Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2018 – 12/31/2018)
Waiver Quarter: 1/2018

June 11, 2018
New Mexico Human Services Department

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Section I: Introduction

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

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. There are approximately 670,000 members currently enrolled in the program.

The goals of the Centennial Care Program at implementation included:

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

In the development of a modernized Medicaid program, New Mexico articulated four (4) guiding principles:

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

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

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

- Blue Cross Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico (MHC)
- Presbyterian Health Plan (PHP)
- UnitedHealthcare (UHC)

Section II: Eligibility, Provider Access and Benefits

Eligibility

As noted in Section III of this report, there are 268,189 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment decrease of 2,895 from DY4 Q4.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through February 2018. Quarterly data is available through the fourth quarter of 2017.

Primary Care Provider (PCP)-to-Member Ratios

The PCP-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties. PHP's PCP-to-Member ratio was improved in the last quarter of 2017 when an agreement with UNM added approximately 200 additional PCPs to PHP's provider network. There are no PCP access concerns at this time.

Table 1 – PCP-to-Member Ratios by MCO

Table X: PCP-to-Member Ratios by MCO												
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
BCBS	1:39	1:39	1:40	1:38	1:38	1:38	1:35	1:35	1:36	1:34	1:35	1:36
MHC	1:102	1:102	1:102	1:100	1:99	1:99	1:98	1:96	1:94	1:94	1:94	1:97
PHP	1:88	1:88	1:86	1:87	1:86	1:84	1:83	1:81	1:82	1:74	1:74	1:74
UHC	1:30	1:30	1:30	1:29	1:29	1:29	1:28	1:28	1:27	1:28	1:28	1:29
Source: [MCO] PCP Report #53, Q4CY17												

Geographic Access

Physical Health and Hospitals

Geographic access standards were met by all MCOs for general hospitals, federally qualified health centers (FQHCs), PCPs, pharmacies and most specialties in urban, rural and frontier counties. This means that at least 90% of members are within distance standards to provider types in specific geographic areas (i.e. urban, rural, or frontier). Please see Attachment B: GeoAccess PH Summary.

New Mexico has a shortage of specialty providers throughout the state, and MCOs actively seek to contract with border area providers to improve overall access for members. In DY4 Q4, all MCOs remained below access standards for dermatology and neurosurgeons in rural and frontier areas. All MCOs remained below access standards in rheumatology in frontier areas, and BCBS was the only MCO that did not meet the rheumatology access standard for rural members. In rural areas, three of the four MCOs were below access standards for urology. In frontier areas, three of the four MCOs did not meet access for endocrinology and neurology. Consistent with previous quarters, BCBS and MHC did not meet access standards for dermatology in urban areas. PHP was able to meet access standards for dermatology in urban areas, because of Presbyterian Healthcare Services, a not-for-profit healthcare "system," that maintains its own medical group (Presbyterian Medical Group). UHC was also able to meet access standards for

dermatology in urban areas, because its smaller enrollment of members does not necessitate as many specialty providers as the other MCOs in order to meet access requirements.

HSD continues to focus on outliers where all but one MCO met distance standards for specific provider types in geographic areas. For this period, BCBS remains the only MCO below access standards in rural areas for rheumatology (77.8%). PHP is close to meeting access standards in rural areas for neurology (85.3%). Access issues may be remedied by transportation to the nearest provider and telemedicine services which have generally been increasing as a result of delivery system improvements. Single case agreements are permitted for providers who may not want to contract with MCOs to ensure members receive medical necessary services.

Of note this quarter, PHP successfully met access standards in two rural county categories: hematology/oncology (98.6%) and certified nurse midwives (93.9%). In the previous quarter, PHP was close to meeting access standards for both specialties with 88.8% and 89.9% respectively. MHC and PHP both met access standards for rheumatology in rural areas, MHC with 91% and PCP (96.8%). In the previous quarter, both MCOs were close to meeting access standards for rheumatology with 85% and 85.2%.

HSD found many positive outliers for which one MCO was able to exceed standards while all other MCOs remain below access standards. PHP is a positive outlier as compared to other MCOs by being the only MCO to meet access standards in rural areas for urology (92.8%). BCBS was the only MCO to exceed access standards in frontier areas for neurology (92.1%). Another positive outlier is MHC who was the only MCO to meet access standards in frontier areas for endocrinology (91%).

Behavioral Health

In DY5 Q1, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions in urban, rural and frontier areas through Core Service Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient provider agencies, psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners.

However, rural and frontier access standards remain unmet with limited exceptions, for the following-- Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs, , Treatment Foster Care 1 & 2, Behavioral Management Services, Day Treatment Services, Intensive Outpatient Services, Methadone Clinics Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST)

Rural access standards for Behavioral Health clinics are not met by the majority of MCOs.

With a few exceptions, none of the urban, rural and frontier access standards were met for residential treatment programs, both accredited and non-accredited, Indian Health Services and Tribal 638s providing BH, Day Treatment Services, and Rural Health Clinics providing BH services.

HSD continues to monitor BH services that do not meet the standards due provider shortages in New Mexico. HSD continues to work with MCOs to strengthen their relationships with providers and to increase provider accessibility through the use of telemedicine and Project ECHO.

MCOs build accessibility by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available network in ways such as having a Behavioral Health Provider Service Representatives routinely vist providers to validate practice information, respond to claims and other issues. Please see Attachment C: GeoAccess BH Summary.

Community Health Worker

The Community Health Worker (CHW) initiative continues outreach to Medicaid members in underserved urban, rural, and frontier areas of New Mexico. In DY5 Q1, an increase of two employed CHWs was reported by the MCOs. The Q1 total is 91 CHWs who are employed and contracted by Centennial Care MCOs. CHWs, in some settings, are called Peer Support Specialists, Member Navigators, and Community Health Representatives. CHW certification is available through the NM Department of Health. Please see Table 2 – Summary of CHW Workforce.

Table 2 – Summary of CHW Workforce by MCO

DY5 Q1			
Community Health Workers			
	Employed	Contracted	Total
BCBS	13	15	28
MHC	22	0	22
PHP	14	4	18
UHC	11	12	23
Totals	**60**	**31**	**91**

Source: [MCO] CHW DSIPT, Q4CY17

CHW interventions include assisting members with primary care physician (PCP) appointments, preventative care, education, health literacy, completing health risk assessments (HRAs), post emergency room/hospital follow up and translation. The highest level of interventions in Q1 included PCP appointments and transportation. CHWs also assist members in acute facilities to complete HRAs and educate them about benefits, and appropriate use of the emergency room. According to information reported by MCOs, CHWs attended meetings alongside members after a Behavioral Health hospitalization and provided medication adherence education and support with follow-up with Behavioral Health provider appointments. Increasingly, CHWs attend recovery support group meetings with members to provide additional support. Maternal health outreach with CHW involvement improved outcomes with increased pre and post-partum care. CHWs also serve incarcerated members returning to the community and who are in need of

medical care, linkages to food assistance, utility assistance, housing, and transportation. Please see Table 3 – Unduplicated Members Served by CHWs.

Table 3 – Unduplicated Members Served by CHWs

DY5 Q1 Unduplicated Members Served					
	BCBS	**MHC**	**PHP**	**UHC**	**Region Totals**
Underserved Urban	4601	1451	721	640	7413
Rural	159	1204	460	574	2397
Frontier	53	231	136	95	515
MCO Totals	**4813**	**2886**	**1317**	**1309**	**10325**

Source: [MCO] CHW DSIPT, Q4CY17

Educational outreach in Q1 included:

- Diabetes & Managing Weight
- Medical Benefits & Services Educational Events
- Cooking for Health

Telemedicine

In DY5 Q1, telemedicine utilization data for Q4 was reviewed. Consistent with previous reporting periods, the data indicates that most telemedicine services provided in New Mexico are for behavioral health diagnoses (Please see Table 4 – Telemedicine Services). All MCOs continue to provide technical assistance to providers and promote the use of technology to allow members to have access to telemedicine services. BCBS reports working with large in-state providers of telehealth specialty services to make sure rural and frontier primary care physicians are aware of their availability. MHC expanded access to specialty services through telemedicine by contracting with three behavioral health prescriber groups and by linking these behavioral health prescriber groups with contracted clinics that are in need of their services. PHP partners with the Presbyterian Healthcare Services delivery system through a Telehealth Operations Committee to identify opportunities to improve access and capacity through expanded telemedicine offerings. UHC began a marketing campaign to better educate its members and held town hall meetings and training sessions with providers on the benefits of telehealth.

Table 4 - Telemedicine Services

DY4 Q4			
Behavioral Health			
	Urban	**Rural**	**Frontier**
BCBS	298	439	117
MHC	312	791	186
PHP	1,141	1,680	734
UHC	244	421	58
TOTAL	1,995	**3,331**	**1,095**

Source: [MCO] Telemedicine DSIPT, Q4CY17
*Urban numbers are for data collection only and do not count towards Delivery System Improvement Performance Target (DSIPT) goal.

Transportation

In DY5 Q1, HSD continued to monitor the administration of the non-emergency medical transportation benefit provided under managed care. HSD requires MCOs to monitor adequate access to safe and timely transportation services while ensuring the benefit is appropriately utilized for medically necessary services. In DY5 Q1, the MCOs provided oversight of transportation contractors through monthly reporting, grievance reports, call center audits, joint operational meetings, and corrective action. For additional detail regarding grievances, please see Section XII: Consumer Issues – Complaints and Grievances.

Provider Network

New Mexico continues to experience a provider shortage; however, the overall provider network remained consistent with previous quarters. During DY4 Q4, HSD monitored MCOs' compliance in maintaining an adequate and efficient provider network by: tracking and trending new and terminated providers, member-to-provider ratios, the number of providers with panels and/or practices that are open and closed to new members, the number of single case agreements, and the transition of members to new providers when a provider or agency was suspended or terminated.

Service Delivery

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program is provided for CY16 to CY17. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

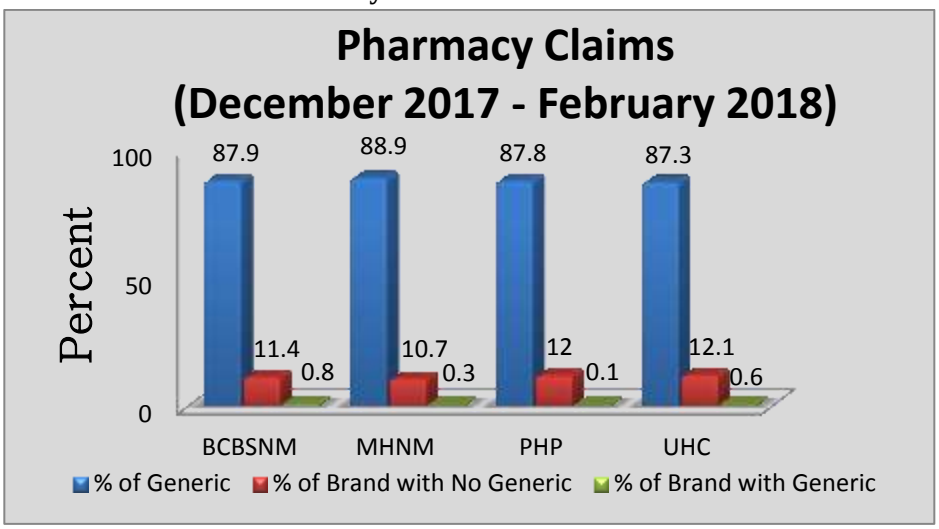
Pharmacy

HSD reviews the monthly MCO pharmacy report to identify trends in prescription claims for brand and generic drugs (Please see Table 5 – Percent of Pharmacy Claims for each MCO). This reporting period showed an average generic drug usage for all four MCOs of 88%, an increase

from 87.4% in the previous reporting period. In comparison to the last quarter, HSD identified the following:

- All MCOs showed an increase, from the previous quarter, in generic drug utilization and usage of brand drugs when no generic is available.
- All MCOs had a decrease, from the previous quarter, in usage of brand drugs with no generic available, with MHNM having a noticeable decrease of 10.7% from 12%.
- The overall usage of brand medication when there was no generic available averaged 11.6%.
- Use of brand drugs when there was a generic available remained the same for three of the MCOs. BCBS had an increase in the use of brand drugs and resulted in an overall average of 0.5% for all MCOs.
- All four MCOs continue to require medical justification for use of a brand drug when there is a generic drug available.

Table 5 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M12CY17, M1CY18, M2CY18

During DY5 Q1, HSD issued a Letter of Direction (LOD) to the MCOs to address community pharmacy reimbursement. The intent of the LOD is to increase reimbursement to the community-based pharmacies to ensure that the pharmacy payment structure more realistically reflects buying power, buying volume, and price negotiating potential. Effective April 1, 2018, the LOD directed the MCOs to ensure that the Maximum Allowed Cost (MAC) for ingredient cost for generic drugs for community-based pharmacies is no lower than the current National Average Drug Acquisition Cost (NADAC) listed for the National Drug Code (NDC) for the drug item.

MCOs are expected to reflect the change in reimbursement policy in their contracts with providers. The increase being implemented is in addition to the MCOs' existing reimbursement rates as of January 1, 2018 and MCOs should apply the increases associated with the LOD, without offsetting the reductions elsewhere. The LOD included a list of 91 community-based

pharmacies, mostly in New Mexico or very close to the New Mexico border. A Community-Based Pharmacy is a pharmacy that has the following characteristics:

- Is open to the public for prescriptions to be filled, regardless of the facility or practice where the prescription was written. This includes multi-site pharmacy operations and franchises whose locations are in New Mexico;
- Is located in New Mexico or near the state border, if the border town is a primary source of prescription drugs for Centennial Care members residing in the border area;
- Is not government-owned, not hospital-owned or hospital-based, not an extension of a hospital, not owned by a corporation owning hospitals, and not an extension of a medical practice or specialty facility;
- Is not owned by a corporate chain with stores outside of New Mexico;
- Is not a mail order pharmacy; and
- Is not part of a national network of pharmacies or specialty pharmacies, including those primarily used for supplying IV admixtures.

Hepatitis C (HCV)

During DY5 Q1, HSD revised the HCV delivery system improvement performance target (DSIPT) reporting template. In addition, the reporting cycle was transitioned from a monthly report to quarterly report. The revised reporting template collects both qualitative and quantitative data related to the requirements set forth in a LOD issued in DY4 Q4. The quantitative data allows HSD to monitor the running number of unduplicated number of patients requesting HCV treatment for the calendar year as well as similar numbers for direct antiviral agent prescription approvals and dispensing by both members' liver fibrosis stages and HCV genotypes. The template also provided the MCOs with a formula to estimate their respective DSIPT treatment target. The qualitative data collects information about the MCOs efforts to develop a provider incentive plan, a comprehensive outreach plan, a comprehensive plan to expand HCV case finding and screening efforts, as well as a comprehensive plan to expand HCV screening efforts to conform to USPSTF/CDC/AASLD/IDSA guidelines.

Nursing Facilities

In DY5 Q1, HSD continued to monitor the MCOs' efforts to address nursing facility (NF) claims issues through regularly scheduled meetings with the MCOs and their NF provider network. HSD also continued to work with Myers and Stauffer on the audit of MCOs' claims payments to NFs. The audit is focused on the MCO processing of crossover claims, denial of payment for preauthorized services, and accuracy of payment rates for retroactive rate changes.

Community Interveners

In DY4 Q4, two Centennial Care members received Community Interveners (CI) services as illustrated below. There were a total of five members who used CI services in 2017. The MCOs provide education to their Care Coordinators to assist in identifying members that meet the criteria for the CI service.

Table 6 – Community Intervener Services Utilization DY4 Q4

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBS	0	0	$0
MHC	0	0	$0
UHC	1	176	$1,050
PHP	1	29	$719
Total	**2**	**205**	**$1,769**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date, 677,475 distinct members, or 72% of all enrollees, have earned at least one reward. Since the launch of Centennial Rewards, members have earned points totaling a value of $49.7 million. Of that amount $12.3 million have been redeemed for a cumulative redemption rate of about 25%. Points expire at the end of the year after the year in which they were earned. Table 7 shows the healthy behaviors rewarded and each behavior's value. It includes the maximum dollar value available for each activity, the total dollars earned, and the amount redeemed.

Table 7 – Healthy Behaviors Rewarded

Eligibility Activities	Reward Value in Points, by Activity	Reward Value in $, by Activity	Total Rewards Earned by Activity in $	Total Rewards Redeemed by Activity in $
Asthma Management	600	$60	$ 1,250,940	$ 437,539
Bipolar Disorder Management	600	$60	$ 1,477,650	$ 386,660
Bone Density Testing	350	$35	$ 69,790	$ 15,428
Healthy Smiles Adults	250	$25	$ 10,880,525	$ 2,225,796
Healthy Smiles Children	350	$35	$ 24,294,305	$ 6,683,107
Diabetes Management	600	$60	$ 5,953,820	$ 1,636,333
Healthy Pregnancy	1000	$100	$ 1,579,000	$ 409,262
Schizophrenia Management	600	$60	$ 737,890	$ 166,384
Health Risk Assessment	100	$10	$ 4,394,320	$ 1,127,030
Step-Up Challenge			$ 599,375	$ 523,176
Other (Appeals and Adjustments)	N/A	N/A	$ 690,653	$ 427,433
Totals		**N/A**	**$ 51,928,268**	**$ 14,038,148**

Section III: Enrollment

Centennial Care enrollment indicates a decrease in enrollment in all populations except SSI and Related Dual and 217 Like Group Dual with the Expansion population remaining stable. The majority of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in the table below.

The following table outlines all enrollment activity under the demonstration. The enrollment counts include unique enrollees, not member months. Please note that these numbers reflect current enrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of the reporting quarter. Since members change eligibility and thus MEGs during the year, the only way to give an unduplicated count for the quarter and YTD is to look at the last month a client was in the MEG within the period. For that reason, the unduplicated total for YTD could be less than a prior quarter.

Table 8 – Enrollment DY5 Q1

Demonstration Population	Total Number Demonstration Participants DY5 Q1 Ending March 2018	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**368,464**	**471,395**
FFS	39,740	59,103
Molina	117,888	153,353
Presbyterian	119,483	148,066
UnitedHealthcare	27,934	34,381
Blue Cross Blue Shield	63,419	76,492
Population 2 – SSI and Related – Medicaid Only	**38,723**	**44,918**
FFS	2,267	3,776
Molina	11,854	13,879
Presbyterian	12,633	13,878
UnitedHealthcare	5,171	5,934
Blue Cross Blue Shield	6,798	7,451
Population 3 – SSI and Related – Dual	**35,883**	**39,183**
FFS	0	265
Molina	7,047	7,765
Presbyterian	6,818	7,372
UnitedHealthcare	15,235	16,549
Blue Cross Blue Shield	6,783	7,232
Population 4 – 217-like Group – Medicaid Only	**266**	**510**
FFS	10	193
Molina	50	67
Presbyterian	49	73
UnitedHealthcare	106	109
Blue Cross Blue Shield	51	68
Population 5 – 217-like Group - Dual	**3,565**	**3,460**
FFS	0	31
Molina	754	762
Presbyterian	635	625
UnitedHealthcare	1,401	1,341
Blue Cross Blue Shield	775	701
Population 6 – VIII Group (expansion)	**268,189**	**287,337**
FFS	25,620	33,722
Molina	73,253	77,705
Presbyterian	68,214	67,439
UnitedHealthcare	38,712	42,985
Blue Cross Blue Shield	62,390	65,486

Disenrollments

The definition of disenrollment is when a member was enrolled in Centennial Care at some point in the prior quarter and disenrolled at some point during that same quarter or in the reporting quarter and did not re-enroll at any point in the reporting quarter. Members who switch MEGs are not counted as disenrolled. The majority of disenrollments are attributed to loss of eligibility and death.

HSD continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any potential gaps in enrollment. Any issues that are identified or reported are researched and addressed.

Table 9 – Disenrollment Counts DY5 Q1

Disenrollments	Total Disenrollments During DY5 Q1
Row Labels	
Population 1 – TANF and Related	**6,550**
FFS	753
Molina	2,034
Presbyterian	1,844
UnitedHealthcare	606
Blue Cross Blue Shield	1,313
Population 2 – SSI and Related – Medicaid Only	**468**
FFS	25
Molina	140
Presbyterian	143
UnitedHealthcare	68
Blue Cross Blue Shield	92
Population 3 – SSI and Related – Dual	**482**
Molina	86
Presbyterian	79
UnitedHealthcare	213
Blue Cross Blue Shield	104
Population 4 – 217-like Group – Medicaid Only	**2**
FFS	1
Molina	0
Presbyterian	0
UnitedHealthcare	0
Blue Cross Blue Shield	1
Population 5 – 217-like Group - Dual	**84**
Molina	19
Presbyterian	17
UnitedHealthcare	31
Blue Cross Blue Shield	17
Population 6 – VIII Group (expansion)	**8,282**
FFS	1,100
Molina	2,117
Presbyterian	2,077
UnitedHealthcare	1,125
Blue Cross Blue Shield	1,863
TOTAL	**15,868**

Section IV: Outreach

In DY5 Q1 HSD staff assisted the Medicaid Member call-center with troubleshooting numerous MCO enrollment issues and recognizing trends in found errors, following the move of the MCO enrollment functionality from Omnicaid to ASPEN, which was implemented during DY4 Q4.

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

Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's outreach efforts. With over 635 active certified Presumptive Eligibility Determiners (PEDs) state-wide, Medicaid application assistance is available in even the most remote areas of the state.

PEDs are employees of participating hospitals, clinics, FQHCs, IHS Facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some NM State Agencies (NM Department of Health, NM Children Youth and Families Department and the NM Department of Corrections).

In DY5 Q1, HSD PE Program staff has been preparing PED refresher trainings to ensure that all PEDs have the most up to date information regarding the NM PE Program. The next scheduled training will be the "Non-Citizen/Immigrant Eligibility Training for Presumptive eligibility Determiners." All PEDs will be required to complete a training session in DY5 Q2 to retain their PE certifications.

PEDs continue to provide application assistance state-wide. In DY5Q1, PEDs:

- Granted **703** PE approvals*
- Submitted applications for **6,568** individuals
- Which resulted in **5,631** ongoing Medicaid approvals

*98.1% of all PEs granted in this reporting period also had an ongoing application submitted

JUST Health Program

PEDs who are employees of the NM Department of Corrections and County Jails or Detention Centers participate in the PE Program through the Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) program.

The JUST Health programs allows for the automated data transfer of information regarding the incarceration status of individuals in New Mexico. Individuals who are Medicaid-enrolled have

their benefits suspended after 30 days of incarceration. Benefits are reinstated upon the individual's release from incarceration which allows immediate access to care. Individuals who are not Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply. Application assistance is provided by PEDs at the correctional facilities.

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

Encounter Data

The MCOs submit encounters daily and/or weekly to stay current with encounter submissions. HSD continues to work with the MCOs to respond to any questions and address any issues related to encounters. HSD works directly with each MCO to address any issues with encounters that have been denied or not accepted. HSD and the MCOs have developed a productive partnership to fix any system edits in either or both systems. HSD meets regularly with the MCOs to address their individual questions and to provide guidance. HSD continues to monitor encounters by comparing encounter submissions to financial reports to ensure completeness. HSD monitors encounters by extracting data on a monthly basis to identify the timeliness and accuracy of encounter submissions. HSD shares this information with the MCOs so they are aware of any potential compliance issues. HSD extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. HSD has seen vast improvements in both the accuracy and timeliness related to encounter data.

Enrollment Data

Data is extracted on a monthly basis to identify Centennial Care enrollment by MCO and for various populations. Any discrepancies that are identified, whether due to systematic or manual error, are immediately addressed. Eligibility and enrollment reports are run on a monthly basis to ensure consistency of numbers. In addition, HSD continues to monitor enrollment and any anomalies that may arise so they are addressed and resolved timely. HSD posts the monthly Medicaid Eligibility Reports to the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx. This report includes enrollment by MCOs and by population.

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

Program Development

Procurement for Centennial Care 2.0 MCOs
HSD conducted a procurement process in late 2017 to select MCOs for the second phase of Centennial Care ("2.0") beginning January 1, 2019. A Request for Proposals (RFP) was released on September 1, 2017. Proposals were submitted by eight MCOs by the November 3, 2017 deadline. Evaluation and scoring was done by HSD in November and December, resulting in the selection of three MCOs for the contract award, which was announced in January 2018. Four non-awarded MCOs subsequently submitted protests following the award announcement.

Documents related to the procurement, including the RFP and protests, can be found at: http://www.hsd.state.nm.us/Centennial_Care_RFP.aspx.

Indian Managed Care Entity RFI
HSD issued a Request for Information (RFI) on January 25, 2018 soliciting information and interest in establishing an Indian Managed Care Entity for New Mexico Native American Medicaid Members. Three responses were received by the March 1 deadline, which HSD reviewed for consideration and further discussion.

Documents related to the RFI, including submissions and responses, can be found at: http://www.hsd.state.nm.us/LookingForInformation/open-rfps.aspx.

Behavioral Health
Please refer to Attachment E: Behavioral Health Collaborative CEO Report for an update on Behavioral Health activities.

MCO Initiatives

Blue Cross and Blue Shield of New Mexico
Based on the difficulties of living with asthma or COPD, throughout DY5 Q1, BCBS initiated a partnership with Albertsons Markets to offer health education classes, at no charge, to BCBS Community Centennial Care members. The objective of these classes is to help members better understand breathing conditions.

The classes are between 60 - 90 minutes long and they will provide BCBS Community Centennial Care members with the option to:

1. Learn from an Albertsons Market pharmacist about:
    - Causes of asthma and COPD
    - Symptoms of asthma and COPD
    - Management of asthma and COPD

2. Better understand how to take inhaled medications. The pharmacist will show them the best techniques and common mistakes using demonstration inhalers.
3. Be part of a question and answer session.
4. Receive education materials at no charge, including:
    - Asthma/COPD booklet
    - Water bottle

The classes are scheduled to begin June 16, 2018 and will be held at numerous Albertsons Market locations. Members will be notified of these classes through member communications that have been approved by HSD.

Molina Healthcare

Santa Fe Fire Department Pilot Program - As previously reported, collaboration with the City of Santa Fire Department (SFFD) targets members with complex care coordination needs who are also high utilizers of 911 services. The objective is to engage these members, who could not be contacted by other means, and re-establish relationships with care coordinators. During the current reporting period, additional planning occurred in preparation for a April 1, 2018 start date.

Ten MHC members will be mutually identified each quarter. SFFD attempts to make contact with the members. Once contact is established, the member is assigned an SFFD lead and a substance abuse history and health issues assessment are completed. The lead is responsible for making appointments and connecting the member to services. The member is reintroduced to the MHC Care Coordinator and a warm transfer is accomplished.

Outcome metrics include the utilization patterns including Emergency Department, Inpatient, and Physical Health (PCP) encounters, and the engagement rate of members sent for SFFD interventions, and subsequent continued engagement in Care Coordination thereafter.

Presbyterian Health Plan

PHP is tracking initiatives described in earlier progress reports. In addition to reporting new initiatives, PHP will provide periodic updates for ongoing activities such as: offering in-house support broker services for self-directed members; using "Pre-Managed" reports for care coordination to quickly identify members who require follow up after emergency department visits; care coordinators embedded in pediatric primary care provider offices with a high volume of high risk pediatric members; and, many other pilots and activities previously presented.

New in DY5 Q1, PHP and the Isleta Presbyterian Medical Clinic collaborated to develop a CHW pilot within the Pediatric, Internal Medicine, and Family Practice clinics. The pilot, called "Healthy Way," focuses on screening members for social determinants of health (SDOH). Members who screen positive for SDOH are offered support and linkages to community

resources and services. The clinic's support staff and the providers are also able to submit direct referrals and/or call on the support of the CHW when needs are identified.

Also new in DY5 Q1 is PHP's delivery system improvement plan to expand provider network capacity by attracting providers to relocate to New Mexico. Specific providers selected for recruitment are those who have been historically difficult to recruit and retain. PHP's areas of focus include: behavioral health – addiction medicine, allergy/asthma, pediatric subspecialties, dermatology, and primary care physicians in rural areas. In an effort to increase provider capacity, PHP strategies include, but are not limited to: growing the workforce via an accredited educational fellowship with academic sponsorship for behavioral health specialties; offering provider incentives such as quality specialty pay; reimbursing travel expenses for providers in active recruitment; increasing attendance to conferences held for specific specialties; and, training PCPs in asynchronous dermatology visits which encompass visits that are amenable to treatment that are now beyond the scope of primary care. PHP is developing measures to quantify the results of its efforts including improved member access for the specialties and subspecialties identified.

UnitedHealthcare

One of the great innovations reported by UHC's Network team stemmed from an HSD mandate to establish routine Provider Forum calls to address provider claims and other issues. UHC reports the initiation of their provider forums are co-led by the network team and the health plan. The pilot for this model was hospitals: they had concerns that were escalated to HSD (around claims, credentialing, authorizations). To assist with the resolution of these issues, HSD mandated that UHC host regularly scheduled forums to hear and resolve the hospitals' and other provider issues. UHC reports a significant improvement by conducting these forums and provide the following examples of steps taken to remain focused in the area:

- All of the concerns are tracked and worked, and each month UHC reports-out and closes outstanding issues. Individual hospitals and the hospital association participate, and UHC also invites HSD staff to observe. UHC states this approach has been a huge success – they hold themselves accountable and providers see traction on their concerns,
- Following that success, UHC initiated similar approaches with the nursing home industry, I/T/Us, and behavior health providers.

These forums continue to be successful for UHC and have not only allowed UHC to address and correct past issues but also allowed the opportunity to identify and act on developing issues as they occur.

Fiscal Issues

During DY5 Q1, cost settlement with the schools and IHS payments were made for calendar year (CY) 2016 and retroactive capitation adjustments for newborns were made for CYs 2016 and 2017. These payments affect the per member per month (PMPM) for MEG 1 for DY3 and DY4. Capitation adjustments were also made for a change in the setting of care for individuals in

institutional nursing facilities for CYs 2016 and 2017. These capitation adjustments affected the PMPM of MEGs 2 to 5.

Systems Issues

HSD continues to implement reporting for analysis and oversight. HSD and the MCOs work together to address any concerns or make any necessary system changes on either side. The issues that were identified as part of the transition of enrollment from the Medicaid Management Information System (MMIS) to the Eligibility and Enrollment (E&E) system, have been researched and resolved. There is a process in place to identify, track, research and resolve any issues that may arise.

Medicaid Management Information System Replacement

HSD's planning for replacement of its legacy MMIS began some time ago, and activity for this effort progressed in DY5 Q1. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the DOH, CYFD, and the Aging and Long-Term Services Department (ALTSD). These three departments have participated in RFP development and replacement planning. HSD is currently in the process of drafting a GSA with CYFD and is in the final stages of the GSA with ALTSD for qualifying activities to receive MMISR funding; the GSA with DOH has been approved.

The first module of the State's Framework for MMIS Replacement, the System Integrator, is in process. The contract has been finalized and the contractor has begun work on the project.

The RFP for the next module of the Framework, the Enterprise Data Services RFP, was released on April 17, 2017. Proposals came in on June 21, 2017, and HSD is currently in an active procurement process. Contract negotiations have begun for Data Services and the contract is in the final stages.

CMS has approved the third module RFP for Quality Assurance. The Quality Assurance RFP was released on March 16, 2018 and proposals are due May 16, 2018.

HSD has begun development of the RFP for the fourth module, Benefit Management Services. This RFP involved meetings with all stakeholders, questionnaires for input, review of other states' procurements and contracts, as well as information from the current fiscal agent contract. This information is being gathered for requirements development and will be vetted through the stakeholder review process for comment prior to submission to CMS. The expectation is to submit the RFP to CMS in April 2018.

Once the Benefit Management Services RFP is submitted to CMS for review, work will continue with the development of the RFP for the fifth module, Financial Services. Some work with stakeholders, questionnaires, and requirements gathering from other states has already been started. Further work will be done as areas are identified that require additional input from stakeholders.

The module previously referenced as Population Health has been renamed Outcomes Based Management. The components that were part of the Population Health module have been transitioned to better align with the other modules.

Deloitte is currently working on the changes to implement the provisions for Real Time Eligibility (RTE) in the E&E system. These changes were previously approved by CMS.

An Implementation Advanced Planning Document Update (IAPD-U) was submitted and approved by CMS and an update will be submitted in the coming months.

Section VII: Home and Community-Based Services

New Mexico Independent Consumer Support System (NMICSS)

The NMICSS is a system of organizations that provide standardized information to beneficiaries about Centennial Care, long-term services and supports (LTSS), the MCO grievance and appeals process, and the fair hearing process.

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

The ADRC coordinators provide phone counseling in care coordination, which is the process for assisting the client in describing his/her issue. ADRC staff offer options, coordinate New Mexico's aging and disability service systems, provide objective information and assistance, and empower people to make informed decisions.

ALTSD provides quarterly reports to HSD including the ADRC Caller Profile Report and Care Transitions Program Data.

Table 10 – ADRC Call Profiler Report DY5 Q1

Topic	# of Calls
Home/Community Based Care Waiver Programs	3,263
Long Term Care/Case Management	9
Medicaid Appeals/Complaints	9
Personal Care	188
State Medicaid Managed Care Enrollment Programs	17
Medicaid Information/Counseling	1,538

Table 11 – ADRC Care Transition Program Report DY5 Q1

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		171	
Medicaid Education/Outreach	1,672		
Nursing Home Intakes		73	
**LTSS Short-Term Assistance			156

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

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

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

CTB hired a Regional Counseling Program Manager to manage the Short-Term Assistance (STA) Program. The STA Program has seen an increase in assisting individuals from last quarter due to Medicaid MCOs providing referrals for individuals transitioning from Medicaid to Medicare due to age or disability needs.

Critical Incidents

HSD continues to meet quarterly with the MCOs' Critical Incident (CI) workgroup in an effort to provide technical assistance. The workgroup supports the Behavioral Health Services Division in the delivery of BH incident reporting protocols to providers. The protocols will be used by BH providers to improve accuracy of information reported and to establish guidelines for the types of BH providers who are required to report.

During DY5 Q1, a total of 5,644 CIRs were filed for Centennial Care members in the areas of physical health, behavioral health, and self-directed community benefit services. One hundred percent of all CIRs received through the HSD CI web portal are reviewed. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.

During DY5 Q1, a total of 561 deaths were reported. Of the 561 deaths reported, 457 deaths were reported as natural or expected deaths, 100 deaths were reported as unexpected and four suicides were reported. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

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

During DY5 Q1, a total of 3,685 critical incidents were reported for Emergency Services. Of those Emergency Services reports, 217 were reported by Behavioral Health providers and 288 were associated with self-directed members. This demonstrates an upward trend in the use of Emergency Services when compared to DY4 Q4 (2,690), DY4 Q3 (2,692), DY4 Q2 (2,910) and

DY4 Q1 (3,172). MCOs continue to identify the use of Emergency Services as the highest critical incident type reported by volume for members with a reportable category of eligibility.

Table 12 – Critical Incident Types by MCO – Centennial Care

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	41	0.85%	90	1.87%	92	1.91%	71	1.48%	294	6.11%
Death	125	2.60%	121	2.52%	101	2.10%	166	3.45%	513	10.66%
Natural/Expected	109		80		85		157		431	
Unexpected	16		41		15		8		80	
Suicide	0		0		1		1		2	
Elopement/Missing	3	0.06%	5	0.10%	9	0.19%	1	0.02%	18	0.37%
Emergency Services	670	13.93%	812	16.88%	877	18.23%	821	17.07%	3,180	66.10%
Environmental Hazard	12	0.25%	16	0.33%	28	0.58%	27	0.56%	83	1.73%
Exploitation	13	0.27%	19	0.39%	19	0.39%	41	0.85%	92	1.91%
Law Enforcement	14	0.29%	33	0.69%	27	0.56%	18	0.37%	92	1.91%
Neglect	107	2.22%	98	2.04%	141	2.93%	193	4.01%	539	11.20%
Total	**985**	**20.47%**	**1,194**	**24.82%**	**1,294**	**26.90%**	**1,338**	**27.81%**	**4,811**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	10	2.22%	50	11.09%	43	9.53%	7	1.55%	110	24.39%
Death	5	1.11%	11	2.44%	3	0.67%	3	0.67%	22	4.88%
Natural/Expected	1		4		1		0		6	
Unexpected	4		7		2		2		15	
Suicide	0		0		0		1		1	
Elopement/Missing	1	0.22%	2	0.44%	4	0.89%	0	0.00%	7	1.55%
Emergency Services	15	3.33%	163	36.14%	25	5.54%	14	3.10%	217	48.12%
Environmental Hazard	0	0.00%	2	0.44%	2	0.44%	0	0.00%	4	0.89%
Exploitation	1	0.22%	3	0.67%	2	0.44%	0	0.00%	6	1.33%
Law Enforcement	5	1.11%	8	1.77%	10	2.22%	0	0.00%	23	5.10%
Neglect	6	1.33%	39	8.65%	8	1.77%	9	2.00%	62	13.75%
Total	**43**	**9.53%**	**278**	**61.64%**	**97**	**21.51%**	**33**	**7.32%**	**451**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	5	1.31%	3	0.79%	13	3.40%	9	2.36%	30	7.85%
Death	2	0.52%	4	1.05%	11	2.88%	9	2.36%	26	6.81%
Natural/Expected	2		2		8		8		20	
Unexpected	0		2		2		1		5	
Suicide	0		0		1		0		1	
Elopement/Missing	0	0.00%	0	0.00%	2	0.52%	0	0.00%	2	0.52%
Emergency Services	30	7.85%	39	10.21%	171	44.76%	48	12.57%	288	75.39%
Environmental Hazard	0	0.00%	0	0.00%	3	0.79%	0	0.00%	3	0.79%
Exploitation	0	0.00%	0	0.00%	7	1.83%	2	0.52%	9	2.36%
Law Enforcement	1	0.26%	5	1.31%	3	0.79%	0	0.00%	9	2.36%
Neglect	1	0.26%	1	0.26%	11	2.88%	2	0.52%	15	3.93%
Total	**39**	**10.21%**	**52**	**13.61%**	**221**	**57.85%**	**70**	**18.32%**	**382**	**100.00%**

Home and Community-Based Services Reporting

In DY5 Q1, HSD began compiling and analyze the on-site validation and participant surveys with Community Benefit providers and members. HSD also continued to update the Statewide Transition Plan milestones as required by CMS.

In DY5 Q1, the LTC Workgroup met to discuss the following agenda items:

- Ride-along feedback from HSD to the MCOs that included recommendations for best practice care coordination interviewing techniques.

HSD conducted Assisted Living Facility (ALF) training to the MCOs to clarify requirements for timeliness of member transitions and authorizations of ALF services.

Self-Directed Community Benefit

In DY5 Q1, HSD continued to meet monthly with PHP to discuss the transition of PHP's Self-Directed Community Benefit (SDCB) members to its in-house Support Brokers (SB) or to one of the two contracted external SB agencies. During the reporting period, PHP began quality auditing with the SBs and early results are promising. Overall, the transition has been a success for PHP and their SDCB members. HSD will continue to monitor the quality outcomes of this project.

Electronic Visit Verification

In DY5 Q1, HSD began to conduct meetings with the MCOs and their EVV Vendor, First Data for the implementation of EVV for the self-directed personal care services. HSD has directed the MCOs to work together with First Data and the SDCB Fiscal Management Agency in order to meet the required January 2019 start date. In DY5 Q2, the MCOs will continue to seek stakeholder input and involve SBs and members in the EVV roll-out for self-directed personal care services.

Section VIII: AI/AN Reporting

Access to Care

Indian Health Service, Tribally operated facility/programs, and Urban Indian clinics (I/T/Us) are concentrated near or on Tribal land where many Native Americans live and receive services. Data from the four Centennial Care MCOs shows for physical health there is 98% access to care for Native Americans in rural areas and 99% access to care for Native Americans in frontier areas. For behavioral health there is a 98% access for Native Americans in rural areas and 99% access for Native Americans in frontier areas.

Contracting Between MCOs and I/T/U Providers

The MCOs continue to work on developing contracts with I/T/Us. One MCO has begun to work with Community Health Representative (CHR) programs to develop agreements. The MCOs currently have agreements with Tribal entities for HRA completion, translation, transportation, health education, audiology, optical, extended hour services, tribal behavioral health services, recovery services, and Wellness Centers.

Ensuring Timely Payment for All I/T/U Providers

The MCOs met timely payment requirements 98% of the time for claims being processed and paid within 15 days of receipt and 99% of claims being processed and paid within 30 days of receipt.

Table 13 – Native American Advisory Board (NAAB) meetings for DY5 Q1

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Zuni Tribal Conference Center Zuni, NM March 22, 2018	**Issue**: How do we know if an HRA has already been completed? **Response**: We can have a care coordinator check in our system to see if the member's HRA is completed. **Issue:** Sometimes appointments come unexpected. How can I give 72-hour notice to book transportation in that case? **Response:** It is possible to get urgent care transportation by calling Logisticare. This will depend on availability. **Issue:** I completed my HRA but my husband didn't. I asked if I could do the HRA for him and they told me no. Since that time he has not completed an HRA. **Response:** If you do not have Power of Attorney for your husband, you do not have legal permission to do the HRA for him.

MHNM	Native American Community Academy Albuquerque, NM March 7, 2018	There was a question about the reimbursement rate from Secure Transportation. The rate is .45 cents per mile not .50 cents per mile. Another member stated that her grandson has an addiction and would like to know more about peer support services. The peer support worker at the meeting provided his card to the grandmother and asked that her grandson contact him, even if he is not a Molina Healthcare member.
PHP	Pueblo of Zuni Tribal Headquarters Zuni, NM March 9, 2018	**Issue:** How can I switch my MCO? **Response**: Member was given Native American FAQs on switching MCOs as well as information on open enrollment beginning October, 2018. **Issue**: How can I get a care coordinator? **Response**: The member or family member can request a care coordinator. You can contact the member services call center at Presbyterian. **Issue:** How can I get a ramp for my home? **Response:** Your care coordinator can you help you with home modifications. She will begin the process with an assessment and help you with the process.
UHC	Future Foundation Family Center Grants, NM March 14, 2018	**Issue**: Do members receive mileage reimbursement if they go to the ER? **Response**: Yes, they can receive mile reimbursement if they call the same day to receive a Trip Number for the ER visit. **Issue:** Do you have to receive verification once someone is discharged from the hospital? **Response:** No, you do not need any verification once being discharged.

HSD's Native American Technical Advisory Committee (NATAC) Update

The NATAC meeting took place on March 19, 2018. The Medicaid Director provided an update to the Committee of the three MCOs that have been selected for Centennial Care 2.0. She also informed the Committee of the release of a Request for Information (RFI) in January 2018 regarding an Indian Managed Care Entity (IMCE). The MAD Native American Liaison went over Medicaid data for Native Americans in Centennial Care.

Update on implementation of the federal reinterpretation of guidance for services received through IHS/Tribal Facilities

- During DY5 Q1, the care coordination agreement (CCA) between the University of New Mexico Hospital (UNMH) and the Albuquerque Area Indian Health Services (AAIHS) progressed as follows:
    - Billing staff finalized the requirements to identify relevant claims;
    - All logic and testing is complete;
    - UNMH and AAIHS completed two preliminary audits;
    - Progress on a second CCA between UNMH and the Navajo Area IHS (NAIHS) included a legal review by NAIHS of the proposed CCA; and
    - A third partnership, Presbyterian Healthcare Services and AAIHS have a fully executed CCA. Presbyterian is working on a flow chart for the proposed process with AAIHS.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment F: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY5 Q1 reflects the CY 2018 rates as provided to CMS on January 4, 2018. The PMPM for DY5 is lower compared to DY4 for MEGs 1, 2, and 3; the PMPM for DY5 is higher than those of DY4 for MEGs 4, 5 and 6 (see Attachment A: Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A: Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY5 is 35.8% below the budget neutrality limit (Table 5.4) based on one quarter of payments.

Section XI: Member Month Reporting

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

Table 14 – Member Months DY5 Q1

Number of Clients by Population Group and MC	
	2018
Row Labels	Q1
Population 1 – TANF and Related	**1,108,827**
FFS	**121,250**
MC	**987,577**
Molina	356,199
Presbyterian	360,005
UnitedHealthcare	82,993
Blue Cross Blue Shield	188,380
Population 2 – SSI and Related – Medicaid Only	**115,715**
FFS	**6,887**
MC	**108,828**
Molina	35,421
Presbyterian	37,724
UnitedHealthcare	15,477
Blue Cross Blue Shield	20,206
Population 3 – SSI and Related – Dual	**105,573**
MC	**105,573**
Molina	20,790
Presbyterian	20,049
UnitedHealthcare	44,901
Blue Cross Blue Shield	19,833
Population 4 – 217-like Group – Medicaid Only	**858**
FFS	**57**
MC	**801**
Molina	160
Presbyterian	159
UnitedHealthcare	319
Blue Cross Blue Shield	163
Population 5 – 217-like Group - Dual	**10,304**
MC	**10,304**
Molina	2,191
Presbyterian	1,833
UnitedHealthcare	4,070
Blue Cross Blue Shield	2,210
Population 6 – VIII Group (expansion)	**755,947**
FFS	**73,858**
MC	**682,089**
Molina	206,939
Presbyterian	190,833
UnitedHealthcare	109,390
Blue Cross Blue Shield	174,927

Section XII: Consumer Issues – Complaints and Grievances

A total of 891 grievances were filed by Centennial Care members in DY5 Q1. Although this presents a slight increase when compared to member grievances received in DY4 Q4 (871), an overall downward trend is demonstrated when compared to Q3 (1,184) Q2 (1,058) and Q1 (968). Non-emergency ground transportation continues to constitute the largest number of grievances reported with 414 (46.46%) of the total grievances received. This remained the same when compared to 414 in DY4 Q4. An overall trend cannot be established when compared to DY4 Q3 (487) Q2 (332) and Q1 (274). Transportation Grievances in Section II of this report provides the MCOs' efforts to address transportation grievances under the guidance of HSD.

The second top grievance filed was Other Specialties with a total of 101 grievances (11.34%) which demonstrates an overall upward trend when compared to DY4 Q4 (45), Q3 (61), Q2 (84) and Q1 (109).

There were 376 (42.20%) variable grievances filed during DY5 Q1. Of those, each MCO reported unique grievances that do not provide data to establish a trend. HSD is monitoring these grievances to identify specific trends.

Table 15 – MCO Grievances DY5 Q1

MCO Grievances DY5 Q1 (January - March 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	205	23.01%	182	20.43%	198	22.22%	306	34.34%	**891**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	122	13.69%	80	8.98%	63	7.07%	149	16.72%	**414**	46.46%
Other Specialties	38	4.26%	0	0.00%	7	0.79%	56	6.29%	**101**	11.34%
Variable Grievances	45	5.05%	102	11.44%	128	14.37%	101	11.34%	**376**	42.20%

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD randomly reviews service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures that the MCOs appropriately allocate and implement the services identified in the member's Comprehensive Needs Assessment (CNA), and that the member's goals are identified in the care plan. There were no identified concerns in DY5 Q1.

Table 16 – Service Plan Audit Results DY5 Q1

Member Records	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	**120**			
BCBS	**30**			
MHC	**30**			
PHP	**30**			
UHC	**30**			
Percent of files with personalized goals matching identified needs	**100%**			
BCBS	**30**			
MHC	**30**			
PHP	**30**			
UHC	**30**			
Percent of service plans with hours allocated matching needs	**100%**			
BCBS	**30**			
MHC	**30**			
PHP	**30**			
UHC	**30**			

NF LOC

HSD reviews Nursing Facility High LOC denials and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria.

Table 17 – Nursing Facility LOC Audit Results DY5 Q1

MCO High NF LOC denied requests (downgraded to Low NF)	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	**15**			
BCBS	**5**			
MHC	**0**			
PHP	**5**			
UHC	**5**			
HSD Reviewed Results	**DY5 Q1**	**DY5 Q2**	**DY5 Q3**	**DY5 Q4**
Number of member files that met the appropriate level of care criteria	**15**			
BCBS	**5**			
MHC	**0**			
PHP	**5**			
UHC	**5**			
Percent of MCO level of care determination accuracy	**100%**			

Table 18 – Community Benefit NF LOC Audit DY5 Q1

Community Benefit denied NF LOC requests	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	**25**			
BCBS	**5**			
MHC	**10**			
PHP	**5**			
UHC	**5**			
Number of member files that met the appropriate level of care criteria determined by the MCO	**25**			
BCBS	**5**			
MHC	**10**			
PHP	**5**			
UHC	**5**			
Percent of MCO level of care determination accuracy	**100%**			

HSD was in agreement with all NF LOC decisions for DY5 Q1. MHC did not have any HNF denials in Q1 and an additional 5 files for Community Benefit were reviewed. All NF LOC decisions were appropriate and complied with HSD's NF LOC criteria.

External Quality Review Organization (EQRO) NF LOC

The EQRO for HSD reviews a random sample of MCO NF LOC determinations every quarter to ensure compliance with HSD's NF LOC criteria.

Table 19 – EQRO NF LOC Review Results DY5 Q1

Facility Based	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
High NF Determination				
Number of member files audited	**23**			
BCBS	4			
MHC	7			
PHP	7			
UHC	5			
Number of member files the EQRO agreed with the determination	**22**			
BCBS	3			
MHC	7			
PHP	7			
UHC	5			
%	**96%**			
BCBS	75%			
MHC	100%			
PHP	100%			
UHC	100%			
Low NF Determination				
Number of member files audited	**85**			
BCBS	23			
MHC	20			
PHP	20			
UHC	22			
Number of member files the EQRO agreed with the determination	**85**			
BCBS	23			
MHC	20			
PHP	20			
UHC	22			
%	**100%**			
BCBS	100%			
MHC	100%			
PHP	100%			
UHC	100%			
Community Based				
Number of member files audited	**156**			
BCBS	39			
MHC	39			
PHP	39			
UHC	39			
Number of member files the EQRO agreed with the determination	**152**			
BCBS	39			
MHC	39			
PHP	39			
UHC	39			
%	**97%**			
BCBS	100%			
MHC	100%			
PHP	90%			
UHC	100%			

The MCO High NF determinations continue to average 96% compliance in DY5 Q1 for EQRO agreement of determinations which equaled the percentage of High NF determinations in DY4

Q4. The Low NF determinations increased in Q1to 100% from an average of 98% in DY4 Q4 for EQRO agreement. The EQRO agreed with 97% of the Community Based determinations, a slight decrease from 98% in DY4 Q4. HSD reviewed all five NF LOC determinations where the EQRO and MCO determinations did not align for DY5 Q1 and HSD was in agreement with all EQRO findings. Issues identified included conflicts in documentation and incomplete information from the MCO. HSD will follow up with the MCOs regarding the identified cases and will continue to provide technical assistance as needed.

Care Coordination Monitoring Activities

Care Coordination Audits

HSD continues to evaluate the MCO internal action plans and met with each MCO in February 2018 to discuss action steps going forward for the Transition of Care audit conducted in DY4 Q3 and the Care Coordination Level of Care (CCL) Audit conducted in DY4 Q4. HSD found with the transition of care audit that member files did not consistently contain all required information such as Medicaid eligibility status, disaster plan or identification of physical health, behavioral health or community needs. The results of these audits prompted HSD to issue additional action steps and recommendations to the MCOs which will be monitored throughout DY5. In addition, MCO internal action plans were updated to include internal monitoring of care coordination level determinations through audits and staff training.

HSD has implemented a quarterly Ad Hoc report for DY5 focusing on member enrollment, member engagement and care coordination timeliness that will allow HSD staff to track and trend the data.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top Emergency Department (ED) utilizers for each MCO. Originally this project included 35 members from each MCO. Over the past 32 months some members have lost Medicaid eligibility for one reason or another leaving 92 active members currently in the project. HSD monitors this effort on a monthly basis. HSD tracks the number of ED visits, reviews next steps of care coordinators to reduce the incidence of ED visits by their members and how supplemental community assistance can complement the services provided by the care coordinator. HSD met with the MCOs in February 2018 to review data since the inception of the project to discuss what challenges care coordinators encounter in working with super utilizers and look at best practices that have been successful for lowering ED usage. HSD shows a 45% decrease over the tenure of this project in ED use among project participants. DY5 Q1 has shown this trend continuing.

All of the MCOs have made a concerted effort to go beyond standard touchpoints for these members and have engaged them in ways that have affected their wellbeing in all areas of their lives. Care Coordinators have assisted with obtaining housing for homeless members,

collaborated with Community Health Workers to deliver food boxes to members facing food insecurity, and arranged to meet with a member at their detox center and utilized a triage team approach. All of these efforts have contributed to member wellbeing and in turn lower ED use.

Care Coordination and EDIE

The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016 with additional hospitals and emergency facilities joining this effort throughout 2017. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical metadata. As a result of the notification, the provider has information in hand before seeing the patient. This allows the provider to take action and to influence health care outcomes. Due to the increased use of EDIE, MCOs have reported data that has allowed them to better assist those members utilizing the ED, rapidly see those members with emergent needs and connect difficult to engage members with care coordinators. HSD regularly reviews how EDIE can assist those care coordinators working with members in the Super Utilizer project. Care Coordinators have reported building relationships with ER staff that assist them in recognizing those members receiving care coordination. Targeted training of MCO staff is being developed and technical issues are being addressed. As the program grows EDIE will become more valuable to the MCOs and in turn the member.

Care Coordination for Incarcerated Individuals

In DY5 Q1, HSD met with staff from 3 MCOs to discuss policy, procedure and best practices used at The Santa Fe County Detention Center (SFCDC). UHC, PHP and BCBS have collaborated with Santa Fe County to provide care coordination to those incarcerated members that are transitioning back into the community. The SFCDC made this program a priority and have certain staff trained to assist with each MCO's unique processes. In DY5 Q1 BCBS had 573 members incarcerated at SFCDC with 142 expressing an interest in care coordination. UHC had 415 members at SFDC with 51 interested in care coordination and PHP had 273 members at SFCDC with 23 interested in care coordination. HSD discussed with UHC, BCBS, PHP and SFCDC how best practices could be implemented in other facilities across the state. SFCDC has agreed to present their policies and procedures, and best practices at a future HSD sponsored event.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY5 Q1, HSD staff attended a ride along with UHC and PHP. HSD staff observed the different interview styles of care coordinators, the CNA process and whether it best addressed the member's needs, whether all pertinent questions were asked and whether the resources and services most needed by the member were provided.

HSD found that care coordinators showed great empathy for their members and that their activities were in compliance with contract requirements including the administration of the Community Benefit Services Questionnaire (CBSQ). Care coordinators, naturally, have a variety of interviewing techniques and skill level. HSD strives to have the CNA process as member centric as possible, focused on the information needed and to serve as a building block in the development of the relationship between the member and the MCO care coordinator.

Section XIV: Managed Care Reporting Requirements

Customer Service

In DY5 Q1, all MCOs met call center metrics (abandonment rate, speed of answer and wait time) for the customer services lines, member services, provider services and the utilization management line.

Metrics were met for the nurse advice line for each month in Q1 by all MCOs with the exception of one metric (percent of calls answered within 30 seconds). BCBS reported a staff shortage for December, January and February and did not meet this metric. New nurse advice line staff have been hired to mitigate the staffing shortage. Please see Attachment G: Customer Service Summary.

MCO Reporting

In the DY5 Q1, the MCOs continued the Technical Assistance (TA) Calls and the Self-Identified Error Resubmission. These two processes allow HSD and MCO Subject Matter Experts (SMEs) to provide clarification and direction on MCO reporting inaccuracies. Reports from MCOs in Q1 have been timely and HSD continues to see a decline in MCOs report extension requests, with two extension requests made in DY5 Q1.

Report Revisions

During DY5 Q1, HSD report reviewers submitted proposed revisions for each of their respective reports, in preparation for Centennial Care 2.0. HSD revises reports to streamline elements, improve monitoring, and incorporate requirements of the managed care final rule.

Member Appeals

A total of 869 member appeals were filed by Centennial Care members in DY5 Q1. This demonstrates a consistent downward trend when compared to member appeals received in DY4 Q4 (876), Q3 (1,043), Q2 (1,000) and Q1 (1,013). Of those 869 appeals, 744 (85.62%) were standard member appeals and 125 (14.38%) were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner. Denial or limited authorization of a requested service remains the reason for member appeals reported with 716 (82.39%) of the total appeals received. Although this presents an increase when compared to 697 in DY4 Q4, an overall downward trend is demonstrated when compared to Q3 (834), Q2 (822), and Q1 (873) in DY4.

The second top reason for member appeals was the reduction of a previously authorized service with a total of 61 (7.02%) member appeals. This demonstrates a slight increase when compared to 54 in DY4 Q4, an overall downward trend is demonstrated when compared to Q3 (79), Q2 (110), and Q1 (81) in DY4.

There were 92 (10.59%) variable appeals in DY5 Q1. Of those, each MCO reported unique appeals during the quarter that do not provide enough information to establish a trend. All MCOs

have complied with the policies and procedures regarding members' exhaustion of the Grievance and Appeal System prior to requesting a State Fair Hearing.

Table 20 – Member Appeals DY5 Q1

MCO Appeals DY5 Q1 (January - March 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member	91	10.47%	165	18.99%	346	39.82%	142	16.34%	**744**	85.62%
Number of Expedited Member	70	8.05%	12	1.38%	6	0.69%	37	4.26%	**125**	14.38%
Total	161	18.52%	177	20.37%	352	40.51%	179	20.60%	**869**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	145	16.69%	140	16.11%	317	36.48%	114	13.11%	**716**	82.39%
Reduction of a previously authorized service	2	0.23%	36	4.14%	8	0.92%	15	1.73%	**61**	7.02%
Variable Appeals	14	1.61%	1	0.12%	27	3.11%	50	5.75%	**92**	10.59%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues throughout DY5 Q1 with activities centered on the collection of outstanding DY4 data as well as preliminary data for DY5. Deloitte and HSD discussions focused on the development of timelines and deliverables for DY5, reporting activities, and report content and structure of the Final Evaluation Report.

The Final Evaluation Report format will be consistent with the Interim Evaluation Report and contain the final conclusions on the effectiveness of the waiver with respect to the established goals of the program. Deloitte continues to meet with HSD regularly to further refine the work plan, discuss data and data questions, as well as identify and review any analysis issues or risks.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Monitoring Spreadsheet
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment E: Behavioral Health Collaborative CEO Report
Attachment F: MCO Action Plans
Attachment G: Customer Service Summary

Section XVII: State Contacts

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Section XVIII: Additional Comments

The following are member success stories from the Centennial Care MCOs who have had positive experiences with care coordination and other unique aspects of Centennial Care.

Centennial Care Member Success Story 1

A community health worker (CHW) embedded in a clinic practice has been collaborating with providers to assist members with social determinants of health. Providers at the clinic are responding to the vital role of CHWs and are identifying members who may benefit from the support of a CHW. Providers are allowing the embedded CHW time to meet with members individually in the exam room.

Recently, a member screened positive for housing insecurity. The CHW met with the member and encouraged the member to follow up on a Housing and Urban Development (HUD) application that was submitted several years prior. The member was ambivalent about contacting the agency because the member reported that she has been on the wait list for many years. The member ultimately contacted HUD and due to her change in health status, the member was able to advance on the waiting list. With the CHW's support and coaching, the member was able to advocate for herself. The member now has a better chance of obtaining permanent housing due to the Section 8 lottery opening in Bernalillo County in April.

Centennial Care Member Success Story 2

A member attended Member Day at Albuquerque Healthcare for the Homeless. The member approached a Member Representative for assistance with a lost Member ID card. The Member Representative immediately contacted Member Services and ordered a replacement card. The member also requested assistance with a Social Security benefit question. The Member Representative assisted by pointing him in the right direction. The member stated he had not collected his SSI benefits for nearly 6 years as he's been homeless and without a permanent address. The Member Representative provided the member with contact information for the nearest Social Security Administration Office as well as Legal Aid. In addition, the Member Representative assisted the member with finding a new PCP and setting up a dental appointment. Lastly, the Member Representative assisted with filling out the paperwork for housing on site and with obtaining a no cost telephone, so he would be able to communicate with his advocates. As a result of the resources that were provided, the member was able to have his SSI benefits reinstated and is pursuing permanent housing. The member has expressed that he is very appreciative of the Member Representative's willingness to listen and be responsive to him.

Centennial Care Member Success Story 3

A member was referred to the care coordinator while inpatient at an Albuquerque hospital. The member was homeless and suffering from alcohol induced pancreatitis, diabetes, hepatitis C, hypertension, and depression. Once he was discharged, the member transitioned to another facility where he continued his detox program before moving to a nursing facility to recover physically. As the member prepared to move back into the community, the care coordinator

worked with Clinical Health Worker and Housing Specialist in addressing his needs and becoming self-sufficient.

During the member's in-person assessment, the member talked about the success of his results with the resources provided. He found a PCP, was clean and sober and motivated to move forward in life, and had obtained a temporary job. At the member's quarterly assessment, he reported he had a one bedroom apartment, had completed his training with Work Force Connections, and was going to start a new job in two weeks.

Centennial Care Member Success Story 4

A member was in the Lubbock hospital when the care coordinator received his referral. He had a self-inflected gunshot wound under his chin and has been a drug addict most of his life. The case worker and discharge planners were not having luck with finding him a placement; a residential treatment facility would not take him because he had a trach collar and a peg tube. A rehab nursing facility would not take him because of his history of drug abuse, his multiple suicide attempts and because he was actually under arrest at the time of his injury. The only alternative was to send him home if possible and get his family to agree. The care coordinator set up specialized equipment for him at home and made an appointment with a counselor at a mental health agency. The care coordinator also made appointments with a PCP, because he did not have one and they would not discharge without one. Additionally, the care coordinator scheduled an appointment with a CNP who specializes and prescribes BH medication, and referred him to a BH care coordinator. The member was discharged on February 22, 2018 and for the following month had numerous problems with his trach tubing/cleaning supplies and liquid nutrition as he cannot eat by mouth. With persistent follow up, the care coordinator was able to assist in getting the member all needed supplies and liquid nutrition. The member has met with his new therapist multiple times as well as with a psychiatrist, new PCP and the BH Nurse Practitioner. The member's family has reported that he is doing remarkably well considering his challenges.