Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2018 – 12/31/2018)
Waiver Quarter: 2/2018

September 14, 2018
New Mexico Human Services Department

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Section I: Introduction

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

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. There are approximately 656,708 members currently enrolled in the program.

The goals of the Centennial Care Program at implementation included:

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

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

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

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

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

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

Section II: Eligibility, Provider Access and Benefits

Eligibility

As noted in Section III of this report, there are 273,093 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment increase of 4,904 from DY5 Q1.

Access

Throughout this report, the most current monthly and quarterly data available is through March 31, 2018. unless otherwise noted.

Primary Care Provider (PCP)-to-Member Ratios

The PCP-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties. There are no PCP access concerns currently.

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar
BCBS	1:34	1:36	1:37
MHC	1:91	1:91	1:90
PHP	1:74	1:74	1:74
UHC	1:30	1:29	1:29

Source: [MCO] PCP Report #53, Q1CY18

Geographic Access

Physical Health and Hospitals

The geographic access standard is defined as at least 90% of members residing within distance requirements to provider types in urban, rural, or frontier geographic areas. See Attachment B: GeoAccess Physical Health Summary for MCO performance in meeting access to specific provider types.

All four MCOs maintained 90% or above access compliance with distance requirements to general hospitals, federally qualified health centers (FQHCs), PCPs, pharmacies and most specialties in urban, rural and frontier areas. MCOs actively seek to contract with border area providers to improve overall access for members and to address the shortage of specialty providers throughout New Mexico. In the previous quarter, all MCOs remained below the access standard for neurosurgeons in rural and frontier areas. All MCOs remained below the access standard for rheumatologists in frontier areas, and two MCOs did not meet the access standard in rural areas. Three of four MCOs were below the access standard for urologists in rural areas. Access to dermatologists, endocrinologists and neurologists in frontier areas were reported below 90% by three MCOs. BCBS and MHC did not meet access standards for dermatologists, which is consistent with previous quarters.

HSD remains focused on outliers where all but one MCO met distance standards for specific provider types in geographic areas. Access issues may be remedied by transportation to the nearest provider and telemedicine services which have generally been increasing because of

delivery system improvements. At least one MCO specifically targets access to dermatologists through recruitment and retention efforts and another MCO specifically targets access to neurology services through telemedicine initiatives. Single case agreements are also permitted for providers who may not want to contract, including in-state providers, whenever possible; border area providers, providers within 100 miles of New Mexico's borders that are considered "in-state" for reimbursement purposes; and, out-of-state providers as necessary to ensure members receive medically necessary covered services which may not be available in-state. PHP is close to meeting the 90% access standard in rural areas for neurology (85.3%).

Of note this quarter, UHC successfully gained access standards in frontier areas for dermatology for the first time in more than 12 quarters. Two MCOs report significant changes in rheumatology in rural areas. BCBS reports a decrease of 8.5%. PHP reports a decrease which falls slightly below the access standard (89.1%). Conversely, one MCO reports significant increases in two geographical areas for neurosurgeon services. PHP reports an increase in member access of 13.5% in rural areas and 12.8% in frontier areas.

HSD found many positive outliers for which one MCO was able to exceed the standard while all other MCOs remain below the access standard. For this quarter, each MCO achieved a positive outlier status. UHC is a positive outlier as the only MCO to meet access standards in frontier areas for dermatology (91.6%) with an increase of 5.9%. BCBS, with slight improvements over last quarter, was the only MCO to exceed access standards in frontier areas for neurology (92.4%). MHC was the only MCO to meet access standards in frontier areas for endocrinology with slight improvements (91%). PHP is a positive outlier in that it meets the 90% standard for distance requirements to urologists in rural areas.

Behavioral Health

In DY5 Q2, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier areas through Core Service Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient provider agencies, psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners. See Attachment C: GeoAccess Behavioral Health Summary for MCO performance in meeting access to specific provider types.

However, rural and frontier access standards remain unmet with limited exceptions, for the following: Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs. Treatment Foster Care 1 & 2, Behavioral Management Services, Day Treatment Services, Intensive Outpatient Services, Methadone Clinics Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST). Rural access standards for Behavioral Health clinics are not met by the majority of MCOs.

With a few exceptions, none of the urban, rural and frontier access standards were met for residential treatment programs, both accredited and non-accredited, Indian Health Services and

Tribal 638s providing BH, Day Treatment Services, and Rural Health Clinics providing BH Services

HSD continues to be aware of the BH services that do not meet the standards due to provider shortages in New Mexico. HSD continues to work with MCOs to strengthen their relationships with providers and to increase accessibility to areas not meeting access standards through increased opportunities to expand use of telemedicine and Project ECHO. The Interdepartmental Council (IDC), made up of Children, Youth, and Families Department (CYFD) and HSD, has been processing applications and conducting site visits to continue to increase approved Intensive Outpatient Programs (IOP). Five new BH providers launched CareLink New Mexico (CLNM) Health Home services on April 1st and a sixth will implement services July 1st, bringing the total number of implementations to eight. By the end of 2019, the new Health Homes are expected to serve nearly 10,000 Medicaid beneficiaries with serious mental illness for adults (SMI) and severe emotional disturbance (SED) for children and adolescents.

MCOs individually work to maintain access with the current network while continually striving to build accessibility through efforts to provide innovative service delivery to their members and by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available network in ways such as having a Behavioral Health provider service representatives routinely visit providers to validate practice information, respond to claims and other issues. Additionally, MCOs are looking at value-based purchasing to increase access with appointment availability and utilizing High Fidelity Wrap around services to meet member's needs.

Community Health Workers

Centennial Care MCOs reported a 23% increase in members served by CHWs for DY5 Q1. For this period, a total of 98 CHWs, are employed or contracted. CHWs work in a variety of settings such as clinics, emergency rooms, paramedic units, and community food banks, with titles that include Peer Support Specialists, Member Navigators and Community Health Representatives. CHW certification is available through the NM Department of Health. Please see Table 2 – Summary of CHW Workforce by MCO.

Table 2 – Summary of CHW Workforce by MCO

DY5 Q2			
Community Health Workers			
	Employed	**Contracted**	**Total**
BCBS	27	15	42
MHC	20	0	20
PHP	8	12	20
UHC	11	5	16
Totals	**66**	**32**	**98**

Source: [MCO] CHW DSIPT, Q1CY18

CHW interventions include assistance with primary care physician (PCP) appointments, appropriate use of emergency room for physical and behavioral health care, contact with over utilizers and/or those who utilize the ER for non-emergent reasons, timely pre-natal and post-partum care, completion of health risk assessments (HRAs), social determinants of health screening with linkages to commonly needed food assistance, utility assistance, housing, transportation, and health education. Examples of CHWs supports include keeping an appointment calendar, appointment reminders, how to create a list of questions or needs for members to share with their PCPs, creating a family budget, on-going health literacy support and translation services.

A CHW team has begun a food bank pilot called the Health Food Center to assist members to access healthy food and attend on-site healthy cooking classes. The pilot includes the availability of a dietician to members. CHWs are being integrated into an addiction recovery-specific workforce in a clinical behavioral health setting, with a pilot called The Healthy Way. The CHWs in this pilot are Peer Support Specialists who will support members with mental health conditions and addiction recovery needs. MCOs also report that CHWs play an important role for members transitioning from incarceration back to the community by providing linkages to community services such as transportation, food assistance, employment and legal services.

The focused areas for the CHW initiative outreach to Medicaid members is the underserved urban, rural, and frontier areas of New Mexico. Please see Table 3 – Unduplicated Members Served by CHWs.

Table 3 - Unduplicated Members Served by CHWs

DY5 Q2 Unduplicated Members Served					
	BCBS	**MHC**	**PHP**	**UHC**	**Region Totals**
Underserved Urban	5286	1045	1550	714	8595
Rural	1107	773	703	664	3247
Frontier	480	120	195	95	890
MCO Totals	**6873**	**1938**	**2448**	**1473**	**12732**

Source: [MCO] CHW DSIPT, Q1CY18

Educational outreach in Q1 included:

- Diabetes & Managing Weight
- Medical Benefits & Services- Educational Events
- Cooking for Health
- Cooking for Health- Kids
- HealthPlex Fitness Classes
- Let's Cook

Telemedicine

In DY5 Q2, telemedicine utilization data for Q1 was reviewed. Consistent with previous reporting periods, the data indicates that most telemedicine services provided in New Mexico are for behavioral health diagnoses (Please see Table 4 – Telemedicine Services). Overall there is in an increase in telemedicine utilization among all MCOs from the previous reporting period. BCBS and UHC both had a slight decrease in urban utilization from the previous quarter but both MCOs report increases in rural and frontier utilization. PHP had a decrease in rural utilization from DY4Q4 to DY5Q1, however PHP reported an increase in urban and frontier utilization. MHC reported increased utilization among urban, rural and frontier. BCBS reported the use of telemedicine for dermatology and optometry (eye exams) visits and indicated that they would like to see an increase in eye exams being done through telemedicine especially for diabetic screening. MHC remains dedicated to educating providers on beginning a telemedicine program and resolving claims issues brought forward by telemedicine providers. Additionally, MHC works closely with their care coordinator staff to inform them of providers who utilize telemedicine so that they can also inform members. PHP's telemedicine interventions include provider education regarding accurate coding of telemedicine services. PHP offers technical assistance to providers who are interested in delivering services via telemedicine. UHC informs members of the options available for telemedicine through originating sites and virtual visit technology. UHC marketing activities include educating members and training providers on the benefits of telehealth.

Table 4 - Telemedicine Services

DY5 Q1			
Behavioral Health			
	Urban	Rural	Frontier
BCBS	287	506	135
MHC	596	1,120	234
PHP	1,338	1,587	801
UHC	219	619	107
TOTAL	2,440	**3,832**	**1,277**

Source: [MCO] Telemedicine DSIPT, Q1CY18

*Urban numbers are for data collection only and do not count towards DSIPT goal.

Transportation

In DY5 Q2, HSD monitored the administration of the non-emergency medical transportation benefit provided under managed care. HSD requires MCOs to monitor adequate access to safe and timely transportation services while ensuring the benefit is appropriately utilized for medically necessary services. MCOs monitor transportation grievances as part of their subcontractor oversight activities. MCOs work with transportation subcontractors to address

issues resulting in grievances. For additional detail regarding transportation grievances, please see Section XII: Consumer Issues – Complaints and Grievances.

Provider Network

New Mexico's documented provider shortage in several specialty areas remain consistent with previous quarters. However, during the reporting period, PHP expanded system-wide provider capacity for difficult to recruit and retain clinical professionals, particularly in rural areas. This effort specifically focuses on traditionally difficult to recruit and retain provider specialists, who are currently out-of-state, and will be *new* as New Mexico providers. For an expanded description of this initiative, please refer to Section VI: PHP Initiatives.

Service Delivery

Utilization Data

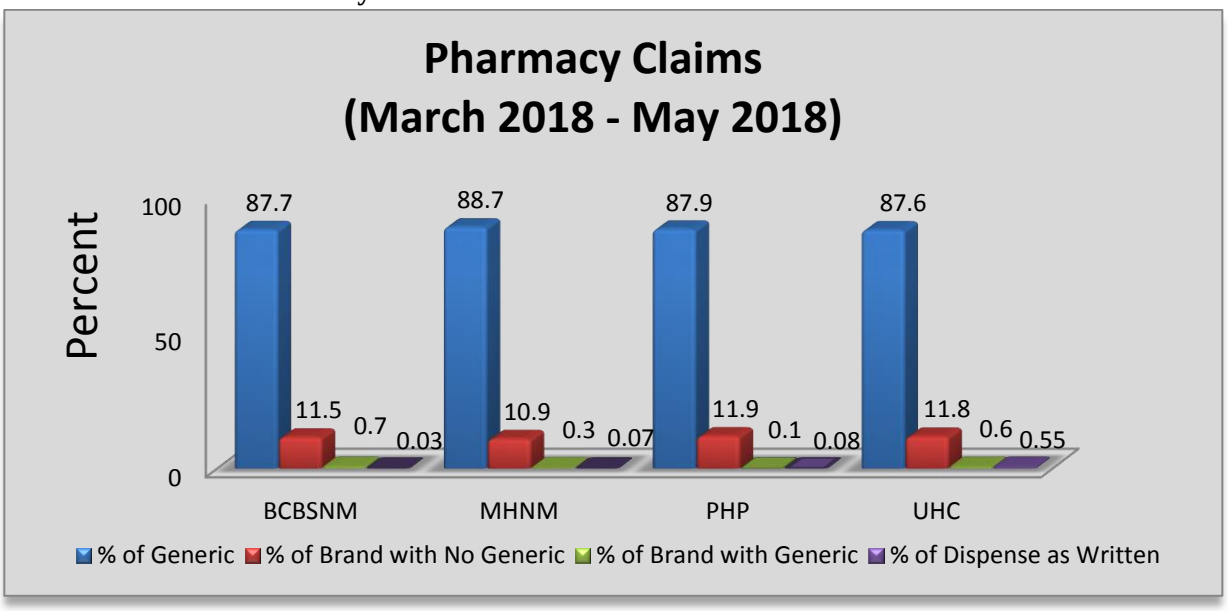
Centennial Care key utilization and cost per unit data by programs m is provided for April 2016 through March 2018. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

HSD reviews and monitors key metrics in monthly MCO pharmacy reports regarding prescription claims on brand and generic drugs (Please see Table 5 – Percent of Pharmacy Claims for each MCO). This reporting period showed an average generic drug usage for all four MCOs of 88% and is consistent with the previous reporting period. In comparison to the last quarter, HSD identified the following:

- Of the MCOs, BCBS and MHC had a slight decrease of 0.2% in generic drug utilization while the other two, PHP and UHC, had a slight increase in generic drug utilization from the previous quarter.
- BCBS and MHC, had a slight increase in usage of brand drugs with no generic available, while PHP and UHC had a slight decrease since the last reporting period in the usage of brand drugs with no generic available.
- The overall usage of brand medication when there was no generic available averaged at 11.5% for the current reporting period with no change from the previous reporting.
- All MCOs require medical justification for the use of a brand drug when there is a generic available. Dispense as Written (DAW) claims averaged at 0.18% with UHC having the highest number of DAW claims paid at 0.55%.

Table 5 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M3CY18, M4CY18, M5CY18

Hepatitis C (HCV)

During DY5 Q2, HSD reviewed MCO Q1CY5 data submitted on the revised HCV delivery system improvement performance target (DSIPT) reporting template. As reported in Q1, the revised reporting cycle transitioned from a monthly report to a quarterly report and captures both qualitative and quantitative data related to the requirements set forth in a Letter of Direction (LOD) issued in DY4 Q4. HSD is monitoring the number of unduplicated number of members requesting HCV treatment for DY5 Q1 as well as similar numbers for direct antiviral agent prescription approvals and dispensing by both members' liver fibrosis stages and HCV genotypes.

In DY5 Q1, BCBS partnered with Tricore labs to identify members receiving confirmatory testing for HCV and provided this list of members to their care coordination team for outreach. BCBS is also running internal lab data to identify members with confirmatory HCV labs. Also, BCBS established a relationship with the Department of Health to discuss data sharing, which will assist in additional case findings. To implement care coordination services and HCV linkage to care when incarcerated members are released, BCBS began discussions with the NM Department of Corrections. BCBS has annual reminders for providers and members about HCV screening and the importance of HCV treatment.

PHP developed a comprehensive plan to expand HCV screening efforts that includes:

- Utilization of demographic/geographic mapping to identify underserved HCV dense areas;
- Health fairs scheduled for 2018 and 2019 to include onsite rapid HCV testing;
- Training seminar to educate CHWs and care coordinators on current screening guidelines;

- Development of screening questions for care coordinators as they interview incarcerated patients nearing release from New Mexico prisons; and,
- Electronic medical record notifications alert providers and identify high risk age group populations to provide recommend testing procedures.

An HCV screening training packet has been created and will be distributed to PHP contracted providers. PHP has also established a provider incentive program, which is anticipated to be implemented in Q2 or Q3. The MCO will pay an incentive for providers who receive HCV training through UNM Project ECHO, initiate treatment for HCV positive members, or complete treatments for HCV positive members.

Nursing Facilities (NFs)

In DY5 Q2, HSD continued to monitor the MCOs' efforts to address nursing facility (NF) claims issues. HSD also continued to work with Myers and Stauffer on the claims payment audit for NFs.

Community Interveners

In DY5 Q1, three Centennial Care members received Community Intervener (CI) services as illustrated below. The MCOs provided education to their care coordinators to assist in identifying members that meet the criteria for the CI service. The MCOs also provided assistance to CI providers when needed regarding billing issues. Please see Table 6 – Community Intervener Services Utilization DY5 Q1.

Table 6 – Community Intervener Services Utilization DY5 Q1

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBS	1	4	$25
MHC	0	0	$0
PHP	1	49	$1,231
UHC	1	172	$1,075
Total	**3**	**225**	**$2,331**

Source: [MCO] Utilization Management Report #41, Q1CY18

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date, 683,228 distinct members, or 69% of all enrollees, have earned at least one reward. Since the launch of Centennial Rewards, members have earned points totaling a value of $57.6 million. Points expire at the end of the year after the year in which they were earned. Table 7 shows the healthy behaviors rewarded and each behavior's value. It includes the maximum dollar value available for each activity, the total dollars earned.

Table 7 – Healthy Behaviors Rewarded

Eligibility Activities	Reward Value in Points, by Activity	Reward Value in $, by Activity	Total Rewards Earned by Activity in $
Asthma Management	600	$60	$ 39,495
Bipolar Disorder Management	600	$60	$ 69,275
Bone Density Testing	350	$35	$ 3,675
Healthy Smiles Adults	250	$25	$ 605,475
Healthy Smiles Children	350	$35	$ 1,590,925
Diabetes Management	600	$60	$ 343,500
Healthy Pregnancy	1000	$100	$ 99,300
Schizophrenia Management	600	$60	$ 39,865
Health Risk Assessment (HRA)	100	$10	$ 380
Other (Appeals and Adjustments)	N/A	N/A	$ 26,830
Step-Up Challenge	250	$25	$ 52,275
Totals	**N/A**	**N/A**	**$ 2,870,995**

Section III: Enrollment

Centennial Care enrollment indicates a decrease in enrollment in all populations except SSI and Related Dual and 217 Like Group Dual with the Expansion population remaining stable. Most of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in Table 8 – Enrollment DY5 Q2 below.

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

Table 8 – Enrollment DY5 Q2

Demonstration Population	Total Number Demonstration Participants DY5 Q2 Ending June 2018	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**370,175**	**471,999**
FFS	43,113	66,569
Molina	115,566	149,875
Presbyterian	119,086	145,707
UnitedHealthcare	27,868	33,878
Blue Cross Blue Shield	64,542	75,970
Population 2 – SSI and Related – Medicaid Only	**38,724**	**44,527**
FFS	2,526	4,152
Molina	11,659	13,523
Presbyterian	12,556	13,644
UnitedHealthcare	5,139	5,856
Blue Cross Blue Shield	6,844	7,352
Population 3 – SSI and Related – Dual	**36,075**	**39,510**
FFS	0	274
Molina	7,108	7,863
Presbyterian	6,985	7,540
UnitedHealthcare	15,057	16,431
Blue Cross Blue Shield	6,925	7,402
Population 4 – 217-like Group – Medicaid Only	**374**	**528**
FFS	106	227
Molina	54	57
Presbyterian	56	75
UnitedHealthcare	100	104
Blue Cross Blue Shield	58	65
Population 5 – 217-like Group - Dual	**3,895**	**3,777**
FFS	0	33
Molina	805	835
Presbyterian	731	714
UnitedHealthcare	1,484	1,402
Blue Cross Blue Shield	875	793
Population 6 – VIII Group (expansion)	**273,093**	**286,598**
FFS	29,379	38,840
Molina	72,324	75,036
Presbyterian	69,832	67,343
UnitedHealthcare	38,168	41,226
Blue Cross Blue Shield	63,390	64,153

Disenrollments

The definition of disenrollment is when a member was enrolled in Centennial Care at some point in the prior quarter and disenrolled at some point during that same quarter or in the reporting quarter and did not re-enroll at any point in the reporting quarter. Members who switch MEGs are not counted as disenrolled. The majority of disenrollments are attributed to loss of eligibility and death. Please see Table 9 – Disenrollment Counts DY5 Q2.

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

Table 9 – Disenrollment Counts DY5 Q2

Disenrollments	Total Disenrollments During DY5 Q2
Row Labels	
Population 1 – TANF and Related	**7,787**
FFS	921
Molina	2,384
Presbyterian	2,146
UnitedHealthcare	773
Blue Cross Blue Shield	1,563
Population 2 – SSI and Related – Medicaid Only	**352**
FFS	29
Molina	103
Presbyterian	96
UnitedHealthcare	54
Blue Cross Blue Shield	70
Population 3 – SSI and Related – Dual	**562**
Molina	123
Presbyterian	123
UnitedHealthcare	191
Blue Cross Blue Shield	125
Population 4 – 217-like Group – Medicaid Only	**4**
FFS	1
Molina	2
Presbyterian	1
UnitedHealthcare	0
Blue Cross Blue Shield	0
Population 5 – 217-like Group - Dual	**67**
Molina	10
Presbyterian	21
UnitedHealthcare	22
Blue Cross Blue Shield	14
Population 6 – VIII Group (expansion)	**9,254**
FFS	1,147
Molina	2,430
Presbyterian	2,303
UnitedHealthcare	1,259
Blue Cross Blue Shield	2,115
TOTAL	**18,026**

Section IV: Outreach

In DY5 Q2, HSD Outreach and Education staff participated in a variety of outreach activities and events:

- Centennial Care overview to the NM Aging & Long-Term Services Department, Adult Protective Services Division call-center.
- Participated in the annual Mental Health Awareness Day and Community Health Fair. More than 1,000 community members attended, and many were provided with information regarding behavioral health services, long-term care services, and the Centennial Care Rewards program.
- Participated in the Gallup, NM Woman's Health Fair and provided Medicaid program information and answered a variety of Medicaid related questions.

All four MCOs participated in a wide variety of community events across the state providing enrollment opportunities and educating the public about Centennial Care. MCOs attended numerous Medicaid enrollment events, health fairs and community events. Attendees included people with disabilities, senior citizens, children and families, Native Americans, and other populations. Please see Table 10 – Schedule of Community Events DY5 Q2.

Table 10 - Schedule of Community Events DY5 Q2

Event Type	Event Location and Date	Audience and Topics
NM Aging & Long-Term Services Dept. – Adult Protective Services	Albuquerque, NM Tuesday 4/4/18	NM Adult Protective Services requested a Centennial Care overview presentation for their new employees during their annual state-wide APS training for the call center staff.
2018 Mental Health Awareness Day	Albuquerque, NM Downtown Civic Plaza Tuesday May 22, 2018	Sponsored by the City of Albuquerque and Bernalillo County. HSD provided Medicaid program information and answered a variety of Medicaid related questions.
Women's Health Fair	Gallup, NM Saturday 6/9/18	NM Rep. Lundstrom requested HSD Outreach and Applicant enrollment assistance at the Gallup Women's Health Fair. HSD provided Medicaid program information and answered a variety of Medicaid related questions.

Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's outreach efforts. With over 505 active certified Presumptive Eligibility Determiners (PEDs) state-wide, Medicaid application assistance is available in even the most remote areas of the state.

PEDs are employees of participating hospitals, clinics, FQHCs, IHS Facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some NM State

Agencies (NM Department of Health, NM Children Youth and Families Department and the NM Department of Corrections).

In DY5 Q2, HSD PE Program staff conducted PED refresher trainings on "Non-Citizen/Immigrant Eligibility". The trainings ensure that all PEDs have the most up to date information regarding the NM PE Program. All PEDs were required to complete a training session in DY5 Q2 to retain their PE certifications. Those who did not complete the PED refresher training were suspended until a full PED certification training is completed.

PEDs continue to provide application assistance state-wide. In DY5 Q2, PEDs:

- Granted **491** PE approvals*
- Submitted applications for **4,928** individuals
- Which resulted in **4,247** ongoing Medicaid approvals

*84.73% of all PEs granted in this reporting period also had an ongoing application submitted

JUST Health Program

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

The JUST Health programs allows for the automated data transfer of information regarding the incarceration status of individuals in New Mexico. Individuals who are Medicaid-enrolled have their benefits suspended after 30 days of incarceration. Benefits are reinstated upon the individual's release from incarceration, which allows immediate access to care. Individuals who are not Medicaid participants, but who appear to meet eligibility requirements are given the opportunity to apply. Application assistance is provided by PEDs at the correctional facilities.

JUST Health PEDs also participated in the "Non-Citizen/Immigrant" training that was developed in this reporting period.

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

Encounter Data

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

Enrollment Data

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

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

Program Development

HSD began revision of the Managed Care Policy Manual that will be effective January 1, 2019. This revision will add a new section to the policy manual to cover pharmacy. The addition will include direction and expectations on the implementation of the MCO's pharmacy benefit. Items covered in the pharmacy section include Preferred Drug List and Formulary Requirements; Treatment Guidance for Chronic Hepatitis C Virus (HCV) Infection, Community Pharmacy Reimbursement, MCO Participation in the Drug Utilization Review (DUR) Board and Submission of a DUR Annual Report, MCO requirements regarding the Drug Rebate Analysis and Management System (DRAMS) and drug rebate dispute resolution, and MCO Compliance with the Pharmacy Benefit Manager Regulation Act.

Behavioral Health

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

MCO Initiatives

Blue Cross and Blue Shield of New Mexico

As an additional component to the BCBS Community Paramedicine Program, BCBS has partnered with American Medical Response (AMR) to pilot the use of remote monitoring tools within the existing BCBS Community Paramedicine program.

Throughout this pilot, AMR has utilized a remote monitoring platform called Life365. Each member is provided with a Samsung Galaxy Tablet, which is pre-loaded with Life365 software. Using a Bluetooth connection, data is gathered through the member's assigned medical devices such as blood pressure cuffs, scales, pulse oximeters and blood glucose monitors. When vitals, blood pressure, weight, oxygen saturation and blood glucose readings are taken from these prescribed devices, the tablet will automatically receive the reading and then send to the community paramedic (CP).

This functionality allows for the CP to remotely monitor daily vitals including those that have not taken their vitals. The CP can log in anytime to view this information and reach out to members who may not be checking their vitals and provide a gentle reminder of the importance of regularly completing these vital checks.

Molina Healthcare

Molina carried out a wide range of innovative activities to identify, treat, and provide services to members with chronic Hepatitis C virus (HCV) infection: During this quarter Molina:

- Formalized a partnership with the Chronic Liver Disease Foundation to provide screening, laboratory testing, and treatment services to members at two Behavioral Health treatment facilities in Albuquerque and Santa Fe;
- Collaborated with the NM Department of Health for the secure exchange of member level information to increase the percentage of HCV Members receiving treatment;
- Collaborated with the NM Department of Corrections to establish HCV treatment options for members after discharge to ensure continuity of care;
- Linked HCV members with Community Health Workers, who provided information and resources for housing and transportation; and
- Expanded the number of practitioners treating chronic HCV with the execution of six provider incentive contracts.

Presbyterian Health Plan

New in DY5 Q2 is PHP's delivery system improvement plan to expand provider network capacity by attracting providers to relocate to New Mexico. Specific providers selected for recruitment are those who have been historically been difficult to recruit and retain. PHP's areas of focus include: behavioral health – addiction medicine; allergy/asthma specialists; pediatric subspecialties; dermatology; and primary care physicians in rural areas. In an effort to increase provider capacity, PHP's strategies include, but are not limited to: growing the workforce via an accredited educational fellowship with academic sponsorship for behavioral health specialties; offering provider incentives such as quality specialty pay; reimbursing travel expenses for providers in active recruitment; increasing attendance for PHP recruiters to conferences held for specific specialties; and, training PCPs in asynchronous dermatology visits which encompass services that are amenable to treatment that are now beyond the scope of primary care. PHP developed measures to quantify system-wide access improvements for new to New Mexico providers.

Other new innovations include the design and implementation of Small Group PCMHs (Patient Centered Medical Homes). PHP is developing a small group of PCMHs for providers with membership of a minimum of 1,000 members or less. The Standard PCMH is for 2,000 members or more. PHP is also developing an offering of Native American Health and Wellness Services for I/T/Us, IHS 638 Tribal facilities and providers. This offering will include services such as traditional herbal remedies, sweat lodge groups, and drumming circles.

Previously reported was the PHP and Isleta Presbyterian Medical Group (PMG) Clinic collaboration to develop a community health worker (CHW) pilot with the Pediatric, Internal Medicine and Family Practice clinics. This pilot is proving successful in connecting with PHP Centennial Care members who are seen at the PMG Isleta clinic. The CHW can connect with multiple family members at once to see how PHP can best meet the social determinants of health needs of the family. In the month of May, the CHW touched 176 individuals representing 79 different homes by meeting with them during their visits to the clinic. The CHW connected

members with food and housing resources as well as assisted with translation services and completing forms for community services. The staff at the clinic acknowledges the valuable resources the CHW brings to the team. PHP is training other CHWs to provide back up for this valuable resource.

Other notable updates from previously reported initiatives and innovations are as follows:

- PHP's partnership with CYFD and All Faiths to deliver WRAP around services for the targeted population has resulted in decreased lengths of stay for those members seeking out of home care through the involvement of the WRAP team.

- PHP's Helping to Engage and Link to Providers (HELP) team's engagement techniques for members who have been difficult to reach or engage in care coordination has resulted in a 30% decrease of members that PHP was previously unable to engage from November 2017 to June 2018.

The most recent Town Hall Efforts, which occur quarterly and where PHP's Provider Network Management meet with providers throughout the state for a variety of trainings and discussion, continues with an addition of webinar availability. The most recent webinar was June 19 with 35 participants and June 21 with 33 participants. The quarter three Town Hall is scheduled for the northern region of New Mexico.

UnitedHealthcare

UHC executed Value Based Contracts with several Behavioral Health providers. UHC is engaged with the NM Hospital Association's new VBC Task Force. Teams from UHC including contracting, health services, quality, and others are partnering with this Task Force, which in turn is working with the state's hospitals to develop competencies to shift toward VBC.

UHC assisted 2,316 members at statewide Member Days, Resource Center in Shiprock, and at Storefronts in Gallup and Las Cruces. The prevalent touchpoints and inquiries involved completion of HRAs, assistance with scheduling transportation, mileage reimbursement requests, and fulfillment of Value Added Benefits. In Q2, UHC also launched its Haircuts for the Homeless project, providing over 540 haircuts across Bernalillo County at community shelters which include the Albuquerque Indian Center, HopeWorks, and Albuquerque Hope & Recovery.

Fiscal Issues

During DY5 Q2, reconciliation payments and recoupments were made for IHS, retroactive eligibility, hepatitis C, patient liability and risk corridor for calendar years (CY) 2016 and 2017. The net effect of the patient liability reconciliations for CY 2016 is an increase in expenditures and affects the per member per month (PMPM) for Medicaid eligibility group (MEG) 2 of DY 3. For MEG 6, retroactive and risk corridor reconciliations result in a net decrease to the expenditure affecting PMPM for DY 3 and retroactive and hepatitis C reconciliations affect the PMPM for DY 4.

Systems Issues

HSD continues to implement reporting for analysis, monitoring and oversight which include encounter accuracy reports, a lag report for comparisons of financials (claims) to encounters, and MCO payment reconciliations reports. HSD and the MCOs work together to address any concerns or make any necessary system changes on either side. There is a process in place to identify, track, research and resolve any issues that may arise.

Medicaid Management Information System Replacement

HSD's planning for replacement of its current legacy Medicaid Management Information System (MMIS) began some time ago, and activity for this effort continued to progress in Q2. The replacement MMIS will be a true Enterprise system. HSD has actively engaged the Department of Health (DOH), Children Youth and Families Department (CYFD), and the Aging and Long-Term Services Department (ALTSD). These three departments have participated in RFP development and replacement planning. HSD is currently in the process of drafting a Governmental Service Agreement (GSA) with CYFD and is in the final stages of the GSA with ALTSD for qualifying activities to receive MMISR funding. The GSA with DOH has been approved.

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

The RFP for the second module, the Enterprise Data Services RFP, was released on April 17, 2017. HSD is currently in an active procurement process. Contract negotiations have been completed for Data Services and the contract is in the final stage for signature.

CMS has approved the RFP for the third module, Quality Assurance. The Quality Assurance RFP was released on March 16, 2018 and proposals came in on May 16, 2018. HSD is currently in an active procurement process to select a vendor.

HSD has begun development of the RFP for the fourth module, Benefit Management Services. This RFP involved meetings with all stakeholders, questionnaires for input, review of other states' procurements and contracts, as well as information from the current fiscal agent contract for requirements gathering. CMS has approved this RFP.

Work continues with the development of the RFP for the fifth module, Financial Services. Some work with stakeholders, questionnaires, and requirements gathering from other states has been initiated. Further work will be done as areas are identified that require additional input from stakeholders.

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

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

An Implementation Advanced Planning Document Update (IAPD-U) was submitted to CMS on June 5, 2018.

Section VII: Home and Community-Based Services

New Mexico Independent Consumer Support System (NMICSS)

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

The NMICSS reporting for the 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 public to access a variety of services, including state and federal benefits, adult protective services, prescription drugs, in-home and community-based care, housing, and caregiver support. The ADRC provides telephonic information, assistance, referrals and advocacy in those areas of daily living that will maximize personal choice and independence for seniors and adults with disabilities throughout New Mexico, as well as for their caregivers.

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

ALTSD provides quarterly reports to HSD including the ADRC Caller Profile Report and Care Transitions Program Data. Please see Table 11 – ADRC Call Profiler Report DY5 Q2 and Table 12 – ADRC Care Transition Program Report DY5 Q2 below.

Table 11 – ADRC Call Profiler Report DY5 Q2

Topic	# of Calls
Home/Community Based Care Waiver Programs	2,825
Long Term Care/Case Management	7
Medicaid Appeals/Complaints	22
Personal Care	408
State Medicaid Managed Care Enrollment Programs	6
Medicaid Information/Counseling	1,580

Table 12 – ADRC Care Transition Program Report DY5 Q2

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		257	
Medicaid Education/Outreach	2,888		
Nursing Home Intakes		167	
**LTSS Short-Term Assistance			242

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

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

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

CTB reported an increase in Short Term Assistance (STA) referrals due to Centennial Care MCOs providing referrals for individuals transitioning from Medicaid to Medicare due to age or disability.

CTB managers participated in Presbyterian Health Care MCOs annual training. CTB staff trained care coordinators and other participants on Short Term Assistance, the ADRC and Care Transition Services. Approximately 300 Presbyterian employees were in attendance. CTB staff provided training to approximately 200 Blue Cross Blue Shield MCO staff to learn about the ADRC and CTB services and programs.

Critical Incidents

HSD continues to meet quarterly with the MCOs' Critical Incident workgroup to provide technical assistance. The workgroup also supports the Behavioral Health Services Division (BHSD) in the delivery of Behavioral Health (BH) incident reporting protocols to providers. BH protocols have been implemented by HSD/BHSD to improve reporting accuracy as well as establish guidelines for the types of BH providers who are required to report.

During DY5 Q2, a total of 5,823 Critical Incident Reports (CIRs) were filed for Centennial Care members in the areas of physical health, behavioral health, and self-directed community benefit services. One hundred percent of all CIRs received through the HSD Critical Incident web portal are reviewed. HSD continues to provide technical assistance to the MCOs when providers are non-compliant.

During DY5 Q2, a total of 431 deaths were reported. Of those deaths reported, 396 were reported as natural or expected deaths while 28 deaths were reported as unexpected and seven deaths were reported as suicides. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

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

During DY5 Q2, a total of 3,797 critical incidents were categorized as Emergency Services. Of those, 262 were reported by BH providers and 288 were associated with self-directed members. This demonstrates an upward trend in the number of incidents categorized as Emergency Services when compared to DY5 Q1 (3,685), DY4 Q4 (2,690), DY4 Q3 (2,692), DY4 Q2 (2,910) and DY4 Q1 (3,172). MCOs continue to identify the use of Emergency Services as the highest critical incident type reported by volume for members with a reportable category of eligibility. Please see Table 13 – Critical Incident Types by MCO – Centennial Care below.

Table 13 – Critical Incident Types by MCO – Centennial Care

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	51	1.04%	119	2.42%	88	1.79%	77	1.56%	335	6.81%
Death	95	1.93%	91	1.85%	83	1.69%	126	2.56%	395	8.03%
Natural/Expected	88		85		74		120		367	
Unexpected	6		3		9		6		24	
Suicide	1		3		0		0		4	
Elopement/Missing	4	0.08%	7	0.14%	11	0.22%	4	0.08%	26	0.53%
Emergency Services	502	10.20%	806	16.38%	1,141	23.19%	798	16.22%	3,247	65.98%
Environmental Hazard	3	0.06%	8	0.16%	16	0.33%	29	0.59%	56	1.14%
Exploitation	12	0.24%	23	0.47%	18	0.37%	52	1.06%	105	2.13%
Law Enforcement	11	0.22%	29	0.59%	15	0.30%	18	0.37%	73	1.48%
Neglect	116	2.36%	115	2.34%	272	5.53%	181	3.68%	684	13.90%
Total	**794**	**16.13%**	**1198**	**24.34%**	**1,644**	**33.41%**	**1,285**	**26.11%**	**4,921**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	5	0.95%	78	14.74%	36	6.81%	7	1.32%	126	23.82%
Death	2	0.38%	9	1.70%	2	0.38%	7	1.32%	20	3.78%
Natural/Expected	2		7		1		5		15	
Unexpected	0		0		1		2		3	
Suicide	0		2		0		0		2	
Elopement/Missing	3	0.57%	5	0.95%	3	0.57%	0	0.00%	11	2.08%
Emergency Services	13	2.46%	204	38.56%	34	6.43%	11	2.08%	262	49.53%
Environmental Hazard	0	0.00%	0	0.00%	2	0.38%	1	0.19%	3	0.57%
Exploitation	1	0.19%	1	0.19%	1	0.19%	0	0.00%	3	0.57%
Law Enforcement	2	0.38%	9	1.70%	4	0.76%	1	0.19%	16	3.02%
Neglect	10	1.89%	50	9.45%	18	3.40%	10	1.89%	88	16.64%
Total	**36**	**6.81%**	**356**	**67.30%**	**100**	**18.90%**	**37**	**6.99%**	**529**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	3	0.80%	10	2.68%	9	2.41%	6	1.61%	28	7.51%
Death	5	1.34%	2	0.54%	4	1.07%	5	1.34%	16	4.29%
Natural/Expected	4		2		4		4		14	
Unexpected	0		0		0		1		1	
Suicide	1		0		0		0		1	
Elopement/Missing	2	0.54%	1	0.27%	1	0.27%	0	0.00%	4	1.07%
Emergency Services	29	7.77%	54	14.48%	165	44.24%	40	10.72%	288	77.21%
Environmental Hazard	0	0.00%	0	0.00%	2	0.54%	1	0.27%	3	0.80%
Exploitation	1	0.27%	2	0.54%	2	0.54%	2	0.54%	7	1.88%
Law Enforcement	1	0.27%	0	0.00%	2	0.54%	3	0.80%	6	1.61%
Neglect	4	1.07%	3	0.80%	11	2.95%	3	0.80%	21	5.63%
Total	**45**	**12.06%**	**72**	**19.30%**	**196**	**52.55%**	**60**	**16.09%**	**373**	**100.00%**

Home and Community-Based Services Reporting
In DY5 Q2, HSD continued to compile and analyze the on-site validation and participant surveys with Community Benefit providers and members. HSD continues to update the Statewide Transition Plan milestones as required by CMS.

Long-Term Services and Supports (LTSS)
In DY5 Q2, HSD continued to conduct ride-alongs with the MCO care coordinators to observe and monitor care coordination interactions and interviewing practices. For more information regarding the ride-alongs, please see Section XIII – Quality Assurance/Monitoring Activities.

Self-Directed Community Benefit
In DY5 Q2, HSD continued to meet with PHP and monitor the quality and outcomes of transitioning all members to in-house Support Brokers and two external SB agencies.

Electronic Visit Verification
In DY5 Q2, HSD continued meetings with the MCOs and their EVV Vendor, First Data, for the planning of implementation of EVV for self-directed personal care services. The MCOs began to solicit member input thorough their regular Member Advisory Board meetings and sent information about EVV to their Support Brokers.

Section VIII: AI/AN Reporting

Access to Care
Indian Health Service, tribally operated facility/programs, and Urban Indian clinics (I/T/Us) are concentrated near or on Tribal land where many Native Americans live and receive services. Approximately 51,000 Native Americans are enrolled in Centennial Care. Data from the four Centennial Care MCOs shows for physical health and behavioral health there is 98% access to care for Native Americans in rural and frontier areas. This is a 5% increase for Physical and Behavioral Health from the previous quarter.

Contracting Between MCOs and I/T/U Providers
The MCOs continue to reach out to Indian Health Service (IHS) and Tribal 638 health providers, as well as Tribal programs to develop provider agreements. Some of the MCOs have contracts with Navajo Area HIS providers. Some of the MCOs consider services rendered at any non-contracted I/T/U as in network for members. There is ongoing outreach to I/T/U programs for reimbursement for telemedicine, peer support recovery programs, Community Health Representative (CHR) services, and non-emergency medical transportation. Some MCOs have been working with Tribal CHR programs to develop a process to reimburse them for their services to the MCO members.

Ensuring Timely Payment for All I/T/U Providers

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

Table 14 – Native American Advisory Board (NAAB) meetings for DY5 Q2

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Gallup Community Services Center Gallup, NM April 18, 2018	**Issue**: The question was asked if you lose your member ID card, can you get a new one? **Response**: You can call the toll-free number for BCBS and request a new card. (BCBS staff assisted member after the meeting.) **Issue:** What is the timeframe to call ahead for transportation? **Response:** You need to call 72 hours in advance to arrange transportation. **Issue:** Can this (Medicaid) insurance be used out of state? **Response:** Only in emergency situations. For other services, you will need to call Customer Service ahead of time because it might not be covered.
MHC	Zuni Wellness Center Zuni Pueblo, NM June 20, 2018	Members were informed that Molina Healthcare will continue to provide Medicaid coverage until the end of 2018 and that they were not selected to be a MCO under Centennial Care 2.0. **Issue:** A person asked how to get a care coordinator. **Response:** Molina explained the Health Risk Assessment (HRA) process and how a care coordinator gets assigned.
PHP	New Mexico Cancer Center Gallup, NM April 20, 2018	**Issue**: A member indicated he had trouble getting transportation to an appointment and ended up walking. **Response**: PHP made sure the member had the right number to call for future appointments. They also explained how to file a complaint if he chose to. **Issue:** A member asked how to change their enrollment status with Medicaid if they need to. **Response**: PHP replied they can call Conduent or go to their Patient Benefits Coordinator (PBC) at IHS.
UHC	Farmington Marriot Courtyard Farmington, NM June 7, 2018	UHC informed the group that they were not selected for Centennial Care 2.0 and are appealing the decision.

		However, they are operating business as usual in the meantime. **Issue**: Member had a comment about a transportation vendor not showing up on time and asked for the rules regarding an attendant going with the member to appointments. **Response**: Logisticare (transportation provider) went over the guidelines for members to bring an attendant with them to appointments.

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

The NATAC meeting took place on June 2018 and the following issues were discussed:

1. An update on the 1115 Waiver renewal with CMS;
2. HSD shared the Centennial Care 2.0 outreach events planned for the fall of this year;
3. An update on the federal match for services received through an I/T/U; and
4. Various data regarding Native Americans in managed care were presented.

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

- **Albuquerque Area IHS (AAIHS) and the University of NM Hospital (UNMH)**
  UNMH and AAIHS completed testing of transmission of referrals, discharge documents and claims submissions with the attachment code. UNMH began submitting claims with the attachment code in April.
- **Navajo Area IHS (NAIHS) and the University of NM Hospital (UNMH)**
  The NAIHS Care Coordination Agreement (CCA) is being reviewed by legal at UNMH. UNMH is working with Navajo Area to have a similar data exchange system to what was implemented with Albuquerque Area IHS. UNMH has received a list of service units within the Navajo Area.
- **Albuquerque Area IHS (AIHS) and Presbyterian Healthcare Services (PHS)**
  PHS is awaiting signatures on the CCA from AAIHS legal department for Amendment 1. The Amendment adds all PHS providers in New Mexico to the CCA. The referral process is in place as well as the discharge report back to the referring IHS provider.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment F: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY5 Q2 reflects the CY 2018 rates as provided to the Centers for Medicare and Medicaid Services (CMS) on January 4, 2018. The PMPM for DY 5 is lower compared to DY 4 for MEGs 1 to 4; the PMPM for DY 5 is higher than those of DY 4 for MEGs 6 (see Attachment A: Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A: Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY 5 is 31.9% below the budget neutrality limit (Table 5.4) based on two quarters of payments.

Section XI: Member Month Reporting

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

Table 15 – Member Months DY5 Q2

Number of client by Population Group and MC	
	2018
	Q2
Population 1 – TANF and Related	**1,105,849**
FFS	125,983
MC	
Molina	347,511
Presbyterian	358,301
UnitedHealthcare	82,648
Blue Cross Blue Shield	191,406
Population 2 – SSI and Related – Medicaid Only	**115,667**
FFS	7,597
MC	
Molina	34,786
Presbyterian	37,428
UnitedHealthcare	15,424
Blue Cross Blue Shield	20,432
Population 3 – SSI and Related – Dual	**105,964**
MC	
Molina	20,799
Presbyterian	20,485
UnitedHealthcare	44,421
Blue Cross Blue Shield	20,259
Population 4 – 217-like Group – Medicaid Only	**1,096**
FFS	313
MC	
Molina	155
Presbyterian	165
UnitedHealthcare	301
Blue Cross Blue Shield	162
Population 5 – 217-like Group - Dual	**11,267**
MC	
Molina	2,348
Presbyterian	2,098
UnitedHealthcare	4,316
Blue Cross Blue Shield	2,505
Population 6 – VIII Group (expansion)	**758,307**
FFS	78,411
MC	
Molina	202,108
Presbyterian	193,880
UnitedHealthcare	107,031
Blue Cross Blue Shield	176,877

Section XII: Consumer Issues – Complaints and Grievances

A total of 850 grievances were filed by Centennial Care members in DY5 Q2. This presents a slight decrease when compared to member grievances received in DY5 Q1 (891). An overall trend cannot be established when compared to DY4 Q4 (871), Q3 (1,184) Q2 (1,058) and Q1 (968).

Non-emergency ground transportation continues to constitute the largest member grievance code reported with 442 (52%) of the total grievances received. This presents an increase when compared to 414 in DY5 Q1. An overall upward trend is demonstrated when compared to DY4 Q4 (414), Q3 (487), Q2 (332) and Q1 (274). Transportation Grievances in Section II of this report provides the MCOs' efforts to address transportation grievances under the guidance of HSD.

Other Specialties was the second top member grievance code filed with a total of 51 (6%) grievances. An overall downward trend is demonstrated when compared to DY5 Q1 (101), DY4 Q4 (45), Q3 (61), Q2 (84) and Q1 (109).

There were 357 (42%) variable grievances filed during DY5 Q2. Of those, each MCO reported unique grievances that do not provide data to establish a trend. HSD is monitoring these grievances to identify specific trends. Please see Table 16 – MCO Grievances DY5 Q2 below.

Table 16 – MCO Grievances DY5 Q2

MCO Grievances DY5 Q2 (April - June 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	247	29.06%	176	20.71%	178	20.94%	249	29.29%	**850**	100.00%
Top Two Prmary Member Grievance Codes										
Transportation Ground Non-Emergency	167	19.65%	40	4.70%	104	12.24%	131	15.41%	**442**	52.00%
Other Specialties	23	2.71%	0	0.00%	0	0.00%	28	3.29%	**51**	6.00%
Variable Grievances	57	6.70%	136	16.00%	74	8.71%	90	10.59%	**357**	42.00%

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD randomly reviews service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures that the MCOs appropriately allocate and implement the services identified in the member's Comprehensive Needs Assessment (CNA), and that the member's goals are identified in the care plan. There were no identified concerns in DY5 Q2. Please see Table 17 – Service Plan Audit Results DY5 Q2 below.

Table 17 – Service Plan Audit Results DY5 Q2

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

NF LOC

HSD reviews Nursing Facility High LOC denials and community benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria. Please see Table 18 – Nursing Facility LOC Audit Results DY5 Q2 below and Table 19 – Community Benefit NF LOC Audit DY5 Q2.

Table 18 – Nursing Facility LOC Audit Results DY5 Q2

MCO High NF LOC denied requests (downgraded to Low NF)	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	**15**	**12**		
BCBS	**5**	**4**		
MHC	**0**	**0**		
PHP	**5**	**5**		
UHC	**5**	**3**		
HSD Reviewed Results	**DY5 Q1**	**DY5 Q2**	**DY5 Q3**	**DY5 Q4**
Number of member files that met the appropriate level of care criteria	**15**	**12**		
BCBS	**5**	**4**		
MHC	**0**	**0**		
PHP	**5**	**5**		
UHC	**5**	**3**		
Percent of MCO level of care determination accuracy	**100%**	**100%**		

Table 19 – Community Benefit NF LOC Audit DY5 Q2

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

HSD agreed with all NFLOC decisions for DY5 Q2; however, three of the files submitted for review were outside of the sample criteria. Of the five sample files submitted by UHC for High NF, two did not qualify as a High NF Level of Care request. Additionally, one of the five samples submitted by BCBS did not qualify as a HNF Level of Care request. HSD will continue to follow up with the MCOs to ensure that selected samples match requested criteria for future audits. MHC did not have any HNF denials in Q2 and an additional five files for Community Benefit were reviewed. All NFLOC decisions were appropriate and complied with NFLOC criteria.

External Quality Review Organization (EQRO) NF LOC

The EQRO for HSD reviews a random sample of MCO NF LOC determinations every quarter. Please see Table 20 – EQRO NF LOC Review Results DY5 Q2 below.

Table 20 – EQRO NF LOC Review Results DY5 Q2

Facility Based	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
High NF Determination				
Number of member files audited	**23**	**22**		
BCBS	4	3		
MHC	7	6		
PHP	7	11		
UHC	5	2		
Number of member files the EQRO agreed with the determination	**22**	**22**		
BCBS	3	3		
MHC	7	6		
PHP	7	11		
UHC	5	2		
%	**96%**	**100%**		
BCBS	75%	100%		
MHC	100%	100%		
PHP	100%	100%		
UHC	100%	100%		
Low NF Determination				
Number of member files audited	**85**	**106**		
BCBS	23	29		
MHC	20	26		
PHP	20	21		
UHC	22	30		
Number of member files the EQRO agreed with the determination	**85**	**101**		
BCBS	23	29		
MHC	20	25		
PHP	20	21		
UHC	22	26		
%	**100%**	**95%**		
BCBS	100%	100%		
MHC	100%	96%		
PHP	100%	100%		
UHC	100%	87%		
Community Based				
Number of member files audited	**156**	**176**		
BCBS	39	44		
MHC	39	44		
PHP	39	44		
UHC	39	44		
Number of member files the EQRO agreed with the determination	**152**	**176**		
BCBS	39	44		
MHC	39	44		
PHP	39	44		
UHC	39	44		
%	**97%**	**100%**		
BCBS	100%	100%		
MHC	100%	100%		
PHP	90%	100%		
UHC	100%	100%		

MCO High NF determinations improved to 100% in DY5 Q2 for EQRO agreement for determinations. The Low NF determinations decreased from 100% in DY5 Q1 to 95% for EQRO

agreement in Q2. Community Based determinations improved in DY5 Q2 to 100% for EQRO agreement, an improvement from 97% in DY5 Q1. Only two of the MCOs, MHC and UHC, had denial determinations in DY5 Q2. HSD reviewed the NF LOC determination disagreements from EQRO audits for DY5 Q2 and agreed with the EQRO findings. Issues identified included conflicts in documentation and information outside of the expected date range. HSD will follow up with the MCOs regarding the identified cases and will continue to provide technical assistance as needed.

Additionally, HSD reviewed five NF LOC determination disagreements for DY5 Q1 with the MCOs, four for PHP and one for BCBS. HSD requested clarification for discrepancies identified in audit documentation, status updates on the identified members, and plans to improve the accuracy of determinations.

BCBS provided clarification for one identified discrepancy on the member's notification form which indicated LNF while supporting documentation indicated HNF. Per BCBS, an incorrect notification form was inadvertently provided for this audit. The corrected form was sent by the MCO to the facility but was not included with the submitted audit documentation. BCBS noted that the member's file has the correct notification form that was submitted to the facility on file and provided a copy to HSD with their clarification. BCBS stated that they have updated their internal job aids to ensure that any communications have the correct approval information and accurate communications are submitted.

PHP also provided clarification for four identified discrepancies in member files and provided status updates for the members. For the four files, information regarding Activities of Daily Living (ADL) deficits from the CNA did not match information in supporting documentation provided in the audit packet which indicated additional ADL deficits. PHP noted that these documents provided additional detail regarding ADLs. Per PHP, the NFLOC Supplemental Assessment and NFLOC Summary provided further clarification of ADL deficits due to the members' health condition and based on this additional information, PHP found that these members met NF LOC criteria.

PHP noted that their NF LOC Summary Note and NF LOC Supplemental Assessment are not embedded within the Comprehensive Needs Assessment (CNN). The NF LOC Summary Note and NF LOC Supplemental Assessment are conducted after the CNA and are designed to detail the member's functional needs in relation to their deficits in Activities of Daily Living. As such, not all the information pertaining to the member's functional limitations is provided at the time the Care Coordinator is documenting within the CNA.

PHP stated that they will continue to summarize all objective observations and member's statements from the CNA, NFLOC Summary Note and NFLOC Supplemental Assessment within their Reviewer template, ensuring that all documentation is comprehensive and cohesive to validate that the member will meet NF LOC. PHP also noted that they will provide further training to all staff to ensure that correct documentation is entered within all assessments.

HSD will continue to monitor the EQRO audit of MCO NF LOC determinations and identify and address any trends and provide technical assistance as needed.

Care Coordination Monitoring Activities

Care Coordination Audits

HSD continues to evaluate the MCO internal action plans and conducted technical assistance calls with MCOs in DY5 Q2 to assist them in understanding what specific points of compliance HSD is requesting. MHC has reported three quarters of over 85% completion rate for back-up and disaster planning. BCBS has met requirements for 2 consecutive quarters addressing its transition of care plans for nursing home to community transitions as well as conducting timely home assessments after discharge. In addition to MCOs auditing member files for transition of care documentation and care coordination level determinations, HSD added Action Steps in DY5 Q2 to monitor member files for compliance with consistency in CNA and comprehensive care plan (CCP) timeliness and member participation.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top Emergency Department (ED) utilizers for each MCO. Originally this project included 35 members from each MCO. Over the past 35 months, some members have lost Medicaid eligibility or are no longer with the MCO, leaving 87 active members in the project. HSD monitors the efforts by care coordinators to engage members, provide alternatives to excessive ED usage and connect members with needed services. HSD tracks the number of ED visits and reviews next steps to reduce the incidence of ED visits and how supplemental community assistance can complement the services provided by the care coordinator. HSD has seen a decrease in ED use among project participants ranging from a 26% decrease among BCBS and UHC members to 34% decrease for PHP members and a 61% decrease from MHC members. HSD has observed that all MCOs have gone beyond standard contract-required touchpoints to address the members' needs including housing assistance, peer support, nutritional needs assistance, treatment center admissions and collaboration with both internal and external partners. For example, one member had 50 ED visits in a previous quarter. With the added support of care coordination and housing arrangements, this member now has a PCP and has reduced use of the ED to 10 ED visits in the most recent quarter. Other members, with the extra support of their care coordinators, have shown a vast decline in ED usage, engaged with peer support and community connectors and communicated to their care coordinators that their outlook has significantly improved.

Care Coordination and EDIE

The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016 with a total of 37 hospitals currently participating in the program statewide, 31 of which are complete and fully integrated. Three more are progressing forward to a completion date in DY5. EDIE allows the

MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical metadata. Because of the notification, the provider has information in hand before seeing the patient. This allows the provider to take action and to influence health care outcomes. Due to the increased use of EDIE, MCOs have reported they are gathering data that has allowed them to better assist those members utilizing the ED, rapidly engaging those members with emergent needs and connecting difficult to engage members with care coordinators. Care coordinators participating in the Care Coordination Super Utilizer Project, have reported building relationships with ER staff that assist them in recognizing those members receiving care coordination. Onsite visits to 26 of the 31 completed hospitals have occurred with targeted training, refreshers, technical assistance and support. Targeted training of MCO staff is being developed and technical issues are being addressed.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY5 Q2, HSD staff attended "ride-alongs" with MHC and BCBS. HSD specifically focused on members receiving Home and Community Based waiver services and utilizing self-direction as their setting of care. During both "ride-alongs", HSD staff observed open, patient, empathetic and professional care coordinators using a member-centric process to conduct annual CNAs. HSD staff observing the CAN process noted a team approach with guardians, support brokers, caregivers and family members. HSD observed that care coordinators were in compliance with contract requirements including the administration of the Community Benefit Services Questionnaire (CBSQ).

Section XIV: Managed Care Reporting Requirements

Customer Service

In DY5 Q2, all MCOs met call center metrics (abandonment rate, speed of answer and wait time) for customer services lines, member services, provider services, nurse advice line and the utilization management line. Please see Attachment G: Customer Service Summary.

MCO Reporting

During DY5 Q2, each of the four MCOs had Technical Assistance (TA) Calls with HSD subject matter expects and submitted Self-Identified Error Resubmission (SIER) requests for report corrections. Both the TA Calls and the submission of the SIER's allow HSD and MCO Subject Matter Experts (SMEs) to provide clarification and direction for MCO reporting inaccuracies. Reports from MCOs in Q2 have been timely and HSD continues to see a decline in MCOs report extension requests, with no extension requests made for DY5 Q1 reports.

Report Revisions

During DY5 Q2, HSD subject matter experts continue to collaborate with Mercer and the MCO's to make report revisions to select reports. There are currently 23 reports that are being revised in preparation for Centennial Care 2.0. HSD revises reports to streamline elements, improve monitoring, and incorporate requirements of the managed care final rule.

Member Appeals

A total of 944 member appeals were filed by Centennial Care members in DY5 Q2. Although this demonstrates an increase when compared to 869 in DY5 Q1, an overall trend cannot be established when compared to member appeals received in DY4 Q4 (876), Q3 (1,043), Q2 (1,000) and Q1 (1,013). Of those 944 appeals, 834 (88.34%) were standard member appeals and 110 (11.65%) were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner.

Denial or limited authorization of a requested service remains the top member appeal code reported with 758 (80.30%) of the total appeals received. Although this presents an increase when compared to 716 in DY5 Q1, an overall downward trend is demonstrated when compared to DY4 Q4 (697), Q3 (834), Q2 (822), and Q1 (873).

Reduction of a previously authorized service was the second top member appeal code with a total of 49 (5.19%) member appeals. This demonstrates a decrease when compared to 61 in DY5 Q1, an overall downward trend is demonstrated when compared to DY4 Q4 (54), Q3 (79), Q2 (110), and Q1 (81) in DY4.

There were 137(14.51%) variable appeals in DY5 Q2. Of those, each MCO reported unique appeals during the quarter that do not provide enough information to establish a trend. All MCOs have complied with the policies and procedures regarding members' exhaustion of the Grievance

and Appeal System prior to requesting a State Fair Hearing. Please see Table 21 – Member Appeals DY5 Q2 below.

Table 21 – Member Appeals DY5 Q2

MCO Appeals DY5 Q2 (April - June 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	122	12.92%	212	22.46%	359	38.02%	141	14.94%	**834**	88.35%
Number of Expedited Member Appeals	59	6.25%	4	0.42%	5	0.53%	42	4.45%	**110**	11.65%
Total	181	19.17%	216	22.88%	364	38.56%	183	19.39%	**944**	100%
Top Two Primary Member Appeal Codes										
Denial or limited authorization of a requested service	143	15.15%	167	17.69%	319	33.79%	129	13.67%	**758**	80.30%
Reduction of a previously authorized service	0	0.00%	49	5.19%	0	0.00%	0	0.00%	**49**	5.19%
Variable Appeals	38	4.02%	0	0.00%	45	4.77%	54	5.72%	**137**	14.51%
Empty Variables									**0**	0.00%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continued in DY5 Q2. Activities conducted during this quarter were devoted to DY4 data collection for review and analysis to be included in the Final Evaluation Report. Deloitte and HSD discussions focused on the development of timelines, measure-specific reporting methodologies, and data source changes.

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

Preliminary observations from DY3 to DY4 indicate an increase for members accessing mental health services across all age cohorts. The rates for 50% medication compliance for people with asthma increased across three out of four age cohorts from DY3 to DY4.

Planned activities for DY5 Q3 will focus on the collection and assessment of DY4 information and drafting measure-level write-ups as final DY4 data is collected and reviewed to be included in the Final Evaluation Report.

Section XVI: Enclosures/Attachments

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

Section XVII: State Contacts

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Section XVIII: Additional Comments

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

Centennial Care Member Success Story 1

A PHP member in Southern New Mexico was identified as an individual who used the Emergency Room (ER) frequently. The member had visited the ER 11 times in 2018. For over two years, there were multiple attempts to connect with the member through phone calls, letters, provider outreach, and unannounced home visits. All attempts were unsuccessful. Due to the extensive amount of ER use, the member was flagged to have real-time notifications of ER visits via the Pre-Manage system (see also MCO Initiatives under Presbyterian Health Plan in the DY5 Q1 report). The ER that the member visited frequently had not been participating with the EDIE program until quite recently.

After the ER began to participate in the EDIE program, a real-time alert of an ER visit was received by PHP's care coordination team. A CHW was deployed to go to the Emergency Room to meet with the member. The CHW spent over an hour with the member to understand the member's needs and to develop a rapport with the member. The member initially agreed to work only with the CHW and refused care coordination. A few days later, PHP received another notification of an ER visit. Again, the CHW was able to meet the member in the ER to assist the member with needs.

Over time, the CHW was able to work with the member toward goals such as visiting a PCP for the first time in almost two years. The member also agreed to meet a care coordinator with the CHW present. The member agreed to complete a CNA and is now engaged in care coordination and is working with the CHW to address multiple ongoing healthcare needs.

Centennial Care Member Success Story 2

A House that Became a Home - A BCBS Community Health Worker (CHW) began working with a family several months ago. Collaboration between care coordinators, advocates, CHWs, and other agencies was vital. The CHW's primary goal was to assist the family in locating housing that would accommodate the family of eleven, nine of which were children. The family consisted of two households that lived in two separate apartments. The new home would bring the two families together, under the same roof. The family was new to the culture, and traditions of living in the United States and with this newness came many unknowns. The children were attending schools, seeing doctors, dentists, therapists, and dealing with the tragedy of their father who has been unable to provide them with the support that the family needed, due to an accident that disabled him. The care coordinators, advocates, and CHWs came together to address the needs of the family. The family had been living in a second floor, two-bedroom apartment. This situation was difficult for the family. It was a small place and it meant carrying the youngest of the family up and down the stairs. Although, the family was going through a time of learning and

struggling, they remained positive, and willing to do all that was asked of them. Mom carried the load and did it with courage, and tenacity. Her determination to see her family through this difficult time of struggle provided her with the valor to move ahead in seeking a better life for her family. The CHW alongside the family advocates worked diligently together to locate suitable housing for the family. The family had been on the Section 8 Public Housing list for some time. The CHW immediately connected with a Section 8 representative and was instrumental in placing this family with adequate housing. The CHW worked closely with the Section 8 representative on a consistent basis through phone calls, and agency visits in hopes that the process of assisting the family would be a smooth transition and the assigned home would be adequate for the family's needs. The CHW received notification from the Section 8 representative that a five-bedroom home was being remodeled, would be handicapped accessible ready, and the family was first on the waiting list. The remodeling took time, but then came the day – it was ready! The CHW immediately advised the advocates and the family who expressed excitement and relief that the family would finally have a home that would be sufficient to meet their needs. The home contains five bedrooms, is counter wheelchair accessible, shower handicapped accessible, it has ramps that will allow easy entrance into the home and has a small yard where the children can be outside. It was only a few months or so after the initial contact from the Section 8 representative that the family moved into their new home. Many agencies, people in the community and friends have reached out to support the family. It has proven how positive forces can come together and bring hope to a family that is no longer in a strange land, but amongst neighbors, family, and friends. The family has turned this house into their home.

Centennial Care Member Success Story 3

Shortly before a Molina member transferred to a new care coordinator, his Personal Care Services (PCS) hours had been reduced and he did not understand why. The new care coordinator spent time explaining to the member the reasons for the decrease and describing the member's right to appeal the decision. The member was grateful and thanked the care coordinator.

This conversation with his care coordinator inspired the member to take more responsibility for managing his health care. The member diligently attended all scheduled appointments and worked with his provider to learn more about his conditions and make changes to improve his health. Six months after the conversation, the care coordinator reported that the member had improved and had made a new goal to no longer require Personal Care Services. The member also found a part time job that accommodated his limitations. The member can find satisfaction in being able to work a few days a week.

Centennial Care Member Success Story 4

A UHC member has struggled for years with depression and anxiety; she had found herself in a situation where she had just let everything go. She soon found herself in desperate need of assistance but wasn't sure where to turn. Her home was in such disarray that she knew that she

would not pass her HUD inspection. This intensified her anxiety and depression. When life would get overwhelming the member would become severely depressed, then suicidal, and usually ended up hospitalized. This time, care coordination was there to help her manage her symptoms without hospitalization. The member's UHC care coordinator contacted a church that the member belonged to and asked them for assistance. The UHC care coordinator spoke with the member to obtain permission before putting into place a plan of care with her congregation. With the member as lead, the team picked a date on the calendar and asked members of this church to volunteer their time and assist the member in getting her home ready for her HUDD inspection. The member had a lot of trouble doing this because she was embarrassed about the state of her home. The member reschedules a few times, but she knew she was running out of time and HUDD was not going to reschedule any more. She needed constant encouragement and support during this time; she would make statements like "I just need to go to the hospital". Her UHC care coordinator would talk her through this saying "if you think you really need to go to the hospital I will take you." Then the member would think about it and say, "I can't run from things because that is how I got here in the first place". The UHC care coordinator worked through this time together. This process was over the period of 6-8 months. The member finally agreed on a Saturday. On the day of the big event the crew showed up with 4 trucks, 2 huge dump trailers, gloves, cleaning supplies, trash bags, and over 20 volunteers. The UHC care coordinator stayed with the member and assisted in clean-up efforts with the volunteer group. The event lasted over 8 hours. The UHC care coordinator also pulled resources in the community to purchase a couch for the member. The member stated she was just so grateful; she could see her floor and walk without climbing over things. The day was filled with all kinds of emotion, but this was a great success.