o Deceased o DTE, Unreachable or Refused Care Coordination o In a Nursing Facility o Lost Medicaid eligibility o Medically Fragile Waiver Recipients • Include HRAs due for Members who are: o Assigned to Shared Functions Model o In a PCMH o Newly enrolled in Centennial Care
Number of HRAs completed for Native American Members newly enrolled in Centennial Care	11	Of the number of HRAs entered above, report the total number of HRAs that were completed within contract timeframes.	Of the total number of HRAs due reported in Row 10 above, report the number of HRAs completed within contract timeframes.

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Row Header	Row	Description	Methodology
Percentage of HRAs completed for Native American Members newly enrolled in Centennial Care	12	This is an auto-calculated field. The total percentage of HRAs that were completed for Native American Members within contract timeframes.	
Number of HRAs due for Native American Members with a change in health condition that requires a higher level of care	13	Report the total number of HRAs due for Native American Members with a change in health condition.	Report the total number of HRAs due for Native American Members with a change of health condition that requires a higher level of care. • Remove HRAs due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o Changed MCOs o Deceased o DTE, Unreachable o In a Nursing Facility o Lost Medicaid eligibility o Newly enrolled in Centennial Care • Include HRAs due for Members who are/have: o Assigned to Shared Functions Model o CCL2 o CCL3 o DD Waiver Recipients o Had change in health condition o In a PCMH o Medically Fragile Waiver Recipients
Number of HRAs completed for Native American Members with a change in health condition that requires a higher level of care	14	Report the total number of HRAs completed for Native American Members with a change in health condition that requires a higher level of care. (contract reference 4.4.2.1)	Of the total number of HRAs due reported in Row 13 above, report the number of HRAs completed.

Native American Care Coordination Assignment Notifications

Row Header	Row	Description	Methodology
Number of Care Coordination Assignment Notifications due for Native American Members	18	Report the total number of Care Coordination Assignment Notifications due.	Report the total number of Care Coordination Assignment Notifications due for Native American Members by the last day of the month (completed HRA that indicates the need for CNA, as outlined in contract section 4.4.3.3) – required notifications include: • Contact information for MCO's care coordination unit

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Row Header	Row	Description	Methodology
			• Name of assigned care coordinator • Timeframe to expect contact from care coordinator Include **ALL** Care Coordination Assignment Notifications Due by the last day of the month.
Number of Care Coordination Assignment Notifications completed for Native American Members	19	Of the number of Care Coordination Assignment Notifications entered above, report the total number of notifications that were completed within contract timeframes.	Of the number of Care Coordination Assignment Notifications reported above in row 18, report the number of Care Coordination Assignment Notifications completed for Native American Members within contract timeframes as of the last day of the month.
Percentage of Care Coordination Assignment Notifications completed for Native American Members	20	This is an auto-calculated field. The total percentage of Care Coordination Assignment Notifications that were completed within contract timeframes.	

Native American Comprehensive Needs Assessments (CNAs)

Row Header	Row	Description	Methodology
Number of CNAs due for Native American CCL2 Members	24	Report the total number of CNAs due for Native American CCL2 Members. This includes initial, annual and change CNAs.	Report the total number of CNAs due for Native American Members by the last day of the month for Native American CCL2 Members whose initial/annual/change CNA contract required due date falls in the reporting period. ➢ Initial: within 30 calendar days of HRA ➢ Annual: anchor date ➢ Change: due to change in health status – 4.4.5.6 (new anchor date) • Remove CNAs due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL3 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination during or after an HRA o In a Nursing Facility o Lost Medicaid eligibility • Include CNAs due for Members who are: o Assigned to Shared Functions Model for their CNA o CCL2

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Row Header	Row	Description	Methodology
			o DD Waiver Recipients o In a PCMH o Medically Fragile Waiver Recipients
Number of CNAs completed for Native American CCL2 Members	25	Of the number of CNAs entered above, report the total number of CNAs that were completed within contract timeframes.	Of the number of CNAs due reported in Row 24 above, report the total number of CNAs completed within contract timeframes.
Percentage of CNAs completed for Native American CCL2 Members	26	This is an auto-calculated field. The total percentage of CNAs for Native American CCL2 Members that were completed within contract timeframes.	
Number of CNAs due for Native American CCL3 Members	27	Report the total number of CNAs due for Native American CCL3 Members. This includes initial, semi-annual and annual CNAs.	Report the total number of CNAs due by the last day of the month for Native American CCL3 Members whose initial/annual/change CNA contract required due date falls in the reporting period. ➢ Initial: within 30 calendar days of HRA ➢ Annual: anchor date ➢ Change: due to change in health status – 4.4.5.6 (new anchor date) • Remove CNAs due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL2 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination during or after an HRA o In a Nursing Facility o Lost Medicaid eligibility • Include CNAs due for Members who are: o Assigned to Shared Functions Model for their CNA o CCL3 o DD Waiver Recipients o In a PCMH o Medically Fragile Waiver Recipients
Number of CNAs completed for Native American CCL3 Members	28	Of the number of CNAs entered above, report the total number of CNAs that were completed within contract timeframes.	Of the number of CNAs due reported in Row 27 above, report the total number of CNAs completed within contract timeframes.
Percentage of CNAs completed for Native American CCL3 Members	29	This is an auto-calculated field. The total percentage of CNAs for CCL3 Members that were completed within contract timeframes.	

Native American Comprehensive Care Plan (CCP)

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Row Header	Row	Description	Methodology
Number of CCPs due for Native American CCL2 Members	33	Report the total number of CCPs due for Native American CCL2 Members. (contract reference 4.4.9)	Report the total number of CCPs due by the last day of the month for Native American CCL2 Members. • Must be completed within (14) business days of completion of the CNA • Remove CCPs due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL3 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination o In a Nursing Facility o Lost Medicaid eligibility • Include CCPs due for Members who are: o Assigned to Shared Functions Model for their CCP o CCL2 o DD Waiver Recipients o In a PCMH o Medically Fragile Waiver Recipients
Number of CCPs completed for Native American CCL2 Members	34	Of the number of CCPs entered above, report the total number of CCPs that were completed within contract timeframes.	Of the number of CCPs reported in line 33 above, report the total number completed within contract timeframes.
Percentage of CCPs completed for Native American CCL2 Members	35	This is an auto-calculated field. The total percentage of CCPs for CCL2 Members that were completed within contract timeframes.	
Number of CCPs due for Native American CCL3 Members	36	Report the total number of CCPs due for Native American CCL3 Members. (contract reference 4.4.9)	Report the total number of CCPs due by the last day of the month for Native American CCL3 Members. • Must be completed within (14) business days of completion of the CNA • Remove CCPs due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL2 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination o In a Nursing Facility o Lost Medicaid eligibility • Include CCPs due for Members who are:

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Row Header	Row	Description	Methodology
			o Assigned to Shared Functions Model for their CCP o CCL3 o DD Waiver Recipients o In a PCMH o Medically Fragile Waiver Recipients
Number of CCPs completed for Native American CCL3 Members	37	Of the number of CCPs entered above, report the total number of CCPs that were completed within contract timeframes.	Of the number of CCPs reported in line 36 above, report the total number completed within contract timeframes.
Percentage of CCPs completed for Native American CCL3 Members	38	This is an auto-calculated field. The total percentage of CCPs for CCL3 Members that were completed within contract timeframes.	

Native American In-Person Visits

Row Header	Row	Description	Methodology
Number of in-person visits due for Native American CCL2 Members	42	Report the total number of in-person visits due for Native American CCL2 Members.	Report the total number of in-person visits due by the last day of the month for Native American CCL2 Members whose contract required CCL2 semi-annual (180 days) in-person visit due date falls in the reporting period. • Remove in-person visits due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL3 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination o Lost Medicaid eligibility o Medically Fragile Waiver Recipients • Include in-person visits due for Members who are: o Assigned to Shared Functions Model for their in-person visits o CCL2 o DD Waiver Recipients o In a Nursing Facility o In a PCMH
Number of in-person visits completed for Native American CCL2 Members	43	Of the number of in-person visits entered above, report the total number of visits that were completed within contract timeframes.	Of the number of in-person visits due for Native American CCL2 Members entered above, on line 42, report the total number of visits that were completed within contract timeframes.

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Row Header	Row	Description	Methodology
Percentage of in-person visits completed for Native American CCL2 Members	44	This is an auto-calculated field. The total percentage of in-person visits that were completed within contract timeframes.	
Number of in-person visits due for Native American CCL3 Members	45	Report the total number of in-person visits due for Native American CCL3 Members.	Report the total number of in-person visits due by the last day of the month for Native American CCL3 Members whose contract required CCL3 quarterly (60-90 days) in-person visit due date falls in the reporting period. • Remove in-person visits due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL2 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination o Lost Medicaid eligibility o Medically Fragile Waiver Recipients • Include in-person visits due for Members who are: o Assigned to Shared Functions Model for their in-person visits o CCL3 o DD Waiver Recipients o In a Nursing Facility o In a PCMH
Number of in-person visits completed for Native American CCL3 Members	46	Of the number of in-person visits entered above, report the total number of visits that were completed within contract timeframes.	Of the number of in-person visits due for Native American CCL3 Members entered above, on line 45, report the total number of visits that were completed within contract timeframes.
Percentage of in-person visits completed for Native American CCL3 Members	47	This is an auto-calculated field. The total percentage of in-person visits that were completed within contract timeframes.	

Native American Telephonic Contacts

Row Header	Row	Description	Methodology
Number of telephone contacts due for Native American CCL2 Members	51	Report the total number of telephone contacts due for Native American CCL2 Members.	Report the total number of telephone contacts due by the last day of the month for Native American CCL2 Members whose contract required CCL2 quarterly (90 days) telephone contact due date falls in the reporting period.

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Row Header	Row	Description	Methodology
			• Remove telephone contacts due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL3 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination o Lost Medicaid eligibility o Medically Fragile Waiver Recipients • Include telephone contacts due for Members who are: o Assigned to Shared Functions Model for their telephonic touchpoints o CCL2 o DD Waiver Recipients o In a Nursing Facility o In a PCMH
Number of telephone contacts completed for Native American CCL2 Members	52	Of the number of telephone contacts entered above, report the total number of contacts that were completed within contract timeframes.	Of the number of telephonic contacts reported as due for Native American CCL2 Members above, in row 51, report the total number of telephonic contacts completed within contract timeframes.
Percentage of telephone contacts completed for Native American CCL2 Members	53	This is an auto-calculated field. The total percentage of telephone contacts that were completed within contract timeframes.	
Number of telephone contacts due for Native American CCL3 Members	54	Report the total number of telephone contacts due for Native American CCL3 Members.	Report the total number of telephone contacts due by the last day of the month for Native American CCL3 Members whose contract required CCL3 monthly (30 days) telephone contact due date falls in the reporting period. • Remove telephone contacts due for Members who are/have: o Assigned to Full Delegation Model o Assigned to a Health Home o CCL2 o Changed MCOs o Deceased o DTE, Unreachable or Refused Care Coordination o Lost Medicaid eligibility o Medically Fragile Waiver Recipients • Include telephone contacts due for Members who are: o Assigned to Shared Functions Model for their telephonic touchpoints o CCL3

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Row Header	Row	Description	Methodology
			o DD Waiver Recipients o In a Nursing Facility o In a PCMH o Native American
Number of telephone contacts completed for Native American CCL3 Members	55	Of the number of telephone contacts entered above, report the total number of contacts that were completed within contract timeframes.	Of the number of telephonic contacts reported as due for Native American CCL3 Members above, in row 52, report the total number of telephonic contacts completed within contract timeframes.
Percentage of telephone contacts completed for Native American CCL3 Members	56	This is an auto-calculated field. The total percentage of telephone contacts that were completed within contract timeframes.	

Native American Unreachable, Difficult to Engage (DTE)

Row Header	Row	Description/Methodology
Number of HRAs completed with Native American Members who were previously Unreachable	60	Of the total number of Members who were reported as Unreachable (in Section VIII, row 25) in the previous reporting period, report the number of Members who were reached during the current reporting period **and** received an HRA.
Number of CNAs completed with Native American Members who were previously DTE	61	Of the total number of Members who were reported as DTE (Section VIII, row 27) in the previous reporting period, report the number of Members who were engaged during the current reporting period **and** received a CNA.

Section X: Analysis

Before entering data in the workbook, ensure that the "Analysis" tab is selected. This section of the report collects qualitative analysis regarding Native Americans. Please respond to the following questions in the analysis worksheet, taking into consideration the data reported for the current reporting period. For each question, identify any changes compared to previous reporting periods and trends over time and provide an explanation of the identified changes. Interpret trends observed over time and describe any actions taken in the last quarter to influence the trends. Additionally, describe any action plans or performance improvement activities addressing any negative changes found during the current reporting period or previous reporting periods. Address how successful past efforts have been in terms of influencing trends or addressing negative changes.

1. Describe your efforts to enter into agreements with Tribes/Pueblos/Nations and IHS, Tribal 638s and Urban Indian Health Centers (I/T/Us).

2. What were the outcomes of your efforts to enter into agreements with Tribes/Pueblos/Nations and Tribal 638s and Urban Indian Health Centers (I/T/Us)?

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3. Describe Native American attendance at Native American Advisory Board (NAAB) meetings. At a minimum, include details regarding the number of attendees, agenda topics, items discussed, and any issues and recommendations that came up at the meeting.

4. How is the MCO ensuring timely follow-ups (within 7 days and within 30 days) with members discharged from a facility? How does the MCO's approach compare to previous reporting periods?

5. Describe any follow-up services members received (within 7 days and within 30 days after discharge from a facility) that are not considered as outpatient, intensive outpatient, or recovery treatment or provided by a mental health practitioner (e.g., meeting with a social worker, therapist, or non-mental health practitioner).

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Addendum A: Provider Type Codes

Provider Type	Provider Type Code	Provider Specialty
Cardiologist	301, 302, and 303	006 Cardiology 042 Cardiology, Pediatric 141 Critical Care
Certified Midwives	322 Midwife, Certified Nurse	
Certified Nurse Practitioner	316 Nurse, Certified Nurse Practitioner (CNP)- specialty required	090 General 091 Family Practice 092 Pediatrics 093 Obstetrical 097 Psychiatric
CRNA	318 Nurse, CRNA (Anesthetist)	
Dentist	421 Dentist - specialty required	055 General Dentistry 056 Oral Surgery, Endodontics, Periodontics, Other Specialty 057 Certified for Behavior Management 150 Endodontist 151 Periodontist 152 Orthodontist
	221 Indian Health Services Hospital or Tribal Compact facility - specialty required, multiple specialties allowed	102 Dental
	422 Dental Clinic, Rural Health 423 Dental Hygienist 902 Clinic, Federally Qualified Health Center, DENTAL	
Dermatologist	301, 302, and 303	007 Dermatology
Endocrinologist	301, 302, and 303	048 Endocrinology/Diabetes/Metabolism
ENT	301, 302, and 303	017 EENT (Eye, Ear, Nose, Throat) 004 ENT (Ear, Nose, Throat)
Hem/Oncology	301, 302, and 303	011 Hematology or Oncology
Licensed Alcohol and Drug Abuse Counselor	440 LADAC Licensed Alcohol & Drug Abuse Counselor	124 LADAC Licensed Alcohol & Drug Abuse Counselor
Licensed Independent Social Worker	444 Social Worker, LISW (Licensed Independent Social Worker)	
Licensed Marriage and Family Therapist	436 LMFT (Lic Marr & Family Therapist)	
Licensed Professional Clinical Counselor	435 LPCC (Licensed Professional Clinical Counselor)	

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Provider Type	Provider Type Code	Provider Specialty
Nephrologist	301, 302, and 303	039 Nephrology
Neurologist	301, 302, and 303	013 Neurology
Neurosurgeons	301, 302, and 303	014 Neurological Surgery
Nutritionist	333 Dietician	
OB-GYN	301, 302, and 303	016 OB-GYN 015 Obstetrics
	316 Nurse, Certified Nurse Practitioner (CNP) - specialty required	093 Obstetrical
Occupational Therapist	451 Occupational Therapist	TBD Business Entity (not an individual) TBD Licensed and Certified (individual) TBD Licensed, not Certified (individual) TBD Occupational Therapist Assistant (individual) TBD School Certified Only (individual)
	452 Occupational Therapist Licensed, not certified	
Oral Surgeon	301, 302, and 303	144 Oral & Maxillofacial Surgery
	421 Dentist - specialty required	056 Oral Surgery, Endodontics, Periodontics, Other Specialty
Orthodontist (for members 20 and under)	421 Dentist - specialty required	152 Orthodontist
Orthopedics	301, 302, and 303	020 Orthopedic Surgery
Pediatrics	301, 302, and 303	037 Pediatrics
	316 Nurse, Certified Nurse Practitioner (CNP) - specialty required	092 Pediatrics
Physical Therapist	453 Physical Therapist	TBD Business Entity (not an individual) TBD Licensed and Certified (individual) TBD Licensed, not Certified (individual) TBD Physical Therapist Assistant (individual) TBD School Certified Only (individual)
	454 Physical Therapist, Licensed, not certified	
Physician Assistant	305 Physician Assistant	
Podiatrist	325 Podiatrist	
Psychiatrist	316 Nurse, Certified Nurse Practitioner (CNP)- specialty required	097 Psychiatric

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Provider Type	Provider Type Code	Provider Specialty
	301, 302, and 303	026 Psychiatry other than Board Certified for Child/adolescent 047 Psychiatry, Board Certification for Child/Adolescent
Psychologist	431 Psychologist (Ph.D., Ed.D., Psy.D.)	111 Not Certified for Prescribing 112 Certified for Prescribing
	438 Psychologist School Certified	
Rheumatology	301, 302, and 303	145 Rheumatology
Speech Therapist	457 Speech Therapist for children or adults Licensed and Certified 458 Speech Therapist for Children, School Certified	
Surgeons	301, 302, and 303	140 Cardiac or Peripheral Vascular Surgery 002 General Surgery or Other Specialized Surgery not otherwise listed 040 Hand Surgery 014 Neurological Surgery 144 Oral & Maxillofacial Surgery 020 Orthopedic Surgery 024 Plastic Surgery 033 Thoracic Surgery 148 Transplant Surgery
	421 Dentist - specialty required	056 Oral Surgery, Endodontics, Periodontics, Other Specialty
Urologist	301, 302, and 303	034 Urology