Centennial Care Waiver Demonstration

Section 1115 Annual Report
Demonstration Year: 4 (1/1/2017 – 12/31/2017)

April 6, 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 is 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. Approximately 670,000 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 1115 demonstration 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: SUMMARY OF QUARTERLY REPORT OPERATIONAL ISSUES

Annual Budget Neutrality Monitoring Spreadsheet

The annual budget neutrality monitoring spreadsheet for demonstration year four (DY4) is included in this report as Attachment A.

Health Care Delivery System Update

Benefits

There were no changes in Medicaid Covered Services during DY4; however, MCOs began offering In Lieu of Services or Settings, which are alternative services or settings that are not Covered Services, but are medically appropriate and cost effective substitutes. Approval from the Human Services Department (HSD) is required prior to utilization. In addition, the MCOs offer Value Added Services (VAS) to their members, which are approved by HSD to supplement Covered Services. VAS vary by MCO and are outlined in Attachment B: 2017 Value Added Services.

New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project

The New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project (CFYP) is a yearly effort to survey the satisfaction of New Mexico Adult individuals, Family/Caregivers and Youth receiving state funded mental health and substance abuse treatment and support services.

The CFYP surveys serve two purposes:

- To inform a quality improvement process to strengthen services in New Mexico; and,
- To fulfill federally mandated data reporting requirements.

Adults, family members and youth answer the survey through face-to-face or telephone interviews. Provider locations for face-to-face interviews are pre-selected each year. Telephone interviews were obtained from a pool of randomly-selected individuals or families who received behavioral health services from New Mexico Medicaid or Behavioral Health programs between July 2016 and February 2017. There is a separate Youth Report which surveys youth in detention centers and shelters; NM Children Youth & Families Department (CYFD) will make results available in late fall, 2017. For more information and findings from DY4, please see Attachment C: 2017 NM Consumer and Family Executive Summary.

Enrollment

Centennial Care enrollment indicates the largest increase in enrollment continues to be Group VIII. The majority of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in Section IV of this report. There were some decreases in Group VIII, SSI and Related, both Medicaid Only and Dual but the other groups

increased other than 217-Like-Medicaid Only which remained stable. Overall, enrollment has started to decrease each quarter in almost every population other than the 217-Like populations, primarily related to failure of members to recertify at time of recertification.

Disenrollment

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

Complaints and Grievances

In DY4 a total of 4,081 member grievances were filed by Centennial Care members; an increase from DY3 (3,787), a decrease from DY2 (4,385), and an increase from DY1 (2,668). There were 871 member grievances received in Q4, 1,184 received in Q3, 1,058 received in Q2 and 968 received in Q1.

In DY4 the top member grievance filed was Non-Emergency Ground Transportation (NMET) with 1,519 (37.22%) of the total grievances received; an increase from 919 received in DY3, 1,241 received in DY2, and 1,006 received in DY1. The MCOs continue to meet regularly with their transportation vendors to ensure members' concerns are addressed and any barriers to care are removed. Process improvement initiatives have been made such as reviewing daily and monthly reports to track and address recurring member issues, hiring of additional resources, providing direction to their vendors and implementing performance plans.

In DY4 the second top member grievance filed was related to Other Specialties with 301 (7.38%) received; a decrease from 514 received in DY3, equal to 301 received in DY2, and an increase from 134 received in DY1. Balance billing, the practice of billing the member for a remaining balance, was the primary issue. Providers are unable to balance bill Medicaid recipients and so the MCOs follow up on all of these instances to resolve the issue. Additionally, the MCOs continue to provide outreach to the top providers identified so that they understand the policy.

The third top member grievance filed was related to Primary Care Physician (PCP) with 118 (2.89%) received; a decrease from 410 received in DY3, 428 received in DY2, and 198 received in DY1. Reported grievances include complaints about appointment timeliness, quality of service issues and dissatisfaction with the PCP for not authorizing requested prescriptions. The MCOs communicate regularly with all departments involved in member grievances to ensure members' concerns are addressed and any barriers to care are removed.

In DY4 the remaining 2,143 (52.51%) grievances are noted, but the information found does not establish a trend. These grievances include complaints about dental, pharmacy and emergency room services. The MCOs state that they are closely analyzing the data to identify needed changes to their internal processes and to assess any gaps or issues to decrease the overall number of grievances.

Table 1 – MCO Grievances DY4

MCO Grievances DY4										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	#	%	#	%	#	%	#	%	#	%
Number of Member Grievances	723	17.72%	1,359	33.30%	817	20.02%	1,182	28.96%	**4,081**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	387	9.48%	401	9.83%	244	5.98%	487	11.93%	**1,519**	37.22%
Other Specialties	12	0.29%	0	0.00%	63	1.54%	226	5.54%	**301**	7.38%
Primary Care Physician	4	0.10%	32	0.78%	82	2.01%	0	0.00%	**118**	2.89%
Variable Grievances	320	7.84%	926	22.69%	428	10.49%	469	11.49%	**2,143**	52.51%

Member Appeals

In DY4 a total of 3,932 member appeals were filed by Centennial Care members. This was a decrease from DY3 (5,104) and DY2 (5,435) and an increase from DY1 (1,764). Of those 3,932 member appeals, 3,592 (91.35%) were standard member appeals and 340 (8.65%) were expedited member appeals. During 2017 a total of 1,013 member appeals were received in Q4, 1,000 received in Q3, 1,043 received in Q2 and 876 received in Q1. 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 3,296 (83.83%). Member appeals included criteria for services not met, including denial of inpatient stay, pharmacy, and dental services. MCO interventions included member education and referrals to the MCO Medical 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 332 (8.44%) member appeals. These member appeals included dissatisfaction with reduction in personal care service hours (PCS) or home health services and denied requests for long term care services due to not meeting the nursing facility level of care criteria (NF LOC). HSD continues to monitor reductions in PCS hours as well as NF LOC determinations through auditing. The audits show the majority of the reductions in PCS hours were due to increased natural support or independence with ADL's and NF LOC denials are consistent with NF LOC criteria.

There were 304 (7.73%) variable appeals in DY4. Of those, each MCO reported unique appeals during each quarter that do not 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 2 – MCO Appeals DY4

MCO Appeals DY4										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	351	8.93%	650	16.53%	2,043	51.96%	548	13.94%	**3,592**	91.35%
Number of Expedited Member Appeals	75	1.91%	86	2.19%	25	0.64%	154	3.92%	**340**	8.65%
Total	426	10.83%	736	18.72%	2,068	52.59%	702	17.85%	**3,932**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	317	8.06%	702	17.85%	1,773	45.09%	504	12.82%	**3,296**	83.83%
Reduction of a previously authorized service	7	0.18%	21	0.53%	200	5.09%	104	2.64%	**332**	8.44%
Variable Appeals	102	2.59%	13	0.33%	95	2.42%	94	2.39%	**304**	7.73%
Empty Variables									**0**	0.00%

Access

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

To ensure the MCOs' compliance in maintaining member access and an adequate provider network, HSD monitors new and terminated providers, member-to-provider ratios and GeoAccess reports. All MCOs were far below the primary care provider (PCP)-to-member contractual required ratio of 1:2000 in DY4. The ratios ranged from 1:27 to 1:102 as reported by the MCOs in the third quarter. Please see Table 3: PCP-to-Member Ratios by MCO.

Table 3 – PCP-to Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
BCBS	1:39	1:39	1:40	1:38	1:38	1:38	1:35	1:35	1:36
MHC	1:102	1:102	1:102	1:100	1:99	1:99	1:98	1:96	1:94
PHP	1:88	1:88	1:86	1:87	1:86	1:84	1:83	1:81	1:82
UHC	1:30	1:30	1:30	1:29	1:29	1:29	1:28	1:28	1:27

Source: [MCO] PCP Report #53, Q3CY17

Geographic access requirements for dentists, hospitals, pharmacies, primary care physicians, and most specialty providers were met in urban, rural and frontier counties. A shortage of providers continues in specialty areas including dermatology, endocrinology, neurology, neurosurgeons, rheumatology, and urology. New Mexico recognizes providers/pharmacies within 100 miles of the border as in-state providers. In areas that MCOs do not meet access criteria, they utilize non-emergency transportation, telemedicine, and single case agreements to ensure that the members who require medically necessary services receive them. Please see Attachment D: 2016-17 GeoAccess PH Summary All MCOs.

In DY4, MHC terminated its contract with Walgreens Pharmacy; however, member access standards were not affected. Members were notified of nearby pharmacy providers and for those members in care coordination levels 2 and 3, care coordinators provided individualized assistance with the transition. Additionally, the DaVita Medical Group notified MHC that it would terminate its contract with MHC and no longer serve MHC members effective December 1, 2017. This termination did not impact member access standards; members were either transitioned within the MHC provider network or allowed to switch to another MCO to ensure continuity of care with DaVita.

Behavioral Health Geo Access

Access standards continued 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. 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

In rural and frontier areas, access standards remained unmet with limited exceptions, for the following: Freestanding Psychiatric Hospitals; General Hospitals with psychiatric units; 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 Federally Qualified Health Centers (FQHCs) are not met by the majority of MCOs.

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 the MCOs to strengthen their relationships with providers and to increase accessibility to those in areas not meeting access through increased opportunities to utilize telemedicine, including psychiatry consults through the University of New Mexico, and Project ECHO.

MCOs have worked throughout the year to maintain access within the current network while 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 networks in ways such as having Behavioral Health Provider Service Representatives routinely vist providers to validate practice information, respond to claims issues and answer provider questions. Please see Attachment E: 2017 BH GeoAccess Summary All MCOs.

Secret Shopper Survey

Medicaid-enrolled providers with the State of New Mexico are potentially able to contract with

any of the four Centennial Care MCOs, all of which provide services to members statewide. Beginning in DY4, MCOs are required to conduct Secret Shopper Surveys with Primary Care Providers (PCPs) semi-annually to monitor appointment timeliness in all regions across the State for routine and urgent visits. MCOs create their own survey scripts that are approved by HSD.

Telemedicine

All MCOs continued to utilize telemedicine services for both PH and BH. In DY4 the majority of telemedicine visits were for BH services. All MCOs continue to promote use of technology to allow members to have access to telemedicine services and are working with large in-state providers of telemedicine specialty services to make sure rural and frontier PCPs are aware of their availability. Technical assistance was offered to providers who are interested in delivering services via telemedicine. Primary interventions include provider education regarding accurate coding of telemedicine services. Additionally, the MCOs continue to inform members of the availability of telemedicine as they strive to meet the goal of an increase in member utilization by 15% over DY3. Please see Table 4: Telemedicine 2013 - 2017 Results.

Table 4 – Telemedicine 2013 - 2017 Results

Telemedicine Professional Services
(Number of visits for Rural and Frontier Members)

	Baseline			1st Year Results			2nd Year Results			3rd Year Results			4th Year Results		
	2013 Behavioral Health	2013 Physical Health	2013 Total	2014 Behavioral Health	2014 Physical Health	2014 Total	2015 Behavioral Health	2015 Physical Health	2015 Total	2016 Behavioral Health	2016 Physical Health	2016 Total	2017 Behavioral Health	2017 Physical Health	2017 Total
BCBSNM	19	3	22	1,078	91	1,169	1,213	803	2,016	2,362	2,803	5,165	2,645	2,062	4,707
MHNM	7 *	0	7	1,909	32	1,941	2,132	754	2,886	3,579	98	3,677	4,213	219	4,432
PHP	2,016	4	2,020	5,006	143	5,149	5,809	134	5,943	5,045	280	5,325	10,119	180	10,299
UHC	89	22	111	1,046	96	1,142	1,833	236	2,069	1,786	1,000	2,786	4,664	1,944	6,608
TOTAL	2,131	29	2,160	7,039	362	7,401	8,987	1,927	10,914	12,772	4,181	16,953	21,641	4,405	26,046

* Most telehealth services provided in New Mexico are for behavioral health diagnoses.

In 2013, Medicaid behavioral health services were administered by OptumHealth New Mexico.

Source: MCO DSIPT Telemedicine Report

Transportation

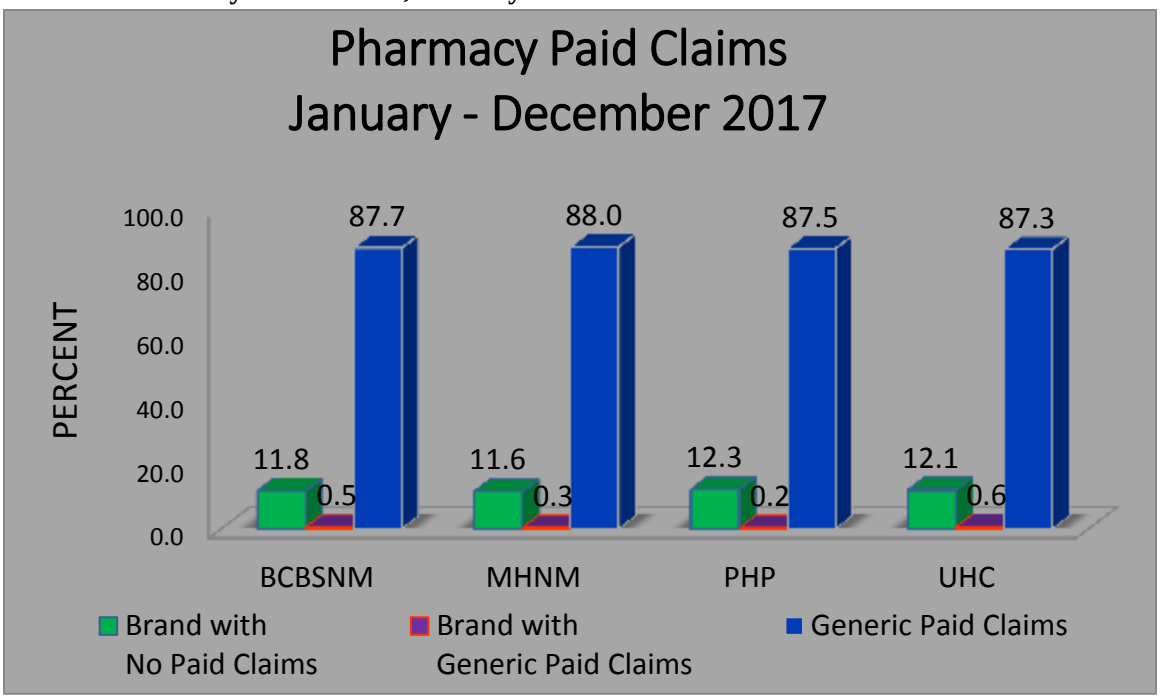
In DY4, all MCOs met geographic access standards for non-emergent ground transportation in urban, rural and frontier areas. Consistent with previous reporting Non-emergency medical transportation (NEMT) grievances have represented the highest percentage of total member grievances in DY4. Please see Complaints and Grievances for additional information.

Pharmacy

HSD monitors the MCOs' utilization of generic medication, brand with generic and brand with no generic. MCOs are required to use generic drugs when available and require medical justification for usage of brand drug use when a generic drug is available. In DY4, HSD identified the following:

- 87.6% average generic drug utilization for all four MCOs;
- 12.0% average brand with no generic available for all MCOs; and
- 0.4% average brand use with a generic drug available for all MCOs

Table 5 – Pharmacy Paid Claims, January – December 2017



Source: [MCO] Report #44, December 2017

In DY4, HSD continued to work on standardizing pharmacy reporting to ensure a consistent methodology is utilized across all MCOs that will allow for a more thorough analysis of pharmacy services. The revised report will continue to monitor claims data, prior authorizations, and therapeutic classifications as well as monitoring of 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.

Hepatitis C (HCV)

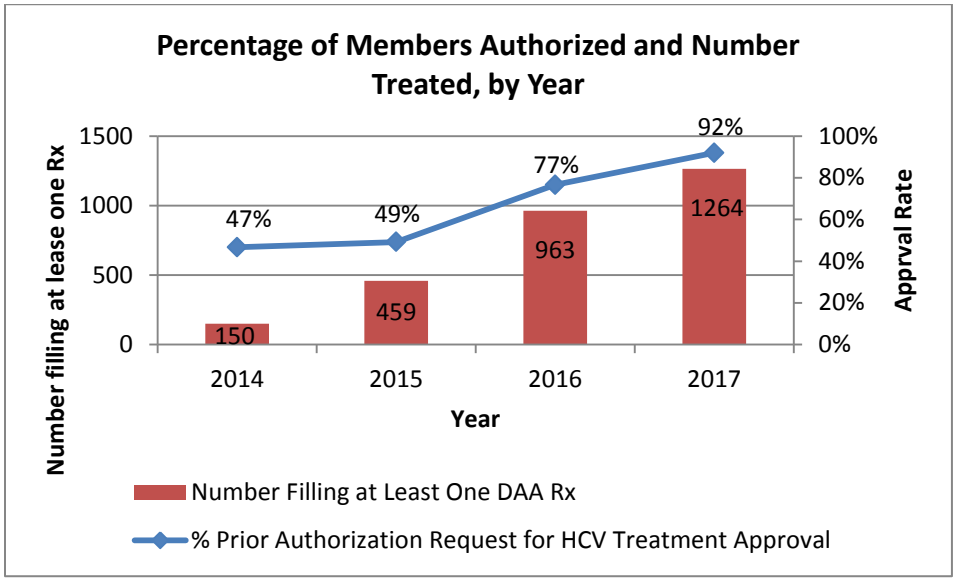
The DY4, HCV Delivery System Improvement Performance Target (DSIPT) was increased to 70% of their member-months, an increase from 50% in 2016. HSD continued to host quarterly meetings and work with the MCOs to support the HCV treatment delivery system and assure members' access to care. The group addressed issues related to screening, case finding, provider training, collaboration with the New Mexico Department of Health on data sharing, and many other issues. HSD worked with the actuarial contractor to provide the MCOs with a formula to estimate the HCV DSIPT based on the MCOs' monthly member enrollment. This enabled the MCOs to evaluate their own performance on a regular basis. By mid-September of 2017, all of the MCOs have asked and were approved to expand their treatment coverage to all adult members with chronic infection, regardless of fibrosis level.

In late 2017 HSD issued a Letter of Direction to the MCOs in order to clarify the Medicaid benefit coverage and expectations related to treatment of HCV. This letter directed the MCOs to expand the treatment criteria for all members over the age of 17 with active HCV infection (F0,

F1, F2, F3, F4, decompensated cirrhosis, and hepatocellular carcinoma). In addition, the MCOs were given specific instructions to reconsider previously denied HCV treatment requests using the new criteria as well as develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico, including incentive(s) to receive training in the treatment of chronic HCV infection, incentive(s) to begin treating such patients, and incentive(s) for treatment of each patient.

HSD reviewed the MCOs' monthly HCV prior authorization reports and at year end compared prior authorization approval rates to the number of members filling at least one direct-acting antiviral (DAA) prescription. In 2017 there was a 92% approval rate for treatment, an increase from the 77% in the previous year. Additionally, preliminary analysis of the 2017 encounter data shows that there were 1,264 members that filled at least one DAA prescription. Please see Table 6: Percentage of Members Authorized for Treatment and Number Treated by Year.

Table 6 – Percentage of Members Authorized for Treatment and Number Treated by Year



Community Interveners

In DY4, there were five Centennial Care members who received Community Intervener (CI) services. The MCOs continue to provide education to their care coordinators to assist in identifying members that meet the criteria for the CI service. The MCOs also continue to provide assistance and resolution on billing issues to the CI providers as needed.

Table 7 – Consumers and Community Intervener Utilization

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBS	2	988	$6,249
MHC	0	0	$0
UHC	2	678	$4,293
PHP	1	351	$9,156
Total	**5**	**2,017**	**$19,698**

Long-Term Services and Supports

Long-Term Care (LTC) Workgroup

The LTC Workgroup continued its activities in DY4. The LTC workgroup had many accomplishments in DY4 including but not limited to:

- Monitoring the implementation of the Community Benefit Services Questionnaire (CBSQ) through ride-alongs with care coordination and monthly MCO reporting of the number of completed CBSQs;
- Collaborating on the implementation of the CMS Final Settings Rule;
- Collaborating on LTC policy changes, including policies and procedures related to the statewide Electronic Visit Verification (EVV) System;
- Recommending improvements to the Functional Assessment Tool;
- Implementing a mandatory requirement for Self-Directed employees to use an online timesheet system;
- Implementation of a project that focused on the alignment of MCOs for dually eligible members; and
- Collaborating on the development of trainings for MCO staff.

Home and Community-Based Services Final Rule

In January 2017, HSD received initial CMS approval of its Statewide Transition plan. In late 2017, HSD in partnership with the Aging and Long-Term Services Department (ALTSD), conducted on-site provider reviews and participant surveys as required by CMS. HSD continues to update its Final Setting Rule milestones.

Training

In DY 4, HSD conducted several LTC related trainings with the MCOs that included the following topics:

- Allocating persons who are not otherwise Medicaid eligible to receive community benefits;

- Provider enrollment requirements for Personal Care Service (PCS) providers who want to also enroll as Respite providers;
- How to become a Centennial Care Community Benefit (CB) provider for CB services; and
- Prior authorization procedures, allowable services and provider policies and rules specific to Assisted Living Facilities.

Electronic Visit Verification (EVV)

The full implementation of an EVV system beginning in November of 2016 has proven successful, even in New Mexico's frontier and no-tech zone areas due to the seven day store and forward capability in the system. In DY4, MCOs and their subcontractors continued to provide assistance to PCS agencies with the EVV system, connectivity issues, and billing as needed. Many agencies have implemented new business practices and employee policies in order to come into compliance with EVV requirements. In DY4, HSD implemented a new reporting process with the MCOs to monitor ongoing EVV compliance.

HSD and the MCOs partnered with the New Mexico Association for Home Health and Hospice Care (NMAHHC) to provide information on the EVV system and discuss provider concerns at the Association's quarterly conferences. Providers appreciate this collaboration.

Centennial Rewards

The Centennial Rewards program was developed with the launch of Centennial Care as a way of providing incentives to members for engaging in and completing healthy activities and behaviors, including:

- **Healthy Smiles** to reward annual dental visits for adults and children;
- **Step-Up Challenge** to reward completion of a 3-week or 9-week walking challenge;
- **Asthma Management** to reward refills of asthma controller medications for children;
- **Healthy Pregnancy** to reward members who join their MCO's prenatal program;
- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes;
- **Schizophrenia and/or Bipolar Disorder Management** to reward members who refill their medications; and
- **Bone Density Testing** to reward women age 65 or older who complete a bone density test during the year.

Members who complete these activities can earn credits, which can then be redeemed for items in the Centennial Rewards catalog. All Centennial Care members are eligible for Centennial Rewards. To date, 685,460 distinct members, or 72% of all Centennial Care enrollees, have earned at least one incentive or reward. While the program just completed its fourth full year, data is not yet available for the fourth year. Three full years of data reflect members have earned points totaling a value of $51 million. The table below shows the healthy behaviors that have

been rewarded and each activity's value in dollars. It includes the maximum dollar value available for each activity and the total dollars earned.

Table 8 – Healthy Behaviors Rewarded

Reward Activities	Reward Value in Points, by Activity	Maximum Reward Dollar Value	Total Rewards Earned (Dollar Value)
Asthma Management	600	$60	$1,221,510
Bipolar Disorder Management	600	$60	$1,438,670
Bone Density Testing	350	$35	$66,465
Healthy Smiles Adults	250	$25	$10,597,350
Healthy Smiles Children	350	$35	$23,941,855
Diabetes Management	60	$60	$5,826,440
Healthy Pregnancy	1000	$100	$1,530,200
Schizophrenia Management	600	$60	$721,615
Step-Up Challenge	500	$50	$580,025
Health Risk Assessment*	10	$10	$4,394,170
Other (Appeals and Adjustments)	N/A	N/A	$646,548
Totals			**$50,964,848**

***HRA completion was discontinued as a rewardable activity at the end of CY2016**

The Step-Up Challenge remains the most popular activity offered through the Centennial Rewards program, with more than 90,000 members having registered for the Challenge and logged their steps to date. Data shows that participants in the Step-Up Challenge continue to show lower costs and improved quality across multiple indicators.

Overall, New Mexico's Centennial Rewards program has achieved over $100 million in savings since 2014, and participants across all conditions have shown 20% to 50% higher compliance with HEDIS-related scores. Participant costs were between 2.2% and 27% lower across all conditions, with reduced inpatient admissions and lower costs per admission among participants being the predominant driver behind cost savings. Notably, rates of behavioral health medication adherence exceed 80% among Rewards participants. The state has also seen overall increases in preventive screenings, high value PCP visits, and pharmacy refills among participants.

Participation in the Centennial Rewards program remains remarkably strong and is likely the highest participation rate for a program of its 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 96% of members reporting satisfaction with the Centennial Rewards program, and 97% reporting that the program has led them to making healthier choices.

Other Operational Issues

Contract Amendments

There was one amendment to the Medicaid Managed Care Services Agreement in DY4 Contract Amendment #7can be found on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx.

Adverse 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 (BHSD) on the delivery of BH 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. The Critical Incident Report (CIR) trainings are held annually to ensure providers have an understanding of reporting requirements.

Daily review of incident reports is conducted by the MCOs and the HSD CI unit. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.

Critical Incidents are being reported quarterly by each MCO. One hundred percent of all critical incidents received through the HSD CI web portal are reviewed. This data is trended and analyzed by HSD.

During DY4, 17,756 critical incidents were filed for Centennial Care, Behavioral Health and Self-Directed members. Of the 17,756 reports filed, 4,094 reports were submitted in Q4; 4,261 in Q3; 4,597 in Q2; and 4,804 in Q1. MCOs have a multi-level educational process with internal and external collaborators to reduce inaccurate and un-timely submissions.

During DY4, a total of 1,743 deaths were reported. This is an increase from DY3 (1,698) and DY2 (1,433); however, the increase correlates with continued annual enrollment increases in the program. Of the 1,743 deaths reported, 1,574 deaths were reported as natural, expected deaths; 160 deaths were reported as unexpected; and nine were reported as suicides. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

All critical incident reports require follow up. Follow up can include medical record review, diagnoses or records from the Office of the Medical Investigator (OMI) to determine a cause of death. MCOs have internal processes to follow up on all deaths.

During DY4, Centennial Care, Behavioral Health and Self Directed populations reported a total of 11,464 (64.56%) critical incidents for Emergency Services. Of those Emergency Services reports, 963 were Behavioral Health related and 735 were for the Self-Directed population. MCOs collaborate with internal and external stakeholders to develop new practices to establish member contact in attempts to better serve the member. HSD will continue to monitor any decreases or increases of emergency services reports.

Table 9 – DY4 Critical Incidents

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	127	0.72%	387	2.18%	301	1.70%	292	1.64%	1,107	6.23%
Death	400	2.25%	410	2.31%	337	1.90%	596	3.36%	1743	9.82%
Natural/Expected	364		346		296		568		1,574	
Unexpected	36		60		38		26		160	
Suicide	0		4		3		2		9	
Elopement/Missi	17	0.10%	28	0.16%	43	0.24%	20	0.11%	108	0.61%
Emergency	2,366	13.33%	3,641	20.51%	2,409	13.57%	3,048	17.17%	11,464	64.56%
Environmental	37	0.21%	49	0.28%	81	0.46%	115	0.65%	282	1.59%
Exploitation	97	0.55%	125	0.70%	98	0.55%	188	1.06%	508	2.86%
Law Enforcement	62	0.35%	116	0.65%	66	0.37%	82	0.46%	326	1.84%
Neglect	395	2.22%	547	3.08%	581	3.27%	695	3.91%	2,218	12.49%
Total	**3,501**	**19.72%**	**5,303**	**29.87%**	**3,916**	**22.05%**	**5,036**	**28.36%**	**17,756**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	36	2.00%	195	10.82%	77	4.27%	16	0.89%	324	17.98%
Death	6	0.33%	58	3.22%	9	0.50%	6	0.33%	79	4.38%
Natural/Expected	1		45		3		4		53	
Unexpected	5		11		4		2		22	
Suicide	0		2		2		0		4	
Elopement/Missi	9	0.50%	9	0.50%	18	1.00%	1	0.06%	37	2.05%
Emergency	56	3.11%	764	42.40%	98	5.44%	45	2.50%	963	53.44%
Environmental	2	0.11%	3	0.17%	8	0.44%	0	0.00%	13	0.72%
Exploitation	5	0.28%	17	0.94%	2	0.11%	1	0.06%	25	1.39%
Law Enforcement	10	0.55%	28	1.55%	15	0.83%	2	0.11%	55	3.05%
Neglect	21	1.17%	213	11.82%	41	2.28%	31	1.72%	306	16.98%
Total	**145**	**8.05%**	**1,287**	**71.42%**	**268**	**14.87%**	**102**	**5.66%**	**1,802**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	11	1.08%	33	3.25%	44	4.33%	11	1.08%	99	9.75%
Death	12	1.18%	12	1.18%	21	2.07%	18	1.77%	63	6.21%
Natural/Expected	12		8		16		17		53	
Unexpected	0		4		5		0		9	
Suicide	0		0		0		1		1	
Elopement/Missi	0	0.00%	4	0.39%	3	0.30%	0	0.00%	7	0.69%
Emergency	113	11.13%	124	12.22%	359	35.37%	139	13.69%	735	72.41%
Environmental	0	0.00%	1	0.10%	2	0.20%	3	0.30%	6	0.59%
Exploitation	5	0.49%	7	0.69%	10	0.99%	11	1.08%	33	3.25%
Law Enforcement	6	0.59%	6	0.59%	7	0.69%	1	0.10%	20	1.97%
Neglect	8	0.79%	2	0.20%	23	2.27%	19	1.87%	52	5.12%
Total	**155**	**15.27%**	**189**	**18.62%**	**469**	**46.21%**	**202**	**19.90%**	**1,015**	**100.00%**

Action Plans

MCOs proactively initiate internal Corrective Actions Plans (CAPs) throughout the year to address areas of noncompliance or areas for improvement. In DY4, HSD monitored each MCO's

initiation, progress, and closure of CAPs, which were reported by the MCOs as follows: In Q1DY4, seven CAPs in progress and three closed; Q2DY4, seven CAPs in progress and two closed; Q3CY4, eight CAPs in progress and three closed; and Q4CY4, eight CAPs in progress and three closed. For additional details, a summary and progress updates are provided as an attachment with each quarterly report.

Evaluation Activities

Progress under the Centennial Care 1115 Waiver Evaluation Design Plan activities continued throughout DY4. Major activities consisted of: finalizing the data and report collection for the completion of the DY3 Annual Report; initiating the data collection process for DY4; development of timelines and contract deliverables for DY4; and initiating discussions on report content and structure of the Final Evaluation Report.

Various discussions were held between Deloitte and HSD's evaluation teams as well as key contacts across Centennial Care reporting divisions to appropriately address any changes in reporting methodologies or to identify new or additional data sources. Deloitte and HSD collaborated to streamline DY3 reporting activities to focus primarily on a review of the analyses performed on each hypothesis and goal. The process of assessing and monitoring progress consisted of analyzing a selected sample of the most relevant performance measures from the Evaluation Design Plan. This approach will provide for a more up to date view of the key analyses and results.

The principal milestone achieved during DY4 was the submission of the Interim Evaluation Report. The report provided detailed information related to the Centennial Care program design and goals, testable hypothesis and analysis, and findings of over one hundred performance measures to provide a basis for drawing conclusions on the effectiveness of Centennial Care.

The following provides a timeline of major activities related to the submission of the Interim Evaluation Report:

- May 1st, 2017: Initiation of Interim Evaluation Report outline drafting;
- July 7th, 2017: Completion of draft outline of Interim Evaluation Report;
- August 8th, 2017: On-site discussion with Deloitte evaluation team, HSD evaluation team and various subject matter experts across different Centennial Care reporting divisions;
- September 10th, 2017: Completion of draft Interim Evaluation Report
- October 13th, 2017: Submission of finalized Interim Evaluation Report to HSD

Interim Findings

During DY4, HSD's contractor completed the Centennial Care Interim Evaluation Report. Highlights from the interim evaluation, based on data through calendar year (CY) 2015 and preliminary CY2016 data, include:

- **Improving Access to Care –** The 1115 Waiver Evaluation noted mixed progress in timely access to care related to several measures as compared to the baseline2 of the Centennial Care program. Improvements were found in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans opting into Centennial Care, the ratio of providers to members, increased access to telemedicine, the percentage of members utilizing newly available BH services (BH respite, family support, and recovery services), and the rate of flu vaccinations.

  Conversely, declines were found in the percentage of members who had an annual dental visit (although the rates across the cohorts are higher than the national averages), the number of adult members accessing preventive/ambulatory services, the percentage of members who had a PCP visit, the percentage of PCPs with open panels (though the overall percentage of open panels remained above 90%), breast cancer screening rates, cervical cancer screening rates, childhood and adolescent immunization rates, and prenatal and postpartum care, and the percentage of members utilizing mental health services (as indicated by their principal diagnosis)3. These declines represent potential areas for improvement in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the continued influx of these members.

  It should be noted that a significant transition within the behavioral health provider network took place during 2015 (DY2). There was a concerted effort to rebuild the network which included supporting Federally Qualified Health Centers (FQHCs) with the expansion of their service offerings to cover behavioral health services through support of obtaining additional required certifications to offer these specialized services. While some gaps in the network existed for a time resulting in service delays, the efforts by New Mexico and other stakeholders helped to quickly resolve these issues and reduce the concern of future service delays or access limitations.

- **Improving Care Coordination and Integration –** The Evaluation indicated general progress in both care coordination and integration activities. Improvements were noted in the percentage of members the managed care organizations (MCOs) were able to engage, the percentage of members for whom Health Risk Assessments (HRAs) were completed, the percentage of Level 2 members who received telephonic and in-person outreach, the percentage of members who had a BH service and also received outpatient ambulatory visits, and the Emergency Room (ER) visit rates among members with BH needs.

There has been an increase in the number of unique members receiving Home and Community-Based services (HCBS), and an overall increase in HCBS provided. New Mexico continues to be successful in its rebalancing efforts with 84.6% of long-term care members receiving long-term services in their homes and 13.6% of members residing in nursing facilities.

Conversely, a higher percentage of LTSS members had ER visits, a lower percentage of members with schizophrenia or bipolar disorder received diabetes screening, a lower percentage of members with schizophrenia and diabetes received tests for diabetes monitoring.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care. There were improvements in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening ratios; increases in monitoring rates of Body Mass Index (BMI) for adults, children and adolescents; and increases in asthma medication management. Hospital admission rates also decreased across all five ambulatory care sensitive (ACS) measures. Finally, there was a decline in the percentage of ER visits that were potentially avoidable.

- **Reducing Expenditures and Shifting to Less Costly Services –** The Evaluation found that the program continued to demonstrate significant savings in comparison to the waiver budget neutrality threshold through DY3. Total program expenditures for DY3 alone were 21.8% below the budget-neutral limits as defined by the Special Terms and Conditions (STCs), which includes per member per month (PMPM) cost caps by MEG, uncompensated care costs, and Hospital Quality Improvement Incentive (HQII) pool amounts. The total cost of Centennial Care for DY1, DY2, and DY3 combined is below the budget neutrality limits as defined in the STCs4 by about $2.5 billion, or 15.8%.

  In addition, inpatient claims exceeding $50,000 as a percentage of healthcare costs were slightly lower. There were also decreases in hospital readmission rates, positive increases in the use of substance abuse services and use of HCBS, positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and positive shifts from higher level of care (LOC) Nursing Facility (NF) utilization to lower LOC NF utilization.

- **Increased Member Engagement** – There was a significant increase in the number of members enrolled in the Centennial Rewards program and performing various wellness-related activities designed to earn rewards under the program; at the end of DY1, approximately 47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered

for the program. There are over 40 activities members can perform to earn rewards from adhering to refilling monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased through DY2.

Note that the Centennial Rewards program was a brand new program that required introductory member outreach for making members aware of the program and how to participate. It began April 1, 2014 and thus there were fewer months in DY1 in which members were able to register and participate in the program.

- **Increased Member Satisfaction –** The Evaluation found that member satisfaction results largely improved from the baseline to DY2. Measures that exhibited improvements included the percentage of expedited appeals resolved on time and the percentage of appeals upheld. Improvement was also noted in the number of appeals partially overturned and overturned, marked by decreases through DY2. Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY2.

  It is important to note that total Centennial Care member months increased from DY1 to DY3 by about 1,306,000, or 17.8%1. The vast majority of this increase was driven by Medicaid Eligibility Group (MEG) 6, (named "VIII Group"), which is the Medicaid adult expansion group. Enrollment in VIII Group grew by 63.3% from DY1 to DY3. Members eligible under this MEG are individuals at or below 133% federal poverty level (FPL) who are between ages 19 and 64 and who do not qualify for Medicaid under a previously implemented MEG (e.g. not disabled and not pregnant women).

Quality Assurance Monitoring Activities

Care Coordination Audits

HSD continues to monitor MCO monthly progress reports evaluating care coordination activities. These progress updates outlined the MCOs' efforts to improve care coordination practices according to HSD's recommendations and action steps from the November 2015 care coordination audit. The MCOs continue to implement internal processes to improve care coordination and provide training on accurate documentation as well as contract and policy requirements for their care coordination teams. HSD conducted a meeting with each MCO in July 2017 to discuss progress reports and review the evaluation results of MCO implemented care coordination interventions. The MCOs' internal audits for action steps and recommendations showed improvement and HSD closed out corrective action plans when the internal audit results evidenced substantial compliance for three consecutive quarters. HSD was pleased that all action steps and recommendations from the 2015 audit were completed for PHP during DY4. BCBS, UHC and MHC also had several action steps completed in DY4.

Additional audits were conducted in September 2017 for transition of care member file compliance as well as level of care coordination designation. HSD found with the transition of care audit that member files did not consistently contain all required information such as Medicaid eligibility status, disaster plan or identification of physical health, behavioral health or community needs. The results of these audits prompted HSD to issue additional action steps and recommendations to the MCOs which will be monitored monthly during DY5. Level of care audits found that some members who met criteria for care coordination level 2 or level 3 were not assigned to care coordination. In some instances this was due to those members being enrolled in the MCOs' Dual Special Needs (DSNP) plans for members with both Medicare and Medicaid eligibility. The DSNPs have specific care coordination requirements apart from Centennial Care. These issues have been addressed and follow up with members has been requested. HSD will continue to audit level of care coordination designation and conduct ongoing quarterly MCO meetings in DY5.

In June and August 2017, HSD provided additional training on accurate documentation, best practices and care coordination requirements to reinforce the areas targeted in the care coordination audits. Topics included consistency in care coordination touchpoints, best practices and tips for conducting Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs) as well as tips on motivational interviewing techniques. Areas covered also included a discussion of the care coordination audit findings, review of the HSD policy and contract, aligning physical health and behavioral health needs identified from the CNA with the CCP goals, enhancing falls documentation, individualizing and distinguishing between backup plans and disaster plans, and effectively capturing on-going care coordination activities and member feedback. HSD received positive feedback that consistent and regular training assist their staff in maintaining a high level of quality in documentation and reinforcing excellent care coordination skills.

Care Coordination for Super Utilizers

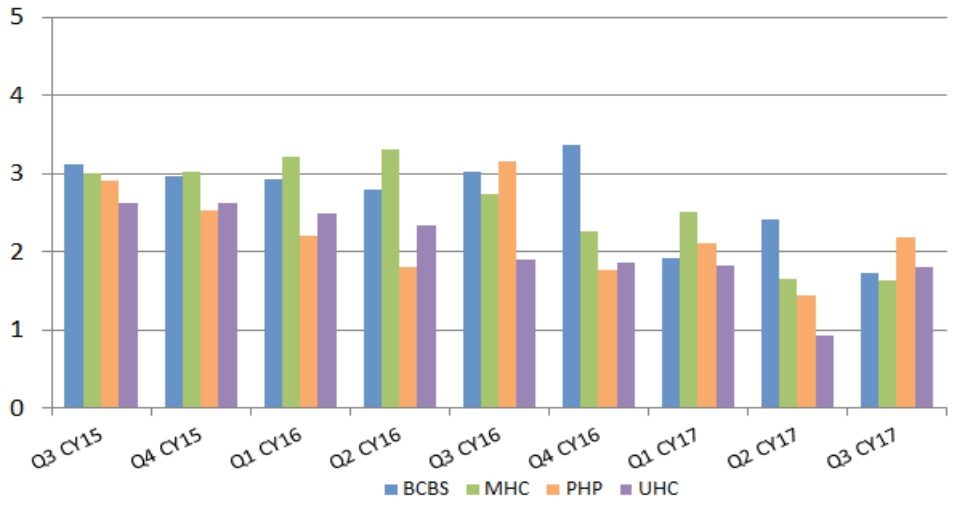
HSD utilizes PRISM software to track members who are high utilizers of the Emergency Department (ED) and works with the MCOs on implementing interventions to reduce unnecessary ED utilization.

- PRISM is an integrated software tool used to support care management interventions for high risk Medicaid patients.
- HSD utilized PRISM data to identify the MCOs' highest utilizers of the ED.
- In DY2, HSD began tracking the top ten members for each MCO. In DY3, HSD began tracking the top 35 super utilizers per MCO.
- During DY4 HSD monitored monthly reports on each "super utilizer" group, tracking the number of ED visits, supplemental care information and care coordination activities to reduce non-emergent ED utilization.

HSD provided feedback to each MCO targeting specific member issues, encouraging unique engagement efforts and working with MCO representatives to devise new methods to reach 'difficult to engage' members. Some of the new initiatives included:

- In DY4, UHC adapted a policy to consider all of its "super utilizer" members to be at care coordination level three with additional touchpoints, targeted interventions and increased attention to these member's needs. This policy, along with continued efforts by care coordinators, has shown success in reducing the average ED usage among members.
- BCBS has had success connecting with difficult to engage members through its regional peer support groups. In addition it has partnered with the New Mexico Hospital Association to assist in finding members who have been "unable to locate".
- In DY4, PHP began connecting with members at methadone clinics and reached over 100 members including "super utilizers" through having a presence at these locations. Using both peer support specialists and care coordinators and by varying the times staff were available, they had success in sharing resources and linking members to needed services.
- MHC successfully assisted several of its members to obtain housing by linking its housing support specialist to those super utilizer members in need. Once housing is secured, other aspects of care coordination are accomplished with more ease for the member.

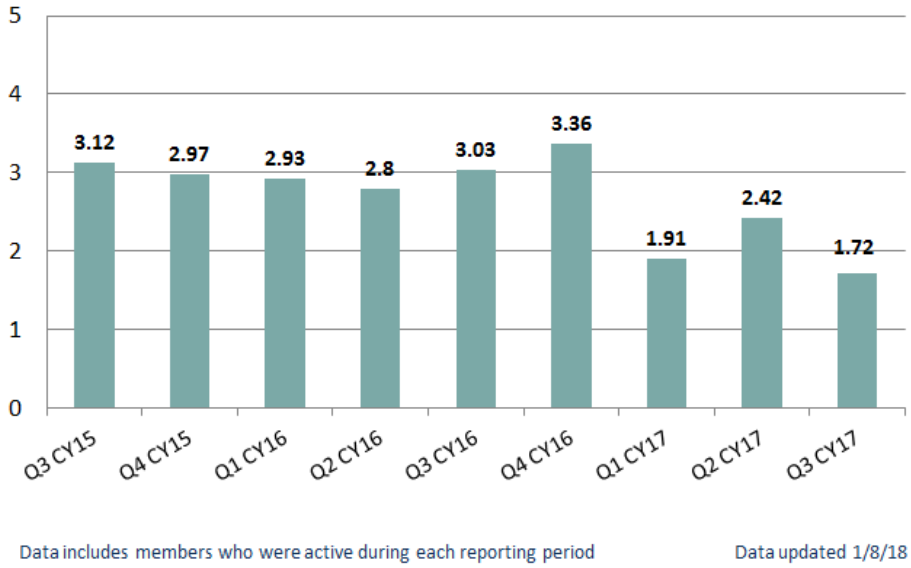
The following graph illustrates average quarterly ED visits for each of the MCOs' top 35 super utilizers.



Data includes members who were active during each reporting period

Data updated 1/8/18

The graph below illustrates the continued decline in average ED use over the period of the project-showing the average ED visits per member for all MCO's has fallen by 45%.



Other MCO efforts to reduce Non-Emergent Emergency Room Use

- Assigning Community Health Workers to high utilizers;
- Engaging members with Peer Support Specialists;
- Meeting members throughout the community for enhanced engagement;
- Utilizing EDIE software for instant notification when a member is in the ER;
- Including Housing Support Specialists to access housing opportunities for homeless members;
- Video physician visits continue to be utilized by all MCOs including access through smart phones;
- Working with local and regional agencies to connect with untapped resources; and
- Employing a team approach to include professionals from all areas to address members' unique needs.

Care Coordination and EDIE System

The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016 with additional hospitals and emergency facilities joining the effort throughout 2017. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit

history, diagnoses, prescriptions, guidelines, and other clinical metadata. As a result of the notification, the provider has information in hand before seeing the patient. This allows the provider to take action and to influence health care outcomes. Due to the increased use of EDIE, MCOs have reported continual incoming data that has allowed them to better assist those members utilizing ED, rapidly see those members with emergent needs and connect difficult to engage members with care coordinators. It is anticipated that this system will reduce the costs associated with unnecessary ED visits especially as more agencies participate. Currently there are 39 hospitals participating across the state. Targeted training of staff is being scheduled with some participating agencies and specific technical issues are being worked on with others. A standardized care plan is being looked at by committee members tasked for that purpose. HSD and all participants are confident that as more sites are launched, training is completed and standardized care plans implemented, more agencies will see the benefits of EDIE and the project will continue to grow.

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. HSD attends monthly meetings with BCMDC and MHC focusing on care coordination activities and member outcomes. Currently there are 366 members who have agreed to participate in this program. The number of participants has steadily increased throughout DY4 with the number of those referred and declining participation decreasing. MHC has worked closely with BCMDC to lower the number of participants who are missed due to early release and have been pleased to show that increased communication has that number currently at zero. Connecting with participants who are released and then difficult to engage has continued to be a priority for MHC. Care coordinators have been connecting with pharmacies and providers for updated participant information when recent claims have occurred. MHC has engaged more community connectors to locate members and identify and address any social determinants as a way to reengage members in care coordination services. A current challenge is understaffing at the BCMDC which is placing a temporary hold on new referrals to the project. On a positive note, BCMDC has broken ground on a re-entry center which HSD believes will assist members who are being released into the community. HSD foresees future expansion of corrections engagement throughout DY5.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY4, "ride-alongs" were conducted with all four MCOs with staff observing initial CNAs in member's homes. During DY4, HSD observed the interviewing styles of care coordinators, whether all the necessary information was gathered, and whether all resources and services were presented to members. 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. Observations during future "ride-alongs" will inform what additional information may be included in DY5 care coordination training.

Service Plans

HSD continues to randomly review 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 the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and the member's goals are identified in the care plan. There were no identified concerns for DY4.

Table 10 – 2017 Service Plan Audit

Service Plans	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017	DY4 Totals
Member files audited	120	120	120	120	480
Percent of service plans with personalized goals matching identified needs	100%	100%	100%	100%	100%
Percent of service plans that hours allocated matched need	100%	100%	100%	100%	100%

Nursing Facility Level of Care (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. HSD was in agreement with all MCO NF LOC decisions for DY4. All NF LOC decisions were appropriate and complied with NF LOC criteria.

Table 11 – 2017 NF LOC Audit

	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017	DY4 Totals
High NFLOC requests denied (and downgraded to Low NF)					
Number of member files audited	17	17	17	15	66
Number of member files that met the appropriate level of care criteria	17	17	17	15	66
Percent of MCO level of care determination accuracy	100%	100%	100%	100%	100%
Low NFLOC requests denied (Community Benefit)					
Number of member files audited	20	22	22	25	89
Number of member files that met the appropriate level of care criteria	20	22	22	25	89
Percent of MCO level of care determination accuracy	100%	100%	100%	100%	100%

The External Quality Review Organization (EQRO) for HSD reviews a random sample of MCO NFLOC determinations every quarter.

Table 12 – 2017 EQRO NF LOC Review

Facility Based	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017	DY4 Totals
High NF Determination					
Number of member files audited	29	27	23	28	107
Number of member files the EQRO agreed with the determination	24	24	22	27	97
%	83%	89%	96%	96%	91%
Low NF Determination					
Number of member files audited	79	81	85	80	325
Number of member files the EQRO agreed with the determination	77	81	85	78	321
%	97%	100%	100%	98%	99%
Home and Community Based					
Number of member files audited	156	156	156	156	624
Number of member files the EQRO agreed with the determination	155	154	153	153	615
%	99%	99%	98%	98%	99%

HSD reviewed NF LOC determination disagreements from EQRO audits from DY4 and was in agreement with all of EQRO findings. Issues identified included: conflicts in documentation, incomplete supporting documentation, and supporting documentation dated outside the required time period. HSD reviewed determinations with the MCOs through technical assistance calls for Q1 and Q2 and via deliverable in Q3 and Q4. All four MCOs provided clarification regarding identified issues and reviewed their internal procedures to monitor quality and plans moving forward to further improve accuracy. HSD noted that the MCO High NF determinations improved over the course of DY4 with the EQRO in agreement with 96% of the determinations in Q3 and Q4 compared to 83% in Q1 and 89% for Q2. MCO HNF determinations totaled 91% for DY4. The MCO Low NF determinations did not go below 97% during DY4 and achieved 100% in Q2 and Q3. MCO Low NF determinations totaled 99% overall for DY4. Community based determinations consistently totaled 98-99% for EQRO agreement and overall determinations totaled 99% for DY4. 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.

Post Award Forum

Beginning in Q4DY3 and throughout DY4, HSD solicited public input about the Centennial Care program in a wide variety of ways. At the end of DY3, HSD created a subcommittee of the

Medicaid Advisory Committee (MAC) to provide input on areas of improvement for the program. The MAC subcommittee met from October 2016 through February 2017 and the Native American Technical Advisory Committee met during the months of December 2016 through April 2017 to develop recommendations for improving Centennial Care. The input from both committees was utilized to develop New Mexico's concept paper for its renewal of the 1115 waiver that authorizes the program, which was released in May 2017. In addition, HSD made improvements to the program that could be implemented without waiver authority and through MCO contractual requirements that are effective on January 1, 2018. In April and October 2017, full MAC meetings were held to solicit public input on Centennial Care as well as for feedback about the changes outlined in the waiver renewal concept paper (April) and in the draft 1115 waiver renewal application (October).

Between May and October 2017, public input regarding Centennial Care was submitted via email, phone, or mail. In June of 2017, HSD staff traveled to different geographical areas of the state to solicit public feedback about the program. Advance newspaper notice was provided to advertise the events. In October 2017, HSD conducted four public hearings in different geographical areas of the state to solicit public input about Centennial Care and the changes to the program proposed in the draft 1115 waiver renewal application Advance newspaper notice was provided to advertise those events. During the months of June and October 2017, HSD also conducted two formal Tribal Consultations regarding the 1115 waiver renewal including proposed programmatic changes. Please see Attachment F: Public Comments Summary and Response. Note that the attachment includes a summary of the comments submitted during the formal public hearings but does not include the entire year-long compilation of public feedback which is contained in a large Excel file.

Table 13 - Summary of Public Input Process for 1115 Waiver Renewal Application

Event	Dates
Planning and Design Meetings:	
Subcommittee of the MAC Meetings	
• Santa Fe	October 14, 2016
• Albuquerque	November 18, 2016
• Santa Fe	December 16, 2016
• Albuquerque	January 13, 2017
• Santa Fe	February 10, 2017
NATAC Meetings	
• Albuquerque	December 5, 2016
• Albuquerque	January 20, 2017
• Santa Fe	February 10, 2017
• Albuquerque	April 10, 2017

Event	Dates
MAC Meetings (All meetings held in Santa Fe)	November 14, 2016 April 3, 2017 October 16, 2017
Publish Date - Concept Paper	May 19, 2017
Gather Feedback - Concept Paper Statewide Public Input Sessions • Albuquerque • Silver City • Farmington • Roswell	 June 14, 2017 June 19, 2017 June 21, 2017 June 26, 2017
NATAC Meeting (Albuquerque)	July 10, 2017
MAC Meeting (Santa Fe)	July 24, 2017
Formal Tribal Consultation (Albuquerque)	June 23, 2017
Notice Period - 60-day advanced notification to Native American / Tribal stakeholders regarding 1115 waiver renewal application	August 31, 2017
Publish Date - Draft 1115 Waiver Application	September 5, 2017
Gather Feedback - Draft Waiver Application Public Hearings & Tribal Consultation Meeting sites: • Public hearing: Las Cruces • Public hearing: Santa Fe (MAC meeting) • Public hearing: Las Vegas • Tribal consultation: Santa Fe • Public hearing: Albuquerque	 October 12, 2017 October 16, 2017 October 18, 2017 October 20, 2017 October 30, 2017
Final Waiver Application Submission to CMS	December 5, 2017

SECTION III: TOTAL ANNUAL EXPENDITURES

Table 14 – Waiver Year 4 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
MEG01 - TANF & Related	$ 1,431,162,319	$ 72,935,913
MEG02 - SSI & Related - Medicaid Only	$ 839,861,416	$ 7,917,402
MEG03 - SSI & Related - Dual Eligible	$ 552,047,932	$ 7,362,093
MEG04 - "217 Like" Medicaid Only	$ 12,410,795	$ 75,896
MEG05 - "217 Like" Dual Eligible	$ 111,430,661	$ 648,379
MEG06 - VIII Group - Medicaid Expansion	$ 1,418,096,328	$ 58,788,989
MEG07 - CHIP	$ 103,055,034	$ 10,593,709
Uncompensated Care "UC" Pool	$ 51,666,993	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Grand Total	**$ 4,519,731,478**	**$ 158,322,381**

Source: New Mexico CMS 64 Submission, FFY18 Quarter 1, February 7, 2018

SECTION IV: YEARLY ENROLLMENT REPORT

Table 15 – Demonstration Year 4 Enrollment

Demonstration Population		
	DY4 Member Months (as of 1/2/18)	DY4 Enrollment (as of 1/2/18)
Population 1 – TANF and Related	1,121,156	373,808
Population 2 – SSI and Related – Medicaid Only	117,287	39,238
Population 3 – SSI and Related – Dual	105,472	35,984
Population 4 – 217-like Group – Medicaid Only	1,152	371
Population 5 – 217-like Group – Dual	9,866	3,461
Population 6 – VIII Group (expansion)	755,981	271,084
Totals	2,110,914	684,708

Note: This data was extracted on January 2, 2018. Due to retro-active eligibility, member months continue to increase slightly after the end of the waiver year.

SECTION V: MANAGED CARE DELIVERY SYSTEM

Accomplishments

Centennial Care Improvements

- The primary care provider-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties.
- In collaboration with HSD, MCOs identified opportunities to improve encounter reporting and performance. MCOs enhanced system capabilities to remediate identified defects and developed process flows to map all data processing points including claims processing, encounter submission, and HSD encounter acceptance.
- MCOs are collaborating with paramedics to target high utilizers of 911 services, Emergency Department (ED) services, and those recently discharged, in order to re-engage these members in care coordination, provide education on preventive care and chronic conditions, promote the utilization of appropriate physical and behavioral health services, and reduce non-emergent ED visits. Some of these programs include, but are not limited to: Community Paramedicine and Santa Fe Fire Department Pilot Program. MCOs continue to utilize telemedicine to provide access to specialty providers and behavioral health providers especially for those members residing in rural and frontier geographic locations. As an example, one MCO implemented virtual physician visits. Members have access to board-certified doctors, psychiatrists, or licensed therapists that can help treat conditions such as allergies, asthma, cough, anxiety, and several other conditions. Access is available twenty-four hours a day, seven days a week and the average wait time is less than ten minutes.
- MCOs were directed to expand the treatment criteria for members with active Hepatitis C Virus (HCV) infection to include all members with active HCV infection for three months. MCOs were to reconsider previously denied HCV treatment requests using the new criteria. Additionally, each MCO was directed to develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico.

Report Revisions

HSD revises reports to streamline elements from various reports, improve monitoring of MCO performance, and incorporate requirements of the managed care final rule, etc. The report revision process is initiated through a formal written process in which HSD and MCOs request needed changes to data elements. A revision workgroup to include subject matter experts (SMEs) is developed for each report revision to ensure the needs of all stakeholders are considered.

Improved Reporting Process

HSD utilizes MCO reports to monitor contract compliance. In DY4 the MCOs continued the Technical Assistance (TA) Calls and the Self-Identified Error Resubmission. These two

processes allow HSD and MCO SMEs to clarify data requirements and correct data inaccuracies. HSD is dedicated to obtaining accurate, complete and uniform data elements as the information received from the MCOs is used for a variety of analyses including state budget, legislative reports, and external stakeholder meetings.

Health Homes

On April 1, 2016 HSD launched the first two Health Homes, CareLink NM (CLNM), with a designated population of adults with serious mental illness and children/adolescents with severe emotional disturbance. The CLNM model provides for enhanced care coordination and integration of primary, acute, behavioral health, long term care services and social supports. Goals include: 1) Promoting acute and long term health; 2) Preventing risk behaviors; 3) Enhancing member engagement and self-efficacy, 4) Improving quality of life for members with SMI and SED; and 5) Reducing avoidable utilization of emergency department, inpatient, and residential services. These goals serve as the foundation for establishing both quality process standards and evaluation criteria for outcomes.

The initial provider base was restricted to two rural counties so processes could be tested, evaluated, and refined. MCOs and HSD staff including Medical Directors, quality experts and other leadership formed the CLNM Steering Committee with responsibilities for design approval, provider application processing and approval, and support and oversight.

The development of the automated information system, BHSDStar, was activated on April 1, 2017 and launched with data modules for registration, service planning and documentation, and interfaces to the Medicaid and MCO claims systems. Since then, the comprehensive needs assessment portion of the system has been finalized, a provider referral module is being developed, and a variety of system enhancements requested by providers have been implemented. Reporting functions have been developed and are being enhanced.

Delivery System Improvement Performance Targets (DSIPTs)

The DSIPTs allow MCOs to be recognized for their quality improvements in specific areas. In DY1 and DY2, HSD required four target areas for DSIPTs. In DY3, HSD expanded target areas by adding emphasis on five specific areas. HSD is currently evaluating the 2017 MCO results for DSIPT targets for DY4, which allows recognition of quality improvements, in the following five areas:

A. *Community Health Workers* – Increase the use of Community Health Workers (CHWs) with continued development of the workforce, for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in urban regions of the State.

   Community Health Worker 2017 Results - In 2017 a total of 53,913 MCO members were served by CHWs for a total increase of 28 percent. Each MCO utilized CHWs to expand services well above the 10 percent goal of members served. The goal for 2018 will be a 10 percent increase in members served.

B. *Patient Centered Medical Home* - A minimum of 5% increase of members being served by Patient Centered Medical Homes (PCMHs) or maintain a minimum of 45% of membership being served by a PCMH (including both PCMHs that have achieved NCQA accreditation and those that have not).

Patient Centered Medical Homes 2017 Results - PCMH membership in 2017 equals 316,211 members. All MCOs met their respective target by increasing PCMHs by 5% or maintaining a minimum of 45% of members served by PCMHs.

C. *Hepatitis C* - During DY4 contract period, MCOs must meet at least 70% of the MCO's target number of patients receiving Hepatitis C drug treatments for the combined Physical Health, Medicaid Only LTSS, and Other Adult Group populations.

Hepatitis C 2017 Results - As of February 2, 2018, utilizing the 2017 encounter data available to date, the preliminary target number of members to be treated was 1,197 for all MCOs and an estimated 1,264 members have been treated; hence, the overall MCOs' treatment number exceeded the target. HSD will be working with the encounter data at a later date when encounters are more complete to evaluate each MCO's performance.

D. *Value Based Purchasing* – In 2017 MCO's must meet a minimum of 16% of payments in VBP arrangements. Additionally at least 3% of the required 16% must be with high volume hospitals and require a readmission reduction target of at least 5% of the hospitals baseline.

Value Based Purchasing 2017 Results – All four MCO's have met the minimum of 16% of payments in VBP arrangements and the 3% requirement with high volume hospitals. One MCO has met the readmission reduction target. Final reporting will be submitted to HSD on May 15, 2018. Since the reporting is based on paid claims, HSD has allowed the MCO's to have a runout that matches the current runout on Financial Reporting.

E. *Telemedicine* - A minimum of a 15% increase in telemedicine "office" visits with specialists, included Behavioral Health providers, for Members in Rural and Frontier areas. At least five percent of the increase must be visits with BH providers.

Telemedicine 2017 Results – Utilization of telemedicine continues to increase. For 2017, there was a total of 26,046 telemedicine visits for all MCOs with 4,405 physical health telemedicine visits and 21,641 behavioral health telemedicine visits, which results in an average total increase of 53.6% from 16,953 in DY3. Three of the four MCOs met their respective target by increasing telemedicine by fifteen percent.

Community Health Workers

In DY4, all four MCOs included the use of Community Health Workers (CHWs) to serve a diversity of ethnic groups in the state's rural, urban, and frontier settings. New Mexico's CHWs are trained to address the Social Determinants of Health needs to improve health outcomes, by offering culturally appropriate education to address barriers to care, teach skills to manage treatment or prevent disease, along with linking individuals to health and social systems. The CHWs also work to inform the clinical care team of the identified need for Social Determinates of Health.

In DY4 HSD required CHW workforce data to include CHWs employed or contracted, for the purpose of tracking workforce development. All MCOs completed DY4 with a total of ninety-one (91) CHWs. The DY4 reported increase of 32 percent includes CHWs employed by and those contracted with the four MCOs. Please see Table 16: Year-over- year growth of the CHW workforce.

Table 16 – Year-over-Year Growth of Community Health Workers

	1st Year CY16	2nd Year CY17		
	2016 YTD Total	2016 YTD Total		
	Total	Employed	Contracted	Total
BCBS	ND	13	12	28
MHC	32	26	0	22
PHP	5	9	9.5	18
UHC	32	12	0	23
Total	69	60	21.5	91

Source: [MCO] DSIPTs, DY4

Training includes state-endorsed certification programs through community colleges. Approximately 103 participants have already completed the community college-based trainings, with additional participants going through the year-long training. Many have obtained tuition scholarships through Health Resources and Services Administration (HRSA).

An example of the diversity of the CHW workforce is seen in the UNM-Taos training program enrollees:

- 100 percent were eligible for tuition awards
- Represent educationally disadvantaged backgrounds
- 81 percent are originally from Northern New Mexico
- 94 percent identify as either Hispanic or Native American

    - Native American tribes represented included San Ildefonso Pueblo, Picuris Pueblo, Taos Pueblo, Navajo Nation, and Jicarilla Apache Nation
- Ages range from 19-63
- Two veterans
- Three referred by local GED/ESL program instructors

Social Determinates of Health screening informs the interventions needed by Medicaid recipients, and is central to the Integrated Primary Care and Community Support (I-PaCS) model used in DY4 by the HSD and the University of New Mexico Health Sciences Center Office for Community Health (OCH) and the Center for Health Innovation (SWCHI).
Social Determinates of Health include: housing, food security, transportation, utilities, personal safety, childcare, income, employment, education, substance abuse concerns, and legal/immigration assistance.

Some of the types of interventions resulting from the assessments include:

- Identifying community-based providers and services.
- Assisting members directly in making appointments to social services agencies.
- Checking EMR for recommended medical screening, pending lab tests or referrals.
- Medicaid, income support, SNAP, housing, or other government programs and services paperwork assistance.
- PCP engagement, by making appointments and setting up transportation.
- Chronic disease management.
- ED alternatives for non-emergent care.
- Nurse Advice line education.
- NM Crisis and Access Line education.
- Urgent Care education.

One of the metrics used by the I-PaCS model to determine the type of intervention(s) required by recipients is whether they had two or more emergency department visits in the last twelve months. Of the 781 recipients surveyed, 319 screened positive for this determinant, with a range of 2-20 visits in the past twelve months. Educating Medicaid recipients on appropriate use of the emergency department, sharing urgent care sites with them, and connecting them to primary care is a key element of the I-PaCS model, which results in reduced healthcare costs and improved health outcomes.

In DY4 interventions frequently include food assistance, utility assistance, transportation to appointments, and on-going health education and support. Please see Table 17: Year-over-Year Unduplicated Members. An increase of 5 percent was reported from the baseline year of CY15 to CY16. An 80 percent increase of Medicaid recipients is reported in CY17 as a result of the successful development of the CHW initiative by the MCOs.

Table 17 – Year-over-Year Unduplicated Members

	Baseline		1st Year CY16		2nd Year CY17				
	2015 Unduplicated Members Served	2016 Baseline Target 5% Increase	2016 YTD Total	2017 Baseline Target 10% Increase	Q1	Q2	Q3	Q4	2017 YTD Total
BCBS	20,714	21,750	27,736	30,509	1155	16,582	11,234	4,813	33,784
MHC	3,138	3,295	5,822	6,404	954	2,632	1,783	2,886	8,255
PHP	2,000	2,100	3,822	4,204	1171	1,731	1,167	1,317	5,386
UHC	2,600	2,730	3,730	4,103	2598	1,300	1,281	1,309	6,488
Total	28,452	29,875	41,110	45,220	5878	22,245	15,465	10325	53,913

Source: [MCO] DSIPTs, DY4

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program for DY3 and DY4 can be found in Attachment G: Key Utilization/Cost per Unit Statistics by Major Population Group.

CAHPS Survey

Centennial Care MCOs are required to submit the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results report on an annual basis with data collected from the prior year. HSD worked with the MCOs to ensure the quality of the data collected through the survey and inclusion of questions that would capture data for all Centennial Care members. HSD required the MCOs to include the 14 additional questions outlined below that were approved by the National Committee Quality Assurance (NCQA) on the CAHPS survey for 2017. To review CAHPS results, please visit the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/2016-cahps-reports.aspx.

1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers?
2. In the last 6 months, who helped to coordinate your child's care?
3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?
4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?
5. In the last 6 months, who helped to coordinate your care?
6. How satisfied are you with the help you received to coordinate your care in the last 6 months?
7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy?
8. In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit?

9. Did your care coordinator sit down with you and create a plan of care?
10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?
11. A fall is when your body goes to the ground without being pushed. In the last 6 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?
12. Did you Fall in the past 6 months?
13. In the past 6 months, have you had a problem with balance or walking?
14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?

Annual Summary of Network Adequacy by Plan

HSD evaluates and provides feedback to each MCO on their respective annual Provider Network Development and Management Plan that retrospectively evaluates the prior year and the coming year. The MCOs' plans must be sufficient to ensure that all medically necessary covered services are accessible and available for the current and new population, as well as assess the current unmet needs and future needs related to membership changes.

MCOs utilize Report #3, the Network Adequacy Report, to evaluate provider ratios, Report#53 Primary Care Provider (PCP) to evaluate PCP member ratios, open panels and change activity, and Report #55, the GeoAccess Report, to evaluate distance requirements to providers as key elements to inform their decisions. HSD tracks the progress of each MCO in meeting GeoAccess standards quarter-over-quarter and focuses on improvements to distance requirements where standards are not being met. Please also see Attachment D: 2016-17 GeoAccess PH All MCOs.

See Section II. for additional information on provider access.

Summary of Outcomes of Reviews and Focused Studies

Service Plan Reductions Audit

HSD continues to review a sample of service plan reductions for legacy members who had HCBS services under a section 1915(c) waiver and continued to meet the NFLOC criteria upon transition to the 1115 waiver, Centennial Care. HSD identified a universe of the legacy members who transitioned from the 1915(c) waivers to the MCO Community Benefits in the 1115 waiver. The MCOs were directed to submit a universe of members who had a reduction in Personal Care Service (PCS) hours during Calendar Year 2016 and HSD selected a random sample of 30 charts from each MCO to review.

BCBS audits revealed the reduction in PCS hours in 27 of the 30 files were appropriate and included reasons such as member improvement, increases in natural supports and shared households. HSD reviewed the results of the audit with BCBS and sought additional information

for the 3 remaining member files. BCBS provided the requested documentation, which included corrected allocation tools referenced in the UM notes for 2 of the files and the CNA and allocation tool associated with the time before reduction for the remaining file. After review of the documentation, HSD determined that the reduction in hours was appropriate for the 3 files in question.

MHC audits revealed the reduction in PCS hours in 26 of the 30 files were appropriate and included reasons such as member improvement, increases in natural supports and shared households. HSD sought clarification for the 4 remaining files, which lacked documentation necessary to review the reduction decision. MHC provided the requested documentation and after review HSD was in agreement that reductions for the 4 remaining files were appropriate.

PHP provided 30 member charts for review and the audit revealed that 28 of the 30 were appropriate and included reasons such as member improvement, increases in natural supports and shared households. Two of the member charts contained insufficient documentation to complete the review. HSD reached out to PHP for additional supporting documentation, which was provided. HSD reviewed the information and determined that reductions in in these two files were appropriate.

UHC also submitted 30 member files for review. 12 of the 30 files revealed the reduction was related to member improvement, increased natural supports, or shared living space. UHC also had 5 audit files which did not reveal a reduction in PCS hours. The remaining 13 member audit files did not have documentation demonstrating any correlation between the members' unchanged condition, supports or housing with reduction in PCS hours. HSD requested that UHC provide an analysis for the remaining 13 members. Of the 13 files that HSD sought clarification: 3 were reduced due to reassessment indicating increased natural supports or independence with ADLs; 3 members received reductions based on assessment but the reductions were overturned in fair hearings; 2 member's hours were decreased based on assessment and both reductions were upheld on appeal; 3 members received a reduction based on assessment indicating fewer ADL needs; 1 member's hours were reduced after a requested environmental modification was completed and reassessment indicated that member required less hours; and 1 member's hours were temporarily increased based on caregiver needs and then returned to previous amount which UHC noted was outside their standard process. HSD reviewed the analysis and accepted their response. HSD presented specific feedback to UHC to provide further detail and documentation regarding ADL's and to provide clear reasons why PCS hours were reduced. In response UHC noted that care coordinators will receive ongoing education on criteria for PCS determinations and appropriate documentation of ADL/IADL needs. This includes education by its Long Term Care Medical Director. Incomplete/Inadequate documentation within an assessment will result in a request for reassessment, mentoring and review by the care coordinator's manager. UHC reported that 9 of these 13 legacy members transitioned into Centennial Care with their previous hours and UHC 'administratively continued' allocated hours until the reassessment date for affected 2016 service hours.

HSD reviewed the results of the audits with each MCO and provided general recommendations for quality improvement for documentation related to PCS reductions. HSD also requested the process from each MCO regarding improvement of accuracy of determinations.

BCBS noted that each Utilization Management (UM) nurse has regular, monthly file audits conducted and confirmation/verification of appropriateness of reviews is a component of those audits. BCBS also revealed that both the medical directors and the UM staff are required to take annual inter-rater reliability tests, which may be inclusive of scenarios involving a reduction of PCS hours. Any concerns identified on audit are addressed with the UM reviewer and applicable coaching is provided.

MHC informed HSD that continuous training to improve accuracy and consistency of determinations for the UM staff remains a priority. Care coordinators have recently received refresher training on documentation requirements to ensure that any changes in health are appropriately documented in the file. Oversight of any decreases will be reviewed with supervisors to ensure documentation clearly reflects the reason for such changes. Supervisors also conduct regular audits of their staff allowing for feedback and improvement regarding decision-making, documentation and to address areas where there seem to be trends of staff needing more information or training.

PHP stated that to ensure accuracy of determinations, they are implementing monthly audits of the UM Reviewers, and Medical Director rounding with UM staff. Additionally, they will continue to host monthly team meetings during which training is provided.

UHC response noted that in addition to the activities stated above, PCS Regulations and MCO Policy Manual PCS Criteria and Assessment for Services are reviewed by the secondary review team (SRT) at least quarterly followed by an inter-rater (IRR) exercise. Peer to Peer review, as well as manager review, is utilized by SRT to validate decisions with significant decrease to member hours. UHC also notes that a formal documented IRR evaluation is conducted with all SRT members involved in PCS determination annually through their online learning application LearnSource. All team members must pass with 80% or greater. If a passing score is not obtained, remediation by the manager and a re-testing scenario is used to ensure competency.

HSD directed all four MCOs to continue training on clear, concise, and comprehensive documentation for member records.

Table 18 – DY4 Service Plan Reduction

Service Plan Reduction	BCBS	PHP	Molina	UHC
Number of member files audited	**30**	**30**	**30**	**30**
Number of files with inappropriate reduction	0	0	0	3*
Number of files with no reduction or increase	0	0	0	5
Number of files which showed an increase	0	0	0	0
Number of files with appropriate reduction	30	30	30	22

***Overturned in the fair hearing process**

Myers & Stauffer Evaluation

Myers and Stauffer, LC provided final reports of its audit findings for 2015 inpatient paid and denied hospital claims (including claims adjudication, prior authorization and provider credentialing) to HSD in March 2016. HSD evaluated Myers and Stauffer findings related to MCO policies and processes. Each MCO responded to HSD regarding the audit findings. HSD issued notice of a formal directed corrective action plan (DCAP) to UHC on August 18, 2016 and all DCAP items were closed on August 7, 2017. For further details concerning the DCAP and closure, please refer to the Q2DY2 Quarterly Report.

HSD has re-engaged Myers & Staffer to conduct an audit on Nursing Facility, Behavioral Health, and Hospital claims processing and payment, prior authorization, contract loading, and related policies and procedures for the timeframe July 1, 2016 through June 30, 2017.

Summary of Performance Improvement Projects

HSD required each MCO to implement four (4) Performance Improvement Projects (PIPs) in CY16. The MCOs designed each PIP to meet the unique needs of the MCOs' members, to ensure sustainable improvements and interventions, and to focus on quality improvement.

Pursuant to the Centennial Care Contract, two MCO PIPs focused on the following areas:

1. Services to Children
2. Long Term Care Services

Within the domains listed above, the MCOs developed each PIP to target relevant clinical or non-clinical services within the MCOs' specific populations as long as the focus was on the services provided within each domain. The MCO selected the study topic, study population, and study indicators. In addition, the MCO determined the sampling methodology and data collection process that would be used for analysis and interpretation.

In addition, the MCOs were directed to continue with the Quality Improvement Projects (QIPs) associated with the Adult Medicaid Quality Grant (AMQG) which expired in December 2015. The MCO developed two PIPs within the HSD selected domains to target the prescribed indicators as listed below:

3. Prevention and enhanced disease management for diabetes
    - Diabetes, short-term complications admission rate
    - Comprehensive diabetes care: HbA1c testing

4. Screening and management for clinical depression
    - Antidepressant medication management
    - Screening for clinical depression and follow-up plan

CMS requires an annual External Quality Review (EQR) of the MCOs contracted with the State. The review validates the PIPs developed by the MCOs and applies the review standards detailed in EQR Protocol 3 published by CMS. The protocol specifies the process that is used to assess the validity and reliability of the PIPs developed by the MCOs.

HealthInsight New Mexico is the External Quality Review Organization (EQRO) contracted to conduct EQR of PIPs submitted to the State by the MCOs. HealthInsight followed the CMS EQR Protocol 3, validated the PIPs and completed the reviews.

Table 19 – CMS-Defined 10 Step Process for Validating PIPs

CMS-Defined 10 Step Process for Validating PIPs	
1. Review the study topic	6. Review data collection procedures
2. Review the study question	7. Review data analysis and interpretation of study results
3. Review identified study population	8. Assess the MCOs improvement strategies
4. Review indicators	9. Assess the likelihood that reported improvement is "real" improvement
5. Review sampling methods	10. Assess sustainability of the documented improvements.

During 2017, the EQRO made the determination that each MCO is compliant with Centennial Care contractual and regulatory requirements for PIPs implemented by each MCO for the 2016 review.

Table 20 – PIPs by MCO for 2016

BCBS	MHC	PHP	UHC
Attention to Dental Health for Children	Improvement of Well Child Check Measure	Services to Children: Annual Dental Visit	Annual Pediatric Dental Visits
Long-Term Care: Diabetic Eye Exams	Fall Risk Factors and Services Referrals for Long Term Services and Supports	Inter-Rater Reliability (IRR) for Personal Care Services Allocation	Nursing Facility Transition
Diabetes Prevention and Enhanced Disease Management	Diabetes Prevention and Enhanced Disease Management	Diabetes Prevention and Enhanced Disease Management	Diabetes Prevention and Enhanced Disease Management
Screening and Management for Clinical Depression	Screening and Management for Clinical Depression	Screening and Management for Clinical Depression	Screening and Management for Clinical Depression

BCBS

PIP#1- Attention to Dental Health for Children: This PIP focused on improving the rate of Children aged 2-18 who received the annual preventive dental visit during the measurement Year. BCBS applied a variety of interventions to improve performance for this target population such as the Preventistry Program. The program is a provider-driven intervention established through DentaQuest, the dental vendor for BCBS. The program targets members who have not completed a dental visit in the past 6 to 12 months. The dental providers receive a toolkit containing provider resource information, member handout materials, and a member gap list so they can reach out to members encouraging them to schedule and complete a dental visit. BCBS also conducts call outreach campaigns and post card mailings to this population.

Table 21 – Annual preventive dental visits (children 2-18)

CY 2014	**CY 2015**	**CY2016**
59.18%	61.18%	63.45%

PIP#2 - Long-Term Care: Diabetic Eye Exams: This PIP focused on improving the rate of diabetic LTSS members who received screening for diabetic retinopathy. BCBS continues to identify barriers in order to improve this PIP outcome. BCBS undertook many interventions designed to increase the rates of LTSS members receiving diabetic eye examinations. Some of these interventions included instituting a checklist-based process for notifying nursing facilities and members about potential gaps in care for diabetic members, publishing various member newsletter articles, and explaining the benefits of the Centennial Care Rewards program as it relates to diabetes care which includes regular eye exams. BCBS was able to develop and implement educational training and outreach initiatives to address these deficits, which have made a significant improvement in this area.

Diabetic Eye Exams (LTSS members)		
CY 2014	**CY 2015**	**CY 2016**
8.90%	20.35%	22.76%

PIP#3 - Diabetes Prevention and Enhanced Disease Management: This PIP focused on diabetes management and reducing diabetes short term complications admissions rates. The study population including members admitted to the hospital due to diabetes-related complications. BCBS performance rates reflect fewer hospital admissions due to complications from diabetes from 23.35% in CY 2014 to 17.93% in CY 2016 (lower percentages are better). BCBS interventions aimed at supporting the reduction of hospital admissions related to complications from diabetes include implementing interdepartmental efforts between Quality Improvement and Health Services and Network Services to discuss how to reach members more effectively, and provide outreach to care coordinators and primary care physicians to educate their patients about diabetes care and the benefits and resources available.

Hospital Admissions due to complications from diabetes		
CY 2014	**CY 2015**	**CY 2016**
23.35%	22.16%	17.93%

PIP#4 – Screening and Management for Clinical Depression: This PIP focused on screening for clinical depression and medication management for members 18 to 65+ years of age who were compliant with their antidepressant medications. The PIP was a continuation of the AMQG QIP. BCBS considered CY 2015 the baseline year for screening for clinical depression and CY 2016 for medication management. In collaboration with PRIME Pharmaceuticals, interventions implemented to improve medication compliance included: an antidepressant first-fill patient information letter providing education about antidepressant and medication compliance sent to members who have filled a prescription for an antidepressant for the first time, and the distribution of "The Care Coordinator Quality Handbook", which assists Care Coordinators in engaging members regarding their antidepressant medications.

Screening for Clinical Depression	**CY 2015**	**CY 2016**
18-64 years of age	0.34%	0.43%
65+ years of age	4.14%	2.43%
Medication Management Acute Post-Hospitalization	**CY 2016** **(Baseline year)**	
18-64 years of age	50.63%	
65+ years of age	34.56%	
Medication Management Continuous Post Hospitalization	**CY 2016** **(Baseline year)**	
18-64 year of age	47.17%	
65+ years of age	32.08%	

MHC

PIP#1 – Improvement of Well Child Check Measure: This PIP focused on improving physician documentation for Well Child Care HEDIS measures, body mass index (BMI), counseling for nutrition, and counseling for physical activity. MHC will consider CY 2016 the baseline year for this PIP. Initiatives developed to support this PIP were trainings conducted with providers to improve the rates for the indicators. The trainings included a discussion of the importance of the screening as well as the use of appropriate coding to capture the information.

Improvement of Well Child Check Measures	**CY 2016** **(Baseline year)**
Body Mass Index	7.79%
Counseling for Nutrition	3.82%
Counseling for Physical Activity	2.95%

PIP#2 - Fall Risk Factors and Services Referrals for Long Term Services and Supports: This PIP focused on reducing falls among the LTSS population by providing additional training to care coordinators on fall risk screening. MHC implemented a pilot program for care coordinators in Bernalillo County. The intervention is to provide education to care coordinators that will increase the delivery of fall risk assessment and fall related preventive services to decrease the rate of falls among LTSS members. The training intervention was not implemented until June 2017.

Members with Falls		
CY 2014	**CY 2015**	**CY 2016**
18.47%	24.13%	26.38%

PIP#3 – Diabetes Prevention and Management: This PIP focused on diabetes management, HbA1c testing and reducing diabetes short term complications admissions rates. The PIP was a continuation of the AMQG QIP. Interventions implemented by MHC include service reminders sent to members and their providers about labs, eye exams, and other tests members may have missed or needed, member education on Centennial Rewards for diabetic screening, and education and outreach to members with chronic conditions through the Manage Your Chronic Disease (MyCD) statewide program.

HbA1c Testing		
CY 2014	**CY 2015**	**CY 2016**
18.47%	24.13%	26.38%

Hospital Admissions due to complications from diabetes		
CY 2014	**CY 2015**	**CY 2016**
14.81%	9.75%	11.80%

PIP#4 – Screening and Management of Clinical Depression: The focus of this PIP was to improve the rates of screening for clinical depression and to improve the member's adherence to antidepressant medication for three month and for six months post hospital discharge. The PIP was a continuation of the AMQG QIP. Interventions implemented by MHC included outreach to members newly released from mental health institutions, educating MHC care coordination staff on the importance of engaging with and educating members on attending follow up visits, and referral to MHC peer support program.

Screening for Clinical Depression		
CY 2014	**CY 2015**	**CY 2016**
0.01%	0.06%	0.07%

Antidepressant Medication Management Acute Phase		
CY 2014	**CY 2015**	**CY 2016**
53.50%	49.55%	47.19%

Antidepressant Medication Management Continuation Phase		
CY 2014	**CY 2015**	**CY 2016**
38.63%	34.67%	32.11%

PHP

PIP#1- Services to Children: Annual Dental Visit: This PIP was initiated by PHP to increase annual dental visits in the children. This PIP was introduced in CY 2015 and focused on assessing the effectiveness of the Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters mailed to members and parents to improve the rate of members ages 2-20 receiving an annual dental visit. The study question submitted was, "Will interventions implemented for the identified ADV (annual dental visit) total rate population demonstrate improved rates starting with the rates reported in (HEDIS) 2017?" PHP applied interventions such as placing calls to members to assist with scheduling dental exams. There was a 2.57% point improvement from CY 2015 to CY 2016 in Annual Dental Visits for Children.

Annual Dental Visits Children Ages 2-20	
CY 2015	**CY 2016**
66.43%	69.00%

PIP#2 - Inter-Rater Reliability for Personal Care Services Allocation: This PIP focused on consistent and accurate implementation of the Personal Care Services (PCS) allocation tool by PHP care coordinators. The PIP was introduced in CY 2014 and has increased consistency in the allocation of PCS hours. The intervention consisted of ongoing training and testing for the entire cohort of care coordinators five times during the year. Additionally, as new staff is hired, the training and testing are repeated for the whole group of care coordinators; current and new employees are trained together and then asked to allocate PCS hours based on varying scenarios. The PIP performance has improved 6.7% points from CY 2014 to CY 2016.

Inter-Rater Reliability for Personal Care Services Allocation (LTSS)		
CY 2014	**CY 2015**	**CY 2016**
93.00%	99.40%	99.70%

PIP#3 – Diabetes Prevention and Management: This PIP focused on reducing diabetes short term complications admissions rates and on improving rates of HbA1c testing. The PIP was a continuation of the AMQG QIP. Interventions implemented by PHP to support this PIP included

partnering with practitioners to identify diabetic members with gaps in care, and focused member outreach to assess needs, preferences, and barriers.

HbA1c Testing	
CY 2015	**CY 2016**
84.64%	83.25%

Hospital Admissions due to complications from diabetes (lower is better)	**CY 2015**	**CY 2016**
18-64 years of age	14.56%	11.81%
65+ years of age	37.11%	11.14%

PIP#4 – Screening and Management for Clinical Depression: The focus of this PIP was to improve the rates of screening for clinical depression and to improve the member's adherence to antidepressant medication for three month and for six months post hospital discharge. The PIP was a continuation of the AMQG QIP. Interventions implemented by PHP to support this PIP included a practitioner education campaign via provider newsletters, incentive letters mailed to members who would receive a rewards card upon responding to letter, and member outreach following identification of first prescription fill.

Screening for Clinical Depression	**CY 2015**	**CY 2016**
18-64 years of age	0.14%	0.15%
65+ years of age	0.57%	0.26%
Medication Management Compliant 3 months Post-Hospitalization	**CY 2015**	**CY 2016**
18 years of age and older	53.36%	51.88%
Medication Management Compliant 6 months Post-Hospitalization	**CY 2015**	**CY 2016**
18 years of age and older	36.24%	35.55%

UHC

PIP#1- Annual Pediatric Dental Visits: This PIP was introduced in CY 2014 with a focus on determining the effectiveness of targeted outreach to members and providers on rates of members ages 0 to 20 to get their annual dental exam. UHC identified members in two categories: members less than of 21 years of age who received a preventive dental visit during the measurement year and members less than 21 years of age who received a dental treatment

visit during the measurement year. Interventions included various trainings for care coordinators, dental benefits explanations in EPSDT member information packets, member outreach, and provider education with the goal to remove barriers.

	CY 2014	CY 2015	CY 2016
Preventive Dental Visit less than 21 yrs. of age	28.38%	30.83%	34.04%
Dental Treatment Visit less than 21 yrs. of age	11.74%	11.24%	15.98%

PIP#2- Nursing Facility Transitions: This PIP focused on the effectiveness of a systematic and prescribed program for identification, assessment, and planning for transition and follow-up to increase the number of members who are discharged from in patient nursing facilities and maintained in home or community-based services for at least six months. Interventions implemented in the nursing facility provided a single care coordinator assigned to each facility, whenever possible, to promote development of a working relationship between UHC and the facility. UHC interventions also targeted the education of family members in providing care relevant to the member's needs. Care Coordinators provided education at the time of inquiry into the transition process to increase the understanding of available services and supports within the community setting. Families were encouraged to participate in the member's care in the facility setting to validate their understanding of care needs of the member.

Transitions from Nursing Facility to Community		
CY 2014	CY 2015	CY 2016
1.13%	1.66%	0.83%

Transitions Maintained for at least 180 days		
CY 2014	CY 2015	CY 2016
82.60%	76.90%	There is a 6-month lag time between the member being discharged and the final determination. To cover the entire review timeframe, UHC cannot provide the data until the subsequent year of review.

PIP#3 - Diabetes Prevention and Enhanced Disease Management: This PIP focused on reducing diabetes short term complications admissions rates and on improving rates of HbA1c testing. The PIP was a continuation of the AMQG QIP. UHC actions and interventions included providing professional development opportunities for providers, staff and diabetes educators through the Provider Summits held in Albuquerque and Las Cruces, and "Clinic Days" that were coordinated for members with gaps in care to include all diabetic testing.

HbA1c Testing		
CY 2014	**CY 2015**	**CY 2016**
51.44%	56.32%	60.65%

Hospital Admissions due to complications from diabetes (lower is better)	**CY 2014**	**CY 2015**	**CY 2016**
18-64 years of age (as measured by 100,000 member months)	38.35%	33.42%	37.50%
65+ years of age (as measured by 100,000 member months)	98.80%	270.89%	150.80%

PIP#4 – Screening and Management for Clinical Depression: The focus of this PIP was to improve the rates of screening for clinical depression and to improve the member's adherence to antidepressant medication for three months and for six months post hospital discharge. The PIP was a continuation of the AMQG QIP. UHC actions and interventions implemented to support the PIP included meeting with providers and office staff to discuss depression screening and the capture of data, and working with Care Coordination and Wellness Centers on patient screening and what happened upon a positive screen.

Screening for Clinical Depression		
CY 2014	**CY 2015**	**CY 2016**
929.93	8.20	16.61

Antidepressant Medication Management Acute Phase		
CY 2014	**CY 2015**	**CY 2016**
62.50%	56.62%	53.16%

Antidepressant Medication Management Continuation Phase		
CY 2014	**CY 2015**	**CY 2016**
48.34%	42.89%	38.79%

Outcomes of Performance Measure Monitoring

HSD contracted with HealthInsight as the EQRO to assess the PMs directed by HSD and to assess the MCOs' continuous quality improvement processes for each of the PMs. Below are the questions used by the EQRO to assess performance:

- Did the MCO demonstrate Continuous Quality Improvement processes?
- Did the MCO identify appropriate individuals for interventions and measurement?

- Did the MCO develop and implement effective interventions? and
- Did the MCO appropriately reassess improvement?

The EQRO reviewed and rated each MCO in accordance with the External Quality Review (EQR), Centers for Medicaid and Medicare Services (CMS) Protocol 2 (Validation of Performance Measures Reported by the MCO). Performance rates reported represent members enrolled in Centennial Care during 2016. The MCO performance rates are compared with the average rates reported from the Department of Health and Human Services Region VI for 2016. All 4 MCOs were rated by the EQRO as fully compliant with Centennial Care contractual and regulatory requirements for data tracking processes, quality improvement efforts and performance rate improvements.

For 2016, all of the New Mexico Medicaid MCOs improved or met the Quality Compass regional average or HSD target for: dental visits; controlling high blood pressure; comprehensive diabetes care (retinal eye exams, nephropathy screening, and poor control >9%); timeliness of prenatal care; timeliness of post-partum care; frequency of ongoing prenatal care; and for 7 and 30 day follow up after hospitalization for mental illness.

While the MCOs perform well in most areas, additional attention is needed in the areas of Antidepressant Medication Management and HbA1c testing. Developing and implementing effective interventions to address these issues remains key to improving the health of the Medicaid population. MCOs have worked with providers to have notifications in place to find gaps in care for members who were discharged with short-term complications of diabetes; to address HbA1C testing, retinal eye exams and nephropathy. MCOs have also placed, "tool kits" with educational materials on multiple disease processes with providers to address gaps in care. MCOs are looking to address Antidepressant medication management by collaboration with members in care coordination, as well as identify high-volume antidepressant medication management prescribers. MCOs have identified that the Antidepressant medication management measure has barriers due to claims, and are collaborating with prescribers and pharmacies to better address the claims barriers.

The MCOs showed improvement in a few measures. Follow up after hospitalization - 7 day data showed that each MCO nearly double their previous year's performance. MCOs addressed the previous year's reporting by working with the members as well as facilities to address barriers that the member may face, including transportation as well as providing incentives. Both Prenatal and Postpartum measures also saw a noticeable increase in performance from the previous reporting year due to incentives such as the Baby Benefits rewards program, as well as providing educational material in person and online to promote the benefits of both prenatal and postpartum care. Initiatives such as rewards programs, program material, and continued member and provider education allow for the MCOs to create better relationship with members and providers, and create a positive reflection on performance.

HSD has included seven HEDIS based PMs in the Centennial Care contract for CY 2017 and CY 2018. These PMs will be tracked by the External Quality Review Organization (EQRO) and reported to HSD. The seven PMs with established targets for CY 2017 and CY 2018 include:

- PM 1- Annual Dental Visit
- PM 2- Medication Management for People with Asthma
- PM 3- Controlling High Blood
- PM 4- Comprehensive Diabetes Care
  - Member 18-75yrs of age who had a diagnosis of Diabetes and had an HbA1c test.
  - HbA1c poor control (>9%).
  - Member 18-75yrs of age who had a diagnosis of Diabetes and had a retinal eye exam.
  - Member 18-75yrs of age who had a diagnosis of Diabetes and had a nephropathy screening test or evidence of nephropathy.
- PM 5- Timeliness of Prenatal and Postpartum Care
  - Prenatal visit in the first trimester or within 42 days of enrollment.
  - Postpartum visit on or between 21 and 56 days after delivery.
- PM 6- Antidepressant Medication Management Member 18yrs and older who received at least 84 calendar days of continuous treatment and antidepressant medication (Acute phase).
  - Member 18yrs and older who received at least 180 calendar days of continuous treatment with an antidepressant medication (Continuous phase).
- PM 7- Follow-up after hospitalization for Mental
  - Member 6yrs and older hospitalized for treatment of selected mental health disorders with follow-up within seven calendar days after discharge.
  - Member 6yrs and older hospitalized for treatment of selected mental health disorders and follow-up with a mental health practitioner within 30 calendar days after discharge.

PMs	BCBS 2014	BCBS 2015	BCBS 2016	MHP 2014	MHP 2015	MHP 2016	PHP 2014	PHP 2015	PHP 2016	UHC 2014	UHC 2015	UHC 2016	NCQA Regional Average 2015
Annual Dental visits													
Ages 2-20	57.46	59.63	61.7	62.75	70.07	70.4	68.14	66.43	68.9	41.52	49.88	53.9	**61**
Medication Management for People with Asthma (not a PM in 2014)													
Medication compliance 50%	NA	51.2	55.9	NA	49.3	50.7	NA	54.5	52.9	NA	56.2	64.1	**68** * HSD directed average. National Average not tracked by NCQA
Controlling High Blood Pressure													
Ages 18-85	51.66	56.99	55.6	49.88	51.38	57.7	55.95	56.42	48.4	53.04	49.88	54.25	**44**
Comprehensive Diabetes Care													
Eye Exam	54.23	47.76	51.2	56.51	54.53	59.8	47.75	46.07	51.7	65.21	62.53	60.5	**45**
HbA1c	83.42	80.43	82.5	85.65	88.08	87.1	86.52	84.64	83.2	84.43	84.43	80.5	**83**

testing													
Nephropathy screening	78.61	85.07	87.4	74.83	88.08	89.4	79.53	86.91	87.6	83.70	90.27	91.4	**90**
Poor control HbA1c (>9%)	47.26	52.90	48.5	48.89	45.03	41.0	43.93	48.34	51.7	49.15	52.55	47.9	**60**
Prenatal and postpartum care													
Prenatal care (Timeliness)	73.08	72.61	75.49	76.80	75.97	77.4	77.88	66.36	79.8	63.75	67.40	74.2	**82**
Postpartum visit (Frequency)	54.52	57.91	58.0	54.50	51.49	54.8	61.88	53.13	59.4	48.18	41.63	59.1	**60**
Frequency of ongoing prenatal care													
80% expected visits complete	55.20	50.56	55.8	61.04	55.38	57.4	48.71	42.92	54.8	48.18	34.06	54.9	**61**
Antidepressant medication management													
Acute treatment	59.97	54.8	50.5	53.50	49.55	47.1	53.94	53.36	51.8	62.50	56.62	53.1	**55**
Continuous treatment	47.77	39.40	34.5	38.63	34.67	32.1	38.97	36.24	35.5	48.34	42.89	38.9	**40**
Follow-up after hospitalization for mental illness													
7-days	39.00	34.27	37.21	41.80	34.64	37.50	43.14	32.56	38.35	55.16	54.96	57.94	**46**
30-days	58.49	55.1	58.27	64.80	59.76	63.81	67.88	59.75	62.13	71.00	73.08	74.61	**64**

Summary of Plan Financial Performance

Overview

The Centennial Care contract contains the following financial reconciliations and risk corridors including the contract periods each is effective:

- Retroactive reconciliation (CY14 to current)
- Patient Liability reconciliation (LTSS only – CY14 to current)
- Hepatitis C risk corridor (CY15 to current)
- Other Adult Group risk corridor (CY14 to CY16)

Additionally, the managed care contract includes a provision limiting the MCO's underwriting gain. The underwriting gain limitation is applicable to the non-Other Adult Group populations for CY14 through CY16. Under this provision, MCOs are permitted to retain one hundred percent (100%) of the underwriting gain up to three percent (3%) of net capitation revenue; the MCOs share fifty percent (50%) of any underwriting gain generated in excess of the three percent (3%) with HSD.

Status and Results

In CY17, HSD finalized the financial reconciliations and risk corridor evaluations for the CY14 and CY15 contract period. The results of the financial reconciliations and risk corridor evaluations are reflected in the underwriting gain calculation as either increases or reductions to capitation revenue. For CY14 and CY15 two of the four MCOs exceeded the three percent (3%) underwriting gain limitation and recoupments have been processed for the amount owed to HSD and reflected in the financial results. In CY17, initial evaluations for the CY16 contract period were completed and the final results are scheduled to be completed and processed by the end of CY18.

Since encounter data expenditures are one of the main sources of information used in the reconciliation and risk corridor determinations, HSD continues to work closely with the MCOs to ensure encounters are submitted in a timely and accurate manner. HSD continues to see improvement in encounter submissions.

All MCOs submitted their CY17 fourth quarter financial reports on February 15, 2018. MCOs are required to submit the CY17 annual supplement financial reports on May 15, 2018. HSD monitors MCO contractual compliance for insolvency, reinsurance, and fidelity and performance bond coverage utilizing the financial reports submitted. In the analysis of the financial reporting packages, HSD evaluates the MCOs financial and operational performance at both the individual MCO level and an aggregate level. HSD continues to focus attention on the categorization of expenditures by program, cohort and category of service. Comparison of reported encounter data to financial data also continues to be a main focus in the analysis of financial reports. Financial reporting is another area of continued improvement.

SECTION VI: SUMMARY OF QUALITY OF CARE/HEALTH OUTCOMES FOR AI/AN BENEFICIARIES

During DY4, data indicated that all MCOs showed increases to specialty care visits for psychotherapy, ophthalmology, orthopedic, and cardiology visits for Native American members. All Centennial Care MCOs continued to work on the numbers of HRAs completed in 2017 for Native Americans, some by partnering with tribal organizations to locate members.

Also in DY4, three of the four MCOs saw decreased medical admissions rates for Native Americans. The average length of stay dropped by at least 33% for two MCOs during 2017. The following chart outlines the top 10 Community Benefits utilized during DY4.

Table 22 – Highest Utilized Community Benefit Services by Native Americans

Rank	Procedure Code Description
1	Personal Care (per hour)
2	Environmental Modifications (project)
3	Emergency Response (month)
4	Homemaker (per hour)
5	Respite (per hour)
6	Assisted Living
7	Related Goods
8	Skilled Therapies
9	Private Duty Nursing for Adults-LPN (15 min)
10	Transportation

For BH services in frontier areas, all four MCOs met the access to services targets by 97% or more. For PH services, three of the four MCOs met access to care by 97% or more in frontier areas. In DY4, frequently accessed value added services by Native American members included traditional/alternative healing, full coverage Medicaid for pregnant women, followed by enhanced transportation.

Native American Advisory Meetings

Centennial Care established the Native American Technical Advisory Committee (NATAC), a subcommittee of the Medicaid Advisory Committee, comprised of tribal leaders, and/or appointed tribal representatives, IHS, tribal 638 clinics, and state leadership, to:

- Advise the Medicaid program about how to best serve the tribal communities and Native American Centennial Care members on resolution of issues with MCOs and to facilitate successful reimbursement and reduce administrative burden;
- Address issues related to enrollment, access to care and payment for services and review of program data; and

- Provide updates on the progress of 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS facility.

The MCOs are also required to conduct individual MCO quarterly Native American Advisory Board (NAAB) meetings to address issues related to benefits, access and delivery of services, and other concerns specifically related to Native American enrollees. The MCOs showed an increase in attendance at their NAAB meetings and have extended invitations to tribal leadership, Indian Health Service and community providers.

Table 23 – Schedule of DY4 NAAB Meetings

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBS	Lovelace Women's Hospital Albuquerque, NM February 23, 2017	Have sound system at meetings. Have info table at entrance to guide people to room. Provide copy of presentation to attendees. Have a traditional healer present.
MHC	Zuni Wellness Center Zuni Pueblo, NM February 22, 2017 Native American Community Academy Albuquerque, NM March 10, 2017	Molina held two Advisory Board meetings this quarter in Tribal programs. Molina uses input from the NAAB meetings to evaluate how well the plan is meeting the needs of its members. The Traditional Medicine Benefit (TMB) is now exclusive to Native Americans age 12 and older and has increased from $100 to $200 dollars per calendar year. Members were encouraged to seek professional help or stay after the meeting to speak to a Molina team member if they were suffering from depression, thoughts of suicide or addiction problems. The Zuni meeting provided translation in the Zuni language. **Issue**: How will changes in the Affordable Care Act affect Medicaid Benefits? **Response**: Molina has served the Medicaid population for 30 years. If there are changes, members will be quickly notified.
PHP	The Cooper Center Albuquerque, NM March 10, 2017	**Issue**: PHP provided clarification that for Native Americans enrolled in their MCO, PHP will automatically assign them to IHS as their primary care provider. **Response**: If the member wants to change to a PCP outside of IHS, they can do so. **Issue**: HME Specialists is the preferred DME vendor for PHP. **Response**: HME will drop off equipment at IHS facilities if the member prefers to pick them up at IHS.
UHC	Mescalero Tribal Office Mescalero, NM March 14, 2017	**Issue**: The MCOs need to be more culturally sensitive on how Tribal members take care of each other in Tribal communities. **Response**: A recommendation is for members to have a companion go with them to their appointments, especially to assist with the language and cultural needs.
BCBS	Hernandez Community Center Hernandez, NM April 26, 2017	BCBS provided an overview of Blue Cross Community Centennial Care including, virtual visits, home and community based services, hypertension and dental education. They also went over the State Behavioral Health survey results.
MHC	San Ildefonso Pueblo Tewa Center San Ildefonso Pueblo, NM May 16, 2017	Members were encouraged to register for MyMolina.com which allows members to manage their health care online. Members were educated on services and benefits offered by MDLive which includes virtual visits, 24/7 online scheduling, and is available after hours and weekends. The members were also presented with two tips for stress relief – deep breathing and muscle relaxation/contraction

MCO	Location/Date of Board Meeting	Issues/Recommendations
		exercises. Members were also informed about the prior authorization process. The Ombudsman educated members about the Ombudsman's roles and responsibilities. Molina members were informed that the cap for the Traditional Medicine Benefit (TMB) has been met and as a result no other application for TMB will be accepted this year. The new funding cycle begins January 1, 2018.
PHP	Alamo Chapter Magdalena, New Mexico May 11, 2017	PHP began their meeting by talking to individuals and families as they entered the meeting room about PHP. PHP decided to do one on one discussions with people while others had food and looked at information. PHP spoke to about 30 people and explained their Native American Affairs program; the difference between FFS and Centennial Care; described their transportation program with Superior Medical Transportation; described the Presbyterian Financial Assistance Program and how it works for individuals who are not insured or underinsured; and explained the Nurse Advice Line, PresRN.
UHC	Eight Northern Pueblos Espanola, New Mexico June 29, 2017	The Native American Advisory Board meeting was held at the Eight Northern Indian Pueblos meeting room. Attendees voiced appreciation for the UHC Tribal Letters Of Agreement (LOA) which allows them to receive payment for the work of their Peer Support teams, translation, health education and health risk assessment (HRA) completion. UHC also described their prior authorization process. Tribes requested a One Stop Shop approach to prior authorizations. UHC will take it back to leadership to discuss.
BCBS	Shiprock Chapter House Shiprock, NM August 24, 2017	BCBS provided an overview of Blue Cross Community Centennial Care and a member advisory board orientation. They explained the importance of attending the Native American Advisory Board meetings. They also discussed what the Alternative Benefits Plan (ABP) is, what it covers and doesn't cover. BCBS talked about the Value Added Services (VAS) they offer, such as the Traditional Healing benefit. The BCBS Ombudsman also was introduced and explained what 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 about 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 Santo Domingo Pueblo, NM 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. Audience asked questions, and PHP provided answers to the questions.
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 area of NM. UHC is actively working on getting more providers in this area.

MCO	Location/Date of Board Meeting	Issues/Recommendations
BCBS	Crownpoint Chapter House Crownpoint, NM October 25, 2017	BCBS shared their participation in community events in the Crownpoint area - the employee sponsored fundraisers for school supplies, Kaboom playground equipment, and scholarship/grant programs. All individuals in attendance were new attendees. Navajo translation was provided. BCBS also went over what the Alternative Benefits Plan (ABP) is, what it covers and doesn't cover. BCBS talked about the Value Added Services (VAS) they offer, such as the Traditional Healing benefit. The BCBS Ombudsman was introduced. He explained what services he provides for members. Many audience members had questions which BCBS staff answered during and after the meeting.
MHC	Tribal Administrative Bldg. Acoma Pueblo, NM November 3, 2017	Molina members were informed of the purpose for Native American Advisory Board (NAAB) meetings, which included an opportunity for members to provide feedback. The feedback received from today's meeting will be shared with the Member and Provider Satisfaction Committee (MPSC). MPSC is comprised of various Molina departments to develop action plans when barriers are identified in the member's community as well as opportunities for improvement. There were questions about personal care services and transportation at the meeting. Molina answered the questions and referred members to the ombudsman as needed.
PHP	Mescalero Tribal Offices Mescalero, NM October 13, 2017	Presbyterian stated the purpose of the NAAB meetings is to get feedback from their Centennial Care members. PHP told their audience that if they need referrals to see specialists outside of IHS, PHP can help with this as well as the transportation piece if needed. Several individuals in the audience asked how members can get home modifications, grab bars, a ramp, etc. PHP explained that the care coordinator will need to come in and do an assessment. Other questions were answered during the meeting or after the meeting.
UHC	Hilton Garden Inn Gallup, NM December 1, 2017	The UHC team discussed the UHC benefits for Native Americans and how to get prior authorizations for specialty referrals. They also informed members where to go to resolve billing issues if they come up. The attendees did not have questions for further discussion.

Update on Enhanced FMAP for Services Received Through an IHS Facility:
In DY4, there were two signed Care Coordination Agreements (CCAs): 1.) The University of New Mexico Hospital (UNMH) and Presbyterian Healthcare Services; and 2.) UNMH and Albuquerque Area Indian Health Service (AAIHS).

The IT and clinical teams for AAIHS and UNMH meet monthly to review and test the processes for services received through an IHS Facility. UNMH developed a flow chart that describes each of the steps in the process. HSD provided UNMH with a provider file which contains a list of AAIHS provider names, domain, NPI numbers, and the direct domain address of the clinicians. This information will be updated on a monthly basis and HSD will provide the file to UNMH. Billing for these services will begin in April 2018.

The PHS and AAIHS agreement was signed late in DY4 and will require additional collaboration in DY5 prior to full implementation. Presbyterian will be working with AAIHS Information Technology Division to ensure the two systems can share information on referrals and follow up

as well as share medical records. Presbyterian will also receive the AAIHS provider file monthly from HSD.

Formal Tribal Consultations in DY4

HSD held two formal Tribal consultations during DY4: One was held June 23, 2017 regarding the Centennial Care 2.0 Concept Paper with eight Tribal leaders or their designee in attendance; and a second formal Tribal consultation was held on October 20, 2017 regarding the Centennial Care 2.0 Draft Application for the renewal of the Section 1115 Demonstration Waiver with six Tribal leaders or their designee in attendance. Input from Tribal Leaders on the 1115 Waiver Renewal is included in Attachment F: Public Comments Summary and Response.

SECTION VII: QUALITY STRATEGY/HCBS ASSURANCES

Quality Strategy

HSD received approval for the Quality Strategy from CMS in May 2014. The Quality Strategy was reassessed and revised in September 2017 to report the program outcomes through calendar year 2016. New Mexico will continue to assess quality outcomes to determine the need for modification to the Quality Strategy.

New Mexico's Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement

Several quality initiatives and monitoring of State standards support the commitment to provide access, quality and appropriateness of care to the States Medicaid Beneficiaries. These ongoing activities, discussed throughout this report include continuous monitoring of State established Standards including; Quality Management and Quality Improvement Standards (QM/QI); Utilization Management Standards; MCO Accreditation Standards; Care Coordination Standards; Access and Network Adequacy Standards, Provider Standards; Transition of Care Standards; and Monitoring and Reporting Standards. Many of the quality strategy activities have been previously explained in other sections of this report.

- Please refer to Section II for information related to Quality Assurance, Access and Network Adequacy, Care Coordination, and Adverse Incidents Monitoring.
- Please refer to Section V for information on activities related to Utilization Management, Performance Measure Monitoring, Performance Improvement Projects, and Member Satisfaction.

HCBS Assurances

HSD uses the CMS approved Centennial Care Quality Strategy to monitor the HCBS assurances. There are four areas identified in the quality strategy.

Level of Care (LOC) Determinations

HSD continues to conduct audits of NF LOC determinations to ensure that members being served through the community benefit have been assessed to meet the required LOC for those services. Please refer to Section II for more information on the NF LOC reviews.

Service Plans

To ensure that MCOs appropriately create and implement service plans based on members' identified needs, HSD conducts monthly audits of each MCO to ensure the appropriate implementation of community benefit service plans. Please refer to Section II for more information on HCBS service plan audits.

EQRO Compliance Audit

HSD contracts with HealthInsight to conduct the External Quality Review (EQRO) for compliance with State Standards. During DY4, the EQRO completed the compliance review for CY 2016 HCBS areas including; Self-Directed Community Benefits, Care Coordination, and Transition of Care from the Nursing Facility to Community. The review process is designed to assess compliance of the MCO policies, procedures, activities and outputs with the contractual obligations.

Health and Welfare of Enrollees

HSD ensures that the MCOs, on an ongoing basis, identify, address, and seek to prevent instances of abuse, neglect and exploitation (ANE). HSD monitors the CI database and MCO reports, follows-up on reports of ANE, and ensures that other agencies are notified as appropriate. HSD provides updates on these activities to CMS in the quarterly reports. Please refer to Section II for the waiver year three report on adverse incidents.

SECTION VIII: STATE CONTACTS

HSD State Name and Title	Phone	Email Address	Fax
Nancy Smith-Leslie Director HSD/Medical Assistance Division	505-827-7704	Nancy.Smith-Leslie@state.nm.us	505-827-3185
Angela Medrano Deputy Director HSD/Medical Assistance Division	505-827-6213	Angela.Medrano@state.nm.us	505-827-3185
Jason Sanchez Deputy Director HSD/Medical Assistance Division	505-827-6234	JasonS.Sanchez@state.nm.us	505-827-3185
Kari Armijo Deputy Director HSD/Medical Assistance Division	505-827-1344	Kari.Armijo@state.nm.us	505-827-3185
Linda Gonzales Deputy Director HSD/Medical Assistance Division	505-827-6222	Linda.Gonzales@state.nm.us	505-827-3185

SECTION IX: ENCLOSURES/ATTACHMENTS

Attachment A: Annual Budget Neutrality Monitoring Spreadsheet
Attachment B: 2017 Value Added Services
Attachment C: 2017 NM Consumer and Family Executive Summary
Attachment D: 2016-17 GeoAccess PH All MCOs
Attachment E: 2017 BH GeoAccess BH Summary All MCOs
Attachment F: Public Comments Summary and Response
Attachment G: Key Utilization/Cost per Unit by Major Population Group

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- PMPM Analysis

DY 4

Start Date: 01/01/2017

End Date: 12/31/2017

Quarter 4

Start Date:10/01/2017

End Date: 12/30/2017

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01 TANF & Related	DY 01 Cost Estimates	DY1 YTD - Actuals [2]	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	4,621,656	5,092,636	4,615,353
PMPM	$ 385.80	$ 329.58	$ 400.77	$ 344.70	$ 416.32	$ 334.16	$ 432.47	$ 310.09
Dollars	$ 1,823,911,159	$ 1,488,754,304	$ 1,948,487,793	$ 1,535,380,277	$ 2,090,074,424	$ 1,544,356,199	$ 2,202,434,150	$ 1,431,162,319

MEG02 SSI & Related - Medicaid Only	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
MMs [1]	508,700	497,958	513,736	494,529	518,976	493,577	524,737	489,679
PMPM	$ 1,763.90	$ 1,656.04	$ 1,842.83	$ 1,784.27	$ 1,925.21	$ 1,752.70	$ 2,008.00	$ 1,715.13
Dollars	$ 897,298,062	$ 824,638,553	$ 946,727,393	$ 882,372,838	$ 999,138,707	$ 865,090,623	$ 1,053,669,000	$ 839,861,416

MEG03 SSI & Related - Dual Eligible	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
MMs [1]	373,823	428,025	380,215	435,140	386,831	447,801	393,832	438,585
PMPM	$ 1,780.77	$ 1,333.13	$ 1,857.34	$ 1,342.48	$ 1,937.21	$ 1,340.20	$ 2,020.51	$ 1,258.70
Dollars	$ 665,692,378	$ 570,612,226	$ 706,189,973	$ 584,167,632	$ 749,372,219	$ 600,142,952	$ 795,742,098	$ 552,047,932

MEG04 "217 Like" Medicaid Only	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
MMs [1]	5,841	2,799	5,898	2,382	5,959	2,987	6,025	4,267
PMPM	$ 4,936.92	$ 2,380.17	$ 5,090.46	$ 2,331.82	$ 5,248.77	$ 2,541.14	$ 5,412.01	$ 2,908.55
Dollars	$ 28,834,295	$ 6,662,084	$ 30,025,379	$ 5,554,385	$ 31,274,952	$ 7,590,384	$ 32,605,551	$ 12,410,795

MEG05 "217 Like" Dual Eligible	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
MMs [1]	27,935	26,895	28,413	27,063	28,907	31,866	29,430	39,673
PMPM	$ 1,776.90	$ 3,226.87	$ 1,853.31	$ 3,143.68	$ 1,933.00	$ 2,874.50	$ 2,016.12	$ 2,808.73
Dollars	$ 49,637,569	$ 86,786,741	$ 52,657,285	$ 85,077,407	$ 55,877,183	$ 91,598,699	$ 59,334,769	$ 111,430,661

MEG06 VIII Group - Medicaid Expansion	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
MMs [1]	1,632,968	1,887,728	1,788,895	2,748,632	1,800,808	3,078,074	1,763,748	3,137,227
PMPM	$ 577.87	$ 454.01	$ 607.34	$ 477.22	$ 638.31	$ 452.75	$ 670.87	$ 452.02
Dollars	$ 943,638,928	$ 857,043,080	$ 1,086,464,733	$ 1,311,689,926	$ 1,149,478,718	$ 1,393,608,289	$ 1,183,239,734	$ 1,418,096,328

MEG08 Uncompensated Care Pool	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
Total Allotment	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 67,294,973	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 51,666,993

MEG09 Hospital Quality Improvement Incentive Pool	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]
Total Allotment	$ -	$ -	$ 2,824,462	$ 2,824,462	$ 5,764,727	$ 7,359,077	$ 8,825,544	$ -

Notes:

1.) Actual member months for Demonstration Year 4 include the reported member months for this Centennial Care Quarterly Report, Section XI.

2.) Expenditures as reported on the CMS-64 Schedule C, FFY17 Quarter 4. Report pulled on 2/7/2018.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 1

Start Date: 01/01/2014

End Date: 12/31/2014

Table 1.1: Budget Neutrality Limit DY 1 (Special Terms and Conditions (STC) 106)

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 385.80	4,517,149	$ 1,742,724,978	70.79%	$ 1,233,678,861	$ 1,488,754,304	$ 1,072,432,494
MEG02 - SSI & Related - Medicaid Only	$ 1,763.90	497,958	$ 878,350,269	70.79%	$ 621,786,095	$ 824,638,553	$ 574,693,649
MEG03 - SSI & Related - Dual Eligible	$ 1,780.77	428,025	$ 762,214,336	70.79%	$ 539,573,212	$ 570,612,226	$ 395,562,918
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	70.79%	$ 48,766,904	$ 68,889,323	$ 47,671,411
MEG09 HQII	NA	NA	$ -	70.79%	$ -	$ -	$ -
Grand Total			**$ 3,452,178,905**		**$ 2,443,805,072**	**$ 2,952,894,406**	**$ 2,090,360,472**

Table 1.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 4,936.92	2,799	$ 13,818,444	69.31%	$ 9,577,968	$ 6,662,084	$ 4,617,670
MEG 05 - "217 Like" Dual Eligible	$ 1,776.90	26,895	$ 47,789,749	69.31%	$ 33,124,475	$ 86,786,741	$ 60,154,448
Grand Total			**$ 61,608,193**		**$ 42,702,443**	**$ 93,448,825**	**$ 64,772,118**

Table 1.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 577.87	1,887,728	$ 1,090,856,222	100.00%	$ 1,090,854,926	$ 857,043,080	$ 857,042,062
Grand Total			**$ 1,090,856,222**		**$ 1,090,854,926**	**$ 857,043,080**	**$ 857,042,062**

Table 1.4: DY 1 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,443,805,072**
Federal Share (Title XIX) Actual Reported	$ 2,090,360,472
Excess Spending - Test 1	$ 22,069,675
Excess Spending - Test 2	$ -
Total Actuals	$ 2,112,430,147
Difference (Actuals - Limit)	$ (331,374,925)
Percentage Difference	-13.6%

Notes:

1.) Member months as of November 3, 2015.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY18 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY18 Quarter 1. Report pulled on 2/7/18.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 2

Start Date: 01/01/2015

End Date: 12/31/2015

Table 2.1: Budget Neutrality Limit DY 2 (Special Terms and Conditions (STC) 106)

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 400.77	4,454,290	$ 1,785,150,637	71.42%	$ 1,274,956,307	$ 1,535,380,277	$ 1,118,116,879
MEG02 - SSI & Related - Medicaid Only	$ 1,842.83	494,529	$ 911,332,877	71.42%	$ 650,874,820	$ 882,372,838	$ 618,970,778
MEG03 - SSI & Related - Dual Eligible	$ 1,857.34	435,140	$ 808,202,928	71.42%	$ 577,219,310	$ 584,167,632	$ 407,989,739
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	71.42%	$ 49,200,821	$ 67,294,973	$ 46,989,091
MEG09 HQII	NA	NA	$ 2,824,462	71.42%	$ 2,017,233	$ 2,824,462	$ 1,987,574
Grand Total			**$ 3,576,400,227**		**$ 2,554,268,491**	**$ 3,072,040,182**	**$ 2,194,054,061**

Table 2.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,090.46	2,382	$ 12,125,476	69.84%	$ 8,468,353	$ 5,554,385	$ 3,880,344
MEG 05 - "217 Like" Dual Eligible	$ 1,853.31	27,063	$ 50,156,129	69.84%	$ 35,028,714	$ 85,077,407	$ 59,416,310
Grand Total			**$ 62,281,604**		**$ 43,497,067**	**$ 90,631,792**	**$ 63,296,654**

Table 2.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 607.34	2,748,632	$ 1,669,354,159	100.00%	$ 1,669,327,108	$ 1,311,689,926	$ 1,311,668,671
Grand Total			**$ 1,669,354,159**		**$ 1,669,327,108**	**$ 1,311,689,926**	**$ 1,311,668,671**

Table 2.4: DY 2 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,554,268,491**
Federal Share (Title XIX) Actual Reported	$ 2,194,054,061
Excess Spending - Test 1	$ 19,799,587
Excess Spending - Test 2	$ -
Total Actuals	$ 2,213,853,648
Difference (Actuals - Limit)	$ (340,414,844)
Percentage Difference	-13.3%

Notes:

1.) Member months as of November 10, 2016.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY18 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY18 Quarter 1. Report pulled on 2/7/18.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 3

Start Date: 01/01/2016

End Date: 12/31/2016

Table 3.1: Budget Neutrality Limit DY 3 (Special Terms and Conditions (STC) 106)

MEG	DY 3 - PMPM	DY 3 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 3 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 416.32	4,621,656	$ 1,924,092,463	72.26%	$ 1,390,352,732	$ 1,544,356,199	$ 1,136,255,766
MEG02 - SSI & Related - Medicaid Only	$ 1,925.21	493,577	$ 950,239,887	72.26%	$ 686,645,080	$ 865,090,623	$ 616,039,423
MEG03 - SSI & Related - Dual Eligible	$ 1,937.21	447,801	$ 867,484,358	72.26%	$ 626,845,784	$ 600,142,952	$ 423,694,301
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	72.26%	$ 49,779,551	$ 68,889,323	$ 48,608,306
MEG09 HQII	NA	NA	$ 5,764,727	72.26%	$ 4,165,602	$ 7,359,077	$ 5,234,511
Grand Total			**$ 3,816,470,759**		**$ 2,757,788,749**	**$ 3,085,838,174**	**$ 2,229,832,307**

Table 3.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 3 - PMPM	DY 3 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 3 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,248.77	2,987	$ 15,678,086	70.60%	$ 11,067,959	$ 7,590,384	$ 5,362,609
MEG 05 - "217 Like" Dual Eligible	$ 1,933.00	31,866	$ 61,596,973	70.60%	$ 43,484,441	$ 91,598,699	$ 64,660,017
Grand Total			**$ 77,275,059**		**$ 54,552,400**	**$ 99,189,083**	**$ 70,022,626**

Table 3.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 3 - PMPM	DY 3 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 3 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 638.31	3,078,074	$ 1,964,773,916	99.94%	$ 1,963,650,508	$ 1,393,608,289	$ 1,392,811,459
Grand Total			**$ 1,964,773,916**		**$ 1,963,650,508**	**$ 1,393,608,289**	**$ 1,392,811,459**

Table 3.4: DY 3 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,757,788,749**
Federal Share (Title XIX) Actual Reported	$ 2,229,832,307
Excess Spending - Test 1	$ 15,470,226
Excess Spending - Test 2	$ -
Total Actuals	$ 2,245,302,533
Difference (Actuals - Limit)	$ (512,486,216)
Percentage Difference	-18.6%

Notes:

1.) Member months as of October 3, 2017.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY18 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY18 Quarter 1. Report pulled on 2/7/18.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 4

Start Date: 01/01/2017

End Date: 12/31/2017

Table 4.1: Budget Neutrality Limit DY 4 (Special Terms and Conditions (STC) 106)

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 432.47	4,615,353	$ 1,996,021,365	72.18%	$ 1,440,796,968	$ 1,431,162,319	$ 1,042,211,260
MEG02 - SSI & Related - Medicaid Only	$ 2,008.00	489,679	$ 983,273,037	72.18%	$ 709,760,344	$ 839,861,416	$ 602,016,959
MEG03 - SSI & Related - Dual Eligible	$ 2,020.51	438,585	$ 886,165,170	72.18%	$ 639,664,541	$ 552,047,932	$ 394,106,425
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	72.18%	$ 49,726,686	$ 51,666,993	$ 36,750,732
MEG09 HQII	NA	NA	$ 5,764,727	72.18%	$ 4,161,178	$ -	$ -
Grand Total			**$ 3,940,113,623**		**$ 2,844,109,718**	**$ 2,874,738,660**	**$ 2,075,085,376**

Table 4.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,412.01	4,267	$ 23,093,047	71.41%	$ 16,490,231	$ 12,410,795	$ 8,860,662
MEG 05 - "217 Like" Dual Eligible	$ 2,016.12	39,673	$ 79,985,483	71.41%	$ 57,115,852	$ 111,430,661	$ 79,571,764
Grand Total			**$ 103,078,530**		**$ 73,606,083**	**$ 123,841,456**	**$ 88,432,426**

Table 4.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 670.87	3,137,227	$ 2,104,661,165	95.19%	$ 2,003,372,351	$ 1,418,096,328	$ 1,349,849,098
Grand Total			**$ 2,104,661,165**		**$ 2,003,372,351**	**$ 1,418,096,328**	**$ 1,349,849,098**

Table 4.4: DY 4 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,844,109,718**
Federal Share (Title XIX) Actual Reported	$ 2,075,085,376
Excess Spending - Test 1	$ 14,826,343
Excess Spending - Test 2	$ -
Total Actuals	$ 2,089,911,719
Difference (Actuals - Limit)	$ (754,197,999)
Percentage Difference	-26.5%

Notes:

1.) Member months as of February 7, 2018.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY18 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY18 Quarter 1. Report pulled on 2/7/18.

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 1/2018

Summary of Expenditures by Waiver Year
Waiver: 11W00285

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,488,754,304	1,535,380,277	1,544,356,199	1,431,162,319	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,999,653,099	5,999,653,099
MEG2- SSI Medicaid Only	0	824,638,553	882,372,838	865,090,623	839,861,416	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3,411,963,430	3,411,963,430
MEG3- SSI DUAL	0	570,612,226	584,167,632	600,142,952	552,047,932	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,306,970,742	2,306,970,742
MEG4-217	0	6,662,084	5,554,385	7,590,384	12,410,795	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32,217,648	32,217,648
MEG5- 217 DUAL	0	86,786,741	85,077,407	91,598,699	111,430,661	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	374,893,508	374,893,508
MEG6-VIII GROUP	0	857,043,080	1,311,689,926	1,393,608,289	1,418,096,328	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,980,437,623	4,980,437,623
MEG8-UHC-Uncompensated care	0	68,889,322	36,005,978	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	104,895,300	104,895,300
MEG9-HQII-Hospital Quality Improve Incentive	0	0	2,824,462	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,824,462	2,824,462
UC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	31,288,995	68,889,323	51,666,993	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	151,845,312	151,845,312
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	7,359,077	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,359,077	7,359,077
Total	**0**	**3,903,386,311**	**4,474,361,900**	**4,578,635,546**	**4,416,676,444**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**16,270,793,462**	**16,270,793,462**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,072,432,494	1,118,116,879	1,136,255,766	1,042,211,260	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,369,016,399	4,369,016,399
MEG2- SSI Medicaid Only	0	574,693,649	618,970,778	616,039,423	602,016,959	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,411,720,809	2,411,720,809
MEG3- SSI DUAL	0	395,562,918	407,989,739	423,694,301	394,106,425	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,621,353,383	1,621,353,383
MEG4-217	0	4,617,670	3,880,344	5,362,609	8,860,662	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22,721,285	22,721,285
MEG5- 217 DUAL	0	60,154,448	59,416,310	64,660,017	79,571,764	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	263,802,539	263,802,539
MEG6-VIII GROUP	0	857,042,062	1,311,668,671	1,392,811,459	1,349,849,098	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,911,371,290	4,911,371,290
MEG8-UHC-Uncompensated care	0	47,671,411	25,207,785	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	72,879,196	72,879,196
MEG9-HQII-Hospital Quality Improve Incentive	0	0	1,987,574	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,987,574	1,987,574
UC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	21,781,306	48,608,306	36,750,732	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	107,140,345	107,140,345
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	5,234,511	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,234,511	5,234,511
Total	**0**	**3,012,174,653**	**3,569,019,386**	**3,692,666,392**	**3,513,366,900**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12,894,399,029**	**12,894,399,029**

M-CHIP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	84,345,576	123,772,734	118,234,205	103,055,034	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	429,407,549	429,407,549
Total	**0**	**84,345,576**	**123,772,734**	**118,234,205**	**103,055,034**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**429,407,549**	**429,407,549**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	66,261,376	105,262,020	118,234,205	103,055,034	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	392,812,635	392,812,635
Total	**0**	**66,261,376**	**105,262,020**	**118,234,205**	**103,055,034**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**392,812,635**	**392,812,635**

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	109,429,793	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	109,429,793	109,429,793
MEG1-TANF & Related	0	1,954,350	65,480,569	65,074,357	72,935,913	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	205,445,189	205,445,189
MEG2- SSI Medicaid Only	0	0	7,486,654	7,092,313	7,917,402	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22,496,369	22,496,369
MEG3- SSI DUAL	0	0	6,529,128	6,427,342	7,362,093	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20,318,563	20,318,563
MEG4-217	0	0	38,262	33,592	75,896	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	147,750	147,750
MEG5- 217 DUAL	0	0	407,768	443,293	648,379	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,499,440	1,499,440
MEG6-VIII GROUP	0	36,482,445	42,490,242	46,181,710	58,788,989	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	183,943,386	183,943,386
MEG7-CHIP GROUP	0	970,894	9,718,323	8,855,541	10,593,709	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	30,138,467	30,138,467
Total	**0**	**148,837,482**	**132,150,946**	**134,108,148**	**158,322,381**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**573,418,957**	**573,418,957**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	72,280,629	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	72,280,629	72,280,629
MEG1-TANF & Related	0	1,033,347	40,936,423	40,554,618	46,773,357	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	129,297,745	129,297,745
MEG2- SSI Medicaid Only	0	0	4,680,219	4,418,426	5,074,390	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14,173,035	14,173,035
MEG3- SSI DUAL	0	0	4,081,721	4,004,682	4,713,978	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12,800,381	12,800,381
MEG4-217	0	0	23,886	21,011	48,602	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	93,499	93,499
MEG5- 217 DUAL	0	0	254,948	276,801	415,617	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	947,366	947,366
MEG6-VIII GROUP	0	24,028,135	26,563,447	28,785,811	37,566,787	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	116,944,180	116,944,180
MEG7-CHIP GROUP	0	643,626	6,075,205	5,511,156	6,749,557	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18,979,544	18,979,544
Total	**0**	**97,985,737**	**82,615,849**	**83,572,505**	**101,342,288**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**365,516,379**	**365,516,379**

Created On: Wednesday, February 7, 2018 11:47 AM

MEMBER MONTHS **CY 2016 Quarter** **CY 2017 Quarter**

CENTENNIAL CARE MEG REPORTING

Eligibility Group	1	2	3	4	Total	1	2	3	4	Total
Population 1 – TANF and Related	1,130,779	1,150,300	1,169,603	1,170,974	**4,621,656**	1,180,160	1,169,838	1,144,199	1,121,156	**4,615,353**
Population 2 – SSI and Related – Medicaid Only	123,597	122,633	123,728	123,619	**493,577**	124,408	125,415	122,569	117,287	**489,679**
Population 3 – SSI and Related - Dual	110,017	111,379	113,425	112,980	**447,801**	111,537	111,476	110,100	105,472	**438,585**
Population 4 – 217-like Group – Medicaid Only	566	1064	564	793	**2,987**	1,133	1,048	934	1,152	**4,267**
Population 5 – 217-like Group - Dual	6,938	8,390	7,911	8,627	**31,866**	9,714	9,991	10,102	9,866	**39,673**
Population 6 – VIII Group (expansion)	753,995	761,293	778,625	784,161	**3,078,074**	806,114	802,822	772,310	755,981	**3,137,227**
Population 7 - CHIP Group	151,824	140,006	134,983	132,292	**559,105**	133,031	130,657	123,218	116,367	**503,273**
Total	2,277,716	2,295,065	2,328,839	2,333,446	**9,235,066**	2,366,097	2,351,247	2,283,432	2,227,281	**9,228,057**

Report extracted on February 7, 2018.

Table #9 - Waiver Year 4 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
MEG01 - TANF & Related	$ 1,431,162,319	$ 72,935,913
MEG02 - SSI & Related - Medicaid Only	$ 839,861,416	$ 7,917,402
MEG03 - SSI & Related - Dual Eligible	$ 552,047,932	$ 7,362,093
MEG04 - "217 Like" Medicaid Only	$ 12,410,795	$ 75,896
MEG05 - "217 Like" Dual Eligible	$ 111,430,661	$ 648,379
MEG06 - VIII Group - Medicaid Expansion	$ 1,418,096,328	$ 58,788,989
MEG07 - CHIP	$ 103,055,034	$ 10,593,709
Uncompensated Care "UC" Pool	$ 51,666,993	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Grand Total	**$ 4,519,731,478**	**$ 158,322,381**

Source: New Mexico CMS 64 Submission, FFY 18 Quarer 1, February 7, 2018.

Attachment B

Molina Healthcare of New Mexico
2017 Value Added Services

DENTAL VARNISH
Description: Prescription strength fluoride product delivered to the dentition by a child's PCP. For members with moderate to high dental risk. Please note this is a Medicaid covered service for children 3 years and older.
Eligible Population: Available to children 0-3 years old. Members in the Alternative Benefit Plan (ABP) are not eligible.
Prior Authorization: No Prior Authorization is required to access this service.
ELECTROCONVULSIVE THERAPY (ECT)
Description: For use as a treatment for severe depression that has not responded to other treatment. Short-term ECT is given for a limited number of times per week for a limited number of weeks. Maintenance ECT is provided as required; maintenance ECT is provided less frequently than short-term ECT, i.e. once per week/two weeks/month. Short-term ECT & maintenance ECT is typically for adults but will evaluate for pediatric population on a case by case basis.
Eligible Population: Medicaid members only. Members in the ABP are not eligible.
Prior Authorization: A Prior Authorization is required to access this service.
INFANT MENTAL HEALTH
Description: Infant Mental Health Services (IMH) targets children (0-5) in distress or with clear symptoms indicating a mental health disorder. IMH address problems with attachment and relationships in families, focus on the parent-child relationship, and are designed to improve infant and family functioning in order to reduce risk for more severe behavioral, social, emotional, and relationship disturbances as infants get older. Relationship-focused interventions to the parents, foster parents, or other primary caregivers with infants and toddlers. $50,000 total program cost per calendar year for all IMH services rendered.
Eligible Population: Benefit available to parents/foster parents/caregivers of Members 0 - 5 years old.
Prior Authorization: A Prior Authorization is required to access this service.
NEW MOTHERS' PROGRAM (Motherhood Matters)
Description: This free program helps women get the education and services needed for a healthy pregnancy. Services may include counseling over the telephone, prenatal education materials and other resources, coordination with social services, and/or case management by a nurse. Members who complete both the Prenatal Care and Car Seat Safety Program before their baby is born are eligible to receive a free infant car seat. Members must register before their 35th week of pregnancy for the program. Members who receive their postpartum check-up within three (3) to eight (8) weeks of having their baby are eligbile to receive a free toddler car seat.
Eligible Population: Both ABP and Medicaid pregnant mothers can access this service.
Prior Authorization: No prior authorization is required to access this service.
NON-MATERNITY RELATED SERVICES TO WOMEN ENROLLED IN COE 301 FOR MATERNITY-RELATED SERVICES ONLY
Description: All Medical, Behavioral Health, Dental, Vision and Transportation for all pregnant women enrolled in maternity-only COE. Women in this COE are provided Medicaid benefits for pregnancy-related services. Molina is providing the full Medicaid benefit to these women, with the exception of Long Term Care and Community Benefits.
Eligible Population: Pregnant women enrolled in maternity-only COE. Members in the ABP are not eligible.
Prior Authorization: Certain services require a Prior Authorization. Please refer to Molina's member handbook for services requiring prior authorization.
POST DISCHARGE MEALS

Description: Designed to support Molina members as they transition from a hospital or SNF inpatient setting, back into the home and community. Home delivered meals to members after discharge from a hospital or SNF inpatient stay, at no charge to the member. Meal types vary, and can include regular, vegetarian, diabetic/low sodium, renal, kosher and pureed selections. Provides up to forty-two (42) home delivered meals per calendar year to homebound members after hospital discharge, to be prepared by USDA or state inspected facility. Homebound means an individual who has difficulty leaving home without assistance because of a disabling physical, emotional, or cognitive impairment.
Eligible Population: Both ABP and Medicaid members can access this service.
Prior Authorization: A Prior Authorization is required to access this service.
POST HOSPITALIZATION HOMELESS LODGING
Description: Allows homeless members to stay in hotels for up to two weeks during the transition from hospital to home. Required care such as infusion therapy or skilled nursing services would be provided in this setting.
Eligible Population: Member must be homeless, requiring additional services. Limited to two weeks. Members in the ABP are not eligible.
Prior Authorization: A Prior Authorization is required to access this service.
SCHOOL SPORTS PHYSICALS
Description: Physical examinations and completion of paperwork so that members can participate in sporting activities. This is a medical examination for administrative purposes rather than medical diagnosis or treatment.
Eligible Population: Available to children 12 -18 years old. One physical per calendar year. Members in the ABP are not eligible.
Prior Authorization: No Prior Authorization is required to access this service.
NATIVE AMERICAN HEALING BENEFIT
Description: Provides spiritual services with cultural sensitivity for traditional healing rituals. The Native American Healing Benefit helps members using traditional healing services. Members may use the healer of their choice for the healing ceremony of their choice. $200 per member per calendar year. Benefit excludes Self-Directed Community Benefit members. $100,000 total program cost per calendar year for Mediciaid members. $50,000 total program cost per calendar year for ABP members.
Eligible Population: Both ABP members and Medicaid members 12 years and older can access this service.
Prior Authorization: No Prior Authorization is required to access this service.

New Mexico Behavioral Health Collaborative

New Mexico Behavioral Health Consumer, Family/Caregiver Satisfaction Project

2017

A Collaborative effort by:

The New Mexico Human Services Department: Behavioral Health Services Division, Office of Peer Recovery and Engagement, Medical Assistance Division; Children Youth and Families Department; Blue Cross/Blue Shield, Molina Healthcare, Presbyterian/Magellan, United Healthcare; and New Mexico Behavioral Health Consumers, Families, Children and Youth.

Table of Contents

FY2017 Consumer Family/Caregiver Report

What is the Consumer Satisfaction Project?

The New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project (CFYP) is a yearly effort to survey the satisfaction of New Mexico Adult individuals, Family/Caregivers and Youth receiving state funded mental health and substance abuse treatment and support services.

The CFYP surveys serve two purposes:

- **To inform a quality improvement process to strengthen services in New Mexico; and,**
- **To fulfill federally mandated data reporting requirements**.

Adults, family members and youth answer the survey through face-to-face or telephone interviews. Provider locations for face-to-face interviews are pre-selected each year. Telephone interviews were obtained from a pool of randomly-selected individuals or families who received behavioral health services from New Mexico Medicaid or Behavioral Health programs between July, 2016, and February, 2017. There is a separate Youth Report which surveys youth in detention and shelters; CYFD will make it available in late fall, 2017.

2017: The Fourth Year of Centennial Care

Since 2014 when Centennial Care began in New Mexico, there were some significant changes in New Mexico's behavioral health care environment that can continue to affect individuals during the period in which they were receiving care and surveyed (July, 2016, through February, 2017.)

- In January, 2014, New Mexico launched its new Medicaid program, *Centennial Care*, which manages both behavioral health and primary care services. At that point, most Medicaid-eligible individuals and families had to enroll in one of four managed care companies, while a portion remained in a separate Medicaid fee-for-service program.
- While the Medicaid benefit packages are primarily identical, each MCO offers some "value added" services that vary.
- All *Centennial Care* members were contacted to determine whether they would qualify for a more intense service - Care Coordination – designed to assist those with complex needs.
- A new emphasis on *integrated* behavioral and physical care was introduced.

The reader will see trend data in each of the domains which reflects the respondents' satisfaction across the four years of Centennial Care (2014-2017.)

What we ask about:

The surveys contain questions that come from the federal Mental Health Statistics Improvement Program (MHSIP). The New Mexico Behavioral Health Collaborative added additional questions, including questions related to the National Outcome Measures System. This report will provide highlights separately from the Adult Survey and then from the Child & Family/Caregiver Survey. Findings from a separate and smaller Youth Survey will also be posted in late fall on the New Mexico Network of Care

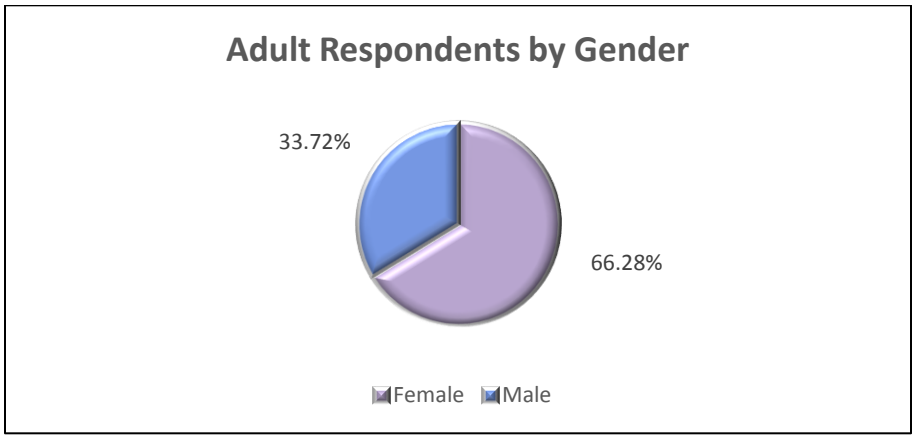
There are seven subscales within the survey that are used nationally. This provides a helpful benchmark for our state's performance. Each of those scales is presented in the report. Responses to most questions were measured in a five point Likert scale, and scale values shown are the percent of respondents for whom the average of the individual's replies to that scale's questions was positive. Each scale result is graphed below to show the 2014, 2015, 2016 and 2017 results for New Mexico. A red dotted line shows what the US average was in 2016 for that measure. The specific questions that make up the scale are listed below the graph, along with sample comments from respondents.

Survey Highlights- Adult

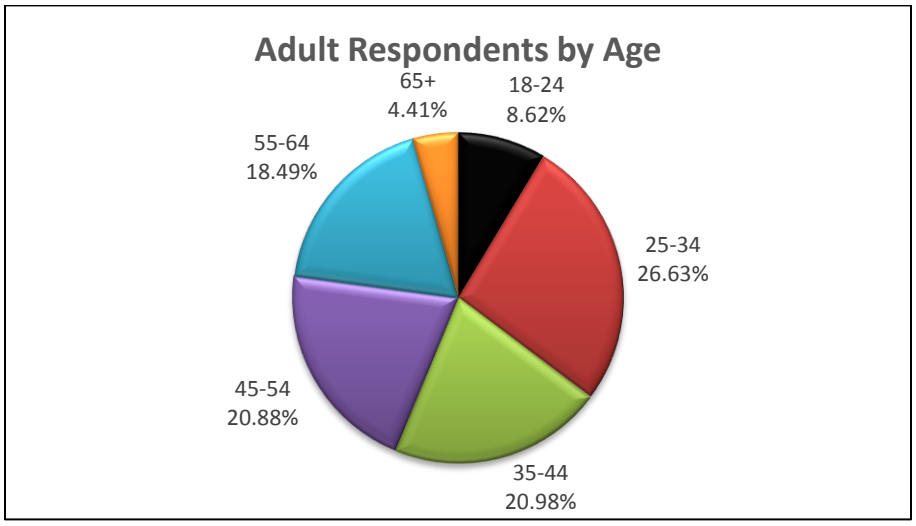
Who we surveyed - Adults

Our sample was drawn from those individuals who had received care anytime between July 1, 2016, and February 29, 2017. However, when called, respondents were free to speak about their experiences throughout the entire previous twelve months. Survey telephone calls were conducted in June, 2017. For the 2017 survey, we heard from 1,044 adults respondents. Generally speaking, the sample well represented the population receiving services.

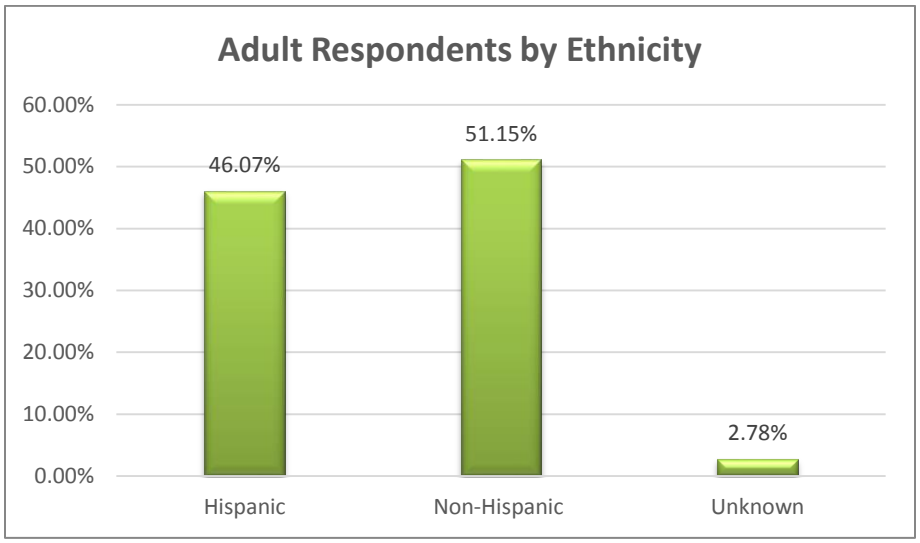
GENDER: However, females (66%) were overrepresented in the sample. They represent only 57% of those receiving services during the same period.



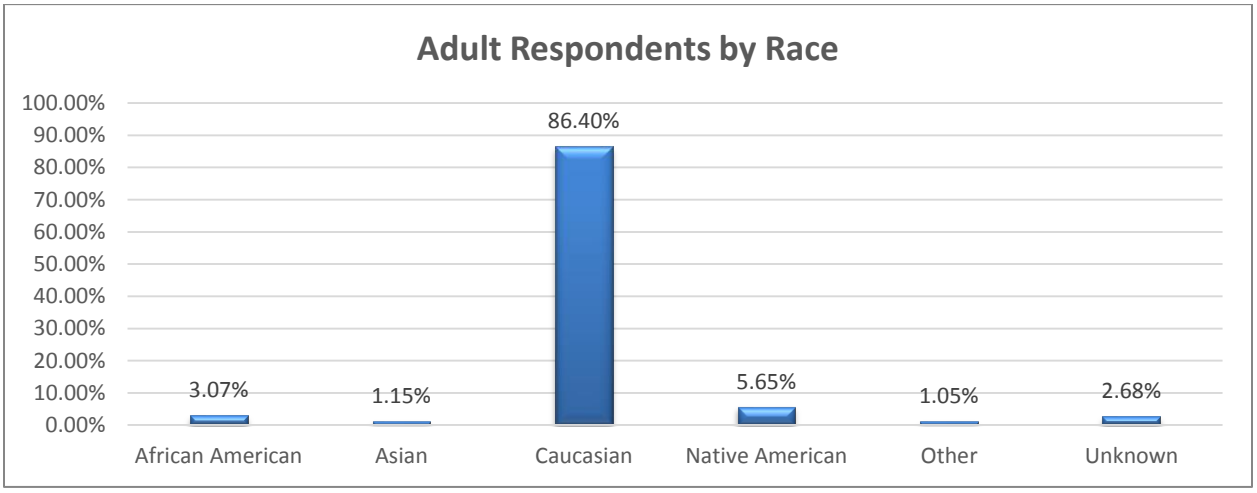
AGE: The respondents ages 45-64 years old (39.4%) were overrepresented in the sample. They represent only 28.7% of those receiving services during the same period. The same is true of the youngest age group, 18-24 years, who were 8.6% of the sample but are 15.2% of the population receiving services.



ETHNICITY: Forty-six percent (46.1%) of the respondents identified their ethnicity as Hispanic. That is very similar to the population receiving services (47.9%) during the same period



RACE: As with the population receiving services, 86% of the respondents identified themselves as Caucasian. Native American respondents (5.65%) were slightly underrepresented as compared to those receiving services (6.7%). And African American respondents (3.1%) were slightly overrepresented as compared to those receiving services (2.6%).



Overview of Findings by Seven Domains: There were two different instruments tailored to the issues pertinent to adults and again for children. The items in each domain are identical to those used nationwide. That allows New Mexico to compare its performance to the National Average. Additional subscales were also

measured (i.e., supportive housing, supportive employment, substance abuse, medication management and care coordination.) Those findings are included at the end of the Adult section of this report on page 13.

Overall, New Mexico has scored higher than the National Average in the majority of the Adult domains (57%). However, we are below the National Average in the domains of: Access; Improved Functioning; and, general Satisfaction. Relative to the prior year, 2016, we were not significantly different in performance across the domains. The MCO's are currently working on their quality improvement strategies to make improvements in these domains.

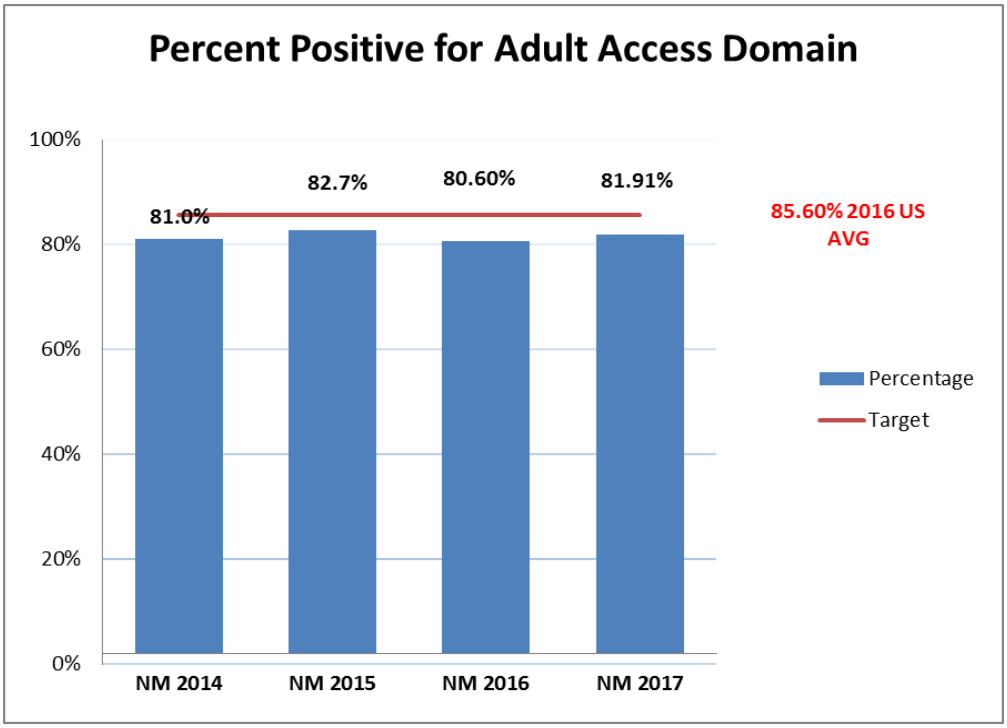
The complete report will be available on the New Mexico Network of Care website at:

www.newmexico.networkofcare.org

Domain: Access

Definition: *Entry into behavioral health services is quick, easy and convenient.*

Observations: The average proportion of positive responses for Access was 81.9%. This is below the national 2016 average of 85.6%, but above the prior year's performance of 80.6%. Respondents were least satisfied with access to their psychiatrist.



Consumer Comments about Access:

"I have liked access to a peer support worker. They gave me the number to the Peer Support line.""

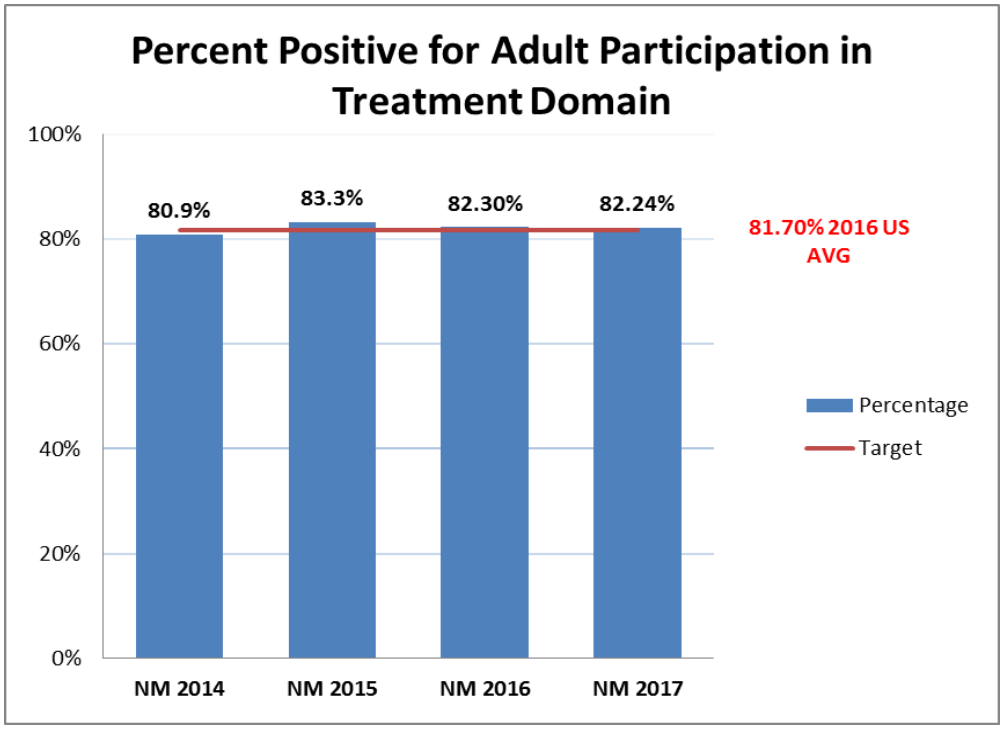
The most frequently cited problems with access were:
needing more psychiatric providers, problems accessing medication, lack of treatment facilities, transportation and housing.

Q #	Items for Access	Domain Item Percentage
4	The location of services was convenient (parking, public transportation, distance, etc.).	86.58%
5	Staff were willing to see me as often as I felt it was necessary.	86.50%
6	Staff returned my call in 24 hours.	81.00%
7	Services were available at times that were good for me.	87.97%
8	I was able to get all the services I thought I needed.	82.58%
9	I was able to see a psychiatrist when I wanted to.	77.79%

Domain: Participation in Treatment

Definition: *Adults feel that they are a part of their treatment team.*

Observations: The average proportion of positive responses for Participation in Treatment was 82.2%. This is above the national 2016 average of 81.7%, and similar to the prior year's performance of 82.3%. While adults were generally satisfied asking questions about their treatment or medications, they were notably less satisfied about the process of setting their treatment goals.



Consumer Comments about Participation in Treatment:

"Services were geared toward the whole person and used the principals of self-determination."

"I'm working with my care coordinator to help me stay out of the hospital."

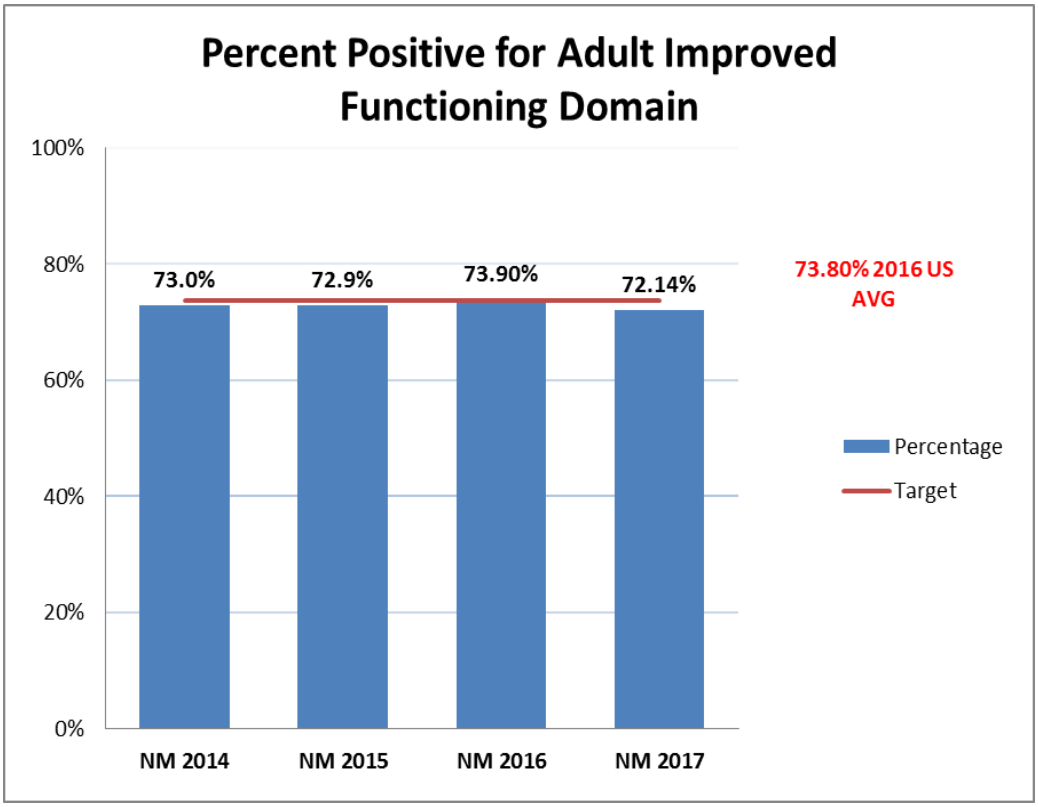
"The doctor at Provider's office is amazing. After decades of looking for help, she was the first person to realize my problem was not an anxiety disorder, but PTSD."

Q #	Items for Participation in Treatment	Domain Item Percentage
11	I felt comfortable asking questions about my treatment and medication.	91.44%
17	I, not staff, decided my treatment goals.	83.91%

Domain: Improved Functioning

Definition: *Adults feel they can manage their daily activities better.*

Observations: The average proportion of positive responses for Improved Functioning was 72.1%. This is below the national 2016 average of 73.8%, and below the prior year's performance of 73.9%. In particular, adults were less satisfied about managing their symptoms and being able to do what they wanted to do.



Consumer Comments about Improved Functioning:

"I believe I can go on a vacation at any time as long as I have my medication and my walker with me. I believe I can do a lot of things when I have my walker and my medication ready."

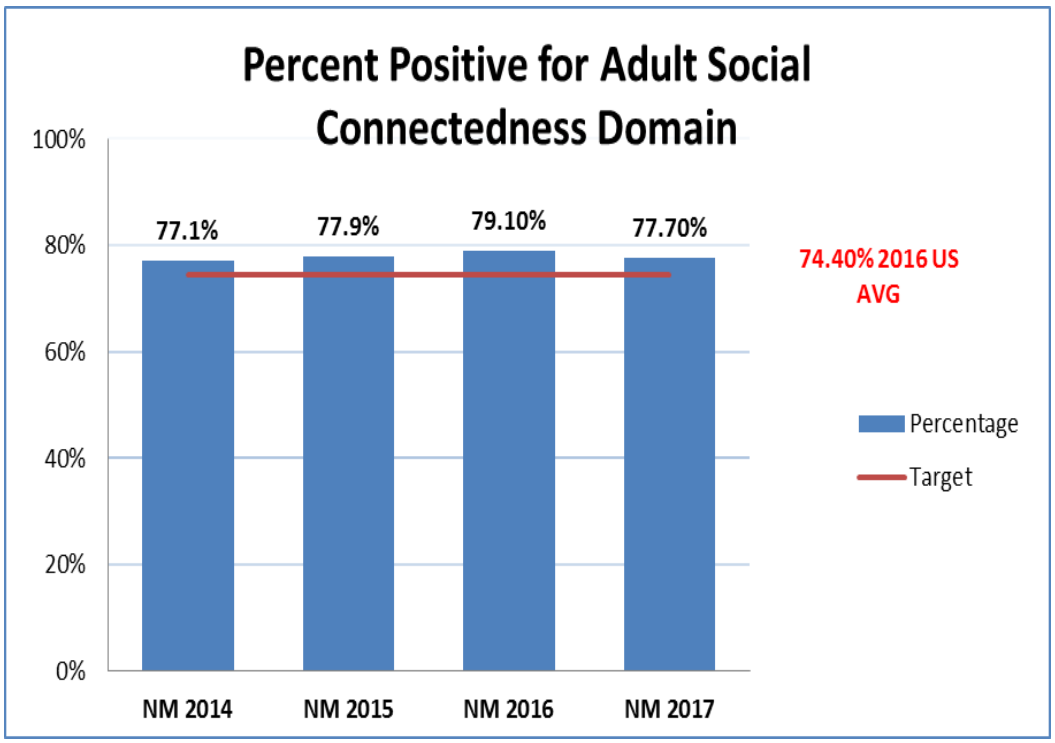
The facility has switched providers three times and he feels that it delayed his progress.

Q #	Items for Improved Functioning	Domain Item Percentage
28	My symptoms are not bothering me as much.	63.27%
29	I do things that are more meaningful to me.	78.27%
30	I am better able to take care of my needs.	79.76%
31	I am better able to handle things when they go wrong.	76.00%
32	I am better able to do things that I want to do.	74.16%

Domain: Social Connectedness

Definition: *Adults feel they are connected in their family and friends, have social supports and belong to their community.*

Observations: The average proportion of positive responses for Social Connectedness was 77.7%. This is above that national 2016 average of 74.4%, but is below the prior year's performance of 79.1%. The area in which adults were less satisfied had to do with their sense of belonging in their community.



Consumer Comments about Social Connectedness:

The provider she was going to was AWESOME!!! They played a very important role in her recovery!

Client said the services received changed his life completely for the better."

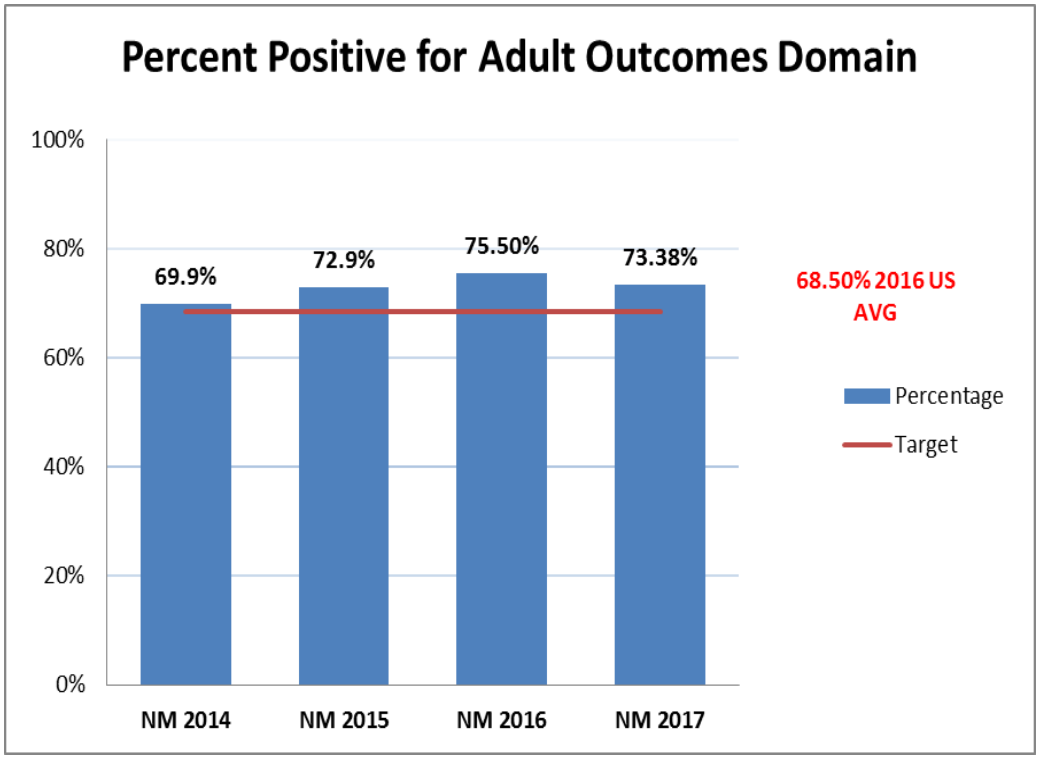
"(I am) very happy with life transitions facility and have been receiving mental health services since I was 13 and would not change it."

Q #	Items for Social Connectedness	Domain Item Percentage
33	I am happy with the friendships I have.	82.67%
34	I have people with whom I can do enjoyable things.	85.64%
35	I feel I belong in my community.	75.02%
36	In a crisis, I would have the support I need from family or friends.	87.04%

Domain: Outcomes

Definition: *The extent to which services provided to individuals with behavioral health needs have a positive or negative effect on their well-being, life circumstances, and capacity for self-management and recovery.*

Observations: The average proportion of positive responses for Outcomes was 73.4%. This is above the national 2016 average of 68.5%, but is down from the prior year's performance of 75.5%. Satisfaction was notably lower in the areas of symptom management, work, housing, and handling social situations.



Consumer Comments about Outcomes:

"Behavior help has helped me to have more patience. Having someone to talk to has helped me also."

"Physician works well. I can take care of myself with the treatment team; I am getting what I need. "

"Physician is a great program and is effective and saves tax payer dollars."

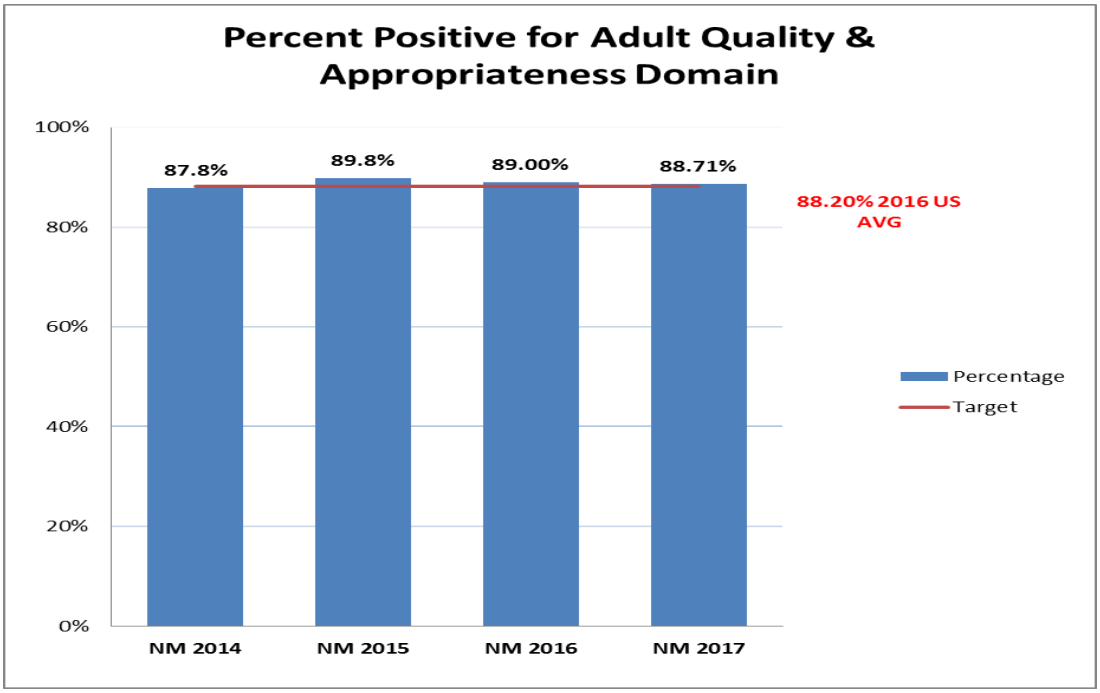
This consumer badly needs a care coordinator to help her with the house and medication access. She was promised someone last October but no one came.

Q #	Items for Social Connectedness	Domain Item Percentage
21	I deal more effectively with daily problems.	81.91%
22	I am better able to control my life.	81.50%
23	I am better able to deal with crisis.	79.16%
24	I am getting along better with my family.	80.23%
25	I do better in social situations.	68.48%
26	I do better in school and/or work.	73.11%
27	My housing situation has improved.	73.10%
28	My symptoms are not bothering me as much.	63.27%

Domain: Quality & Appropriateness

Definition: *Services are individualized to address the consumer's strengths and needs, cultural context, preferences and recovery goals.*

Observations: The average proportion of positive responses for Quality & Appropriateness was 88.7%. This meets the national 2016 average of 88.2%, and is down slightly from the prior year's performance of 89.0%. Adults were generally pleased with areas in this domain; however, they were less satisfied with staff's encouragement to use consumer-run programs and for help in watching out for side effects in their care.



Consumer Comments about Quality & Appropriateness:

"'My counselor asked me to study (a new form of) meditation…that was a stabilizing thing for me.

"They haven't addressed the take home medications."

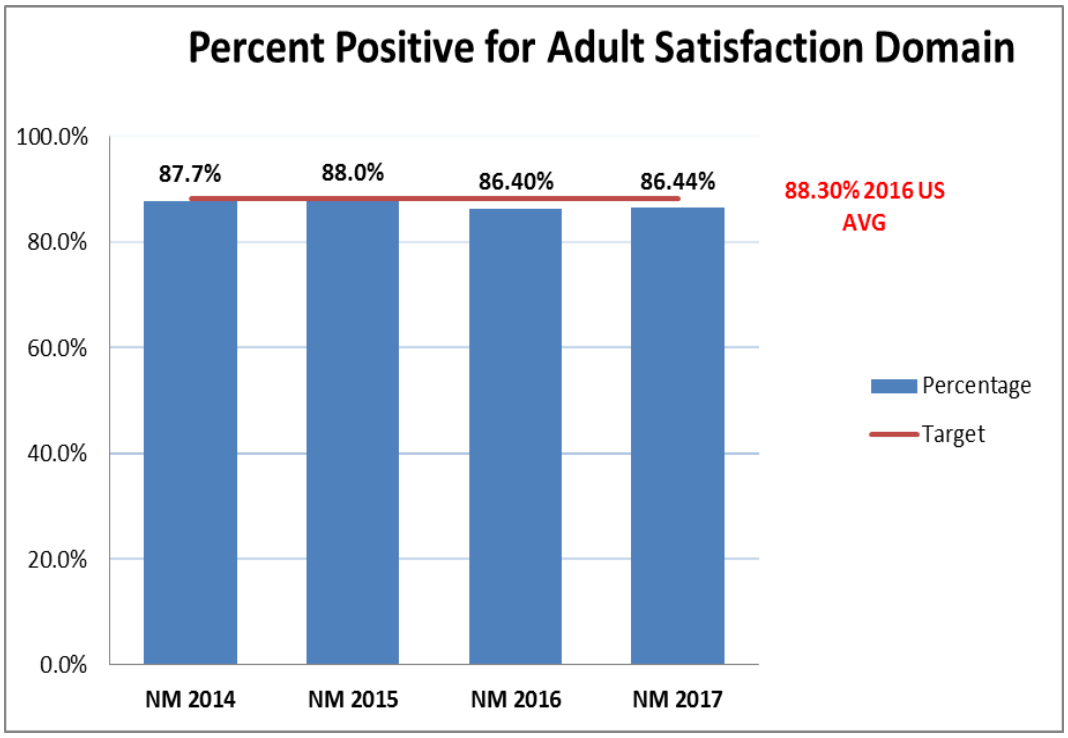
"Provider kept switching my counselor on me."

	Items for Quality & Appropriateess	Domain Item Percentage
10	Staff here believe that I can grow, change and recover.	89.03%
12	I felt free to complain.	88.63%
13	I was given information about my rights.	94.36%
14	Staff encouraged me to take responsibility for how I live my life.	89.07%
15	Staff told me what side effects to watch out for.	84.87%
16	Staff respected my wishes about who is and who is not to be given information about my treatment.	93.08%
18	Staff were sensitive to my cultural background (race, religion, language, etc.)	90.71%
19	Staff helped me obtain the information I needed so that I could take charge of managing my illness.	86.87%
20	I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	77.00%

Domain: Satisfaction

Definition: *Adults are generally happy with the services they are provided.*

Observations: The average proportion of positive responses for Satisfaction was 86.4%. This is lower than the national 2016 average of 88.3%, and is the same as the prior year's performance of 88.4%. Adults were less satisfied with the range of provider choices available to them.



Q #	Items for Satisfaction	Domain Item Percentage
1	I like the services that I received here.	90.96%
2	If I had other choices, I would still get services from this agency.	84.35%
3	I would recommend this agency to a friend or family member.	88.68%

Consumer Comments about Satisfaction:

"The Provider was very is very educated and knowledgeable."

"I would recommend the (therapist) to my closest, dearest friend."

"Thank you so much for helping me. If it wasn't for you, I would still be on drugs."

"Consumer states it is extremely hard to get in to see a psychiatrist. There's no incentive for them to stay. More funding!!!! "

The front desk staff was not helpful. The customer service line was not good.

Other Areas

Problems in the support areas of housing and employment are often crucial factors affecting behavioral health recovery.

Housing: When asked "*Is your housing situation getting in the way of your mental health/recovery?*", about ten percent (9.8%) of the total sample said "*Yes*." Among those respondents, on average, the majority (52.0%) indicated they "agreed or strongly agreed" to this subscale of items:

- My housing needs were part of my treatment plan.
- When I had a housing problem, I was assisted by staff.
- If I had to wait to get housing assistance, I still received support for my other needs from my treatment team.

Employment: When asked "*Does having work (either paid or volunteer) help you with your recovery from mental health or substance abuse disorders?*", 38% of the total sample said "*Yes"*. Among those respondents, on average, the majority (55.0%) indicated they "agreed or strongly agreed" to this subscale of items:

- My work goals were not part of my treatment plan.
- When I had a problem with work, I was assisted by staff.
- Because of the staff's help in general, my work situation is better.

Substance Abuse: A smaller cohort of respondents (17.6%) said they had received services for drug or alcohol use in the past year. But among those respondents, on average, almost all (95.1%) indicated they "agreed or strongly agreed" to this subscale of items:

- I have the tools I need to understand and continue with my recovery.
- The substance abuse services I received helped me reduce my use of drugs and/or alcohol.

Medications: Over two-thirds of respondents (68.3%) indicated that they received medication services as part of their treatment in the past year. Among those respondents, on average, 78.3% indicated they "agreed or strongly agreed" to this subscale of items:

- I am getting my medications when I need them.
- The medication(s) I am taking helps me control symptoms that used to bother me.
- I was offered a choice in, or alternative to, medication.

Care Coordination: About 16.8% of respondents had been assigned care coordination assistance at higher levels (Level 2 or 3) in Centennial Care. The percent of positive response per each item was as follows:

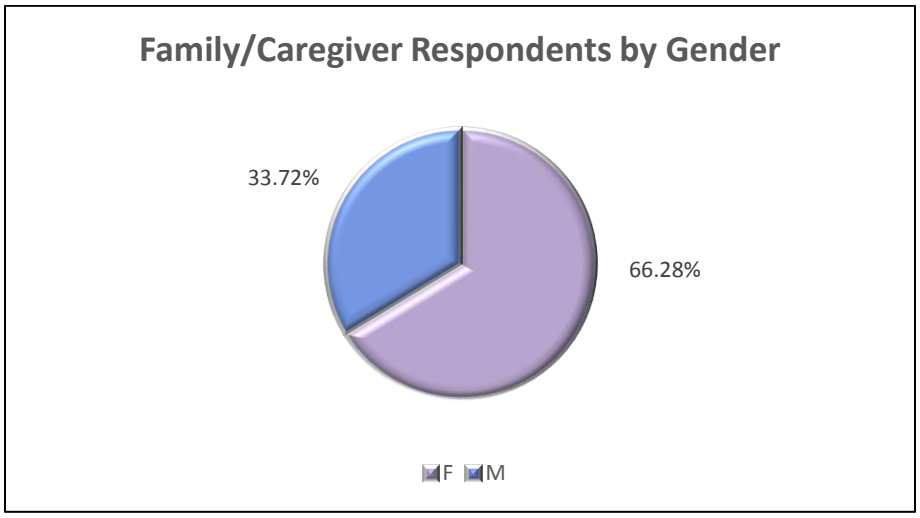
85.2% You were involved in developing your goals for your Care Plan.
81.3% Your physical health was included in your Care Plan.
80.5% Your Care Coordinator reviewed progress on your goals when you met together.
73.2% When your Care Coordinator talked with you on the phone, it helped you with your goals.
77.1% Your Care Coordinator assisted you when there was an interruption or change in your care.

Survey Highlights- Child Family/Caregiver Survey

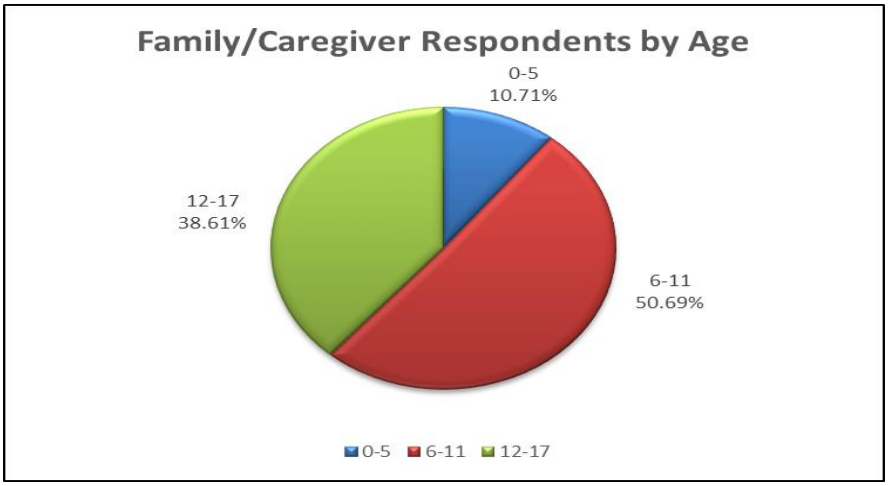
Who we surveyed - Child Family/Caregivers

Our sample was drawn randomly from those children who had received care between July 1, 2016, and February 29, 2017. We spoke to their Family/Caregivers; and, they were free to speak about their experiences of their children in service through the entire previous twelve months. Telephone surveys were conducted in June, 2017. For the 2017 survey, we heard from 1,018 Family/Caregiver respondents.

GENDER: Sixty-six percent (66.3%) of the children receiving services were females, which is a notable overrepresentation of the overall population of females receiving care (44.11%) during this period.

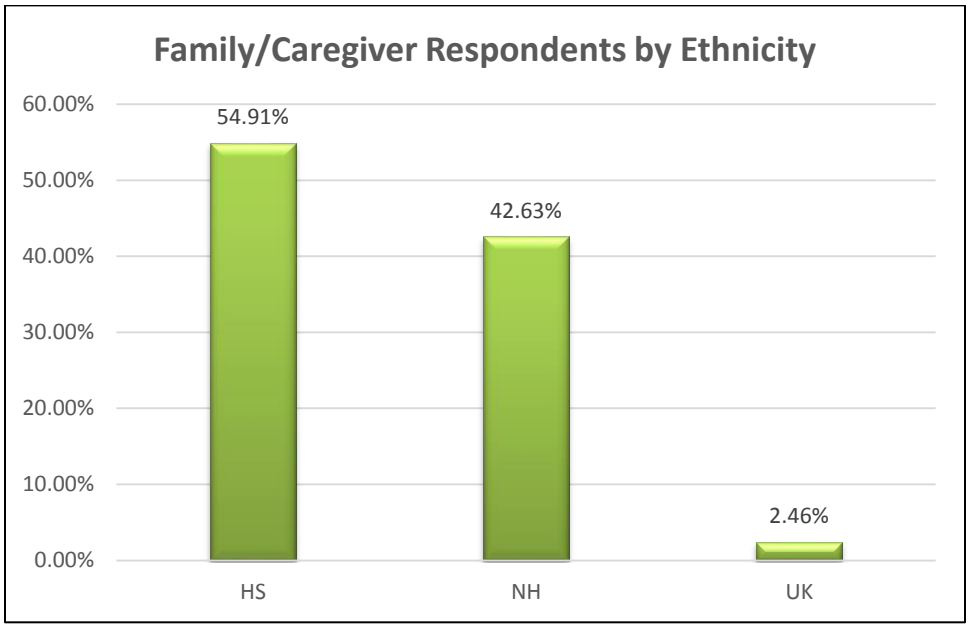


AGE: The majority of children sampled were 6-11 years old (50.7%). This over represents that population in care (43.0%). The 12-17 year old children in the sample (38.6%) were slight underrepresented when compared to that same group in care (48%). That may be due to the fact that this population group was shared with the Youth Survey and may have been sampled in that effort instead.

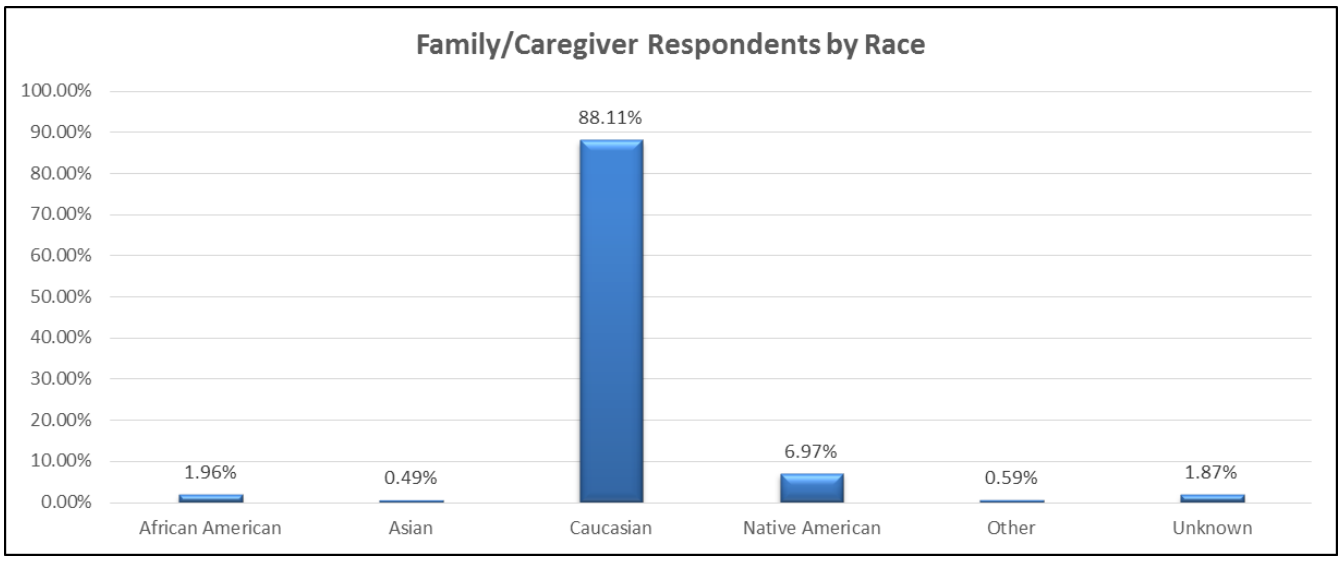


ETHNICITY: There were slightly more Hispanic children sampled (54.9%) than non-Hispanics (42.6%).

This is similar to the proportions in the population receiving services during this period.



RACE: The 88.1% of the group of children sampled were Caucasian. Both Native Americans (7.0%) and African Americans (1.96%) were slightly under represented.



Overview of Findings by Seven Domains: There were two different instruments tailored to the issues pertinent to adults and again for children. The items in each domain are identical to those used nationwide. That allows New Mexico to compare its performance to the National Average. Additional subscales were also measured (i.e., medication management, access to care, interest in Respite and Family Specialist services, and care coordination.) Those findings are included at the end of the Family/Caregiver section of this report on page 24.

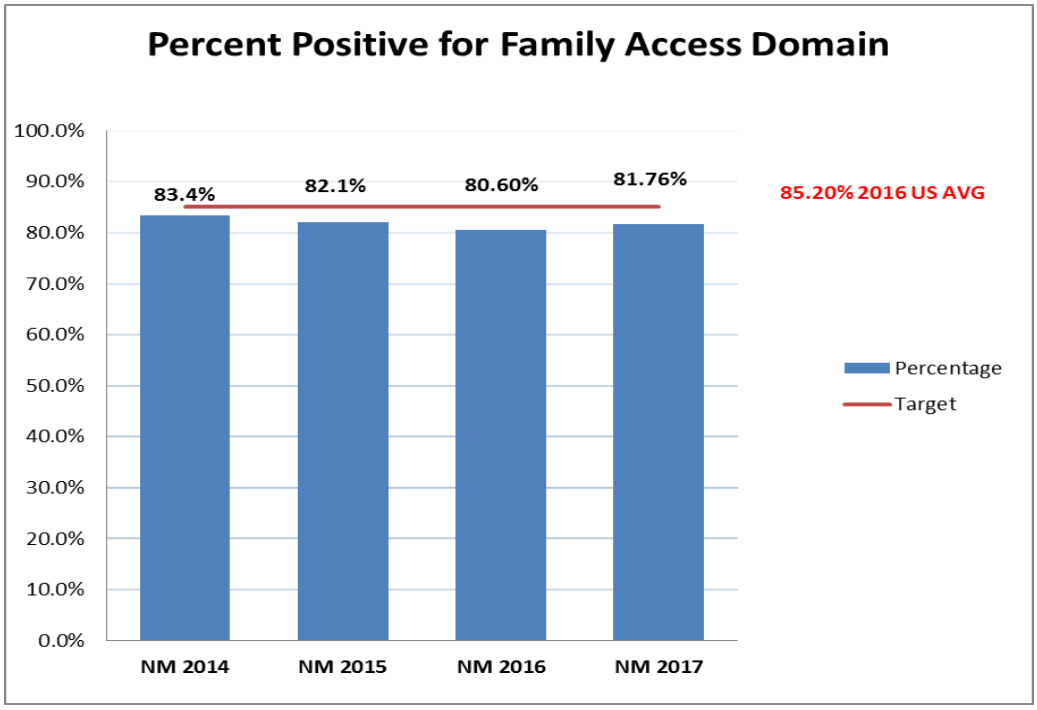
Overall, New Mexico has scored higher than the National Average in the majority of the Family/Caregiver domains (57%). However, we are below the National Average in the domains of: Access; Participation in Treatment; and, general Satisfaction. Relative to the prior year, 2016, we were statistically significantly lower in one domain, Participation in Treatment. The MCO's are currently working on their quality improvement strategies to make improvements in these domains.

The complete report will be available on the New Mexico Network of Care website at:
www.newmexico.networkofcare.org

Domain: Access

Definition: *Entry into behavioral health services is quick, easy and convenient.*

Observations: The average proportion of positive responses for Access was 81.8%. This is below the national 2016 average of 85.2%, but slightly higher than the prior year's performance of 80.6%.



Q #	Items for Access	Domain Item Percentage
8	The location of services was convenient for us.	87.39%
9	Services were available at times that were convenient for us.	86.88%

Consumer Comments about Access:

Overall, he was very happy with personnel and agency

The therapy sessions she is receiving does not fit with her daughter's school schedule. Her daughter often has to miss class due to the inconvenient therapy session times.

"There is a dire need for good counselors to help children in need. Too many behavioral needs children cannot function in a school setting. More BMS workers are needed."

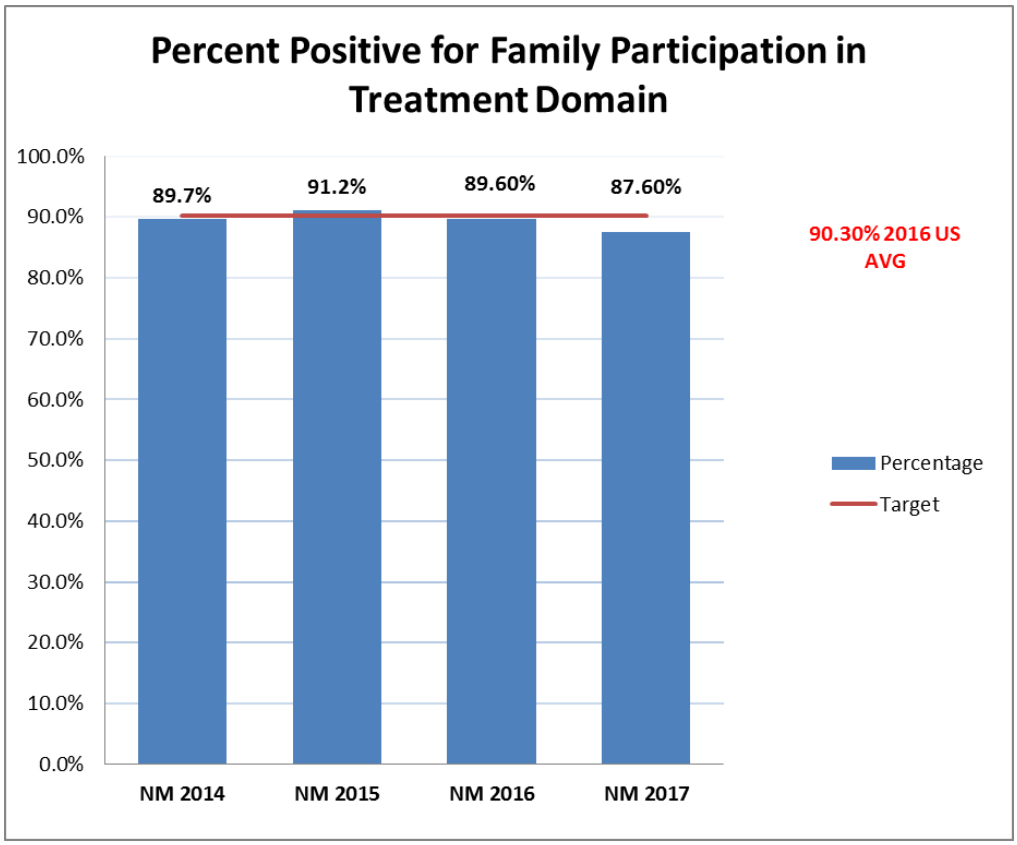
"Services are not provided, not paid for and don't exist outside of Albuquerque."

"Still waiting to receive Respite Services."

Domain: Participation in Treatment Planning

Definition: *Families feel that they are a part of their child's treatment team.*

Observations: The average proportion of positive responses for Participation in Treatment was 87.6%. This is below the national 2016 average of 90.3% and statistically significantly lower than the prior year's performance of 89.6%. However, Families feel very positive about being part of their child's treatment team.



Q #	Items for Participation in Treatment	Domain Item Percentage
2	I helped to choose my child's services.	88.83%
3	I helped to choose my child's treatment goals.	90.00%
6	I participated in my child's treatment.	92.82%

Consumer Comments about Participation in Treatment Planning:

Human Services has been a blessing to grandparents raising grandchildren.

Was extremely happy with and thankful for the care her son has received at Provider and wanted it noted that all services they have were given were extremely helpful and came as a huge blessing.

Therapists have not addressed their questions to the child but speak over him as if he is not there. He is old enough to verbalize his own feelings.

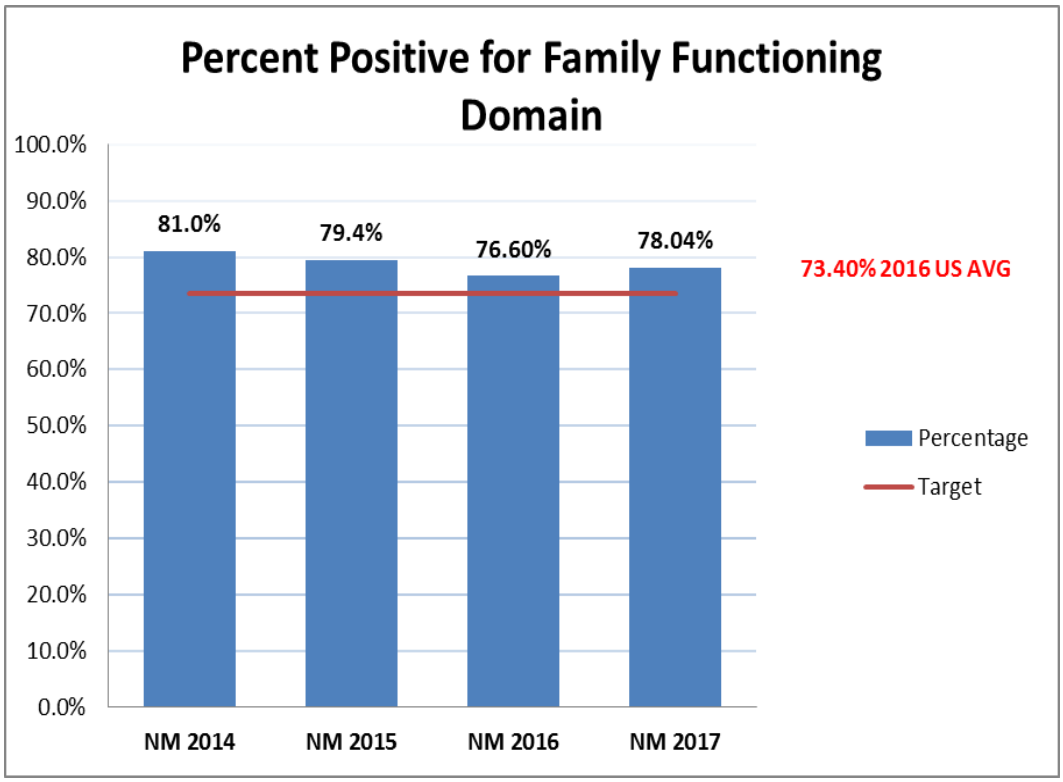
The parent overall was not happy with the services she was provided and mentioned that specialists should consider patient's background and listen more to what the parent has to say.

"As a parent I did not feel supported by the counselor at (the agency.) I will not recommend this agency to help with parent/child relationships."

Domain: Improved Functioning

Definition: *Families feel their child is better able to do the things they want to do, and have someone with whom they can enjoy things.*

Observations: The average proportion of positive responses for Improved Functioning was 78.0%. This is above the national 2016 average of 73.4%, and higher than the prior year's performance of 76.6%. While generally satisfied, families are least positive about their child doing being better able to cope when things go wrong.



Q #	Items for Functioning	Domain Item Percentage
16	My child is better at handling daily life.	78.39%
17	My child gets along better with family members.	83.79%
18	My child gets along better with friends and other people.	80.54%
19	My child is doing better in school and/or work.	78.74%
20	My child is better able to cope when things go wrong.	74.73%
22	My child is better able to do things he/she wants to do.	85.88%

Consumer Comments about Improved Functioning:

"I am very happy with the services we got from our agency and even though my daughter has not received services lately. She was requesting to go back to therapy and we are in the process of setting up an appointment."

"I want to thank you for giving us the services it has helped out my family so much."

Family is not being given tools/support they need and they are in crisis.

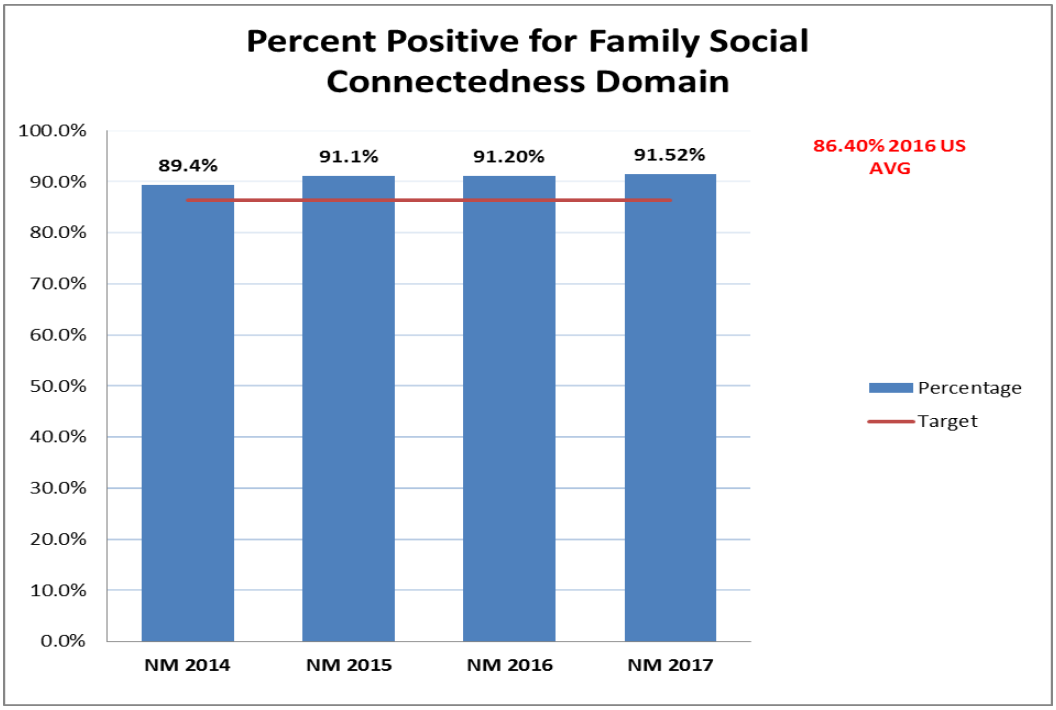
Parent doesn't receive any information about how the sessions are going.

"I would like to be contacted whenever my son gets any kind of services."

Domain: Social Connectedness

Definition: *Families feel they have the social supports to listen to them when they need to talk and have help to deal with their child's problems or crises.*

Observations: The average proportion of positive responses for Social Connectedness was 91.%. This is above that national 2016 average of 86.4%, and is slightly higher than the prior year's performance of 91.2%. Families were least satisfied with they themselves getting the help they needed for their child.



Consumer Comments about Social Connectedness:

Guardian would like to have known about services offered such as Respite services or Family Specialists initially when they really needed them.

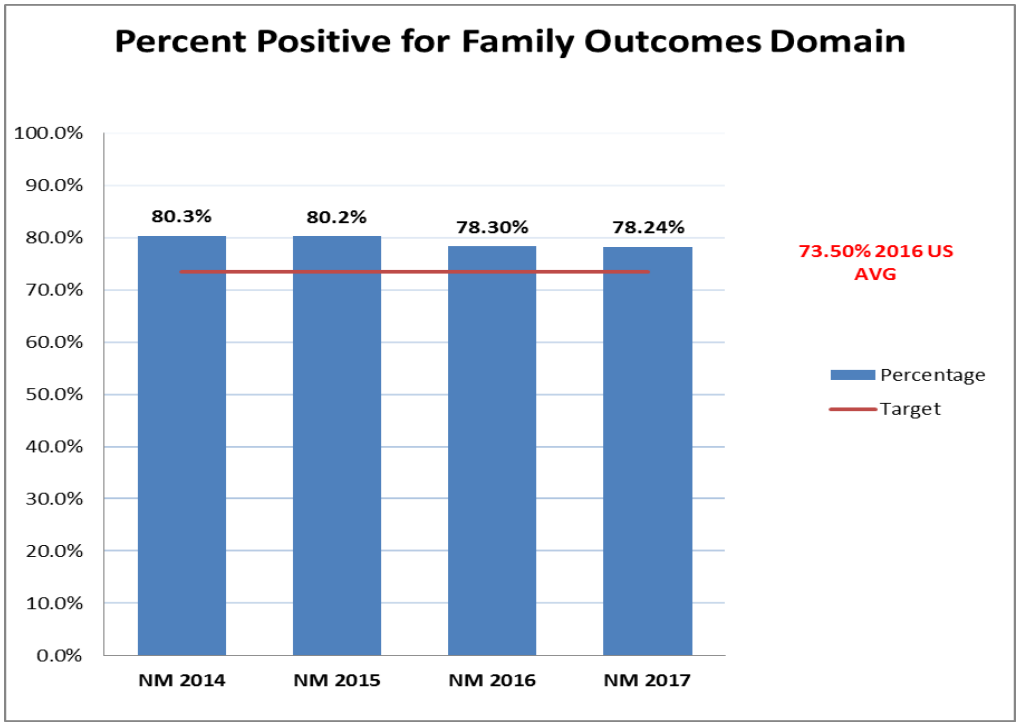
Was extremely happy with and thankful for the care her son has received at Provider and wanted it noted that all services they have were given were extremely helpful and came as a huge blessing.

Q #	Items for Satisfaction	Domain Item Percentage
1	Overall, I am satisfied with the services my child received.	90.53%
4	The people helping my child stuck with us no matter what.	86.94%
5	I felt my child had someone to talk to when he/she was troubled.	86.59%
7	The services my child and/or family received were right for us.	87.54%
10	My family got the help we wanted for my child.	84.30%
11	My family got as much help as we needed for my child.	80.30%

Domain: Outcomes

Definition: *The extent to which services provided to families with behavioral health needs have a positive or negative effect on their child's ability to get along with family and friends, do better in school, handle daily activities and cope with problems.*

Observations: The average proportion of positive responses for Outcomes was 78.3%. This is substantially above that national 2015 average of 69.9%, but is down a bit from the prior year's performance of 80.2%. Satisfaction was notably lower in the areas of school and coping when things went wrong.



Q #	Items for Outcomes/Functioning	Domain Item Percentage
16	My child is better at handling daily life.	78.39%
17	My child gets along better with family members.	83.79%
18	My child gets along better with friends and other people.	80.54%
19	My child is doing better in school and/or work.	78.74%
20	My child is better able to cope when things go wrong.	74.73%
21	I am satisfied with our family life right now.	87.34%

Consumer Comments about Outcomes:

"The services at school are helping and also help at home."

"My child has gotten better with the services he has received."

The services has helped her daughter a lot do far.

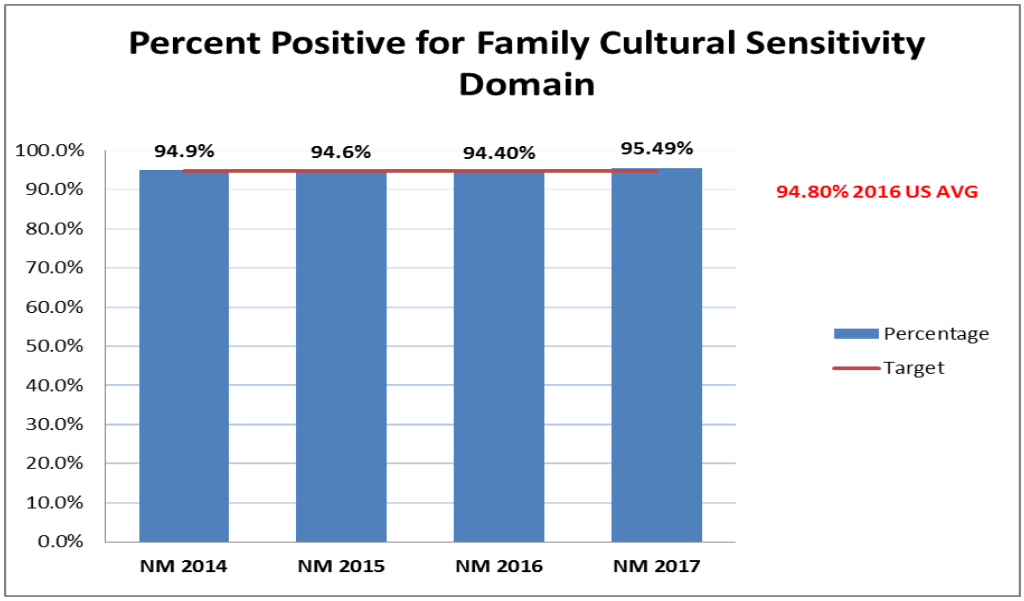
Child's first case manager stopped working with him. It took quite a while to get a replacement worker. To reenter treatment was a horrible nightmare although once child was in, everything went very well.

"The school her son attends does not offer help or special classes for the disorder that he has.

Domain: Cultural Sensitivity

Definition: *The extent to which services provided to families are delivered in a manner that is respectful of cultural background, language and spiritual beliefs.*

Observations: The average proportion of positive responses for Cultural Sensitivity was 95.5%. This is above that national 2016 average of 94.8%, and higher than the prior year's performance of 94.4%. Families are very satisfied with staff's respect for and sensitivity to the family's cultural background and spiritual beliefs. They also felt they were spoken to in a way they understood.



Consumer Comments about Cultural Sensitivity:

Parent likes that the agency that serves her son is very respectful and helpful.

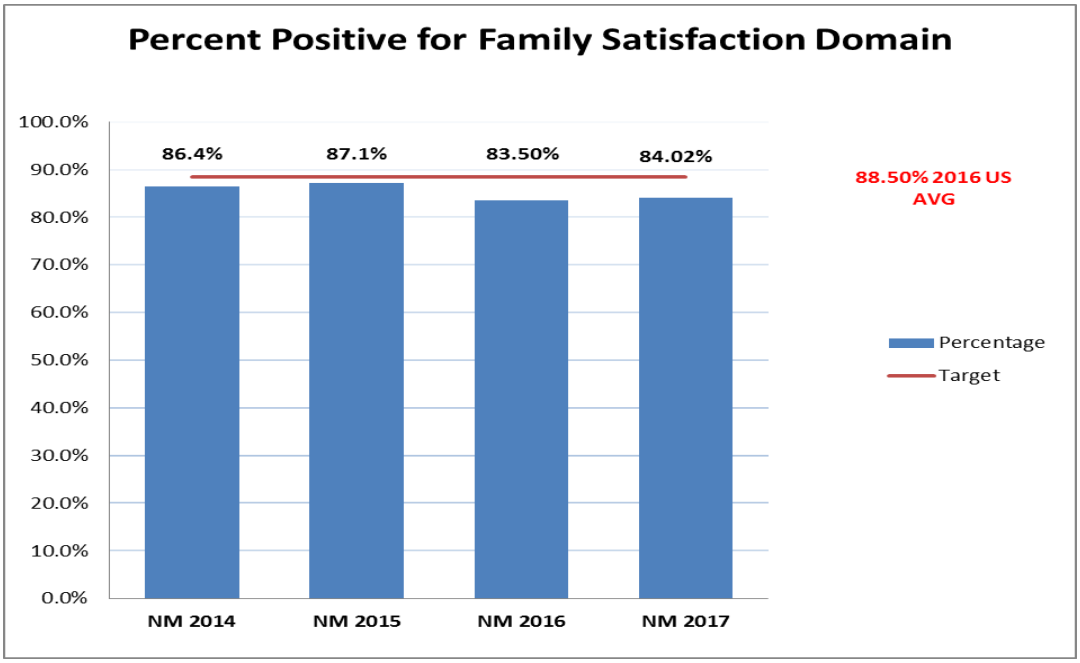
Caregiver did say he prefers Spanish but the provider does not provide a Spanish speaker- his daughter has to interpret.

Q #	Items for Cultural Senistivity	Domain Item Percentage
12	Staff treated me with respect.	94.59%
13	Staff respected my family's religious/spiritual beliefs.	96.69%
14	Staff spoke with me in a way that I understood.	98.03%
15	Staff was sensitive to my cultural/ethnic background.	96.23%

Domain: Satisfaction

Definition: *Families are generally happy with the services that are provided to their child.*

Observations: The average proportion of positive responses for Satisfaction was 84.0%. This is below the national 2016 average of 88.5%, but slightly higher than the prior year's performance of 83.5%. While families were very satisfied with the services their child received, they were less satisfied about getting the amount of help they wanted or needed.



Q #	Items for Satisfaction	Domain Item Percentage
1	Overall, I am satisfied with the services my child received.	90.53%
4	The people helping my child stuck with us no matter what.	86.94%
5	I felt my child had someone to talk to when he/she was troubled.	86.59%
7	The services my child and/or family received were right for us.	87.54%
10	My family got the help we wanted for my child.	84.30%
11	My family got as much help as we needed for my child.	80.30%

Consumer Comments about Satisfaction:

"(I am) extremely thankful for the services my child receives."

"The behavioral health services has been so great and the school system go above and beyond to help my son they have helped him how to cope its better than the school system

"As a parent I did not feel supported by the counselor at (the agency). I will not recommend this agency to help with parent/child relationships.

"(The) Provider has been amazing and they have helped tremendously. She would really be in a hard position if funding for them was eliminated."

Parent would like the assistance of a Care Coordinator as services are not providing adequate supports.

Other Areas

Access to Care: This is an important area for all families. Most Family respondents (81.0%) indicated that staff who understood their situation returned calls within 24 hours all or most of the time. Most respondents (80.1%) indicated that when their children needed behavioral health services, they received them within two weeks all or most of the time. Nearly all children and families (98.9%) received the information needed and their services in the language they preferred. And when needed, 70-% of the respondents indicated they were provided an interpreter. An additional indication of their satisfaction is reflected in the finding that 86% of the respondents indicated they would recommend the agency to a friend or family member.

Medications: One-third (33.2.0%) of families indicated that their children received medication services as part of their treatment in the last year. Of those respondents, the most (56.9%) . on average, indicated they "agreed or strongly agreed" to this subscale of items: However, access to a psychiatrist was rated notably lower than the other two items.

- My child had difficulty getting in to see a psychiatrist when we wanted.
- Staff told me what side effects to watch for regarding prescribed medications for my child.
- I was offered alternatives to or choices about, my child taking medication.

Behavioral Services received at School: Fifty-two (51.6%) of the families indicated that their child received Behavioral Health Services at school .And 58% stated that their child had an IEP, a 504, a Behavioral Intervention Plan, and/or a Functional Behavioral Assessment

Use of newer behavioral health services: We wanted to know whether families were interested in receiving three newer services: Respite, Family and Youth Specialist services. Fifty-eight percent (58%) said they would use Respite Services if they were offered to them. And 75.5% would use Family Specialist services if offered to them. And 86.3% would encourage their child to use Youth Specialist services if offered to them.

Care Coordination: About 10.0% of respondents indicated that the child was enrolled in a higher level of Centennial Care care coordination (Level 2 or 3). Among those 10.0%:

Care Coordination: Overall, very few families surveyed had children assigned to Care Coordination (5.6%.) in Centennial Care. The percent of positive response per each item was as follows:

80.0% I participated in developing my child's Care Plan.
80.8% My child's physical health was included in his/her Care Plan.
76.8% I had contact with my health plan's Care Coordinator and we talked about my child's goals.
73.2% I had contact with my health plan's Care Coordinator and we talked about action steps to take to meet my child's goals.
76.9% My health plan's Care Coordinator helped me get services that actually helped my child, even if there had been changes or loss of services.
80.7% I am satisfied with my overall experience with my health plan's Care Coordination services.

Acknowledgments

There are many individuals who assisted in obtaining the information for this survey, and it is impossible to mention everyone by name. The Project Steering Committee would like to extend their gratitude to all of the workers, volunteers, family members, and other stakeholders who participated.

Consumer, Family, Youth Satisfaction Project Steering Committee:

Monica Miura, Family Advocate

Rex Givens, Adult Advocate

Children, Youth and Families Department:

Erica Padilla, Youth Specialist

Jeff Tinstman

Medical Assistance Division, HSD:

Kathy Leyba, Quality Bureau

Josh Vigil, Quality Bureau

Behavioral Health Services Division, HSD:

Mark Garnand

Manny Martinez

Cindy Romero

Behavioral Health Collaborative:

Betty Downes, Quality & Evaluation Consultant

Managed Care Companies:

Blue Cross Blue Shield of New Mexico: Lisa Mortensen, Russell Liles, & Jessica Moriarty

Molina Healthcare: Donald Hume & Jeanette Tapia

Presbyterian Health/Magellan: Pilo Bueno & Carin Skapars

United Health Care: Amilya Ellis & Mari Jiménez

Special Thanks to:

Falling Colors: Reba Serafin, Pam Koster, Mindy Hale, & Gordon O'Brien

Families ASAP: Delfy Roach

Albuquerque Center for Hope and Recovery: Elise Padilla & Maxine Henry

Attachment D

BCBSNM 2016 - 2017

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY17**	**Q2FY17**	**Q3FY17**	**Q4FY17**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY17**	**Q2FY17**	**Q3FY17**	**Q4FY17**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY17**	**Q2FY17**	**Q3FY17**	**Q4FY17**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%		99.9%	99.8%	99.8%	97.4%	99.8%	99.8%	99.8%		100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	
Pharmacies	99.9%	100.0%	100.0%	100.0%	97.7%	100.0%	100.0%		99.9%	99.9%	99.9%	100.0%	98.4%	100.0%	99.9%		99.2%	99.2%	99.2%	99.3%	98.1%	99.8%	99.8%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		91.3%	91.1%	90.9%	90.8%	90.6%	90.4%	90.2%		97.3%	97.4%	97.4%	97.3%	97.3%	97.3%	97.5%	
PH - Standard 2																								
Cardiology	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%		99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	
Certified Nurse Practitioner	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.9%	99.7%	99.8%	99.7%	98.1%	99.7%	99.7%		99.8%	99.8%	99.8%	99.8%	98.6%	99.8%	99.8%	
Certified Midwives	99.2%	99.1%	99.2%	99.2%	99.2%	99.2%	99.2%		91.1%	90.9%	90.9%	90.5%	90.5%	90.6%	91.2%		96.5%	96.6%	96.6%	96.6%	96.6%	96.6%	99.8%	
Dermatology	71.8%	71.7%	72.0%	72.1%	72.2%	72.6%	72.5%		57.4%	57.7%	57.4%	56.5%	56.8%	57.3%	57.3%		74.3%	74.3%	74.2%	74.3%	74.3%	74.8%	74.9%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Endocrinology	94.7%	94.8%	94.7%	95.8%	95.7%	95.8%	95.8%		72.9%	73.2%	73.3%	72.5%	71.5%	71.8%	71.9%		76.1%	76.4%	76.3%	76.4%	76.4%	76.7%	76.7%	
ENT	99.2%	99.1%	99.1%	99.1%	99.2%	99.2%	99.2%		98.3%	90.7%	90.4%	91.5%	91.5%	91.5%	91.5%		96.1%	94.8%	94.7%	94.9%	94.9%	95.0%	95.2%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	
Hematology/Oncology	99.2%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%		98.6%	99.7%	99.3%	98.9%	99.0%	97.7%	97.7%		99.1%	99.3%	99.4%	99.5%	99.5%	100.0%	99.4%	
Neurology	99.2%	99.1%	99.1%	99.1%	99.2%	99.2%	99.2%		98.5%	98.5%	98.6%	97.3%	97.4%	97.4%	97.8%		91.4%	91.6%	91.5%	92.2%	92.2%	92.3%	92.3%	
Neurosurgeons	99.2%	99.1%	99.1%	99.1%	99.2%	99.2%	99.2%		39.4%	39.3%	39.2%	39.2%	39.5%	40.3%	40.4%		69.7%	69.8%	69.6%	69.6%	69.7%	70.4%	70.5%	
OB/Gyn	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	99.0%		99.7%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%		99.7%	99.7%	99.8%	99.7%	99.7%	99.7%	99.7%	
Orthopedics	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.9%	99.9%	99.9%	99.9%	99.9%	99.7%	99.7%		96.4%	96.6%	96.5%	97.2%	97.2%	97.3%	97.5%	
Pediatrics	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.7%	99.7%	99.8%	99.8%	99.4%	99.4%	99.6%		99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%		99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	
Rheumatology	99.2%	99.1%	92.9%	94.1%	94.0%	94.1%	94.3%		77.9%	77.8%	77.0%	76.9%	76.8%	76.6%	69.1%		81.8%	82.1%	81.9%	81.7%	81.5%	81.5%	81.6%	
Surgeons	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%		99.8%	99.8%	99.8%	99.9%	99.9%	99.9%	99.9%	
Urology	99.2%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%		91.3%	82.3%	81.9%	81.1%	81.4%	81.5%	81.6%		92.5%	92.6%	92.4%	92.7%	92.7%	92.8%	92.9%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	99.2%	99.2%	99.2%	99.2%	98.1%	98.1%	95.1%		99.0%	99.0%	99.0%	99.0%	90.5%	90.6%	99.8%		100.0%	100.0%	100.0%	100.0%	99.8%	99.8%	99.8%	
Personal Care Service Agencies (PCS) - directed	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	98.1%		99.0%	99.0%	99.0%	99.0%	99.1%	99.1%	90.5%		99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	
Nursing Facilities	94.8%	94.9%	94.9%	94.9%	95.1%	95.1%	99.2%		99.4%	99.5%	99.4%	99.4%	99.8%	99.8%	99.0%		99.8%	99.9%	99.9%	99.9%	99.8%	99.8%	99.8%	
General Hospitals	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%		99.8%	99.7%	99.7%	99.3%	99.3%	99.3%	99.3%		100.0%	99.8%	99.8%	97.4%	99.8%	99.8%	99.8%	
Transportation	100.0%	100.0%	100.0%	99.2%	99.2%	99.2%	99.2%		99.6%	99.6%	99.6%	94.6%	94.6%	94.7%	94.8%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

nd - no data

Source: BCBSNM, GeoAccess Report#55, Q1CY16 - Q3CY17

MHNM 2016-17 GeoAccess PH

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY17**	**Q2FY17**	**Q3FY17**	**Q4FY17**	**Q1FY16**	**ets Stand**	**Q3FY16**	**Q4FY16**	**Q1FY17**	**Q2FY17**	**Q3FY17**	**Q4FY17**	**Q1FY16**	**Q2FY16**	**Q3FY16**	**Q4FY16**	**Q1FY17**	**Q2FY17**	**Q3FY17**	**Q4FY17**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100.0%	
FQHC - PCP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		92.0%	93.0%	100.0%	93.0%	93.0%	93.0%	93.0%		99.0%	98.0%	99.0%	98.0%	98.0%	98.0%	94.0%	
PH - Standard 2																								
Cardiology	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	99.0%	99.0%	99.0%	99.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Certified Nurse Practitioner	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Certified Midwives	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	98.0%		82.0%	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.0%	97.0%	100.0%	100.0%	100.0%	98.0%	98.0%	
Dermatology	75.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%		63.0%	83.0%	64.0%	64.0%	63.0%	64.0%	63.0%		88.0%	87.0%	87.0%	88.0%	88.0%	87.0%	90.0%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Endocrinology	98.0%	98.0%	98.0%	99.0%	98.0%	98.0%	98.0%		68.0%	68.0%	68.0%	68.0%	68.0%	56.0%	75.0%		89.0%	89.0%	88.0%	88.0%	88.0%	87.0%	91.0%	
ENT	98.0%	98.0%	98.0%	99.0%	98.0%	98.0%	98.0%		99.0%	98.0%	92.0%	92.0%	92.0%	92.0%	92.0%		95.0%	98.0%	91.0%	93.0%	92.0%	91.0%	94.0%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Hematology/Oncology	98.0%	98.0%	98.0%	99.0%	98.0%	98.0%	98.0%		98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%		93.0%	94.0%	93.0%	93.0%	93.0%	93.0%	100.0%	
Neurology	99.0%	98.0%	98.0%	99.0%	98.0%	98.0%	98.0%		93.0%	94.0%	95.0%	94.0%	94.0%	94.0%	94.0%		89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	
Neurosurgeons	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%		47.0%	47.0%	49.0%	48.0%	49.0%	66.0%	66.0%		69.0%	71.0%	68.0%	68.0%	68.0%	87.0%	88.0%	
OB/Gyn	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	98.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Orthopedics	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	
Pediatrics	98.0%	98.0%	98.0%	99.0%	99.0%	98.0%	98.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		94.0%	95.0%	94.0%	94.0%	94.0%	94.0%	94.0%	
Rheumatology	98.0%	98.0%	98.0%	99.0%	98.0%	98.0%	99.0%		80.0%	98.0%	98.0%	98.0%	98.0%	98.0%	85.0%		84.0%	90.0%	90.0%	90.0%	90.0%	93.0%	93.0%	
Surgeons	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Urology	98.0%	98.0%	98.0%	99.0%	98.0%	98.0%	98.0%		94.0%	94.0%	94.0%	95.0%	95.0%	82.0%	81.0%		94.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.0%	99.0%	99.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Personal Care Service Agencies (PCS) - directed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nursing Facilities	92.0%	93.0%	94.0%	94.0%	93.0%	94.0%	94.0%		99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
General Hospitals	99.0%	98.0%	99.0%	99.0%	99.0%	99.0%	98.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Transportation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

nd - no data

Source: MHNM, GeoAccess Report#55, Q1CY16 - Q3CY17

PHP 2016-17 GeoAccess PH

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	Q1FY16	Q2FY16	Q3FY16	Q4FY16	Q1FY17	Q2FY17	Q3FY17	Q4FY17	Q1FY16	Q2FY16	Q3FY16	Q4FY16	Q1FY17	Q2FY17	Q3FY17	Q4FY17	Q1FY16	Q2FY16	Q3FY16	Q4FY16	Q1FY17	Q2FY17	Q3FY17	Q4FY17
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%		99.9%	99.9%	100.0%	99.7%	99.7%	99.7%	99.7%	
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.8%	99.8%	99.8%	99.8%	100.0%	99.9%	99.7%		99.7%	99.7%	99.6%	99.7%	99.8%	99.8%	99.8%	
FQHC - PCP Only	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.7%	99.6%	99.5%	91.5%	97.3%	99.4%	99.2%		99.0%	98.9%	98.9%	92.1%	92.2%	92.4%	98.6%	
PH - Standard 2																								
Cardiology	99.1%	99.0%	99.1%	99.1%	99.0%	99.1%	99.0%		99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	98.9%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.8%	
Certified Nurse Practitioner	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Certified Midwives	96.7%	96.7%	96.7%	96.7%	99.1%	99.1%	99.1%		98.9%	92.8%	92.8%	92.9%	93.0%	99.4%	88.8%		98.8%	98.8%	98.7%	98.7%	98.7%	99.9%	98.7%	
Dermatology	85.3%	85.2%	99.0%	99.0%	99.0%	99.0%	99.0%		69.9%	69.7%	69.8%	69.8%	69.7%	70.3%	70.3%		78.5%	78.3%	78.1%	78.0%	77.8%	77.9%	77.8%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Endocrinology	99.1%	99.0%	99.1%	99.1%	99.0%	99.1%	99.0%		68.9%	68.6%	68.7%	69.0%	77.3%	75.1%	82.9%		86.8%	86.5%	86.6%	86.4%	87.4%	86.4%	87.1%	
ENT	99.1%	99.0%	99.1%	99.1%	99.1%	99.1%	98.9%		98.5%	98.5%	94.4%	99.0%	98.9%	98.9%	92.6%		98.3%	98.3%	95.7%	92.8%	92.7%	92.9%	86.5%	
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Hematology/Oncology	99.2%	99.2%	99.2%	99.2%	99.1%	99.2%	99.1%		98.9%	98.9%	98.9%	98.0%	97.9%	98.0%	89.9%		99.7%	99.7%	99.6%	99.6%	98.0%	97.8%	99.6%	
Neurology	99.1%	99.0%	99.1%	99.1%	99.0%	99.1%	99.0%		91.6%	91.7%	91.7%	85.9%	91.9%	92.1%	85.1%		90.3%	90.5%	90.5%	90.5%	90.6%	91.2%	83.5%	
Neurosurgeons	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		59.0%	58.8%	58.4%	58.5%	58.5%	59.1%	62.4%		75.1%	74.9%	74.9%	74.7%	74.6%	74.7%	74.4%	
OB/Gyn	99.2%	99.1%	99.1%	99.1%	99.1%	99.2%	99.1%		99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		99.9%	99.9%	99.9%	99.9%	99.8%	99.8%	99.8%	
Orthopedics	99.1%	99.1%	99.2%	99.2%	99.1%	99.2%	99.1%		99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		98.8%	98.8%	98.7%	98.7%	98.8%	98.9%	98.6%	
Pediatrics	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.6%	99.6%	99.6%	99.6%	99.6%	99.9%	99.9%		100.0%	100.0%	99.9%	99.9%	100.0%	100.0%	100.0%	
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.3%	99.2%	99.2%	99.2%	99.2%	99.2%	99.1%		99.3%	100.0%	100.0%	99.6%	99.6%	99.6%	99.6%		99.9%	98.9%	99.9%	98.9%	98.9%	99.0%	99.8%	
Rheumatology	99.1%	99.0%	99.1%	99.1%	99.0%	99.1%	99.0%		88.9%	89.1%	89.1%	88.2%	88.0%	91.7%	85.2%		87.2%	87.3%	87.7%	86.5%	86.5%	88.5%	85.6%	
Surgeons	99.2%	99.2%	99.2%	99.2%	99.1%	99.2%	99.1%		99.6%	99.6%	99.6%	99.5%	99.5%	99.6%	99.6%		99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	
Urology	99.1%	99.0%	99.1%	99.1%	99.0%	99.1%	99.0%		98.0%	98.0%	98.1%	98.1%	98.1%	98.2%	92.7%		95.9%	95.9%	96.1%	96.1%	96.0%	95.9%	95.6%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.5%	99.6%	99.7%	99.7%	99.6%	99.5%	99.7%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Personal Care Service Agencies (PCS) - directed	99.1%	99.3%	99.3%	100.0%	100.0%	100.0%	100.0%		99.5%	99.6%	99.7%	99.7%	99.6%	99.5%	99.7%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nursing Facilities	97.0%	97.1%	96.8%	96.7%	96.8%	96.8%	97.1%		98.2%	98.6%	98.8%	98.8%	99.4%	99.3%	99.4%		100.0%	100.0%	100.0%	99.9%	99.8%	99.8%	100.0%	
General Hospitals	99.2%	99.1%	96.3%	99.2%	99.1%	99.1%	99.1%		99.4%	99.4%	99.4%	99.3%	99.3%	99.3%	99.3%		99.9%	99.9%	99.1%	99.4%	99.5%	99.5%	99.5%	
Transportation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

nd - no data

Source: PHP, GeoAccess Report#55, Q1CY16 - Q3CY17

UHC 2016-17 GeoAccess PH

Meets Standard | Does Not Meet

	Urban								Rural								Frontier							
PH - Standard 1	Q1FY16	Q2FY16	Q3FY16	Q4FY16	Q1FY17	Q2FY17	Q3FY17	Q4FY17	Q1FY16	Q2FY1	Q3FY16	Q4FY16	Q1FY17	Q2FY17	Q3FY17	Q4FY17	Q1FY16	Q2FY1	Q3FY16	Q4FY16	Q1FY17	Q2FY17	Q3FY17	Q4FY17
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%		100.0%	99.7%	99.7%	100.0%	100.0%	97.8%	97.9%	
Pharmacies	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	98.8%	100.0%	100.0%	100.0%	99.9%	100.0%		99.0%	99.4%	99.4%	99.4%	99.7%	99.5%	100.0%	
FQHC	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%		100.0%	99.1%	99.1%	99.1%	99.1%	99.1%	98.9%		100.0%	98.1%	98.2%	98.1%	97.9%	98.0%	97.9%	
PH - Standard 2																								
Cardiology	99.0%	99.1%	99.1%	99.1%	99.1%	99.2%	99.1%		99.0%	99.5%	99.5%	99.5%	99.5%	99.5%	99.5%		100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	
Certified Nurse Practitioner	100.0%	100.0%	100.0%	93.9%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	95.1%	100.0%	100.0%	100.0%		100.0%	99.9%	100.0%	96.0%	100.0%	100.0%	100.0%	
Certified Midwives	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		91.0%	90.7%	99.8%	99.8%	99.8%	99.8%	99.8%		98.0%	97.9%	97.8%	99.8%	97.6%	97.7%	97.8%	
Dermatology	95.0%	95.2%	94.0%	93.9%	93.9%	94.1%	94.0%		68.0%	67.2%	61.3%	61.3%	65.9%	66.5%	57.0%		88.0%	88.2%	87.4%	86.8%	86.5%	86.4%	86.9%	
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	
Endocrinology	95.0%	99.1%	94.0%	93.9%	93.9%	94.1%	94.0%		73.0%	90.0%	82.6%	83.1%	68.4%	68.3%	68.9%		94.0%	91.0%	85.5%	85.1%	85.3%	85.5%	86.0%	
ENT	99.0%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%		93.0%	93.0%	93.1%	94.6%	98.5%	98.5%	98.8%		93.0%	93.2%	97.4%	97.2%	97.0%	97.2%	97.3%	
FQHC	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Hematology/Oncology	99.0%	99.0%	99.1%	99.1%	99.1%	99.1%	99.1%		98.0%	99.1%	99.3%	98.4%	98.1%	98.5%	98.1%		100.0%	99.8%	99.7%	99.8%	99.7%	99.8%	99.2%	
Neurology	95.0%	99.1%	99.1%	99.1%	99.1%	99.1%	94.0%		89.0%	89.4%	89.8%	90.0%	89.5%	90.9%	90.3%		89.0%	88.6%	93.7%	93.8%	88.6%	88.6%	88.9%	
Neurosurgeons	99.0%	98.8%	99.1%	99.1%	99.1%	99.1%	99.1%		40.0%	43.1%	42.8%	43.0%	43.0%	44.2%	43.0%		69.0%	74.2%	73.4%	72.8%	72.7%	73.8%	73.9%	
OB/Gyn	99.0%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%		100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%		100.0%	99.8%	99.8%	99.8%	99.9%	99.9%	99.9%	
Orthopedics	100.0%	100.0%	100.0%	94.9%	99.1%	99.1%	100.0%		100.0%	99.8%	99.8%	99.8%	98.5%	99.5%	99.5%		100.0%	97.7%	97.6%	97.6%	99.1%	99.4%	99.5%	
Pediatrics	100.0%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%		100.0%	99.3%	99.9%	98.8%	98.8%	98.8%	99.1%		98.0%	98.0%	98.1%	100.0%	100.0%	100.0%	100.0%	
Physician Assistant	96.0%	96.3%	94.9%	94.9%	100.0%	100.0%	100.0%		100.0%	99.3%	99.8%	99.8%	99.8%	99.8%	99.8%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Podiatry	99.0%	99.1%	99.1%	99.1%	99.1%	99.2%	99.2%		99.0%	99.3%	98.9%	98.8%	100.0%	100.0%	99.5%		100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	93.9%	
Rheumatology	95.0%	95.3%	94.0%	93.9%	93.9%	94.1%	94.0%		74.0%	73.8%	93.1%	92.7%	93.0%	97.1%	92.0%		84.0%	83.9%	92.5%	92.7%	92.4%	92.2%	92.7%	
Surgeons	99.0%	99.1%	99.1%	99.1%	99.1%	99.2%	99.1%		99.0%	99.3%	99.8%	99.8%	99.8%	98.8%	99.1%		100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	100.0%	
Urology	99.0%	99.0%	99.1%	99.1%	99.1%	99.1%	99.1%		98.0%	98.0%	97.9%	97.3%	89.3%	89.8%	89.2%		95.0%	94.7%	94.5%	89.3%	93.8%	94.0%	94.3%	
LTC - Standard 2																								
Personal Care Service Agencies (PCS) - delegated	99.0%	100.0%	99.1%	99.1%	100.0%	100.0%	100.0%		95.0%	99.4%	98.4%	98.4%	98.8%	98.8%	99.1%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Personal Care Service Agencies (PCS) - directed	99.0%	100.0%	99.1%	99.1%	100.0%	100.0%	100.0%		90.0%	99.4%	98.4%	98.4%	98.8%	98.8%	99.1%		98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nursing Facilities	99.0%	99.3%	99.3%	99.3%	99.3%	94.3%	94.2%		98.0%	98.0%	97.7%	97.7%	97.7%	98.8%	97.9%		100.0%	97.7%	97.7%	97.3%	97.1%	99.9%	97.3%	
General Hospitals	95.0%	95.3%	99.1%	99.1%	99.0%	99.0%	99.0%		96.0%	96.6%	99.5%	99.6%	98.5%	99.5%	99.5%		99.0%	99.0%	99.8%	99.2%	99.8%	99.8%	99.8%	
Transportation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	99.8%	99.1%	99.0%	99.0%	99.0%	99.3%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

nd - no data

Source: UHC, GeoAccess Report#55, Q1CY16 - Q3CY17

BH GeoAccess Annual Summary - DY4 - 2017

Meets Standard | Does Not Meet

	Q1												Q2												Q3												Q4											
	Urban				Rural				Frontier				Urban				Rural				Frontier				Urban				Rural				Frontier				Urban				Rural				Frontier			
Standard 2	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP
Freestanding Psychiatric Hospitals	87.7%	78.7%	90.0%	85.3%	38.3%	29.5%	18.0%	40.4%	58.0%	81.2%	67.0%	71.3%	87.8%	97.6%	90.0%	85.5%	39.2%	53.0%	18.0%	40.7%	58.7%	90.2%	67.0%	71.5%	88.2%	91.1%	90.0%	71.0%	39.2%	52.2%	17.0%	40.5%	58.8%	97.3%	67.0%	85.4%	88.0%	97.4%	90.0%	85.3%	38.9%	52.4%	17.0%	40.5%	58.4%	90.8%	67.0%	70.9%
General Hospitals with psychiatric units	21.8%	98.5%	91.0%	96.4%	32.9%	71.7%	80.0%	84.7%	31.8%	81.6%	82.0%	81.9%	21.4%	98.5%	91.0%	96.5%	35.8%	71.8%	80.0%	84.7%	35.7%	81.0%	82.0%	81.8%	21.3%	82.4%	93.0%	96.4%	35.9%	72.1%	80.0%	84.4%	35.9%	98.4%	82.0%	81.6%	22.2%	98.4%	93.0%	96.5%	36.3%	71.5%	80.0%	84.2%	35.8%	81.1%	82.0%	81.6%
Partial Hospital Programs	92.8%	98.5%	32.0%	18.9%	25.5%	71.8%	13.0%	4.8%	63.6%	85.5%	11.0%	5.3%	93.0%	99.1%	32.0%	18.4%	26.1%	98.8%	13.0%	4.9%	64.5%	100.0%	11.0%	5.4%	92.9%	100.0%	32.0%	19.3%	26.1%	90.1%	13.0%	5.0%	64.5%	99.1%	11.0%	5.3%	92.7%	94.0%	33.0%	19.2%	25.8%	90.3%	13.0%	4.9%	64.2%	97.8%	12.0%	5.5%
Accredited Residerntial Treatment Centers (ARTC)	87.7%	78.7%	90.0%	85.3%	30.5%	34.3%	28.0%	52.7%	67.3%	71.7%	67.0%	71.5%	87.8%	99.1%	90.0%	85.5%	31.4%	83.9%	28.0%	54.1%	68.1%	99.9%	67.0%	72.8%	88.2%	100.0%	90.0%	85.5%	31.6%	82.8%	29.0%	53.7%	68.1%	83.0%	67.0%	72.3%	88.0%	82.0%	91.0%	85.4%	31.1%	83.4%	28.0%	53.8%	67.8%	100.0%	67.0%	72.3%
Non-Accredited Residential Treatment Center & Group Homes	72.0%	52.9%	84.0%	82.7%	53.8%	37.4%	74.0%	71.0%	72.9%	57.6%	89.0%	94.2%	72.5%	92.3%	58.0%	83.1%	46.3%	84.4%	70.0%	63.9%	66.9%	93.2%	78.0%	87.5%	72.4%	88.5%	58.0%	66.1%	46.2%	76.7%	71.0%	57.6%	67.0%	92.0%	78.0%	82.1%	71.3%	91.7%	57.0%	66.0%	46.0%	77.2%	71.0%	57.5%	67.0%	88.2%	78.0%	82.0%
Treatment Foster Care I & II	82.2%	93.6%	92.0%	96.3%	44.3%	71.3%	64.0%	77.1%	57.2%	88.4%	91.0%	95.1%	82.4%	99.1%	92.0%	96.5%	45.1%	73.9%	64.0%	75.1%	56.9%	88.5%	91.0%	89.9%	82.8%	88.8%	92.0%	96.3%	45.2%	72.7%	64.0%	74.8%	57.3%	99.1%	91.0%	89.6%	82.4%	98.7%	92.0%	96.4%	44.8%	73.5%	64.0%	74.8%	57.5%	88.5%	91.0%	89.5%
Core Service Agencies	100.0%	99.1%	93.0%	99.2%	79.4%	98.8%	100.0%	99.9%	88.5%	100.0%	100.0%	100.0%	100.0%	94.1%	93.0%	99.2%	79.7%	98.7%	100.0%	99.9%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	99.1%	79.6%	99.1%	100.0%	99.9%	88.8%	94.0%	100.0%	100.0%	100.0%	93.8%	92.0%	99.1%	79.2%	98.7%	100.0%	99.9%	88.8%	100.0%	100.0%	100.0%
Community Mental Health Centers	93.4%	99.1%	99.0%	99.2%	68.9%	98.4%	100.0%	99.9%	99.8%	99.8%	100.0%	99.9%	93.6%	98.1%	98.0%	99.2%	68.7%	98.7%	100.0%	99.9%	99.9%	100.0%	100.0%	99.9%	93.5%	100.0%	98.0%	99.2%	68.5%	99.1%	100.0%	99.9%	99.9%	99.1%	100.0%	100.0%	93.3%	99.1%	98.0%	99.2%	63.2%	98.7%	100.0%	99.9%	96.0%	100.0%	100.0%	99.9%
Indian Health Service and Tribal 638s providing BH	71.3%	73.3%	nd	80.2%	45.1%	60.6%	nd	67.4%	81.8%	85.1%	nd	86.9%	72.6%	73.9%	91.0%	80.6%	55.5%	62.2%	97.0%	68.1%	82.0%	84.8%	98.0%	87.2%	72.5%	85.3%	91.0%	79.7%	55.7%	59.7%	97.0%	68.0%	82.2%	73.7%	98.0%	87.1%	71.3%	72.6%	nd	79.8%	55.4%	62.0%	nd	68.3%	82.1%	85.0%	nd	87.0%
Outpatient Provider Agencies	86.2%	99.3%	99.0%	100.0%	28.6%	100.0%	100.0%	100.0%	50.3%	100.0%	100.0%	100.0%	86.4%	100.0%	99.0%	100.0%	29.6%	100.0%	99.0%	100.0%	50.9%	100.0%	100.0%	100.0%	86.8%	100.0%	99.0%	100.0%	29.7%	100.0%	99.0%	100.0%	50.9%	100.0%	100.0%	100.0%	86.5%	100.0%	98.0%	100.0%	29.3%	100.0%	99.0%	100.0%	45.9%	100.0%	100.0%	100.0%
Agencies providing Behavioral Mgmt. Srvs.	86.1%	93.0%	98.0%	99.1%	18.1%	39.2%	37.0%	58.5%	41.8%	85.7%	74.0%	86.7%	86.3%	99.1%	98.0%	99.2%	18.9%	90.6%	37.0%	58.8%	42.0%	100.0%	73.0%	86.8%	86.8%	99.9%	97.0%	99.1%	18.8%	90.1%	37.0%	58.4%	42.1%	99.1%	74.0%	86.7%	86.5%	99.1%	97.0%	99.1%	18.6%	90.3%	36.0%	58.3%	51.0%	97.8%	73.0%	86.7%
Agencies providing Day Treatment Services	0.0%	73.4%	58.0%	66.1%	98.6%	83.0%	29.0%	38.3%	92.0%	92.0%	48.0%	57.5%	100.0%	74.0%	58.0%	79.4%	91.0%	83.6%	29.0%	48.9%	100.0%	91.8%	47.0%	63.4%	0.0%	100.0%	59.0%	78.5%	9.0%	99.1%	29.0%	48.4%	0.0%	99.1%	47.0%	63.0%	0.0%	72.5%	58.0%	78.6%	9.0%	32.5%	29.0%	48.3%	0.0%	68.1%	47.0%	62.8%
Agencies providing Assertive Community Treatment	60.5%	53.0%	84.0%	96.1%	18.3%	17.1%	51.0%	49.3%	44.7%	40.1%	71.0%	74.7%	61.1%	74.0%	84.0%	96.3%	19.0%	83.6%	51.0%	49.5%	45.0%	96.1%	71.0%	74.7%	61.5%	95.0%	84.0%	96.2%	18.9%	91.8%	51.0%	49.3%	45.4%	99.1%	71.0%	74.4%	60.1%	99.1%	84.0%	96.3%	18.8%	83.4%	51.0%	49.1%	45.2%	94.9%	71.0%	74.4%
Agencies providing Multi-Systemic Therapy	0.0%	93.2%	66.0%	98.8%	0.0%	58.3%	56.0%	71.1%	0.0%	73.3%	60.0%	77.0%	0.0%	94.0%	92.0%	98.8%	0.0%	92.0%	58.0%	71.2%	0.0%	91.8%	70.0%	77.6%	71.9%	95.0%	93.0%	98.7%	25.6%	91.8%	58.0%	70.6%	55.3%	99.1%	71.0%	77.2%	70.7%	99.1%	92.0%	98.7%	25.3%	83.4%	57.0%	70.5%	55.3%	94.9%	71.0%	77.2%
Intensive Outpatient Services	71.4%	93.7%	67.0%	96.7%	51.2%	68.3%	83.0%	95.6%	61.8%	81.6%	83.0%	99.8%	71.5%	94.0%	66.0%	96.9%	50.4%	83.6%	83.0%	89.7%	62.1%	91.8%	83.0%	94.1%	71.5%	92.1%	67.0%	96.7%	50.3%	82.8%	83.0%	89.4%	62.2%	94.0%	83.0%	99.8%	71.4%	99.1%	66.0%	96.8%	55.0%	76.3%	83.0%	89.3%	63.2%	92.3%	83.0%	99.8%
Methadone Clinics	94.1%	93.7%	91.0%	96.6%	41.7%	38.0%	39.0%	66.7%	76.4%	77.5%	77.0%	80.9%	94.2%	93.9%	92.0%	96.7%	42.0%	38.0%	39.0%	67.0%	76.7%	77.1%	77.0%	99.1%	94.1%	78.4%	91.0%	96.6%	42.0%	38.7%	39.0%	58.4%	76.8%	93.8%	77.0%	69.0%	93.9%	93.6%	91.0%	96.7%	41.7%	37.3%	39.0%	66.7%	76.6%	77.2%	77.0%	80.7%
FQHCs providing BH services	98.6%	99.1%	100.0%	100.0%	92.0%	86.2%	87.0%	92.0%	85.3%	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	83.1%	90.1%	87.0%	91.7%	85.7%	100.0%	100.0%	99.9%	99.1%	100.0%	100.0%	100.0%	83.1%	89.0%	87.0%	91.9%	85.9%	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	82.9%	89.8%	87.0%	92.0%	85.8%	100.0%	100.0%	100.0%
Rural Health Clinics providing BH Services	0.7%	0.1%	0.0%	0.1%	46.9%	17.7%	36.0%	16.5%	68.0%	60.5%	26.0%	26.5%	0.7%	0.6%	0.0%	91.0%	45.0%	17.2%	36.0%	16.0%	68.3%	61.0%	26.0%	26.4%	0.0.7%	60.9%	0.0%	0.1%	45.0%	17.9%	36.0%	15.9%	67.9%	99.9%	26.0%	26.4%	0.7%	0.7%	0.0%	0.1%	46.3%	16.9%	36.0%	15.8%	67.6%	60.6%	26.0%	26.5%
Psychiatrists	100.0%	99.1%	100.0%	99.9%	99.9%	81.9%	100.0%	100.0%	99.8%	92.7%	98.0%	99.9%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	99.8%	99.8%	100.0%	99.0%	99.8%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%	99.8%	99.8%	100.0%	98.0%	99.9%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%	99.8%	99.8%	100.0%	98.0%	99.9%
Psychologists	100.0%	99.3%	99.0%	99.9%	89.1%	87.0%	93.0%	94.2%	99.9%	99.7%	100.0%	99.9%	100.0%	100.0%	99.0%	99.9%	89.1%	100.0%	100.0%	94.1%	99.9%	100.0%	100.0%	99.9%	100.0%	100.0%	99.0%	99.9%	89.3%	100.0%	93.0%	94.1%	99.9%	100.0%	100.0%	99.9%	100.0%	100.0%	98.0%	99.9%	89.1%	100.0%	93.0%	94.1%	99.9%	100.0%	100.0%	99.9%
Suboxone certified MDs	99.2%	93.7%	99.0%	99.4%	100.0%	51.2%	99.0%	92.3%	99.8%	69.8%	100.0%	92.4%	99.2%	99.1%	100.0%	99.2%	97.9%	92.9%	99.0%	92.4%	99.8%	95.1%	100.0%	92.5%	99.2%	95.0%	100.0%	99.1%	97.9%	92.4%	100.0%	93.2%	99.8%	99.1%	100.0%	100.0%	99.2%	99.1%	99.0%	99.1%	97.9%	92.8%	100.0%	93.3%	99.8%	94.9%	100.0%	99.0%
Other Licensed Independent BH practioners	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Inpatient Psychiatric Hospitals	98.6%	98.5%	98.0%	98.8%	69.9%	71.8%	81.0%	84.8%	24.9%	85.5%	86.0%	85.6%	98.6%	98.6%	98.0%	99.9%	80.4%	74.2%	81.0%	95.7%	81.9%	94.4%	86.0%	99.9%	98.6%	95.4%	98.0%	98.8%	80.6%	74.7%	80.0%	84.6%	81.9%	98.5%	86.0%	85.3%	98.6%	98.5%	98.0%	98.8%	80.6%	73.8%	80.0%	84.5%	81.6%	94.2%	86.0%	85.2%

nd - no data

Distance Standard 2 - For the providers described in Attachment 8 to the Contract:

- Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.
- Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.
- Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

Public Comment Summary for the Draft 1115 Waiver Renewal Application

Comment Overview

The Human Services Department (HSD) received comments from 255 people related to its Draft 1115 Demonstration Waiver renewal application (released on September 5, 2017 and revised and re-released on October 6, 2017) through multiple public comment opportunities that included four public hearings, a Tribal Consultation, email submissions and voicemail comments. Comments were submitted from Centennial Care members, the general public, Tribal representatives, Centennial Care providers, provider organizations, legal advocates, advocacy groups, non-profit organizations, religious organizations, and healthcare management entities. The majority of commenters expressed opposition to several proposals in the waiver that advance member engagement and personal responsibility, in particular about proposed cost-sharing for Medicaid participants. More than a third of commenters provided feedback opposing specific proposals in benefit design and eligibility refinements, viewing those as reductions to services and an attempt to decrease enrollment.

Two letters with comments were submitted on behalf of organizations and individuals expressing strong opposition to Medicaid benefits and coverage reductions. One of the letters submitted on behalf of and signed by 24 organizations and 19 individuals stated that proposals in the draft waiver are cuts to the program that will leave thousands without healthcare coverage, create health and financial hardships for families and drive-up long-term costs for the state's healthcare system. The second letter, submitted on behalf of 58 organizations and 271 individuals also strongly opposed proposals in the waiver that they perceived as reductions to health coverage and services that will result in medical debt for families, deter patients from seeking care, and shift costs to healthcare providers. A number of comments received expressed support for the state's effort to improve the Centennial Care program with a strong emphasis on improving care coordination, behavioral health services and provider network adequacy even if they shared opposition to other sections of the waiver proposal.

Response: Many dedicated organizations, advocates, stakeholders and community members have expended significant effort to review and comment on various draft proposals that ultimately informed the final waiver application. HSD appreciates and acknowledges those efforts and the valuable input it received throughout the year-long process. This feedback has been incorporated throughout the process—from discussions during the early subcommittee meetings, to comments received on the draft concept paper and most recently, for the draft waiver renewal application. HSD developed many of its initial proposals based on public feedback and has since modified them in response to the comments received. For example, it reduced premium amounts that were initially set at two percent of income in the concept paper to one percent in the draft waiver renewal application. It also removed the CHIP and WDI programs from premium requirements in the final waiver renewal application. Additionally, the six copayment requirements in the draft waiver renewal were reduced to only two copayments in the final waiver application. HSD is also eliminating the copayments that exist today in the CHIP and WDI programs in order to align incentives across the system for the most appropriate care, in the most appropriate setting. It is also continuing to provide retroactive eligibility for one month during the first year of the renewal in response to concerns about members in crisis who should receive presumptive eligibility at the point of service but are not completing the process. This will provide additional time for HSD to retrain hospital staff and other safety net providers in the presumptive eligibility process.

Summary of Comments by Waiver Proposal Subject

The summary of comments that follows is organized by subject area. Throughout the public input process, HSD has presented the proposed waiver modifications by subject, including: care coordination, benefit and delivery system (including long term supports and services and physical and behavioral health integration), payment reform, member engagement and personal responsibility, and administrative simplification through eligibility modifications.

1. Care Coordination

1. a. Increase care coordination at the provider level *(13 comments)*

Many commenters expressed support for increasing care coordination activities at the provider level as part of Value Based Purchasing (VPB). Providers and advocates speaking in support of care coordination expressed concern that appropriate oversight and quality measures are needed and should be imposed on MCOs and providers as part of VBP arrangements. Providers suggested that funding flow from MCOs to providers as part of VBP arrangements to allow for infrastructure development. Commenters encouraged expansion of Patient-Centered Medical Homes (PCMHs) and more inclusive care coordination for behavioral health needs. Pediatric provider groups expressed concerns with PCMHs and said reimbursement rates are inadequate and achieving National Committee for Quality Assurance (NCQA) certification is burdensome. One commenter representing hospitals expressed support for the opportunity for more hospitals to participate but providers will need technical assistance and infrastructure support. A commenter asked the state to require MCOs to assist. One commenter recommended the state provide Medicaid claims data and other data which will enable providers to plan interventions and track progress.

Some advocacy organizations believe care coordination has not met the goals promoted in Centennial Care and is need of improvement. Advocates from the disability and aging community recommended including information on community supports, reasonable ratio of care coordinators to members, and adequate reimbursement. Commenters asked the state to make care coordination a priority for the dually-eligible population and individuals using long-term services and supports (LTSS) adding that these individuals can benefit from targeted interventions to improve health and bring costs down.

Comments from Tribal organizations were supportive of increasing care coordination at the provider lever, but concerns were expressed regarding the reimbursement process and recommendations were made for contracts between Tribes and the state.

Response: In response to comments about care coordination during the year-long public input process, HSD developed the proposal to target care coordination efforts to high-need, high-cost members and improve transitions of care. Efforts in these areas are being implemented today, through strengthening requirements in the managed care organizations' contracts rather than through changes via the waiver renewal. HSD has also responded to providers who requested increased delegation of care coordination at the provider level by developing a comprehensive plan to implement VBP goals over four years and include requirements for a full delegation model and a shared functions model of care coordination activities. The plan offers flexibility within the VBP arrangements and the delegated structure for both providers and the MCOs. Additionally, HSD has added contractual requirements that will increase the use of Community Health Representatives working with Tribal organizations to conduct care coordination activities, which was in response to comments received through the NATAC. HSD continues to work with the NATAC and meet on a quarterly basis to discuss areas in need of improvement, including care coordination.

1. b. Improve transitions of care *(8 comments)*
Commenters expressed support to improve transitions of care and target care coordination. One commenter expressed support of in-home assessments for members in need of Community Benefit (CB) services when transitioning from a facility. One commenter recommended transitions of care could be improved by using VPB initiatives. Advocates warned that MCOs may be incentivized to deny access to subsequent treatments that impacted their VBP revenue. The state was asked by one commenter to include family caregivers in the discharge process from inpatient and nursing homes stays. One commenter stated the Lay Caregiver Act of 2015 requires hospitals to record designated caregiver information, and a commenter suggested that the MCOs train care coordinators about the law.

Response: In response to comments about improving transitions of care, HSD included clarifying language in the sample MCO contract for Centennial Care 2.0 to include a variety of transitions that the MCOs will be required to address such as members transitioning from a nursing facility to the community or from an inpatient-hospital stay to home. Care coordinators must address the member's service needs such as Home and Community Based Services, follow-up appointments, treatments, medications and durable medical equipment. The contract also requires the MCOs to perform an in-home assessment within three calendar days of discharge followed by three monthly contacts after a transition from in-patient hospital or nursing facility stay to assess the member's needs and ensure the needs are being met. HSD will review its training requirements for care coordinators and identify additional educational opportunities about family caregivers.

1. c. Leverage partnerships to expand successful programs that target high-needs populations *(7 comments)*
Commenters expressed support for efforts to leverage partnerships to expand successful programs targeting high-needs populations. Support was expressed for increased utilization of community health workers (CHW) with requirements that contractors describe sustainable funding streams for CHW. One commenter expressed concern for inadequate funding and resources that are needed to have successful programs. Organizations and individuals expressed support of the wraparound approach for youth involved with the Children, Youth, and Families Department (CYFD). A few commenters suggested collaboration with providers at the community level. One advocacy group supportive of wraparound approaches had a concern that this could be used to deny services to children in need of residential treatment center (RTC) placement.

Response: In response to comments about targeting high-need populations, HSD developed a new section in the sample MCO contract for Centennial Care 2.0 to address this population. The MCOs are required to employ or contract with dedicated care coordinators to meet the needs of individuals with intellectual disabilities, special health care needs, housing insecurity, and/or complex behavioral health needs and individuals that are considered medically-fragile and/or justice-involved individuals. Specialized care coordinators are required to pursue training specific to the particular population's needs and be familiar with available services. In addition, HSD added requirements for the MCOs to include Community Health Workers (CHWs) and Community Health Representatives (CHRs) as part of their delivery system and included goals specific to CHWs and CHRs within a Delivery System Improvement Performance Target.

1. d. Initiate care coordination for justice-involved individuals prior to their release from incarceration *(9 comments)*
Providers and individuals support care coordination for justice-involved individuals prior to their release from incarceration. One organization recommended MCOs collaborate with community organizations to identify best practices to effectively coordinate healthcare needs for this population. One commenter expressed support stating individuals in the facilities are often in need of community supports and do not know how to access them.

Response: In response to comments regarding care coordination for justice-involved individuals, HSD added language to the sample MCO contract for Centennial Care 2.0 that requires the MCOs to participate in care coordination efforts for justice-involved individuals to facilitate the transition of members from prisons, jails and detention facilities into the community. Care coordination for the justice involved will require the MCOs to collaborate with criminal justice partners to identify members with physical and behavioral health chronic/complex care needs prior to release. The MCOs will also be required to designate a justice-involved liaison to be the point of contact for the prisons, jails, and detention facilities and ensure appropriate transition of care prior to release.

1. e. Pilot a home visiting program that focuses on pre-natal care, post-partum care and early childhood development with the Department of Health and the early Childhood Service Program within CYFD *(9)*
Commenters expressed support for piloting an evidence-based home visiting project and improving birth outcomes. Legal advocates commented this proposal will encourage state agencies to work together which could lead to reducing administrative waste and duplication of services. One commenter believes home visiting programs are needed to improve better health outcomes.

Response: HSD added language in this section to further clarify the home visiting models, services and provider qualifications for the pilot.

1. f. Obtain 100% Federal Funding for covered services delivered to Native American members in Centennial Care that are received through Indian Health Services (IHS) or Tribal Facilities *(4)*
Support was expressed for efforts to obtain 100% federal funding for covered services delivered to Native American members in Centennial Care that are received through IHS or Tribal Facilities. Native American providers clarified their interpretation for the referral process to come from IHS or Tribal site and that the MCOs are not allowed to require prior authorization. One commenter stated that collecting more federal dollars to help Native Americans would benefit the state.

Response: HSD included this proposal in the waiver to primarily address long-term care services. Since Native American members in need of long term care services are required to enroll in Centennial Care, the MCOs have contractual relationships with long-term care providers, including nursing facilities and personal care service agencies, while IHS does not typically have such contractual relationships nor traditionally refer for such services. Additionally, the MCOs are responsible for developing and maintaining the care plans of those members, and so having them serve as the responsible party for record custody but share the records with IHS/ITUs will reduce administrative burden and barriers to care in such circumstances.

2. Long-Term Services and Supports (LTSS)

2. a. Align Services between ABCB and SDCB models *(8 comments)*
Strong support was expressed by commenters for an aligned process between ABCB and SDCB models. Some advocates believe all Community Benefits (CB) should be available to both models which would equalize the service array options. One organization expressed gratitude for the development of the Community Benefit Service Questionnaire (CBSQ) but wanted more focus on ensuring CB participants are properly assessed.

Response: Several Self-Directed services such as related goods and specialized therapies were added to the Self-Directed benefit package under the previous Mi Via Waiver prior to Centennial Care and were never intended to be managed or provided by an MCO in the agency-based model. The MCOs are implementing the CBSQ with members as required by HSD. As of September 30, 2017, and 11 months with full implementation of the CBSQ, over 19,000 CBSQs have been completed with members in the long-term care program. HSD also monitors CB assessments though ride-alongs with care coordinators and quality audits. It also has its External Quality Review Organization conduct reviews.

2. b. Allow for one-time start-up goods when a member transitions from ABCB to SDCB *(3 comments)*
Commenters support the allowance for one-time start-up goods when a member transitions from ABCB to SDCB. One commenter asked that allowance for rare exceptions to limits for unusual cases be considered for additional resources for the transition to be successful.

Response: This a new benefit added to the list of self-direction services. Prior to recommending a $2000 cap for start-up goods, HSD researched the average cost of items that are beneficial for individuals who are self-directing services, such as computers, printers and fax machines. All of these items may be purchased within the $2000 cap.

2. c. Address the need for additional caregiver respite *(6 comments)*
Commenters support adding additional hours to address the need for additional caregiver respite. One commenter stated that any proposed limit to the use of respite must be sufficiently flexible to allow for exceptions to avoid violating the Americans with Disabilities ACT (ADA). Commenters expressed appreciation for needed respite hours to help relieve caregivers. Advocates from the aging community expressed support for the additional respite hours to support people using LTSS. One commenter asked the state to not impose a program cap on the hours and suggested using a sliding scale.

Response: *HSD has had an exception process in Centennial Care to allow additional respite over the 100 hour limit when a member's health and safety needs exceed the limit and will preserve this policy under Centennial Care 2.0. See 8.308.12.13.K.(4) NMAC.*

2. d. Establish limitations on costs for certain services in the SDCB model *(6 comments)*
Advocacy organizations believe establishing limitations on costs for certain services in the SDCB model violates the ADA. Providers expressed support for hippotherapy, biofeedback and cognitive rehabilitation specialty services and are concerned about caps. One commenter stated that the cap is arbitrary and will ensure a lack of supportive therapies that maintain or improve health. One commenter stated caps will result in a lack of continuity of care and poorer health outcomes. A few commenters asked the state to allow individuals in SDCB to make their own decisions on how much to spend depending on their needs and not target certain services. One commenter stated limiting non-

emergency transportation will negatively impact older adults in rural areas with limited access to public transportation.

Response: *As the SDCB program continues to experience increased enrollment, the limitations will help to ensure long-term sustainability of the program and continue to allow HSD to offer access to the community benefit to all eligible Medicaid members who meet a NF LOC without needing a waiver allocation for such services. HSD will "grandfather" budgets that exceed the limits for existing SDCB members, and their approved amounts over the proposed cost limits will become their on-going cost limit for as long as they remain in the SDCB model. To clarify, the MCOs are responsible for providing non-emergency medical transportation to all members and there is not a limit or cap for this service. The SDCB transportation benefit that will be subject to the limit provides non-medical transportation to social activities including community events, libraries, museums etc.*

2. e. Implement an ongoing automatic NF LOC approval with specific criteria for members whose condition is not expected to change *(3 comments)*
Commenters strongly support implementing an ongoing automatic NF LOC approval with specific members whose condition is not expected to change. One commenter stated this policy will help alleviate stressors for members and preserve access to services.

Response: HSD has not made any additional changes to this proposal in the final waiver application.

2. f. Require inclusion of nursing facilities in VBP arrangements and leverage Project ECHO and the UNM Section of Geriatrics to provide expert consultation to nursing home staff working with members with complex conditions, systemic improvements in nursing home quality of care, and reductions in avoidable readmissions from nursing facilities to hospitals *(2 comments)*
Two comments were offered in support of VBP arrangements with nursing facilities and working with Project ECHO. One commenter would like to see more information that supports using an alternative reimbursement method through VBP and allocate more LTSS funding for HCBS.

Response: HSD's collaborative work with Project ECHO and UNM Section of Geriatrics will begin in 2018 and include the New Mexico Health Care Association in the development of the VBP plan for nursing facilities in 2019. New Mexico continues to be a national leader in spending more of its long-term care program dollars in home and community-based settings rather than institutional settings.

3. <u>Physical Health and Behavioral Health Integration</u>

3. a. Expand the Health Home model *(5 comments)*
Comments were expressed in favor of expanding Health Home models to better integrate physical and behavioral health with one commenter asking for more data demonstrating successful models. Support was provided for expansion of the CareLink NM model to additional sites, including a Native American Health Home provider site. One commenter suggested the state provide explicit expectations with respect to behavioral health network adequacy, and evaluate and enforce network adequacy when the MCOs are operational. One commenter expressed concern that it is not clear what services Health Home members receive compared to other Medicaid members.

Response: The purpose of the Health Home model is to provide more comprehensive care coordination and whole-person chronic condition care management to groups of Medicaid beneficiaries with complex health care needs. The goals of the CareLink NM are to 1) Promote acute and long term health; 2)

Prevent risk behaviors; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED; and 5) Reduce avoidable utilization of emergency department, inpatient and residential services. Early quality evaluations of CareLink NM are very positive and member satisfaction is reported as high.

3. b. Establish an alternative payment methodology to support workforce development *(10 comments)*

Commenters expressed support for an alternative payment methodology to support workforce development to improve access to care. One legal advocacy organization referenced New Mexico's designation as a "Health Professional Shortage Area" and although is supportive of funding that is dedicated to increasing provider access believes it is not enough. One commenter stated the proposal does not address the insufficiencies in the state's behavioral health system. One commenter asked for clarification from the state, on behalf of primary care providers, of the difference between funding Graduate Medical Education (GME) for Family Medicine and Psychiatry as opposed to Primary Care. One commenter is concerned the state intends to require training for family physicians in an integrated Primary Care and Behavioral Health services setting. Two commenters recommended that Accreditation Council of Graduate Medical Education (ACGME) be the standard for clinic eligibility to participate in the alternative payment methodology program, and requested that the state provide Indirect Graduate Medical Education (IME) support for the hospital's portion of the training costs. These commenters also requested clarifying language on an existing State Plan Amendment and state regulations for IME and GME. A commenter from the Native American community suggested funding increases for Primary Care Physicians, Psych Nurses, Nurse Practitioners and Physician Assistants. A hospital provider expressed concerns with moving residency resources from hospital settings and recommends a comprehensive approach to enhance reimbursement across the system. One commenter expressed concerns with moving residency resources from hospital settings to community clinics, which could reduce resources that will contribute to workforce shortages that already exist. Commenter speaking on behalf of hospitals expressed opposition to shifting dollars when GME funding should be maintained for existing GME slots and enhanced for expanded opportunities and new hospital slots.

Response: *HSD's proposed alternative payment methodology is designed to support primary care, family medicine, and psychiatric resident physicians. The state's proposal seeks flexibility to choose clinics that are located in primarily rural, frontier or tribal communities to maximize the state's ability to address workforce shortages within the constraints of available funding. The state does not intend to impose additional training requirements for family physicians. Waiver language was revised to clarify that HSD is not moving residents out of hospital-based settings. HSD disagrees that ACGME accreditation should be the standard for clinic eligibility to receive alternative payments under this program, as this would greatly reduce the likelihood that clinics can participate across different regions of the state. As proposed in the final waiver, HSD is seeking to support the full cost of the resident, which may include the hospital's portion of training costs. HSD will consider comments relating the state's SPA and IME/GME regulations separately.*

3. c. Develop Peer-Delivered Pre-Tenancy and Tenancy Support *(7 comments)*

Commenters expressed support in developing peer-delivered pre-tenancy and tenancy support to participants with Serious Mental Illness (SMI). Advocates view this approach as an addition to other fully integrated behavioral health treatments. One commenter in expressing support said he/she believes it will help people with SMI. One health plan commented that this expansion will have a beneficial impact for members and reduce unnecessary hospitalizations and emergency department use.

Response: HSD added language in the final waiver application to further describe this benefit.

4. <u>Payment Reform</u>

4. a. Pay for value versus volume and increase the share of provider payment arrangements that are risk-based *(6 comments)*
Commenters expressed support for pay for value versus volume and increase the share of provider payment arrangement that is risk-based. One health plan suggested a flexible range of models including shared savings, shared risk, and partial and full capitation payment. Advocates support efforts to improve outcomes but asked the state to monitor MCOs possible denial or reduction of services to meet VBP goals.

Response: HSD has been incrementally increasing the amount of provider payments that are in value-based purchasing arrangements since 2015. For CY 18, 20 percent of provider payments must be in VBP arrangements. The ultimate goal of VBP arrangements is to improve healthcare outcomes for members and ensure that members are receiving high-quality care. These arrangements are not designed to reduce or deny services, but rather to incentivize providers to achieve improved rates for routine and preventive care services while reducing rates for potentially preventable services such as emergency room visits and readmissions to hospitals. The Centennial Care 2.0 MCO sample contract requirements outline a four-year plan to continue to drive VBP goals with annual increases in the percentage of provider payments in VBP arrangements, including requirements to include nursing facilities, rural providers and behavioral health providers.

4.b. Leverage VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization *(7 comments)*
Comments were offered in support of leveraging VBP to incentivize and drive key program goals in areas of care coordination, physical and behavioral health integrated models, improving transitions of care and improving population health outcomes, including avoidable emergency department utilization. One commenter recommended including MCOs in developing solutions and evaluating performance against goals. Advocates expressed concerns that VBP could translate into MCO cost savings instead of health outcomes. One commenter expressed concern the MCOs will take away services to meet their VBP goals. One commenter asked the state to include hospital associations and hospitals in efforts to improve readiness to participate in risk-based payment arrangements and to leverage VBP arrangements that drive key program goals. Commenter stated that VBP arrangements should be consistent across MCOs and enable achievement of mutually-agreed upon goals based on hospital capacity and performance.

Response: As stated in response above, HSD has outlined a detailed plan for its VBP program in its Centennial Care 2.0 MCO contracts, with specific targets and provider payment thresholds in three different VBP levels over four years. The plan includes requirements for inclusion of rural, behavioral health and nursing facility providers, data reporting requirements and specific targets for achieving certain quality metrics. The 2.0 sample contract may be found at this website:

http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Amended_Version__RFP_A2__RFP_Sample_Contract.pdf

4. c. Advance Safety Net Care Pool (SNCP) Initiatives *(5 comments)*
Commenters support advancing SNCP initiatives to expand participation to all willing hospitals. Support was expressed for initiatives that are data-informed and focus on health outcomes. One hospital provider expressed concerns with MCO contractual requirements and adding stress on safety net hospitals. One commenter stated that under federal law, states must assure Medicaid payments are sufficient to enlist healthcare providers to the same extent they are available to the general population in the same geographic area. One commenter representing hospitals stated that Medicaid payments to all New Mexico hospitals in aggregate are approximately 85 percent of actual costs for delivering services. Hospital representatives believe the "enhanced rate" does not fully cover their shortfall and is unsustainable. Commenter cited a report that was commissioned by Manatt to provide an analysis with examples from other states to illustrate the rationale for not reducing the uncompensated care (UC) pool and recommended that the state maintain the UC pool at $68.8 million, or expand it.

One commenter expressed concern with the proposal to expand the range of provider groups participating in SNCP, specifically the inclusion of nursing homes. Commenter explained the SNCP program aligns with county funding and state law, and is applicable only to hospitals. One commenter recommended creating a related program specific to nursing homes and funded separately from hospitals as a more logical approach. Commenter asked the state to consider removing any suggestion about "requiring participating providers to be network providers with each Centennial Care MCO". Hospital providers expressed concern with the requirement that hospitals must contract with all Medicaid health plans to receive funds from the safety net care pool and that it unreasonably interferes with the free market by mandating that hospitals enter into certain business arrangements.

Response: HSD seeks authority to retain the Safety Net Care Pool funding. It proposes to incrementally shift the funding ratio between the Uncompensated Care Pool and Hospital Quality Improvement Incentive Pool (HQII) so that 43% of the funding is allocated for the UC pool and 57% for the HQII. This ratio aligns with Centennial Care's goal to prioritize paying for quality versus volume.

In addition to the revised allocation of funding, HSD proposes:

- *Expanded flexibility to modify or update measures that factor into funding of the HQII pool;*
- *Continue increases to the enhanced inpatient rates and increase outpatient rates; and*
- *Require good-faith contracting efforts between the MCOs and providers that participate in SNCP to ensure a robust provider network for the Centennial Care MCOs.*

HSD did remove language that included nursing facilities in this section as it has advanced other proposals in the final waiver application specific to nursing facilities and removed the expansion to all willing hospitals.

5. <u>Advance Member Engagement and Personal Responsibility</u>

5. a. Advance Centennial Rewards Program *(5 comments)*
Support was expressed for Centennial Rewards Program and suggestions were made to better educate members about how the rewards program works. Support for utilizing rewards towards premiums was expressed and one health plan recommended a 90-day buffer for processing. Advocates and individual commenters expressed support for rewards improving health outcomes. One commenter stated support for the rewards program but thinks people don't know about it or how to use it.

Response: HSD did not modify this section in the final waiver.

5. b. Implement premiums for populations with income that exceeds 100% FPL *(141 comments plus joint organizational sign-on letters)*
The majority of the comments received explicitly oppose the implementation of premiums for populations with income that exceeds 100% FPL. Many of the comments in opposition to premiums were submitted as form letters or as part of a joint organizational and individual letter. Commenters consistently argued against imposing premiums and offered examples of research that discourages the use of premiums. Commenters suggested the Medicaid program would see enrollment decline and people would lose coverage. One commenter expressed concern that adding more expenses for Medicaid individuals, such as premiums, will directly impact their health. Individuals expressed fear and worry about their ability to afford other expenses like housing, food and transportation. One commenter expressed concern for families living on the edge of poverty, children in CHIP and working disabled individuals. One commenter expressed worry about having to pay both premiums and co-payments. A broad range of providers including family physicians, pediatricians, nurses, social workers, behavioral health providers and others strongly oppose premiums and other forms of cost sharing and believe it will lead to a reluctance to seek care and result in chronic diseases leading to higher emergency care utilization and hospitalizations. Hospital providers expressed concern that premiums will have an effect on enrollment and impact members' ability to stay consistently connected to the Medicaid program. Some commenters suggested the state look for new revenue streams for New Mexico that could benefit the Medicaid program. Some cited an increased administrative burden on the state to collect premiums, which would outweigh any potential savings from cost sharing.

A few commenters expressed support for cost sharing in Medicaid and were in support of premiums.

Response: HSD carefully considered the comments related to premiums and made the decision to restrict premiums to only one category of eligibility—the Expansion Adult population with income greater than 100% of the FPL. It removed premium requirements for the CHIP and WDI programs in the final application. With this change, the premium structure is simplified, consisting of one income tier for adults with income between 101 and 138% FPL, so that the monthly premium amount is the same for all adults in this category ($10). The annual premium amount is calculated at one percent of the lowest annual income in the tier, which is $12,060. At its discretion, HSD is requesting authority to increase the premium amount to two percent of annual income in future years of the Demonstration. HSD does not consider this policy as a reduction to eligibility or services—eligible individuals have the ability to retain coverage and continue accessing all covered services by complying with the premium requirements. Additionally, the premium requirement for this subgroup of the Adult Expansion population with higher income lessens the impact of the cost sharing cliff that is experienced when individuals transition from Medicaid coverage to coverage through the federal Marketplace or commercial market where cost sharing responsibilities are much higher.

5. c. Require co-payments for certain populations *(136 comments plus joint organization sign-on letters)*
The majority of the comments received explicitly oppose requiring co-payments for certain populations. Most of the comments in opposition to co-payments were submitted as form letters or as part of a joint organizational and individual letter. Commenters consistently argued against and offered examples of research that discourages imposing co-payments. Commenters suggested the Medicaid program would see enrollment decline and people would lose coverage leading to poor health outcomes. Individuals

expressed fear and worry about their ability to afford other expenses like housing, food and transportation. One commenter stated that the department is applying moral judgement that people need to have more "skin in the game". One commenter stated that research should be used to prove co-payments work. Families and individuals with chronic health conditions worry about out of pocket cost becoming unaffordable. Concern was expressed for families living on the edge of poverty, children in CHIP and working disabled individuals. A broad range of providers including family physicians, pediatricians, nurses, social workers, behavioral health and others strongly oppose co-pays and other forms of cost sharing and believe it will lead to a reluctance to seek care and result in chronic diseases leading to higher emergency care utilization and hospitalizations.

Hospital providers commented that requirements around co-payments and cost sharing for Medicaid members create increasing administrative burdens for healthcare providers and could impact a rate reduction for services requiring co-payments. They also suggested the administrative burden will offset system savings for Medicaid by increasing costs for providers.

A few commenters expressed support for cost sharing in Medicaid and co-payments.

Response: *HSD carefully considered the comments related to copayment requirements and made the decision to remove most copayments from the final waiver application. Furthermore, it is removing copayments that exist today in the CHIP and WDI programs with the commencement of the waiver renewal. HSD is requesting authority to apply only two copayments in the final waiver, which are consistent with policy priorities to reduce unnecessary use in the delivery system and to incentivize preventive and routine care. HSD's decision to reduce the number of copayments addresses concerns raised about the complexity of the former copayment structure and increasing the administrative burden for providers.*

5. d. Seek authority to modify the tracking requirements for cost sharing *(2 comments)*
Commenters oppose efforts by the state to seek authority to modify the tracking requirements for cost sharing.

Response: Since HSD has made decisions to restrict the premium payment requirements and to reduce the copayment requirements, tracking the five percent out of pocket maximum is simplified. HSD is requesting authority to waive federal tracking requirements for the two copayments since the members are choosing those service options rather than alternative options that do not require copayments. Because the premium amount is calculated at one percent of annual household income it should not exceed any member's out of pocket maximum, which is calculated at five percent of annual household income. This simplified cost sharing structure reduces any potential administrative costs that may have been incurred to track member cost sharing.

5. e. Seek authority for providers to charge nominal fees for three or more missed appointments *(62 comments plus joint organization sign-on letters)*
The majority of commenters expressed opposition to fees for missed appointments and pointed to obstacles some members face, for example, with access to reliable transportation, health issues that affect their ability to keep appointments, or cognitive issues related to a disability. One commenter expressed concerns for people with behavioral health issues being penalized. One commenter stated that transportation is limited in rural areas. Commenters stated that transportation is not reliable and people sometimes miss appointments. Some providers expressed concerns with administrative burdens they would face in collecting fees. One provider association expressed support for fees as a way to

reduce missed appointments. One commenter suggested using a multiple reminder approach. Some commenters who oppose co-pays and premiums support a small fee for missed appointments but suggested lowering the amount.

Response: HSD appreciates the feedback received related to this proposal. It is at the provider's discretion to charge the nominal fee after three missed appointments without notification to the provider in a calendar year. HSD has not made any additional changes in the final waiver as a result of these comments.

5. f. Expand opportunities for Native American members enrolled in Centennial Care *(8 comments)*
Commenters were supportive of expanding opportunities for Native Americans enrolled in Centennial Care. Native American providers and tribes expressed support for the states effort to seek authority to collaborate with Indian Managed Care Entities (IMCE). One commenter emphasized that this effort would not negate the need for fee-for-service (FFS) in New Mexico. Commenter believes the language in the draft waiver does not include a mandate for Native Americans to join an ICME. Most of the commenters reminded the state that they are sovereign. Some Tribal organizations expressed interest in becoming an IMCE as well as becoming other types of Medicaid providers. One commenter stated that because tribes are sovereign, agreements should be between the state and Tribal governments. All of the commenters encouraged the state to work directly with the Tribal community.

Response: HSD continues to collaborate with the Navajo Nation as it seeks to establish an IMCE. It will also work with other interested Tribal organizations at their request. HSD is not requesting mandatory enrollment for Native American members as part of this proposal to expand opportunities for Native American members. HSD expanded the language in this section of the draft waiver application to clarify expectations for establishment of IMCEs, including the requirement to meet all other aspects of federal and state managed care requirements, including but not limited to, financial solvency, licensing, provider network adequacy and access requirements and to demonstrate compliance with the requirements in the Centennial Care Managed Care Professional Services Agreement, including delivery of all Medicaid services as listed.

6. <u>Administrative Simplification through Eligibility Modifications</u>

6. a. Redesign the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered adults *(85 comments plus joint organization sign-on letters)*
The majority of the comments received explicitly opposes redesigning the Alternative Benefit Plan (ABP) and provide a uniform benefit package for most Medicaid-covered adults. Most of the comments in opposition to redesigning the ABP were submitted as form letters or as part of a joint organizational and individual letter. Many individual commenters expressed concern with cutting essential benefit and EPSDT for 19-20-year-olds and believe it will have a negative effect. One commenter believes elimination of EPSTD in the ABP will impact families. Physical, Occupational and Speech-Language therapy providers strongly oppose changes that would reduce or eliminate therapy services. Providers, advocacy organizations and individuals commented changes would create higher costs for members and shift costs to healthcare providers.

Response: HSD carefully considered the comments related to this proposal and made the following change to the benefit design—it removed the proposed elimination of habilitative services. However, HSD is seeking a waiver of federal EPSDT requirements for 19 and 20 year olds in the ABP to streamline the adult benefit package and since individuals who qualify for a medically-frail exemption in the ABP

have access to the traditional Medicaid benefits that includes EPSDT services. The medically frail exemption criteria includes a list of specific conditions as well as the condition of needing assistance with one activity of daily living. HSD is proposing to add a limited vision benefit to the ABP which will provide access to this service to more than 240,000 adults who previously did not have this benefit. The ABP will continue to offer comprehensive benefits, including routine and preventive services, inpatient and outpatient services, pharmacy, non-emergency medical transportation, physical, occupational and speech therapy services and a dental benefit.

6. b. Develop buy in premiums for dental and vision services for adults, if needed *(33 comments)*
The majority of commenters oppose buy-in premiums for dental and vision services for adults and any cuts to services that exist. One commenter expressed opposition to another cost to people who have limited income or lack coverage from their employer. Opposition to changes to adult dental services was received from the oral health coalition and hygienists expressing concern for increased disease risk like heart disease, diabetes and prenatal complications if dental services are reduced. Providers in ophthalmology and optometry also expressed opposition to premiums and changes to vision services stating that it would lead to reductions in thousands of eye exams and contribute to health risks and conditions.

A few commenters expressed support for buy-in premiums for dental and vision services. One commenter stated that the state does not have the money to pay for everything.

Response: HSD appreciates the comments it received related to this proposal and did not make any changes to this proposal in the final waiver application. This proposal remains to allow flexibility in future years to address potential federal financing policy changes and/or state general fund budgetary deficits.

6. c. Incorporate eligibility requirements of the Family Planning program *(10 comments)*
Commenters oppose incorporating eligibility requirements of the Family Planning program.
One commenter expressed concerns that limits on the age of recipients would deny access for treatments available through the family planning program. One commenter specifically opposes the age cap of 50 for family planning. Advocates raised concerns that people with disabilities will lack reproductive health coverage and recipients will face co-payments for family planning services in Medicaid and the ABP. Individuals commented that New Mexico already has a high unintended pregnancy rate that leads to cycles of poverty and the state should not reduce access. One commenter stated that risks for sexually transmitted infections with older adults are growing and they need to have access to these services.

Response: HSD appreciates the comments it received related to this proposal and did not make any changes to this proposal in the final waiver. HSD's policy to target the family planning to those who are accessing the services aligns with the age limitation of up to 50 years old. There are no proposed copayments for family planning services in the Medicaid program.

6. d. Eliminate the three-month retroactive eligibility period for most Centennial Care members *(86 comments plus joint organization sign-on letters)*
The majority of commenters expressed strong opposition to eliminating the three-month retroactive eligibility period for most Centennial Care members. Most of the comments in opposition were submitted as form letters or as part of a joint organizational and individual letter. One commenter stated opposition to eliminating the retroactive coverage and that it will leave families exposed to massive financial debt. Advocates and individuals believe ending coverage would take away important

protections that protect people from medical debt. UNMH specifically asks the state to remove this provision from the Waiver proposal. They state that the elimination retroactive cases would have a disproportionate impact on hospitals and other safety net providers. One hospital association commenter stated that the limitation of retroactive eligibility cases would have a disproportionate impact on hospitals and other safety net providers.

Response: In consideration to the comments received to this proposal, HSD has modified the proposal. The final policy decision is to phase out the retroactive period of eligibility by reducing it to one month in 2019, then eliminating it with the start of the second year of the demonstration (2020). Providing one month of retroactive eligibility to new recipients during the first year of the waiver renewal allows ample time for the delivery system to develop the necessary processes to secure coverage at point of service and provides additional time for HSD to retrain hospitals and other safety net providers in presumptive eligibility determinations. Additionally, HSD is moving toward an environment in which Medicaid eligibility, both initial determinations and renewals, is streamlined where possible. Real-Time eligibility is scheduled to roll-out by the end of 2018, meaning that many individuals will receive an eligibility determination at the point of application. Additionally, the ACA and expansion of Medicaid to adults who were previously uninsured have dramatically changed the landscape of coverage options. New Mexico hospitals have substantially reduced their uncompensated care needs and are able to make individuals presumptively eligible for Medicaid at the time of service. In calendar year 2016, only one percent of the Medicaid population requested retroactive coverage (10,000 individuals). Safety Net Clinics are also able to immediately enroll individuals at point of service through the Presumptive Eligibility program and receive payment for services. These changes provide an opportunity to reduce the administratively complex reconciliation process with the MCOs for retroactive eligibility periods.

6.e. Accelerate the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increase income *(73 comments plus joint organization sign-on letters)*

The majority of commenters expressed strong opposition to accelerating the transition off of Medicaid for individuals who are eligible for the Transitional Medical Assistance (TMA) program due to increased income. Most of the comments in opposition were submitted as form letters or as part of a joint organizational and individual letter. Many individuals expressed opposition and are concerned this will cause financial problems for families changing jobs or accepting raises.

One commenter stated that ending transitional Medicaid would result in coverage loss for the lowest income families. One commenter expressed concern the proposal will penalize people for working and earning more money. Legal advocates stated that TMA cannot be waived under Section 1115 authority and cautioned the state. One legal advocate commented that ending transitional Medicaid will make it difficult for families to gain economic security and will disrupt healthcare coverage.

Response: HSD appreciates the comments it received for this proposal. No changes were made as a result of the comments. As an expansion state, New Mexico has an option available to individuals in the Parent/Caretaker category when their earnings increase and make them ineligible for the Parent/Caregiver category, which it did not have prior to the passage of the Affordable Care Act (ACA). As stated in the final waiver application:

- *TMA is a concept that predates the ACA and was intended to provide coverage to Parent/Caretaker adults whose income increases above the eligibility standard for full coverage. Most of these individuals are transitioned to the adult expansion category, which has resulted in diminishing enrollment in TMA;*

- *In 2013, 26,000 individuals were enrolled in the TMA category; today, fewer than 2,000 individuals are enrolled; and*
- *Parent/Caretakers that have increased earnings above the income threshold for the adult expansion category (138% of the FPL) are eligible to receive subsidies to purchase coverage through the federal Marketplace.*

6. f. Request waiver from limitations imposed on the use of Institutions for Mental Disease *(3 comments)*
One commenter expressed support in waiving limitations imposed on the use of institutions for mental disease. Disability advocates do not support incentivizing the use of institutional care and asked the state to focus on funding community-based services reducing the need for hospitalization. One commenter representing hospitals commended the state for requesting a waiver of the IMD exclusion and stated it would greatly expand access to inpatient psychiatric care and reduce the administrative burden on MCOs.

Response: HSD appreciates the comments submitted for this proposal. Other proposals in the final waiver application support use of community-based services rather than institutional settings of care; however, when necessary and in certain circumstances, individuals may require services in an IMD and the State seeks authority to utilize IMDs in those instances without exclusions. Additionally, HSD has added new language to this section of the final application to add several behavioral health services to the benefit package that are needed to fill gaps in care, including expanding use of Screening, Brief Invention, and Referral to Treatment (SBIRT) services through primary care settings, community health centers, and urgent care facilities; and including residential treatment for adults with substance use disorder (ASAM Level 3).

6. g. Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states *(2 comments)*
Commenters expressed support for requesting waiver authority to cover former foster care individuals up to age 26. One advocate believes foster care is overrepresented by people with disabilities and behavioral health needs.

Response: HSD did not modify this proposal in the final waiver application.

6. h. Request waiver authority for enhanced administrative funding to expand availability of LARC for certain providers *(5 comments)*
Commenters expressed support for enhanced administrative funding to expand availability of LARC for certain providers**.** One commenter raised concerns for people with disabilities covered by Medicare and do not have access to LARC would need the Family Planning program for services not available to them.

Response: HSD did not modify this proposal in the final waiver application.

6. i. Continue to provide access to Community Interveners *(3 comments)*
Commenter expressed support for continuing to provide access to Community Interveners. Disability advocates think this opportunity has been underutilized. One commenter expressed support for expanding use of Community Interveners.

Response: HSD did not modify this proposal in the final waiver application.

7. Comments for related to Multiple or Not Specific Wavier Proposals

7. a. Miscellaneous Comments *(6 comments)*
Comments were received from independent pharmacists and pharmacies offering recommendations for the state to consider. One commenter asked that the state require all pharmacy reimbursement through Centennial Care be in compliance with NADAC pricing. One commenter asked the state to clarify the prior-authorization process for pharmacy and expressed concern that MCOs are using prior-authorization as a way to deny access to prescription drugs. One commenter asked the state to raise reimbursement rates and expressed concerns with contracting with the MCOs. One commenter expressed concerns with the lack of enforcement regarding use of tamper-resistant prescription pads.

One commenter representing hospitals expressed concerns with current infrastructure for oversight of the MCOs and believes it is significantly under-resourced. Commenter stated providers do not have a formal appeal process with the Department and asked the state for a complete restructuring of the fair hearing process.

One commenter expressed frustration with the state's lack of creating new revenue that could help the Medicaid program. One commenter suggested that the state create a tax on New Mexico corporations.

Response: HSD appreciates these comments; however, the comments are best addressed through review of contractual requirements with and monitoring of the MCOs and review of the agency's internal procedures and processes. Revenue enhancement and modifications to the tax structure are not within the scope of the Medicaid agency's authority.

Key Utilization / Cost per Unit Statistics by Major Population Group

Physical Health Population: TANF, Aged, Blind, Disabled, CYFD, Pregnant Women				
	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	CY 2016	CY 2017	CY 2016	CY 2017
Inpatient (Admissions)	96.4	77.8	$ 9,620	$ 8,187
Inpatient (Days)	461.6	342.9	$ 2,010	$ 1,858
Practitioner / Physician (Services)	8,632.3	7,363.1	$ 68	$ 66
Emergency Department (Visits)	556.2	478.7	$ 348	$ 348
Outpatient (Visits)	1,466.1	1,231.5	$ 276	$ 270
Pharmacy (Scripts)	5,063.5	4,755.7	$ 61	$ 65
Other (Services)[1]	9,150.2	8,219.6	$ 59	$ 56
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY 2016	CY 2017	CY 2016	CY 2017
Brand	13.8%	13.1%	$ 321	$ 365
Generic	84.8%	85.4%	$ 18	$ 18
Other Rx[2]	1.4%	1.5%	$ 102	$ 98

Notes:
1 - Other services include dental, transportation, vision.
2 - Other Rx includes diabetic supplies

Adult Expansion: Other Adult Group				
	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	CY 2016	CY 2017	CY 2016	CY 2017
Inpatient (Admissions)	77.4	62.5	$ 15,725	$ 15,080
Inpatient (Days)	505.3	497.5	$ 2,410	$ 1,894
Practitioner / Physician (Services)	9,137.5	7,591.8	$ 79	$ 76
Emergency Department (Visits)	670.9	572.6	$ 489	$ 485
Outpatient (Visits)	2,382.8	1,809.1	$ 309	$ 306
Pharmacy (Scripts)	10,347.5	9,497.2	$ 76	$ 77
Other (Services)[1]	9,836.3	8,981.8	$ 68	$ 63
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY 2016	CY 2017	CY 2016	CY 2017
Brand	11.0%	10.8%	$ 554	$ 576
Generic	87.2%	87.3%	$ 15	$ 15
Other Rx[2]	1.8%	1.9%	$ 90	$ 89

Notes:
1 - Other services include dental, transportation, vision.
2 - Other Rx includes diabetic supplies

Key Utilization / Cost per Unit Statistics by Major Population Group

Long Term Services and Supports: Dual Eligible - Nursing Facility Level of Care				
	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	CY 2016	CY 2017	CY 2016	CY 2017
Inpatient (Admissions)	251.8	184.5	$ 2,777	$ 2,798
Inpatient (Days)	1,475.3	1,077.0	$ 474	$ 479
Nursing Home (Days)	293,856.3	226,323.7	$ 38	$ 40
Personal Care (Services / hr.)	786,765.7	667,448.2	$ 15	$ 15
Outpatient (Visits)	5,238.6	3,937.3	$ 122	$ 145
Pharmacy (Scripts)	1,973.6	1,278.3	$ 35	$ 18
HCBS (Services)	4,980.1	5,725.2	$ 148	$ 122
Other (Services)[1]	43,998.2	36,743.5	$ 47	$ 43
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY 2016	CY 2017	CY 2016	CY 2017
Brand	20.1%	22.4%	$ 128	$ 54
Generic	77.8%	75.2%	$ 10	$ 6
Other Rx[2]	2.0%	2.4%	$ 75	$ 60

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies

Long Term Services and Supports: Medicaid Only - Nursing Facility Level of Care				
	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	CY 2016	CY 2017	CY 2016	CY 2017
Inpatient (Admissions)	347.7	298.7	$ 18,252	$ 18,189
Inpatient (Days)	2,343.0	1,992.3	$ 2,708	$ 2,727
Nursing Home (Days)	14,609.1	12,819.4	$ 186	$ 165
Personal Care (Services / hr.)	782,787.3	651,395.1	$ 15	$ 15
Outpatient (Visits)	7,565.1	6,481.0	$ 435	$ 430
Pharmacy (Scripts)	44,216.0	41,033.2	$ 91	$ 90
HCBS (Services)	11,808.4	11,647.3	$ 104	$ 89
Other (Services)[1]	65,454.2	56,284.9	$ 83	$ 82
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY 2016	CY 2017	CY 2016	CY 2017
Brand	12.7%	12.6%	$ 575	$ 577
Generic	85.1%	85.0%	$ 19	$ 18
Other Rx[2]	2.2%	2.4%	$ 84	$ 82

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies

Key Utilization / Cost per Unit Statistics by Major Population Group

Long Term Services and Supports: Self-Directed Population (Dual and Medicaid Only)

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	CY 2016	CY 2017	CY 2016	CY 2017
Inpatient (Admissions)	236.4	183.5	$ 8,566	$ 8,621
Inpatient (Days)	1,360.8	1,179.1	$ 1,488	$ 1,342
Nursing Home (Days)	9,985.0	6,635.6	$ 17	$ 17
Personal Care (Services / hr.)	132.2	67.4	$ 11	$ 16
Outpatient (Visits)	6,562.6	5,438.5	$ 207	$ 233
Pharmacy (Scripts)	13,693.8	13,856.4	$ 107	$ 115
HCBS (Services)	342,443.2	276,972.9	$ 104	$ 96
Other (Services)[1]	57,036.0	50,039.9	$ 49	$ 54

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY 2016	CY 2017	CY 2016	CY 2017
Brand	13.3%	14.4%	$ 500	$ 588
Generic	83.8%	82.4%	$ 45	$ 32
Other Rx[2]	2.8%	3.2%	$ 109	$ 119

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies

Long Term Services and Supports: Dual Eligible - Healthy Dual Population

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	CY 2016	CY 2017	CY 2016	CY 2017
Inpatient (Admissions)	75.3	57.3	$ 4,080	$ 4,113
Inpatient (Days)	449.0	337.5	$ 684	$ 698
Practitioner / Physician (Services)	9,472.9	7,960.3	$ 26	$ 26
Emergency Department (Visits)	673.4	504.8	$ 146	$ 167
Outpatient (Visits)	3,013.6	2,234.7	$ 124	$ 132
Pharmacy (Scripts)	1,622.5	1,336.4	$ 37	$ 22
Other (Services)[1]	10,060.4	8,303.1	$ 150	$ 153

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY 2016	CY 2017	CY 2016	CY 2017
Brand	20.1%	23.6%	$ 129	$ 63
Generic	77.9%	74.1%	$ 12	$ 9
Other Rx[2]	2.0%	2.3%	$ 65	$ 51

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies

Key Utilization / Cost per Unit Statistics by Major Population Group

Behavioral Health Services - All Populations (PH, OAG, LTSS)				
	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	CY 2016	CY 2017	CY 2016	CY 2017
Inpatient (Admissions)	35.4	34.3	$ 1,006	$ 1,040
Inpatient (Days)	101.2	97.4	$ 352	$ 366
BH Practitioner (services)	159.1	184.8	$ 133	$ 123
Core Service Agency (Services)	258.7	179.2	$ 102	$ 107
BH outpatient / clinic (Services)	2,306.8	2,523.3	$ 70	$ 59
Pharmacy (Scripts)	1,878.2	1,782.3	$ 57	$ 56
Residential Treatment Center (days)	97.9	75.5	$ 1,001	$ 1,005
Other (Services)[1]	148.9	119.8	$ 62	$ 52
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY 2016	CY 2017	CY 2016	CY 2017
Brand	5.9%	6.3%	$ 409	$ 435
Generic	94.1%	93.7%	$ 35	$ 30
Other Rx[2]	0.0%	0.0%	$ -	$ -

Notes:

1 - Other services includes BMS, PSR and PES services.