Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 2 (1/1/2015 – 12/31/2015)
Waiver Quarter: 1/2015

5/29/2015
Submitted by:
New Mexico Human Services Department

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Section I: Introduction

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. Highlights from the first waiver year (January 2014-December 2014) include:

- Successful transition to Centennial Care;
- New benefits and features in Centennial Care;
- Improved care coordination;
- Expanded access to home and community-based services (HCBS);
- Centennial Rewards Program;
- Native American Technical Advisory Committee (NATAC) and Native American Advisory Boards (NAAB); and
- Addressing provider workforce issues and broadening access to care.

There are many initiatives in development during demonstration year two (DY2) that include:

- Creation of health homes targeted to persons with chronic conditions;
- Implementation of electronic visit verification that monitors member receipt and utilization of community-based services;
- Payment reform projects for both hospitals and other providers;
- Connecting jail-involved individuals who are being released with Medicaid and care coordinators in the Centennial Care program; and
- Expanding the use of community health workers through a pilot project.

Section II: Enrollment and Benefits

Eligibility

As noted in Section III of this report, there are 222,093 enrollees in the Expansion/VIII Group who are in Centennial Care. This is an increase of 20,757 enrollees from the prior quarter.

Enrollment

Centennial Care enrollment for DY2 quarter one (Q1) indicates a decrease for Temporary Assistance for Needy Families (TANF) and the 217-like Group and increases in all other populations, specifically Group VIII. The expansion of Medicaid eligibility has contributed to the overall increase in enrollment. The majority of Centennial Care members are enrolled in Population 1-TANF and Related with Population 6-Group VIII (expansion) being the next largest group as reflected in Section III of this report.

Disenrollment

The Human Services Department (HSD) continues to run the file for the short-term fix for the isolated disenrollment of Centennial Care members that was identified and addressed in demonstration year 1 (DY1) Q2 as validation to ensure that the long-term fix is successful. The isolated disenrollment was linked to the processing of the eligibility file between the Automated System Program and Eligibility Network (ASPEN) that determines eligibility and the Medicaid Management Information System (MMIS) that determines enrollment and disenrollment to Centennial Care. The short-term fix was implemented to ensure that members do not lose access to any services. The long-term fix to resolve these disenrollment issues was implemented in DY1 Q4. HSD continues to run the short-term fix to be proactive and identify any potential issues that may arise. The disenrollment numbers continue to decrease from quarter to quarter.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through February 2015. Quarterly data is available through the fourth quarter of 2014.

Primary Care Provider (PCP)-to-Member Ratios

The PCP-to-member ratio standard of 1:2000 was met by all MCOs in urban, rural and frontier counties in the fourth quarter. Open-panels were above 90 percent for each MCO. There are no identified PCP concerns at this time.

Physical Health (PH) & Hospitals

Geographic access standards were met by all MCOs in general hospitals, PCPs, federally qualified health centers (FQHCs), pharmacies and many specialties in urban, rural and frontier counties. See Attachment B: GeoAccess PH Summary.

In the report presented, Molina Healthcare of New Mexico (MHNM) omitted enrollment of two FQHC facilities in its access calculation. This was an error and resulted in the MCO reporting an

access deficiency since Q2 DY1. MHNM will make the necessary correction in its next GeoAccess submission to HSD. MHNM met the standard and accurately reported in the analysis section of the report that there is a contracted FQHC in each rural county.

In addition to the quarterly attachment that reflects each MCO's geographic access for the quarter, please also see Attachment C: GeoAccess Report PH by MCO, 2014. This expanded chart reflects access percentages for all four quarters of DY1 by MCO. Detailed progress in addressing deficiencies is reflected in this chart. When comparing the fourth quarter to earlier quarters, the MCOs made progress in improving access in most areas. Dermatology is the most challenging PH specialty in that access standards were not met by the MCOs statewide, with two exceptions, UnitedHealthcare (UHC) in urban and MHNM in frontier areas. There are four additional specialties that have deficiencies in the rural and frontier areas (endocrinology, neurology, neurosurgeons, and rheumatology). Access issues are primarily remedied by providing member transportation to the nearest provider. Other options include telemedicine and single case agreements with out-of-network providers.

On January 1, 2015, Presbyterian Health Plan (PHP) began offering "Video Visits," as an alternative to urgent care or having to schedule an appointment for an office visit. Video Visits are a convenient and modern approach to treat common health issues such as allergies, asthma, bronchitis, cold and flu. Video Visits can be made from home, work, or while a member is traveling (in New Mexico or out-of-state). A member can use a computer that has a webcam or a smartphone using a mobile app. The service is secure and follows all medical privacy rules and regulations.

Another innovative service that PHP developed is a home paramedic program in Central New Mexico. PHP will identify a list of high emergency room (ER) utilizers as well as members who are at high risk for emergency hospital readmission following acute facility stay discharge. PHP will use its contracted ambulance paramedic service to schedule visits with those members, assess them proactively with vital signs and medication reconciliation, and identify any additional interventions that can be deployed for non-emergent issues outside of the ER setting. The goal of this program is to reduce non-emergent ER visits; reduce hospital readmissions; provide medication reconciliation; and, provide connectivity with primary care providers and care coordination to ensure optimal continuity of care for members. The program is targeted for implementation in the second quarter.

Long-Term Care

All MCOs met standards in delegated personal care service (PCS) agencies, directed PCS agencies and nursing facilities (NFs) in urban, rural and frontier counties.

Transportation

All MCOs met the standards in urban and rural counties for transportation. The GeoAccess report and instructions were revised in DY1 Q4 to better identify areas where standards were not

met. For example, Blue Cross Blue Shield of New Mexico (BCBSNM) met the overall standard in rural and frontier areas, but it did not meet the access standard in the rural county of Rio Arriba and the frontier counties of Catron, DeBaca, Guadalupe, Harding, Hidalgo and Sierra.

It was recently discovered that some of the MCOs were not counting fleet vehicles in different locations or counties that are part of one established non-emergency transportation provider. MCOs were only counting the home office and not the fleet locations. Adjustments have been made.

UHC continues to have an access deficiency in frontier areas, though access is up in these areas to 85.4 percent. UHC's subcontractor, Logisticare, is working to identify and recruit providers in both the rural and frontier counties. UHC has expanded the vehicle fleets with existing providers by 30 vehicles statewide. Please also see Section IX.: MCO Action Plans.

Behavioral Health (BH)

Three Core Service Agencies (CSAs) gave notification of closure in early 2015. Efforts were made to prevent the closures and one CSA did rescind its notification.

Turquoise Health and Wellness (THW)

THW, an adult and children's CSA, gave official notification of closure in January 2015 with a closing date of March 31, 2015. THW cited financial difficulties as the reason for withdrawing services at their five locations in Roswell, Carlsbad, Clovis, Fort Sumner, and Tucumcari. Strategic planning by HSD, the MCOs and two other CSAs (Presbyterian Medical Services and Mental Health Resources) resulted in transitioning members with minimal interruption of services.

In Roswell, an established FQHC, La Casa Family Health Center decided to include BH services. State agencies continue to work closely with leadership at La Casa to complete the Community Mental Health Center (CMHC) credentialing process. Additionally, other established BH providers accepted former THW members and immediately began providing services.

The Psychological Rehabilitation Program in Roswell was in jeopardy of closing, but members receiving services had another plan. Working with the State and a care coordination team (with representatives from each MCO), the members established a board and applied for 501(c)(3) status to create a Wellness Center. This teamwork has kept the doors open until La Casa's CMHC credentialing work is completed. La Casa has provided groceries to keep the kitchen open and THW donated their cars so transportation of members in rural areas can continue.

Tri County Community Services (TCCS)

TCCS, an adult CSA, gave official notification of closure for two of its three facilities on March 10, 2015 with a closing date of May 29, 2015. The facilities expected to close were in the frontier areas of Union and Colfax counties. Shortly after notice was given, leadership at TCCS

changed. The BH consulting team of Parker Dennison preformed an audit on TCCS. While deficits were found in previous management along with financial instability, the new leadership at TCCS decided to address the issues and not close. TCCS rescinded the notification of closure on March 20, 2015.

HSD and the MCOs continue to provide technical support to the new leadership at TCCS. Over the past few months there have been significant changes. The new leadership has resolved insurance and tax issues and is now able to meet payroll.

La Frontera (LF)
LF, an adult and children's CSA, gave official notification of closure in March 9, 2015 with a closing date of May 31, 2015. LF cited financial difficulties as the reason for withdrawing services at their 12 locations in seven counties. Parker Dennison preformed an audit on LF that provided information for the LF board to make a final decision about the closure. The board decided not to continue delivering services in any location. However, working with HSD and the MCOs, LF agreed to stagger the closing of the locations over three months extending the final closing date to July 31, 2015.

Presbyterian Medical Services (PMS) has an established CSA serving adults in the same area as LF. PMS has agreed to take over adult services in one county. In the largest urban county, La Clinica De Familia, an established FQHC stepped forward. La Clinica, with 12 established locations, had a long-term goal of becoming a CSA and expanding services to include BH. With the help of HSD and the MCOs, La Clinica will become a CSA and provide services in Las Cruces.

In the southwest counties of the LF service area, Hidalgo Medical Services (HMS) has agreed to take members from the three frontier locations. HMS is an established FQHC and will work with HSD to acquire the necessary credentials to provide BH services.

Medication Assisted Treatment and Intensive Outpatient Services
HSD plans to grow the network of Medication Assisted Treatment and Intensive Outpatient (IOP) providers to address high numbers of people with Substance Use Disorder (SUD) and complex BH needs.

As of May 2015, there are 13 methadone clinics in New Mexico. Of the 13, eight currently accept Medicaid, two opened in late 2014 and should accept Medicaid in the summer of 2015, two have begun the Medicaid application process, and one clinic will begin the process by summer of 2015. Additionally, three new Medication Assistant Treatment programs have been approved and their clinics should be open by the spring of 2016. As of May, 2015, there are 18 Medicaid approved IOP programs.

The increase of providers delivering these two services will assist communities and their members on many fronts. The overarching goal is to have multiple BH providers in the 33 counties throughout the State.

See Attachment D: GeoAccess BH Summary for more information on BH Access.

Service Delivery

PH Utilization Data

In the first quarter of 2015, Centennial Care MCOs provided utilization data for all service areas, including PH and LTC, for 2014. As with all reports received by HSD, staff reviews the data for any irregularities and provides feedback to the MCO. If data is missing or the data is determined to be inaccurate, the report is rejected and a resubmission is required by the MCO within ten calendar days. In April, 90-day supplements to the fourth quarter reports were submitted to capture claims run out. Two of the supplements for 2014, one from UHC and one from MHNM, were rejected due to inaccuracies and require report resubmission. PH utilization data for 2014 will be provided to CMS in the second quarter report.

Pharmacy

High claim denials for both formulary and non-formulary medications were re-evaluated during the first quarter using December 2014 data. Both MHNM and UHC resubmitted their December reports with corrections. HSD calculated the total denial rate for all MCOs in December as 18 percent. In reviewing the most current data, from February 2015, the total denial rate for all MCOs is now approximately 22 percent (see Table #1. below).

Table #1. Pharmacy Claim Denials

MCO	Formulary Claim Denials	Non-Formulary Claim Denials	Total Claims Denied	Total # of Processed Claims	% of Claims Denied Out of Total Claims Processed
BCBSNM	10,597	14,766	25,363	137,391	18.46%
UHC	16,024	13,833	29,857	113,761	26.25%
MHNM	48,025	11,796	59,821	258,368	23.15%
PHP	32,605	5,237	37,842	191,521	19.76%
Total	**107,251**	**45,632**	**152,883**	**701,041**	**21.81%**

Source: MCO Reports #44, February 2015

These denials are used as monitoring tools to ensure proper payment by the MCO when the member has had a change in eligibility, claims have invalid NDC numbers, claims exceed plan limitations, claims exceed maximum day supply, or when members are filling medications too soon.

Nursing Facilities (NFs)

In the first quarter of 2015, a meeting was requested by the New Mexico Health Care Association (NMHCA) to address issues that NFs were encountering with the MCOs, HSD, and with the ASPEN system. On February 2, 2015, a meeting was held. In attendance were representatives from each of the Centennial Care MCOs, the NMHCA, the HSD Medical Assistance Division (MAD), and the HSD Income Support Division (ISD). Also in attendance were representatives from several NFs.

The issues that were raised during the February meeting focused on the following concerns. First, the NFs were receiving different responses for prior authorization requirements for bed hold days by the MCOs. Second, the NFs wanted to know the specifics regarding a rate adjustment and processing of resubmitted claims. Lastly, the facilities were experiencing eligibility problems with ASPEN and were having difficulties in obtaining eligibility determinations from ISD.

The prior authorization requirements for bed hold days were reviewed and clarified. Neither BCBSNM nor UHC requires a prior authorization. PHP does not require a prior authorization but found that some claims were denied for not having a prior authorization. PHP is re-educating its staff on this issue, and claims will be resubmitted by the NFs as applicable. MHNM requires a notification for bed hold days in order to enter a revenue code. This notification requirement is in addition to the original NF stay authorization.

Beginning in July 2014, MCOs were to increase each NF's "low level of care" rate by 3.7 percent. By March 2015, all MCOs had completed the rate adjustment and reprocessed claims.

The eligibility concerns with ASPEN varied. The outcome from the discussion was that the NFs will send a list of examples of what they believe to be discrepancies for medical care credits (MCC) calculated on the State portal. The calculations will be reviewed for logic errors. With regard to NFs having to pay the discount portion, for those members who have court orders, HSD is proceeding with a rule change to exempt court orders when determining eligibility for a member. With regard to receiving confirmation when a nursing facility level of care (NF LOC) is entered in the ASPEN system, HSD created a daily exception report to notify MCOs of any error(s) in their transmittals. HSD is actively examining this process to determine if the report eliminates NF LOC delays.

ISD noted that a new Institutional Care (IC) unit was being implemented in April 2015. The creation of this unit will result in moving all IC and waiver cases, active and pending, from the field offices to a central location.

HSD created a contact list of subject matter experts that was distributed to all parties, including: the MCOs, ISD, and the NFs. HSD's goal is to facilitate direct contact with subject matter experts who can assist the NFs without delays. HSD is monitoring the progress of all the issues presented at the meeting.

Durable Medical Equipment (DME)
Oxygen continues to be the highest cost and utilized DME item. Oxygen is approved by the MCOs based on medical necessity, and MHNM indicates that the member must have room saturation below 88 percent. Respiratory infections increased in the fourth quarter due to seasonal differences which may have increased utilization during the reporting period. Utilization is monitored by the MCOs and analysis is provided in the Over/Under Utilization report to HSD quarterly.

High DME utilization is a common trend for disposable undergarments in the Medicaid population. HSD is requesting the MCOs' procedures requiring documentation, based on Medicaid policy, for providers or medical suppliers that routinely supply items to members. Orders for additional supplies must be requested by the member, or his or her authorized representative, and the provider or supplier must confirm that the member does not have in excess of a 15 calendar day supply of the item before releasing the next supply order to the member. A provider must keep documentation in his or her files, available for audit, that show compliance with this requirement.

Dental
Diagnostic and preventive dental services for members 20 years and under are in the top five utilized services for PH in 2014. There were 181,752 unduplicated members, who received diagnostic services, and there were 175,066 unduplicated members, who received preventive services. Additionally, the most rewards earned in the Centennial Rewards program were due to child preventive dental services, followed by adult preventive dental services.

BH Utilization Data
New Mexico recently submitted its CMS Annual Report: Behavioral Health. That report provides detailed analyses of state-level BH utilization patterns in Centennial Care. Since the submission, HSD has obtained and analyzed additional information on BH utilization during DY1, including county-level data.

With the carve-in of BH services in Centennial Care, significant work was done in the first year to refine BH utilization reporting to allow HSD to monitor changes to access. Report 41: BH Utilization now provides valuable information to monitor and plan the provision of BH services in all areas of the State.

To provide tracking of pre-and post-Centennial Care utilization, Report 41 was originally structured with similar parameters as the BH utilization reporting template that had been used by HSD prior to Centennial Care. Over the first year of Centennial Care, the reporting logic has been refined and modules for PH and LTC have been added. The report examines the utilization of over 70 BH services in five categories: Inpatient, Residential, Intensive Outpatient, Recovery, and Outpatient. It shows the unduplicated number of members receiving services by age group,

as well as units of service and expenditures. The report is submitted quarterly, one month after the end of the quarter.

An annual supplement for Report 41 was developed in April 2015 to allow for all 2014 claims to be settled. At the highest level, this report shows that a significant percent of members in each plan received a BH service (between 14.79 percent and 18.96 percent depending on the plan).

Table #2. Members Receiving BH Services in CY 2014 – State-Level Unduplicated Members

	Unduplicated BH Service Recipients	Total CC 2014 Enrollment as of 1/2/2015	BH service users/All
PHP	29,454	195,191	14.79%
MHNM	43,702	209,788	17.60%
UHC	12,623	75,873	16.63%
BCBSNM	21,705	114,493	18.96%
Total	**107,484**	**595,345**	**18.05%**

To provide a better understanding of access to services in the counties across the State, MCOs also provided county-level managed care utilization data for the 2014 Annual Supplement. HSD used this detailed information to examine whether members in all New Mexico counties had accessed BH services and whether an array of services was provided.

For the initial analysis of county-level utilization, HSD examined both managed care and fee-for-service (FFS) utilization. Managed care data was compiled from county-level utilization reports from the MCOs. FFS utilization information was available on the unduplicated members receiving a BH service in each county, but detailed information about the types of BH services provided was not available. Therefore, the analysis of the array of services is only available for Centennial Care. Utilization was analyzed according to the county location of the provider. MCOs also identified services that were performed out-of-state.

BH services were provided to Medicaid recipients in all counties and some services were provided out of state.

Table #3. New Mexico Medicaid BH Services DY1: By County-Managed Care and FFS

Where Members Live				Where Member Get BH Services			
	All Medicaid Members Who Live In THIS County (March 2015)	Percent of NM Medicaid Members		Managed Care BH Services	Fee for Service BH Services	Total BH Services	Of Members Getting BH Services - Percent Who Were Served In THIS County
Bernalillo	228,511	29.0%	Members Served	52,327	6,537	58,864	44.5%
(urban)			Dollars	$92,347,946	$8,111,235	$100,459,181	
Catron	1,077	0.1%	Members Served	63	18	81	0.1%
(frontier)			Dollars	$16,721	$6,882	$23,603	
Chaves	29,241	3.7%	Members Served	5,474	642	6,116	4.6%
(rural)			Dollars	$5,150,993	$1,308,823	$6,459,816	
Cibola	12,437	1.6%	Members Served	840	646	1,486	1.1%
(frontier)			Dollars	$1,654,958	$1,206,776	$2,861,734	
Colfax	4,558	0.6%	Members Served	1,176	161	1,337	1.0%
(frontier)			Dollars	$1,586,702	$299,661	$1,886,363	
Curry	17,820	2.3%	Members Served	2,052	584	2,636	2.0%
(rural)			Dollars	$2,877,673	$1,376,635	$4,254,308	
De Baca	866	0.1%	Members Served	90	38	128	0.1%
(frontier)			Dollars	$94,636	$36,046	$130,682	
Dona Ana	100,659	12.8%	Members Served	14,991	3,193	18,184	13.7%
(urban)			Dollars	$26,823,704	$6,987,259	$33,810,963	
Eddy	19,541	2.5%	Members Served	3,530	418	3,948	3.0%
(rural)			Dollars	$2,990,695	$459,150	$3,449,845	
Grant	11,271	1.4%	Members Served	1,117	298	1,415	1.1%
(rural)			Dollars	$1,329,615	$224,095	$1,553,710	
Guadalupe	2,020	0.3%	Members Served	335	84	419	0.3%
(frontier)			Dollars	$421,630	$78,959	$500,589	
Harding	136	0.0%	Members Served	7	2	9	0.0%
(frontier)			Dollars	$1,149	$10,644	$11,793	
Hidalgo	1,842	0.2%	Members Served	720	43	763	0.6%
(frontier)			Dollars	$404,776	$57,263	$462,039	
Lea	23,409	3.0%	Members Served	2,168	221	2,389	1.8%
(rural)			Dollars	$2,962,358	$458,358	$3,420,716	
Lincoln	7,163	0.9%	Members Served	447	143	590	0.4%
(frontier)			Dollars	$414,837	$366,906	$781,743	
Los Alamos	1,193	0.2%	Members Served	199	20	219	0.2%
(urban)			Dollars	$156,453	$26,093	$182,546	
Luna	14,999	1.9%	Members Served	1,045	164	1,209	0.9%
(rural)			Dollars	$702,952	$328,280	$1,031,232	
McKinley	40,513	5.1%	Members Served	1,140	2,383	3,523	2.7%

(rural)			Dollars	$662,116	$2,712,812	$3,374,928	
Mora	1,841	0.2%	Members Served	166	32	198	0.1%
(frontier)			Dollars	$70,687	$31,764	$102,451	
Otero	19,807	2.5%	Members Served	2,469	559	3,028	2.3%
(rural)			Dollars	$1,742,332	$1,159,342	$2,901,674	
Quay	3,971	0.5%	Members Served	766	136	902	0.7%
(frontier)			Dollars	$1,007,629	$330,711	$1,338,340	
Rio Arriba	21,922	2.8%	Members Served	3,132	731	3,863	2.9%
(rural)			Dollars	$4,231,541	$1,388,594	$5,620,135	
Roosevelt	7,040	0.9%	Members Served	362	202	564	0.4%
(rural)			Dollars	$714,005	$494,984	$1,208,989	
San Juan	50,772	6.5%	Members Served	3,347	2,536	5,883	4.4%
(rural)			Dollars	$4,142,528	$3,149,293	$7,291,821	
San Miguel	12,742	1.6%	Members Served	3,537	314	3,851	2.9%
(frontier)			Dollars	$4,122,193	$434,034	$4,556,227	
Sandoval	41,719	5.3%	Members Served	5,514	1,555	7,069	5.3%
(rural)			Dollars	$5,495,027	$2,371,594	$7,866,621	
Santa Fe	40,168	5.1%	Members Served	9,033	1,155	10,188	7.7%
(urban)			Dollars	$15,900,897	$1,727,884	$17,628,781	
Sierra	5,970	0.8%	Members Served	404	181	585	0.4%
(frontier)			Dollars	$325,333	$285,789	$611,122	
Socorro	8,141	1.0%	Members Served	670	363	1,033	0.8%
(frontier)			Dollars	$355,467	$646,594	$1,002,061	
Taos	14,691	1.9%	Members Served	3,684	521	4,205	3.2%
(rural)			Dollars	$4,104,419	$763,457	$4,867,876	
Torrance	8,284	1.1%	Members Served	811	206	1,017	0.8%
(frontier)			Dollars	$641,655	$109,781	$751,436	
Union	1,105	0.1%	Members Served	81	47	128	0.1%
(frontier)			Dollars	$112,163	$70,999	$183,162	
Valencia	30,520	3.9%	Members Served	2,582	659	3,241	2.4%
(rural)			Dollars	$2,432,396	$993,099	$3,425,495	
Unknown or Served Out of State	1,092	0.1%	Members Served	9,006	20	9,026	6.8%
			Dollars	$24,060,040	$16,720	$24,076,759	
Grand Total	**787,041**	100.0%	Members Served	107,484	24,812	132,296	16.8%
			Dollars	$210,058,224	$38,030,516	$248,088,740	

HSD received additional details about the types of Centennial Care services provided in each county. The detailed county-level analysis shows that 107,484 (18.05 percent) members received an array of services in all five categories of service in most New Mexico counties (Attachment

G: BH Services by County DY1). Additional analysis by age also shows that members in all age groups were provided an array of services in each county.

The new county-level reporting provides valuable information to monitor services. Utilization patterns reviewed alongside GeoAccess reports and Network Adequacy Reports, allow HSD to closely monitor the Centennial Care service network and plan to address any potential gaps in services. This level of reporting will also be valuable in planning for the allocation of non-Medicaid resources and any transition of local BH providers. County-level reporting will be required quarterly in 2015.

The initial version of New Mexico's Applied Behavior Analysis (ABA) rule required revision to allow for the array of services CMS would expect members identified with Autism Spectrum Disorder (ASD) to receive. The rule was revised during DY2 Q1 and went into effect on May 1, 2015.

ABA services are provided to eligible members under 21 years of age as part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment which stipulates that ABA services be provided in coordination with other medically necessary services (e.g., Family Infant Toddler Program services, occupational therapy, speech language therapy, medication management, etc.).

As members with ASD present with a wide range of skills and deficits it is imperative that MCOs base prior authorization of units on the member's presenting needs, not on a predetermined maximum of units. The MCOs must also be responsive to shifts in the member's behaviors to allow for additional units or for Targeted Evaluations, Integrated Service Plan (ISP) Updates, or re-assessment and ABA Treatment Plan Updates to fine-tune services for the eligible recipient.

In DY2 Q2, the MCOs and HSD will work to operationalize the rule changes and expand the provider network.

Provider Network

As reported in DY1 Q4, the frequency of the Provider Suspension and Termination report was changed to annual. The first annual report was received in January 2015. The number of new providers exceeded the number of terminated providers in most instances. BCBSNM recently performed a system review, as did the other MCOs earlier in 2014, and made appropriate adjustments. Periodic adjustments are made primarily due to duplicate entries of providers, providers leaving practices and not notifying the MCO, providers changing provider groups and not notifying the MCO, providers moving out of state and providers retiring. BCBSNM had 830 terminations of which 75.3 percent (625) were demographic and affiliation updates.

There were some improvements in adding specialty providers as detailed in Attachment C: GeoAccess Report PH by MCO, 2014. MCOs continue their efforts in adding new providers and

terminations are within normal attrition ranges. Single case agreements remain low and BCBSNM decreased its single case agreements from 126 in the third quarter to 88 in the fourth quarter.

UHC initiated new, value-based contracts in 2015. This began with La Clinica de Familia in Southern New Mexico in the first quarter. UHC developed a "per member per month" (PMPM) pay for performance initiative tied to nine quality performance measures. UHC also held its first Annual Quality Provider Summit with multi-departmental presentations provided to approximately fifty provider groups. UHC states that the presentations were well received.

Centennial Rewards Program

The Centennial Rewards program has more than 340,000 members earning rewards, a 29 percent increase from DY1. At the end of DY1, members had accumulated $9.6 million in reward points, and by March 31, 2015, an additional $3.8 million points were accumulated. The number of redeemed points, $1.4 million year-to-date, is low but is a modest increase from the prior quarter. The table below shows credits earned by activity.

Table #4. DY2 Q1 Credits Earned and Redeemed by Activity

Eligibility Activities	Reward Credits	Total Credits Earned by Activity	Total Credits Redeemed by Activity
Healthy Smiles for Adults	$25	$2,687,925	$751,703
Healthy Smiles for Children	$35	$6,807,430	$253,832
Step-Up Challenge	$50	$25,775	$13,908
Health Risk Assessment (HRA)	$10	$718,700	$10,471
Healthy Pregnancy	$100	$503,300	$56,445
Diabetes Management	$80	$1,608,020	$169,661
Asthma Management	$75	$338,430	$39,612
Schizophrenia Management	$75	$233,790	$18,690
Bipolar Disorder Management	$75	$410,280	$23,823
Bone Density Testing	$35	$15,575	$1,557
Other (Appeals)	NA	$32,495	$13,145
TOTAL		**$13,381,720**	**$1,352,847**

Enrollment in the program is an indicator that members are aware of the Centennial Rewards program, while the number of points earned indicates that members recognize healthy changes are important and these healthy choices can mean rewards. Activity suggests that the incentives are driving members' behaviors.

Community Interveners

In the first quarter of 2015, Community Outreach Program for the Deaf (COPD), the community intervener (CI) subcontractor for the Centennial Care MCOs, provided training to all four MCOs on the definition of deaf-blindness. The training also included information on the roles of CIs and recruitment and training requirements that COPD has in place for them.

MHNM requested COPD provide risk factors (e.g. syndromes frequently associated with deaf-blindness), so that its care coordinators could search their records in order to identify those members who might be deaf-blind and who might benefit from CI services. Four trainings were held for MHNM's care coordination team. On March 18, 2015, the MHNM care coordination manager visited COPD to clarify the service model and best practice for referring members to the program. MHNM developed a quick reference guide to assist its care coordination team in identifying and referring members to COPD.

There are currently seven members receiving CI services. COPD reported a total of 291 units of CI support services billed under Medicaid. This totaled $ 8,157.75 in claims for the fourth quarter of 2014.

Section III: Enrollment Counts

The following table outlines all enrollment activity under the demonstration. The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment in each 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.

Table #5. Enrollment for DY2 Q4

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – March 2015	Current Enrollees (Year to Date)	Disenrolled in Current Quarter
Population 1 – TANF and Related	365,502	365,502	7,275
Population 2 – SSI and Related – Medicaid Only	41,838	41,838	1,326
Population 3 – SSI and Related – Dual	36,305	36,305	1,095
Population 4 – 217-like Group – Medicaid Only	248	248	32
Population 5 – 217-like Group – Dual	2,237	2,237	47
Population 6 – VIII Group (expansion)	222,093	222,093	8,013
Totals	668,223	668,223	17,788

Disenrollments

Disenrolled is defined as when a member was in Centennial Care at some point in the prior quarter and disenrolled at some point during that quarter or in the reporting quarter and not re-enrolled at any point in the reporting quarter. Members who switch MEGs are not counted as disenrolled.

Table # 6. Disenrollment Counts for DY2 Q4

Disenrollments	From DY1 Q4 to DY2 Q1		Disenrollments During DY2 Q1
Last Month Member Was Disenrolled	**01-Jan-15**	**01-Feb-15**	
Population 1 – TANF and Related	3,256	4,019	7,275
Population 2 – SSI and Related – Medicaid Only	1,007	319	1,326
Population 3 – SSI and Related – Dual	752	343	1,095
Population 4 – 217-like Group – Medicaid Only	21	11	32
Population 5 – 217-like Group - Dual	21	26	47
Population 6 – VIII Group (expansion)	3,179	4,837	8,013
Total (without MEG 7)			17,788

Section IV: Outreach

Through the Children's Health Insurance Program Reauthorization Act (CHIPRA) Cycle III, HSD developed an on-line screening tool and electronic application submission tool exclusively for the use of presumptive eligibility determiners (PEDs). This system, Yes New Mexico for PEDs (YESNM-PE), is available to PEDs state-wide. It accurately screens individuals (or entire households) for possible Medicaid eligibility. Once the screening is complete, PE may be granted to eligible individuals. The system then allows the information supplied for the screening to be used in an application for ongoing eligibility if the individual chooses to apply for ongoing coverage.

HSD continues to provide YESNM-PE webinar trainings to certify PEDs in New Mexico. In this quarter, 13 PED certification sessions were held with approximately 185 attendees and 159 new PEDs became certified for a total of 779 PEDs active in the State of New Mexico. HSD also continues to provide demo sessions on YESNM-PE; HSD offers this webinar as a tool for active PEDs to use. The YESNM-PE demo sessions walk PEDs through the process of utilizing YESNM-PE for screening and applying for Medicaid benefits for their clients. These voluntary demo sessions are held the first and third Friday of each month.

In DY2 Q1, the number of applications submitted increased by 1,658. The individual number of PEs and ongoing Medicaid applications granted also increased.

Table # 7. YESNM-PE Statistics DY2 Q1

Total # of PEDs Who Utilized YESNM-PE	240
Total Applications Received Through YESNM-PE	5,283
Total # of Individuals Who Applied for Ongoing Medicaid Benefits	7,995
Individuals Approved for Ongoing Coverage	4,239
Individuals Denied	811
Pending	2,945
Total # of PEs granted	**1,417**

Promising Practices

In the reporting period, HSD implemented the following promising outreach practices.

- Developed new brochures for Centennial Care with a target audience of non-enrolled, eligible Medicaid recipients.
- Collaborated with Medicaid eligibility offices state-wide to develop up-to-date marketing materials and activities designed for potential Medicaid recipients.
- Collaborated with Head Start Programs to reach potential CHIP and Medicaid enrollees.
- Updated the Centennial Care Marketing & Member Communication Policy Manual to continue to develop effective communication with potential and current members.

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

All four MCOs are in production for all invoice types, professional, institutional, and dental. The MCOs continue to submit encounters daily and/or weekly to stay current with their encounter submissions. As explained in the DY1 Q4 report, the MCOs are current with their encounters other than some encounters they are holding for providers not yet enrolled with Medicaid.

During the reporting period, HSD continued development and testing of the management dashboard report that was discussed in the DY1 Q4 report.

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

MCO Assigned Primary Care Providers (PCPs) and Member Change Requests

BCBSNM and UHC both report successful implementation of suppressing auto-assignment of a PCP for members who have not chosen one, until the 16th business day after enrollment. The quarterly PCP reports reflect a declining percentage of members as having been auto-assigned a PCP by BCBSNM or UHC. BCBSNM's percentage of auto-assigned members decreased from 90 percent in January 2014 to 39 percent in DY2 Q1. Similarly, UHC dropped from 100 percent in January 2014 to 81 percent in quarter one of 2015 (the report frequency was changed from monthly to quarterly).

Unreachable Member Campaign

Fundamental to the Centennial Care program is a comprehensive care coordination system that requires coordination at a level appropriate to each member's needs. The care coordination system creates a person-centered environment in which members receive the care they need in the most efficient and appropriate manner. HSD is concerned that members who have not been reached for a health risk assessment (HRA) may not be receiving the benefits of coordinated care.

In 2014, HSD directed all four MCOs to initiate unique and innovative campaigns to connect with their unreachable members. In 2015, the monthly goal of reaching five percent of unreachable members remains in effect. Results for the first quarter are provided in Table #8, below.

In January, BCBSNM did not reach its goal. In February, neither BCBSNM nor UHC, reached its goal. BCBSNM initiated an internal plan in response to not meeting the metric, and this has been closely monitored by the HSD contract manager. As part of the monitoring process, BCBSNM has been required to submit a weekly update on their progress. For the month of April, BCBSNM exceeded the metric by reducing the unreachable population by 6.84 percent. UHC reached the five percent goal in March and has also met the goal in April 2015. From January through March 2015, the four MCOs combined have reached 44,239 members who had been previously determined to be unreachable. A member is determined to be unreachable when, after at least three attempts, the member cannot be reached by the MCO.

Table #8. Unreachable Member Campaign DY2 Q1

	Jan				Feb				Mar			
	Baseline	5% Target	Reached	Percent Improved	Baseline	5% Target	Reached	Percent Improved	Baseline	5% Target	Reached	Percent Improved
BCBSNM	8,080	404	40	0.50%	9,101	455	324	3.56%	11,216	561	328	2.92%
UHC	27,625	1,381	7,149	25.88%	21,307	1,065	1,062	4.98%	20,642	1,032	1,434	6.95%
MHNM	35,910	1,796	2,700	7.52%	33,581	1,679	2,787	8.30%	32,080	1,604	1,620	5.05%
PHP	99,552	4,978	19,748	19.84%	82,975	4,149	16,197	19.52%	69,380	3,469	11,928	17.19%
Source: MCO monthly reporting												

Electronic Visit Verification (EVV)

Significant progress on the EVV project was made in the first quarter of DY2. The corrective action plan (CAP) only has two outstanding issues, both of which have proposed solutions. First, the MCOs provided recommendations for "no tech zone" areas for providers in the rural and frontier areas of the State. A pilot provider group will be created to work with the MCOs to identify system changes for the "no tech zone" areas. The second adjustment is a system change scheduled for release in August 2015. Weekly meetings have been moved to bi-monthly. Statewide implementation, with the exception of "no tech zone" areas, is scheduled for September 2015.

Behavioral Health Provider Training

In January 2015, HSD issued Supplement 15-01. This supplement provided direction to BH providers about changes in specialized BH services. Included in the supplement were revised billing instructions for services specific to CSAs, CMHCs, and BH Agencies.

HSD and the MCOs began to develop a provider training that will be delivered in early summer 2015. The design of the training will mirror the 2014 state-wide provider training. The training will be offered on-site and via Web-Ex.

As part of the HSD's initiatives in clinical practice improvement, a series of trainings has been planned and designed in *Clinical Reasoning and Case Formulation.* It is targeted to both independently licensed and non-independently licensed BH clinicians delivering care throughout the State. The newly modified materials will also provide interactive practice with using case formulations to strengthen the treatment plans and progress notes. Five trainings will be delivered before the end of June 2015. Over 65 clinicians are expected to participate. Registration has been opened; a waiting list has already been established.

This training supports the HSD policy to expand the number of clinicians in the BH network and improve services to clients by quality supervision and training of staff, especially those who have not yet attained independent licensure. The *Clinical Reasoning and Case Formulation* training is therefore being offered to BH Agencies (432) who, in July, will be allowed to bill for non-independently licensed therapists.

In addition, HSD and the MCOs continue to support the transition of BH providers in the eastern and southern parts of the State. Two of the *Clinical Reasoning and Case Formulation* training events will be customized and delivered onsite to Mental Health Resources in Clovis, and Presbyterian Medical Services statewide. It is anticipated that this will assist those transition providers with supporting their clinical team of practitioners.

Health Plan Contract Compliance and Financial Performance Relevant to the Demonstration

The Centennial Care contract specifically allows for assessment of sanctions against the contracted MCO for failure to comply with requirements of the contract. Since the implementation of Centennial Care, HSD has been closely monitoring MCO performance to evaluate compliance with contractual requirements, including report submissions. In its analysis, HSD has determined that MCO noncompliance, where it occurs, are in areas primarily related to regularly scheduled reports (e.g. submission timeframes, report completeness and accuracy of data). All four MCOs have been notified of sanctions for calendar year 2014, primarily related to reporting compliance.

Fiscal Issues

HSD successfully implemented the DY2 capitation rates. As discussed in the previous quarterly report, these rates include adjustments for hepatitis C treatments. HSD began monitoring the MCOs' compliance with the clinical protocol and issuance of these prescriptions during the first quarter of demonstration year two. Once complete encounter data is available, HSD will begin the risk corridor analysis around these drug treatments.

HSD continued to work on guidelines and processes to automate the reconciliation of capitation payments in a timely manner. These reconciliations include retroactive eligibility changes, including Medicare eligibility and SSI eligibility and aligning with date-of-death data.

Delivery System Improvement Fund

HSD evaluated the MCO results for the 2014 Delivery System Improvement Fund (DSIF) targets. The four target areas were:

1. Increase the use of electronic health records (EHR) and the number of contracted providers who participate in the exchange of electronic health information using the Health Information Exchange (HIE);
2. A minimum of 15 percent increase in telehealth "office" visits with specialists, including BH specialists, for members in rural and frontier areas;
3. A minimum of five percent increase in the number of members being served by Patient-Centered Medical Homes (PCMH); and
4. A minimum of 10 percent reduction in non-emergent use of the ER.

Results indicated that two of the four MCOs met all the targets and the remaining two MCOs met targets with the exception of the ER diversion target.

HSD is in the process of releasing 25 percent of the funds withheld for each successfully met target. Total withheld funds were equal to 1.5 percent of capitation payments net of taxes and assessments.

Systems Issues

The NF LOC and setting of care (SOC) issues that were previously identified and impacted all four MCOs have been resolved. Requiring that both clinical and systems staff attend systems meetings so that they receive the same information, additional training and technical assistance on the two separate interfaces for MMIS and ASPEN, implementing an error report for the MCOs, and having a dedicated eligibility unit to process applications for institutional care have all contributed to the resolution of this issue.

HSD is continuing to address issues regarding patient pay amount differences between the MMIS and ASPEN. HSD has conducted significant research and analysis regarding this issue and identified that not all patient pay amounts are being sent from the eligibility system, ASPEN to the MMIS. The system fix was implemented in the fourth quarter and will resolve patient liability amount discrepancies prospectively. The next step in the process is to work to identify and resolve any patient pay discrepancies that existed prior to the fix and correct those discrepancies.

As previously noted, the system fixes for the eligibility issues impacting disenrollment that are addressed in Section II were implemented in DY1 Q4. HSD is continuing to run the file that was utilized for the short-term fix to ensure the long-term fix is successful and identify any other potential issues.

Pertinent Legislation or Litigation

The following legislation, pertinent to the demonstration, was passed in this year's legislative session and signed into law.

Senate Bill 42

Senate Bill 42 (SB 42) requires HSD to provide for continued Medicaid eligibility for incarcerated individuals who were enrolled in Medicaid upon incarceration and eligibility for Medicaid for individuals during incarceration. HSD is working with the New Mexico Corrections Department and the New Mexico Association of Counties on the development and implementation of the requirements related to this bill. Medicaid services provided to this population will be reimbursed through FFS.

House Bill 212

House Bill 212 (HB212) enacts a new section of the Public Assistance Act for recipients of services from a "crisis triage center", meaning a health facility that is licensed by The New Mexico Department of Health (DOH); is not physically part of an inpatient hospital or included in a hospital's license; and provides stabilization of BH crises, including short-term residential stabilization. HB212 requires HSD to adopt rules to establish a reimbursement rate for services

provided by such a crisis triage center to Medicaid recipients and requires DOH to adopt rules relating to licensure of such centers by July 1, 2016. State general funds were also directed to HSD for support of regional crisis stabilization units. A Medicaid state plan amendment may be needed following determination of reasonable reimbursement rates and programming changes needed to make payments to this new type of provider.

House Bill 274

House Bill 274 (HB 274) will allow an individual to fill or refill a prescription for less than a 30-day supply of a prescription drug. The prescription will have a prorated daily copayment or coinsurance applied, and allows the individual to synchronize their prescription drug fills or refills.

HB274 will require that the insurance plans as well as the medical assistance program (the State Medicaid program including medical assistance managed care plans) not deny the coverage of filling a maintenance medication with less than a 30-day supply when the fill is done to synchronize prescriptions. The bill will also not allow MCOs or other insurers to prorate dispensing fees paid to pharmacies that fill prescriptions for the purpose of synchronizing prescriptions.

Since HB274 will not allow dispensing fees to be prorated, this could increase the dispensing fee costs to Medicaid and the Medicaid MCOs when an individual requests a partial fill to synchronize their prescriptions. Therefore, there would be additional dispensing fees paid out that would not currently be incurred by either the managed care organization or FFS Medicaid program.

House Memorial 33

House Memorial 33 (HM33) creates a task force to review, discuss and provide recommendations for the process of transitioning high needs youth, when they reach the age of majority (18), to adult primary care.

Quality Assurance/Monitoring Activity

The final care coordination audit reports from the on-site audit that took place from December 15 to December 18, 2014, at the Centennial Care MCOs, were made available during the reporting period.

The audit evaluated the efficacy of the MCOs' action plans and training that was provided by HSD to the MCOs during September and October of 2014. This rapid cycle approach assessed improvements to MCO members' records as a result of developed action plans, training initiatives and ongoing quality improvement efforts.

Each MCO had progress in implementing its individual action plans. The MCOs presented evidence on enhancements to their technology-based systems for clearer tracking of member milestones. Each MCO placed emphasis on complying with contractual timeframe requirements

in conducting HRAs, CNAs, and Comprehensive Care Plans (CCP) along with completion of other mandatory processes related to member engagement.

Opportunities and next steps for action plans for each MCO were identified by HSD. The MCOs have responded by further developing their internal action plans to comply with HSD recommendations. HSD will continue to monitor progress, audit and provide technical assistance as needed.

Quality Services Review (QSR) Protocols

In response to the movement toward integrated behavioral and physical health care, HSD is planning on developing an expanded Quality Services Review (QSR) protocol to assess local clinical practice.

The first phase will be to assemble a design team of integrated care experts to provide advice and approval of the new review protocol. Once developed, the protocol will be piloted with providers who want to strengthen their clinical practice with clients with both physical and BH needs.

Behavioral Health Quality Improvement Committee (QIC)

The cross-agency Quality Improvement Committee has representatives from Medicaid, CYFD, Behavioral Health Services Division and the Department of Health's Division of Health Improvement. As part of its adopted charter, the committee is identifying common priorities for quality improvement, driven by departmental priorities, within a framework for BH quality of care. The MCOs' annual Quality Management/Quality Improvement Program description and work plan (Report #22) reports have been reviewed by the committee and feedback is being provided to HSD. The committee's targeted priorities will be tracked and reported to them throughout the year to assess improvements.

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

New Mexico Independent Consumer Support System (NMICSS)

The NMICSS continues to recruit and establish a system of organizations that 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 NMICSS reporting for the first quarter is provided by the Aging and Long-Term Services Department (ALTSD) Aging and Disability Resource Center (ADRC). The 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 activities of daily living (ADLs) that will maximize personal choice and independence for seniors and adults with disabilities throughout New Mexico, as well as for their caregivers.

ADRC coordinators provide over the phone counseling in care coordination to resolve issues. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions. The ALTSD provides quarterly reports to HSD.

The numbers below reflect calls made to the ADRC hotline from January 1 to March 31, 2015.

Table #9. DY2 Q4 ADRC Call Profiler Report

Topic	# of Calls
Home/Community-Based Care Waiver Programs	1,555
Long Term Care/Case Management	122
Medicaid Appeals/Complaints	63
Personal Care	104
Transitional Case/Care Management	210
State Medicaid Managed Care Enrollment Programs	5
Medicaid Information/Counseling	549

The ALTSD Care Transition Bureau (CTB) is actively engaged in other activities related to the NMICSS. The CTB provides Medicaid beneficiaries enrolled in Centennial Care receiving LTSS (institutional, residential and community-based) assistance to navigate and access 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 that system. CTB staff also monitor to ensure that needed services are provided by the

MCO, MCO subcontractors and other community provider agencies. Their main purpose is to help consumers identify and understand their needs and to assist them in making informed decisions about appropriate LTSS choices in the context of their personal needs, preferences, values and individual circumstances. The CTB assisted 195 individuals during this reporting quarter.

The CTB continues to see an increase in referrals this quarter and caseloads within the program continue to grow statewide. As a result of increased referrals, the CTB has added one full-time employee (FTE) during this quarter to serve individuals in the southeast region of the State.

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from January 1, 2015 to March 31, 2015.

Table #10. ADRC Care Transition Program Report

Counseling Services	**# of hrs**	**# of Nursing Home Residents**	**# of Contacts**
Transition Advocacy Support Services		165	
Medicaid Education/Outreach	1072		
*Medicaid Options/Enrollment	146		
Pre/Post Transition Follow-up Contact			**1717

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

** Seventy-seven percent of the contacts are pre-transition contacts and the remaining 23 percent are post transition contacts.

Critical Incidents

HSD continues to work with the Critical Incident (CI) workgroup to finalize the BH protocols. The BH protocols will be used by BH providers to improve accuracy of reported information and to establish guidelines for the types of incidents that BH providers are required to report.

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

The HSD CI Unit engaged in the following monitoring activities during the first quarter with respect to the performance oversight of the MCOs and their provider agencies:

- CI workgroup meetings are being held monthly between MCOs and HSD to discuss issues and concerns about the CI reporting process. Issues addressed this quarter included high utilization of the ER. Each MCO has an internal process in place to address this issue. The overall goal is to reduce the unnecessary visits to the ER when the visit is for

reasons that could have been addressed by a PCP or urgent care. Reduction of duplicate reporting was also addressed in the workgroup.

- A written protocol is being drafted by HSD to provide the MCOs with a framework to direct their providers in BH reporting. Once the protocol is finalized, the MCOs will notify and train their personal care services (PCS) and BH providers in the implementation of the protocols throughout the State. Each training will identify training supports for caregivers of members who live with mental illness in an effort to continue to enhance the delivery of HCBS and outcomes for these members. The MCOs are required by HSD to conduct one training per fiscal year.
- HSD requested enhancement to the CI reporting application. The new version will add functionality to the portal. Portal enhancements include: allowing access to the ad-hoc report function for State agencies; changing certain fields from optional to required; adding multiple choice selection of which method was used for a report; and adding a new BH CI type to the description of medication/treatment error in the CIR report website. These system improvements will provide additional opportunities to receive, track and trend CIs. Centennial Care providers, including HCBS, LTC, and self-direction must establish access to this system and to report incidents into the system within 24 hours of knowledge of the incident.
- Daily review of incident reports is conducted by the MCOs and the HSD CI unit. Quality of reporting by providers and the documentation of follow-up by the MCOs continue to show improvement. In an effort to overcome issues of incorrect reporting, inadequate information or requests for specific follow-up with egregious situations, procedure documents for duplicate reports, eligibility confirmation and verification of NF LOC have been developed and established for the MCOs. Bi-weekly aggregated reports of concerns are emailed to each MCO. The MCOs respond with sufficient information to assure HSD that the MCOs and agencies are doing due diligence. MCO CI procedures have been implemented to create a uniform message of direction from HSD.
- Internal collaborations continue between the HSD CI Unit and other HSD staff. The HSD CI Unit also shares relevant information with other state agencies when a system issue is identified. A discussion was initiated with representatives from ALTSD regarding the duplication of reports received via fax, phone, email, or website and possibilities for reduction of these duplications.

A quarterly review of all deaths submitted through the HSD CI web portal is conducted. HSD clinical staff review decedent data and consults on mortality cases and complex cases**.**

There were a total of 352 reported deaths: 308 were expected deaths, 44 were unexpected, including one suicide and two homicides. The suicide did not occur during authorized services hours or while the member was in a facility. This case has been researched by a clinical reviewer (MCO), remains “unexpected” and has been closed.

Of the remaining 41 unexpected deaths, 18 cases have been investigated and closed by the MCO as no further actions required. Twenty-one cases are still open and under review by the MCO. These cases are also being investigated by the police or the Office of the Medical Investigator. Two cases were reclassified as "Expected" after review by the MCO.

Three unexpected deaths occurred during authorized service hours; one of these cases has been investigated by the MCO and is now closed. Two cases remain under review and are pending further information. All three cases occurred at the members' personal residences. Of the three deaths occurring during authorized service hours, none raised concern about the care or services provided to the recipient. The member was found by the caretaker upon entering the residence or resident's room.

Thirty-seven cases of Elopement-Missing occurred. Law enforcement was notified in all cases and protocols were followed.

Table #11. DY2 Q1 Critical Incidents

Critical Incident Types	Centennial Care		Behavioral		Self Directed	
	#	%	#	%	#	%
Abuse	206	8%	59	25%	8	5%
Death	{352}		{9}		{15}	
Natural/Expected	308	12%	3	0%	13	8%
Unexpected	41	2%	5	2%	2	1%
Homicide	2	0%	1	0%	0	0%
Suicide	1	0%	0	0%	0	0%
Emergency	1536	58%	87	37%	110	70%
Environmental	48	2%	1	0%	0	0%
Exploitation	98	4%	4	2%	10	6%
Law	136	5%	45	19%	9	6%
Missing/Elopmen	37	1%	14	6%	4	3%
Neglect	252	9%	14	6%	2	1%
Total	**2665**		**233**		**158**	

HSD has further broken out critical incidents by MCO and also included the non-Centennial Care (fee-for-service) data in the table below.

Table #12. DY2 Q1 Critical Incidents by MCO and FFS

Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	27	7%	55	9%	55	12%	69	6%	0	
Death	81	22%	100	17%	35	8%	135	11%	1	100%
Emergency	206	55%	275	47%	259	56%	796	64%	0	
Environmental	4	1%	15	3%	8	2%	21	2%	0	
Exploitation	12	3%	23	4%	15	3%	48	4%	0	
Law	15	4%	46	8%	37	8%	38	3%	0	
Missing/Elopeme	8	2%	15	3%	10	2%	4	0%	0	
Neglect	21	6%	57	10%	42	9%	132	11%	0	
Total	374		586		461		1243		1	

Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	6	19%	17	27%	32	33%	4	10%	0	
Death	2	6%	2	3%	2	2%	3	8%	0	
Emergency	13	41%	22	34%	27	28%	25	64%	0	
Environmental	8	25%	0	0%	1	1%	0	0%	0	
Exploitation	0	0%	3	5%	1	1%	0	0%	0	
Law	0	0%	13	20%	20	20%	4	10%	0	
Missing/Elopeme	3	9%	5	8%	6	6%	0	0%	0	
Neglect	0	0%	2	3%	9	9%	3	8%	0	
Total	32		64		98		39		0	

Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		FFS/HSD	
	#	%	#	%	#	%	#	%	#	%
Abuse	2	9%	2	5%	0	0%	4	5%	0	
Death	2	9%	5	13%	1	9%	7	8%	0	
Emergency	15	65%	22	58%	9	82%	64	74%	0	
Environmental	0	0%	0	0%	0	0%	0	0%	0	
Exploitation	2	9%	1	3%	1	9%	6	7%	0	
Law	1	4%	4	11%	0	0%	4	5%	0	
Missing/Elopeme	1	4%	3	8%	0	0%	0	0%	0	
Neglect	0	0%	1	3%	0	0%	1	1%	0	
Total	23		38		11		86		0	

Self-Directed Community Benefit (SDCB)

An update to the Centennial Care Policy Manual was approved and released, effective March 3, 2015. Three primary changes were made. First, if an SDCB member has a power of attorney (POA) or is a legal guardian over financial matters, that POA/legal guardian must also be the SDCB member's employer of record (EOR). This clarifies authority over financial or personnel matters related to the SDCB member with the MCO and HSD staff. Second, non-medical transportation (i.e. mileage reimbursement) is now limited to a 50 mile radius from the member's residence. Third, budget determination instructions and examples are provided for members who

transitioned from the Mi Via program to SDCB. This addition was specifically made to assist care coordinators to accurately determine SDCB budgets for these members.

Section VIII: AI/AN Reporting

The updated reporting tool for 2015 for the Native American Members Report added data such as BH utilization, use of the ER for non-emergent conditions, dental utilization, pharmacy under and over utilization, and care coordination.

In the first quarter of 2015, there was a steady decrease in ER utilization for non-emergent conditions for most of the MCOs. The most utilized dental services were for diagnostic and preventative (oral evaluations, fluoride varnish, prophylaxis) for adults and children. The data showed no concerns regarding pharmacy under or over utilization and there was a steady increase in the number of HRAs completed.

Access to Care

I/T/Us are concentrated near or on Tribal land where the majority of Native Americans live and receive services. Native Americans in Centennial Care may access services at IHS and Tribal 638 clinics at any time. HRAs and comprehensive needs assessments (CNAs) are used to evaluate health outcomes. As needs are identified, they are communicated to care coordinators and/or management for review and resolution.

Contracting Between MCOs and I/T/U Providers

In this reporting period there were a few new contracts between the MCOs and I/T/U providers involving partnership agreements to assist with HRAs, translation and transportation. There also was a new agreement with a Tribal program for BH services. The MCOs continue to reach out to I/T/Us to finalize agreements that are pending. Indian Health Service (IHS), Tribal health providers, and I/T/Us are not required to contract with the MCOs under Centennial Care.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements ranging from 98 percent to 100 percent of claims being processed and paid timely.

Table #13. Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)

MCO	Date of Board Meeting	Issues/Recommendations
BCBSNM	Zuni Pueblo, NM 3/26/15	BCBSNM held their first quarter meeting at the Tribal Administration at Zuni Pueblo which resulted in many more attendees, including Tribal leadership. They plan to schedule future advisory board meetings in Tribal communities.
MHNM	Albuquerque, NM 03/18/15	Molina offers Native American Advisory Board meetings quarterly to providers as well as members. They have a high turnout of members at their meetings. At their last Native American provider board meeting they focused on care coordination, self -directed and agency based community benefits.
PHP	Albuquerque, NM 03/20/15	Members suggested that the HRAs be standard for all MCOs and that PE determiners give the HRA to members when they are approved for Medicaid. Tohajiilee wants to pursue a partnership agreement with PHP for BH services. I/T/U providers requested more training on Centennial Care billing (which PHP scheduled for the following month).
UHC	Bernalillo, NM 03/05/15	UHC has proposed to partner with the NM Indian Affairs Department (IAD) for their next NAAB meeting. They will work with I/T/Us, Tribal administrators, and health directors to increase membership at the NAAB meetings. One concern is the lack of Native American members at their NAAB meetings.

The first NATAC meeting for this quarter was March 30, 2015. There were several new board members at this meeting. The focus of the NATAC for 2105 is:

- Reviewing current enrollment numbers for Native Americans in an MCO vs. FFS;
- Access to care;
- Payment to I/T/Us;
- Behavioral Health; and
- Planning for a new Medicaid Management Information System (MMIS).

Section IX: Action Plans for Addressing Any Issues Identified

Detailed action plans for BCBSNM's and UHC's transportation subcontractor, Logisticare, are below. For more information on other action plans, see Attachment E: MCO Action Plans.

BCBSNM action plan, March 14, 2015 update:

1. Appeals & Grievance Department management will continue to attend monthly Joint Operating Meetings with Delegation Oversight to review Logisticare's monthly report cards to identify any trends. This report card is the key data tool that both Logisticare and BCBSNM use to manage contract performance and track and trend provider no shows and lateness.
2. Logisticare will continue to conduct daily monitoring and research of the transportation providers' reasons for the no shows, lateness and other issues.
3. For complaints that have been substantiated, Logisiticare has taken the appropriate action through education, warnings, noting the provider's performance evaluation, notifying the provider that continual lateness and/or non-response to inquiries may result in a reduction of trips assigned, etc.
4. BCBSNM conducts weekly meetings with Logisticare to review the action plan.

A review was conducted by the Delegation Oversight Committee on January 16, 2015 resulting in a decision to close Logisticare's action plan.

UHC action plan, latest update, December 8, 2014:

1. Quarterly Logisticare transportation provider meetings are held that include discussion, training and coaching to network providers on Logisticare provider line usage to coordinate, prevent and proactively address transportation issues.
2. Provider training at the Community Transportation Association of America (CTAA) was completed September 2014.
3. Since October 2014, three Native American providers and Sandia Transportation in Albuquerque were added. Logisticare is still working on recruiting other transportation providers.
4. Representatives from Logisticare attended Member Advisory Board meetings in December 2014. Logisticare will now be standing attendees. Logisticare will also educate members on the Logisticare "Where's My Ride" line to provide and empower members with a communication tool to report if they are experiencing a transportation issue.
5. Logisticare and UHC December 8, 2014. They identified process improvement opportunities to ensure appropriate coordination and follow-up on standing order medical trips. Workgroup meetings have been scheduled to finalize policy.
6. Daily operation review by the regional manager is on-going, and includes daily review for prior day trip cancellations due to provider late/no show.

7. Review of provider dissatisfaction complaints is done daily by regional manager on an on-going basis. Customer Service Representatives are educated on an on-going basis.
8. Weekly operation meetings are held with Logisticare and routers to review trip trends.
9. The Region Manager conducts weekly service review with the top transportation providers.
10. Logisticare has expanded their vehicle fleets with existing providers by 30 vehicles and is working with network transportation providers to place vehicle(s) in frontier counties of Catron, Quay and Harding counties.
11. Logisticare and UHC have met to work through ways to prevent members from not receiving care due to transportation issues.

Section X: Financial/Budget Neutrality Development/Issues

HSD's monitoring of eligibility and enrollment during the first year of Centennial Care has established a strong understanding of the new dynamics in the New Mexico Medicaid program. Those dynamics include the movement in both directions of individuals between our expansion adults and the "base" Medicaid program as income and household compositions change. As HSD finalizes guidelines and processes to automate reconciliations of capitation payments that will reflect the movement between programs, expenditures will continue to be reported properly in the correct MEG and align with member enrollment.

Attachment A: Budget Neutrality Monitoring includes the following new tables assessing the budget neutrality limit for the waiver in the first demonstration year. These tables are included in the Annual Report Summary spreadsheet.

- Table 1. Budget Neutrality Limit (STC 106)
- Table 2. Supplemental Budget Neutrality Test 1:Hypothetical Groups (STC 107)
- Table 3. Supplemental Budget Neutrality Test 2: VIII Group (STC 108)
- Table 4. DY1 Assessment of Budget Neutrality (STCs 102, 104, 111)

Centennial Care is 15 percent below the budget neutrality limit as assessed for the first year of the waiver as summarized in Table 4. MEGS 1-3 and the Uncompensated Care and Hospital Quality Improvement Incentive (HQII) Pools were all well within the budget neutrality limit as Table 1 summarizes. Table 2 summarizes the supplemental budget neutrality test 1 for the hypothetical groups of the "217-Like." MEG 5 exceeded its own budget neutrality limit and the excess spending was recognized against the total budget neutrality limit in Table 4. It was not significant enough to impact overall budget neutrality but HSD is researching further to investigate the cause of MEG 5's surpassing of its limit. Table 3 summarizes the supplemental budget neutrality test 2 for MEG 6 - VIII Group, or the Medicaid Expansion. This group also was well within its own established budget neutrality limit.

Section XI: Member Month Reporting

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

Table #14. DY2 Q1 Member Months

Eligibility Group	Member Month
Population 1 – TANF and Related	1,104,148
Population 2 – SSI and Related – Medicaid Only	123,759
Population 3 – SSI and Related – Dual	105,790
Population 4 – 217-like Group – Medicaid Only	706
Population 5 – 217-like Group – Dual	6,490
Population 6 – VIII Group (expansion)	618,463
Total	136,910

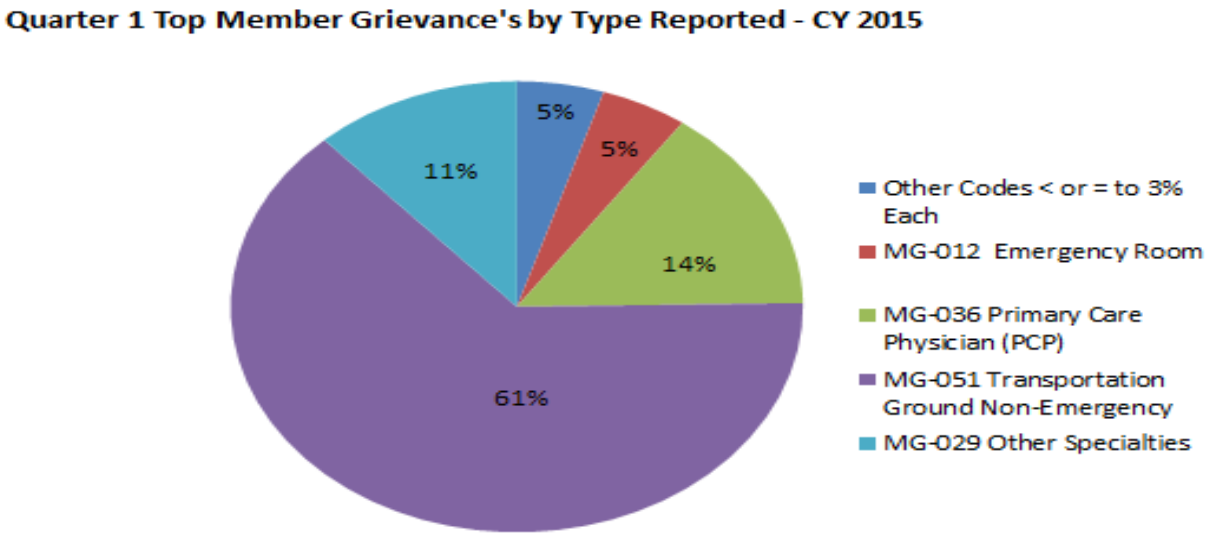
Section XII: Consumer Issues (Complaints and Grievances)

A total of 956 grievances were filed by all Centennial Care members in the first quarter. Ground transportation non-emergency continues to constitute the largest number of grievances reported with 362 (61 percent) out of the 593 top three types of grievances received by all MCOs. Driver no-show and drivers arriving late are the most frequent member reported transportation issues.

The MCOs continue to report that actual grievances-per-thousand-trip count remain low as the number of trips continue to increase monthly. MCOs express continued commitment to work on reducing member dissatisfaction by providing feedback to their individual transportation vendors, vendor process review and implementation of action plans as necessary.

Eighty-five (14 percent) of the total 593 top three grievance types reported were with regard to primary care providers. Sixty-four (11 percent) of the total 593 top three grievances types were related to other specialties. Member reported grievances include; dissatisfaction with care provided, provider denied pain medication, disrespectful staff, and a variety of other issues that do not indicate any specific trends. The remaining 82 (14 percent) top three types of grievances consist of five percent or less of any specific type. No trends were identified within each of the various types.

Figure #15.



Section XIII: Quality Assurance/Monitoring Activity

Service Plans

The HSD/MAD Quality Bureau (QB) completed an audit of service plan reductions for transitioning members for DY1. All transitioning members with service plan reductions were audited. The QB continues to randomly review service plans to ensure that the MCOs are using the correct tools and processes. The review of service plans ensures that the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and that the member's goals are identified in the care plan. In DY2 Q1, 15 files were audited and 100 percent of the reductions were justified by an increase in the member's abilities or use of natural supports. No concerns were identified.

Nursing Facility Level of Care (NF LOC)

QB continues to review high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and based on NF LOC criteria. No concerns were identified in the first quarter of 2015.

Table #16. NFLOC Audit DY2 Q1

High NF Denied Requests (Downgraded to Low NF)	DY2 Quarter 1
# of member files audited	14
# of member files that met the appropriate level of care criteria	14
% of MCO level of care determination accuracy	100%

Community Benefit Denied Requests	DY2 Quarter 1
Number of member files audited	16
Number of member files that met the appropriate level of care criteria	16
Percent of MCO level of care determination accuracy	100%

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process

HSD reviews a comprehensive array of reports from which to evaluate trends and MCO performance. HSD provides feedback to the MCOs to ensure contract compliance and to evaluate progress toward achieving HSD strategic goals. Report data is utilized to facilitate data-informed decision making and to detect possible areas of concern, and to address concerns, should they arise. As such, HSD is attentive to the accuracy and consistency of the data reported by the MCOs.

GeoAccess Chart

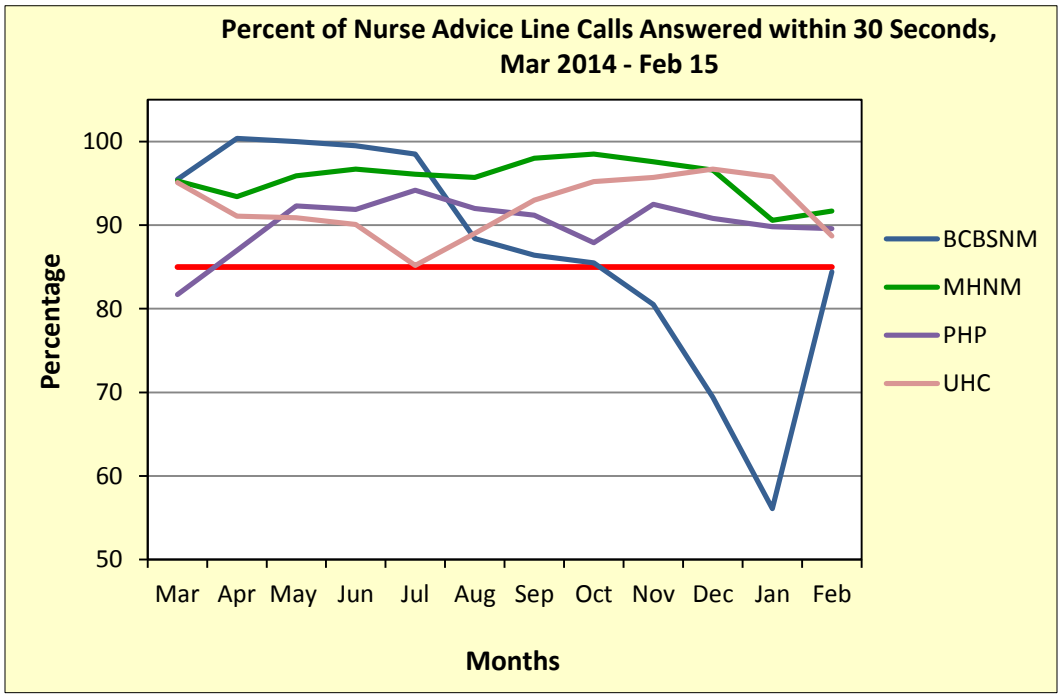
Beginning next quarter, HSD will remove FQHCs, RHCs, I/T/Us and ALFs from the GeoAccess chart and will report whether each MCO has contracted with all available Medicaid approved facilities for each facility type.

Customer Service

In January and February 2015, UHC, MHNM and PHP again met or exceeded contract standards for all customer service and advice lines, though there was some decline in performance as higher-than-normal call volumes occurred during flu season.

BCBSNM continued to meet contract metrics for all customer service lines except the Nurse Advice Line. Calls are contractually required to be answered within 30 seconds 85 percent of the time. BCBSNM did not meet the 85 percent calls answered within 30 seconds for four months (November 2014 – February 2015). BCBSNM initiated a corrective action plan with its subcontractor to improve performance. In February 2015, BCBSNM brought the answer time to less than 30 seconds 84.4 percent of the time and reports increased performance to 85.4 percent in March. Some of the changes that were implemented include: an increase in staff involving three waves of hiring over two months, incentives for staff to work extra hours, and limiting approved time off. See Attachment E: MCO Action Plans.

Figure #17. Nurse Advice Line Calls Answered with 30 Seconds



Appeals

A total of 708 appeals were filed by members of all MCOs in the first quarter. Of the total appeals filed, 459 (65 percent) were upheld, 144 (20 percent) were overturned and the remainder are pending resolution. All MCOs have processed appeals in a timely manner.

All MCOs combined report a total of 655 appeals (93 percent) were due to denial or limited authorization of a requested service, all other reasons for appeal constitute less than five percent of the total number of appeals filed by members. Trending by MCOs has identified no specific trends to date on appeals.

Section XV: Demonstration Evaluation

HSD signed a contract with Deloitte Consulting, LLP as the demonstration evaluation vendor on February 24, 2015. The Deloitte team met face-to-face with HSD in March 2015 and has developed a proposed work plan and deliverable schedule. In addition, Deloitte has created and delivered a data request document identifying the data needed to begin the analysis required for the evaluation plan.

Proposed Evaluation Work Plan

Since the start of the contract, Deloitte has met with HSD in person and over the phone to further refine the work plan and data request. These discussions are on-going. A high level overview of the work plan in Gantt chart format is shown Appendix F.

Key steps to accomplish in DY2 Q2 include obtaining the necessary reports and beginning to validate and organize the data. Deloitte has reviewed the list of the various reports generated by the MCOs, EQRO, and HSD and identified those reports needed to conduct the evaluation. HSD is sending samples of these reports for Deloitte's analysis so they may ascertain whether the reports provide the detailed data needed to meet the needs of the evaluation plan. Any issues with the data such as missing or corrupted information will be identified and a workaround developed. Following the validation and organization of the data, Deloitte will begin to develop the baseline measures.

Baseline Measures

HSD has determined that the baseline measures will be established with pre-Centennial Care data. Many of the reports generated for Centennial Care did not exist in their previous programs current form prior to its introduction. Therefore, Deloitte will develop baseline measures from prior Salud! and Coordination of Long-Term Services (CoLTS) data. HSD will provide Deloitte with a list of available Salud! and CoLTS reports to determine what reports will be required. Once received, Deloitte will review the reports to identify missing elements. Any missing elements will be supplemented with encounter and paid claims data as well as eligibility and enrollment data, where available.

Because the Salud! and CoLTS programs varied from Centennial Care, Deloitte must make certain assumptions to develop baseline measures applicable to Centennial Care. Such assumptions could include expected changes in utilization of certain services, changes in the rate of cost growth, or changes in enrollment patterns. Where available, assumptions will be informed by those used in the waiver application. HSD will review all assumptions for appropriateness and reasonableness before they are incorporated into the baseline measures.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Tables (January 1, 2015–March 31, 2015)
Attachment B: GeoAccess PH
Attachment C: GeoAccess PH by MCO, 2014
Attachment D: GeoAccess BH
Attachment E: MCO Action Plans
Attachment F: Evaluation Work Plan
Attachment G: BH Services by County DY1

Section XVII: State Contacts

HSD Staff Name and Title	Phone Number	Email Address	Fax
Nancy Smith-Leslie Director HSD/Medical Assistance Division	(505)827-7704	Nancy.Smith-Leslie@state.nm.us	(505)827-3185
Russell Toal Deputy Director HSD/Medical Assistance Division	(505)827-1344	Russell.Toal@state.nm.us	(505)827-3185
Angela Medrano Deputy Director HSD/Medical Assistance Division	(505)827-6213	Angela.Medrano@state.nm.us	(505)827-3185

Section XVIII: Additional Comments

As there have been so many success stories with Centennial Care, HSD has included success stories from members enrolled with the Centennial Care MCOs who have had positive experiences with care coordination and other unique aspects of Centennial Care.

Centennial Care Success Story #1

While conducting HRAs, a care coordinator encountered a family of six, where three of the family members needed HRAs. She conducted a home visit to this family. The parents were Spanish speaking only but the children spoke English. While conducting the HRAs, the family had several questions. They had received a letter in the mail from their MCO that they didn't understand. The care coordinator explained to the family that the letters were giving them the option to change MCOs or to stay with their current MCO. Further into the HRAs, she determined that this family did not have an established PCP, and they had never been to a dentist. While at their residence she assisted the family in choosing a PCP and dentist by identifying PCPs/dentists in the area and contacting the PCP and dentist they chose to set up an appointment. This family was unaware of the Centennial Care benefits available to them. The care coordinator explained the different resources available to them through their MCO such as transportation services, the 24/7 nurse advice line and educated them on the use of a PCP vs. the ER. This family will greatly benefit from Centennial Care and their MCO now that they are aware of what services are available to them through Centennial Care.

Centennial Care Success Story #2

A care coordinator reached out to a member after the member's HRA was completed and scheduled an appointment with the member to complete a CNA the next morning. Upon arrival to the residence, the care coordinator was shocked to see a member in such need for services. The member shared documents that included her medical history including two brain surgeries and a cerebral bleed from an arterial malformation in the brain. She now has seizures, approximately once a week, and severe migraine headaches. She also suffered a traumatic head injury from a motor vehicle accident. She spends a lot of time in the dark, because the light makes her headaches worse. Her trauma has left her with BH problems including severe anxiety, panic disorder with agoraphobia, and major depressive disorder. She has difficulty completing tasks, and has recently had a lapse in her disability income because her neurologist moved. When she tried to see another neurologist, she had to cancel her appointment for an emergency dental procedure. As the care coordinator conducted the CNA, the member had her four year old child by her side. She stated she was a single mom, trying to complete college in her spare time. She was upset that she had to drop out of school this semester, saying she had been so overwhelmed. She obviously was having some anxiety, short-term memory problems, and difficulty concentrating. She expressed a will to complete college and to get her headaches and seizures under control. She became overwhelmed easily and started to express anxiety when the care coordinator discussed creating a disaster plan. By the time the care coordinator left, the member

had a neurology appointment as well as a psychiatry appointment scheduled for the following week, along with scheduled transportation. Following the CNA, the member was informed she would receive personal care services. The member was overwhelmed and started to cry, she had been insured by another insurance company for years, and had never received any assistance and had only been with Centennial Care a week and obtained the needed services.

Centennial Care Success Story #3

A 46 year old female who lives in a rural area with her daughter was recently diagnosed with diabetes mellitus type II. She was very anxious and depressed with this diagnosis. She has a family history of severe diabetes with complications and deaths and has other chronic illnesses/comorbidities. She had been trying to walk daily, was attending healthy cooking classes at her local county extension site, and was taking her prescribed medications. She had frequent trips to the ER with elevated blood sugars.

The member had a comprehensive nursing assessment on in her home. The care coordinator assisted her in obtaining and setting up appointments to endocrinology, rheumatology, and counseling services. The member was also referred to Healthy Solutions for health coaching. She was encouraged to follow-up with her podiatrist for increased pain in her lower extremities. She was given written materials from her care coordinator and later from the health coach, including information about her chronic illnesses, symptoms management, lifestyle changes, diet, and medications.

Over the past six months, the member states she is feeling so much better. Her blood sugars are more stable, she has not been over 200 in several weeks. She feels that she and her daughter understand how to treat her symptoms. She was walking daily up to two and a half miles but recently had to stop due to surgery on her left leg. Her medications had required frequent adjustments but she now has a stable regime. She has changed her diet; her daughter is now preparing the meals and the member states her whole family has learned to eat healthy.

The member continues to work with her health coach and her care coordinator. She has made her own follow-up appointments with her PCP as well as her specialists. She makes her own counseling appointments and has been attending these regularly. She has had surgery on one leg and foot, and when this heals, she will have surgery on her other leg. She has to rely on caregivers during this healing process, which is expected to be several months, but adds she is so glad she has been able to improve her health enough to tolerate the surgeries that are needed. She feels so much better physically and feels positive about herself and her life again.

Centennial Care Success Story #4

One of the MCOs recently received a thank you letter from a member who had at first been hesitant to accept needed personal care services (PCS). This member has been suffering from both physical and behavioral health problems for many years and had a lot of anxiety about allowing PCS staff to come into her home to help her. The care coordinator continued to reach

out to the member, knowing that she could really benefit from the services a PCS agency would provide. Once the member finally agreed to services, the care coordinator contacted a local PCS agency. Not only did the member benefit from the cleaning and personal care assistance that the PCS employee began to provide, but when our member suffered an unexpected dental emergency, the PCS employee helped the member to get an emergency dental appointment to resolve the issue. The member expressed her gratitude that the care coordinator continued the outreach attempts to align her with the services that she truly needed.