Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2016 – 12/31/2016)
Waiver Quarter: 1/2016

May 31, 2016
New Mexico Human Services Department

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Section I: Introduction

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. Approximately 640,000 members are enrolled in the program. Highlights from the second year (January – December 2015) of the program include:

Emphasizing Patient-Centered Care

- Completed health risk assessments for 70% of members;
- More than 70,000 members in higher levels of care coordination;
- More than 200,000 members receiving care in patient-centered medical homes;
- More than 21,000 members receiving home and community benefits;
- 500 high need/high cost members served in a program administered by the University of New Mexico (UNM), ECHO Care, that provides access to an intensivist team, which includes primary care physicians, behavioral health counselors, specialists as needed, and community health workers.

Supporting Provider Capacity

- Continuation of the Primary Care Physician Enhanced Rate—1,982 providers receiving increased payments;
- Maximizing Scopes of Practice for Certain Providers;
- Managed care organizations (MCOs) expanding use of telehealth office visits and launching virtual physician visits, including with behavioral health providers; and
- Increasing use of Community Health Workers.

Implementing Payment Reform Projects

- The Human Services Department (HSD) approved 10 payment reform projects in early 2015; all projects launched in July 2015.

There are many initiatives in development during demonstration year three (DY3) that include:

- Health Homes was implemented in DY3 and are further explained in Section VI.

- HSD and the MCOs continue to explore and implement Emergency Department (ED) diversion options and strategies. This includes implementation of ED tracking software.

- HSD continues to work on Value Based Purchasing initiatives and will meet with the MCOs and stakeholders to begin discussions on expanding these efforts.

Section II: Enrollment and Benefits

Eligibility

As noted in Section III of this report, there are 262,621 enrollees in the Group VIII (expansion) who are in Centennial Care. Growth in the expansion group shows 13,289 new enrollees for the first quarter of demonstration year 3 (DY3 Q1).

Enrollment

Centennial Care enrollment has experienced the largest increase in enrollment in Group VIII. The majority of Centennial Care members are enrolled in TANF and Related MEG with Group VIII being the next largest group as reflected in Section III of this report. Overall enrollment continues to increase each quarter.

Disenrollment

The New Mexico Human Services Department (HSD) continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any potential gaps in enrollment. Any issues that are identified or reported are researched and addressed. Overall disenrollment has decreased.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through February 2016. Quarterly data is available through the fourth quarter of 2015.

Primary Care Provider (PCP)-to-Member Ratios

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

Physical Health (PH) and Hospitals

Geographic access (GeoAccess) reports are currently under HSD review to ensure consistent methodology across MCOs. In question is whether the MCOs have the ability within their software packages to choose point-to-point distance measurements or actual mileage to travel to the nearest provider, and if so, which methodology has been selected. No significant changes to MCO networks have been reported in the quarter, and HSD will resume reporting geographic access in DY3 Q2 report. Any adjustments needed to standardize methodologies will be presented at that time.

Transportation

In DY3 Q1, HSD approved the MCOs' work plan and Severity Tier Levels for non-emergent transportation member complaints: Tier 1: "Serious" – issue involving safety (e.g. traffic accident, reckless driving, evidence of weapon, assault, inappropriate sexual behavior); Tier II "Major" – issue involving service, behavior and timeliness (e.g. vehicle requires maintenance, air conditioner broken); Tier III: "Moderate" – issue involving service or behavior (e.g. CSR/driver rude, cleanliness of vehicle/member impact); Tier IV: "Minor" – complaint/issue not involving safety, behavior or timeliness, or unsubstantiated claim, cleanliness/no member impact. Please see Attachment B: MCO Action Plans for transportation internal action plans.

Service Delivery

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program is for January through December of 2015. Please see Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

The changes to treatment guidance for chronic Hepatitis C virus (HCV) infection issued in November 2015, have shown an increase in the number of members being treated for HCV with genotype fibrosis levels "F2" or greater. Harvoni® and Sovaldi are the most utilized therapies among all MCOs, based on MCO expenditures. Utilization of combination therapies including Viekira Pak, Ribavirin, Daklinza, Technivie and/or Interferon is reported by MCOs.

Among all four MCOs, antiviral medications including Hepatitis C agents and combination therapies are the number one pharmacy expenditure seen in paid claims for first quarter 2016. Antidiabetic treatment including insulin therapy is the second highest in expenditures for drug treatment seen in paid claims for first quarter 2016.

HSD is currently reviewing pharmacy reports to ensure a consistent methodology is utilized across managed care organizations (MCOs) including therapeutic classifications. No significant changes to MCO pharmacy reporting have been noted within the quarter. Any adjustments needed to standardize methodologies will be presented at DY3 Q2.

Provider Network

All MCOs actively review and analyze the provider network to ensure the accessibility of Primary Care Physicians (PCPs), specialists, behavioral health providers, and long term providers. Each MCO has a unique way of monitoring provider networks:

- Blue Cross Blue Shield of New Mexico (BCBSNM) has a Contract Provider Review Committee that meets monthly and a Service Quality Improvement Committee that meets every other month to review network issues, GeoAccess analyses, provider and member satisfactory surveys, and to address needs for expanding the network or closing identified gaps in coverage that may occur as a result of provider terminations or providers with closed panel.
- Since implementation of Centennial Care, Molina Health of New Mexico (MHNM) has a contracted network that has been stable with retention high and the addition of new providers every year to meet member demand. Monitoring activities include assessing practitioner and provider availability by completing an availability analysis of the provider network presented to the Quality Improvement Committee and Network Operations. Other monitoring activities by MHNM include reviewing of reports and data used to analyze network adequacy, methodologies used to identify gaps, and remediation and quality improvement activities to address network gaps. To ensure an adequate and comprehensive network of providers.
- Presbyterian Health Plan (PHP) applies a systematic process for evaluation and selection of practitioners and providers to participate in the network. This consistent process ensures a retention process, follows the criteria to assess network adequacy, select healthcare practitioners to furnish covered services and meet the healthcare needs of the members.
- UnitedHealthcare (UHC) monitors the network from several sources in order to properly maintain the network; member grievances, member surveys, quality management/quality improvement programs, credentialing/re-credentialing, PCP changes, Joint Operating Committees, PCP panel size, provider advocacy training, and appointment availability survey.

Community Health Workers (CHWs)

As reported in DY2 Q4, MCOs are utilizing CHWs as extensions of their provider networks. One MCO is reporting 1,200 CHW referrals per month, and another MCO is reporting over 32,000 members served. All MCOs are working towards a goal of increasing members served within DY3. Activities continue to evolve and include:

- Increasing the number of CHWs;
- UNM and Molina are implementing social determinates needs assessment that is completed with members during the first visit to address food insecurity, utilities, employment, transportation, housing, and education;
- Increasing access to food by offering food vouchers through UNM and Roadrunner Foodbank as well as delivering food boxes to members; and

- Increasing utilities access by connecting members with LIHEAP, PNM, social services, local resources, medical homes, and case management. All in addition to activities previously established.

Telehealth

All MCOs have implemented telemedicine initiatives for the convenience of their members while improving access and potentially reducing healthcare costs. One MCO has reportedly trained more than 500 Care Coordinators in telemedicine, to promote member utilization when access to services is limited. All MCOs have set a goal to increase member utilization by 15% over DY2 goals. Through the first quarter of DY3, we are seeing an improvement in the telehealth utilization rate for both physical and behavioral health needs.

Table #1 – Telemedicine Professional Services (Rural and Frontier Members for DSITs) Managed Care – Number of Visits

	Baseline			1st Year Results			2nd 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	Percent Change
BCBS	19	3	22	1,078	91	1,169	1,213	803	2,016	72%
UHC	89	22	111	1,046	96	1,142	1,833	236	2,069	81%
MHNM	7 *	0	7	1,909	32	1,941	2,132	754	2,886	49%
PHP	2,016	4	2,020	3,006	143	3,149	3,809	134	3,943	25%
TOTAL	2,131	29	2,160	7,039	362	7,401	8,987	1,927	10,914	47%

* 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 2015 DSIT Results Reporting

Amendments

Restated and amended Centennial Care MCO contracts, Amendment 5, went into effect on January 1, 2016. Please see Attachment D: Centennial Care Contract Amendment #5.

Centennial Rewards Program

All Centennial Care members are eligible for rewards and in DY3 Q1, 229,837 new/distinct members earned rewards. To date, 542,661 total members are earning rewards, for an overall participation of 67.2%.

The table below shows the healthy behaviors rewarded and each behavior's value. It includes the dollar value of the activity, the total dollars earned and the amount redeemed in DY3 Q1.

Table #2 – DY3 Q1 Credits Earned and Redeemed by Activity

Eligibility Activities	Activity Completion Reward Value in $	Total Rewards Earned by Activity in $	Total Rewards Redeemed by Activity in $
Healthy Smiles Adults	25	$847,275	$149,486
Healthy Smiles Children	35	$1,795,815	$410,421
Step-Up Challenge	50	$75,300	$69,132
Health Risk Assessment (HRA)	10	$724,230	$143,452
Healthy Pregnancy	100	$73,200	$28,778
Diabetes Management	80	$350,820	$106,253
Asthma Management	75	$93,930	$30,953
Schizophrenia Management	75	$44,265	$8,638
Bipolar Disorder Management	75	$79,050	$24,996
Bone Density Testing	35	$5,530	$881
Other (Appeals)	N/A	$56,230	$51,093
Totals		**$4,145,645**	**$1,024,083**

More than 62,588 members have received rewards for the Step-Up Challenge which is a walking program that allows members to earn a $25 reward for completing 135,000 total steps over a three week period and earn another $25 reward if they continue the program for nine additional weeks by meeting a goal of 30,000, 45,000, or 60,000 steps each week. At this point 8,821 members completed the three week challenge and 2,396 went on to complete the nine week program.

Reward redemption in DY3 Q1 was $1.1 million, increasing the total to date redemption to $6.5 million since the Centennial Rewards program started in January 2014. Redemption activity by members is slowly increasing: DY2 Q3 = 15.7% increase, DY2 Q4 = 23% increase and DY3 Q1 = 24.7% increase.

Community Interveners (CI)

In DY3 Q1, there were seven Centennial Care members receiving Community Intervenor services. The MCOs will continue to provide training and education to Care Coordinators to identify potential members who could benefit from CI services.

Table #3 – Community Intervener Services Utilization DY3 Q1

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBSNM	3	129.25	$3,230.50
MHNM	0	0	$0
UHC	3	94.75	$2,413.00
PHP	1	0	$0
Total	**7**	**224.00**	**$5,642.50**

Section III: Enrollment Counts

The following table outlines all enrollment activity under the demonstration. The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG they were enrolled in at the end of the reporting quarter.

Table #4 – Enrollment DY3 Q1

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – March 2016	Current Enrollees (Rolling 12 month period)	Disenrolled in Current Quarter
Population 1 – TANF and Related	368,465	357,175	6,237
Population 2 – SSI and Related – Medicaid Only	41,266	42,014	714
Population 3 – SSI and Related – Dual	36,628	39,479	536
Population 4 – 217-like Group – Medicaid Only	170	229	56
Population 5 – 217-like Group – Dual	2,342	2,646	39
Population 6 – VIII Group (expansion)	262,621	316,101	8,966
Totals	711,492	757,644	16,548

Disenrollments

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

Table #5 – Disenrollment Counts DY3 Q1

Disenrollments	From 2015 Q4 to 2016 Q1		Total Disenrollments During Q1
Last Month Client was Disenrolled	**Jan 1, 2016**	**Feb 1, 2016**	
Population 1 – TANF and Related	2,666	3,571	6,237
Population 2 – SSI and Related – Medicaid Only	337	377	714
Population 3 – SSI and Related – Dual	225	311	536
Population 4 – 217-like Group – Medicaid Only	56	0	56
Population 5 – 217-like Group - Dual	18	21	39
Population 6 – VIII Group (expansion)	3,827	5,139	8,966
Total Without MEG 7	7,129	9,419	16,548

Section IV: Outreach

In DY3 Q1, HSD provided Centennial Care monthly informational training to the New Mexico Aging and Long-Term Services Department, Adult Protective Services Division staff from across the State.

All four MCOs participated in a wide variety of community events all across the state providing enrollment opportunities and educating the public about Centennial Care. They attended Medicaid enrollment events, health fairs and events comprised of senior citizens, children and families, Native Americans and other populations. The MCOs also held events with the Advancement of Latino Professional for America (ALPFA), Local Chambers of Commerce providing Centennial Care information to those in attendance.

The MCOs and HSD collaboratively developed curriculum which was presented to the Health Home (CareLink New Mexico) provider staff in San Juan and Curry counties. This was an in depth Centennial Care, Care Coordination training provided to these new providers. These sessions were also used to introduce the MCO staff to the CareLink New Mexico provider staff and have them begin working together for the benefit of Centennial Care members.

HSD submitted an application to the Centers for Medicare & Medicaid Services (CMS) for the Children's Health Insurance Program Reauthorization Act (CHIPRA) IV Grant. The application describes how funding will be used to enhance current state systems to recertify Centennial Care members more quickly to ensure New Mexicans continue to meet eligibility requirements. CHIPRA IV notice of award is expected mid-May 2016.

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

The MCOs submit encounters daily and/or weekly to stay current with their encounter submissions. HSD continues to work with the MCOs to respond to questions and address any issues related to encounters. HSD has also scheduled weekly meetings with the MCOs to address any encounters that have been denied to work through those issues and educate the MCOs of system edits.

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

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

Program Development

In DY3 Q1, HSD identified program areas for which MCOs would benefit from enhanced trainings. HSD provided MCOs with a schedule and list of proposed topics. In collaboration with the MCOs, HSD began implementation of a series of trainings beginning with: Federally Qualified Health Center (FQHC) billing; Health Homes; Crossover Claims; Community Benefits; Nursing Facility/Setting of Care (Part 1); and Crossover Claims non-IHS. Additional trainings will be conducted in DY3 Q2.

Unreachable Member Campaign

The continuation of the Unreachable Campaign (results shown in table 5 below) demonstrates MCO progress in decreasing the number of unreachable members. All MCOs met the established target of the 5% decrease per month.

Table #6 – Unreachable Member Campaign DY3 Q1

	Jan-16				Feb-16				Mar-16			
	Baseline	5% Target	Reached	Percent Completed	Baseline	5% Target	Reached	Percent Completed	Baseline	5% Target	Reached	Percent Completed
BCBSNM	9,403	470	539	5.73%	8,870	444	576	6.49%	8,157	408	618	7.58%
UHC	13,273	664	1,073	8.08%	12,996	650	955	7.35%	12,346	617	900	7.29%
MHNM	25,423	1,271	1,741	6.85%	25,239	1,262	2,278	9.03%	24,239	1,212	1,420	5.86%
PHP	36,282	1,814	2,622	7.23%	48,897	2,445	3,918	8.01%	46,474	2,324	3,258	7.01%
Source: MCO monthly reporting												

The HSD-identified population of "difficult to engage" (DTE) members as described in the Annual Report, is reported by the MCOs on a weekly basis. HSD actively monitors this population because of its impact on the care coordination process. DTE members impact the care coordination process because of on-going member contact and care coordinator review enhances continuity of care and improves outcomes, by anticipating member needs rather than responding to emergencies or complaints.

Electronic Visit Verification (EVV)

In DY3 Q1 the temporary exemption for "no tech zones," as described in the previous quarter report, remained in effect until the details on all of the alternative options are finalized. The EVV vendor is completing work that will allow data to be stored for 10 days so that caregivers in rural areas will be able to use the system and the information will upload when the caregiver is within cell phone range. This feature will solve the issue of "no tech zones" so that exemptions for this reason will be avoided. Additionally, HSD and the MCOs are exploring a partnership with Verizon to provide an alternative to the use of members' landline phones by including the option of tablets for the caregivers to use the EVV application. The EVV vendor is also completing work on other enhancements to the system as requested by providers, including interfaces that will allow disparate systems to share information.

Payment Reform Project

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

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

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

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

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

Behavioral Health

Strategic Planning

HSD facilitated deliberations within three behavioral health strategic planning workgroups to lay the foundation for a detailed set of actions that have been prescribed for the following 18 months. Each workgroup met on three occasions between September and December 2015 to create specific action plans relative to each goal and objective:

Finance Workgroup:

- Enhance the financial strength of the current provider network;
- Move toward a value-based purchasing system that supports integrated care; and
- Create ways for state and local governments to collaborate around fiscal issues that lead to better local systems of care.

Regulations Workgroup:

- Identify and recommend how to remedy the complex and sometimes contradictory behavioral health (BH)-related regulations and policies;
- Increase the ability of providers to engage with consumers more quickly and effectively; and
- Integrate the paraprofessional workforce into the system more broadly.

Workforce Workgroup:

- Create easier entry into BH professions;
- Support the multi-disciplinary nature of providing integrated holistically oriented care; and
- Promote a future of excellence in the workforce.

The implementation plans of each workgroup were submitted to the BH Collaborative at the January 2016 meeting for review and will be presented for formal adoption at the April 14, 2016 meeting. The Implementation Team has been meeting weekly to identify appropriate steps and timeframes for all the activities under the Goals and Objectives, and identifying individuals or groups are to assume relevant tasks. A progress report will be presented at each quarterly meeting of the BH Collaborative through the 18-month implementation period. An evaluation of the Plan will be completed at the conclusion of its implementation.

CareLink NM: Health Homes

This system innovation is intended to enhance integration and coordination of primary, acute, behavioral health, and long-term care services and supports for persons with chronic conditions across the lifespan. CareLink NM Health Homes involve a multi-disciplinary team that partner with enrolled members to develop and implement a service plan designed to meet all of the person's behavioral, social, and health needs. This is a patient-centered approach within which care coordination will occur at the community level for both Centennial Care enrollees and fee-for-service (FFS). The state plan amendment for this program received CMS approval and the initial roll-out of CareLink NM occurred April 1, 2016 in San Juan County under the auspices of Presbyterian Medical Services (PMS) and in Curry County by Mental Health Resources (MHR). Following this implementation, and based on lessons learned, HSD will consider additional sites in other areas of New Mexico, as well as, expansion of qualifying conditions to include Substance Use Disorders.

Behavioral Health Investment Zones (BHIZ)

HSD received a $1 million allocation in FY16 for the establishment of BH Investment Zones. The two counties, Rio Arriba and McKinley, were identified as the two counties in New Mexico with the highest levels of combined incidence of mortality related to alcohol use, drug overdose and suicide. HSD established an application process for these two counties to be designated as BH Investment Zones which qualifies each of them for $500,000 to implement a plan that will best address the needs in these priority zones. Both counties have completed and submitted their respective applications which have been approved.

Rio Arriba County has established a coalition know as Opioid Use Reductions (OUR) as the BHIZ collaboration structure. The partners include: the lead agency, Rio Arriba County Health and Human Service Department, El Centro Family Health, Presbyterian Medical Services, Hoy Recovery Program, Espanola Presbyterian Hospital, Rio Arriba County Detention Center, La Clinica del Pueblo de Rio Arriba, Espanola Public Health Office, Espanola Valley School District, Agave Health, Las Cumbres Community Service, Inside Out, Valle del Sol of New Mexico, Santa Fe Mountain Center, North Central Community Based Services, Honor of Our Pueblo Existence, Rio Arriba County Substance Treatment, Outreach and Prevention Program, and Rio Arriba Youth Service Providers.

McKinley County has developed a BHIZ oversight board that includes the City of Gallup as the Local Lead Agency, and the following authorities: McKinley County, Northwest New Mexico Council of Governments, Navajo Nation, and Zuni Pueblo. The Implementation Team includes Rehoboth McKinley Christian Health Care Services, the Northwest New Mexico Council of Governments, Navajo Nation, Pueblo of Zuni, Na'nízhoozhí Center, Inc., Western New Mexico University, Health Alliance, Gallup Police Department, Gallup Fire and Rescue, and Gallup Share & Care Coalition.

Applied Behavior Analysis (ABA)

On May 1, 2015, ABA went into effect providing an array of services for Centennial Care members identified with Autism Spectrum Disorder (ASD).The new regulation expanded the age limit for services from under the age of 5 to under the age of 21.

Last year, the service launched with only one Stage 1 provider and six Stage 2 and Stage 3 agencies available to serve Centennial Care members. In one year, the number of providers increased to five agencies Stage 1 providers and nine Stage 2 and Stage 3 agencies.

An Autism Workgroup was formed with representation from State agencies and all four MCOs. The workgroup developed Level of Care (LOC) Guidelines and Prior Authorizations forms, all utilized by the four MCOs. The work resulted in minimal provider administrative burden and continuity of information in the ABA provider community.

PAX Good Behavior Game

The PAX Good Behavior Game (PAX GBG) has been found to reduce disruptive behaviors, hyperactivity, and emotional symptoms. Its long term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, and initiation of sexual activity with increases in high school graduation rates and college attendance. The most recent cost benefit analysis on the PAX GBG conducted by the Washington State Institute for Public Policy has shown that the program returns $57.53 for every $1 invested.

The plan is by June 2016, PAX GBG will be implemented into 219 elementary grade classrooms, impacting about nearly 5000 children. In January 2016, the PAXIS Institute provided the first two-day training for 35 first grade teachers and administrators in Farmington.

Future trainings with Santa Fe Public Schools, Espanola Public Schools, and Bloomfield Public Schools are planned for spring 2016.

Crisis Triage and Stabilization Centers

Established by House Bill 212, a Crisis Triage and Stabilization Center is a health facility that is licensed by the Department of Health (DOH), is not physically part of an inpatient hospital or included in a hospital's license; and provides stabilization of behavioral health crises, including short-term residential stabilization. The enabling legislation calls for HSD to establish a reimbursement structure for this new Level of Care (LOC) and provided $1.75 million towards their implementation. This is an LOC that has been missing in New Mexico's BH service system and was recommended for establishment by the House Joint Memorial 17 Task Force.

HSD and DOH are drafting rules both for facility licensing and program reimbursement. The draft rules will allow a community to choose a variety of models of crisis triage and stabilization, including solely outpatient or ambulatory, residential with and without detox services, not to exceed medically monitored detox (ASAM level 3.7). The facilities will be licensed by DOH, and the Program will be certified by HSD. While the initial phase of such centers will focus on adults, CYFD is continuing to investigate mechanisms that would allow for similar services for youth. Avenues allowing for prospective payment mechanisms, possibly through the new Certified Community Behavioral Health Clinics (CCBHC), are also being researched to identify other states that have used this form of payment mechanisms.

Certified Community Behavioral Health Clinics (CCBHC)

The Substance Abuse and Mental Health Services Division (SAMHSA) selected New Mexico as one of twenty states as a recipient of the planning grant funds to establish CCBHCs. CCBHCs represent an opportunity for New Mexico to improve behavioral health services by providing community-based behavior health treatment, advancing to the next stage of integration with physical health care, utilizing evidence-based practices, and providing improved access to high quality services.

A CCBHC Implementation Team has completed Readiness Assessments with six of the prospective CCBHC sites. The team will continue working closely with these sites to develop clinic-specific prospective payment system rates based on their cost reports, provide training on a range of related topics, and provide guidance on improving clinic readiness.

The Request for Certification is in process and incorporates the standards outlined in several federal documents. Standards are being cross-referenced to Readiness Assessment items to assure comprehensiveness and to facilitate the certification decision-making process.

UNM serves as the evaluator of this grant, and has taken the lead on gathering readiness assessment data, designing a statewide needs and gaps analysis, and ensuring timeline data entry into the SAMSHA TRAC database on a quarterly basis.

Network of Care (NOC)

The Network of Care (NOC) is now the official website for the Behavioral Health Collaborative. The intent is for this website to be the one-stop-shop for behavioral health in New Mexico. Key features of the NOC include a behavioral health learning center, designed to educate, inform, and provide access to relevant behavioral health information; a user-friendly client interface that enables NOC partners to easily display local content throughout the site; an advanced Social Networking platform which is designed to promote collaboration and coordination across diverse groups; and a HIPAA- and HL7-compliant, Personal Health Record which stores valuable medical and legal information and documents. This portal can be accessed at: http://www.newmexico.networkofcare.org/mh/

Other available portal domains include: Seniors and People with Disabilities, Children and Families, Developmental Disabilities, Domestic Violence, Public Health, Prisoner Re-entry and Corrections, and lastly, Foster Care.

Prevention "Partnership for Success" (PFS) Grant

HSD's Office of Substance Abuse Prevention (OSAP) has been awarded this SAMHSA grant of $1.68 annually for five years ($8 million total) to address underage drinking and youth prescription drug abuse. The counties receiving funding through the new grant are Chaves,

Cibola, Curry, and Roosevelt. These counties were selected using a data-driven analysis of risk factors and need, including youth use of alcohol and prescription drugs. Each county's coalition is undergoing a rigorous needs assessment, capacity building, and planning process to ensure that prevention strategies implemented through the new grant are successful in reducing underage drinking and prescription drug misuse in their respective communities.

The new sub-grantees attended an OSAP Recipient Meeting and New Grantee Orientation Meeting in Albuquerque in February where they received information on substance abuse epidemiological data, community level data collection, New Mexico ATODA Prevention Workforce Trainings, the Strategic Prevention Framework process, training on Synar tobacco prevention activities, and PFS 2015 grant requirements, timelines, and expectations. Technical assistance visits for the new counties were conducted in February and a Coalition Development Training was held in March. A Coalition Development Training and a Needs Assessment Training are scheduled for spring of 2016.

National Strategy for Suicide Prevention (NSSP)

National Strategy for Suicide Prevention (NSSP) is a $1.47 million, three-year SAMHSA grant to be implemented in Bernalillo, Otero and Curry counties as pilot sites. Each site has completed the first of the standardized screening and safety planning trainings. The target audience was behavioral health providers in these selected counties and surrounding counties.

Currently, HSD and UNM are creating training modules for primary care and emergency departments. Training modules include a 60-90 minute presentation for physicians, nurse practitioners, physician assistants, nurses; and may also be of interest to pharmacists, and administrative and clerical personnel. The primary care provider module covers information about suicidality among patients in healthcare, development of office policies and protocols, patient education, and intervention including screening and safety planning. The emergency department module covers information about suicidality among patients presenting to emergency departments, primary and secondary screening tools, suicide risk assessment, management of the suicidal patient, and discusses SAMHSA's Suicide Assessment Five-step Evaluation and Triage (SAFE-T) Guide. After the modules are complete, a follow-up survey will be conducted to determine if methods were implemented, and if policies and procedures were changed as a result of the trainings.

Dose of Reality Campaign

This research-based statewide campaign has been launched statewide by HSD's OSAP to raise awareness and to educate teens and their parents about the serious risks for addiction and overdose from prescription painkiller abuse. To date, 64 million Dose of Reality ad impressions have been viewed across TV, internet, digital boards, billboards, news print, and movie theater ads. Two websites provide the media materials free for public use: http://www.nmprevention.org/Dose-of-Reality/Home.html and http://doseofrealitynm.com.

Included are education materials, a parent resource kit, fact sheets, and recent state and national epidemiological data. The campaign has provided 399,000 prescription bags with prevention messages to 130 pharmacies statewide.

In addition, a new media campaign was developed to increase awareness of naloxone, a medication used to reverse the effects of an opioid overdose. The campaign began in September 2015 with 353,189 ad impressions viewed across newsprint and 3,090,800 impressions heard over radio through mid-January 2016. An additional 6,826,030 impressions were released, to include billboard advertisements. Radio, billboards, news print, and pharmacy bags ads will continue through September 2016. In March, the naloxone strip print ad (stating "Reverse the deadly effects of a prescription painkiller overdose" in mirror image, followed by "Ask your pharmacist about naloxone") won the American Ad Federation New Mexico Advertising Award for Great Idea.

Information about prescription opioids, signs of an overdose, and patient education videos can be accessed at: http://doseofrealitynm.com/2015/08/31/more-info-about-naloxone/. Media materials are available for download on the website.

FY16 Withdrawn Initiatives due to State Budget Crisis

- Prescription drug collection boxes which would have provided a monitored source of disposal for many unused and improperly stored prescription opiates often sitting in home medicine cabinets;
- Prescription drug incinerators would have provided local communities and law enforcement agencies with a means to collect prescription painkillers and dispose of them without problems associated with bio contamination, theft, transportation and transfer;
- Mobile Crisis Response Teams, that were planned for McKinley and Rio Arriba Counties, would have diverted those in BH crisis from psychiatric hospitalization, would have linked suicidal individuals discharged from the emergency department and hospitals to community-based services; and would have also provided diversion from arrest and subsequent jailing;
- New Mexico Supported Employment BH Center of Excellence would have built a supported employment service capacity in New Mexico using an evidence-based best practice;
- New Mexico Peer Empowerment Center would have been peer managed and operated to serve the recovery needs of youth, family, and peers whether veterans, first responders, law enforcement, corrections, or emergency room staff who require recovery supports for PTSD and other related conditions;

- Behavioral Health Planning Council (BPHC) was slated to receive additional funding to develop and implement an orientation and mentorship program that would have included an orientation manual for new members; and a small portion of this additional funding was to be used to support the designated BHPC members who review and analyze the Block Grant Application and other reports;
- Local Collaborative Alliance (LCA) was also slated for additional funding to match its resource development achievements to support capacity-building and infrastructure development; and
- Mesilla Valley Hospital Addiction Recovery Center would have supported the expansion of services to include partial hospitalization, residential, and intensive outpatient treatment.

Fiscal Issues

LTSS Rates

HSD in conjunction with the HSD's actuary continued to review the Long Term Services and Supports (LTSS) program in preparation of developing final rates, retroactive to January 1, 2016. HSD worked with the MCOs during the first quarter to further improve the financial data of the LTSS program. HSD anticipates submitting the LTSS rate certification packet for CMS review in June 2016.

Cost Containment

State revenue forecasts and legislation from the 2016 New Mexico legislative session have directed HSD to begin cost containment measures for the Medicaid and CHIP programs. In March, HSD convened a subcommittee of the Medicaid Advisory Committee that was charged with the task of providing recommendations for reductions to provider payments. The subcommittee voted on a final set of recommendations that were formally submitted to HSD in April 2016. Changes to provider rates for cost containment are targeted for July 1, 2016. HSD anticipates submitting the associated rate certification packet for CMS review in June 2016.

Myers and Stauffer Audit Findings

HSD reviewed the Myers and Stauffer audit findings for inpatient paid and denied hospital claims (including claims adjudication, prior authorization and provider credentialing). HSD responded to selected Myers and Stauffer recommendations that related to HSD policy and procedures by drafting new contract language and revisions to the New Mexico Administrative Code (NMAC). These changes are expected to be finalized in DY3 Q2. In addition, HSD evaluated Myers and Stauffer findings related to MCO processes and forwarded those findings to the MCOs for their review and action. MCO comments and action plans will be reported in the next quarter.

Delivery System Improvement Fund

As stated in the WY2 report, HSD evaluated the MCO results for the 2015 Delivery System Improvement Fund (DSIF) targets. The four target areas were:

1. Increase the use of Community Health Workers (CHWs) 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.
2. A 15% increase in telemedicine "office" visits with specialist, including BH providers, for members in rural and frontier areas. At least 5% of the increase must be visits with BH providers.
3. A 5% increase in the number of members being served by Patient-Centered Medical Homes (PCMH) or maintain a minimum of 40%.
4. A 10% reduction in the per capita use of non-emergent emergency room use.

All targets were met with the exception of the emergency room diversion target that 2 MCOs did not meet.

Systems Issues

HSD has identified that the submission of the Nursing Facility Level of Care (NF LOC) and Setting of Care (SOC) is impacting the cohort designation and capitation for members. Through ongoing auditing and analysis, any discrepancies have been identified and corrected. HSD conducted training with the MCOs to address these concerns and any questions. HSD will conduct a session in the upcoming months to follow up on the training that was conducted and to address any new issues. HSD continues to implement reporting to monitor any discrepancies that may arise.

Reconciliation Projects

HSD has implemented quarterly reconciliations for retro Medicare and date of death adjustments.

Medicaid Management Information System (MMIS) Replacement

HSD began its planning for replacement of its current legacy MMIS some time ago, and activity for this effort intensified in the quarter. The RFP for an Independent Verification and Validation (IVV) vendor was released, a finalist has been selected, and the contract is at CMS for review and approval. Information on the upcoming RFP for a Platform/System Integrator and the proposed modular framework of the new MMIS was shared with all stakeholders, including the MCOs, provider associations and the Medicaid Advisory Committee. This draft request for proposal (RFP) will be submitted to CMS in DY3 Q2 for review.

HSD has reviewed the new CMS certification and modularity guidance and has taken steps to ensure that it is in compliance. When the Platform Integrator is sent to the CMS Regional Office it will have a crosswalk to show that all aspects of the CMS guidance have been addressed. HSD has begun work on drafting of the Enterprise Data Services RFP, the next module. Tribal and stakeholder discussions are underway.

HSD is working with its two prime vendors on matters related to the replacement system. An amendment with Xerox addressing conversion matters is about to be executed, and with Deloitte, our integrated eligibility system vendor. In 2017, we will have the ASPEN system assume responsibility for managed care enrollment of members.

An Implementation Advance Planning Document Update (IAPDU) was submitted to the CMS Regional Office in March 2016, and an updated planning document will be submitted to the CMS Regional Office in August 2016 for federal fiscal year 2017. The New Mexico legislature fully funded the Department's request for the project in its final SFY17 budget.

Pertinent Legislation or Litigation

The following legislation, pertinent to the demonstration, was passed during the 2016 legislative session and signed into law.

House Bill 61 Accounts for Persons with Disabilities Act

House Bill 61 (HB 61) Accounts for Persons with Disabilities Act is new legislation that allows for individual tax-free savings accounts for a designated beneficiary, pursuant to Section 529A of the Internal Revenue Code of 1986, as amended. For beneficiaries of federal means-tested programs, these provisions apply to Supplemental Security Income under Title 16 of the Social Security Act. Any amount in an account in excess of $100,000 is considered an excess resource of the designated beneficiary. HSD shall not terminate benefits, but suspend benefits by reason of excess resources attributable to an amount in the account. The office of the New Mexico State Treasurer shall maintain and monitor the program, pursuant to 26 U.S.C Section 529A.

House Bill 277 Administration of Opioid Antagonists

House Bill 277 (HB 277) Administration of Opioid Antagonists gives authority to possess, store, distribute, dispense, prescribe and administer opioid antagonists. Emergency treatment of an opioid-related drug overdose is readily available to at-risk individuals. Licensed prescribers are allowed to prescribe, dispense, or distribute an opioid antagonist to the individual who is at risk of overdose or to a person in a position to assist an individual who is experiencing an opioid-related drug overdose. Family members, friends or other persons who can now carry opioid antagonists are often the first persons to be at the scene of an overdose emergency, when timely treatment is critical. An individual who possesses, administers, dispenses, or distributes an opioid antagonist to another individual pursuant to this section shall not be subject to civil liability, criminal prosecution, or professional disciplinary action as a result of the possession, administration, distribution or dispensing of the opioid antagonist; provided that actions are taken with reasonable care and without willful, wanton or reckless behavior.

Senate Bill 234 Health Provider Credentialing by Insurers

Senate Bill 234 (SB 234) amends the New Mexico Insurance Code related to health plan requirements. The amendment refines requirements for credentialing of health care providers by health insurers; making requirements applicable to out-of-state providers; ensuring that all eligible providers receive prompt payment for clean claims and interest on unpaid claims. New definitions were added, including one for "applicant", which is a physician or other individual licensed or otherwise authorized to furnish health care services in New Mexico or another state, who is applying to be credentialed by the health plan in order to be in the health plan's provider network, and who meets the criteria for payment while awaiting a credentialing decision. In addition, the bill will amend the Health Insurance Contracts to require the Superintendent of the Office of Insurance to promulgate rules to allow for provisional credentialing for a period of one year providing the applicant meets specifications which are detailed in the bill. *Note: There is no particular administrative impact to HSD; the performance implication would be if providers are required to first enroll with Medicaid and MCOs could not proceed with credentialing until that process is complete.*

Section VII: Home and Community Based Services (HCBS)

New Mexico Independent Consumer Support System (NMICSS)

The NMICSS continues to recruit and establish a system of organizations that provides standardized information to beneficiaries about Centennial Care, LTSS, the MCO grievance and appeals process, and the fair hearing process.

The NMICSS reporting for the quarter is provided by the Aging and Long-Term Services Department (ALTSD) ADRC. ADRC coordinators provide over the phone counseling in care coordination to resolve issues. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions.

The numbers below reflect calls made to the ADRC hotline from January 1, 2016 to March 31, 2016.

Table #7 – ADRC Call Profiler Report

Topic	# of Calls
Home and Community-Based Care Waiver Programs	2,704
Long Term Care/Case Management	166
Medicaid Appeals/Complaints	18
Personal Care	108
State Medicaid Managed Care Enrollment Programs	111
Medicaid Information/Counseling	1,802

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from January 1, 2016 to March 31, 2016.

Table #8 – ADRC Care Transition Program Report

Counseling Services	# of hours	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		196	
Medicaid Education/Outreach	1,979		
*Medicaid Options/Enrollment	189		
**Pre/Post Transition Follow-up Contact			2,293
***LTSS Short-Term Assistance			115

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

****80% of the contacts are pre-transition contacts and the remaining 20% are post transition contacts. These numbers are resident specific and situation dependent.**

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

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

The CTB staff continues to work directly with the MCOs when facing challenges with member transitions.

Critical Incidents

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

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

During DY3 Q1, a total of 4,504 CIs were filed. A review of all deaths submitted through the HSD CI web portal is conducted. HSD clinical staff reviews and consults on mortality cases, quality of care and complex cases.

Table #9 – DY3 Q1 Critical Incidents

Critical Incident Types by Population Group						
Critical Incident Types	**Centennial Care Members**		**Behavioral Health Members**		**Self-Directed Members**	
	#	**%**	**#**	**%**	**#**	**%**
Abuse	324	7%	116	19%	18	9%
Death	{450}		{39}		{21}	
Natural/Expected	408	9%	36	6%	21	10%
Unexpected	41	1%	3	0%	0	0%
Homicide	0	0%	0	0%	0	0%
Suicide	1	0%	0	0%	0	0%
Emergency Services	2921	65%	367	60%	141	67%
Environmental Hazard	66	1%	5	1%	0	0%
Exploitation	121	3%	10	2%	8	4%
Law Enforcement	123	3%	26	4%	9	4%
Missing/Elopment	30	1%	10	2%	0	0%
Neglect	469	10%	39	6%	13	6%
Total	**4504**		**612**		**210**	

HCBS Reporting
In February 2016, HSD submitted the updated State-Wide Transition Plan (STP) to CMS for review and feedback. The STP addresses more stringent CMS guidelines for HCBS residential and non-residential settings.

Community Benefit
HSD revised the Community Benefits (agency-based and self-directed) sections of the Centennial Care Policy Manual effective March 1, 2016. HSD requested and received public comment from advocates, providers and the MCOs. Many of the recommendations were incorporated into the final version of the updated policy manual.

The Centennial Care Long-Term Care (LTC) Workgroup began meeting in December 2015. The workgroup includes members of HSD and each MCO and focuses on improvements to long-term services and supports. The LTC workgroup developed a brochure for Community Benefits that explains the program and available services. The Community Benefits brochure was finalized and implemented in May 2016. The workgroup also developed a questionnaire, which will become part of the Comprehensive Needs Assessment (CNA) and is scheduled to be piloted by the MCOs in June 2016. The intent of the questionnaire is to ensure the care coordination processes adequately and accurately explains available community benefits to members and captures member's choice in receiving or declining these services.

HSD began regular meetings with its sister agency, ALTSD to discuss Centennial Care issues related to our aging Medicaid members including Community Benefits allocations and reintegration of members back into the community from nursing facilities. These meetings will continue to occur monthly.

In March 2016, HSD provided several Community Benefits trainings to the MCOs.

- March 10 and March 21 – Community Benefits services training provided to care coordinators to ensure all Community Benefits services are being offered to members eligible for LTSS.
- March 18 – Transmission of NF LOC and SOC training provided to MCO systems and clinical teams to ensure timely submission via the State interfaces.

Section VIII: AI/AN Reporting

Access to Care

I/T/Us are concentrated near or on Tribal land where many Native Americans live and receive services. Native Americans in Centennial Care may access services at Indian Health Service (IHS) and Tribal 638 clinics at any time. The data from the four Centennial Care MCOs shows that there is a 97.8% access to care for Native Americans in frontier areas for physical health and a 98.1% access to care for Native Americans for behavioral health services when I/T/Us are included in the provider group.

United Healthcare opened a community resource center in Shiprock to focus on addressing social determinants of health. The resource center offers the following: job training to include technology and health literacy education; community resource identification and assistance, to include SNAP, LIHEAP, LITAP, Housing, Job Search, Disease Management, and Transportation; coordination with local health care providers, inclusive of IHS to provide Virtual Visits when clinics are closed or local providers are not open for business (in effort to reduce avoidable ED visits); "Cyber Café" for the general public to use at no cost (printing and scanning also available); provision of local hub for United Healthcare members to meet with their care coordinator and other staff to assist with questions, health risk assessments, addressing gaps in care, a resource coordination inclusive of transportation and mileage reimbursement processing; fresh food days once per week for all members of the public, regardless of Medicaid or United membership; and family festivals once per quarter or more, open to the public, regardless of Medicaid or United membership.

Contracting Between MCOs and I/T/U Providers

The MCOs continue to reach out to IHS and Tribal 638 health providers, as well as Tribal programs to develop agreements (which I/T/Us prefer to use in place of the term contracts). Even though very few IHS and Tribal 638 providers have agreements with the MCOs, the MCOs consider them to be contracted and adjudicate claims as if they were participating providers.

There was a change in a statewide durable medical equipment (DME) contractor for two of the MCOs recently. Negotiations took place between the DME contractor and Tribal programs offering these services so that they would remain "in network". For this reporting period transportation, translation, optometry/vision services, and DME continue to be areas the MCOs have agreements with Tribal programs.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements of clean claims being processed and paid within 30 days of receipt.

Table #10 – Issues Identified and Recommendations Made by the Native American Advisory Board (NAAB) and the Native American Technical Advisory Committee (NATAC)

MCO	Date of Board Meeting	Issues/Recommendations
BCBSNM	New Life Homes/Sundowner Albuquerque March 11, 2016	BCBSNM provided an overview of their Blue Cross Community Centennial program, discussed recommendations from previous meetings, talked about diabetes education, and invited member feedback and input. About 10 people were present.
MHP	First Nations Clinic Albuquerque March 4, 2016	Molina had about 18 members attend their NAAB meeting. Molina provided information about care coordination, the traditional healing benefit, Value Added Services, Centennial Rewards, their health education programs, telehealth, and addressed comments/questions from the group.
PHP	The COOP Auditorium Albuquerque March 19, 2016	PHP presented on their Native American Affairs program, care coordination, video visits, PresRN program, and answered questions. About 12 people attended the meeting.
UHC	Shiprock Chapter House April 7, 2016	UHC provided lunch and had over 60 people at their NAAB meeting. They talked about care coordination, transportation, outreach updates, and how they can improve their services. There was time for Q&As.

The NATAC meeting for this quarter took place on March 14, 2016. The majority of the meeting was spent discussing the Medicaid budget, enrollment numbers, long term services data, and Native American FFS expenditures for CY2015. New tribal leaders were given a brief overview of the goals and purpose of the NATAC.

Representatives from the Income Support Division began attending the NATAC and will continue to attend all meetings to discuss eligibility issues.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment B: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

With the implementation of new CY16 rates for physical health and behavioral health, the PMPM analysis in Attachment A indicates no concern for those MEGs most impacted by these new rates. Demonstration year three (DY3) year–to-date MEG PMPMs appear normal. These would include MEGs 1-3 and 6. MEGs 2 and 3 will see further impact with the finalization of LTSS program rates in June 2016. In addition, MEGs 4 and 5 will see changes.

Attachment A – Budget Neutrality Monitoring for the waiver in demonstration year two has been revised with updated CMS-64 data and member months. With the refreshed data, HSD is now at 13% below the budget neutrality limit as assessed for the second year of the waiver summarized in Table 2.4. Previously, HSD had been at 14%.

HSD has corrected the reporting of disproportionate share hospital (DSH) payments and Uncompensated Care Pool payments on the CMS-64. MEG 8 now has reported Uncompensated Care Pool payments for demonstration year 2. DSH payments are now reported on the base CMS-64 report and not included in budget neutrality calculations.

Section XI: Member Month Reporting

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

Table #11 – DY3 Q1 Member Months

Centennial Care MEG Reporting	
Eligibility Group	**Member Months**
Population 1 – TANF and Related	1,118,654
Population 2 – SSI and Related – Medicaid Only	123,390
Population 3 – SSI and Related – Dual	108,316
Population 4 – 217-like Group – Medicaid Only	447
Population 5 – 217-like Group – Dual	6,839
Population 6 – VIII Group (expansion)	740,507
Population 7 – CHIP Group	151,079
Total	2,170,073

Section XII: Consumer Issues (Complaints and Grievances)

A total of 1,094 grievances were filed by Centennial Care members in DY3 Q1. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 272 (24.86%) of the total grievances received. The MCOs have identified a trend with transportation grievances and have developed process improvement plans to reduce specific trends that are occurring.

The second top grievance filed, with a total of 138 grievances (12.61%), was regarding other specialties, such as canceled appointments, dissatisfaction with service provided, and dissatisfaction with payment on services provided. The grievances within this category do not identify a specific trend.

The third top grievance filed, with a total of 126 grievances (11.51%), was regarding the Centennial Care member's primary care provider. Specific member grievances relate to dissatisfaction of service, billing discrepancies, canceled appointments, and prescriptions not being provided.

The remaining 558 (51%) of grievances filed during Q1 were reported for multiple grievance reasons, such as dental, emergency room, and vision. Similarly, DY2 Q4 and DY3 Q1 indicated slight differences in multiple grievance codes, but not enough information to provide a substantial trend. HSD will monitor these grievances to identify specific trends in DY3Q2.

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

The HSD/MAD Quality Bureau (QB) randomly reviews service plans to ensure that the MCOs use the correct tools and processes to create service plans. The review of service plans also ensures that the MCOs appropriately allocate and implement the services identified in the member's comprehensive needs assessment, and that the member's goals are identified in the care plan. There were no identified concerns in DY3 Q1,

Table #12 – DY3 Q1 Service Plan Audit

Service Plans	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	**120**			
Percent of service plans with personalized goals matching identified needs	**100%**			
Percent of service plans with hours allocated matching needs	**100%**			

Nursing Facility Level of Care (NF LOC)

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

Table #13 – DY3 Q1 NF LOC Audit

High NF denied requests (and downgraded to Low NF)	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	10			
Number of member files that met the appropriate level of care criteria	10			
Percent of MCO level of care determination accuracy	100%			

Table #14 – DY3 Q1 Community Benefit LOC Audit

Community Benefit denied requests	DY2 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	16			
Number of member files that met the appropriate level of care criteria determined by the MCO	16			
Percent of MCO level of care determination accuracy	100%			

The External Quality Review Organization (EQRO) for HSD/MAD has reviewed a random sample of MCO NF LOC determinations. All reviews by the EQRO that were in disagreement with the MCO determination were then reviewed by HSD/MAD QB. HSD/MAD QB has set up meetings with the MCOs to discuss these reviews and will update the appropriate determinations in the chart below in Q2 based on the outcome of the MCO meetings.

Table #15 – EQRO NF LOC Review

Facility Based	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
High NF Determination				
Number of member files audited	**24**			
Number of member files the EQRO agreed with the determination	**18**			
%	**75%**			
Low NF Determination				
Number of member files audited	**84**			
Number of member files the EQRO agreed with the determination	**83**			
%	**99%**			
Community Based				
Number of member files audited	**156**			
Number of member files the EQRO agreed with the determination	**155**			
%	**99%**			

Care Coordination Monitoring Activities

Evidence from the care coordination audit conducted in November 2015 indicates that training offered by HSD, BHSD and the MCOs resulted in improved quality of documentation and integration practices. However, the audit also identified the MCOs will need to continue to implement procedures in the areas of addressing potential behavioral health needs through more detailed documentation and ensuring updates to assessment, medications and progress on members goals are clearly documented as newly updated information to the records. HSD will be providing training in June to the MCO's Care Coordinators on documentation best practices and expectations in these areas.

HSD continued to work on the development of a standardized Health Risk Assessment (HRA) tool for implementation by all of the Centennial Care MCOs. The tool was finalized and the MCOs were given direction to implement in their systems by July 1, 2016.

HSD continued to evaluate the progress of the 10 super utilizers of ED services (defined as having > 4 outpatient ED visits in the past 12 months) from each MCO which were reported on in the DY2 Q4 report. Each MCO continues to submit monthly reports to HSD on care coordination efforts to engage the identified members and to work with these members on education of appropriate ED use. HSD will meet with the MCOs in May to further discuss expanding the number of members in the project to 25 per MCO, enhance monthly data reporting elements and review successes and challenges to progression with the identified members.

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process

In an effort to maximize efficiency and timeframes, HSD implemented a Technical Assistance (TA) Call process, and an HSD Directed Report Resubmission process. These processes provide a systematic approach to educate and enhance collaboration between HSD and the MCOs. This procedure creates a forum for dialogue anticipated to lead to long-term, positive outcomes regarding MCO reporting compliance.

In alignment with HSD's continuous quality improvement initiatives, HSD implemented a Self-Identified Error Resubmission form. The form is designed to allow MCOs to submit self-identified errors they find within a given report. This new process is anticipated to significantly increase the level of reporting and data accuracy achieved by the MCOs.

Customer Service

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

Appeals

A total of 1,221 appeals were filed by Centennial Care Members in Q1. Of the total appeals filed, 790 (64%) were upheld, 378 (31%) were overturned and the remainder are pending resolution. Pending appeals received late in the quarter are carried over to the following month for resolution. The majority of appeals are due to denial or limited authorization of a requested service.

Section XV: Demonstration Evaluation

Progress under the work plan continues as expected with quarter activities generally devoted to wrapping up the data analysis and drafting/revising the annual report. At the end of the first quarter of 2016, Deloitte Consulting delivered the 2014 annual report to HSD for review and comment. As noted previously, data sources for 12 measures have not been identified and were not available in time to establish Baseline for Demonstration Year 1 calculations for the Annual Report. With delivery of the annual report (pending any further adjustments), the Deloitte Consulting team has initiated planning for 2016 and assessed how lessons learned from the first year of the evaluation can be incorporated into year two to streamline and simplify the process of collecting, evaluation and reporting on available data provided by HSD. Deloitte Consulting continues to meet with HSD on a weekly checkpoint conference call to further refine the work plan and discuss data and analysis issues. These discussions are on-going.

Data Identification and Acquisition

Throughout year 1, Deloitte Consulting reviewed hundreds of reports and data files received from HSD through HSD's secure data transfer system. The team reviewed each report to identify and acquire the appropriate data elements. There were instances where the data was either insufficient for developing baseline for demonstration year 1 (DY1) comparisons for purposes of the evaluation. Where the data was insufficient, Deloitte Consulting tracked and reported those issues to HSD for further review throughout year 1. Deloitte Consulting continued to intake new or revised data well into DY3 Q1 to supplement the 2014 annual report as much as possible; however, not all measures were reported on for 2014. As previously reported, 113 of 125 measures had enough data to complete an initial evaluation, although limited in some instances. Limitations were discussed generally in the Annual Report Executive Summary and in more detail where applicable in each measure's detailed write-up.

For DY2, Deloitte Consulting will provide HSD with an updated data request that will include a summary of files that will be requested in aggregate and at the measure level. As many measures utilize the same reports, a summary of files will be the checklist to review for completeness, with the measure level detail verifying where gaps may still exist.

Baseline Measures

Deloitte Consulting has worked to develop baselines for as many measures as possible based on the available data using either pre-Centennial Care 2013 data or where HSD determined that 2013 data was not available (or appropriate); Deloitte Consulting was directed to use 2014 data as the baseline. This allowed for the development of a baseline for 113 of 125 measures for the 2014 Annual Report. Work continues to establish the baseline values for measures not previously analyzed due to lack of data or inconsistency of data. We will use data that becomes available to fill those gaps as the data permits. Where able, a procedure consistent with the development of baseline values for the analysis of Demonstration Year 1 (DY1) will be applied. That is, if possible, full year data will be utilized; otherwise the best available data will be used. In some

cases assumptions are needed to develop baseline measures applicable to Centennial Care based on the available data. Deloitte Consulting provides HSD all assumptions to review for appropriateness and reasonableness before they are incorporated into the baseline measures. Deloitte Consulting will attempt to use apply this process consistently to develop any outstanding baselines where new data is presented and document if deviations are required.

Evaluation Model

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

Annual Report

The 2014 Annual Report was developed and delivered to HSD for review and comment prior to submission to CMS. Where comments were received from HSD, Deloitte Consulting reviewed the work needed to address and verified the effort was appropriate based for the evaluation, the Annual Report and maintained the independence of Deloitte Consulting as a third party evaluator. After reviewing and discussing the comments with HSD, Deloitte Consulting worked to address as many comments as possible when deemed necessary to complete the report in a reasonable amount of time. The Annual Report contained information on the data utilized, evaluation process, as well as high level and measure specific results for DY1 compared to baseline where able.

It should be noted that some measures do not yet have a measurement period that utilizes data differently from the baseline. Therefore analysis was not completed at this time. Further, where analysis was possible and observations of changes between the baseline and DY1 were noted, detailed analysis on the drivers of the change was often unrealistic due to the transition from pre-Centennial Care to Post-Centennial Care at this time. The reason identified was that changes observed could be caused by changes in the underlying program, differences in the population or inconsistencies in the data utilized between the baseline and DY1. Due to data limitations, it was not realistic to adjust for all changes; therefore, completing an analysis to understand drivers of change and opine on the drivers was not appropriate for DY1. Where opportunities present themselves in future evaluation years, Deloitte Consulting will work to analyze drivers or adjust for differences in programs or populations to normalize data sets for consistency of comparisons which will allow for more meaningful analysis of the progress of Centennial Care against its goals.

DY3 Q2 Planned Activities

Activities for DY3 Q2 will be devoted to finalizing the Annual Report based on HSD feedback and awaiting questions from CMS. Following completion of the Annual Report, Deloitte Consulting will meet with HSD staff to discuss a data request and possible changes in data reported by MCOs to prepare for the coming year. There will be a review of DY1 to identify

what practices worked well and what could be improved upon for DY2. This will help streamline and simplify the process for completing the evaluation and developing required reports. As part of those discussions, a review of data gaps, requested data changes, project timelines, etc., will be reviewed to verify that HSD and Deloitte Consulting are operating on a consistent plan for DY2 of the evaluation.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Tables (January 1, 2016-March 31, 2016)
Attachment B: MCO Action Plans
Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment D: Centennial Care Contract Amendment #5

Section XVII: State Contacts

HSD Staff Name and Title	Phone Number	Email Address	Fax
Nancy Smith-Leslie Director HSD/Medical Assistance Division	(505)827-7704	Nancy.Smith-Leslie@state.nm.us	(505)827-3185
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Section XVIII: Additional Comments

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

Centennial Care Member Success Story 1

While conducting Heath Risk Assessments (HRAs), a care coordinator came across a family who was new to the area. The family consisted of a mother and father with two small children. The family did not have a PCP established or a pediatrician for the children. The member also stated one of the children had heart issues and that the child was not receiving appropriate healthcare. This family was living with one source of income, and seemed to be depressed due to their current living situation. The care coordinator was able to address these issues with the family by accompanying the mother to a local PCP and pediatrician to schedule appointments for her and her family. The care coordinator also connected the family with the local food distributor as well as provided a list of resources in the community. Because the care coordinator was so helpful, the family will be scheduling dental appointments as they were unaware of the coverage through Centennial Care. This is a great start for this family in improving their health. The care coordinator was grateful to be able to help this family and will be following up with them to ensure their medical needs are met as well as for any further assistance they may need.

Centennial Care Member Success Story 2

A care coordinator recently worked with a member who was in an inpatient hospice facility. After learning the member did not have any family or a support system in place, the care coordinator wanted to make sure the member knew that someone cared about them. The care coordinator would frequently visit the member in hospice and took presents to the member over the holidays from one of the local senior charitable organizations. The care coordinator also took the member outside on walks when the member had enough strength to do so. The care coordinator was with the member when the member took their last breath in hospice. It was important to the care coordinator that this member knew they were not alone.

Centennial Care Member Success Story 3

A member had steps in need of repair to the front door, and the member had already fallen down on the steps. In addition, the member had a very irregularly sized exterior door that was badly damaged with only two hinges, and the door was held together with packing tape. The member was also stuffing newspapers into the gaps to prevent the cold air from entering. The member did not qualify for an environmental modification and had no natural support to assist her. After reaching out to multiple local agencies without success, the care coordinator was able to find three community volunteers to custom build safe stairs with a platform and handrail for the member. The volunteers also customized a new door to fit the irregular size of the member's door frame and added a new screen door as well.

Centennial Care Member Success Story 4

A Centennial Care member has been incarcerated since 1993, and began working with a care coordinator in June of 2015. At the time of the member's release, the member was contacted by a care coordinator, and a CNA was completed at a halfway house in Los Lunas. The care coordinator linked the member with a PCP and behavioral health therapist whom the member sees regularly. With help from this care coordinator and a case manager at Albuquerque HealthCare for the Homeless, the member currently has his own apartment in SE Albuquerque. In addition, the member attends a support group twice a week and is currently looking into enrolling in GED courses through UNM to further his education. Care coordination has allowed the member to have more opportunities in life.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- PMPM Analysis

DY 3

Start Date: 01/01/2016

End Date: 12/31/2016

Quarter 1

Start Date:01/01/2016

End Date: 03/31/2016

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]
MMs [1]	4,727,584	4,517,149	4,861,847	4,448,382	5,020,343	1,118,654
PMPM	$ 385.80	$ 341.86	$ 400.77	$ 354.36	$ 416.32	$ 302.15
Dollars	$ 1,823,911,159	$ 1,544,223,822	$ 1,948,487,793	$ 1,576,335,459	$ 2,090,074,424	$ 338,003,189

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]
MMs [1]	508,700	497,958	513,736	494,616	518,976	123,390
PMPM	$ 1,763.90	$ 1,654.12	$ 1,842.83	$ 1,760.79	$ 1,925.21	$ 1,818.70
Dollars	$ 897,298,062	$ 823,680,001	$ 946,727,393	$ 870,916,363	$ 999,138,707	$ 224,409,117

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]
MMs [1]	373,823	428,025	380,215	434,994	386,831	108,316
PMPM	$ 1,780.77	$ 1,333.08	$ 1,857.34	$ 1,336.38	$ 1,937.21	$ 1,364.50
Dollars	$ 665,692,378	$ 570,590,871	$ 706,189,973	$ 581,316,723	$ 749,372,219	$ 147,796,884

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]
MMs [1]	5,841	2,799	5,898	2,279	5,959	447
PMPM	$ 4,936.92	$ 2,374.61	$ 5,090.46	$ 2,443.66	$ 5,248.77	$ 2,654.52
Dollars	$ 28,834,295	$ 6,646,544	$ 30,025,379	$ 5,569,098	$ 31,274,952	$ 1,186,572

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]
MMs [1]	27,935	26,895	28,413	27,057	28,907	6,839
PMPM	$ 1,776.90	$ 3,226.80	$ 1,853.31	$ 3,146.30	$ 1,933.00	$ 3,093.57
Dollars	$ 49,637,569	$ 86,784,754	$ 52,657,285	$ 85,129,331	$ 55,877,183	$ 21,156,952

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]
MMs [1]	1,632,968	1,887,728	1,788,895	2,743,654	1,800,808	740,507
PMPM	$ 577.87	$ 541.53	$ 607.34	$ 544.10	$ 638.31	$ 501.92
Dollars	$ 943,638,928	$ 1,022,265,951	$ 1,086,464,733	$ 1,492,826,112	$ 1,149,478,718	$ 371,675,970

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]
Total Allotment	$ 68,889,323	$ 68,889,322	$ 68,889,323	$ 36,005,978	$ 68,889,323	

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]
Total Allotment	$ -	$ -	$ 2,824,462	$ 2,824,462	$ 5,764,727	

Notes:

1.) Actual member months for Demonstration Year 3 include the reported member months for this Centennial Care Quarterly Report, Section XI and updated member months for prior quarters in Demonstration Year 2.

2.) Expenditures as reported on the CMS-64 Schedule C, FFY16 Quarter 2.

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	4,448,382	$ 1,782,782,882	70.66%	$ 1,259,714,384	$ 1,576,335,459	$ 1,123,525,400
MEG02 - SSI & Related - Medicaid Only	$ 1,842.83	494,616	$ 911,493,203	70.66%	$ 644,061,097	$ 870,916,363	$ 610,600,863
MEG03 - SSI & Related - Dual Eligible	$ 1,857.34	434,994	$ 807,931,756	70.66%	$ 570,884,579	$ 581,316,723	$ 405,987,353
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	70.66%	$ 48,677,196	$ 36,005,978	$ 25,207,785
MEG09 HQII	NA	NA	$ 2,824,462	70.66%	$ 1,995,765	$ 2,824,462	$ 1,987,574
Grand Total			**$ 3,573,921,626**		**$ 2,525,333,021**	**$ 3,067,398,985**	**$ 2,167,308,975**

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	2,279	$ 11,601,158	69.84%	$ 8,102,249	$ 5,569,098	$ 3,889,880
MEG 05 - "217 Like" Dual Eligible	$ 1,853.31	27,057	$ 50,145,009	69.84%	$ 35,021,274	$ 85,129,331	$ 59,452,728
Grand Total			**$ 61,746,167**		**$ 43,123,523**	**$ 90,698,429**	**$ 63,342,608**

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	2,743,654	$ 1,666,330,820	100.00%	$ 1,666,330,820	$ 1,492,826,112	$ 1,492,826,112
Grand Total			**$ 1,666,330,820**		**$ 1,666,330,820**	**$ 1,492,826,112**	**$ 1,492,826,112**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,525,333,021**
Federal Share (Title XIX) Actual Reported	$ 2,167,308,975
Excess Spending - Test 1	$ 20,219,085
Excess Spending - Test 2	$ -
Total Actuals	$ 2,187,528,060
Difference (Actuals - Limit)	$ (337,804,961)
Percentage Difference	-13%

Notes:

1.) Member months as of May 12, 2016.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY16 Quarter 2 submission.

2.) Expenditures as reported on the CMS-64 Schedule C, FFY16 Quarter 2.

Q1DY3 ATTACHMENT B: MCO Action Plans

Quarter 2 DY1

UHC

Q2DY1		
Action Plan #1	Implementation Date	Completion Date
Vision Care Recruitment	5/8/2014	Closed 12/31/15

Description
This plan was created to alleviate service provider gaps caused by loss of Walmart Vision Centers. Grant County is the primary focus with at least one of three providers verbally committed to a contract.

Status
12/16/2014 – There are 1,263 members who were impacted by the loss of Walmart Vision. March Vision has since contracted with Dr. Jason Bracher. March Vision is working to recruit additional providers. 4/15/2015 – Walmart has lifted the moratorium and March Vision is working to add these providers back into the network. March Vision recently recruited an additional hardware provider, Tru Vision. UHC is targeting a closure date of 6/30/2015, or sooner, once Walmart is back in-network. 7/2/2015 – Walmart is still awaiting an updated NM Medicaid ID. Upon receipt, Walmart will be back in-network for New Mexico areas. Additional IHS providers are also being recruited. 9/28/2015 – UHC continues to work with March Vision on options. Walmart is contracted, still awaiting Medicaid IDs. Upon receipt of Medicaid IDs, network will be restored and action plan closed out.

Quarter 3 DY1

UHC

Q3DY1		
Action Plan #1	Implementation Date	Completion Date
Regulatory Reports	9/30/2014	Closed 2/2/16

Description
UHC was non-compliant with timely submission of contractual reports. UHC was also non- compliant with the submission of accurate data on contractual reports.

Status
UHC has implemented a new quality review process that will oversee the timely submission of reports and the data quality of the contractual reports. Reports are to be available to the quality review team at least five business days prior to the HSD's submission deadline. If the quality review identifies issues with the report data that puts the timely submission in jeopardy than a report extension will be submitted to HSD. If the report is not submitted to the quality review team five business days before submission deadline, then a report extension will be submitted to HSD.

This will ensure to the best of UHCs knowledge timely and accurate contractual reports.

UHC states that November 2014 monthly reports were submitted timely to HSD on 12/15/2014, and that its process is working appropriately. 7/7/2015 - UHC continues to review and improve its reporting process through the continuous monitoring of the reporting data and streamlining the process for all of the reports due to HSD. 9/28/2015 – On 9/24/2015 UHC submitted an action plan closure request to HSD. UHC has made great progress with 2015 data. UHC, to this point, has had no rejected reports and has only had one report that was untimely which was due to a local server issue. 1/6/16 – UHC is monitoring its progress utilizing its internal corrective action plan process. 2/2/16 – This internal action plan has been closed.

Quarter 4 DY1

BCBSNM

Q4DY1		
Action Plan #1	Implementation Date	Completion Date
Logisticare/Transportation	12/16/2014	Closed 2/5/16

Description
Large volume of LogistiCare complaints regarding no shows and missed appointments.

Status
Since concern was raised by HSD, BCBSNM held two meetings to discuss the no show concern with Logisticare. BCBSNM and Logisticare developed a spreadsheet that included the 39 reported no shows from the January and February 2015 reports. The spreadsheet details the name of the provider, a or b leg of the trip, missed appointment, rescheduled appointment, valid no show, valid late and comments.

BCBSNM updates HSD regarding progress on a bi-weekly basis. The MCO continues to meet with Logisticare to discuss late and no show transportation services. The MCO continues to populate the tracking spreadsheet and track services by region and providers contracted with Logisticare.

10/06/15 – There has been a noticeable decrease of the number of overall transportation grievances reported. This includes a decrease of the number of late arrivals and the number of no shows. August reports reflect a total of 33 transportation grievances, which is a decrease from June and July. There were 15 reported late arrivals and 9 reported no shows. BCBSNM continues to work collaboratively with LogistiCare's regional manager who is continuing to provide training and re-training to all transportation providers. LogistiCare's regional manager is also putting together resource cards which will help drivers know what to do if there is an accident; they are running late; or, they cannot locate the member.

1/4/16 – Beginning September 2015, BCBSNM along with other MCO's collaboratively created a Workgroup who met and prepared a Project Plan, that outlined implementation and improvements related to transportation issues and standardizing reporting and tracking. The Workgroup agreed upon definitions of complaints, grievances and sentinel events. The Workgroup also discussed and agreed on how to improve the delivery of information on Report #37 that included weighing and categorizing transportation related grievances by severity. In addition, BCBSNM noticed a continued decrease of the number of late and no show grievances in the last three months of 2015.

BCBSNM will continue to work with LogistiCare to reduce the number of overall grievances related to transportation.

04/04/16 - The standardized reporting and tracking that was created from the MCO Workgroup that now includes weighing and categorizing by severity, was approved by HSD on 02/05/16. As a result, each Report #37 beginning in February 2016, will now reflect the weighing and categorization by severity for each transportation grievance reported. BCBSNM Delegation Oversight Coordinator will however continue to review the number of transportation grievances and work with LogistiCare on any trends identified.

Quarter 1 DY2

PHP

Q1DY2		
Action Plan #1	Implementation Date	Completion Date
Magellan Behavioral Health	12/12/2014	In Progress

Description
A Quality Improvement Plan was put into place to ensure contractual compliance.

Status
A detailed Quality Improvement Plan was provided to HSD on 12/12/2014. All remediation actions are substantially complete. Weekly operational meetings occur between PHP and Magellan leadership to review QIP activities. Bi-weekly executive meetings occur between PHP and Magellan to discuss performance and progress. A re-audit is in process to evaluate the success of interventions. July 2015 – The re-audit identified opportunities for process improvement related to care coordination event management. A process improvement specialist completed an end-to-end review and interventions/process changes are being implemented. The process improvement activities are to be completed by 7/31/2015. Another re-audit will occur in October to evaluate effectiveness of these interventions.

Magellan has hired a clinical auditor who will be responsible for conducting care coordination audits and monitoring compliance. New operational reports have been developed and implemented. Compliance against care coordination requirements are monitored through weekly reporting. Care coordination supervision policies and procedures have been revised to support compliance concerns identified in the CAP. The Magellan General Manager position has been replaced with a Chief Operating Officer. One of the job requirements for this new position is clinical operations experience. PHP Compliance has hired an audit manager who will be responsible for conducting independent care coordination audits including those done by Magellan care coordinators.

Quarter 3 DY2

BCBSNM

Q3DY2		
Action Plan #1	Implementation Date	Completion Date
Davis Vision	8/25/2105	Closed 3/23/16

Description
Davis Vision was requesting Davis Vision providers to submit their "Acceptance Letter" when re-credentialing. This was because Davis Vision needed proof from each provider that they were enrolled as a Medicaid provider.

Status
10/06/2015 – Since a concern was raised by HSD that Davis Vision providers were being asked to submit their Medicaid "Acceptance Letters." BCBSNM chose to implement a self-imposed action plan. It was discovered that Davis Vision was not receiving a "Provider Master File," which reflects all of the providers that are enrolled as Medicaid providers. As a result, BCBSNM implemented a process where a Provider Master File will be sent to Davis Vision monthly, via a secure system, in which Davis Vision will view and validate the vision provider's Medicaid enrollment in order to credential/re-credential and eliminate the need to request Medicaid Acceptance Letters.

04/04/16 - On 03/23/16, the NM Medicaid Operations Delegation Oversight Coordinator proposed to the Delegation Oversight Committee (DOC) to close this Self-Imposed CAP as processes have been put in place with Davis Vision. If Davis Vision and/or BCBSNM receive a complaint from a Vision Provider who has received a request for their Acceptance Letter prior to the 08/25/15 corrective action effective date, they will follow the established processes. BCBSNM will continue to send Davis Vision a Provider Master File (PMF) monthly, via a SECURE email, so Davis Vision can verify if a Vision provider is registered with the State. On 03/23/16, DOC approved the closure of the Self-Imposed CAP.

MHNM

Q3DY2		
Action Plan #3	Implementation Date	Completion Date
Regulatory Reports	7/27/2015	In Progress

Description
Identify errors in report submission data. Ensure analyses address trends and details of report activity. Perform a quality review of report data and analyses prior to submission to HSD.

Status
MHNM has engaged Corporate IT, the Enterprise Project Management Office, and other key resources to complete a priority 1, "State Remediation Report Project." This project is being actively sponsored at the highest executive levels within the company. Twenty-four state reports have been identified in this project. This initiative involves redesigning and auditing all aspects of the data gathered and submitted for these reports.

Report redesign includes identifying subject matter experts (SMEs) for each report and compiling a data dictionary so data can be pulled using the same logic across multiple reports. The report requirement documents are also being updated to ensure report data is supplied to report owners sooner, increasing the time report owners have to review the data prior to submission to HSD.

This technical design review (TDR) process will yield a high quality report. Due to the enormous amount of data and sourced systems involved in the creation of these reports, the TDR process will

be in progress until it is completed correctly. TDR is an industry standardized best practice and is a proven method that will result in repeatable and systematic quality output for the reports and will result in consistent and high quality reports. The company remains committed to supplying accurate and timely reporting to the Human Services Department (HSD). The TDR method overseen by our top engineering talent, coupled with key NM experts who are focusing on this project, will execute and deliver on this commitment.

March 2016 – MHNM's State Remediation Report Project encompasses several reports that have been prioritized by "waves." Each report listed now has a data dictionary, which is part of the normalization process and is a well-established industry standard for data modeling based on business rules and modeling. The data dictionaries for the Wave A reports are 100% complete.

The reports included in this report project are broken down by Waves (tentative dates): Wave A – Preliminary work – Completed by 12/2/15
Wave B – Completed by mid-January, 2016
Wave C – Completed by mid-April, 2016
Wave D – Completed by July, 2016

Report Name & Number	Wave Assignment	Other Actions
Network Adequacy - #3	A	
Self-Directed - #4	Not in project scope	Care coordinator training, change in final analysis process
Admissions/Readmissions - #5	C	Changes implemented in discharge planning process
Care Transition - #7	A	Changes in data collection and final analysis process
ABCB - #9	A	Changes in data collection and final analysis process
Under/Over Utilization - #40	B	Criteria correction, changes in data collection and final analysis process
Utilization Mgmt. - #41	B	
Core Service Agencies - #45	On hold	Changes in configuration, data collection and final analysis process
GeoAccess - #55	C	Changes in final analysis process
School Based Health Ctrs. - #61	C	Changes in data collection and final analysis process

PHP

Q3DY2		
Action Plan #4	Implementation Date	Completion Date
Environmental Modifications	8/6/2015	In Progress

Description
Internal action plan to ensure PHP is using contracted, state registered, and state certified vendors for environmental modifications; modification comport with contract requirements.

Status
PHP Clinical Ops notified environmental modification (e-mod) providers in writing that their e-mod authorizations were rescinded. Home Mod Solutions (HMS) was deployed to complete work for rescinded authorizations. Care coordinators trained on e-mod eligibility criteria. A certified e-mod provider list is being sent to Clinical Ops regularly. PHP is working with state agencies to obtain standard e-mod pricing. E-mod provider, Tru Quality, was certified by HSD effective 8/31/2015. Control reports have been developed to ensure claims are paid only to certified e-mod providers. PHP is re-working, end-to-end, the e-mod process. The end-to-end e- mod process will be validated via an external audit. PHP is working with a NM non-profit agency, who has considerable ADA and E-Mod experience. PHP has opted to outsource the administration of the E-Mod construction process in order to obtain experienced architects familiar with ADA regulations and to establish reasonable and standard E-Mod pricing. Contract is in the process of being developed with a tentative start date of March 1, 2016.

Quarter 1 DY3

UHC

Q1DY3		
Action Plan #1	Implementation Date	Completion Date
Myers & Stuaffer Audit	3/24/16	In progress

Description
UHC began an internal action plan to address preliminary findings.

Status
3/24/16 – Some of the Myers & Stauffer preliminary findings, such as the delegated entity oversight and claim policy updates, will be tracked and monitored until resolved via self-initiated internal corrective action plan.

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	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Inpatient (Admissions)	130.8	115.5	$ 8,330	$ 8,558
Inpatient (Days)	562.0	501.9	$ 1,939	$ 1,970
Practitioner / Physician (Services)	10,545.9	10,778.8	$ 70	$ 68
Emergency Department (Visits)	620.2	651.1	$ 332	$ 340
Outpatient (Visits)	1,490.4	1,498.6	$ 284	$ 296
Pharmacy (Scripts)	5,333.1	5,228.1	$ 52	$ 57
Other (Services)[1]	9,690.0	10,716.6	$ 57	$ 58

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Brand	15%	15%	$ 231	$ 264
Generic	84%	84%	$ 19	$ 19
Other Rx[2]	1%	1%	$ 96	$ 102

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	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Inpatient (Admissions)	97.6	85.1	$ 14,956	$ 15,900
Inpatient (Days)	562.7	590.9	$ 2,594	$ 2,290
Practitioner / Physician (Services)	10,077.6	9,023.3	$ 80	$ 80
Emergency Department (Visits)	713.9	674.3	$ 456	$ 485
Outpatient (Visits)	2,685.7	2,530.1	$ 300	$ 319
Pharmacy (Scripts)	9,834.9	10,017.1	$ 55	$ 65
Other (Services)[1]	10,923.2	12,977.0	$ 61	$ 66

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Brand	12%	13%	$ 341	$ 385
Generic	86%	85%	$ 16	$ 16
Other Rx[2]	2%	2%	$ 80	$ 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: Dual Eligible - Nursing Facility Level of Care

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Inpatient (Admissions)	227.7	282.5	$ 2,681	$ 2,667
Inpatient (Days)	1,211.6	1,579.1	$ 504	$ 477
Nursing Home (Days)	98,150.4	177,943.9	$ 117	$ 64
Personal Care (Services / hr.)	898,150.6	896,570.3	$ 15	$ 15
Outpatient (Visits)	5,135.6	4,725.3	$ 126	$ 126
Pharmacy (Scripts)	1,355.0	696.6	$ 29	$ 22
HCBS (Services)	4,276.8	3,669.5	$ 125	$ 157
Other (Services)[1]	41,857.7	42,292.0	$ 46	$ 46

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Brand	19%	20%	$ 112	$ 54
Generic	80%	77%	$ 11	$ 9
Other Rx[2]	2%	3%	$ 92	$ 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	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Inpatient (Admissions)	406.9	324.4	$ 14,945	$ 17,528
Inpatient (Days)	2,539.0	2,144.9	$ 2,395	$ 2,651
Nursing Home (Days)	21,112.2	17,745.1	$ 183	$ 180
Personal Care (Services / hr.)	990,255.4	832,802.7	$ 15	$ 15
Outpatient (Visits)	8,671.9	7,290.6	$ 384	$ 416
Pharmacy (Scripts)	45,460.9	41,536.1	$ 65	$ 73
HCBS (Services)	5,743.3	6,033.4	$ 84	$ 104
Other (Services)[1]	71,376.2	64,030.2	$ 79	$ 83

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Brand	14%	13%	$ 375	$ 409
Generic	84%	82%	$ 21	$ 19
Other Rx[2]	2%	5%	$ 100	$ 53

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	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Inpatient (Admissions)	282.2	267.6	$ 6,987	$ 8,637
Inpatient (Days)	1,636.0	1,898.1	$ 1,205	$ 1,218
Nursing Home (Days)	11,762.1	10,424.2	$ 48	$ 33
Personal Care (Services / hr.)	9,353.1	18,470.7	$ 17	$ 9
Outpatient (Visits)	6,052.0	5,240.2	$ 171	$ 187
Pharmacy (Scripts)	7,798.0	5,819.5	$ 92	$ 88
HCBS (Services)	265,834.1	335,315.9	$ 112	$ 110
Other (Services)[1]	63,963.6	56,725.6	$ 56	$ 49

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Brand	16%	12%	$ 443	$ 280
Generic	81%	83%	$ 31	$ 33
Other Rx[2]	3%	5%	$ 75	$ 41

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	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Inpatient (Admissions)	71.4	79.8	$ 3,741	$ 3,724
Inpatient (Days)	456.0	470.6	$ 585	$ 632
Practitioner / Physician (Services)	8,634.6	10,312.1	$ 25	$ 25
Emergency Department (Visits)	575.4	514.7	$ 133	$ 141
Outpatient (Visits)	2,810.5	2,637.7	$ 118	$ 119
Pharmacy (Scripts)	987.8	504.9	$ 27	$ 27
Other (Services)[1]	9,603.3	8,047.9	$ 92	$ 151

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**CY2014**	**CY2015**	**CY2014**	**CY2015**
Brand	23%	20%	$ 72	$ 83
Generic	75%	75%	$ 12	$ 11
Other Rx[2]	2%	4%	$ 81	$ 53

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	CY2014	CY2015	CY2014	CY2015
Inpatient (Admissions)	51.0	49.5	$ 859	$ 913
Inpatient (Days)	169.8	144.3	$ 258	$ 313
BH Practitioner (services)	523.9	438.8	$ 73	$ 78
Core Service Agency (Services)	448.2	306.3	$ 85	$ 100
BH outpatient / clinic services	2,121.2	2,396.4	$ 78	$ 69
Pharmacy (Scripts)	1,896.2	2,068.6	$ 54	$ 49
Other (Services)[1]	140.0	121.4	$ 800	$ 955

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	CY2014	CY2015	CY2014	CY2015
Brand	6%	4%	$ 469	$ 446
Generic	94%	96%	$ 28	$ 32
Other Rx	0%	0%	$ -	$ -

Notes:

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