Centennial Care Reporting Instructions
Community Benefit – Report #4

Report Objective

To (i) monitor benefit utilization for agency-based community benefit and self-directed community benefit members, (ii) identify the number of members whose cost of care in the community if greater than 80% of the cost of care in a private nursing facility, and (iii) monitor the number of members that change between agency-based community benefit and self-directed community benefit and vice versa.

General Instructions

The managed care organization (MCO) is required to submit the Community Benefit report on a quarterly basis. This report is due on April 30th, July 30th, October 30th, and January 30th of each year. Please adhere to the following reporting periods and due dates:

Quarter	Reporting Period	Report Due Date
1	January 1 – March 31	April 30th
2	April 1 – June 30	July 30th
3	July 1 – September 30	October 30th
4	October 1 – December 31	January 30th

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 are locked and 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.

Note that throughout the Excel workbook there are grayed-out cells that indicate where services/items are not applicable for the particular field. These cells are locked to prevent any data entry.

The MCO shall submit the electronic version of the report using the following file labeling format: MCO.HSD4.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.

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

Note that the report through date entered in the first worksheet is also used to populate many column/section headings within this workbook. As such, it is important that the correct date format of MM/DD/YYYY be used when entering the applicable report through date.

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 Requirements

1. Section 4.6 – Self-Directed Community Benefit
2. Section 4.21 – Reporting Requirements
3. Section 4.5.7 – Community Benefit
4. Section 7.3 – Failure to Meet Agreement Requirements

Definitions

Agency-Based Community Benefit (ABCB)	The consolidated benefit of home and community-based services (HCBS) and personal care services that is available to members meeting the nursing facility level of care where members work with their care coordinators to develop a care plan and select a community provider in the MCO network. The member's MCO ensures payment to the community benefit providers.
ABCB Eligibility Category	This information is provided to the MCO by HSD through enrollment records. Agency Non-Waiver (ANW) is used to identify members who are between 0% and 138% of the federal poverty level (FPL). Agency-Based Benefit (ADB) is used to identify members who are between 139% and 235% of the FPL.

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Care Plan	For the purpose of this report, care plan means only self-directed community benefit services and related goods (for SDCB members) or it means only agency-based community benefit services (for ABCB members).
Care Plan Year	A member's care plan year begins the day that the member's care plan is implemented and ends one year later with the end date aligned with the NFLOC. Use the MiVia care plan for members transitioning from MiVia to Centennial Care. A member transitioning from ABCB to SDCB may also have a prorated budget until the new care plan year begins.
Community Benefit	Services are for members who qualify for nursing facility services but want to live at home or in the community. Benefits supplement the members' natural supports through either Agency-Based Community Benefits (ABCB) or Self-Directed Community Benefits (SDCB). ABCB and SDCB are subject to the annual allotment as determined by HSD on an annual basis.
Community Benefit Services Questionnaire (CBSQ)	The questionnaire is utilized by a Care Coordinator during a face-to-face assessment and defines services under Agency-Based Community Benefit and Self-Directed Community Benefit. A member reviews services that may be provided through the member's Care Plan and signs an acknowledgement related to the CBSQ.
Employer of Record (EOR)	Individual responsible for directing the work of SDCB employees by recruiting, hiring, training, supervising and terminating employees, and ensuring payment to employees and vendors.
Self-Directed Community Benefit (SDCB)	The consolidated benefit of home and community-based services (HCBS) and personal care services that is available to members meeting the nursing facility level of care where members work with a support broker, develop a care plan, select their own vendors and authorize timesheets and ensure payment to their vendors.
SDCB Eligibility Category	This information is provided to the MCO by HSD through enrollment records. Self-Directed Non-Waiver (SNW) is used to identify members who are between 0% and 138% of the federal poverty level (FPL). Self-Directed Benefit (SDB) is used to identify members who are between 139% and 235% of the FPL.

Section I: Analysis

Before entering data in the workbook, ensure that the "Analysis" tab is selected. This section of the report collects qualitative analysis regarding the SDCB and ABCB community benefit. Please respond to the following questions taking into consideration the data reported for the reporting period. Respond to the questions based on date of service. For each question, identify any changes compared to previous reporting periods and trends over time and provide an explanation of the identified changes. 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.

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1. What are the top 3 complaints received from members regarding Support Broker Agencies? List the names of contracted Support Broker agencies with the most complaints during the quarter. What actions are being taken to address member complaints? If you have employed Support Brokers, were there any issues requiring attention or correction? If yes, what actions were taken? How does this compare to previous reporting periods?

2. Describe any Support Broker monitoring and training that occurred during the quarter. What corrective actions were required and how were issues resolved? How does this compare to previous reporting periods?

3. How many legally responsible individuals were approved to provide care to SDCB members within this report period? How does this compare to previous reporting periods?

4. How many unique ABCB members utilized 41 or more Personal Care Service hours per week? Of these, how many unique members did not have more than one Care Giver and why? Refer to the Benefit Usage Section of this report to complete the analysis question.

5. For members with a Care Plan ending in the quarter list all the reasons why members did not utilize services. Describe each group, ABCB and SDCB, separately. What actions did the MCO take to ensure utilization of services for ABCB and SDCB members? Refer to the Benefit Usage Section of the report when answering this analysis question.

6. List the top three reasons why members refused to complete the Community Benefit Services Questionnaire (CBSQ). How does this compare to the prior period? Refer to the Benefit Usage Section of the report when answering this analysis question.

7. How many members completed community reintegration transitions from nursing facilities to the community during the quarter? What difficulties did members face with this transition? Briefly describe the actions taken to ensure transitions happened efficiently and how difficulties were overcome. How does this compare to previous periods? Refer to data in the Transitions Section of report when completing the analysis question.

8. Provide an explanation why members voluntarily terminated or involuntarily terminated from SDCB. Explain any identified trends and how this compares to previous reporting periods. Refer to the Transitions Section of the report when answering the analysis question.

9. How many PCS transfer requests were there this reporting period and how many were approved and/or denied? Explain the reasons for the denials. How does this compare to prior periods? Refer to the Transitions Section of the report when completing the analysis question.

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Section II: Benefit Usage

Before entering data in the workbook, ensure that the "Benefit Usage" tab is selected. This section of the report monitors member usage of community benefit services in the current calendar year. The date of service should be used when reporting utilization.

This report should only include quarterly data from the current calendar year. Data reported for previous quarters in the current calendar year should not change with the current quarter's submission. For example, Q1 data reported in Q1 should remain the same in the Q2, Q3, and Q4 report submissions.

Members should only be counted once, based on their setting of care at the end of the reporting period.

Members that transition from ABCB to SDCB or from SDCB to ABCB during the quarter should only be counted once. Use the last day of the quarter/reporting period to determine the model in which the member should be reported. For example, if the member is ABCB on the last day of the quarter, then count as ABCB. If the member is SDCB on the last day of the quarter, count the member as SDCB.

ABCB & SDCB Unique Members With Services in Care Plan and Unique Members Who Used the Services in the Reporting Period (Rows 6 through 33)

Row Header	Row Number	Description
Number of Unique Members	9	The number of unique members by SDCB and ABCB eligibility categories with community benefit services in their care plan and the number of unique members who used the services in the reporting period. Note: For each service, a unique member can only be counted once within a single quarter/reporting period.
Community Benefit Services - Adult Day Health - Assisted Living - Behavior Support Consultation Services - Community Transition Services - Customized Community Support - Emergency Response - Employment Supports - Environmental Modifications - Home Health Aide - Nutritional Counseling - Personal Care Services 0-10 hours week - Personal Care Services 11 - 20	11 – 32	In the columns titled "In Care Plan" enter the number of unique members whose care plan includes the particular service listed in Column A. In the columns titled "Used" enter the number of unique members who used the particular service during the reporting period.

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Row Header	Row Number	Description
hours week - Personal Care Services 21 - 40 hours week - Personal Care Services 41+ hours week - Private Duty Nursing for Adults - Related Goods - Respite - Self Directed Personal Care - Skilled Maintenance Therapy Services - Specialized Therapies - Start Up Goods - Transportation (Non-Medical)		

Percent of Unique Members With Services in Care Plan and Unique Members Who Used the Services in the Reporting Period (Rows 35 through 62)

Rows 38 through 62 auto-calculate the percent of services in care plans and services used based on the data in Rows 9 through 33. Data entry is not required in these fields.

ABCB & SDCB Care Plan End Dates (Rows 65 through 68)

Row Header	Row Number	Description
Number of Care Plans Ending in Quarter (Excludes Transition of Care Plans)	68	The number of members whose care plans are ending in the quarter. Does not include Transition of Care Plans.

SDCB Employer of Record (EOR) Self-Assessments (Rows 71 through 78)

Percentage fields are auto-calculated based on reported self-assessment counts; data entry is not required.

Row Header	Row Number	Description
Number of Initial Self-Assessments Completed in Quarter & Percent	73	The number of SDCB Member initial self-assessments completed during the reporting period.
Initial Self-Assessments Approved & Percent	74	Of the initial self-assessments completed during the reporting period, the number approved.

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Row Header	Row Number	Description
Initial Self-Assessments Denied & Percent	75	Of the initial self-assessments completed during the reporting period, the number denied.
Number of Annual Self-Assessments Completed in Quarter & Percent	76	The number of SDCB Member annual self-assessments completed during the reporting period.
Annual Self-Assessments Approved & Percent	77	Of the annual self-assessments completed during the reporting period, the number approved.
Annual Self-Assessments Denied & Percent	78	Of the annual self-assessments completed during the reporting period, the number denied.

Community Benefit Services Questionnaire – CBSQ (Rows 81 through 84)

Row Header	Row Number	Description
Total Number of Members who Completed the CBSQ	83	The number of members who completed the CBSQ during the reporting period.
Total Number of Members Who Refused to Complete the CBSQ	84	The number of members who refused to complete the CBSQ during the reporting period.

Section III: Transitions

Before entering data in the workbook, ensure that the "Transitions" tab is selected. This section of the report tracks transitions in community benefit.

Members should only be counted once, based on their setting of care at the end of the reporting period.

Data reported for previous quarters in the current calendar year should not change with the current quarter's submission. For example, Q1 data reported in Q1 should remain the same in the Q2, Q3, and Q4 report submissions.

Members Transitioning From Nursing Facility to Community (Rows 5 through 9)

Row Header	Row Number	Description
Institutional Care Transitions (COE 081, 083, 084) to Community	8	The total number of member transitions from institutional care to community-based settings of care during the quarter.

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Row Header	Row Number	Description
		Category of Eligibility Reference: 081 – Institutional Aged 083 – Institutional Blind 084 – Institutional Disabled
Member Transitions (Not COE 081, 083, 084) to Community	9	The total number of transitions by members not in one of the three institutional COEs to community-based settings of care during the quarter.

Community Benefit Changes (Rows 12 through 19)

Row Header	Row Number	Description
Number of Members that Changed to SDCB from ABCB during the reporting period.	15	The total number of members that changed to SDCB from ABCB during the reporting period.
Number of Members that Changed from SDCB to ABCB during the reporting period.	17	The total number of members who changed from SDCB to ABCB during the reporting period. This row is auto-populated and does not require data entry.
Involuntary Change	18	The total number of members who made an involuntary change from SDCB to ABCB during the reporting period.
Voluntary Change	19	The total number of members who made a voluntary change from SDCB to ABCB during the reporting period.

Consumer Directed or Consumer Delegated Changes (Rows 22 through 28)

Row Header	Row Number	Description
ABCB Changes To	24	This is a row header; data input is not required.
Consumer Directed	25	The total number of members who changed to the consumer-directed model during the reporting period.
Consumer Delegated	26	The total number of members who changed to the consumer-delegated model during the reporting period. This row is auto-populated and does not require data entry.
Involuntary Change	27	The total number of members who made an involuntary change to the consumer-delegated model during the reporting period.

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Row Header	Row Number	Description
Voluntary Change	28	The total number of members who made a voluntary change to the consumer-delegated model during the reporting period.

PCS Transfer Requests (Rows 31 through 36)

Row Header	Row Number	Description
Total Number of PCS Transfer Requests this Period	34	The total number of PCS transfer requests during the reporting period from one agency to another.
Total Number of Approved PCS Transfer Requests this Period	35	The total number of approved PCS transfer requests during the reporting period.
Total Number of Denied PCS Transfer Requests this Period	36	The total number of denied PCS transfer requests during the reporting period.

Section IV: Cost of Community Care

Before entering data in the workbook, ensure that the "Cost of Community Care" tab is selected. This section of the report is used to assess the average cost of care in the community for all members receiving the community benefit.

Members in the SDCB eligibility category must only be counted once in this section of the report based on the member's annual budget determination. If the member has a change to their annual budget determination that also changes the category of the member, the member should be reported in the quarter that the budget change was effective.

Data reported for previous quarters in the current calendar year should not change with the current quarter's submission. For example, Q1 data reported in Q1 should remain the same in the Q2, Q3, and Q4 report submissions.

HSD, on an annual basis and prior to the annual waiver period, will determine the average annual cost of being served in a private nursing facility in New Mexico. The average annual cost will be determined utilizing the Medicaid nursing facility fee schedule for low level of care in effect at the time of annual determination. The State, at its discretion, may adjust the maximum allowable cost of care to reflect any modifications to the Medicaid fee schedule for private nursing facilities. The State will communicate the maximum allowable cost of care to contracted Centennial Care MCOs for use prior to each annual contract period. The cost of private nursing facility care provided by the State must be used when determining the cost of a member's budget in the community relative to the cost of care in a private nursing facility. For members "grandfathered-in" from Mi Via, their prior approved self-directed budget will become their annual cost limitation.

Quarterly and calendar year-to-date amounts are auto-calculated; data entry is not required in these fields.

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Row Header	Row Number	Description
Number of Members With Annual Budgets or Care Plans Between 80% and 100% of the Cost of Care in a Private Nursing Facility	9	The number of members whose annual budget or care plan indicates that the cost of receiving services in the community is between 80% and 100% of the cost of care in a private nursing facility.
Total Amount of ALL Annual Budgets or Care Plans Between 80% and 100% of the Cost of Care in a Private Nursing Facility	10	The total amount of all annual budgets or care plans for members whose annual budget or care plans indicate that the cost of receiving services in the community is between 80% and 100% of the cost of care in a private nursing facility.
Average Annual Budget or Care Plan For a Member (Annual Budget Between 80% and 100%)	11	The total amount of all annual budgets or care plans between 80% and 100% of the cost of care in a private nursing facility (Row 10) divided by the number of members whose annual budget or care plan is between 80% and 100% of the cost of care in a private nursing facility (Row 9). Data entry is not required in this field.
Number of Members With Annual Budgets or Care Plans that Exceed the Cost of Care in a Private Nursing Facility at 101% or More	12	The number of members whose annual budget or Care Plan indicates that the cost of receiving services in the community is greater than the cost of care in a private nursing facility (101% or more).
Total Amount of ALL Annual Budgets or Care Plans at 101% or More of the Cost of Care in a Private Nursing Facility	13	The total amount of all annual budgets or care plans for members whose annual budget or care plan indicates that the cost of receiving services in the community is 101% or more of the cost of care in a private nursing facility.
Average Annual Budget or Care Plan For a Member at Annual Budget 101% or More	14	The total amount of all annual budgets or care plans 101% or greater of the cost of care in a private nursing facility (Row 13) divided by the number of members whose annual budget or care plan is 101% or more of the cost of care in a private nursing facility (Row 12). Data entry is not required in this field.