Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 4 (1/1/2017 – 12/31/2017)
Waiver Quarter: 3/2017

December 30, 2017
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. As of September 2017, there were approximately 680,000 members are 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 275,130 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment decrease of 13,450 from DY4 Q2.

Access

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

Primary Care Provider (PCP)-to-Member Ratios

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

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	April	May	Jun
BCBS	1:39	1:39	1:40	1:38	1:38	1:38
MHC	1:102	1:102	1:102	1:100	1:99	1:99
PHP	1:88	1:88	1:86	1:87	1:86	1:84
UHC	1:30	1:30	1:30	1:29	1:29	1:29
Source: [MCO] PCP Report #53, Q2CY17						

Geographic Access

Physical Health and Hospitals

During DY4 Q3, HSD reviewed the geographic access (GeoAccess) reports for each MCO with a focus on outliers that did not meet access distance standards in urban areas. There are four urban counties in New Mexico: Bernalillo, Dona Ana, Los Alamos, and Santa Fe. BCBS and MHC did not meet access standards for dermatology in urban areas. HSD's review of the data determined that both MCOs did not meet access standards due to not having a contracted dermatologist in Dona Ana County. PHP and UHC are both contracted with two dermatologists in Dona Ana County, and these MCOs meet access standards in urban areas. Dermatology is a specialty for which New Mexico continues to experience a shortage of providers throughout the state. Consistent with previous reporting periods, all MCOs did not meet dermatology in rural and frontier areas. HSD conducted technical assistance calls with both BCBS and MHC to discuss the findings and to advise the MCOs to seek contracting opportunities with the few dermatologists available in Dona Ana County. Dona Ana is a county that borders Texas; therefore, members may utilize border area providers in El Paso, Texas. Access issues may be remedied by transportation to the nearest provider, telemedicine, and single case agreements with out-of-network providers. It is noted that PHP successfully met access standards for rheumatology in rural areas with 91.7%. In the previous quarter, PHP was close to meeting access standards with 88%. PHP met access in DY4Q3 due to a decrease in rural membership and an increase in the number of rural members with access. HSD anticipates that there may be

other subtle shifts, such as this, if overall Medicaid enrollment continues to decrease. Please see Attachment B: GeoAccess PH Summary.

Behavioral Health

Statewide there is continued access that meets standards 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, Federally Qualified Health Centers (FQHCs), psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners. Geographic access for behavioral health providers in rural and frontier areas for Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs, residential treatment programs, both accredited and non-accredited, Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST) remain unmet with limited exceptions.

HSD continues to be aware of the BH services that do not meet the standards due to a limited number of providers in New Mexico. HSD continues to work with MCOs to strengthen their relationships with providers and to increase accessibility to those in areas not meeting access through increased opportunities to utilize and access services through use of telemedicine and Project ECHO.

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 vist providers to validate practice information, respond to claims and other issues. The state is reviewing the current access report from BCBS which is showing lower access and will provide additional technical assistance and feedback. Please see Attachment C: GeoAccess BH Summary.

Community Health Worker

MCOs increased their CHW workforce of employed and contracted CHWs since the first quarter. The total number of CHWs employed is 85.5, an increase of four from DY4 Q1. CHW certification is a voluntary certification process offered by the New Mexico Department of Health (DOH) for experienced CHWs. Please see Table 2 – Summary of CHW Workforce.

Table 2 – Summary of CHW Workforce for each MCO

DY4 Q2 Community Health Workers			
	Employed	Contracted	Total
BCBS	13	15	28
MHC	28	0	28
PHP	9	9.5	18.5
UHC	11	0	11
Totals	**61**	**24.5**	**85.5**

Source: [MCO] CHW DSIPT, Q2CY17

Overall, MCO outreach increased in DY4 Q2 by contracting with multiple agencies for CHW services, including new CHW agencies in rural and frontier areas of the state. Initiatives included education activities and telephonic outreach for CHW interventions such as: Health Risk Assessment (HRA), Home Medical Equipment (HME), pregnancy and post-partum compliance calls, and coordination of emergency food assistance.

BCBS reported a significant increase in the numbers of members served in this quarter by the implementation of a newly structured CHW program that includes a focus on work done by internally hired CHWs for Health Risk Assessments (HRAs) and Home Medical and Equipment Supplies (HME).

Table 3 – Unduplicated members served by CHWs

DY4 Q2 Unduplicated Members Served					
	BCBS	MHC	PHP	UHC	Region Totals
Underserved Urban	14,757	1,334	1,009	696	17,796
Rural	1,578	1,125	620	532	3,855
Frontier	247	173	102	72	594
MCO Total	**16,582**	**2,632**	**1,731**	**1,300**	**22,245**

Source: [MCO] CHW DSIPT, Q2CY17

CHWs work one-on-one with members, including Medicaid eligible incarcerated individuals being released from prisons, jails, etc. The social determination of needs assessments support members to access needed services, including behavioral health resources. The following is a list of specific types of interventions reported for DY4 Q2:

- Locate Member
- Educate Member on the role of Care Coordination
- Complete HRA with Member

- Refer member for further assessments
- Assist Member when a Higher Level of Care Coordination is needed
- Educate Member on Emergency Room vs Urgent Care utilization
- Educate Member on PCP role
- Educate Member on use of Nurse Advise Line
- Assist Member to connect with PCP
- Assist Member with referrals for care
- Provide Community Resources
- Assist with Food resources
- Assist with Housing resources
- Assist with Financial resources
- Assist with Employment resources
- Assist with Legal resources

CHWs who are also trained as Peer Support Specialists offer their life experiences and recovery stories to support members by linking them with resources, while working with the care team to meet identified goals, and help the member to build skills to improve their overall health. The Peer Support Specialists employ the following when they engage a member:

- Mentor to provide one-on-one opportunities of inspiration
- Identify overall goals to improve quality of life
- Model behaviors to set positive examples
- Review alternate ways of responding to stress
- Coach new skills, including different ways to communicate
- Assist members to become their own advocate
- Increase knowledge of the varying paths of recovery, with symptom identification

CHWs continue to provide a wide variety of outreach events statewide. Please see Table 4 – CHW Education Activities for a list of some of the events by location.

Table 4 – CHW Educational Activities

Statewide
• Molina Day events are continually planned to improve important health tests and screenings • Native American Affairs Outreach, including tribal jails, care coordination & wellness events
Urban
• Let's Cook (Bernalillo) • Community Engagement Events with general education information (Dona Ana) • Welcome Baby Event (Dona Ana) • Boys & Girls Club (Bernalillo) • Lovelace Bump to Baby program for pregnant Members to provide prenatal education and health education classes (Bernalillo) • Dental Health (Bernalillo) • Blood Pressure (Bernalillo) • Diabetes and Sleep Disorders (Bernalillo, Dona Ana)

• High Blood Pressure (Bernalillo, Los Alamos, Santa Fe) • Nutrition (Los Alamos) • Dia de Los Ninos (Bernalillo)
Rural
• Nutrition (Sandoval) • Diabetes (McKinley) • Diabetes (Otero) • Jump into Summer Health Education Event(Grant) • Los Lunas Health & Wellness Fair (Valencia)
Frontier
• Nutrition (Mora) • Nutrition Health Fair (Harding) • Nutrition (Mora) • Diabetes/High Blood Pressure (Colfax, Otero, Quay)

Source: [MCO] CHW DSIPT, Q2CY17

For SFY18, HSD renewed a contract for a program known as Integrated Primary Care and Community Support (I-PaCS), which is a collaboration between the University of New Mexico, Health Sciences Center - Office for Community Health (UNM OCH), the Southwest Center for Health Innovation (SWCHI) and the Human Services Department (HSD)/Medical Assistance Division (MAD). The collaboration will focus on developing, evaluating, and disseminating the model for integration of CHWs into patient care sites and communities. The goal is to improve population health outcomes and reduce healthcare costs for Medicaid recipients.

I-PaCS will work to strengthen collaborative efforts and partnerships by supporting the development of the CHW curriculum and workforce and providing technical assistance, as needed, to the MCOs for the initiative.

Telemedicine

During DY4 Q3 HSD reviewed telemedicine utilization data for Q2 and continues to review the telemedicine reporting template and reporting methodologies for consistency across MCOs. As in quarter one, the data reflects that most telemedicine services provided in New Mexico are for behavioral health diagnoses.

Table 5 – Telemedicine Services

DY4 Q2			
Behavioral Health			
	Urban	Rural	Frontier
BCBS	193	318	42
MHC	332	887	155
PHP	418	951	372
UHC	256	463	72
TOTAL	**1,199**	**2,619**	**641**

Source: [MCO] Telemedicine DSIPT, Q2CY17

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

Transportation

MHC transitioned to a new transportation vendor in April 2017. During DY4 Q3, the number of transportation grievances steadily increased from twelve in May to forty-seven in September. MHC reported that some of the grievances involved its previous transportation vendor. HSD requested that MHC provide additional data, root cause analysis, and strategies to ensure optimal non-emergency medical transportation services for its members. HSD is also monitoring Member Line call volume and transportation utilization to identify material changes that may be related to the change in subcontractors.

Provider Network

During DY4 Q3, the provider network has remained consistent with the previous quarter. HSD continues to monitor network adequacy by evaluating trends regarding new and terminated providers, the number of providers with panels and/or practices that are open and accepting new members, the number of providers with panels and/or practices that are closed and no longer accepting new members. HSD also monitors member-to-provider ratios and the number of single case agreements.

Service Delivery

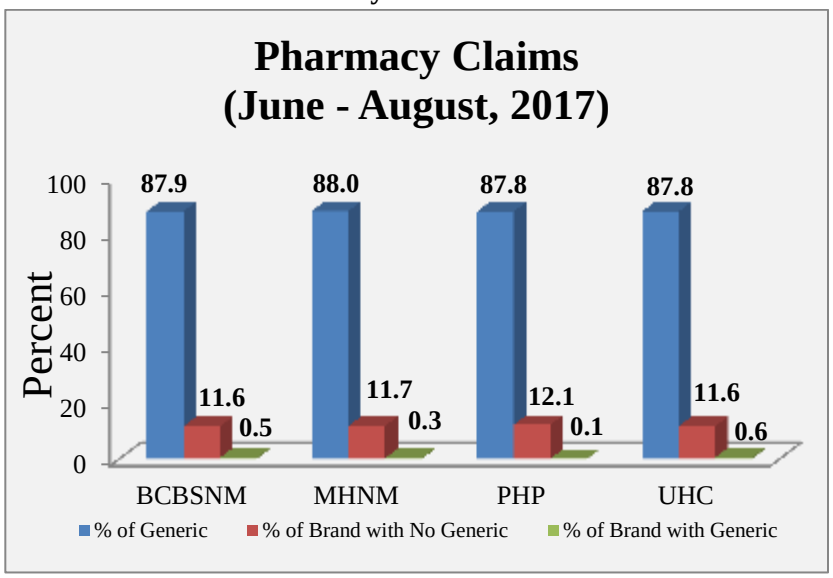
Utilization Data

Centennial Care key utilization and cost per unit data by overall programs as well as by a specific program is provided for July 2015 through June 2017. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

The MCO monthly pharmacy report captures key metrics regarding prescription claims for brand and generic drugs. The average generic drug usage for all four MCOs was at 87.9%. All MCOs had a slight decrease in generic drug utilization except for BCBS, which had a 0.2% increase from the previous quarter. BCBS and MHC had a slight decrease in usage of brand drugs when there was no generic available. PHP and UHC had a slight increase of usage of brand drugs when there was no generic available from the previous quarter. The overall usage of brand medication when there was no generic available averaged 11.7% for the quarter. Use of brand drugs when there was a generic drug available remained at an average of 0.4% for all MCOs. All four MCOs require medical justification for usage of a brand drug when there is a generic drug available. HSD has not identified any concerns at this time and will continue to monitor generic and brand name drug utilization. Please see Table 6 – Percent of Pharmacy Claims for each MCO.

Table 6 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M6CY17, M7CY17, M8CY17

Hepatitis C (HCV)

During DY4 Q3, HSD continued to meet quarterly with the MCO workgroup to address HCV treatment. The HCV workgroup initiated a *Hepatitis C Screening and Treatment Survey* directed toward health care providers to identify gaps and opportunities in HCV education, screening, and linkages to care. The survey was prepared using Survey Monkey and opened on May 16, 2017, when the survey link was sent to representatives of each MCO and HSD. All representatives agreed to post the link on their provider portals and to include the link in their provider newsletters and/or via emails to the provider networks. However, subsequent and more active distribution options were implemented:

- **Presbyterian Health Plan** sent a directed email to 902 providers in its network on June 2 and re-sent the email on August 24
- **Molina Healthcare of New Mexico** sent a directed email to 491 providers in its network on August 15 and re-sent the email on September 8.
- **New Mexico Medical Society** included a link to its members in an August 28 email.
- **Presbyterian Medical Services** (PMS) sent a directed email and link to approximately 120 providers on September 22, 2017.

Nursing Facilities

As previously reported in DY3 Q4, several issues related to MCO processing of Nursing Facilities (NF) claims payments were reported to HSD. In DY4 Q3, HSD continued to monitor the MCOs' efforts to address these issues through regularly scheduled meetings with the MCOs and their NF provider networks to discuss claims payment issues, root causes, and solutions. Progress was made in DY4 Q3 as the MCOs continued to analyze their claims processing procedures and made systemic changes to improve claims processing by automating as many functions as possible. HSD will continue to monitor NF payment issues to resolution.

Community Interveners

In DY4 Q2, five Centennial Care members received Community Interveners (CI) services as illustrated below.

Table 7 – Community Intervener Services Utilization DY4 Q2

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBS	2	161	$1,027.25
MHC	0	0	$0
UHC	2	42.75	$1,104
PHP	1	133	$3,398.50
Total	**5**	**336.75**	**$5,529.75**

Centennial Rewards Program

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

Table 8 – Healthy Behaviors Rewarded

Eligibility Activities	Reward Value in Points, by Activity	Reward Value in $, by Activity	Total Rewards Earned by Activity in $	Total Rewards Redeemed by Activity in $	Redemption Percentage
Asthma Management	600	$60	$1,186,780	$388,471	32.7%
Bipolar Disorder Management	600	$60	$1,393,120	$334,664	24.5%
Bone Density Testing	350	$35	$62,930	$12,567	19.9%
Healthy Smiles Adults	250	$25	$10,221,950	$1,917,421	18.7%
Healthy Smiles Children	350	$35	$23,478,735	$5,813,015	24.7%
Diabetes Management	600	$60	$5,658,040	$1,424,655	25.1%
Healthy Pregnancy	1000	$100	$1,466,300	$357,756	24.3%
Schizophrenia Management	600	$60	$700,700	$139,825	19.9%
Health Risk Assessment	100	$10	$4,394,070	$1,065,263	24.2%
Other (Appeals and Adjustments)	N/A	N/A	$600,413	$359,390	59.8%
Step-Up Challenge	500	$50	$562,425	$480,114	85.3%
Totals			**$49,725,463**	**$12,293,141**	**24.7%**

Across all categories, the *cumulative* redemption rate is just under 25%. Redemption in the first year of the program was below 10% but has been approximately 30% in subsequent years. Both earning and redemption has remained steady since 2015.

The table above shows that members who complete the Step-Up Challenge have the highest likelihood of redeeming the reward they earn. This highlights the fact that the more active a member is in earning a reward, the more likely they are to redeem it.

Finity, the company that administers the Centennial Rewards program, recently produced the Year 3 (CY2016) annual report for the program. In 2016, Centennial Rewards saved over $24 million and cost savings have been about $100 million over the first three years of the program. The dominant driver for cost savings is a reduction in hospital services, particularly inpatient admissions.

Centennial Rewards program participation remains remarkably strong and is likely the highest participation rate for a program of this kind in the nation. Since the beginning of the program, there have been over one million visits to the Centennial Rewards member portal. Most importantly, member satisfaction has remained exceptionally high, with the percentage of people reporting satisfaction with the program and who say that the program has helped them stay healthier in the mid- to upper-90s.

The Step-Up Challenge continued to be successful with over 90,000 members registering for the walking challenge and tracking their steps since the program was introduced in 2015. Step-Up Challenge participants continue to show lower costs and improved quality.

Section III: Enrollment

Centennial Care enrollment indicates a decrease in enrollment in 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 the table below. Overall, enrollment indicates a decrease in each population, other than SSI Related Dual and 217-Like Dual populations.

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 9 – Enrollment DY4 Q3

Demonstration Population	Total Number Demonstration Participants DY4 Q3 Ending September 2017	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**378,386**	**468,268**
FFS	42,618	59,175
Molina	124,542	153,190
Presbyterian	122,718	148,587
UnitedHealthcare	27,006	32,841
Blue Cross Blue Shield	61,502	74,475
Population 2 – SSI and Related – Medicaid Only	**41,281**	**45,470**
FFS	2,871	4,584
Molina	13,050	13,873
Presbyterian	13,446	13,941
UnitedHealthcare	5,234	5,936
Blue Cross Blue Shield	6,680	7,136
Population 3 – SSI and Related – Dual	**37,153**	**39,085**
FFS		283
Molina	7,317	7,576
Presbyterian	7,028	7,227
UnitedHealthcare	15,918	16,970
Blue Cross Blue Shield	6,890	7,029
Population 4 – 217-like Group – Medicaid Only	**338**	**488**
FFS	92	347
Molina	49	33
Presbyterian	55	46
UnitedHealthcare	102	35
Blue Cross Blue Shield	40	27
Population 5 – 217-like Group - Dual	**3,346**	**2,797**
FFS		31
Molina	725	605
Presbyterian	586	494
UnitedHealthcare	1,345	1,135
Blue Cross Blue Shield	690	532
Population 6 – VIII Group (expansion)	**275,130**	**279,299**
FFS	27,856	34,713
Molina	75,422	75,580
Presbyterian	68,283	64,367
UnitedHealthcare	39,959	41,756
Blue Cross Blue Shield	62,610	62,883

Disenrollments

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

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

Table 10 – Disenrollment Counts DY4 Q3

Disenrollments	Total Disenrollments During DY4 Q3
Row Labels	
Population 1 – TANF and Related	**12,804**
FFS	1132
Molina	3896
Presbyterian	4134
UnitedHealthcare	1158
Blue Cross Blue Shield	2484
Population 2 – SSI and Related – Medicaid Only	**601**
FFS	48
Molina	200
Presbyterian	173
UnitedHealthcare	76
Blue Cross Blue Shield	104
Population 3 – SSI and Related – Dual	**716**
Molina	160
Presbyterian	156
UnitedHealthcare	247
Blue Cross Blue Shield	153
Population 4 – 217-like Group – Medicaid Only	**16**
FFS	8
Molina	2
Presbyterian	2
UnitedHealthcare	3
Blue Cross Blue Shield	1
Population 5 – 217-like Group - Dual	**140**
Molina	28
Presbyterian	23
UnitedHealthcare	55
Blue Cross Blue Shield	34
Population 6 – VIII Group (expansion)	**15965**
FFS	1504
Molina	4291
Presbyterian	3898
UnitedHealthcare	2429
Blue Cross Blue Shield	3843

Section IV: Outreach

In DY4 Q3, HSD participated in the 39th annual New Mexico Conference on Aging. Over 800 New Mexico residents from around the state attended; conference attendees were provided information regarding long-term care services, behavior health services and the Centennial Rewards program.

HSD provided Medicaid training to the NM Aging and Long-Term Services Department (ALTSD), Adult Protective Services. Information provided was specifically related to the various NM Medicaid categories of eligibility, income guidelines and how and when Medicaid and SSI work with each other.

HSD was invited by the University of New Mexico and the Continuing Education Department to participate in an Employment Resource Event for correctional facility professionals and individuals released from incarceration. New Mexico Medicaid information was made available and discussed with attendees interested in health care coverage for themselves and their family members.

HSD participated in the Santa Fe Mental Health Awareness Day and Community Health Fair. Over 500 community members attended; event attendees were provided information regarding long-term care services, behavior health services and the Centennial Rewards program.

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

Table 11 – Schedule of Community Events DY4 Q3

Event Type	Event Location and Date	Audience and Topics
2017 Conference on Aging	Albuquerque, NM August 15-16, 2017	Sponsored by the City of Albuquerque and Bernalillo County. HSD provided Medicaid program information, and answered a variety of Medicaid related questions. Some specific questions were related to Behavioral Health services, Long Term Care services and the Centennial Care Rewards program.
NM Aging & Long-Term Services Dept. – Adult Protective Services	Albuquerque, NM September 12, 2017	The NM Aging and Long-Term Services Department, Adult Protective Services requested information/training for the Resource Center Volunteer-Partner program. Information provided was specifically related to the available NM Medicaid categories of eligibility, income guidelines and how and when Medicaid and SSI work with each other.
NM Behavior Rally for Recovery & Community Health Fair.	Santa Fe, NM September 18, 2017	Attendees were provided information and education regarding behavior health services, long-term care services and the Centennial Care Rewards program.

JUST Health Program

In DY4 Q3, HSD continues to expand facility participation and fine-tune the processes of the Justice-Involved Utilization of State Transitioned Health Care (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 state-certified Presumptive Eligibility Determiners (PEDs) at the correctional facility. The JUST Health program is active in 26 separate correctional or detention facilities. These entities include 12 New Mexico Department of Corrections facilities, the State of New Mexico Children, Youth and Family Department, New Mexico Department of Health – Forensic Unit, juvenile detention facilities and adult and juvenile facilities in 6 different counties.

The JUST Health program also allows and encourages Centennial Care MCOs to make contact with incarcerated members prior to their release to begin care coordination activities. A pilot project with the Bernalillo County Detention Center and MHC is currently underway. Thus far, this pilot has connected 296 Bernalillo County Detention Center detainees to MHC's care coordination program. The Santa Fe County Adult Detention facility is also piloting a similar program with two Centennial Care MCOs (BCBS and UHC). The Santa Fe County facility process includes assisting MCO members to contact their respective MCO to conduct a health risk assessment and initiate the process to receive care coordination.

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

Encounter Data

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

Enrollment Data

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

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

Program Development

During DY4 Q3, the draft for Centennial Care 2.0 1115 Demonstration Waiver Renewal Application was released on September 1, 2017. Centennial Care 2.0 builds on successes achieved during the past four years. Improvements and reforms will ensure sustainability of the program while also assuring comprehensive services. The focus areas for Centennial Care 2.0 are care coordination, benefit and delivery system modifications, payment reform, member engagement and personal responsibility, and administrative simplification through refinements to eligibility. HSD is accepting comments from the public about Centennial Care and changes to the program are being considered as part of the renewal of the Centennial Care federal 1115 waiver, which will be effective on January 1, 2019. Comments will be accepted through November 6, 2017. HSD will also conduct four public hearings in October 2017, hosted in Las Cruces, Santa Fe, Las Vegas, and Albuquerque.

Behavioral Health

Please refer to the following attachments for an update on Behavioral Health activities:

- Attachment E: Behavioral Health Collaborative CEO Report
- Attachment F: 2017 Behavioral Health Consumer & Family Satisfaction Report
- Attachment G: Behavioral Health Performance Measure Report

MCO Initiatives

Blue Cross Blue Shield of New Mexico

- National Committee for Quality Assurance (NCQA) Health Plan Rating - Blue Cross and Blue Shield of New Mexico recently completed the NCQA's rigorous Health Plan accreditation process, which evaluates how well a health plan manages all parts of its delivery system, including, but not limited to, physicians, hospitals, other providers and administrative services for its members. NCQA updates the comprehensive program annually, adding new measures and more challenging standards to build on best practices in quality. During the recent NCQA accreditation process, BCBS successfully achieved a NCQA Health Plan accreditation rating of "Commendable". This accreditation rating was granted on 09/01/2017, and expires on 09/01/2020. Of the Health Plans accredited by NCQA, BCBS is part of the 34% of accredited health plans across the nation that has achieved this level of accreditation.

Molina Healthcare

- Medication Therapy Management (MTM) - Molina Healthcare has made a major commitment to assist its members in the appropriate use of their prescribed medications through medication therapy management interventions by pharmacists. The UNM College of Pharmacy MTM Center performed 205 telephonic comprehensive medication reviews and 82

follow-up medication reviews with Molina Healthcare members in calendar year 2017. A total of 2,307 telephonic MTM reviews have been performed since program inception in September 2014 through August 2017.

Presbyterian Health Plan

- CYFD High Fidelity Wrap-around Program
  All youth in out-of-home treatment are assigned to level 3 care coordination. Care coordinators remain engaged with the member, CYFD, family members, and the provider during the treatment episode. Community-based providers from the member's community are also engaged in the care and transition planning process. Since 2015 when PHP experienced its highest out-of-home treatment rates, PHP has achieved significant reductions in the number of members in all out-of-home settings. Residential treatment center (RTC) admissions dropped by 58%, out-of-state RTC admissions decreased by 72%, and treatment foster care (TFC) admissions declined by 59%.

  In addition to the efforts by PHP's employed care coordinators, the managed care organization initiated a partnership with CYFD and HSD a care coordination delegation pilot in early 2017 that was designed to support the development of a high-fidelity wraparound alternative. CYFD provided intensive training to All Faiths, the selected pilot provider. PHP targeted CYFD youth in long term RTC placements, both in-state and out-of-state. For members who engaged in high fidelity wraparound services, PHP compared their average per member per month (PMPM) costs for the 12 months prior to enrollment in wraparound to average costs over just 3 months in the program and are already seeing a 4:1 return on investment. Thirteen youth have returned to the community from out-of-home placements, including four who were in out-of-state treatment.

- Integrated Substance Use Disorder and Community Collaborative Initiative
  The Integrated Substance Use Disorder (SUD) and Community Collaborative initiative was developed and implemented by PHP and the Presbyterian Delivery System in partnership with HSD to improve the health outcomes of individuals affected by substance use disorders and addictions. This initiative uses a scalable, integrated care model that provides access to a wide range of physical health, mental health, and substance use prevention, treatment and recovery services. The initiative employs innovative and evidence-based care and maintains protocols for managing patients at any point of entry into the healthcare system; provides seamless transition between acute care, primary care, and the recovery community; and utilizes community supports, wrap-around services, and funding channels. Interventions include:
    - A specialized consultative/liaison clinical team dedicated to identifying and treating patients in acute care settings
    - Clinical education regarding prevention, early identification and treatment
    - An addiction-and chronic-pain-focused teleECHO clinic to mentor and support

providers throughout the Presbyterian Healthcare System
  - SUD specialists who facilitate engagement and connect patients and members to resources
  - Peer-engagement and support to link patients and members with community services
  - A triage/referral process to route patients and members to the appropriate level of care
  - A universal screening tool
  - Evidence-based treatment recommendations to guide the provider's clinical practice
  - Opioid stewardship to support standardized, evidence-based treatments
  - Alternative, lower-cost models of care for long-term treatment
  - Partnerships with community organizations, such as mutual help groups, that support individuals through recovery

The goals are to sustain a replicable model of care that compassionately identifies, engages and treats patients with SUDs; to improve the patients' physical health, mental health and quality of life; to reduce harm; to reduce recidivism; and, to avoid unnecessary costs related to care. Early indications show that the interventions are reducing recidivism and supporting engagement in treatment for substance use disorders.

- Opioid Milligram Equivalent Edit
  PHP is planning to configure a cumulative Morphine Milligram Equivalent (MME) pharmacy edit on January 1, 2018. This edit is designed to calculate a member's cumulative MME dose and will result in a soft rejection at the pharmacy if member's cumulative opioid dose exceeds 90 MME's per day. This is a soft edit which means dispensing pharmacist will have the ability to resolve using National Council for Prescription Drug Program (NCPDP) Drug Utilization Review (DUR) over-ride codes. Members with MME greater than 90/day and their providers have been notified. Members in hospice and members with a cancer diagnosis are excluded from the edit.

  Improving Prenatal and Postpartum Data CollectionCurrently, obstetric (OB) providers submit claims according to bundled payment arrangements with each MCO. The CPT II codes used to collect data are informational $0 payable codes; therefore, provider groups or their billing companies have little incentive to include these additional codes in their claims submissions to health plans. PHP is joining the efforts of MHC and UHC in incentivizing OB providers for three measures contingent upon the providers submitting the associated CPT II codes for these measures. PHP anticipates data collection to be significantly enhanced and will lead to improved reported measure rates.

UnitedHealthcare

- Community Collaborations
    - UHC entered into a Letter of Agreement with the NM American Heart Association (AHA) to partner on a pilot project for members with hypertension. The goal of the project is for UHC's Care Coordination staff to collaborate with AHA in providing health education for members diagnosed with hypertension and engaging them in managing their condition to achieve better health.
    - UHC Care Coordination and Member Engagement staff initiated a meeting with relevant stakeholders to discuss safety concerns for members and MCO staff on the Alamo Reservation. The goal was to establish a relationship with the Reservation's new police officer and the APS representative, and for all parties to understand each other's role. The meeting went well and UHC is working with the Alamo Reservation Police Lieutenant to develop a safety event for the community.

Fiscal Issues

During DY4 Q3, MCO reconciliations were completed for CY 2015 patient liability, underwriting gains for CY 2014 and CY 2015, and penalties assessed for those MCOs not meeting delivery system improvement targets. The result of the reconciliations is a recoupment that affected MEG 1 of DY1 and DY2. There is also Indian Health Service (IHS) payment for CY 2016 that affected the PMPM of MEG 1 of DY3. As for the Other Adult Group (OAG), the risk corridor reconciliations for calendar year 2016 resulted in recoupments that affected the PMPM for MEG 6 of DY3.

Systems Issues

The system issues have stabilized by continuing to run reports on a regular basis and working continually with the MCOs. HSD has established processes to handle any nursing facility level of care (NFLOC) and setting of care (SOC) system issues. HSD continues to implement reporting for analysis and oversight. HSD and the MCOs work together to address any concerns or implement any necessary system changes on either side.

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 progressed in DY4 Q3. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the DOH, Children Youth and Families Department (CYFD), and the ALTSD. These three departments have participated in RFP development and replacement planning. HSD is currently in the process of drafting GSAs with CYFD and 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 the procurement process and the contract has been sent to CMS for approval.

The RFP for the next module of the Framework, the Enterprise Data Services RFP, was released on April 17, 2017. Proposals were received on June 21, 2017, and HSD is currently in an active procurement process. Contract negotiations will begin in the upcoming weeks.

CMS has approved the third module RFP for Quality Assurance. The decision was made to restructure the Quality Assurance module by excluding the Provider Management and Member Management functions. These changes were discussed and approved by CMS. The Quality Assurance RFP is being routed and reviewed internally prior to release.

HSD has begun development of the RFP for the fourth module, Benefit Management Services.. This RFP involved meetings with all stakeholders, questionnaires for input and review of other states' procurements and contracts for similar services, including Electronic Health Record (EHR. This information is being gathered for requirements development and will be vetted through the stakeholder review process for comment prior to submission to CMS.

Once the Benefit Management Services RFP is submitted to CMS for review, work will continue with the development of the RFP for the fifth module, Financial Services. Some work with stakeholders, surveys, and gathering of requirements from other states has already been started.

The module previously referenced as Population Health has been renamed Outcomes Based Management and will not require a formal procurement process. Some of the components that were originally included in the Population Health module have been moved into other modules to better align with the project's overall objectives.

HSD is currently working with Deloitte, our integrated eligibility system vendor to move managed care enrollment from our MMIS to our Eligibility and Enrollment (E&E) system. Then our ASPEN eligibility system will become a true E&E system. Deloitte is currently working on the changes to implement managed care enrollment in ASPEN as well as provisions for Real Time Eligibility (RTE). These changes were previously approved by CMS.

An Implementation Advanced Planning Document Update (IAPD-U) was submitted to the CMS Regional Office in August 2017 for approval.

Section VII: Home and Community-Based Services

New Mexico Independent Consumer Support System (NMICSS)

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

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

The ADRC coordinators provide phone counseling in care coordination, which is the process for assisting the client in describing his/her issue. ADRC staff offer options, coordinate New Mexico's aging and disability service systems, provide objective information and assistance, and empower people to make informed decisions. ALTSD provides quarterly reports to HSD regarding the ADRC Caller Profile Report and Care Transitions Program Data.

Table 12 – ADRC Call Profiler Report DY4 Q3

Topic	# of Calls
Home/Community Based Care Waiver Programs	3,574
Long Term Care/Case Management	179
Medicaid Appeals/Complaints	16
Personal Care	219
State Medicaid Managed Care Enrollment Programs	26
Medicaid Information/Counseling	1,331

Table 13 – ADRC Care Transition Program Report DY4 Q3

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		134	
Medicaid Education/Outreach	833		
Nursing Home Intakes		80	
*Pre/Post Transition Follow-up Contact	2,015		
**LTSS Short-Term Assistance			44

*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 member of the NMICSS, the ALTSD Care Transition Bureau (CTB) is providing 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 needed services identified are provided by the MCO, MCO subcontractors and other community provider agencies. The main purpose 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.

The CTB staff continues to work directly with the MCOs when facing challenging issues with members. The CTB works with the MCOs in explaining the Short Term Assistance referrals and how they can assist the MCOs with their members. This includes assistance with the Income Support Division application, assisting in the eligibility process to identify the reason(s) a client's eligibility has not been established. They also will provide assistance to home bound persons.

Critical Incidents

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

During DY4 Q3, a total of 4,235 critical incident reports (CIRs) were filed for Centennial Care (Physical Health), Behavioral Health and Community Benefit Self-Directed members. One hundred percent of all CIRs received through the HSD CI web portal are reviewed. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.

During DY4 Q3, a total of 412 deaths were reported. Of the 412 deaths reported, 362 deaths were reported as natural or expected deaths, 49 deaths were reported as unexpected and one (1) was reported as a suicide. 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 request for records from the Office of the Medical Investigator (OMI) to determine a cause of death. MCOs have internal processes on follow-up for all member deaths.

During DY4 Q3, a total of 2,692 critical incidents were reported for Emergency Services. Of those Emergency Services reports, 245 were reported by Behavioral Health providers and 208 were associated with Self-Directed members. 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. MCOs continue to monitor high utilizers of the emergency department (ED). ED reduction initiatives reported include improved processes for identifying and appropriately classifying reports, implementing member engagement initiatives to assist in identifying member challenges to utilizing care coordination, and system wide activities designed to decrease inappropriate ED utilization.

Table 14 – Critical Incident Types by MCO – Centennial Care Physical Health

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	35	0.83%	124	2.93%	72	1.70%	71	1.68%	302	7.13%
Death	97	2.29%	96	2.27%	70	1.65%	149	3.52%	412	9.73%
Natural/Expected	87	2.05%	75	1.77%	59	1.39%	141	3.33%	362	8.55%
Unexpected	10	0.24%	20	0.47%	11	0.26%	8	0.19%	49	1.16%
Suicide	0	0.00%	1	0.02%	0	0.00%	0	0.00%	1	0.02%
Elopement/Missing	2	0.05%	11	0.26%	13	0.31%	7	0.17%	33	0.78%
Emergency Services	581	13.72%	852	20.12%	600	14.17%	659	15.56%	2692	63.56%
Environmental Hazard	10	0.24%	15	0.35%	21	0.50%	27	0.64%	73	1.72%
Exploitation	30	0.71%	3	0.07%	22	0.52%	40	0.94%	95	2.24%
Law Enforcement	16	0.38%	35	0.83%	14	0.33%	17	0.40%	82	1.94%
Neglect	96	2.27%	160	3.78%	150	3.54%	140	3.31%	546	12.89%
Total	867	20.47%	1296	30.60%	962	22.72%	1110	26.21%	4235	100.00%

Table 15 – Critical Incident Types by MCO – Behavioral Health

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	16	2.97%	68	12.61%	24	4.45%	7	1.30%	115	21.33%
Death	2	0.37%	16	2.97%	4	0.74%	2	0.37%	24	4.46%
Natural/Expected	0	0.00%	10	1.86%	2	0.37%	1	0.19%	13	2.41%
Unexpected	2	0.37%	5	0.93%	2	0.37%	1	0.19%	10	1.86%
Suicide	0	0.00%	1	0.19%	0	0.00%	0	0.00%	1	0.19%
Elopement/Missing	0	0.00%	2	0.37%	7	1.30%	1	0.19%	10	1.86%
Emergency Services	18	3.34%	191	35.43%	25	4.64%	11	2.04%	245	45.45%
Environmental Hazard	0	0.00%	2	0.37%	3	0.56%	0	0.00%	5	0.93%
Exploitation	2	0.37%	3	0.56%	1	0.19%	1	0.19%	7	1.30%
Law Enforcement	4	0.74%	12	2.23%	8	1.48%	1	0.19%	25	4.64%
Neglect	6	1.11%	78	14.47%	14	2.60%	10	1.86%	108	20.04%
Total	48	8.91%	372	69.01%	86	15.95%	33	6.13%	539	100.00%

Table 16 – Critical Incident Types by MCO – Self Directed

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	2	0.67%	19	6.40%	12	4.04%	4	1.35%	37	12.46%
Death	1	0.34%	5	1.68%	3	1.01%	7	2.36%	16	5.39%
Natural/Expected	1	0.34%	2	0.67%	2	0.67%	7	2.36%	12	4.04%
Unexpected	0	0.00%	3	1.01%	1	0.34%	0	0.00%	4	1.35%
Suicide	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Elopement/Missing	0	0.00%	3	1.01%	1	0.34%	0	0.00%	4	1.35%
Emergency Services	34	11.45%	43	14.48%	93	31.31%	38	12.79%	208	70.03%
Environmental Hazard	0	0.00%	1	0.34%	1	0.34%	0	0.00%	2	0.67%
Exploitation	0	0.00%	0	0.00%	2	0.67%	3	1.01%	5	1.68%
Law Enforcement	1	0.34%	4	1.35%	1	0.34%	0	0.00%	6	2.02%
Neglect	4	1.35%	0	0.00%	7	2.36%	8	2.69%	19	6.40%
Total	42	14.14%	75	25.25%	120	40.41%	60	20.20%	297	100.00%

Home and Community-Based Services Reporting
In moving toward compliance with the federal HCBS Settings Rule, HSD, in partnership with the ALTSD, began on-site provider validation and participant surveys in September 2017. The on-site activities were completed by the end of October 2017. HSD is also continuing to update the Statewide Transition Plan (STP) milestones as required by CMS.

Community Benefit
In July 2017, HSD conducted training for tribal providers at the Advancing Tribal Healthcare Conference. The training provided information on how Tribal providers can apply to become a Centennial Care Community Benefit (CB) provider for CB services such as adult day health, respite, private duty nursing, etc.

In August 2017, at HSD's direction, the MCOs and HSD conducted a joint training for Assisted Living Facilities which included how to request prior authorization from the MCOs, what services are included in the Assisted Living benefit and other important provider policy and rule requirements. The training was well attended by the provider community.

In September 2017, HSD conducted training for enrolled personal care services (PCS) providers who also want to enroll as a community benefit respite provider. The training provided information on how to apply.

Self-Directed Community Benefit
In DY4 Q3, HSD continued to monitor the implementation of the mandatory online timesheet requirement for Self-Directed Community Benefit (SDCB) employees that began June 1, 2017. The MCOs have approved exceptions to the online submission requirement for members that live in an area without internet access, or who are unable to submit timesheets online due to their disability.

In DY4 Q3, PHP made some changes to their Support Broker (SB) network. PHP began to provide SB services by directly employing SBs as permitted in the MCO contract with HSD. HSD directed PHP to also offer their members a choice of at least two other external SB agencies. PHP issued a request for information to interested SB agencies with a focus on quality and selected the two top scoring agencies. PHP terminated contracts with agencies that were not selected (two), and members were successfully transitioned to the new SB agencies by the end of October 2017. HSD is closely monitoring the transition through weekly meetings with PHP and a readiness review. PHP will oversee the new contracted agencies as well as their own employed SBs to ensure that their internal quality metrics are met. PHP will regularly report outcomes to HSD.

Electronic Visit Verification
Electronic Visit Verification (EVV) for Personal Care Services (PCS) was fully implemented statewide on November 14, 2016. Effective March 1, 2017, all PCS claims must be submitted to

the MCOs through the EVV system. The MCOs continue to deploy targeted on-site technical assistance to specific PCS agencies as needed.

HSD and the MCOs partner with the New Mexico Association for Home Health and Hospice (NMAHHC) to provide information on the EVV system to providers at its quarterly conferences. At the August 2017 conference, the MCOs responded to provider concerns on EVV; however, there were fewer issues and the overall tone of the conference session was much more collaborative than at past conferences.

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. The last quarter data from the four Centennial Care MCOs shows for physical health there is 97.6% access to care for Native Americans in rural areas and 98.1% access to care for Native Americans in frontier areas. For behavioral health there is a 97.5% access for Native Americans in rural areas and 98% access for Native Americans in frontier areas. This is an improvement from the previous quarterly report.

The data shows members are accessing specialty services such as cardiology, orthopedics, ophthalmology, nephrology, and psychology outside of I/T/Us.

Contracting Between MCOs and I/T/U Providers

For this quarter there have not been any new contracts (agreements) with I/T/Us. The MCOs currently have agreements with Tribal entities for HRA completion, translation, transportation, disease management, audiology, optical, extended hour services, recovery services, and Peer Support Wellness Centers. The MCOs continue to work on developing contracts with I/T/Us.

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 99.7% of claims being processed and paid within 30 days of receipt.

Table 17 – Native American Advisory Board (NAAB) meeting for DY4 Q2

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Shiprock Chapter House Shiprock, NM August 24, 2017	BCBS provided an overview of Blue Cross Community Centennial Care and conducted a member advisory board orientation. They explained the importance of attending the Native American Advisory Board meetings. They described the Alternative Benefits Plan (ABP) including covered and non-covered services. BCBS talked about their Value Added Services (VAS) such as the Traditional Healing benefit. The BCBS Ombudsman introduced himself and explained the services he provides for members.
MHC	Mescalero Tribal Building Mescalero, NM August 16, 2017	Members were informed about the following goals: • Explanation of the healthcare systems and benefits; • Engage Members in healthcare initiatives; and • Empower Members to take a proactive role in their care. Members were encouraged to register for MyMolina.com which allows members to manage their health care online. Molina Healthcare uses the input from NAAB meetings to evaluate how well the plan is serving and meeting the needs of its members.

PHP	Santo Domingo Pueblo New Mexico August 11, 2017	PHP began their meeting by having the Ombudsman for PHP distribute a brochure and information about her role as a member advocate and how to address issues prior to a grievance and appeal. PHP care coordinators also provided a presentation on what the role of a care coordinator is. PHP and the audience engaged in a question and answer session.
UHC	Shiprock Chapter House Shiprock, NM September 12, 2017	The Native American Advisory Board meeting was held at the Shiprock Chapter House on the Navajo reservation. The UHC team discussed the Native American Traditional Healing benefit, prior authorizations for specialty referrals, behavioral health peer support services, and innovations regarding economic development with supporting Tribal CHR programs. UHC recognizes there is a need for UHC providers in Pagosa Springs and Durango, CO for their members living in the northern border area of NM. UHC is actively working on getting more providers in this area.

HSD's Native American Technical Advisory Committee (NATAC)

The NATAC meeting for this quarter included discussion about:

- HSD;s monitoring and oversight of MCO performance including specific monitoring tools utilized and the reporting requirements and extensive review process as well as EQRO activities and reviews;
- Care coordination reports;
- The Agency Based Community Benefits (ABCB) program;
- Announcement of the next Tribal Consultation for the Centennial Care 2.0 1115 Waiver Renewal scheduled for October 20, 2017; and
- A brief update on the work to implement the reinterpreted federal guidance related to services received through IHS and/or Tribal facilities.

Update on the work to implement the federal guidance for services received through IHS/Tribal Facilities

IT and clinical teams for both the Albuquerque Area his (AAIHS) and UNM held several meetings to develop information system flowcharts to include the referral, scheduling and documentation sharing processes.

Next steps include:

- UNM is drafting language to amend the CCA to adjust the timeframe for UNM sharing documentation with IHS after an appointment.
- AAIHS will provide UNM with weekly updates of all providers.
- AAIHS will train their providers on the new process.
- The large group will meet again on 11/21/17 to check-in on how everyone is progressing.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment H: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY4 Q3 is the third quarter with the CY 2017 rates that exhibits the full effect of a series of cost containment initiatives that started in July 2016. In addition to round one (rate reductions for inpatient and outpatient hospitals, practitioner and dental, and termination of primary care providers enhanced payments) and round two (rate reductions for practitioner reimbursement for both non-radiology and radiology codes), round three of the cost containments went into effect January 1, 2017 with rate reductions for professional fee schedule codes that remain at or above 100% of the Medicare rate to 94% of the Medicare rate. The effects of these costs containments are apparent in the PMPM of DY4 Q3 compared to the PMPM of DY3; the PMPMs of DY4 Q3 are lower than the PMPMs of DY3 for MEGs 1, 2, 3 and 5 (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 DY4 is 27% below the budget neutrality limit (Table 4.4) based on three quarters of data.

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 18 – Member Months DY4 Q3

Number of Clients by Population Group and MC	
	2017
Row Labels	**Q3**
Population 1 – TANF and Related	**1,128,024**
FFS	128,822
MC	
Molina	372,291
Presbyterian	366,433
UnitedHealthcare	78,909
Blue Cross Blue Shield	181,569
Population 2 – SSI and Related – Medicaid Only	**122,355**
FFS	8,672
MC	
Molina	38,558
Presbyterian	39,671
UnitedHealthcare	15,618
Blue Cross Blue Shield	19,836
Population 3 – SSI and Related – Dual	**108,603**
MC	
Molina	21,291
Presbyterian	20,475
UnitedHealthcare	46,824
Blue Cross Blue Shield	20,013
Population 4 – 217-like Group – Medicaid Only	**1,042**
FFS	315
MC	
Molina	147
Presbyterian	162
UnitedHealthcare	301
Blue Cross Blue Shield	117
Population 5 – 217-like Group - Dual	**9,618**
MC	
Molina	2,091
Presbyterian	1,699
UnitedHealthcare	3,849
Blue Cross Blue Shield	1,979
Population 6 – VIII Group (expansion)	**758,604**
FFS	77,849
MC	
Molina	210,410
Presbyterian	187,165
UnitedHealthcare	110,416
Blue Cross Blue Shield	172,764

Section XII: Consumer Issues – Complaints and Grievances

A total of 1,084 grievances were filed by Centennial Care members in DY4 Q3. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 487 (44.93%) of the total grievances received. The MCOs report they continue to communicate and meet regularly with their transportation vendors to address identified issues that involve transportation vendors and the appropriate service levels. Transportation Member Grievances in Section II of this report provides an analysis of the MCOs' efforts to address transportation grievances under the guidance of HSD.

The second top grievance filed was Other Specialties with a total of 61 grievances (5.63%) which demonstrates a decrease from Q2 (84) and Q1 (109). Members reported dissatisfaction with balance billing by providers, customer service practices, and quality of care. MCO interventions include regular communication with providers, outreach by the provider advocates and the development of a performance improvement project to track and verify provider billing practices.

There were 536 (49.44%) variable grievances filed during DY4 Q3. Of those, each MCO reported unique grievances that do not provide data to establish a trend. Examples of variable grievances include Pharmacy, Primary Care Physician, and Provider Specialist. MCO interventions include pharmacy reviews of medication denials, education by member services, and continued communication with Provider Network Management to resolve issues at the lowest level. HSD is monitoring these grievances to identify specific trends.

Table 19 – MCO Grievances DY4 Q3

MCO Grievances DY4 Q3 (July - September 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	112	10.33%	385	35.52%	232	21.40%	355	32.75%	**1084**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	76	7.01%	130	11.99%	96	8.86%	185	17.07%	**487**	44.93%
Other Specialties	1	0.09%	0	0.00%	7	0.65%	53	4.89%	**61**	5.63%
Variable Grievances	35	3.23%	255	23.52%	129	11.90%	117	10.79%	**536**	49.44%

While MCOs work toward optimizing member satisfaction, it should be noted that grievance reporting is generally encouraged to ensure adequate member protections across grievance types, quantification and identification of concerns, and appropriate and effective interventions. Analysis of grievance data has the potential to inform network needs, program planning, program evaluation, and resource allocation for staff, provider, and/or vendor technical assistance and training. It is important to note that categories, which consistently reflect the highest percentages of total grievances, are not necessarily indicators of poor performance. Several performance measures, such as grievances per service units and severity levels, must be taken into consideration when evaluating performance and needed improvements.

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD randomly reviews service plans to ensure the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures 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 DY4 Q3.

Table 20 – Service Plan Audit DY4 Q3

Member Records	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**120**	**120**	**120**	
BCBS	**30**	**30**	**30**	
MHC	**30**	**30**	**30**	
PHP	**30**	**30**	**30**	
UHC	**30**	**30**	**30**	
Percent of files with personalized goals matching identified needs	**100%**	**100%**	**100%**	
BCBS	**30**	**30**	**30**	
MHC	**30**	**30**	**30**	
PHP	**30**	**30**	**30**	
UHC	**30**	**30**	**30**	
Percent of service plans with hours allocated matching needs	**100%**	**100%**	**100%**	
BCBS	**30**	**30**	**30**	
MHC	**30**	**30**	**30**	
PHP	**30**	**30**	**30**	
UHC	**30**	**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.

Table 21 – Nursing Facility LOC Audit DY4 Q3

MCO High NF LOC denied requests (downgraded to Low NF)	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**17**	**17**	**17**	
BCBS	**5**	**5**	**5**	
MHC	**3**	**2**	**2**	
PHP	**5**	**5**	**5**	
UHC	**4**	**5**	**5**	
HSD Reviewed Results	**DY4 Q1**	**DY4 Q2**	**DY4 Q3**	**DY4 Q4**
Number of member files that met the appropriate level of care criteria	**17**	**17**	**17**	
BCBS	**5**	**5**	**5**	
MHC	**3**	**2**	**2**	
PHP	***5***	**5**	**5**	
UHC	**4**	**5**	**5**	
Percent of MCO level of care determination accuracy	**100%**	**100%**	**100%**	

Table 22 – Community Benefit NF LOC Audit DY4 Q3

Community Benefit denied NF LOC requests	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
Number of member files audited	**20**	**22**	**22**	
BCBS	**3**	**5**	**5**	
MHC	**7**	**7**	**7**	
PHP	**5**	**5**	**5**	
UHC	**5**	**5**	**5**	
Number of member files that met the appropriate level of care criteria determined by the MCO	**20**	**22**	**22**	
BCBS	**3**	**5**	**5**	
MHC	**7**	**7**	**7**	
PHP	**5**	**5**	**5**	
UHC	**5**	**5**	**5**	
Percent of MCO level of care determination accuracy	**100%**	**100%**	**100%**	

HSD was in agreement with all NF LOC decisions for DY4 Q3; however, one chart submitted for review was outside of the sample criteria. HSD will continue to follow up with the MCOs to ensure that selected samples match requested criteria for future audits. All NF LOC decisions were appropriate and complied with NF LOC criteria.

External Quality Review Organization (EQRO) NF LOC

The EQRO for HSD reviews a random sample of MCO NF LOC determinations every quarter.

Table 23 – EQRO NF LOC Review DY4 Q3

Facility Based	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
High NF Determination				
Number of member files audited	**29**	**27**	**23**	
BCBS	7	2	5	
MHC	5	8	3	
PHP	8	7	9	
UHC	9	10	6	
Number of member files the EQRO agreed with the determination	**24**	**24**	**22**	
BCBS	6	2	5	
MHC	5	6	3	
PHP	6	6	9	
UHC	7	10	5	
%	**83%**	**89%**	**96%**	
BCBS	86%	100%	100%	
MHC	100%	75%	100%	
PHP	75%	86%	100%	
UHC	78%	100%	83%	
Low NF Determination				
Number of member files audited	**79**	**81**	**85**	
BCBS	20	25	22	
MHC	22	19	24	
PHP	19	20	18	
UHC	18	17	21	
Number of member files the EQRO agreed with the determination	**77**	**81**	**85**	
BCBS	20	25	22	
MHC	22	19	24	
PHP	19	20	18	
UHC	16	17	21	
%	**97%**	**100%**	**100%**	
BCBS	100%	100%	100%	
MHC	100%	100%	100%	
PHP	100%	100%	100%	
UHC	89%	100%	100%	
Community Based				
Number of member files audited	**156**	**156**	**156**	
BCBS	39	39	39	
MHC	39	39	39	
PHP	39	39	39	
UHC	39	39	39	
Number of member files the EQRO agreed with the determination	**155**	**154**	**153**	
BCBS	39	39	39	
MHC	39	39	39	
PHP	38	37	37	
UHC	39	39	38	
%	**99%**	**99%**	**98%**	
BCBS	100%	100%	100%	
MHC	100%	100%	100%	
PHP	97%	95%	95%	
UHC	100%	100%	97%	

The EQRO review of the MCO High NF determinations shows a trend in the rate of agreement with 83% in DY4 Q1; 89% in DY4 Q2; and 96% in DY4 Q3. The Low NF determinations continue to average at 100% agreement and the Community Based determinations were 98%

agreement. HSD reviewed two NF LOC determination disagreements from EQRO audits in July and August of DY4 Q3 and were in agreement with all EQRO findings. Issues identified included conflicts in documentation and incomplete information. HSD noted that the number of denial determinations from the MCOs continued to decrease in DY4 from eight in Q1, five in Q2, and four in Q3.

Additionally, HSD reviewed the NF LOC determination disagreements for DY4 Q2. HSD conducted a technical assistance call with PHP and MHC to review and discuss issues related to supporting documentation. At HSD's request, PHP provided information to HSD about their internal peer review process to ensure accurate NF LOC determinations. PHP also provided an update regarding each member's current NF LOC status. At HSD's request, MHC provided confirmation to HSD that one of the members had appropriately received HNF status for the period in question and not LNF which had been previously documented. Additionally, HSD reviewed the skilled nursing criteria for HNF with MHC. HSD also noted that BCBS and UHC did not have any denial determinations for Q2, an improvement from Q1. BCBS also did not have any denial determinations for Q3. 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 targeted MCO Internal Action Plans (IAPs), evaluating self-reporting of issues identified in an earlier audit conducted by HSD to evaluate the MCOs overall care coordination practice. The MCOs were given recommendations and action steps to implement and perform in an effort to improve care coordination. Upon analyzing DY4 Q3 self-reporting from each MCO IAP, HSD anticipates activating new recommendations and action steps to ensure transition of care plans as well as post transition of care assessments are comprehensive and member-centered as a result of an HSD transition of care audit and external quality review audit. BCBS was successful in ensuring records contain consistent and detailed disaster and back-up plans. PHP was successful in developing and ensuring that fast-action protocols are in place and activated when members or their families call into the health plan call center for crisis referral or assistance. UHC was successful in implementing a process for ensuring that updates to assessments are clearly documented as updates and that the information collected is the most recent information. MHC continues its attempt at successful implementation of HSD's recommendations and action steps. HSD will audit the MCOs IAPs in DY4 Q4.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top 35 Emergency Department (ED) utilizers for each MCO. HSD monitored monthly reports on each MCO's "super utilizer" group, tracking the amount of ED visits, supplemental case information, and care

coordination activities to reduce non-emergent ED utilization. Since the project's inception in 2015, MHC, Presbyterian and UHC have demonstrated an overall decline in average ED visits/member, whereas BCBS has shown an increase. Despite an increase demonstrated by BCBS, the average monthly ED visits per super utilizer has decreased from 2.9 visits per month to 2.26 visits per month. Presbyterian demonstrated the lowest amount of ED visits compared to the other three MCOs in the review period. In July 2017, HSD met with the MCOs to present descriptive data findings on super utilizers and to discuss care coordination best practices for ED reduction.

Care Coordination and EDIE

HSD continues to participate in the statewide "ER is for Emergencies" PreManage ED committee, also known as the EDIE Project. EDIE is a database that is able to share real time data of member ED utilization when the member is accessing services among participating New Mexico hospitals, EMS agencies, and all four Centennial Care MCOs. This collaboration will potentially allow for same day care coordination intervention with the member. Currently New Mexico has 39 hospitals participating in the EDIE Project; 27 hospitals have launched, 5 are in the contract readiness stage, and 7 are in the information and technology implementation stage on their way to participation.

At the last monthly meeting the New Mexico Association of Certified Emergency Physicians, agreed to form a committee to standardize care plans in New Mexico. The goal is to establish a standardized care plan to easily retrieve a member's most recently updated health care information through the PreManage program.

Care Coordination for Incarcerated Individuals

HSD continues to provide technical assistance for a care coordination pilot project with MHC and the Bernalillo County Metropolitan Detention Center (BCMDC). The project focuses on providing incarcerated members with care coordination to address members' immediate healthcare needs upon release. Overall the program has continued to demonstrate declines in the reduction of member ED visits, BH claims, PH claims, and pharmacy claims. MHC has reached out to the other MCOs and begun the planning stages of assisting BCMDC in providing care coordination in the detention center. As part of this coordination, MHC will take the lead on screening incarcerated individuals as they have demonstrated success in this area. Since June 1, 2016, 336 MHC members who were incarcerated were referred from BCMDC to MHC for care coordination while being incarcerated. Three hundred and ten MHC members agreed to participate while 26 refused. One hundred and twenty-five members are no longer incarcerated and are being managed by a MHC care coordinator. Seventy-five members who had care coordination while incarcerated but after release have become unable to engage.

Care Coordination Ride-Alongs

HSD continued to conduct "ride-alongs" with MCO care coordinators in August 2017 to observe member assessments in the home setting. HSD staff conducted one ride-along per MCO, observing initial CNAs. One member's power of attorney stated that she thought personal care coordination felt like she had her own personal concierge. For DY4 Q3 ride-alongs, HSD found that the care coordinator's activities were in compliance with contract requirements, including the administration of the Community Benefit Services Questionnaire (CBSQ) and the CNA.

Section XIV: Managed Care Reporting Requirements

Customer Service

In DY4 Q3, three MCOs met call center metrics (abandonment rate, percent of calls answered within 30 seconds, and wait time) for member services, provider services, nurse advice line, and the utilization management line. In July, UHC did not meet call center metrics for the abandonment rate for the nurse advice line and for the percentage of calls answered within 30 seconds. UHC reported a temporary staffing issue that resulted in its performance falling below contract standards. UHC adjusted its staffing, and all call center standards were met by each MCO in August 2017. Please see Attachment I: Customer Service Summary.

In addition, all MCOs have agents that are bilingual in English and Spanish. PHP also has agents that speak the Navajo language. Member calls are being made by BCBS for an on-going Health and Wellness Campaign and they are maintaining over 2,300 calls documented each month in Q2. The campaign is designed to educate members on yearly check-ups with their PCP, annual dental check-ups and cleanings, as well as to provide transportation information.

MCO Reporting

HSD continued the process of the technical assistance calls with the MCOs regarding report issues and accepting the MCO's Self-Identified Error Resubmissions of reports. Both processes continue to support the improvement of the MCO quality review of report data submissions and analyses submitted to HSD.

Report Revisions

During DY4 Q3, HSD conducted review of the final draft of the pharmacy report. The revised pharmacy report focuses on monitoring drugs for the treatment of opioid dependence, alcohol and nicotine dependence, methadone use in pain management, HIV treatment, and utilization of antipsychotic medications in children. To ensure a thorough analysis of pharmacy services from the medical and pharmacy benefits, these revisions will provide a broader overview of utilization across the MCOs.

Member Appeals

A total of 1,017 member appeals were filed by Centennial Care members in DY4 Q3. Of those appeals, 918 (90.27%) were standard member appeals and 99 (9.73%) were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner. Denial or limited authorization of a requested service constitutes the largest number of appeals reported with 834 (82.01%) of the total appeals received. In this quarter, member appeals included denial of inpatient stay, eligibility criteria for services not met, pharmacy, and dental services. MCO interventions include member education, review for trending, and referrals to Medical Directors and Clinical Operations Directors for continued ways to improve processes.

The second top reason for appeals was the reduction of a previously authorized service with a total of 79 (7.77%) member appeals. Issues for member appeals included dissatisfaction with reduction in personal care service hours or home health services, and denied requests for long term care and nursing facility level of care.

There were 104 (10.22%) variable appeals in DY4 Q3. Of those, each MCO reported unique appeals during the quarter that do not provide enough information to establish a trend. All MCOs have complied with the policies and procedures regarding members' exhaustion of the Grievance and Appeal System prior to requesting a State Fair Hearing.

Table 24 – Member Appeals DY4 Q3

MCO Appeals DY4 Q3 (July - September 2017)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member	78	7.67%	180	17.70%	528	51.92%	132	12.98%	**918**	90.27%
Number of Expedited Member	13	1.28%	33	3.24%	7	0.69%	46	4.52%	**99**	9.73%
Total	91	8.95%	213	20.94%	535	52.61%	178	17.50%	**1017**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	58	5.70%	210	20.65%	448	44.05%	118	11.60%	**834**	82.01%
Reduction of a previously authorized service	0	0.00%	2	0.20%	54	5.31%	23	2.26%	**79**	7.77%
Variable Appeals	33	3.24%	1	0.10%	33	3.24%	37	3.64%	**104**	10.22%
Empty Variables									**0**	0.00%

Section XV: Demonstration Evaluation

Interim Evaluation Report

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues as expected. Throughout DY4 Q3, Deloitte completed major activities for the Centennial Care 1115 Waiver Evaluation including development of the final Interim Evaluation Report which includes data from DY1, DY2, and DY3. Deloitte continued the data collection and analysis phase for DY3.

During the development of the initial Interim Evaluation Report draft, HSD determined that several measures required more up-to-date reports than originally collected, some measures required a refresh of MCO data and a few additional measures required new data sources. The goal of these revisions was to collect more accurate and consistent data in terms of how the MCOs are reporting. Due to these changes, there was a need to re-establish a baseline value for these measures to allow for appropriate analysis of program performance over the term of the evaluation. Deloitte discussed this information with HSD, completed data collection activities, updated baseline values as necessary, and resolved outstanding questions with HSD for all measures.

Deloitte continues to meet with HSD as needed to further refine the work plan, discuss data and data questions, as well as identify and review any analysis issues or risks.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Monitoring Spreadsheet
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment E: Behavioral Health Collaborative CEO Report
Attachment F: 2017 Behavioral Health Consumer and Family Satisfaction Report
Attachment G: Behavioral Health Performance Measure Report
Attachment H: MCO Action Plans
Attachment I: 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 member was an alcoholic with a history of being homeless. When the member started receiving care coordination, the member was living in a boarding house and was receiving ongoing Medicare as Healthcare for the Homeless. However, the member was also continuing to drink vodka daily. Then in January, after being detained for loitering and subsequently being released from jail, the member verbalized wanting to quit using alcohol. The care coordinator worked with the member's power of attorney to explore community resources available and linked with Mesilla Valley Hospital in Las Cruces. Mesilla Valley Hospital has a 30 day out-patient program for alcohol and substance abuse. The member used LogistiCare for transportation to Las Cruces and was admitted to the program on February 14, 2017. The member recently celebrated 6 months of sobriety and no longer requires assistance because he is sober. The member has bought a car, moved out of the boarding house and is camping out. The member is receiving services from Life Link, which helps find permanent housing as well as providing case management and psychiatric services. This is a huge success!

Centennial Care Member Success Story 2

A member, diagnosed with spastic diplegic Cerebral Palsy at 9 months old, was approved for and participating in weekly physical therapy sessions at a hospital. The member reported that his lower extremity pain has reduced considerably and his ability to walk comfortably has therefore increased. A neurological evaluation led to corrective surgery for the member, lengthening and correction of ankle deformity in early 2017, which has also contributed to decreased pain and greater ambulatory stability. The member happily reports that he is relatively pain free. He also reports feeling safer and less likely to stumble or lose balance while participating in the school sports program at his elementary school and Special Olympics at the state level. The member is 13 years old and able to bathe alone. He has not fallen in the tub because of a home modification to the bathroom.. The member also reports happiness, hopefulness, and looks forward to a normal pain free life. The member also received counseling at Valle del Sol, and no longer feels he needs to continue. The member stated feeling better physically, mentally and emotionally all because of the improvements made and support received.

Centennial Care Member Success Story 3

One care coordinator has been working with an elderly member for the past two years. This member was diagnosed with type 2 diabetes and hypertension, but had not been seeing a PCP or taking any medications. The care coordinator worked with the member to set goals via Comprehensive Care Plan (CCP) as well as renewing her NFLOC. The member is close to completing all of those goals, including completely quitting smoking. The member has also formed a relationship with a new PCP whom the member sees regularly and is in compliance

with all medications. The member checks his own blood sugar and blood pressure daily and is more conscientious of a diet and exercise routine. The member's numbers are now within target range for both medical conditions. Best of all, both the member's disposition and outlook have greatly improved, most likely due to the improvement with the self-management skills.