# Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 2 (1/1/2015 – 12/31/2015)
Waiver Quarter: 4/2015

February 29, 2016
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 of more than 400,000 members 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, including expanding the use of community health workers.

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

- Development of a health homes initiative targeted to persons with chronic conditions to be launched in demonstration year three (DY3);
- 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
- Increased utilization of telemedicine in rural areas, particularly for behavioral health (BH) services.

**Section II: Enrollment and Benefits**

**Eligibility**

As noted in Section III of this report, there are 249,332 enrollees in the Group VIII (expansion) who are in Centennial Care. Growth in the expansion group shows 3,351 new enrollees for the fourth quarter of demonstration year 2 (DY2 Q4).

**Enrollment**

Centennial Care enrollment indicates an increase in all populations other than the 217 Like Group-Medicaid Only. The largest increase in enrollment continues to be Group VIII. The majority of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in Section III of this report. Overall enrollment continues to increase each quarter.

**Disenrollment**

The New Mexico Human Services Department (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. Overall disenrollment has decreased.

**Access**

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

*Primary Care Provider (PCP)-to-Member Ratios*

The PCP-to-member ratio standard of 1:2000 was met by all managed care organizations (MCOs) in urban, rural and frontier counties. There are no PCP access concerns at this time.

*Physical Health (PH) 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. Specialty provider shortages are consistent across MCOs and occur primarily in rural and frontier areas. There is one exception, dermatology, where there is a shortage in all geographic areas including urban. HSD is currently focusing on those outliers where all but one MCO met distance standards for specific provider types in geographic areas. One such outlier, hematology/oncology in rural areas, from last quarter now exceeds the 90% distance access standard. The outliers in Q4, of which there are three, include: FQHC-PCP in frontier areas, neurology in rural and frontier areas, and certified midwives in rural areas. Each MCO is very close to meeting the access standards for the outliers this quarter. Please see Attachment B – GeoAccess PH.

Access issues, when they occur, are primarily remedied by providing member transportation to the nearest provider. Other options include telemedicine and single case agreements with out-of-network providers. Telemedicine is a delivery system improvement target (DSIT) for the Centennial Care demonstration, and all MCOs reached their target goals for 2015.  Results of the DSIT will be provided in the annual report.

*Transportation*
A collaborative MCO transportation vendor workgroup convened in October 2015 to discuss HSD's recommendations for non-emergent transportation services as described in the previous quarterly report. The MCOs developed a work plan, and each MCO has an annual evaluation process for its transportation vendor. The MCOs collectively proposed Severity Tier Levels for non-emergent transportation member complaints and recommended placement of the codes and tiers within the resolution column of the MCO Grievances and Appeals Report.

**Service Delivery**

*PH Utilization Data*
HSD is reviewing MCO utilization data as well as the hierarchical category structure of the report to ensure that all applicable medical codes, and code combinations are included and categorized appropriately.

*Pharmacy*
Monthly data, from late third quarter into the fourth quarter, reflect a slight decrease for two MCOs (United Health Care (UHC) and Molina Health Care of New Mexico (MHNM)) and a slight increase for the others (Blue Cross Blue Shield of New Mexico (BCBSNM) and Presbyterian Health Plan (PHP)) in the percent of claims denied as compared to prior months. UHC reports denials averaging slightly less than 25% of the total claims processed. Denial reasons continue to be front-end edits as reported in Q3 and are mainly due to pharmacy adjudication errors and medication utilization or over-utilization edits. UHC has had a higher percentage of edits compared to the other MCOs, and the average for all MCOs in 2015 is 21.13%. Pharmacy claims processed may be denied with front-end edits to determine if the claim(s) meet basic requirements of HIPAA standards, then edits post based on the plan requirements.

**Table #1. September – November 2015, Denied Claims as a % of Total Claims Processed**

| MCO | 2015 | | | Average |
|---|---|---|---|---|
| | September | October | November | |
| BCBSNM | 18.4% | 18.1% | 17.4% | 17.96% |
| UHC | 23.7% | 24.8% | 24.8% | 24.43% |
| MHNM | 22.7% | 22.1% | 21.6% | 22.13% |
| PHP | 17.3% | 17.3% | 17.5% | 17.36% |

Source:  MCO Report 44 (Sept-Nov 2015)

As of December 2015, monitoring of hepatitis C treatment shows 2,031 claims paid for Centennial Care members. Additional claims, for the last quarter in 2015, may still be submitted for payment during the first quarter of 2016.

For BCBSNM, UHC and MHNM, Harvoni® has been the most utilized therapy, and Sovaldi second, based on MCO expenditures. Utilization of Viekira Pak is the third most utilized drug by MHNM. PHP reports Viekira Pak as the most utilized therapy, and Sovaldi second, based on the MCO's expenditures. Harvoni® continues to be PHP's third most utilized drug for treatment. All MCOs report combination therapy with Ribavirin, Daklinza, Technivie, and/or Interferon.

With guidance from HSD's contracted medical director, a Letter of Direction for "Changes to treatment guidance for chronic Hepatitis C virus (HCV) infection" was issued on November 24, 2015. Centennial Care MCOs were provided with an attached "Uniform New Mexico HCV Checklist for Centennial Care." The checklist was posted on HSD's website, and the new guidelines were presented at the New Mexico Hepatitis C Coalition and were received positively by treating practitioners. HSD continues to monitor hepatitis C treatment initiatives for all MCOs. The December 2015 report shows an increase in the numbers of members in treatment with HCV genotypes that are a fibrosis level of "F2" or greater. The 2016 report has been enhanced to capture prior authorization data to reflect evidence-based standards of care.

**Provider Network**
One MCO reports implementing "provider care teams" that consist of a provider service representative, a corporate claims representative to address claims issues and a health care services representative to answer prior authorization questions. A medical director is consulted as needed. The MCO reports that this team approach has worked very efficiently to address the needs of providers. Provider care teams have been created for three of the largest hospital systems in New Mexico and will be cascaded to other providers in DY3.

Three MCOs have implemented, and the forth is currently pursuing, live video visits for the convenience of their members while improving access and potentially reducing healthcare costs. Virtual Urgent Care, Doctor on Demand and Virtual Visits are innovations which:  eliminate the need for transportation; potentially reduce urgent care and non-emergent visits to the emergency room; are available after traditional office hours; are available when a member is traveling; and, provide "real-time" audio and video with a physician or, in some instances, other providers (e.g. psychologist or lactation consultant). Video visits can be with nurse practitioners or physician assistants who have the ability to diagnose and prescribe. The video visits provide appropriate care for acute, non-emergent health conditions and can assist members in managing acute exacerbations of chronic conditions. Each MCO is providing outreach to inform its members and expects ongoing growth for this modern treatment option.

All of the MCOs are utilizing Community Health Workers (CHWs) as extensions of their provider networks.  CHWs are trained to serve as health navigators and health promoters for members within their communities. CHWs may be especially effective in Native American communities since the CHW is a member of the community who can speak the language and who knows the customs. CHWs can engender trust where an outside health work may not. CHWs have proven positive effects in helping to manage chronic health care conditions in their communities such as hypertension, diabetes, asthma and others.

Two MCOs have pilot projects and are working in collaboration with the University of New Mexico Health Sciences Center, Office for Community Health (UNMHSC/OCH) to connect Medicaid enrolled members to resources. The Community Health Workers Initiatives (CHWI) unit at UNMHSC/OCH has been developing models to integrate CHWs into care teams at primary care centers. As part of MHNM's collaboration with UNMHSC/OCH, the following health literacy and health promotion activities were reported in the fourth quarter:  classes for healthy and active living, nutrition and other health prevention related issues; informational events such as health fairs, eligibility and enrollment fairs, walking groups, and cooking classes; grassroots efforts to address social issues that affect the health of community members; and, activities at provider sites in addition to the CHW medical home pilot projects. MCOs also reported attendance at the New Mexico Community Health Worker Association annual conference held in Albuquerque.

**Centennial Rewards Program**

All Centennial Care members are eligible for rewards and in Q4 109,741 distinct/new members earned rewards. To date, 502,448 total members are earning rewards, or an overall participation of 65%.

The table below shows the healthy behaviors rewarded and each behavior's value. It includes the dollar value of the activity, the total dollars earned and the amount redeemed in DY2 Q4.

**Table #2. DY2 Q4 Credits Earned and Redeemed by Activity**

| Eligibility Activities | Activity Completion Reward Value in $ | Total Rewards Earned by Activity in $ | Total Rewards Redeemed by Activity in $ |
|---|---|---|---|
| Healthy Smiles Adults | $ 25 | $ 567,275 | $ 338,991 |
| Healthy Smiles Children | $ 35 | $ 766,220 | $ 1,011,340 |
| Step-Up Challenge | $ 50 | $ 82,575 | $ 75,580 |
| Health Risk Assessment (HRA) | $ 10 | $ 513,400 | $ 176,015 |
| Healthy Pregnancy | $ 100 | $ 95,100 | $ 55,414 |
| Diabetes Management | $ 80 | $ 256,800 | $ 252,839 |
| Asthma Management | $ 75 | $ 79,530 | $ 64,693 |
| Schizophrenia Management | $ 75 | $ 21,405 | $ 18,292 |
| Bipolar Disorder Management | $ 75 | $ 78,120 | $ 55,828 |
| Bone Density Testing | $ 35 | $ 3,955 | $ 1,726 |
| Other (Appeals) | N/A | $ 131,399 | $ 45,420 |
| **Totals** | | **$ 2,595,779** | **$ 2,096,138** |

The table above shows the DY2 Q4 Step-Up Challenge rewards and is reflective of more than 40,000 members. Step-Up Challenge is a walking program that allows members to earn a $25 reward for completing 135,000 total steps over a three week period and earn another $25 reward if they continue the program for nine additional weeks by meeting a goal of 30,000, 45,000, or 60,000 steps each week. At this point 7,075 members completed the three week challenge and 1,543 went on to complete the nine week program.

Reward redemption in Q4 was $2.1 million, increasing the total to date redemption to $5.5 million. Redemption activity by members is slowly increasing and at the end of Q3 it was 15.7% while Q4 ended at 23%. Centennial Care members can have up to two years to spend their points; for example, any rewards points received in 2015 will expire on December 31, 2016.

**Community Interveners (CI)**
In Q3, 2015, there were seven Centennial Care members receiving the Community Intervenor service, with total claims paid of approximately $7,202. In Q3 Community Outreach Program for the Deaf (COPD) provided training to BCBS Care Coordinators to educate them on identifying members who may be eligible for the Community Intervener service.

**Table #3. Community Intervener Services Utilization**

| MCO | # of Members Receiving CI | Total # of CI Hours Provided | Claims Billed Amount |
|---|---|---|---|
| BCBS | 3 | 116.76 | $2,920.75 |
| MHP | 0 | 0 | $0 |
| UHC | 3 | 156.75 | $3,918.75 |
| PHP | 1 | 362.50 | $362.50 |
| **Total** | **7** | **636.01** | **$7,202.00** |

**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 #4. Enrollment DY2 Q4**

| Demonstration Population | Total Number of Demonstration Participants Quarter Ending – December 2015 | Current Enrollees (Rolling 12 month period) | Disenrolled in Current Quarter |
|---|---|---|---|
| Population 1 – TANF and Related | 368,985 | 355,192 | 6,431 |
| Population 2 – SSI and Related – Medicaid Only | 41,725 | 42,672 | 533 |
| Population 3 – SSI and Related – Dual | 36,702 | 39,481 | 555 |
| Population 4 – 217-like Group – Medicaid Only | 179 | 276 | 11 |
| Population 5 – 217-like Group – Dual | 2,343 | 2,613 | 30 |
| Population 6 – VIII Group (expansion) | 249,332 | 306,183 | 8,658 |
| Totals | 699,266 | 746,417 | 16,218 |

**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 #5. Disenrollment Counts DY2 Q4**

| Disenrollments | From 2015 Q3 to 2015 Q4 | | Total Disenrollments During Q4 |
|---|---|---|---|
| **Last Month Client was Disenrolled** | **Oct 1,2015** | **Nov 1, 2015** | |
| **Population 1 – TANF and Related** | 3,140 | 3,291 | 6,431 |
| **Population 2 – SSI and Related – Medicaid Only** | 269 | 264 | 533 |
| **Population 3 – SSI and Related – Dual** | 267 | 288 | 555 |
| **Population 4 – 217-like Group – Medicaid Only** | 4 | 7 | 11 |
| **Population 5 – 217-like Group - Dual** | 13 | 17 | 30 |
| **Population 6 – VIII Group (expansion)** | 4,059 | 4,599 | 8,658 |
| **Total Without MEG 7** | 7,752 | 9,269 | 16,218 |

**Section IV: Outreach**

In DY2 Q4, HSD provided Centennial Care informational training to the New Mexico Aging and Disability Resource Center (ADRC) staff from across the State.

HSD continued its outreach efforts in regards to the Medicaid Health Homes initiative (now CareLink NM) that will be implemented April 1, 2016, after formal approval from CMS. CareLink NM is a program that will coordinate both behavioral and physical health care along with community services to improve quality of care and reduce health care costs. The initial phase of CareLink NM will focus on members with serious mental illness (SMI) or serious emotional disturbance (SED) living in San Juan or Curry Counties. Public meetings to discuss the Health Home concept and to solicit comments and suggestions were held in Clovis and Farmington New Mexico as well as Window Rock Arizona. In addition, presentations were made to medical and behavioral health providers in New Mexico.

The CareLink NM Steering Committee was created to include members from the HSD and the four MCOs. Health Home provider applications were posted on the HSD website resulting in completed applications from two providers. After vetting the two applications and receiving presentations from the providers regarding their plans to become a Health Home, the CareLink NM Steering Committee deemed both providers were appropriate for the program. Readiness site visits occurred in Clovis, NM on February 2, 2016 and in Farmington, on February 4, 2016. The Health Home Rule and CareLink NM Policy Manual are posted to the HSD website for public comment.

In DY2 Q4, HSD held nine training sessions to certify 123 new Presumptive Eligibility Determiners (PEDs). In addition, HSD conducted 10 demonstration sessions for over 160 PEDs who needed additional systems and process training. HSD, through its partnership with the New Mexico Primary Care Association, continues to provide educational and outreach support to several rural clinics and Indian Health Services (IHS) Centers across New Mexico.

All four MCOs participated in a wide variety of community events all around New Mexico to provide enrollment opportunities, and educate the public about Centennial Care. They attended Medicaid enrollment events, health fairs and assisted in accepting cold weather coat/jacket donations for children in need around New Mexico. MCOs held events with various local Chambers of Commerce and Hispano Chambers of Commerce providing Centennial Care information to those in attendance. The MCOs also helped organize other community events at places such as local Boys & Girls Clubs and Job Corp.

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

The MCOs submit encounters daily and/or weekly to stay current with their encounter submissions. HSD continues to work with the MCOs to respond to questions and address any issues related to encounters.

Data is extracted on a monthly basis to identify Centennial Care enrollment by MCO and for different populations. Any discrepancies that are identified, whether due to systematic or manual error, are immediately addressed. Eligibility and enrollment reports are run on a monthly basis to ensure consistency and tracking of numbers. HSD continues to monitor enrollment and any anomalies that may arise so that they are addressed and resolved timely.

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

### Program Development
Centennial Care MCOs continued their collaborative workgroups in the fourth quarter. The emergency room (ER) reduction workgroup, including representatives from HSD and the New Mexico Hospital Association, met in October 2015. Among other topics, the MCOs discussed the definition of a "non-emergent" ER visit with respect to the delivery system improvement targets. There was a presentation on an Emergency Department Information Exchange (EDIE), a web-based technology that facilitates communication between emergency room clinicians in real time. The EDIE system assists in identifying frequent users of emergency room services and/or members with complex care needs to ensure that members are directed to appropriate settings of care. Also discussed were member education, member incentives and potential rewards for utilizing appropriate settings of care. Workgroup participants took back action items and will reconvene in February 2016.

### Post Award Forum
The Centennial Care post award form was held on Monday, November 23, 2015 as part of a regular Medicaid Advisory Committee meeting.  Medicaid Director, Nancy Smith-Leslie, introduced the discussion and explained the purpose and the intent of the forum – to hear public comment about the program.  A detailed account of the public forum will be included in the Annual Report.

### Unreachable Member Campaign
The DY2 Q4 Unreachable Member Campaign results represent the MCOs' unique and innovative attempts to connect with their members during the quarter. In an initiative that began approximately one and a half years ago, HSD directed each MCO to improve its unreachable count by a minimum of 5% each month. During the course of the campaign, HSD identified an additional member group not defined in the contract, or otherwise predicted by the program, as the member who is "difficult to engage" (DTE). The DTE member has been reached but has not followed through with completing a health risk assessment (HRA) or has declined the assessment at the time of contact. Therefore, an MCO must make subsequent attempts to complete the assessment, because the member has not been determined as unreachable and initial and annual assessments are required by the contract.

The DTE category has been added to the weekly statistics report of care coordination activities in DY3. Based on data observations to date, HSD predicts that while unreachable member rates are likely to remain stable, the number of DTE members and members who decline an HRA are likely to increase. This is because healthy members in care coordination level 1 (CCL1) may not want to repeat annual HRAs year after year. HSD will be monitoring this, as well as HRA completion rates and other trends, in 2016. A summary of the Unreachable Member Campaign will be provided in the annual report.

**Table #6. Unreachable Member Campaign DY2 Q4**

| | Oct-15 | | | | Nov-15 | | | | Dec-15 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | 5% Target | Reached | Percent Completed | Baseline | 5% Target | Reached | Percent Completed | Baseline | 5% Target | Reached | Percent Completed |
| BCBSNM | 11,564 | 578 | 768 | 6.64% | 11,719 | 586 | 768 | 6.55% | 10,717 | 536 | 750 | 7.00% |
| UHC | 14,373 | 719 | 1,006 | 7.00% | 15,594 | 780 | 1,536 | 9.85% | 13,625 | 681 | 870 | 6.39% |
| MHNM | 27,475 | 1,374 | 1,954 | 7.11% | 26,422 | 1,321 | 1,989 | 7.53% | 26,206 | 1,310 | 1,468 | 5.60% |
| PHP | 36,268 | 1,813 | 1,964 | 5.42% | 36,719 | 1,836 | 2,236 | 6.09% | 36,027 | 1,801 | 2,384 | 6.62% |
| Source: MCO monthly reporting | | | | | | | | | | | | |

## Electronic Visit Verification (EVV)

The temporary exemption for "no tech zones," as described in the previous quarterly report, remains in effect. HSD and the MCOs are continuing to explore alternative technologies for a solution that could increase the percentage of personal care service providers who are able to utilize the EVV system, including the use of tablets and cell phone applications available for the caregiver to download.

## Payment Reform Project

HSD approved 10 payment reform projects that launched in July 2015. The projects include a variety of approaches-- from accountable care organizations with shared savings to bundled payments for episodes of care such as for pregnancy and bariatric surgery-- and engage a wide-range of providers, from large urban hospital systems to smaller rural clinics.

For example, one of the MCOs is working with larger provider groups, such as the University of New Mexico (UNM) and Albuquerque Health Partners, to establish an Accountable Care Organization (ACO) model that assigns members to primary care providers to manage the members' total care and offers shared savings when cost and utilization is well-managed and quality outcomes are achieved. The goal is to eventually move these providers to a risk sharing arrangement with a per-member per-month payment. This same MCO is also implementing bundled payments for maternity and diabetes episodes of care with UNM and the Lovelace Health System.

Another MCO that has been at the forefront of developing patient-centered medical homes (PCMHs) is implementing shared savings with some of its larger PCMHs that rewards achievement of specific quality targets. This same MCO is also implementing a sub-capitated arrangement with a Federally-Qualified Health Clinic to manage the total care of assigned members and achieve performance measures.

A third MCO is offering a three-tier reimbursement structure for PCMHs with increased per-member-per-month reimbursement for providing care coordination activities and telehealth capability and using electronic health records. An additional incentive payment is possible for meeting established performance measures. This same MCO is also implementing bundled payments for targeted inpatient admission episodes such as pneumonia with certain hospitals and for outpatient episodes of care for colonoscopies.

The Center for Healthcare Strategies worked with agency staff, including the deputy director of finance and the healthcare reform manger, to develop report templates and tools for the MCOs to use for each project. The templates identify broad milestones throughout the project period, which will assist agency staff to track progress across the MCOs and projects. The work plan template also includes milestones for submitting data and narrative reports to the agency. Agency staff is meeting quarterly with each MCO to monitor progress of the projects.

As phase one, implementation of the projects is underway. Phase two of the project is development of an evaluation framework to assess the achievements and challenges of each project. After the evaluation phase, decisions about how best to leverage the most effective projects for statewide implementation across the delivery system will take place, including garnering stakeholder input. Then phase three of the project will be statewide implementation of the selected payment reform initiatives.

**Behavioral Health**

*Strategic Planning*
The Behavioral Health (BH) Collaborative kicked-off its "Strategic Initiative to Strengthen New Mexico's Behavioral Health Service Delivery System" with a day-long strategic planning session on July 30, 2015. The Strategic Action Plan that ultimately results from this process will enhance the sustainability of the publicly-funded BH service system in New Mexico.

Three workgroups were formed to focus on the following areas: finance, regulation, and workforce. These three domains have been consistently cited as crucial to meaningful system improvement. Since July 30, individual work groups have met to develop a practical, achievable, set of tasks, objectives, and priorities that can be accomplished within a two-year timeframe that will create sustainable improvements. A full Strategic Action Plan will be completed by December 18, 2015. An accountability team will be created to monitor progress during the two-year implementation period.

*Permanent Supportive Housing (PSH)*
Studies have found that PSH for individuals with BH disorders, compared with treatment as usual, reduced homelessness, increased housing tenure over time, and resulted in fewer emergency room visits and hospitalizations. Moreover, consumers consistently rated PSH more positively than other housing models and preferred it over other more restrictive forms of care. On the basis of this evidence, PSH is recommended by SAMHSA, HUD and other authorities to be included as a covered service as part of a full spectrum of options that support recovery for individuals with BH conditions.

In 2015, New Mexico was selected by HUD for on-site technical assistance to build upon the Behavioral Health Purchasing Collaborative's Long Range Supportive Housing Plan, by creating a short term action plan to integrate subsidized housing and health care services at a systems level, including efforts to streamline Medicaid access. A draft of a Housing and Healthcare action plan has been completed by representatives of the Housing Leadership Group, an ad hoc subcommittee of the Collaborative. That system-wide planning process coincides with the implementation of a three-year SAMHSA grant – Housing Supports, Health, and Recovery for Homeless Individuals – aimed at providing accessible, effective, comprehensive, coordinated, and sustainable PSH to 450 individuals in three counties who experience chronic homelessness and have substance use disorders, serious mental illness, or co-occurring disorders.

*New Mexico Crisis and Access Line*
The telephone is often the first point of contact with any comprehensive crisis response system for a person in crisis or a member of his/her support system. The New Mexico Crisis and Access Line (NMCAL) operates statewide and is available 24 hours a day, 7 days a week, and 365 days a year to provide assessment, screening, triage, preliminary counseling, information, and referral services. A primary role of NMCAL's independently licensed clinicians is to assess the need for face-to-face crisis intervention services and to arrange for such services when and if indicated. Increasingly, NMCAL has contractually assumed the crisis line responsibilities of local providers thereby creating both efficiencies and a uniform response capability. Fourteen of the 17 Core Service Agencies now utilize NMCAL for phone crisis services. In 2015, 50% of total calls NMCAL received were from Centennial Care members.

NMCAL opened a Peer-to-Peer Warmline designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peers are Certified Peer Support Workers, with "lived experience," and trained to provide non-crisis supportive counseling to callers. Between September and end of 2015, the Peer-to-Peer Warmline answered 2,334 calls.

*Behavioral Health Investment Zones*
The New Mexico Behavioral Health Collaborative's Behavioral Health Investment (BHI) Zones initiative seeks to further invest in New Mexico's counties that lead the State in deaths attributable to alcohol, drugs, or suicide by preventing adverse childhood experiences, building developmental assets, conducting early screening and assessments, improving access to quality trauma informed treatment services, diverting those with behavioral health conditions from emergency room utilization and incarceration, reducing serious and violent crime, integrating behavioral health with physical health care, leveraging private funding, and assisting local leaders in navigating appropriate federal and state programs. McKinley and Rio Arriba counties were selected based on their composite behavioral health-related death rates to apply for designation as BHI Zones. Both counties have completed applications that include comprehensive plans for better addressing behavioral health needs which will qualify each of them for $500,000 of additional funding annually.

*Crisis Response Teams*
The evidence that BH crisis services are effective is growing. The research shows, for example, that triage and stabilization services, which use 24-hour observation and supervision to prevent or resolve crises or manage detoxification, are as effective at improving symptoms as longer psychiatric inpatient care or other hospitalization. Plus, patients report strong satisfaction with these services. These services are also proving to be cost-effective. According to SAMHSA, several studies demonstrate that these crisis services can result in significant cost savings. Reduced use of inpatient services, diversion from emergency departments and jail, and more appropriate use of community-based BH services all drive lower costs. The research on crisis response teams has demonstrated a reduction in the costs associated with inpatient hospitalization by about 79% in the six months after a crisis. Year-end data on crisis services indicates 909 Centennial Care members received crisis services from a team during 2015 (Source: MCO Q4 2015 Report 41). A Crisis Response team is currently being established in Rio Arriba County and another is being planned for McKinley County, both of which are BHI Zone counties.

*Certified Community Behavioral Health Clinics*
In late October, New Mexico was awarded $982,373 to fund Certified Community Behavioral Health Clinics (CCBHC) year-long planning grant from SAMHSA. This funding will support efforts to study effective ways to deliver community-based mental and substance use disorder treatment and integrate physical and behavioral health. New Mexico was one of 24 states awarded this grant.

HSD's Behavioral Health Services Division (BHSD) proposes to use the grant to serve all those currently served in New Mexico's behavioral health system, which includes adults with SMI, children with SED, and those with long term and serious substance use disorders (SUDS), as well as, others with BH conditions. The year-long planning grant will help identify ways to expand services to ensure the availability of all services required through a community needs assessment that in turn will determine capacity, access, and availability of services while also integrating BH services with health care.

During the planning year, four workgroups are planning the following:
- Statewide coordination of services;
- Prospective payment methods;
- Data collection and reporting; and
- CCBHC site certification.

Also, during this planning year, our CCBHC project team is working with selected sites to prepare for CCBHC certification by completing a needs assessment and providing training and technical assistance.

*Annual Consumer and Family/Caregiver Satisfaction Survey*

The Annual Consumer and Family/Caregiver Satisfaction Survey is a joint effort between the Children, Youth and Families Department (CYFD), HSD/MAD and HSD/BHSD and the four MCOs. The results are used to identify areas for service improvement.

Each year, a random sample of Adults and Family/Caregivers whose children are receiving behavioral health services are surveyed. Trained family members and adult consumers conduct the telephone survey. In 2015, over 1,100 Adults and 1,200 Family/Caregivers completed surveys. An additional 272 youth were surveyed by trained youth peers.

The Survey reports on seven domains that are then compared to national data. The seven domains are:

1. Access
2. Participation in Treatment
3. Improved Functioning
4. Social Connectedness
5. Quality and Appropriateness
6. Cultural Sensitivity Outcomes
7. Overall Satisfaction

**Table #7. Four of the seven domains from the Adult Survey**
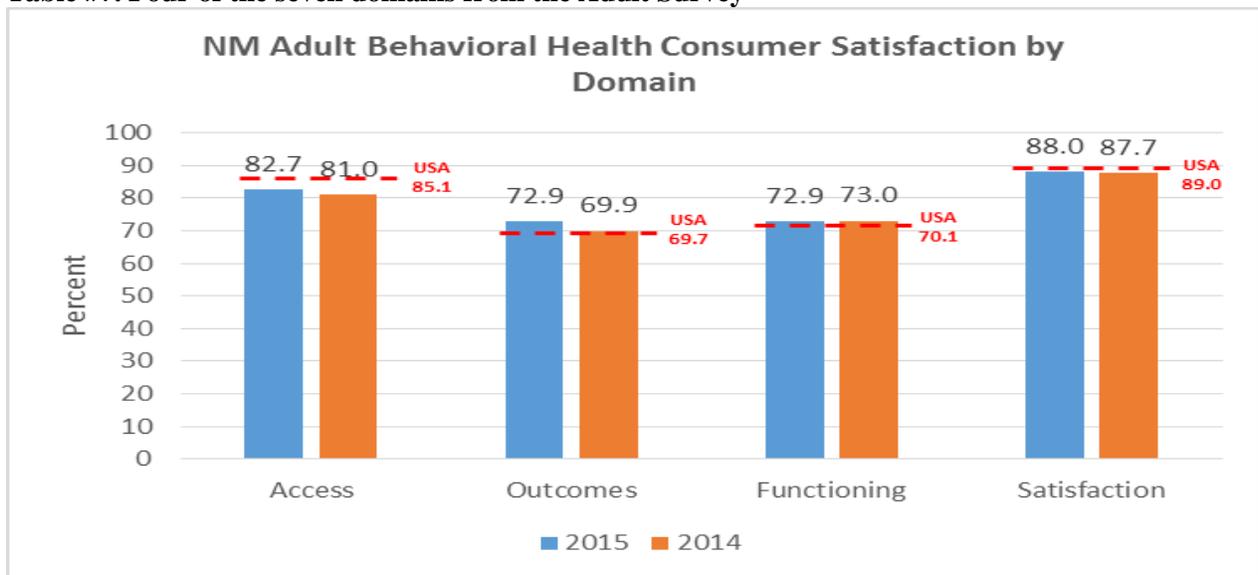
**Table #8. Four of the seven domains from the Family/Caregiver Survey**
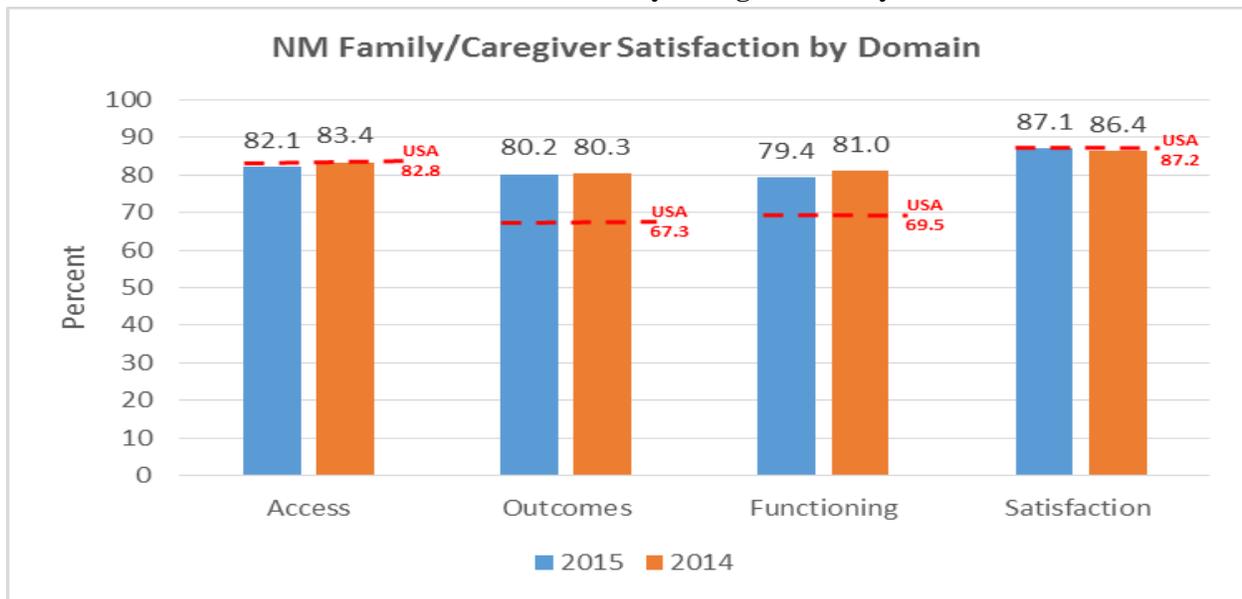


When New Mexico was compared to the U.S. Average (2014) results for the seven domains:

- The Family/Caregivers reported satisfaction levels that met, or in most cases, exceeded that National Average.
- The Adults reported satisfaction levels that exceeded the National Average in five out of the seven domains. The Access domain was slightly lower.

Full reports of the 2015 Annual Consumer, Family/Caregiver Satisfaction Survey and the separate smaller Youth Survey are available on the Network of Care website (http://newmexico.networkofcare.org/mh/content.aspx?id=6049).

***Billing for Non-Independently Licensed Clinicians***

In response to the need for additional clinicians in the BH network, HSD has implemented a process where existing New Mexico BH agencies (type 432) can request certification for status as an agency that can provide clinical supervision to and bill for non-independently licensed clinicians. When certification is granted, the non-independently licensed clinicians at that agency will then be able to provide supervised clinical services that are not currently covered by Medicaid due to level of licensure.

Since implementation on October 1, 2015, 33 BH agencies were identified as being approved under the previous Statewide Entity's Supervisory Protocol (OptumHealth Supervisory Protocol) and are able to provide clinical supervision to and bill for BH services provided by non-licensed clinicians. Forty-nine unique BH providers and/or BH agencies have requested information. Eighteen of the providers who inquired about the certification were not eligible. One applicant agency has received full certification status and another has received provisional certification status to provide supervision to non-independently licensed clinicians and to bill for services those individuals provide. HSD is following up with the other 29 BH agencies that are in various

stages of the certification process. HSD is implementing monthly technical assistance calls with BH agencies that are requesting certification status.

HSD is actively working with other state and regulatory agencies to promulgate changes to NMAC 8.321.2.9 to allow BH agencies (type 432) to provide clinical supervision to and bill for BH services provided by supervised non-licensed clinicians.

**Fiscal Issues**
Myers and Stauffer was engaged to assist HSD with monitoring and reporting of the MCOs' performance under Centennial Care. Myers and Stauffer staff reviewed each MCO's systems and processes as they related to: inpatient paid and denied hospital claims for areas of claims adjudication, prior authorization, and provider credentialing. A claims data sample was provided by each MCO. Myers and Stauffer also reviewed provider contract loading dates for behavioral health, long term care, and hospital providers as well as complaints, appeals, grievances, health plan compliance, program integrity, and subcontractor/delegated services monitoring. Myers and Stauffer is currently compiling the MCOs' responses to the draft report into an appendix for the final report. A summary of findings and resulting actions and activities will be reported in the DY3 Q1 report.

**Systems Issues**
As discussed in previous reports, HSD identified reporting issues with the Nursing Facility Level of Care data and with MCO submission of the correct Setting of Care, which impacts the cohort designation and capitation payment for members. Through ongoing auditing and analysis, all discrepancies have been identified and corrected. HSD will conduct training with the MCOs in March 2016 to address these concerns and implement improvements in the processes.

HSD continued to make progress with the MCOs on timely and accurate reporting of encounters. Additionally, in the quarter, all four MCOs implemented a common format for submission of Third Party Liability (TPL) data. The weekly calls with MCO system managers continued during the quarter, and these forums have proved useful for discussion of data issues.

HSD began its planning for replacement of its current legacy Medicaid Management Information System (MMIS) some time ago, and activity for this effort intensified in the quarter. The RFP for an IVV vendor was released, and a finalist has been selected. Information on the upcoming RFP for a Platform/System Integrator and the proposed modular framework of the new MMIS was shared with all stakeholders, including the MCOs, provider associations and the Medicaid Advisory Committee. The RFP will be submitted to CMS in the current quarter for review.

**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, LTSS, the MCO grievance and appeals process, and the fair hearing process.

The NMICSS reporting for the quarter is provided by the Aging and Long-Term Services Department (ALTSD) ADRC. 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 numbers below reflect calls made to the ADRC hotline from October 1, 2015 to December 31, 2015.

**Table #9. ADRC Call Profiler Report**

| Topic | # of Calls |
|---|---|
| Home and Community-Based Care Waiver Programs | 2,654 |
| Long Term Care/Case Management | 205 |
| Medicaid Appeals/Complaints | 28 |
| Personal Care | 85 |
| State Medicaid Managed Care Enrollment Programs | 112 |
| Medicaid Information/Counseling | 1,488 |

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

**Table #10. ADRC Care Transition Program Report**

| Counseling Services | # of hrs | # of Nursing Home Residents | # of Contacts |
|---|---|---|---|
| Transition Advocacy Support Services | | 189 | |
| Medicaid Education/Outreach | 1,412 | | |
| *Medicaid Options/Enrollment | 213 | | |
| Pre/Post Transition Follow-up Contact | | | **2,030 |

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

** Note: 75% of the contacts are pre-transition contacts and the remaining 25% are post transition contacts. These numbers are resident specific and situation dependent.

As a member of the NMICSS, the ALTSD Care Transition Bureau (CTB) provides assistance to Medicaid beneficiaries enrolled in Centennial Care receiving LTSS (institutional, residential and community-based) in navigating and accessing covered healthcare services and supports. CTB staff serves as advocates and assists individuals with linking them to both long-term and short-term services and resources within the Medicaid system and outside of that system. CTB staff also monitors to ensure that services identified as a need are provided by the MCO, MCO subcontractors and other community provider agencies. Its 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 has assisted 97 individuals with these initiatives during this reporting quarter.

The CTB staff completed meetings with MCOs this quarter. The purpose of these meetings was to make staff introductions, describe CTB services, provide training to MCO staff regarding CTB transition assistance and establish a formal communication process to address challenges regarding member transitions.

**Critical Incidents**
HSD continues to work with the Critical Incident (CI) workgroup to finalize the BH protocols for providers. The BH 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.

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

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

**Table #11. DY2 Q4 Critical Incidents**

| Critical Incident Types | Centennial Care | | Behavioral Health | | Self-Directed | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| **Abuse** | 220 | 6% | 60 | 16% | 9 | 7% |
| **Death** | {384} | | {25} | | {12} | |
| Natural/Expected | 331 | 10% | 21 | 6% | 11 | 8% |
| Unexpected | 50 | 1% | 4 | 1% | 1 | 1% |
| Homicide | 1 | 0% | 0 | 0% | 0 | 0% |
| Suicide | 2 | 0% | 0 | 0% | 0 | 0% |
| **Emergency Services** | 2165 | 62% | 200 | 53% | 87 | 66% |
| **Environmental Hazard** | 60 | 2% | 3 | 1% | 3 | 2% |
| **Exploitation** | 117 | 3% | 7 | 2% | 10 | 8% |
| **Law Enforcement** | 137 | 4% | 39 | 10% | 5 | 4% |
| **Missing/Elopement** | 36 | 1% | 14 | 4% | 1 | 10% |
| **Neglect** | 353 | 10% | 29 | 8% | 5 | 4% |
| **Total** | **3472** | | **377** | | **132** | |

## Community Benefit

HSD is revising the Community Benefits (agency-based and self-directed) sections of the Centennial Care Policy Manual with an effective date of March 1, 2016. HSD is currently soliciting public input on the proposed changes.

CMS approved a postponement of the Medically Fragile (MF) population transition to Centennial Care. The MF population will be included as a population in the renewal of the Centennial Care waiver for 2018. In the interim, the Medically Fragile 1915c waiver will be renewed to continue coverage of this population.

**Section VIII: AI/AN Reporting**

**Access to Care**
DY2 Q4 data shows that Native American members are accessing specialty services such as orthopedics, cardiology, podiatry, and oncology outside of I/T/Us.

**Contracting Between MCOs and I/T/U Providers**
The MCOs continue to reach out to IHS, Tribal health providers, and Urban Indian providers (I/T/Us) to develop agreements even though these providers 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 93% to 99% of claims being processed and paid timely within 30 days of receipt.

**Table #12. Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)**

| MCO | Location/Date of Board Meeting | Issues/Recommendations |
|---|---|---|
| BCBSNM | Shiprock Chapter House Shiprock, NM November 13, 2015 | BCBSNM held their NAAB meeting at the Shiprock Chapter House. About 47 participants attended. BCBSNM went over their Centennial Care rewards, ABP benefits, and answered questions regarding transportation, doctors out of state, and care coordination. |
| MHNM | Upper Fruitland Chapter House Upper Fruitland, NM November 14, 2015 | About 57 participants attended this meeting. The audience had questions about transportation, if MHNM pays for out of state trips, ramps, wheelchairs, and car seats. Suggestion that future meetings have a larger space, no children at the meeting, and notebooks. The meeting was translated in Navajo. |
| PHP | Lincoln County Medical Center Ruidoso, NM December 3, 2015 | About four providers from IHS attended the meeting. PHP presented on their services and focused on how care coordination works. They also talked about Presbyterian's Financial Assistance Policy for non-insured people needing help with medical bills. |
| UHC | Farmington, NM November 10, 2015 | UHC had about 20 providers at their NAAB meeting. There was discussion on care coordination, benefits and services, and a discussion on how UHC can improve their services (suggestions for future value added services). |

The most recent NATAC meeting for this quarter took place on November 16, 2015. The majority of the meeting was spent discussing the third quarter Native American reports from the Centennial Care MCOs. Handouts were provided with graphs on Native American Centennial Care enrollment, care outside of an I/T/U, BH utilization, inpatient statistics, emergency room utilization, dental utilization, and value added services.

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

See Attachment D: MCO Action Plans

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

During this quarter, HSD developed DY3 managed care rate adjustments for all programs except Long Term Services and Supports (LTSS). LTSS rate development is occurring in the spring of 2016 for rates that will be retroactive back to January 1, 2016. The next quarterly report budget neutrality summary will monitor the impact of the new rates.

Attachment A – Budget Neutrality Monitoring includes new tables assessing the budget neutrality limit for the waiver in demonstration year two. New Mexico is 14% below the budget neutrality limit as assessed for the second year of the waiver as summarized in Table 2.4. MEGS 1-3 and the Hospital Quality Improvement Incentive (HQII) Pool were all well within the budget neutrality limit as Table 2.1 summarizes. Table 2.2 summarizes the supplemental budget neutrality test 1 for the Hypothetical groups of the "217 Like." MEG 5 once again exceeded its own budget neutrality limit and the excess spending was recognized against the total budget neutrality limit in Table 2.4. It was not significant enough to impact overall budget neutrality. Table 2.3 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.

HSD has determined that DSH payments and Uncompensated Care Pool payments have been reported incorrectly on the CMS-64. These will be corrected on the CMS-64 report and the subsequent budget neutrality tables should present actual payments for the Uncompensated Care Pool.

**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 #13. DY2 Q3 Member Months**

| Eligibility Group | Member Month |
|---|---|
| Population 1 – TANF and Related | 1,109,669 |
| Population 2 – SSI and Related – Medicaid Only | 124,213 |
| Population 3 – SSI and Related – Dual | 107,499 |
| Population 4 – 217-like Group – Medicaid Only | 510 |
| Population 5 – 217-like Group – Dual | 6,764 |
| Population 6 – VIII Group (expansion) | 713,358 |
| Total | 2,062,013 |

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

An updated number of total grievances that were filed by Centennial Care members in the fourth quarter are unavailable at the time of this report. A full analysis of non-emergent transportation complaints/grievances was provided in the DY2 Q3 report as well as a description of the collaborative MCO workgroup and HSD direction. Please also see Section II:  Enrollment and Benefits, Access – Transportation in this quarterly report.

## Section XIII: Quality Assurance/Monitoring Activity

### Service Plans

The HSD/MAD Quality Bureau (QB) randomly reviews service plans to ensure that the MCOs use 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, and that the member's goals are identified in the care plan. In DY2 Q4, there were no identified concerns.

**Table #14. DY2 Service Plan Audit**

| Service Plans | DY2 Q1 | DY2 Q2 | DY2 Q3 | DY2 Q4 |
|---|---|---|---|---|
| Number of member files audited | **120** | **120** | **120** | **120** |
| % of service plans with personalized goals matching identified needs | **100%** | **100%** | **100%** | **100%** |
| % of service plans with hours allocated matching needs | **100%** | **100%** | **100%** | **100%** |

### Nursing Facility Level of Care (NF LOC)

QB reviews high NF LOC and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria.

**Table #15. DY2 NF LOC Audit**

| High NF denied requests (and downgraded to Low NF) | DY2 Q1 | DY2 Q2 | DY2 Q3 | DY2 Q4 |
|---|---|---|---|---|
| Number of member files audited | 14 | 15 | 14 | 16 |
| Number of member files that met the appropriate level of care criteria | 14 | 15 | 14 | 16 |
| % of MCO level of care determination accuracy | 100% | 100% | 100% | 100% |

**Table #16. DY2 Community Benefit LOC Audit**

| Community Benefit denied requests | DY2 Q1 | DY2 Q2 | DY2 Q3 | DY2 Q4 |
|---|---|---|---|---|
| Number of member files audited | 16 | 15 | 16 | 14 |
| Number of member files that met the appropriate level of care criteria determined by the MCO | 16 | 15 | 15 | 14 |
| Percent of MCO level of care determination accuracy | 100% | 100% | 94% | 100% |

### Care Coordination Monitoring Activities

In November 2015, HSD conducted a desk audit of the MCOs' care coordination activities. The audit evaluated the MCOs' adherence to contractual obligations related to care coordination delivery and the efficacy of additional training that was provided to their care coordination teams. The audit findings are currently being compiled; the findings will be included in the annual report.

A Super-Utilizer project using PRISM, a predictive risk modeling database, to monitor ongoing interventions of care coordination and its impact on reducing emergency department (ED) visits was initiated by HSD. PRISM is an integrated decision support tool used by MCOs and HSD to support care management interventions for high-risk Medicaid patients.

A sample cohort of members with the highest number of ED visits in the past 12 months was pulled from PRISM for each MCO. This established the Super-Utilizer cohort for each MCO. Super-Utilizers were defined as, a MCO member having greater than four outpatient ED visits in the past 12 months (365 days).

HSD met individually with each MCO to discuss the project and identify the cohorts. MCOs were asked to closely focus on care coordination interventions for the identified members and to provide scheduled updates to the State on touchpoints, successes of interventions, challenges to reductions and overall impact on reduction of ED use. HSD will continue to monitor this project as it moves forward and collaborate with the MCOs to provide technical assistance as needed.

**Section XIV: Managed Care Reporting Requirements**

**MCO Reporting Process**

In alignment with HSD's continuous quality improvement initiatives and ensuring contract compliance for MCO reporting, forms used for tracking submissions and report status (e.g. report rejection form, resubmission form, etc.) were created, revised and implemented to enhance clarity and communication between HSD and the MCOs.

**Customer Service**

All call center metrics (abandonment rate, speed of answer and wait time) for all customer services lines (member services, provider services, nurse advice line and the utilization management line) were met by each MCO during the quarter.

**Appeals**

A total of 1,095 appeals were filed by Centennial Care Members in Q4. Of the total appeals filed, 709 (65%) were upheld, 305 (28%) were overturned and the remainder are pending resolution. Pending appeals received late in the quarter are carried over to the following month for resolution. The majority of appeals are due to denial or limited authorization of a requested service.

**Section XV: Demonstration Evaluation**

Progress continues as expected with DY2 Q4 activities generally devoted to data analysis and evaluation. In addition, work commenced on drafting the Annual Report. At the end of the fourth quarter, Baseline figures have been established for 111 measures with an additional one measure pending receipt and analysis of data and the second pending data analysis only. Data sources for 12 measures have not been identified and will not be available in time to establish Baselines or Demonstration Year 1 calculations for the Annual Report. Deloitte also made progress on developing the structure for the Annual Report including the charts and exhibits. Deloitte continues to meet with HSD on a weekly checkpoint conference call to further refine the work plan and discuss data and analysis issues.

**Data Identification and Acquisition**
During the fourth quarter of 2015, the Deloitte Team continued to work with HSD to identify the various data elements needed to conduct the evaluation. In addition, Deloitte continued to develop the Evaluation Model incorporating both the pre-Centennial Care Baseline and the Centennial Care measures. Deloitte met face-to-face with HSD staff in October to discuss the structure of the Annual Report, including the format of the tables and exhibits to be included. Deloitte and HSD staff participated in weekly progress checkpoint calls to discuss data issues and resolve outstanding issues.

Deloitte reviewed over 100 reports received from HSD through HSD's secure data transfer system. The team analyzed each report to identify and acquire the appropriate data elements. In cases where the data was insufficient, Deloitte tracked and reported those issues to HSD for further review. As of the end of the quarter, Deloitte had received the data needed to complete the first year evaluation for 111 of the 125 measures under review. HSD informed Deloitte that data was not available for 12 of the measures as of this report. For the Demonstration Year 1 measures, calculations have been made for 108 measures. Data has been received for three of the measures but calculations are scheduled to occur in early January and data for the remaining two measures is expected from HSD in early January. Each month Deloitte provided HSD with a Data Status report by measure.

**Baseline Measures**
Work continues on establishing the Baseline measures using pre-Centennial Care data where applicable. Where pre-Centennial Care programs were combined under Centennial Care, Deloitte is developing baseline measures by combining data from the prior Salud!, behavioral health, and CoLTS data. Because the Salud!, behavioral health, and CoLTS programs varied from Centennial Care, in some cases assumptions are needed to develop Baseline measures applicable to Centennial Care. Deloitte provides HSD all assumptions to review for appropriateness and reasonableness before they are incorporated into the baseline measures. In other cases, HSD determined that 2013 data was not available and directed Deloitte to use 2014 data as the Baseline.

**Evaluation Model**

The evaluation model serves as a practical way to organize the data for comparison. The model presents each measure by baseline and demonstration year with the baseline serving as the benchmark. This model will allow HSD to quickly assess the change in a given measure over time.

**Annual Report**

A prototype of the structure of the Annual Report was developed to provide the framework needed to deliver a consistent look and feel for each measure. Deloitte shared this structure with HSD in October for its review and input. As required, the annual report will contain information on the progress made during the year, the key milestones achieved, challenges and delays experienced, and associated mitigation strategies.

**DY3 Q1 Planned Activities**

The first part of the DY3 Q1 will be devoted to finalizing any outstanding Baseline of Demonstration Year 1 calculations, entering those into the Evaluation Model, and drafting and finalizing the Annual Report. Following completion of the Annual Report, Deloitte will meet with HSD staff to discuss a data request and possible changes in data reported by MCOs to prepare for the coming year.

**Section XVI: Enclosures/Attachments**

Attachment A: Budget Neutrality Tables (October 1, 2015–December 31, 2015)
Attachment B:  GeoAccess PH
Attachment C:  GeoAccess BH
Attachment D:  MCO Action Plan Grid

## Section XVII: State Contacts

| HSD Staff Name and Title | Phone Number | Email Address | Fax |
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**Section XVIII: Additional Comments**

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

**Centennial Care Member Success Story 1**
On July 7, 2015, a behavioral health care coordinator met with a new member and offered the member care coordination. The member accepted, and a comprehensive needs assessment (CNA) was completed. The member was homeless and had no job. Since this date, the member has been clean, no alcohol. The member was assisted with finding a dentist and an optometrist. He was also assisted by the care coordinator in finding a PCP and is now an established patient. The member is now working at the outreach center and is assisting others with counseling. This member is very pleased with his outcome.

**Centennial Care Member Success Story 2**
One of the care coordinators was recently completing a CNA for a member. The member's PCP had been recommending that the member make an appointment with a gastroenterologist to discuss having a colonoscopy. The member had made the appointments with the gastroenterologist but had cancelled them at the last minute each time. She was afraid of the "prep," and the procedure itself, because she had heard they were difficult. She feared allowing herself to be so vulnerable. The care coordinator described her own experiences with colonoscopies and received our member's permission to allow her to help and to coordinate transportation with the member's sister. The care coordinator promised to follow up with our member after the procedure, and when she did, she found out that the colonoscopy had revealed suspicious polyps which needed to be biopsied. It turned out that the member had early colon cancer. The care coordinator continued to follow up with our member throughout the surgery to remove the cancerous polyps. The surgery was successful, and due to the help of the care coordinator and the early intervention, the member's physician believes that the cancer was caught before it had a chance to spread.

**Centennial Care Member Success Story 3**
While meeting with a member to complete an Emergency Room (ER) referral, a care coordinator discovered that the member had a lot of things going on. She had had multiple visits to the ER, depression, overdosing on medications, and other health issues. The care coordinator met with the member at the clinic, visited, and discussed her health concerns and the different services the MCO provides. This member stated that she was very interested in obtaining some help/assistance. The care coordinator discussed the importance of having a PCP, regular appointments with a PCP, and how this might benefit her. The care coordinator was able to assist the member in scheduling an appointment for behavioral health services and offered to attend the appointment, or any other medical appointments, with her. The care coordinator expressed the importance of the member's health and encouraged the member to contact care coordination. The care coordinator was there to assist the member in any manner possible.

**Centennial Care Member Success Story 4**

A care coordinator started working with a member after completing her HRA in September. From the answers she provided, the care coordinator could tell that she needed a lot of help. The member had recently moved from out-of-state and needed help establishing a PCP, getting started with behavioral health therapy sessions and applying for a replacement social security card and birth certificate. The care coordinator helped her navigate her first doctor's appointment, and she even trusted the care coordinator to attend her first behavioral health session. After months without medical care, the member found the motivation to start focusing on her health. She is currently being assisted in getting enrolled in reading classes, so she can learn how to read books to her grandchildren. As the care coordinator got to know her better, she revealed that she had moved to the area to start a new life and was focused on bettering herself in mind, body, and soul. One of her goals is to be able to build a closer relationship with her family. The care coordinator is honored to be a first step in her journey.