Centennial Care Waiver Demonstration

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

December 8, 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 690,000 members are enrolled in the program. Initiatives continuing in the third year of the program (January 2016 – December 2016) include:

Emphasizing Patient-Centered Care

- As of June 30, 88% of members had been reached in order to conduct a health risk assessment (HRA).
- More than 70,000 members are in higher levels of care coordination.
- More than 280,000 members are receiving care in patient-centered medical homes.
- More than 25,000 members are receiving home and community benefits.
- Launched two health home sites for members with complex behavioral health (BH) conditions.
- Identified high cost/high need members and designing programs to reduce inappropriate use of the emergency department (ED), including pilots with community agencies such as Albuquerque Ambulance, Kitchen Angels and Addus Homecare.
- Implemented a justice involved pilot program with county jails to connect incarcerated individuals with care coordination upon release from the facility.

Supporting Provider Capacity

- Maximized Scopes of Practice for Certain Providers.
- Managed care organizations (MCOs) expanded use of telehealth office visits by 45% and launching virtual physician visits, including with BH providers.
- Increased use of Community Health Workers.

Implementing Payment Reform Projects

- MCOs continue to expand value-based purchasing efforts with implementation of bundled payments for episodes of care, shared savings arrangements, pay for performance payments and global capitation with upside risk.

Other initiatives in development during Demonstration Year 3 (DY3)

- Implemented ED diversion strategies, including implementation of ED tracking software to be used by hospitals and MCOs.
- Planned for Certified Community Behavioral Health Clinics and expansion of health homes.
- Collaborated with the MCOs on dually eligible members to align MCO enrollment and better coordinate care.
- Implemented Electronic Visit Verification for members receiving Personal Care Services.

Section II: Eligibility, Provider Access and Benefits

Eligibility

As noted in Section III of this report, there are 272,718 enrollees in the Group VIII (expansion) who are in Centennial Care. Growth in the expansion group shows 6,918 new enrollees for the third quarter of DY3 (DY3 Q3).

Access

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

Network Adequacy

HSD monitors the MCOs' compliance in maintaining an adequate and efficient provider network, tracking new and terminated providers, and transition of members to new providers when a provider or agency is suspended or terminated. Member-to-provider ratios and the number of single case agreements required during the quarter are considered with respect to provider adequacy and the strength of each MCO's network. In July 2016, HSD initiated provider rate reductions; however, all of the MCOs reported their respective provider networks remained stable and rate reductions have not resulted in provider termination during DY3 Q3.

Population Density Designations

Urban counties in New Mexico include: Bernalillo, Los Alamos, Santa Fe and Doña Ana. (4)

Frontier counties in New Mexico include: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. (15)

Rural counties in New Mexico are not frontier or urban and include: Chaves, Curry, Eddy, Grant, Lea, Luna, McKinley, Otero, Rio Arriba, Roosevelt, Sandoval, San Juan, Taos and Valencia. (14)

Primary Care Provider (PCP)-to-Member Ratios

As reflected in the table below, the average PCP-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural and frontier counties from January through June 2016. There are no PCP access concerns at this time.

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June
BCBS	1:56	1:55	1:54	1:55	1:56	1:56
MHC	1:111	1:111	1:111	1:108	1:107	1:105
UHC	1:17	1:17	1:17	1:16	1:16	1:16
PHP	1:83	1:85	1:87	1:88	1:89	1:89
Source [MCO] PCP Report #53, Q2CY16						

Provider Distance Standards

Distance Standard 1 - For PCPs including internal medicine, general practice and family practice provider types and (ii) pharmacies:

- Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.
- Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles.
- Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

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

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

Geographic Access

New Mexico's Geographic Access (GeoAccess) report monitors member's geographic access to services and MCO contracted providers across urban, rural and frontier counties. New Mexico also recognizes providers/pharmacies within 100 miles of the border as in-state providers. The GeoAccess report captures forty-nine (49) different provider types as well as out-of-state providers that each MCO is either contracted with or has a single case agreement.

During DY3 Q3, GeoAccess reports continued to be reviewed by HSD to ensure consistent methodology across MCOs. HSD identified discrepancies in an MCO's reporting, including duplication in provider location count and inability to accurately calculate physical location of provider. To ensure consistent methodologies among MCOs, HSD conducted technical assistance (TA) calls with the appropriate MCO to ensure all MCOs report accurate provider location counts and physical location of provider. Please see Attachment B: GeoAccess PH Summary and Attachment C: GeoAccess BH Summary.

GeoAccess Attachments

The GeoAccess attachments to the Q3 report are comparative grids that demonstrate to what degree each MCO "meets" (green), or "does not meet" (orange), the distance standards for each provider type listed. The percentage represents the number of members who have access to a provider divided by the total number of members who reside in the geographic area (urban, rural or frontier counties).

Example: The distance standard for Cardiology (Standard 2 below) is that 90% of urban members shall travel no farther than (30) miles to reach a Cardiologist. Presbyterian (PHP) has 111,782 individual members living in urban counties and who have at least one Cardiologist within 30 miles of their residence. The total number of PHP members in urban counties is 112,872. Therefore, 99% of urban members live within 30 miles of a Cardiologist practice. The cell is green (right of "Cardiology," under urban and PHP), because the percentage or members who have a provider within 30 miles meets or exceeds the distance standard of 90%. The grid facilitates a comparison across MCOs.

In addition, each MCO GeoAccess Report captures detail at the county level; however, HSD submits a higher level summary (by geographic area) for brevity.

Secret Shopper Survey

Medicaid enrolled providers with the State of New Mexico contract with any number of the four Centennial Care MCOs, all of which provide services to members statewide. While MCO GeoAccess Reports measure proximity of members to providers and Network Adequacy Reports measure capacity by MCO, HSD recently conducted a Secret Shopper Survey in order to determine whether the overall Medicaid network of providers are able to offer timely appointments to managed care members across MCOs. HSD provided a script to surveyors that measured time to a new patient appointment, an established patient appointment, and a sick/urgent patient appointment along with other data points including, but not limited to: whether the practice accepted Medicaid for reimbursement, whether the practice was accepting new patients, availability of extended hours, and the MCOs with which the practice was contracted. The script was designed to be conversational and without specific member information provided. Please see Attachment E: HSD Secret Shopper Survey Scripts.

HSD selected primary care physicians (PCPs) and three specialty care provider types from the State's Medicaid Management Information System (MMIS). Providers from the specialty areas of Cardiology, Obstetrics and Gynecology, and Pediatrics were surveyed. (See Attachment F: HSD Secret Shopper Survey Methodology). HSD staff members were trained to ensure consistency and reliability across surveyors. One-to-two attempts were made to reach a provider or practice. Except for new patient Cardiology appointments, the time-to-appointment statistics met or were earlier than the managed care contract standards defined in the Medicaid Managed Care Services Agreement. Additional items of note include: 13% of PCPs offer extended hours (evening or weekend hours or both); 93% of PCPs who were reached accept Medicaid and of

those 88% are contracted with all four MCOs; and only 2% of providers referred members to Urgent Care or an Emergency Room when asked how soon an established patient could be seen for a sick or urgent appointment. On average, established patients who identified as sick or needing an urgent appointment could be seen within one (1) business day. Time to appointment results are as follows.

PCPs

80% *of practices were reached of which* ***87%*** *are accepting new patients.* ***93%*** *accept Medicaid & of those* ***88%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	2 weeks	3-4 days	1 day

Cardiologists

100% *of practices were reached of which* ***93%*** *are accepting new patients.* ***79%*** *accept Medicaid & of those* ***100%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	7 weeks	3-7 days	Same day

Pediatricians

91% *of practices were reached of which* ***98%*** *are accepting new patients.* ***100%*** *accept Medicaid & of those* ***100%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	1 week	2-4 days	Same day-1 day

OB-GYNs

81% *of practices were reached of which* ***90%*** *are accepting new patients.* ***90%*** *accept Medicaid & of those* ***77%*** *are contracted with all 4 MCOs.*

Average time to:	New Pt. Appt.	Est. Pt. Appt.	Sick/Urgent
	3 weeks	5 days	Same day-1 day

Transportation

In DY3 Q3, HSD does not have transportation issues to report.

Service Delivery

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program is for April 2016 through June 2016. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

During DY3 Q3, the pharmacy report workgroup continued to meet to review the pharmacy report. The HSD pharmacy workgroup determined additional adjustments were needed to standardize consistent methodologies across MCOs. Revisions to the pharmacy report will include monitoring drugs for the treatment of opioid dependence, alcohol and nicotine dependence, methadone use in pain management, HIV treatment, and utilization of antipsychotic medications in children. The data will include the total number of claims submitted as well as paid claims for unduplicated members and any prior authorization requirements. In addition, reporting of therapeutic classifications will be based on "Generic Product Indicators" to prevent the reporting of high numbers of miscellaneous items. As directed by CMS, elements required for Drug Utilization Review (DUR) reporting will also be included in the report revision. These revisions will reduce variance in reporting among MCOs and ensure a thorough analysis of pharmacy services.

On July 27, 2016, HSD provided the MCOs with an updated Letter of Direction (LOD) regarding the treatment guidance for chronic Hepatitis C virus (HCV) infection. The LOD included a revised Uniform New Mexico HCV Checklist for Centennial Care, provider network education, expanded role of care coordination, treatment criteria expanding screening efforts, and financial changes. It is HSD's goal to lower average drug treatment costs by 25% from the period July 1, 2015 – June 30, 2016 to the period July 1, 2016 – June 30, 2017.

Emergency Department Information Exchange (EDIE)

In July 2016, implementation of the Emergency Department Information Exchange (EDIE) project was launched in an effort to promote appropriate ED utilization. The EDIE project is a collaborative effort by all four MCOs. EDIE enables MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all Emergency Department and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical meta data. As a result of the notification, the provider has information in hand before seeing the patient. This allows the provider to take action and to influence health care outcomes. Furthermore, EDIE will reduce non-emergent visits, so the ER providers have the capacity to rapidly see those with emergent needs as well as reduce the associated costs due to unnecessary ED visits. It is anticipated EDIE will be implemented in December of 2016.

Community Health Workers (CHWs)

CHWs are trusted members of the community who work within the local health care system in rural, frontier, tribal and urban areas. CHWs have been referred to as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives, peer health promoters, peer educators, and community connectors. CHWs are in a unique position to provide interpretation and translation services, culturally appropriate health education, serve as liaisons between the member and the health care system by assisting them in obtaining needed care. CHWs are able to provide informal counseling and guidance on health behaviors while encouraging self-efficacy. CHWs' roles vary from community to community depending on the sector in which they work and the unique needs of their communities.

During DY3 Q3, an MCO conducted a train-the-trainer session on how to teach the diabetes and depression modules to other CHWs. The training included one module on depression and one module on "My Diabetic Plate" and eating healthy by understanding portions and how carbohydrates and how other foods impact blood glucose levels. Throughout Q3, all MCOs continued to cultivate and refine CHW services as needed by the member population served.

Telehealth

Through DY3 Q3, utilization of telehealth for both physical and behavioral health remains strong. Blue Cross Blue Shield of New Mexico (BCBSNM) reports that the majority of equipment funded for practices earlier this year resulted in an increase in behavioral health telemedicine bandwidth. All MCOs have active recruitment initiatives underway to pursue telehealth providers. Molina Health of New Mexico (MHNM) reported recruitment of Behavioral Health medication management providers as well as the purchase of block time services of BH medication management providers through an external vendor among the current priorities. All MCOs continue to provide technical assistance, as needed, to make sure practices understand correct coding.

Contract Amendments

Amended Centennial Care MCO contracts, Amendment 6, went into effect on July 1, 2016. Please see Attachment G: Centennial Care Contract Amendment #6.

Community Interveners (CI)

In DY3 Q3, there were seven Centennial Care members receiving Community Intervener (CI) services. The MCOs will continue to provide training and education to Care Coordinators to identify potential members who could benefit from CI services.

HSD recently approved another provider to provide CI services, All 4 You Home Care Corp. HSD directed the MCOs to provide outreach to this provider for contracting for the CI service.

Table 2 – Community Intervener Services Utilization DY3 Q3

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBSNM	3	837.00	$5,289.75
MHNM	0	0	$0
UHC	3	436.00	$2,791.75
PHP	1	0	$0
Total	**7**	**1,273.00**	**$8,081.50**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date 606,681 distinct members have earned at least one reward, or 70.9% of enrollees. Table 3 shows the healthy behaviors rewarded and each behaviors value. It includes both the point and dollar value of the activity, the total dollars earned and the amount redeemed, and the associated percentage of redemption by activity.

Table 3 – Health Behaviors Rewarded

Eligibility Activities	Activity Completion Reward Value in Points	Activity Completion Reward Value in $	Total Rewards Earned by Activity in $	Total Rewards Redeemed by Activity in $	Redemption Percentage
Asthma Management	750	$ 75	$ 907,770	$ 278,959	30.73%
Bipolar Disorder Management	750	$ 75	$ 1,003,845	$ 234,831	23.39%
Bone Density Testing	350	$ 35	$ 37,905	$ 7,906	20.86%
Healthy Smiles Adults	250	$ 25	$ 7,175,375	$ 1,389,435	19.36%
Healthy Smiles Children	350	$ 35	$ 17,089,555	$ 4,216,651	24.67%
Diabetes Management	800	$ 80	$ 4,119,620	$ 1,045,517	25.38%
Healthy Pregnancy	1,000	$ 100	$ 1,038,500	$ 263,194	25.34%
Schizophrenia Management	750	$ 75	$ 494,925	$ 97,707	19.74%
Health Risk Assessment (HRA)	100	$ 10	$ 4,082,300	$ 805,823	19.74%
Other (Appeals and Adjustments)	N/A	N/A	$ 398,210	$ 227,546	57.14%
Step-Up Challenge	500	$ 50	$ 434,075	$ 367,125	84.58%
Totals			**$ 36,782,080**	**$ 8,934,694**	**24.29%**

The table also reflects dental services as having the highest value of rewards earned at $24 million. This may suggest the availability of the rewards has led to the increase in dental visits, as well as the availability of dental coverage under Medicaid.

The Step-Up Challenge shows that members who complete the activity have a high likelihood of redeeming the reward. The Step-Up Challenge is an activity group that individuals have to opt-in to. The other activity groups are based on a health diagnosis.

Section III: Enrollment

Centennial Care enrollment indicates the largest increase in enrollment continues to be Group VIII. The majority of Centennial Care members are enrolled in Temporary Assistance for Needy Families (TANF) and Related Medicaid Eligibility Group (MEG) with Group VIII being the next largest group as reflected in Section III of this report. Overall enrollment continues to increase each quarter in almost every population.

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 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 Q3

Demonstration Population	Total Number of Demonstration Participants Quarter Ending – September 2016	Current Enrollees (Rolling 12 month period)	Disenrolled in Current Quarter
Population 1 – TANF and Related	384,101	363,815	7,372
Population 2 – SSI and Related – Medicaid Only	41,293	41,574	685
Population 3 – SSI and Related – Dual	37,694	40,264	613
Population 4 – 217-like Group – Medicaid Only	142	208	8
Population 5 – 217-like Group – Dual	2,617	2,910	48
Population 6 – VIII Group (expansion)	272,718	331,302	9,895
Totals	738,565	780,073	18,621

Disenrollments

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

HSD continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any potential gaps in enrollment. Any issues that are identified or reported are researched and addressed. There is a slight increase in disenrollment but only in certain populations and is tied to the overall increase in enrollment.

Table 5 – Disenrollment Counts DY3 Q3

Disenrollments	From 2016 Q2 to 2016 Q3		Total Disenrollments During Q3
Last Month Client was Disenrolled	**July 1, 2016**	**August 1, 2016**	
Population 1 – TANF and Related	3,119	4,253	7372
Population 2 – SSI and Related – Medicaid Only	341	344	685
Population 3 – SSI and Related – Dual	303	310	613
Population 4 – 217-like Group – Medicaid Only	5	3	8
Population 5 – 217-like Group - Dual	21	27	48
Population 6 – VIII Group (expansion)	4,404	5,491	9,895
Total Without MEG 7	8,193	10,428	18,621

Section IV: Outreach

In DY3 Q3, HSD continued to provide Centennial Care monthly informational training to staff of the New Mexico Aging and Long-Term Services Department, Adult Protective Services Division and the Aging and Disability Resource Center; Parents Reaching Out; and First Choice Community Healthcare. Other events HSD participated in include Senior Citizen Celebration-Healthy Living Day at the New Mexico State Fair; 38th Annual Conference on Aging Health and Enrichment Fair; and the Local National Recovery Month recovery event.

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.

Description of Promising Practices for DY3 Q3

HSD continues to work on implementation of eligibility suspensions for justice-involved individuals. In Q3, automatic electronic interfaces and ASPEN system updates were implemented for the following facilities around the State: New Mexico Department of Corrections (NMDC); Bernalillo County Metropolitan Detention Center; Children, Youth and Families Department (CYFD), Juvenile Justice Division; Sandoval County Detention Center; Santa Fe County adult and juvenile detention centers; Doña Anna County adult and juvenile detention centers; and San Juan County juvenile detention center.

The automatic electronic interfaces and ASPEN system updates allow prison and jail facilities to send their daily booking and release records with no administrative intervention. The ASPEN system updates that were put into place allow HSD to electronically identify all Medicaid-eligible individuals who are incarcerated for more than 30 days. If the individual remains incarcerated for more than 30 days, the system automatically suspends Medicaid; HSD then reactivates Medicaid when the correctional facility informs HSD of the individual's release.

HSD also continues to conduct outreach and training for correctional and county detention center staff. In Q3 HSD conducted four trainings and certified 30 Presumptive Eligibility Determiners (PEDs) in correctional facilities. These PEDs are trained to help the justice-involved population apply for Medicaid while incarcerated when they do not have Medicaid or other health care coverage. The PEDs help justice-involved individuals get connected with their MCO care coordinators and help these individuals access Medicaid-covered services as quickly as possible upon release.

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 scheduled bi-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. HSD continues to monitor encounters by comparing encounter submissions to financials to ensure completeness.

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 they are addressed and resolved timely with each MCO. HSD posts the monthly Medicaid Eligibility Reports to the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx and includes enrollment by MCOs and by county.

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

Program Development

In DY3 Q3, HSD conducted the following trainings:

- ***Care Coordination for Members enrolled in Centennial Care as well as those enrolled in the Developmental Disabilities, Mi Via, and Medically Fragile 1915(c) Waivers.*** The training included guidance on care coordination for members enrolled in the 1915(c) waivers, an overview of the 1915(c) Home and Community-Based Services Waiver Programs, completing a Comprehensive Needs Assessment and Comprehensive Care Plan for these members receiving waiver services, and member transitions from community benefit to a 1915(c) waiver program.

- ***Part II: Nursing Facility Level of Care (NFLOC) and Setting of Care (SOC) Requirements.*** The training covered system requirements for the MCOs when submitting NFLOC and SOC changes for member's who have Appeals, Fair Hearings, and Level of Care Denials.

MCO Initiatives

- Molina Healthcare of New Mexico (MHNM):
  - Maternal Fetal Medicine Initiative to address NICU admissions, low-birth weights, and preterm deliveries;
  - Opioid Reduction Program to address inappropriate opioid utilization which can result in increased ER visits, worsening of medical conditions, and health care costs;
  - Partnership with Central Consolidated School District (CCSD) to sponsor, "Creating Change through Knowledge" and conduct outreach in the community to focus on behavioral health and suicide prevention resources; and
  - Propeller Health Pilot to develop a program for MHNM members to reduce asthma acerbations, improve member asthma medication management, and reduce the number of preventable ER visits and hospitalizations related to Asthma exacerbations.
- Presbyterian Health Plan (PHP):
  - Video Visits – Improve member engagement rates with Disease Management and Care Coordination by improving the following key results:
    - Increased member satisfaction;
    - More personalized service vs. telephonic coaching;
    - Reduction in ED visits for members in Disease Management; and
    - Improved A1C for members in Disease Management.
- Blue Cross Blue Shield of New Mexico (BCBSNM):
  - Created an overall guide to pre-manage ED (EDIE) with other MCOs to be distributed to organizations and emergency rooms across the State;

    - In the process of updating system logic to omit member mailings from being sent to HSD when only the HSD mailing address is provided on the enrollment file. This new process will reduce the number of mailings being sent to HSD; and
    - Successfully managed workgroup for Behavioral Health Provider Critical Incident Reporting Protocol.
- United Healthcare (UHC):
    - Onsite Readiness Review: Community Care – Joint review with HSD to demonstrate new clinical system; and
    - Community Benefit Care Plan Monitoring/Audits by achieving 100% for all three focus areas including:
        - Member record includes a completed CNA, CCP with specific goals and corresponding documentation;
        - Documentation clearly identifying the care coordinator is addressing member specific needs; and
        - Evidence of a completed PCS Allocation Tool that is complete and accurate.

Unreachable Member Campaign

The HSD directed Unreachable Member Campaign concluded on June 30, 2016 and in Q3 results were analyzed. Each MCO had fluctuations in performance as it initiated and refined its strategies and processes. Overall, the MCOs exceeded the established goals. The data reflects that a total of 248,513 previously "unreachable" members were successfully reached by MCOs during the campaign. The percent of Unreachable Members, as compared to enrollment, decreased to 11.6%. In addition, 164,267 total Health Risk Assessments (HRAs) were completed for members who had initially been unreachable. From January 2015 through June 2016, the number of Members Reached can be compared to HRAs Completed for a penetration rate of 73.3%.

Beginning July 1, 2016, an annual Health Risk assessment is no longer required for members who are not in higher levels of care (Care Coordination Levels 2 and 3). Rather, MCOs are required to conduct an initial HRA for members newly enrolled in Centennial Care and a new HRA for members who are identified as having a change in health status. A member can also self-report a change in health status, and the MCO will complete a new HRA to determine the member's appropriate level of care. For the population of members who are not assigned a higher level of care, MCOs will focus on accessing available utilization and claims data, including Emergency Room visits, services and supports history, medications and medication history in order to identify a member's current and emergent needs related to Care Coordination. Care Coordination anticipates members' needs rather than responding to emergencies or exacerbated health conditions.

Electronic Visit Verification (EVV)

In DY3 Q3, HSD extended the date for mandatory full implementation of the EVV system for members receiving Personal Care Services (PCS) to November 14, 2016. This was due to resource issues with the tablet vendor, and an unexpected high demand for tablets. Many "no tech zone" providers have already begun using the tablets and are implementing ahead of the deadline.

Behavioral Health

SAMHSA Monitoring Visit

The Substance Abuse and Mental Health Services Administration (SAMHSA) had selected New Mexico as one of ten sites for a federal fiscal year (FFY) 2016 combined Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant monitoring visit. The visit was conducted on August 2-4 and included staff from the Center for Mental Health Services, the Center for Substance Abuse Prevention, Center for Substance Abuse Treatment, and Office of Financial Resources. The purpose of the visit was to assess New Mexico's compliance with the authorizing legislation and implementing regulations governing the block grants, as well as, SAMHSA's statutory fiscal and financial management policy. In preparation for the visit, BHSD submitted requested pre-site visit materials. SAMHSA visited with staff from HSD and CYFD, OptumHealth and other contractors and stakeholders. Visits were conducted with a variety of behavioral health provider organizations. BHSD received a teleconference debrief roughly four weeks after the onsite visit. Feedback overall was positive but a final report may take as long as a year and a half.

Medical Detoxification

Medically managed inpatient detoxification is a Medicaid reimbursable service if provided in general hospital settings. Standardized evidence-based protocols are available to systematically guided medically managed detoxification, but too often this has not been part of regular practice among general hospitalists and nurses in New Mexico. In order to increase capacity within the New Mexico healthcare system, it is important to disseminate best practices for screening patients who are risk for complicated withdrawal and treatment algorithms for medically managed detoxification.

An educational summit entitled, *Demystifying Hospital and Ambulatory Based Detoxification and Withdrawal* was convened on June 18, 2016 at the University of New Mexico (UNM). It was co-sponsored by UNM Hospitals, UNM Department of Psychiatry and Behavioral Sciences, New Mexico Behavioral Health Collaborative, Presbyterian Health Plan, the New Mexico Hospital Association and UNM Continuing Medical Education & Professional Development. Unfortunately, hospital staff was not well represented. As a result, planning has been initiated to bring this training first to areas served by Certified Community Behavioral Health Clinics (CCBHC) with Las Cruces designated as the first priority. In addition, Dr. Carli Bonham and Dr. Wayne Lindstrom presented on this topic and the ASAM levels of social detox before a

joint meeting of the Taos County Commissioners and the Taos City Council in September 2016. This meeting was followed by a meeting with the leadership at Holy Cross Hospital around the need to make medical detox more available and accessible.

Adolescent Substance Use Reduction Effort (ASURE)

Children Youth and Family Division's (CYFD) – Behavioral Health Division has used the State Youth Treatment Planning Grant (SYT-P) to institute an Interagency Council called the Adolescent Substance Use Reduction Taskforce (ASURT). This taskforce was convened on June 28, 2016 by CYFD Cabinet Secretary Monique Jacobson. ASURT has representation and active collaboration with multiple state agencies, providers, research institutions and other community stakeholders to create a three-year plan to improve behavioral health services for youth and families in New Mexico. This taskforce has formed three subcommittees to focus efforts on the following areas:

1. Behavioral Health Workforce Mapping;
2. Financial Mapping; and
3. Strategic Planning.

Each subcommittee has met and progressed with all three efforts. ASURE received Technical Assistance (TA) from SAMHSA onsite in July. This visit provided the project with feedback from the TA providers and from stakeholders who participated in the visit. The next meeting is scheduled for October 18, 2016 and will provide ASURT with report from the three subcommittees. This meeting will provide another opportunity for stakeholders to provide input into the planning process. Dr. Wayne Lindstrom attended the kick-off meeting on June 28, 2016, and plans to attend a site visit in July.

New Mexico SMVF In-State Policy Academy

Since 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been using the Policy Academy (PA) model to engage interagency teams from states and territories to support the development of strategic plans for strengthening the behavioral health systems for service members, veterans, and their families (SMVF). The SMVF Technical Assistance Center (SMVF TA Center) has been working with state and territory teams providing technical assistance and training to PA graduates and supporting the engagement of new states and territories in the process. The New Mexico In-State Policy Academy was convened by the New Mexico Department of Veterans' Services under the direction of the Governor on June 21-22, 2016. Following the June Leadership Brief, the New Mexico team has started a campaign to identify existing New Mexico resources and assess those that have a mission to help veterans.

The team has also initiated a Memorandum of Understanding (MOU) with the New Mexico Corrections Department to facilitate warm handoff actions for those incarcerated veterans that were under behavioral health clinical supervision. Work is also underway with New Mexico State University to utilize graduate students to analyze large data sets to determine where the

greatest need for behavioral health services for this population is in the State. The team has been aligned into three subcommittees: Administration, Health, and Education. The Policy Academy is constantly providing guidance and best practices from other states to help find solutions to the problems experienced by SMVF. The administrative team will be publishing the Academy's New Mexico Action Plan, which will evolve as services are secured and other initiatives are implemented.

Behavioral Health Strategic Plan

The Implementation Team continues to meet bi-weekly to identify appropriate steps and timeframes for all the activities under the Goals and Objectives, and identify individuals or groups to assume relevant tasks. An 18-month Implementation Plan Matrix was developed which tracks progress on all the goals and activities in the three major goal areas.

A progress report will be presented at each quarterly meeting of the Behavioral Health Collaborative throughout the 18-month implementation period. An evaluation of the Plan will be completed at the conclusion of its implementation.

Some of the accomplishments, during DY3 Q3, are highlighted below:

The Regulations Workgroup Goals:

1) To identify, align and eliminate inconsistencies in behavioral health statutes, regulations, and policies in order to allow for more effective and efficient operation of the publicly-funded service delivery system: Departmental interviews are underway to determine behavioral health-related regulatory barriers; and

2) To increase the adoption of person-centered interventions: The "Treat First" six-month trial period and evaluation were completed. (The "Treat First" section of this report regarding provides more information about this topic.)

The Finance Workgroup Goals:

1) To increase the productivity, efficiency and effectiveness of the current provider network;

2) To implement a value-based purchasing (VBP) system that supports integrated care and reinforces better health outcomes: VBP report was presented to HSD Secretary in July, 2016; and

3) To identify, develop and promote implementation of effective strategies for the State, counties and municipalities to work together to fund the provision of better behavioral health care, especially for high utilizers: In August, a meeting was convened with County behavioral health leadership to explore potential synergies. A special pre-conference day is being planned for the semi-annual Association of Counties meeting in January, 2017 entitled Behavioral Health Innovations by/in Counties to Explore Accomplishments in Innovations Statewide.

The Workforce Workgroup Goal:

1) To support the development of behavioral health practitioners: A survey of behavioral health providers for current behavioral health intern placements has been completed; an inventory of graduate behavioral health programs to determine intern candidates needing placements is underway; a Behavioral Health Clinical Provider Guide is being developed for Fall orientations to students enrolled in behavioral health-related professional programs; and the behavioral health subcommittee of the Health Workforce Committee is reviewing findings on barriers to reciprocity;

2) To build a more multidisciplinary and competent behavioral health workforce; A Medicaid Supplement related to Nursing has been drafted; and a gap analysis on behavioral health EHR adoption has been completed; and

3) To promote the future of excellence in the behavioral health workforce and prepare for integrated care: An Integrated Quality Service Review methodology has been developed and related Clinical Practice Improvement training has been provided to three FQHC's in southern New Mexico.

CareLinkNM – Health Homes

New Mexico's health home project, CareLinkNM, continues to develop. Approximately 350 Medicaid members are enrolled in a CareLinkNM Health Home. The CareLinkNM Health Homes incorporated New Mexico's Treat First Model, allowing a member to be assessed over a period of 4 visits to treat the member's immediate needs and keep the member engaged. The Steering Committee for the project met with the two current health homes sites to identify lessons learned from their experience and areas in which future health home processes can be improved. Some of the areas identified for future improvement include: release of information processes and lack of familiarity with Memoranda of Understanding in small primary care practices, changes to the application process for new health homes, experiences with community liaison and health promotion staff, use of peer support, and a need for more flexibility in staffing. Providers also indicated that integrated care and the relationships with small providers is a culture change and will take time, though some progress in both communities has been made. HSD and the steering committee will review the areas identified for improvement and incorporate necessary changes to the CareLinkNM Policy Manual based on lessons learned.

Behavioral Health Investment Zones (BHIZ)

BHSD received a $1 million allocation in FY16 for the establishment of Behavioral Health Investment Zones. The two counties, Rio Arriba and McKinley Counties have submitted their year 2 plans and budgets for review.

The Rio Arriba County BHIZ convened "Our Enterprise" Table Top Sim Day, October 4, which included approximately 50 representatives from BHIZ partner agencies, MCOs and other community providers. The four-hour Sim Day began with an overview by Rio Arriba County Health and Human Services Director, Lauren Reichelt and health planning consultant, Anne Hays Egan. The large group then divided into two small groups to work on a series of simulation scenarios.

The large group reconvened for further discussion to examine the different options available to someone needing detox resources – both services and gaps. Medical detox is available for a very small percentage of people seeking detox, based upon hospital admitting criteria. Social detox is available through a number of programs in nearby counties. In addition, short-term rehab services are available through the BHIZ network as well as other facilities that are working informally in collaborative relationships with the BHIZ Hub and partner agencies. The challenges which the BHIZ network core agencies will address is facilitating clients in their effort to be admitted to short-term detox or rehab, providing intensive case management support to clients as they access services. They also stressed the importance of intensive case management for clients at risk. BHIZ is using the Pathways outcome-focused system for tracking outcomes, which has been an important national model.

McKinley County BHIZ has redesigned their approach after recognizing the breadth of the challenges that those with behavioral health challenges face. The Gallup McKinley County-BHIZ (GMCK-BHIZ) year two plan includes the following goals:

- Provide direct, intensive services to the "Top 200" chronic, repeat protective custody/public inebriation clients, moving 25% from the abuse/shelter cycle into the path of recovery along the continuum of services, and contribute toward sustenance of core operations of the Gallup NCI Sheltercare & Detox Center.
- Identify the social detox clients with the highest annual rate of utilization of the NCI facility/program.
- Establish a cost basis for providing both standard social detox/sheltercare services and intensive services to the "Top 200" clients.
- Establish cost of "next step" residential treatment services for a pilot sample of 24 (12 %) of the "Top 200" clientele.
- Establish BHIZ contribution to core therapeutic and paramedical operations of the Gallup Sheltercare & Detox Center.
- Continue to develop the GMCK-BHIZ Network.

- Establish of inter-agency agreements and protocols for ensuring continuum of services for BHIZ clients.
- Design and implement case management database for use by the BHIZ Case Manager and case managers representing all participating providers.
- Coordination and support for stakeholder working groups.
- Monitoring and evaluation of the BHIZ program.
- Ongoing strategic planning and funding development for the BHIZ system.

PAX Good Behavior Game

The PAX Good Behavior Game (PAX GBG) has been found to reduce disruptive behaviors, hyperactivity, and emotional symptoms. According to the PAX literature, PAX GBG are found to have long term outcomes that include reduced need for special education, reductions in drug and alcohol addictions, reduction in serious violent crime, suicide contemplations and attempts, reduction in initiation of sexual activity, and an increase 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 final results were reported for the 2016 PAX GBG New Mexico spring pilot across the following participating school districts:

- Bloomfield Public Schools: 62% reduction in disruptive behaviors (as compared to initial report of 41%);
- Espanola Public Schools: 57% reduction in disruptive behaviors (as compared to initial report of 44%); and
- Santa Fe Public Schools: 65% reduction in disruptive behaviors (as compared to initial report of 34%).

During fall 2016, Espanola Public School and Santa Fe Public School districts committed to support the trainings, with approximately 75 new teachers. This resulted in an additional 2,331 students receiving PAX GBG without additional State funding (last year, 3,329 new students received PAX with state funding).

- Espanola Public Schools (EPS) held a two-day PAX GBG teacher training September 30, 2016 with Claire Richardson of PAXIS Institute: New teachers in grades K, 1, 2, 3, and 4, as well as all teachers in grades 5 and 6 participated in the training. There are now 70 elementary teachers trained. At approximately 14 students per classroom, an additional 630 students will be reached. EPS used district funds of $17,445 to cover the training and materials.
- Santa Fe Public Schools (SFPS) worked with Dr. Dennis Embry and PAXIS Institute staff to set up a six-part series of web-based teacher trainings which began October 4, 2016. Thirty new teachers in 10 schools were selected to participate across the district.

This initial training will be followed by five - 90 minutes classes. In these ten schools, 120 teachers are now trained in PAX GBG. This includes both general and special education teachers and 1,171 students participating in PAX GBG. SFPS used $6,000 in district funding to support the trainings.

- Training for principals in SFPS occurred in October 2016 with Dr. Embry: Thirty principals and seven administrators participated in this training.

Lastly, a PAX GBG Community Forum with Dr. Embry and several Farmington and Bloomfield teachers occurred on October 12 at the UNM Dominici Auditorium in Albuquerque, New Mexico. The purpose of the Forum was to educate Albuquerque Public School District administrators and teachers about the opportunity PAX GBG presents to improve student performance and free up teachers' time to what they love most—to teach.

Crisis Triage and Stabilization Centers

Established by HB 212, a Crisis Triage and Stabilization Center is a health facility that is licensed by DOH with programmatic approval by BHSD. These Crisis Triage Centers (CTCs) are not expected to be physically part of an inpatient hospital or included in a hospital's license. CTCs are intended to provide stabilization of behavioral health crises, including short-term residential stabilization. HSD has been working with DOH to establish the new standards for facility licensing and internally to establish the new level of care and program reimbursement mechanisms. Communities will be allowed to choose from a variety of models, including solely outpatient and also detox services that don't exceed medically monitored detox at ASAM level 3.7.

DOH has drafted rules both for facility licensing serving adults. The draft rules are currently under review by HSD. While the initial draft rules focus on adults, CYFD and DOH are expected to collaborate on drafting standards for facilities that would serve adolescents. Collaborative agencies will be notified when rules are available for public input.

Fiscal Issues

Managed care rates effective July 1, 2016 and August 1, 2016 were implemented for all programs. These rates contain the first round of cost containment measures implemented by the HSD. As discussed in the DY3 Q2 report, these measures are restricted to rate reductions for specific providers including inpatient hospitals, outpatient hospital and dental providers.

HSD and its actuary began work on rate development for CY17. As the State continues to face budget deficits, HSD continues to pursue long-term cost containment measures for Medicaid which will be factored into future rate developments. HSD is also analyzing and planning for compliance with the CMS mental health parity and managed care rules which may also have fiscal impacts.

Systems Issues

HSD continues to run reports to conduct ongoing auditing and analysis of NFLOC assessments to ensure compliance with criteria. HSD conducted another in-depth process training with the MCOs to address issues related to staff turnover and gaps in knowledge. HSD continues to monitor reporting to identify discrepancies that may arise.

Medicaid Management Information System (MMIS) Replacement

HSD began its planning for replacement of its current legacy Medicaid Management Information System (MMIS) some time ago, and activity for this effort progressed in Q3. The selected Independent Verification and Validation (IVV) vendor began work in August 2016. The first module of the State's Framework for MMIS Replacement (the Integration Platform vendor) was approved by CMS and was released in late August. Work on the next module, the Enterprise Data Services RFP, began with stakeholders, including the MCOs, provider associations, tribal and Indian health agencies, multiple agency State staff, and the Medicaid Advisory Committee. The draft RFP has been submitted to CMS for review.

HSD has reviewed the new CMS certification and modularity guidance and has taken steps to ensure that it is in compliance. This includes hiring an employee whose sole responsibility is to ensure compliance with the certification and MITA guidelines. The newly issued guidance on the role and responsibilities of the System Integrator has caused the State to revisit both the IP and Data Services RFPs.

The replacement MMIS will be a true Enterprise system, so the Department has actively engaged the allied departments of Health, Children Youth and Families, and Aging and Long Term Services. These three departments have participated in RFP development and replacement planning.

HSD is working with its two prime existing vendors on matters related to the replacement system. An amendment with Xerox addressing conversion matters has been executed, and with Deloitte, our integrated eligibility system vendor, we completed the definitional work to have the ASPEN eligibility system become a true Eligibility and Enrollment system. The amendment to have the ASPEN system assume responsibility for managed care enrollment of members also includes provisions for Real Time Eligibility. CMS has approved the amendment and plans.

The Implementation Advance Planning Document Update that was submitted to the Regional Office in March with an updated planning document has been approved by CMS for federal fiscal year 2017.

Section VII: Home and Community-Based Services (HCBS)

New Mexico Independent Consumer Support System (NMICSS)

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

The NMICSS reporting for the quarter is provided by the Aging and Long-Term Services Department (ALTSD), Aging & Disability Resource Center (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 July 1, 2016 to September 30, 2016.

Table 6 – ADRC Call Profiler Report

Topic	# of Calls
Home- and Community-Based Care Waiver Programs	2,618
Long-Term Care/Case Management	198
Medicaid Appeals/Complaints	16
Personal Care	81
State Medicaid Managed Care Enrollment Programs	18
Medicaid Information/Counseling	1,358

The numbers below reflect counseling services provided by the ALTSD Care Transition Program from July 1, 2016 to September 30, 2016.

Table 7 – ADRC Care Transition Program Report

Counseling Services	# of hours	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		125	
Medicaid Education/Outreach	238		
Nursing Home Intakes		66	
*Pre/Post Transition Follow-up Contact			1,263
**LTSS Short-Term Assistance			129

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

****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 LTSS 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 health care services and supports. CTB staff serves as advocates and assists individuals by 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 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 (CI)

HSD continues to work with the CI workgroup in an effort to provide technical assistance to the MCOs. The workgroup supports the Behavioral Health Services Division (BHSD) on the delivery of BH protocols to providers. The protocols will be used by BH providers to improve accuracy of information reported and establish guidelines for the types of BH providers who are required to report. The CI workgroup meetings continue to be held quarterly and the annual Critical Incident Reporting trainings will be held early November 2016.

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

During Q3, a total of 4,368 CIs were filed. 100% of critical incidents received through the CI web portal are reviewed. All deaths reported through the CI Reporting System are reviewed by HSD and the MCOs.

MCOs identified the use of Emergency Services as the highest CI type reported by volume for members with reportable category of eligibility (COE).

- Emergency Services reports account for 63% of the total CIs reported in Q3 (2,754), which is a slight 0.4% increase compared to Q2 (2,744). No specific reason has been attributed to the slight increase. HSD will continue to monitor any decrease or increases of emergency service reports.

- MCOs have member initiatives underway that include interventions for high utilizers of the Emergency Department that includes education on appropriate use of emergency services and alternative, more appropriate settings of care.

Table 8 – DY3 Q3 Critical Incidents

Critical Incident Types by Population Group						
Critical Incident Types	**Centennial Care**		**Behavioral**		**Self Directed**	
	#	**%**	**#**	**%**	**#**	**%**
Abuse	315	7%	111	21%	24	13%
Death	{422}	10%	{23}	4%	{15)	8%
Natural/Expected	379	9%	17	3%	15	8%
Unexpected	38	1%	5	1%	0	0%
Suicide	5	0%	1	0%	0	0%
Elopement/Missing	34	1%	15	3%	0	0%
Emergency Services	2754	63%	293	57%	118	61%
Enviormental Hazard	86	2%	8	2%	5	3%
Exploitation	129	3%	10	2%	13	7%
Law Enforcement	109	2%	22	4%	5	3%
Neglect	519	12%	35	7%	12	6%
Total	**4368**		**517**		**192**	

Table 9 – Critical Incidents by MCO

Critical Incident Types by MCO - Centennial Care								
Critical Incident Types	**BCBS**		**Molina**		**Presbyterian**		**UHC**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Abuse	37	4%	119	8%	71	11%	88	7%
Death	110	13%	127	8%	67	10%	118	9%
Elopement/Missing	3	0%	11	1%	9	1%	11	1%
Emergency Services	535	63%	1,045	70%	357	54%	817	61%
Environmental Hazard	10	1%	26	2%	26	4%	24	2%
Exploitation	21	2%	32	2%	25	4%	51	4%
Law Enforcement	20	2%	45	3%	17	3%	27	2%
Neglect	115	14%	95	6%	95	14%	214	16%
Total	**851**		**1,500**		**667**		**1,350**	

Critical Incident Types by MCO - Behavioral Health								
Critical Incident Types	BCBS		Molina		Presbyterian		UHC	
	#	%	#	%	#	%	#	%
Abuse	7	26%	69	18%	29	33%	6	21%
Death	2	7%	17	5%	4	5%	0	0%
Elopement/Missing	0	0%	6	2%	8	9%	1	3%
Emergency Services	12	44%	238	64%	26	30%	17	59%
Environmental Hazard	0	0%	4	1%	4	5%	0	0%
Exploitation	1	4%	5	1%	2	2%	2	7%
Law Enforcement	3	11%	14	4%	3	3%	2	7%
Neglect	2	7%	20	5%	12	14%	1	3%
Total	27		373		88		29	

Critical Incident Types by MCO - Self Directed								
Critical Incident Types	BCBS		Molina		Presbyterian		UHC	
	#	%	#	%	#	%	#	%
Abuse	1	4%	10	20%	7	11%	6	11%
Death	3	12%	3	6%	3	5%	6	11%
Elopement/Missing	0	0%	0	0%	0	0%	0	0%
Emergency Services	18	69%	29	58%	40	63%	31	58%
Environmental Hazard	0	0%	1	2%	2	3%	2	4%
Exploitation	4	15%	3	6%	4	6%	2	4%
Law Enforcement	0	0%	1	2%	3	5%	1	2%
Neglect	0	0%	3	6%	4	6%	5	9%
Total	26		50		63		53	

HCBS Reporting

The public comment period for New Mexico's Statewide Transition Plan (STP) ended on September 19, 2016. CMS provided feedback to HSD on the STP Systemic Assessment in September 2016. HSD made the requested changes and will resubmit the entire STP to CMS by the end of October 2016.

Community Benefit

In July 2016, the Community Benefit Services Questionnaire (CBSQ) pilot results were presented to the Long-Term Care (LTC) Workgroup. HSD developed criteria for administering the questionnaire to ensure that it will be an appropriate and effective tool. The CBSQ was finalized in September 2016. HSD will issue detailed direction to the MCOs in October 2016. The MCOs will train their care coordinators in October and fully implement the CBSQ by November 14, 2016. HSD will monitor the implementation through “ride-alongs” with care coordinators.

The LTC Workgroup also focused on implementing the requirements of the HCBS Statewide Transition Plan (STP) for certain services within the Community Benefit package. The MCOs provided feedback on the latest version of the STP prior to submission to CMS. The MCOs plan to create a letter for providers to explain the requirements of the STP.

On August 4, 2016 HSD presented on the Centennial Care personal care and respite services to the New Mexico Association for Home Health and Hospice Care (NMAHHC). On September 1, 2016 HSD provided training to the MCO long-term care and systems staff on proper submission of the NFLOC and Setting of Care data related to denials and closures.

In DY3 Q3, HSD met with one of its MCOs to discuss the alignment of MCO selection for Centennial Care members who are also eligible for Medicare. The discussion involved providing education to members to explain the benefits of aligning their Centennial Care MCO selection with the Medicare plan administered by the same MCO. The MCO will collaborate to develop an effective communication strategy.

Section VIII: AI/AN Reporting

Access to Care

Indian health facilities, Indian Health Service, Tribally operated facility/program, and urban Indian clinics (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 last quarter data from the four Centennial Care MCOs shows there is 96% access to PH care for Native Americans in rural areas and 98% access to PH care for Native Americans in frontier areas.

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. There are formal contract agreements in place for:

- Health Risk Assessment completions;
- Translation services;
- Transportation services;
- Durable Medical Equipment;
- Optometry and Vision services;
- Disease management; and
- Peer Support/Wellness Centers.

Ensuring Timely Payment for All I/T/U Providers

All four MCOs met timely payment requirements 97% of the time for claims being processed and paid within 15 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	Zuni Tribal Health Zuni, New Mexico July 29, 2016	There were questions about how the vision benefit works, how to use the member rewards programs, the length of time to receive reimbursement for the traditional healing benefit, how to reach a care coordinator, and if the meetings could be extended to allow for translation. BCBSNM addressed all of the issues with the members and followed up on all requests.

MCO	Date of Board Meeting	Issues/Recommendations
MHNM	Butterfly Healing Center Taos, New Mexico July 7, 2016	MHNM held their advisory board meeting at the adolescent treatment facility at Taos Pueblo. There was a request to simplify the paperwork for the traditional healing benefit. MHNM explained the importance of members completing the HRA.
PHP	Isleta Pueblo, New Mexico September 16, 2016	The question was asked if PHP does criminal background checks for home healthcare companies. The response yes, one is done by the home healthcare agency. If the member has concerns, bring it to the attention of the care coordinator. PHP explained how often a health assessment and comprehensive needs assessment is completed. There was a request for PHP to offer acupuncture as a value added service.
UHC	Dulce Community Center Dulce, New Mexico September 26, 2016	The Vice President of the Jicarilla Apache Nation was present for the NAAB meeting. He expressed concern about substance abuse, PTST among veterans, and correctional system involvement with Tribal members. His administration would like to build strong partnerships and have UHC "come along side". There was discussion about ways the Tribe could be a transportation provider so that there is accessibility for members to get to their medical appointments.

The NATAC meeting for this quarter took place on August 29, 2016. HSD presented on the Access Monitoring Review Plan (Tribal Notification 16-13). HSD also reviewed the State's 2016 General Appropriations Act and provided an update on the work of three Cost Containment Subcommittees, the FY17 Provider Rate Changes, the FY17 Professional Fee Schedule changes, and a list of all the cost-containment Public/Tribal Notifications that have been sent out. There also was an update on work to implement the new federal interpretation of 100% FMAP for services "received through" an IHS/Tribal facility.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment H: MCO Action Plans and Attachment I: Notice to CMS and Directed Corrective Action Plan

Section X: Financial/Budget Neutrality Development/Issues

Attachment A – Budget Neutrality Monitoring, Table 3 "PMPM Summary by Demonstration Year and MEG" shows the immediate impact of cost containment for the most populous MEGs. MEGs 1 and 6 show a declining PMPM in DY3 as compared to DY2.

The reprocessing of the LTSS capitations for the period January 2016 through June 2016 for the new certified rates has yet to occur. The reprocessing will occur in November and December 2016. With the reprocessing, the next quarterly report will have changes to the PMPMs for MEGs 2 through 5.

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 Q3 Member Months

Centennial Care MEG Reporting	
Eligibility Group	**Member Months**
Population 1 – TANF and Related	1,162,954
Population 2 – SSI and Related – Medicaid Only	123,735
Population 3 – SSI and Related – Dual	111,164
Population 4 – 217-like Group – Medicaid Only	454
Population 5 – 217-like Group – Dual	7,635
Population 6 – VIII Group (expansion)	770,223
Population 7 – CHIP Group	134,000
Total	2,310,165

Section XII: Consumer Issues (Complaints and Grievances)

A total of 871 grievances were filed by Centennial Care members in DY3 Q3 and involved each MCO equally. Non-emergency ground transportation continues to constitute the largest number of grievances reported with 207 (23.76%) of the total grievances received. All four MCOs report decreases in the number of transportation grievances received in Q3 when compared to 211 in Q2 and 272 in Q1. HSD is developing a process for the MCOs to report their improvement activities related to reoccurring grievances. The MCOs acknowledged the identified trend with transportation grievances and continue to meet regularly with their transportation vendors to address identified issues.

The second top grievance filed, with a total of 138 grievances (15.84%), was regarding other specialties, such as dissatisfaction with payment on services provided. The grievances within this category do not identify a specific trend. MCO staff continues to educate providers in billing issues on a case by case basis.

The third top grievance filed, with a total of 86 grievances (9.87%), was regarding the Centennial Care member's PCP. Specific member grievances relate to dissatisfaction of service, staff member attitudes, prescriptions not being provided and service authorization issues. The MCOs actions include outreach and education to the provider by resolutions analysts.

The remaining 440 (50.51%) grievances filed during Q3 were reported for multiple grievance reasons, such as dental, emergency room and provider specialist issues. Specific reasons include staff member attitudes, billing issues, and quality of service. MCOs are working with internal departments to analyze data and identify opportunities for process improvements.

HSD continues to monitor grievances to identify specific trends.

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD randomly reviews service plans to ensure the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs appropriately allocate and implement the services identified in the member's CNA, and that the member's goals are identified in the care plan. There were no identified concerns in DY3 Q3.

Table 12 – DY3 Q3 Service Plan Audit

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

NFLOC

HSD reviews high NFLOC and community benefit NFLOC denials on a quarterly basis to ensure the denials were appropriate and comply with NFLOC criteria.

Table 13 – DY3 Q3 NFLOC Audit

High NF denied requests (and downgraded to Low NF)	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	10	17	18	
Number of member files that met the appropriate level of care criteria	10	17	18	
Percent of MCO level of care determination accuracy	100%	100%	100%	

Table 14 – DY3 Q3 Community Benefit LOC Audit

Community Benefit denied requests	DY2 Q1	DY3 Q2	DY3 Q3	DY3 Q4
Number of member files audited	16	20	20	
Number of member files that met the appropriate level of care criteria determined by the MCO	16	20	20	
Percent of MCO level of care determination accuracy	100%	100%	100%	

The External Quality Review Organization (EQRO) for HSD reviewed a random sample of MCO NFLOC determinations. All reviews by the EQRO that were in disagreement with the MCO determination were then reviewed by HSD. HSD continues to meet with the MCOs regarding these determinations and to provide technical assistance on low and high NFLOC criteria.

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**	**28**	**26**	
Number of member files the EQRO agreed with the determination	**18**	**20**	**19**	
%	**75%**	**71%**	**73%**	
Low NF Determination				
Number of member files audited	**84**	**80**	**82**	
Number of member files the EQRO agreed with the determination	**83**	**78**	**82**	
%	**99%**	**98%**	**100%**	
Community Based				
Number of member files audited	**156**	**156**	**156**	
Number of member files the EQRO agreed with the determination	**155**	**153**	**154**	
%	**99%**	**98%**	**99%**	

Care Coordination Monitoring Activities

Care Coordination Audits

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 BH needs through more detailed documentation and ensuring updates to assessment, medications, progress on members goals, and a clear backup and disaster plan are properly updated in the member's file. Face-to-face meetings were conducted with the MCOs in July and August 2016 to address their internal action plans approved by HSD. Continued evaluation of monthly MCO plans is ongoing. Additional HSD responses will be sent to the MCOs by December 2016. Development of new HSD care coordination audit criteria shall be completed by December 2016, including review of the implementation of the new standardized Health Risk Assessment (HRA) tool by all MCOs effective July 1, 2016.

HSD continued to provide technical assistance as needed to all of the MCOs as it relates to care coordination. Collaboration with internal HSD staff and MCOs has been provided by way of consultation specific to MCO members who have complex needs, primarily behavioral health, to determine ways to effectively engage members to work with care coordinators directly. Education has been provided to internal HSD staff and to an MCO to utilize required processes with high health risk/high resource utilizers by using "Engagement of Members" policies.

Care Coordination for Super Utilizers

HSD continued to evaluate the progress of the 10 super utilizers of ED services (defined as having greater than four out-patient ED visits in the past 12 months) from each MCO which were reported 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 use of the ED. HSD met with each of the MCOs individually in May 2016 to provide technical assistance and further discuss successes and challenges with each of their identified members. HSD expanded the number of members participating in the project to 35 per MCO and enhanced monthly data reporting elements for the project. ED visits have decreased for the initial 40 members by 67% during the time period of July 2015 through July 2016. HSD plans to provide data analysis to date and revised reporting template with instructions to all MCOs individually in November 2016 and to organize an in person meeting with all MCOs in January 2017 to review and share information gleaned from the project and outline effective approaches used to engage members successfully.

Care Coordination and EDIE

HSD began monthly participation in the statewide "ER is for Emergencies" committee in July 2016. Also known as the EDIE (Emergency Department Information Exchange) Project or PreManage ED, this collaborative effort among all of the MCOs is designed to increase care management resources, reduce medically-unnecessary ED readmissions and inappropriate ED utilization, and improve patient outcomes through consistent delivery of care. A Clinical Consensus Group has been formalized and HSD will participate in the development of a statewide standardized care plan accessible to participating emergency room departments and MCO care coordinators. The focus will be on high utilizer members who may need more active management through shared information and collaboration.

Care Coordination for Incarcerated Individuals

HSD continues to provide technical assistance for a pilot project involving a sample population of jail-involved members enrolled with one of the MCOs. This project involves connecting members being released from jail with care coordination, to address members' immediate needs upon release, and ultimately achieve such goals as reducing recidivism and improving public health. Care coordination is provided by the MCO staff in collaboration with detention center staff to members prior to release. Various approaches are being utilized to effectively engage members to participate in care coordination and complete HRAs and Comprehensive Needs Assessments (CNAs), and schedule appointments with appropriate providers. Consultative

review of project reports has been provided to the project since D3Q2 and recommendations for refinement of data collection and care coordination approaches are made by HSD to the MCO and MDC staff regularly.

Care Coordination Software

HSD collaborated with an MCO for the implementation of a new clinical software system migration. This process led by HSD Care Coordination staff included oversight of contract required elements to be included in the new system design and function. A formal onsite readiness review was conducted by HSD and a demonstration was provided by the MCO to HSD staff in September 2016. The new system has improved functionality which allows for more efficient care coordination and auditing. HSD verified that MCO users, including care coordinators, participated in the system design, and has given positive feedback to date.

HSD conducted "ride-a-longs" with MCO care coordinators in July and August 2016 to observe member visits in the home setting. HSD reviewed ride-a-long experiences with the MCOs identifying the need to continue Care Coordination training on assessments and available services. Modifications to assessment tools and technical assistance was provided to the MCOs based on the observations. MCO acknowledged the need for continued training and that the process was helpful to the MCO care coordinators.

Section XIV: Managed Care Reporting Requirements

MCO Reporting Process

During DY3 Q3, HSD's implementation of the Technical Assistance (TA) call process continues to improve the quality of MCO reports and provides them with an opportunity to obtain valuable guidance from HSD Contract Managers. Additionally, HSD continues to evaluate its managed care reporting resubmission processes to make certain they are effective, align with HSD policies and procedures, and subsequently lead to positive outcomes.

Furthermore, HSD subject matter experts (SMEs) consistently perform quality reviews of MCO reports to ensure the data is accurate and adheres to HSD's compliance requirements and performance standards. HSD SMEs are selected to review specific MCO reports based on their level of expertise and ability to identify data trends and patterns. HSD developed a data analytics methodology and tools for SMEs to utilize in conducting a comprehensive analysis of MCO reports.

Customer Service

In June, July, and August 2016, MHNM and UHC, met or exceeded contract standards for all customer service lines (member services, provider services, nurse advice lines and utilization management).

BCBSNM continues to meet contract metrics for all customer services lines except for the provider services line. One hundred percent of voicemails are contractually required to be returned by the next business day. In June, BCBSNM did not meet contractual requirements by returning 94.8% of voicemails by the next business day. As a result, additional staff was trained to ensure all voicemails were returned. In July and August 2016, BCBSNM reported 100% of voicemails were returned by the next business day.

PHP continues to meet contract metrics for all customer service lines except the member services line, provider services line, and UM services line. Calls are contractually required to be answered within 30 seconds 85% of the time. In July, PHP experienced network/telecommunication interruptions, which impacted the ability of call center staff to answer calls in a timely manner. PHP reported 83.6% of calls were answered within 30 seconds for member services line and the provider services line. Additionally, PHP reported 80.1% of calls were answered within 30 seconds for the UM services line. In June and August 2016, PHP met all contract metrics.

Appeals

A total of 1,143 appeals were filed by Centennial Care Members in DY3 Q3. Of the total appeals filed, 731 (64%) were upheld, 374 (33%) were overturned and 14 (1%) were partially overturned. The remaining appeals filed in Q3 were pending resolution, transferred to Fair Hearings, dismissed or were received late in the quarter and were carried over to the following month for resolution.

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues as expected with DY3 Q3 activities generally devoted to data collection, data review, and preparations to complete analysis of received data.

For the DY2 evaluation period, Deloitte Consulting provided HSD with an updated data request that included a summary of files that were required to complete yearly evaluation activities. The data request incorporated a tracking component that allowed the Deloitte team and HSD to have an understanding of what had been received and what was still outstanding at any given time. Further, questions related to the data files from Deloitte Consulting to HSD were tracked in this workbook to consolidate all data related activities into one document for ease of use and to provide each user with a full up to date picture of current data standings.

Due to ongoing data collection activities, the Evaluation Model is currently being updated to reflect DY2 data and adjusted for revised analyses based on lessons learned from DY1 of the Evaluation. After completing all data collection and review, the final Evaluation Model Exhibit will be included as supporting documentation of the analytic review.

The fourth quarter of 2016 will be devoted to completing the collection of all data files, verifying appropriateness and reasonableness of data received and receiving answers to outstanding and new data questions related to received data files. By the end of the fourth quarter, all data analysis should be completed to allow for the DY2 annual report to be finalized by DY4 Q1.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Tables (July 1 – September 30, 2016)
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment E: HSD Secret Shopper Survey Scripts
Attachment F: HSD Secret Shopper Methodology
Attachment G: Centennial Care Contract Amendment #6
Attachment H: MCO Action Plans
Attachment I: Notice to CMS and Directed Corrective Action Plan

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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Jason Sanchez Deputy Director HSD/Medical Assistance Division	(505)827-6234	JasonS.Sanchez@state.nm.us	(505)827-3185
Kari Armijo Deputy Director HSD/Medical Assistance Division	(505)827-1344	Kari.Armijo@state.nm.us	(505)827-3185

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
A member was diagnosed with colon and liver cancer a few months ago. Their local hospital, located in a remote part of the State, informed the member that they were not taking new patients. The member was forced to look for treatment options out of state. However, a few weeks ago, the member's port broke, and a replacement was needed so chemotherapy could be continued. The care coordinator worked with one of the medical directors to intervene with the member's local hospital, explaining that the port replacement was a continuation of service. The port was replaced, and the member was able to continue with chemotherapy. The care coordinator continues to work with the member on their recovery and future service needs.

Centennial Care Member Success Story 2
A care coordinator has a member with physical and BH issues. The member had not seen a Primary Care Physician (PCP) or BH provider in a few years and as a result did not have the appropriate medication. The care coordinator was able to find the member a PCP and a BH provider. The member was very good about attending all PCP appointments, but refused to attend any BH appointments.

The care coordinator suggested to the member and the member's guardian that they try telehealth for the BH appointment. The member and the guardian agreed to try it. The care coordinator went to the member's home, set up telehealth services, and showed them how to make an appointment, even scheduling an appointment for the member for the following day.

A week later, the care coordinator received a phone call from the member's guardian indicating the telehealth appointment went really well. In addition, the BH provider sent a prescription to the pharmacy for the member's BH medication. The member was pleased with the process and is excited to be able to receive the services needed.

Centennial Care Member Success Story 3
A family receiving care coordination has been connected with HELP-NM, a local non-profit organization, for assistance in several situations. HELP-NM will be assisting this family with funding of $300 for car repairs. Although the repairs will exceed the $300 donation, Uptown Auto Clinic is willing to cover the remainder of the cost so their car can be fixed. Additionally, the care coordinator scheduled a meeting to assist with completing a housing application. HELP-NM is trying to help get the family into a home/apartment and is also looking for a service agency to get the family in obtaining ongoing case management services. HELP-NM stated that the family was crying when they received this news. In addition, the husband of the family is scheduled to start his new job.

Centennial Care Member Success Story 4

A member's mother called the Centennial Care Customer Service Center requesting mileage reimbursement from Albuquerque, New Mexico to Denver, Colorado. The member's mother was referred by Superior Medical Transportation. The member's mother was emotional and overwhelmed because of her daughter's illness and the future expenses for their travel to Denver. One of the Centennial Care customer service representatives assisted the member's mother by listening to the mother's concerns. The customer service representative provided outstanding customer service by explaining and offering travel and lodging arrangements. The customer service representative submitted the travel reimbursement request, contacted care coordination, and explained the situation to the member. The member's mother was very impressed by the customer service. In addition, the member's mother did not know that a member has travel and lodging benefits out of the State. The customer service representative was able to sooth the families' financial worries and direct them to their care coordinator for future services.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- PMPM Analysis

DY 3

Start Date: 01/01/2016

End Date: 12/31/2016

Quarter 3

Start Date:07/01/2016

End Date: 09/30/2016

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01 TANF & Related	DY 01 Cost Estimates	DY1 YTD - Actuals [2]	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	3,440,593
PMPM	$ 385.80	$ 338.59	$ 400.77	$ 328.28	$ 416.32	$ 318.26
Dollars	$ 1,823,911,159	$ 1,529,464,005	$ 1,948,487,793	$ 1,462,262,310	$ 2,090,074,424	$ 1,095,006,886

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	494,529	518,976	371,462
PMPM	$ 1,763.90	$ 1,653.28	$ 1,842.83	$ 1,762.71	$ 1,925.21	$ 1,809.35
Dollars	$ 897,298,062	$ 823,264,304	$ 946,727,393	$ 871,709,997	$ 999,138,707	$ 672,103,077

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	435,140	386,831	331,602
PMPM	$ 1,780.77	$ 1,333.08	$ 1,857.34	$ 1,336.43	$ 1,937.21	$ 1,355.09
Dollars	$ 665,692,378	$ 570,591,720	$ 706,189,973	$ 581,532,132	$ 749,372,219	$ 449,350,553

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	2,382	5,959	1,455
PMPM	$ 4,936.92	$ 2,374.61	$ 5,090.46	$ 2,342.16	$ 5,248.77	$ 2,604.72
Dollars	$ 28,834,295	$ 6,646,544	$ 30,025,379	$ 5,579,029	$ 31,274,952	$ 3,789,865

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	27,063	28,907	22,117
PMPM	$ 1,776.90	$ 3,226.79	$ 1,853.31	$ 3,142.27	$ 1,933.00	$ 2,946.26
Dollars	$ 49,637,569	$ 86,784,521	$ 52,657,285	$ 85,039,200	$ 55,877,183	$ 65,162,524

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	2,748,632	1,800,808	2,280,965
PMPM	$ 577.87	$ 540.98	$ 607.34	$ 536.96	$ 638.31	$ 496.79
Dollars	$ 943,638,928	$ 1,021,228,516	$ 1,086,464,733	$ 1,475,901,523	$ 1,149,478,718	$ 1,133,160,302

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	$ 68,889,340	$ 68,889,323	$ 34,444,670

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 4. Report pulled on 11/14/16

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 1

Start Date: 01/01/2014

End Date: 12/31/2014

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

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 385.80	4,517,149	$ 1,742,724,978	70.77%	$ 1,233,326,467	$ 1,529,464,005	$ 1,100,651,139
MEG02 - SSI & Related - Medicaid Only	$ 1,763.90	497,958	$ 878,350,269	70.77%	$ 621,608,485	$ 823,264,304	$ 573,696,344
MEG03 - SSI & Related - Dual Eligible	$ 1,780.77	428,025	$ 762,214,336	70.77%	$ 539,419,086	$ 570,591,720	$ 395,548,338
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	70.77%	$ 48,752,974	$ 68,889,322	$ 47,671,411
MEG09 HQII	NA	NA	$ -	70.77%	$ -	$ -	$ -
Grand Total			**$ 3,452,178,905**		**$ 2,443,107,011**	**$ 2,992,209,351**	**$ 2,117,567,232**

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

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 4,936.92	2,799	$ 13,818,444	69.31%	$ 9,577,563	$ 6,646,544	$ 4,606,604
MEG 05 - "217 Like" Dual Eligible	$ 1,776.90	26,895	$ 47,789,749	69.31%	$ 33,123,075	$ 86,784,521	$ 60,152,886
Grand Total			**$ 61,608,193**		**$ 42,700,639**	**$ 93,431,065**	**$ 64,759,490**

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

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 577.87	1,887,728	$ 1,090,856,222	100.00%	$ 1,090,856,222	$ 1,021,228,516	$ 1,021,228,516
Grand Total			**$ 1,090,856,222**		**$ 1,090,856,222**	**$ 1,021,228,516**	**$ 1,021,228,516**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,443,107,011**
Federal Share (Title XIX) Actual Reported	$ 2,117,567,232
Excess Spending - Test 1	$ 22,058,851
Excess Spending - Test 2	$ -
Total Actuals	$ 2,139,626,083
Difference (Actuals - Limit)	$ (303,480,928)
Percentage Difference	-12%

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY16 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY16 Quarter 4. Report pulled on 11/14/16.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 2

Start Date: 01/01/2015

End Date: 12/31/2015

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

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 400.77	4,454,290	$ 1,785,150,637	70.80%	$ 1,263,886,651	$ 1,462,262,310	$ 1,047,412,754
MEG02 - SSI & Related - Medicaid Only	$ 1,842.83	494,529	$ 911,332,877	70.80%	$ 645,223,677	$ 871,709,997	$ 611,364,240
MEG03 - SSI & Related - Dual Eligible	$ 1,857.34	435,140	$ 808,202,928	70.80%	$ 572,207,673	$ 581,532,132	$ 406,139,496
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	70.80%	$ 48,773,641	$ 68,889,340	$ 48,111,047
MEG09 HQII	NA	NA	$ 2,824,462	70.80%	$ 1,999,719	$ 2,824,462	$ 1,987,574
Grand Total			**$ 3,576,400,227**		**$ 2,532,091,361**	**$ 2,987,218,241**	**$ 2,115,015,111**

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

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,090.46	2,382	$ 12,125,476	69.85%	$ 8,469,645	$ 5,579,029	$ 3,896,960
MEG 05 - "217 Like" Dual Eligible	$ 1,853.31	27,063	$ 50,156,129	69.84%	$ 35,029,040	$ 85,039,200	$ 59,389,504
Grand Total			**$ 62,281,604**		**$ 43,498,685**	**$ 90,618,229**	**$ 63,286,464**

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

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 607.34	2,748,632	$ 1,669,354,159	100.00%	$ 1,669,354,159	$ 1,475,901,523	$ 1,475,901,523
Grand Total			**$ 1,669,354,159**		**$ 1,669,354,159**	**$ 1,475,901,523**	**$ 1,475,901,523**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,532,091,361**
Federal Share (Title XIX) Actual Reported	$ 2,115,015,111
Excess Spending - Test 1	$ 19,787,779
Excess Spending - Test 2	$ -
Total Actuals	$ 2,134,802,890
Difference (Actuals - Limit)	$ (397,288,471)
Percentage Difference	-16%

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY16 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY16 Quarter 4. Report pulled on 11/14/16.

Q3 2016 Attachment B - GeoAccess PH Q2DY3 (Apr 1 - Jun 30, 2016)

Meets Standard | Does Not Meet

	Urban				Rural				Frontier			
PH - Standard 1	**BCBSNM**	**UHC**	**MHNM**	**PHP**	**BCBSNM**	**UHC**	**MHNM**	**PHP**	**BCBSNM**	**UHC**	**MHNM**	**PHP**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	99.9%	100.0%	99.7%	100.0%	99.9%
Pharmacies	100.0%	100.0%	100.0%	100.0%	99.9%	98.8%	100.0%	99.8%	99.2%	99.4%	99.0%	99.7%
FQHC - PCP Only	100.0%	100.0%	100.0%	100.0%	91.1%	99.1%	82.0%	99.6%	97.4%	98.1%	98.0%	98.9%
PH - Standard 2												
Cardiology	99.2%	99.1%	99.0%	99.0%	99.7%	99.5%	100.0%	99.6%	99.8%	99.8%	100.0%	99.9%
Certified Nurse Practitioner	99.2%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	99.8%	99.9%	100.0%	100.0%
Certified Midwives	99.1%	100.0%	99.0%	96.7%	90.9%	90.7%	93.0%	92.8%	96.6%	97.9%	97.0%	98.8%
Dermatology	71.7%	95.2%	76.0%	85.2%	57.7%	67.2%	63.0%	69.7%	74.3%	88.2%	87.0%	78.3%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	94.8%	99.1%	98.0%	99.0%	73.2%	90.0%	68.0%	68.6%	76.4%	91.0%	89.0%	86.5%
ENT	99.1%	99.1%	98.0%	99.0%	90.7%	93.0%	98.0%	98.5%	94.8%	93.2%	98.0%	98.3%
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/Oncology	99.1%	99.0%	98.0%	99.2%	99.7%	99.1%	98.0%	98.9%	99.3%	99.8%	94.0%	99.7%
Neurology	99.1%	99.1%	98.0%	99.0%	98.5%	89.4%	94.0%	91.7%	91.6%	88.6%	89.0%	90.5%
Neurosurgeons	99.1%	98.8%	98.0%	99.0%	39.3%	43.1%	47.0%	58.8%	69.8%	74.2%	71.0%	74.9%
OB/Gyn	100.0%	99.1%	99.0%	99.1%	99.9%	99.8%	100.0%	99.6%	99.7%	99.8%	100.0%	99.9%
Orthopedics	99.2%	100.0%	99.0%	99.1%	99.9%	99.8%	100.0%	99.6%	96.6%	97.7%	98.0%	98.8%
Pediatrics	100.0%	99.1%	98.0%	100.0%	99.7%	99.3%	100.0%	99.6%	99.8%	98.0%	100.0%	100.0%
Physician Assistant	100.0%	96.3%	100.0%	100.0%	99.9%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.2%	99.1%	99.0%	99.2%	99.9%	99.3%	99.0%	100.0%	99.8%	99.9%	95.0%	98.9%
Rheumatology	99.1%	95.3%	98.0%	99.0%	77.8%	73.8%	98.0%	89.1%	82.1%	83.9%	90.0%	87.3%
Surgeons	99.2%	99.1%	99.0%	99.2%	99.9%	99.3%	100.0%	99.6%	99.8%	99.8%	100.0%	99.9%
Urology	99.1%	99.0%	98.0%	99.0%	82.3%	98.0%	94.0%	98.0%	92.6%	94.7%	93.0%	95.9%
LTC - Standard 2												
Personal Care Service Agencies (PCS) - delegated	99.2%	100.0%	100.0%	100.0%	99.0%	99.4%	99.0%	99.6%	100.0%	100.0%	100.0%	100.0%
Personal Care Service Agencies (PCS) - directed	99.2%	100.0%	100.0%	99.3%	99.0%	99.4%	100.0%	99.6%	99.8%	100.0%	100.0%	100.0%
Nursing Facilities	94.9%	99.3%	93.0%	97.1%	99.5%	98.0%	99.0%	98.6%	99.9%	97.7%	100.0%	100.0%
General Hospitals	99.2%	95.3%	98.0%	99.1%	99.7%	96.6%	100.0%	99.4%	99.8%	99.0%	100.0%	99.9%
Transportation	100.0%	100.0%	100.0%	100.0%	99.6%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

nd - no data

Distance Standard 1 - For PCPs including internal medicine, general practice and family practice provider types and (ii) pharmacies:

- Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles.
- Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles.
- Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

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

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

Q3 2016 Attachment C - GeoAccess BH Q2DY3 (Apr 1 - Jun 30, 2016)

Meets Standard | Does Not Meet

Standard 2	Urban				Rural				Frontier			
	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP
Freestanding Psychiatric Hospitals	87.6%	78.7%	90.0%	85.3%	37.3%	30.8%	18.0%	41.0%	54.2%	81.5%	68.0%	71.3%
General Hospitals with psychiatric units	23.0%	98.6%	93.0%	96.3%	33.8%	72.2%	79.0%	85.1%	32.9%	82.5%	83.0%	81.8%
Partial Hospital Programs	92.7%	98.7%	33.0%	19.0%	26.0%	72.2%	13.0%	5.0%	63.7%	86.2%	12.0%	5.2%
Accredited Residerntial Treatment Centers (ARTC)	87.6%	78.7%	90.0%	85.3%	30.0%	34.8%	28.0%	53.1%	67.3%	72.0%	68.0%	71.5%
Non-Accredited Residential Treatment Center & Group Homes	71.5%	54.6%	84.0%	82.7%	58.7%	38.6%	73.0%	71.5%	72.9%	56.5%	89.0%	94.1%
Treatment Foster Care I & II	82.9%	95.3%	92.0%	96.2%	44.7%	71.3%	62.0%	77.5%	57.0%	95.4%	91.0%	95.2%
Core Service Agencies	100.0%	99.1%	92.0%	99.1%	80.0%	99.4%	100.0%	99.9%	88.6%	100.0%	100.0%	100.0%
Community Mental Health Centers	94.1%	99.1%	98.0%	99.2%	72.0%	98.4%	94.0%	99.6%	99.6%	99.8%	100.0%	99.9%
Indian Health Service and Tribal 638s providing BH	70.9%	ND	ND	80.0%	45.2%	ND	ND	67.2%	81.7%	ND	ND	87.3%
Outpatient Provider Agencies	81.5%	99.3%	98.0%	100.0%	27.5%	100.0%	95.0%	100.0%	53.1%	100.0%	94.0%	100.0%
Agencies providing Behavioral Mgmt. Srvs.	81.4%	93.3%	96.0%	99.1%	18.3%	39.4%	36.0%	59.0%	44.4%	87.4%	73.0%	86.7%
Agencies providing Day Treatment Services	0.0%	75.1%	58.0%	66.0%	8.9%	82.8%	29.0%	38.6%	0.0%	92.1%	48.0%	57.5%
Agencies providing Assertive Community Treatment	60.0%	54.6%	84.0%	96.1%	18.4%	18.0%	49.0%	49.9%	44.6%	39.6%	71.0%	74.9%
Agencies providing Multi-Systemic Therapy	0.0%	94.7%	66.0%	98.7%	0.0%	59.1%	54.0%	71.6%	0.0%	73.8%	60.0%	76.9%
Intensive Outpatient Services	70.4%	95.2%	66.0%	96.7%	50.8%	73.4%	83.0%	95.9%	62.1%	84.4%	83.0%	99.8%
Methadone Clinics	94.6%	95.2%	92.0%	96.6%	42.6%	38.4%	38.0%	54.8%	76.6%	78.2%	77.0%	81.0%
FQHCs providing BH services	99.1%	99.1%	100.0%	100.0%	92.0%	85.7%	76.0%	92.0%	85.8%	100.0%	100.0%	100.0%
Rural Health Clinics providing BH Services	0.7%	0.1%	0.0%	0.0%	52.6%	17.8%	36.0%	16.3%	68.2%	62.4%	5.0%	9.3%
Psychiatrists	100.0%	99.1%	100.0%	99.9%	99.9%	87.3%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%
Psychologists	100.0%	99.2%	99.0%	100.0%	90.7%	88.3%	93.0%	94.4%	99.9%	99.7%	100.0%	99.9%
Suboxone certified MDs	99.2%	74.8%	100.0%	99.1%	75.2%	44.0%	99.0%	93.8%	99.8%	64.3%	100.0%	99.9%
Other Licensed Independent BH practioners	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Inpatient Psychiatric Hospitals	87.6%	98.7%	98.0%	98.8%	69.9%	72.2%	80.0%	85.3%	67.6%	86.2%	87.0%	85.5%

nd - no data

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

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

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	**July 14 - June 15**	**July 15 - June 16**	**July 14 - June 15**	**July 15 - June 16**
Inpatient (Admissions)	106.2	95.0	$ 8,825	$ 9,027
Inpatient (Days)	458.9	452.3	$ 2,043	$ 1,895
Practitioner / Physician (Services)	9,197.8	8,606.1	$ 68	$ 68
Emergency Department (Visits)	563.1	534.9	$ 322	$ 341
Outpatient (Visits)	1,440.1	1,407.4	$ 263	$ 277
Pharmacy (Scripts)	5,093.8	4,936.3	$ 53	$ 62
Other (Services)[1]	8,999.3	9,133.4	$ 58	$ 58

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**July 14 - June 15**	**July 15 - June 16**	**July 14 - June 15**	**July 15 - June 16**
Brand	15%	15%	$ 234	$ 300
Generic	83%	84%	$ 19	$ 19
Other Rx[2]	1%	1%	$ 97	$ 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	**July 14 - June 15**	**July 15 - June 16**	**July 14 - June 15**	**July 15 - June 16**
Inpatient (Admissions)	81.1	71.7	$ 15,203	$ 16,829
Inpatient (Days)	487.9	531.7	$ 2,528	$ 2,269
Practitioner / Physician (Services)	9,662.7	8,992.8	$ 80	$ 80
Emergency Department (Visits)	659.6	642.5	$ 456	$ 483
Outpatient (Visits)	2,680.9	2,362.8	$ 278	$ 295
Pharmacy (Scripts)	10,027.3	10,093.8	$ 59	$ 74
Other (Services)[1]	10,036.0	9,795.9	$ 64	$ 68

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**July 14 - June 15**	**July 15 - June 16**	**July 14 - June 15**	**July 15 - June 16**
Brand	12%	12%	$ 369	$ 489
Generic	86%	86%	$ 16	$ 16
Other Rx[2]	2%	2%	$ 80	$ 87

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	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Inpatient (Admissions)	229.9	219.9	$ 2,912	$ 2,624
Inpatient (Days)	1,280.8	1,228.5	$ 523	$ 470
Nursing Home (Days)	198,983.5	207,417.7	$ 57	$ 51
Personal Care (Services / hr.)	836,852.7	794,542.4	$ 15	$ 15
Outpatient (Visits)	4,563.2	4,300.2	$ 133	$ 123
Pharmacy (Scripts)	1,573.1	1,501.9	$ 24	$ 24
HCBS (Services)	4,029.3	4,349.6	$ 145	$ 155
Other (Services)[1]	42,095.1	40,999.1	$ 42	$ 47

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Brand	19%	21%	$ 68	$ 72
Generic	78%	76%	$ 11	$ 9
Other Rx[2]	2%	2%	$ 69	$ 74

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	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Inpatient (Admissions)	356.3	332.3	$ 17,273	$ 18,973
Inpatient (Days)	2,355.7	2,245.6	$ 2,612	$ 2,807
Nursing Home (Days)	19,320.6	16,782.3	$ 180	$ 170
Personal Care (Services / hr.)	905,184.0	797,969.7	$ 15	$ 15
Outpatient (Visits)	7,433.1	7,505.5	$ 380	$ 397
Pharmacy (Scripts)	44,725.0	42,688.9	$ 71	$ 86
HCBS (Services)	7,026.5	9,457.2	$ 94	$ 109
Other (Services)[1]	69,212.0	66,977.6	$ 80	$ 82

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Brand	14%	13%	$ 380	$ 508
Generic	84%	84%	$ 20	$ 20
Other Rx[2]	2%	2%	$ 87	$ 86

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	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Inpatient (Admissions)	250.8	217.3	$ 7,332	$ 9,196
Inpatient (Days)	1,593.0	1,535.6	$ 1,155	$ 1,302
Nursing Home (Days)	28,440.2	8,982.8	$ 17	$ 28
Personal Care (Services / hr.)	165.1	94.5	$ 9	$ 11
Outpatient (Visits)	5,602.3	5,780.3	$ 170	$ 188
Pharmacy (Scripts)	8,268.4	11,428.3	$ 81	$ 107
HCBS (Services)	396,023.6	311,468.9	$ 115	$ 108
Other (Services)[1]	66,764.3	60,041.6	$ 59	$ 52

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Brand	14%	14%	$ 390	$ 460
Generic	82%	83%	$ 28	$ 49
Other Rx[2]	4%	3%	$ 50	$ 89

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	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Inpatient (Admissions)	77.4	73.0	$ 4,314	$ 3,001
Inpatient (Days)	496.2	414.5	$ 673	$ 529
Practitioner / Physician (Services)	9,234.3	8,426.6	$ 26	$ 24
Emergency Department (Visits)	561.6	536.7	$ 143	$ 133
Outpatient (Visits)	2,787.6	2,599.0	$ 131	$ 113
Pharmacy (Scripts)	1,348.5	994.4	$ 40	$ 25
Other (Services)[1]	10,191.4	10,580.8	$ 128	$ 188

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Brand	19%	22%	$ 139	$ 76
Generic	78%	75%	$ 14	$ 8
Other Rx[2]	3%	2%	$ 77	$ 75

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	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Inpatient (Admissions)	30.5	32.0	$ 1,061	$ 1,051
Inpatient (Days)	103.0	96.3	$ 314	$ 349
BH Practitioner (services)	463.5	360.1	$ 77	$ 92
Core Service Agency (Services)	340.7	260.4	$ 96	$ 102
BH outpatient / clinic services	1,838.5	2,187.7	$ 76	$ 70
Pharmacy (Scripts)	2,023.4	2,088.4	$ 52	$ 45
Other (Services)[1]	107.7	102.4	$ 943	$ 946
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 14 - June 15	July 15 - June 16	July 14 - June 15	July 15 - June 16
Brand	5%	3%	$ 489	$ 383
Generic	95%	97%	$ 28	$ 32
Other Rx[2]	0%	0%	$ -	$ -

Notes:

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

New Mexico Medicaid
Centennial Care Secret Shopper Survey Scripts

Scenario: I'm new to the area and want to get set up with a doctor.

Information Points:

- Is the provider/practice accepting new patients?
- Does the provider/practice accept Medicaid (Centennial Care)?
- With which MCOs is the provider/practice contracted?
- What is the time to the first (new) appointment (date)?
- Does the provider/practice offer extended hours (evening, weekend or both)?
- Once established, what is the number of days to appointment? If sick (more urgent)?

PCP Sample Script (Internal Medicine, Family, Certified Nurse Practitioner, Physician Assistant):

Hi, I'm new in the area and heard Dr. <<name>> is good. I'd like to make an appointment.
If doctor's name isn't available, than ask "Are you accepting new patients?"
If not accepting new patients – Is there anyone else in the office that is taking new patients?
Please verify on your tracking sheet if this is an Individual or Group practice. Please also note if you are offered an alternative physician or mid-level practitioner, e.g. PA or CNP)
I just got Medicaid (Centennial Care), and I haven't picked my insurance company yet. What insurance do you accept?
When can I get in for an appointment? (first available - date)
Do you have any extended hours? (evenings, weekends or both)
If I were already your patient, how long would it take me to get in? (# days)
Would it be the same if I was really sick and needed to come in? (Y/N, # days)
Thank you for the information. I'll need to call you back.

OBGYN:

I'm new to the area and about six weeks pregnant. I need to get a new OB…

Cardiology:

I'm new to the area and I'm told that I have an irregular heartbeat. I was told that I should see a cardiologist…
If asked, "Who is your PCP?" Please answer, "I don't have one yet. Who would you recommend?"

Peds:

I'm new to the area, and I have a son who's five years old. I'd like to have him see a pediatrician…

NEW MEXICO CENTENNIAL CARE
SECRET SHOPPER SURVEY METHODOLOGY

The Human Services Department Medical Assistance Division (HSD/MAD) selected primary care physicians (PCPs) and specialty care provider types from the state's Medicaid Management Information System (MMIS/Omnicaid). For purposes of this survey, a PCP is defined as a: Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO)/General Practice, Family Practice, Internal Medicine, Preventive Medicine and Certified Nurse Practitioner (excluding Psychiatric) provider. PCPs are also located at the following facilities that were included in the selection: Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) Freestanding and Hospital Based. Additional criteria used to select providers include: an active provider type; an Unrestricted billing code (billing and /or rendering provider); a Billing (only) billing code; New Mexico location; and, at least one active MCO affiliation. The specialty types selected for this survey include those for the following: Cardiology, Obstetrics and Gynecology (OB-GYN) and Pediatrics.

The survey was conducted in August 2016. One hundred percent of specialists in each specialty category were surveyed. A random sample of PCPs, using a random number generator, was selected to return a 95% confidence level with a +/- 5 confidence interval. Statistically valid sample sizes were determined using a sample size calculator. A total of 196 PCPs were surveyed. HSD/MAD measured: the number and percent of open panels, time to appointment for new and established patients, and time to appointment for more urgent appointments including same day. Other measures included: practices with extended hours; practices offering midlevel practitioner appointments when physicians were not available; and, the number of MCOs with which the practice is contracted.

Caller id was blocked when calling the providers/practices. Surveyors were trained and coached by staff managers to deliver the script in a conversational format. HSD/MAD provided one-page (16 records) of providers/practices that were identical across surveyors. Appointment times and other responses were compared to ensure consistency and reliability across surveyors. The survey was conducted after public schools were back in session, so that a potential surge in appointments for sports physicals or immunizations would not misrepresent time-to-appointment results particularly for pediatrician appointments. Similarly, the timing was such that potential surges during the cold and flu season were avoided so that seasonal fluctuations would not affect the results of the time-to-appointment measures. For ranges of days to appointment, the earliest number of days were averaged and the latest number of days were averaged by provider type. Same day appointments were measured as zero (0) days to appointment.

HUMAN SERVICES
DEPARTMENT

State of New Mexico
Human Services Department

Amendment 6 to Medicaid Managed Care Agreement

Among

New Mexico Human Services Department,
New Mexico Behavioral Health Purchasing Collaborative
and
HCSC Insurance Services Company, operating as Blue Cross and Blue Shield of New Mexico

PSC: 13-630-8000-0021 A-6

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAID MANAGED CARE SERVICES AGREEMENT
FOR CENTENNIAL CARE

AMENDMENT NO. 6

This Amendment No. 6 to PSC: 13-630-8000-0021 is made and entered into by and between the New Mexico Human Services Department ("HSD"), the New Mexico Behavioral Health Purchasing Collaborative (the "Collaborative") and HCSC Insurance Services Company, operating as Blue Cross Blue Shield of New Mexico ("CONTRACTOR"), and is to be effective July 1, 2016.

WHEREAS, there are certain clarifications and revisions to the Contract that are necessary;

IT IS MUTUALLY AGREED BY THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE REFERENCED CONTRACT ARE AMENDED AND RESTATED AS FOLLOWS:

1) **Section 2 of the Contract is amended to add the following definitions:**

Coordination Level (CCL): identifies the level of support a Member needs through Care Coordination services for the Member to improve or maintain, and manage their individual health needs effectively.

Comorbid Conditions: the presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder; or the effect of such additional disorders or diseases. The additional disorder may also be a behavioral or mental disorder.

Comprehensive Needs Assessment (CNA): The CNA will assess the Member's physical, behavioral health, and long-term care needs; identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the member's assessed needs. The CNA may also include a functional assessment, if applicable.

Health Risk Assessment (HRA): the HSD approved and standardized health screening questionnaire, used by the CONTRACTOR to provide individual Members with an evaluation of their health risks and identification of their current health needs.

Treat First Definition: The Treat First Model is a clinical practice approach that is used to achieve immediate formation of a therapeutic relationship while gathering needed historical assessment and treatment planning information over the course of a four therapeutic encounters.

2) **Section 2 of the Contract is amended to add the following list of acronyms at the end of the Section:**

ABA—Applied Behavioral Analysis
ABP—Alternative Benefit Plan
ACA—Affordable Care Act (Patient Protection and Affordable Care Act)
ACIP—Advisory Committee on Immunization Practices
ACT—Assertive Community Treatment
ADL—Activities of Daily Living
AHRQ—Agency for Healthcare Quality and Research
ARRA—American Recovery and Reinvestment Act
ARTC—Accredited Residential Treatment Center
BAA—Business Associate Agreement
BC-DR—Business Continuity and Disaster Recovery
BHH—Behavioral Health Home
BHPC—Behavioral Health Planning Council
BMS—Behavioral Management Service
BP—Blood Pressure
CAHPS—Consumer Assessment of Healthcare Providers and Systems
CNA—Comprehensive Needs Assessment
CAP—Corrective Action Plan
CAS—Claims Adjustment Code identifying the detailed reason the adjustment was made
CCC—Children with Chronic Conditions
CCL—Care Coordination Level
CCP—Comprehensive Care Plan
CCSS—Comprehensive Community Support Services
CD—Compact Disc
CDD—Center for Development & Disability
CEO—Chief Executive Officer
CFDA—Catalog of Federal Domestic Assistance
CFO—Chief Financial Officer
CFR—Code of Federal Regulations
CHW—Community Health Worker
CIO—Chief Information Officer
CLIA—Clinical Laboratory Improvement Amendments
CLNM - CareLink NM (New Mexico's Health Home)
CMHC—Community Mental Health Center
CMMI—Center for Medicare and Medicaid Innovation
CMO—Chief Medical Officer
CMS—Centers for Medicare & Medicaid Services
CNP—Certified Nurse Practitioner
CNS—Clinical Nurse Specialist
COBA—Coordination of Benefits Agreement
CPT—Current Procedural Terminology

CSA—Core Service Agencies
CY—Calendar Year
CYFD—New Mexico Children, Youth and Families Department
DCAP—Directed Corrective Action Plan
DD—Developmental Disability
DM—Disease Management
DME—Durable Medical Equipment
DMZ—DMZ is short for DeMilitarized Zone and is software/web page for the transmission and storage of data.
DOH—New Mexico Department of Health
DSM—Diagnostic and Statistical Manual of Mental Disorders
DWI—Driving While Intoxicated
ECHO—Extension for Community Healthcare Outcomes
EDI—Electronic Data Interchange
EEO—Equal Employment Opportunity
EHR—Electronic Health Record
ENT—Ear, Nose, Throat
EOR—Employer of Record
EPSDT—Early and Periodic Screening, Diagnosis, and Treatment
EQRO—External Quality Review Organization
ER—Emergency Room
FAQ—Frequently Asked Question
FDA—U.S. Food and Drug Administration
FDIC—Federal Deposit Insurance Corporation
FEIN—Federal Employer Identification Number
FEMA—Federal Emergency Management Agency
FICA—Federal Insurance Contributions Act
FMA—Fiscal Management Agency
FQHC—Federally Qualified Health Center
FS—Family Services
FTE—Full-time Equivalent
FTP—File Transfer Protocol
FUTA—Federal Unemployment Tax Act
GH—Group Home
HCAC—Health Care Acquired Condition
HCBS—Home and Community-Based Service
HCPCS—Healthcare Common Procedure Coding System
HCSC—Health Care Service Corporation
HEDIS—Healthcare Effectiveness Data and Information Set
HIE—Health Information Exchange
HIPAA—Health Insurance Portability and Accountability Act
HITECH Act—Health Information Technology for Economic and Clinical Health Act
HIT—Health Information Technology
HIV—Human Immunodeficiency Virus

HIX — Health Insurance Exchange
HRA—Health Risk Assessment
HSD—New Mexico Human Services Department
HTN—Hypertension
I/T/U—Indian Health Service, Tribal health provider, and Urban Indian provider
IADL—Instrumental Activities of Daily Living
ICD-10—International Classification of Diseases 10
ICD-9— International Classification of Diseases 9
ICF/MR/DD— Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disabilities
ICSS—Independent Consumer Supports System
ICWA—Indian Child Welfare Act
ID—Identification
IEP—Individualized Education Plan
IHS—Indian Health Service
IOP—Intensive Outpatient Program
IPF—Inpatient Psychiatric Facility/Unit
IPoC—Individualized Plan of Care
IPRA—Inspection of Public Records Act
IRS—Internal Revenue Service
ISP—Individual Service Plan
IT—Information Technology
IV—Intravenous
JJS—Juvenile Justice Services
LEIE—List of Excluded Individuals/Entities
LEP—Limited English Proficiency
LISW—Licensed Independent Social Worker
LMFT—Licensed Marriage and Family Therapist
LPCC—Licensed Professional Clinical Counselor
LTC—Long-Term Care
LTSS—Long-Term Services and Supports
MAD—Medical Assistance Division
MCO—Managed Care Organization
MD—Doctor of Medicine
MDS—Minimum Data Set
MDT—Multi-Disciplinary Team
MFEAD—New Mexico Medicaid Fraud & Elder Abuse Division
MHSIP—Mental Health Statistics Improvement Project
MIC—Medicaid Integrity Contractor
MIS—Management Information System
MMIS—Medicaid Management Information System
MST—Multi-Systematic Therapy
NCPDP—National Council of Prescription Drug Programs
NCQA—National Committee for Quality Assurance
NFLOC—Nursing Facility Level of Care

NMAC—New Mexico Administrative Code
NMHIC—New Mexico Health Information Collaborative
NMMIP—New Mexico Medical Insurance Pool
NMSA—New Mexico Statute Annotated
NPI—National Provider Identifier
NQMC—National Quality Measures Clearinghouse
OB-GYN—Obstetrics and Gynecology
OIG—Office of Inspector General
OMB—Office of Management and Budget
OPPC—Other Provider Preventable Condition
PASRR—Pre-Admission Screening and Resident Review
PCMH—Patient-Centered Medical Home
PCP—Primary Care Physician/ Primary Care Provider
PCS—Personal Care Service
PHH—Physical Health Home
PHI—Protected Health Information
PIP—Performance Improvement Project
PL—Public Law
PM—Performance Measure
PMPM—Per-Member Per-Month
PPACA—Patient Protection and Affordable Care Act
PPC—Provider Preventable Condition
PPS—Prospective Payment System
PS—Protective Services
PSC—Professional Services Contract
PSR—Psychosocial Rehabilitation
Q1—First Quarter
Q2—Second Quarter
Q3—Third Quarter
Q4—Fourth Quarter
QM/QI—Quality Management/ Quality Improvement
RAC—Recovery Audit Contractor
RFP—Request for Proposal
RHC—Rural Health Clinic
RN—Registered Nurse
RTC—Residential Treatment Center
SAMHSA—Substance Abuse and Mental Health Services Administration
SBHC—School-Based Health Center
SDCB—Self-Directed Community Benefit
SED—Serious Emotional Disturbance
SFY—State Fiscal Year
SMI—Serious Mental Illness
SNP—Special Needs Plan
SOE—Summary of Evidence
SSN—Social Security Number

SSRI—Selective Serotonin Reuptake Inhibitor
TBD—To Be Determined
TCN—Transaction Control Number
TDD—Text Telephone
TDM—Team Decision Making
TFC—Treatment for Foster Care
TM—Tracking Measure
TPL—Third Party Liability
TTY—Telecommunication Device for the Deaf
UM—Utilization Management
UNM/CDD—University of New Mexico Center for Development and Disability
UNM—University of New Mexico
USC—United States Code
VPN—Virtual Private Network
WIC—Supplemental Food Program for Women, Infants, and Children
YTD—Year-to-Date

3) **Section 4.1.1 of the Contract is amended to add the following new Section 4.1.1.4:**

4.1.1.4 The CONTRACTOR may delegate care coordination functions with prior approval from HSD. The CONTRACTOR shall comply with 7.14 of this Agreement for all delegated activities.

4) **Section 4.1.1.2 of the Contract is amended and restated to read as follows:**

4.1.1.2 Recipients in the Medically Fragile 1915(c) Waiver will continue to receive HCBS through that waiver unless and until such services are transitioned into Centennial Care. Recipients in the Medically Fragile 1915(c) Waiver are required to enroll in the CONTRACTOR's MCO for all non-HCBS upon Go-Live.

5) **Section 4.2.4.2.1 of the Contract is amended and restated to read as follows:**

4.2.4.2.1 If the Recipient was previously enrolled with an MCO and lost eligibility for a period of six (6) months or less, the Recipient will be re-enrolled with that MCO;

6) **Section 4.4.1.2 of the Contract is amended and restated to read as follows:**

4.4.1.2 The CONTRACTOR shall design and implement care coordination that includes the following steps addressed in this Section 4.4 of this Agreement, unless otherwise stated in 4.13.2 of this Agreement, due to the Member's enrollment in a Health Home:

7) **Section 4.4.1.2.1 of the Contract is amended and restated to read as follows:**

4.4.1.2.1 Perform the HSD standardized Health Risk Assessment and determine if the Member's may need a comprehensive needs assessment;

8) **Section 4.4.2.1 of the Contract is amended and restated to read as follows:**

4.4.2.1 The CONTRACTOR shall conduct the HSD standardized Health Risk Assessment (HRA) on all members who are newly enrolled in Centennial Care, per HSD guidelines and processes for the purpose of (i) introducing the CONTRACTOR to the Member, (ii) obtaining basic health and demographic information about the Member, and (iii) confirming the need for a CNA.

9) **Section 4.4.2.2 of the Contract is amended and restated to read as follows:**

4.4.2.2 The HSD standardized HRA may be conducted by telephone or in-person; HRA information must be obtained from the Member or representative and must be documented in the Member's file .The MCO shall ensure its staff, or vendor(s) conducting the HSD standardized HRA, is adequately trained to effectively conduct the HSD standardized HRA.

10) **Section 4.4.2.3 of the Contract is amended and restated to read as follows:**

4.4.2.3 The HRA shall be completed with each new to Centennial Care Member within thirty (30) Calendar Days of the Member's enrollment in the CONTRACTOR'S MCO.

11) **Sections 4.4.2.4 and 4.4.2.4.1 of the Contract are deleted:**

4.4.2.4 Reserved

4.4.2.4.1 Reserved

12) **Section 4.4.2.5 of the Contract is amended and restated to read as follows:**

4.4.2.5 The CONTRACTOR shall use the HSD standardized HRA as well as any available utilization and Claims data to identify a Member's current and emergent needs related to care coordination. The CONTRACTOR may add questions to the HSD standardized HRA only with HSD approval.

13) **Sections 4.4.2.5.1 through 4.4.2.5.8 of the Contract are deleted:**

4.4.2.5.1 Reserved

4.4.2.5.2 Reserved

4.4.2.5.3 Reserved

4.4.2.5.4 Reserved

4.4.2.5.5 Reserved

4.4.2.5.6 Reserved

4.4.2.5.7 Reserved

4.4.2.5.8 Reserved

14) **Sections 4.4.2.6 through 4.4.2.6.5 of the Contract are deleted:**

4.4.2.6 Reserved

4.4.2.6.1 Reserved

4.4.2.6.2 Reserved

4.4.2.6.2 Reserved

4.4.2.6.3 Reserved

4.4.2.6.4 Reserved

4.4.2.6.5 Reserved

15) **Section 4.4.2.7 of the Contract is amended and restated to read as follows:**

4.4.2.7 The CONTRACTOR shall make reasonable efforts to contact new Members to conduct an HRA and provide information about care coordination. Such efforts shall include, but shall not be limited to, engaging community supports such as Community Health Workers, CSAs and Centers for Independent Living. The CONTRACTOR shall document

at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member using the Member's last reported residential address. The three (3) attempts shall be followed by a letter sent to the Member's most recently reported address that provides information about care coordination and how to obtain an HRA. Documentation of the three (3) attempts shall be included in the Member's file. Such attempts shall occur on not less than three (3) different Calendar Days, at different hours of the day, including day and evening hours and after business hours.

16) **Section 4.4.2.7 of the Contract is amended to add the following new Sections 4.4.2.7.1 and 4.4.2.7.2:**

4.4.2.7.1 After these attempts have been made, and documented, the member is categorized "Unreachable" and the CONTRACTOR will continue attempts to reach the member, as directed by HSD.

4.4.2.7.2 Members who have been reached by the CONTRACTOR, but who have not completed a required HRA: A member may be categorized as "difficult to engage" (DTE), if reached at least once, with an additional two attempts to contact documented by the CONTRACTOR. The CONTRACTOR will continue attempts to complete the HRA as directed by HSD.

17) **Sections 4.4.3.1 through 4.4.3.3 of the Contract are amended and restated to read as follows:**

4.4.3.1 The HRA shall determine if a Member requires a comprehensive needs assessment to determine if the Member should be assigned to care coordination level two (2) or level three (3).

4.4.3.2 Within seven (7) Calendar Days of completion of the HRA, Members who have been identified as needing a comprehensive needs assessment shall be informed of such action. If the Member is enrolled in a Health Home, refer to Agreement section 4.13.2.

4.4.3.3 Within ten (10) Calendar Days of completion of the HRA, Members requiring a comprehensive needs assessment shall receive:

18) **Section 4.4.3.4 of the Contract is amended and restated to read as follows:**

4.4.3.4 Members who are identified as NOT needing a comprehensive needs assessment shall be monitored by the care coordination unit according to the provisions in Section 4.4.4 of this Agreement.

19) **Section 4.4.3.5.9 of the Contract is amended and restated to read as follows:**

4.4.3.5.9 Has high emergency room use, defined as three (3) or more emergency room visits in a thirty (30) days;

20) **Sections 4.4.4 through 4.4.4.1.2 of the Contract are amended and restated to read as follows:**

4.4.4 Requirements for Members Not Assigned to Care Coordination Level 2 or Level 3

4.4.4.1.1 Review of predictive modeling software, claims and utilization data at least quarterly to determine if the Member has a change in health status and is in need of a comprehensive needs assessment and potentially higher level of care coordination:

4.4.4.1.2 Reserved.

21) **Section 4.4.5.1 of the Contract is amended and restated to read as follows:**

4.4.5.1 The CONTRACTOR shall perform an in-person, in-home comprehensive needs assessment on all Members identified for care coordination level 2 or level 3-at the Member's primary residence. The visit may occur in another location only with HSD approval. For members who reside in a nursing facility, rather than conduct a CNA, the CONTRACTOR shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

22) **Sections 4.4.5.2 through 4.4.5.2.2 of the Contract are amended and restated to read as follows:**

4.4.5.2 For all Members the CONTRACTOR shall:

4.4.5.2.1 Schedule a comprehensive needs assessment within fourteen (14) Calendar Days

4.4.5.2.2 Complete the comprehensive needs assessment within thirty (30) Calendar Days of the HRA if required, unless the member is in a health home and/or using the Treat First model of care.

23) **Sections 4.4.5.3 through 4.4.5.3.6 of the Contract are amended and restated to read as follows:**

4.4.5.3 The CONTRACTOR shall:

4.4.5.3.1 Members who have been reached by the CONTRACTOR, but who have not completed a required CNA: A member may be categorized as "difficult to engage" (DTE), if reached at least once, with an additional two attempts to contact documented by the CONTRACTOR. The CONTRACTOR will continue attempts to complete the CNA as directed by HSD.

4.4.5.3.2 Reserved.

4.4.5.3.3 Reserved.

4.4.5.3.4 Reserved.

4.4.5.3.5 Reserved; and

4.4.5.3.6 Reserved.

24) **Section 4.4.5.5.2 of the Contract is amended and restated to read as follows:**

4.4.5.5.2 Assess Long-Term Care needs including but not limited to: environmental safety including items such as smoke detectors, pests/infestation, and trip and fall dangers and adaptive needs such as ramps or other mobility assistance. If the member is eligible for the Community Benefit, the CONTRACTOR shall assess for all Community Benefit services.

25) **Section 4.4.6.1.2 of the Contract is amended and restated to read as follows:**

4.4.6.1.2 High emergency room use, defined as three (3) or more emergency room visits in thirty (30) days;

26) **Section 4.4.6.1.6 of the Contract is amended and restated to read as follows:**

4.4.6.1.6 Poly-pharmaceutical use is defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class.

27) **Section 4.4.6.2 of the Contract is amended and restated to read as follows:**

4.4.6.2 The CONTRACTOR shall assign a specific care coordinator to each Member assigned to care coordination level two (2).

28) **Section 4.4.6.3.6 of the Contract is amended and restated to read as follows:**

4.4.6.3.6 Semi-annual, in-person, in-home visits with the Member; and

29) **Section 4.4.7.1.2 of the contract is amended and restated to read as follows:**

4.4.7.1.2 Excessive emergency room use as defined as 4 or more emergency room visits in a twelve (12) month period;

30) **Section 4.4.7.3.3 of the Contract is amended and restated to read as follows:**

4.4.7.3.3 Quarterly in-person, in-home visits with the Member; and

31) **Section 4.4.8.2.6 of the Contract is amended and restated to read as follows:**

4.4.8.2.6 Information from a periodic review, at least quarterly, of the following: (i) Claims or Encounter Data; (ii) hospital admission or discharge data; (iii) pharmacy data; (iv) predictive modeling software and (v) data collected through UM processes.

32) **Section 4.4.9.2 of the Contract is amended and restated to read as follows:**

4.4.9.2 The Contractor shall develop and authorize the CCP within fourteen (14) Business Days of completion of the comprehensive needs assessment, unless the member is in a health home and/or using the Treat First model of care.

33) **Section 4.4.10.1 of the Contract is amended and restated to read as follows:**

4.4.10.1 The CONTRACTOR shall conduct ongoing care coordination to ensure that Members receive all necessary and appropriate care. Ongoing care

coordination functions shall include at a minimum, unless the member is enrolled in a health home, the following activities:

34) **Section 4.4.11.2.5 of the Contract is amended and restated to read as follows:**

4.4.11.2.5 The most recent health risk assessment, comprehensive needs assessment, level of care assessment, and documentation of care coordination level;

35) **Section 4.4.12.5.1 through 4.4.12.5.3.3 of the Contract is amended and restated to read as follows:**

4.4.12.5.1 Care coordination level two (2), Members not residing in a nursing facility 1:75, and care coordination level two (2) Members residing in a nursing facility 1:125;

4.4.12.5.2 Care coordination level three (3), Members not residing in a nursing facility 1:50; and care coordination level three (3) for Members residing in a nursing facility 1:125; and

4.4.12.5.3 Care coordination for Members who participate in the Self-Directed Community Benefit:

4.4.12.5.3.1 For Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination level two (2), 1:100;

4.4.12.5.3.2 For Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination level three (3), 1:75; and

4.4.12.5.3.3 For Members under age of twenty-one (21) who participate in the Self-Directed Community Benefit 1:40.

36) **Section 4.4.14.1 of the Contract is amended and restated to read as follows:**

4.4.14.1 The CONTRACTOR, together with the other Centennial Care MCOs, shall contract with a vendor to implement a statewide electronic visit verification system to monitor Member receipt and utilization of the Community Benefit. The CONTRACTOR shall ensure that all contracted personal care service providers are participating in the EVV system unless granted an exception as approved in writing by HSD. The CONTRACTOR shall ensure, in the development of such system, the following minimal functionality, including the ability to:

37) **Section 4.6.1.2 of the Contract is amended and restated to read as follows:**

4.6.1.2 The CONTRACTOR shall enter into a contract with the FMA specified by HSD to provide assistance to members who choose the SDCB. The CONTRACTOR shall conduct contract oversight and ensure that FMA issues with SDCB provider payments are addressed within ten (10) business days.

38) **Section 4.8.2.7 of the Contract is amended and restated to read as follows:**

4.8.2.7 Conduct screening of all subcontractors and Contract Providers in accordance with the Employee Abuse Registry Act, NMSA 1978 § 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq. and NMAC 7.1.9, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, NMSA 1978, §§ 32A-15-1 to 32A-15-4, PPACA (see Section 4.17.1.7 of this Agreement) and ensure that all subcontracts and Contract Providers are screened against the United States Department of Health and Human Services Office of Inspector General Exclusion List ("List of Excluded Individuals/Entities") and the Medicare exclusion databases;

39) **Section 4.8.14.1 of the Contract is amended to add the following new Section 4.8.14.1.13:**

4.8.14.1.13 MCOs must load provider contracts and claims systems must be able to recognize the provider as a network provider no later than forty-five (45) calendar days after a provider is credentialed, if required.

40) **Section 4.11.5 of the Contract is amended to add the following new Sections 4.11.5.7 and 4.11.5.8:**

4.11.5.7 The CONTRACTOR shall schedule claims/billing calls at least quarterly with the Albuquerque Area I and the Navajo Area I.

4.11.5.8 The CONTRACTOR shall conduct semi-annual in-person visits with the I/T/Us to resolve billing/claims issues.

41) **Section 4.12.8 of the Contract is amended to add the following new Section 4.12.8.3:**

4.12.8.3 Calendar Year 2016 Performance Measure Targets:
Performance Measures listed in the MCOs' Contract, Section 4.12.8.2, will require a two percent (2%) improvement above the MCO's 2015

Audited HEDIS rates for Calendar Year 2014. If the MCO has achieved the 2015 National Average as determined by the Quality Compass or HSD's determined target as listed below for each Performance Measure, then the MCO must maintain that same percentage at the end of Calendar Year 2016 in order to have met the target.

Failure to meet the required 2% improvement to the Performance Measure will result in a monetary penalty based on 2% of the total capitation paid to the MCO for Calendar Year 2016, divided by the 14 points listed below:

4.12.8.3.1 PM 1- Annual Dental Visits (1 point). 2015 Quality Compass National Average: 49%.

4.12.8.3.2 PM 2- Medication Management for People with Asthma (1 point). HSD target: 68%.

4.12.8.3.3 PM 3- Controlling High Blood Pressure (1 point). 2015 Quality Compass National Average: 57%.

4.12.8.3.4 PM 4- Comprehensive Diabetes Care (4 points)

- Member 18-75yrs of age who had a diagnosis of DM and had an HbA1c test. 2015 Quality Compass National Average: 86%.
- HbA1c poor control (> 9%). 2015 Quality Compass National Average: 44% (lower is better)
- Member 18-75yrs of age who had a diagnosis of DM and had a Retinal eye exam. 2015 Quality Compass National Average: 54%.
- Member 18-75yrs of age who had a diagnosis of DM and had a nephropathy screening test or evidence of nephropathy. 2015 Quality Compass National Average: 81%

4.12.8.3.5 PM 5- Timeliness of Prenatal and Postpartum Care (2 points).

- Prenatal visit in the first trimester or within 42 days of enrollment. 2015 Quality Compass National Average: 82%
- Postpartum visit on or between 21 and 56 days after delivery. 2015 Quality Compass National Average: 62%.

4.12.8.3.6 PM 6- Frequency of Ongoing Prenatal Care (1 point). 2015 Quality Compass National Average: 55%.

4.12.8.3.7 PM 7- Antidepressant Medication Management (2 points)

- Member 18yrs and older who received at least 84 Calendar days of continuous treatment with antidepressant medication (Acute phase). 2015 Quality Compass National Average: 52%.

- Member 18yrs and older who received at least 180 Calendar days of continuous treatment with an antidepressant medication (Continuous phase). 2015 Quality Compass National Average: 37%.

4.12.8.3.8 PM 8- Follow-up after hospitalization for Mental Illness (2 points)

- Member 6yrs and older who were hospitalized for treatment of selected mental health disorders with follow-up with a mental health practitioner within 7 Calendar days after discharge. 2015 Quality Compass National Average: 44%.

- Member 6yrs and older who were hospitalized for treatment of selected mental health disorders with follow-up with a mental health practitioner within Follow up within 30 Calendar days after discharge. 2015 Quality Compass National Average: 63%.

42) **Section 4.12.17 of the Contract is amended to add the following new Sections 4.12.17.6 and 4.12.17.7:**

4.12.17.6 TM#4 – Well-Child Visits in the First 15 Months of Life. Use current reporting year HEDIS technical specifications for reporting.
The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six or more well-child visits.

4.12.17.7 TM#5- Children and Adolescents' Access to Primary Care Practitioners. Use current reporting year HEDIS technical specifications for reporting.
The percentage of members 12 months – 19 years of age who had a visit with a PCP.

43) **Section 4.13.2.2 of the Contract is amended and restated to read as follows:**

4.13.2.2 The Contractor shall implement Health Homes in accordance with New Mexico's Medicaid State Plan and the Managed Care Policy Manual.

44) **Section 4.14.1.3 of the Contract is amended and restated as follows:**

4.14.1.3 Member and Marketing materials shall be approved by HSD in accordance with the procedures specified in the Managed Care Policy Manual.

45) **Section 4.19.1.7 of the Contract is amended and restated to read as follows:**

4.19.1.7 Paying interest as required in Paragraph (1) of Subsection 8.308.20.9 (E) of NMAC.

46) **Section 4.19.1.18 of the Contract is amended to add the following new Section 4.19.1.18.3:**

4.19.1.18.3 MCOs shall adjudicate all claims, which did not pay according to the lesser of logic/COB claims processing guidelines to ensure Medicaid is the payer of last resort.

47) **Section 4.19.2.2.13 of the Contract is amended and restated to read as follows:**

4.19.2.2.13 Meet Encounter accuracy requirements by submitting CONTRACTOR paid Encounters with no more than a three percent (3%) error rate per adjudication invoice type (Inpatient and Inpatient crossovers and pharmacy encounters are adjudicated at the header level, all others are adjudicated at the line level), calculated for a quarter's worth of submissions. HSD will monitor the CONTRACTOR corrections to denied Encounters for services covered under this Agreement by random sampling performed quarterly and over the term of the Agreement. The methodology for the error rates will be determined by HSD. Seventy-five percent (75%) of the denied Encounters for services covered under this Agreement included in the random sample must have been corrected and resubmitted by the CONTRACTOR within thirty (30) Calendar Days of denial;

48) **Section 4.19.2.2.14 of the Contract is amended and restated to read as follows:**

4.19.2.2.14 The CONTRACTOR shall submit a quarterly report of the number of paid Claims by adjudication type (Inpatient and Inpatient crossovers and pharmacy encounters are adjudicated at the header level, all others are adjudicated at the line level) by date of payment and date of service as directed by HSD. This report will be compared to Encounter Data to evaluate the completeness of data submitted. A variance between the CONTRACTOR's report and the record of Encounters received cannot exceed five percent (5%) for months of payment greater than ninety (90) Calendar Days. The methodology for the variances will be determined by HSD;

49) **Section 4.22.2 of the Contract is amended and restated to read as follows:**

4.22.2 The CONTRACTOR shall monitor the potential for abuse or overuse of services and require that a Member visit a certain PCP when the CONTRACTOR has identified continuing utilization of unnecessary services. Prior to placing the Member on PCP lock-in, the CONTRACTOR shall inform the Member of the intent to lock-in, including the reasons for imposing the PCP lock-in. The CONTRACTOR's Grievance procedure shall be made available to any Member being designated for PCP lock-in. The PCP lock-in shall be reviewed and documented by the CONTRACTOR and reported to HSD every quarter. The Member shall be removed from PCP lock-in when the CONTRACTOR has determined that the utilization problems have been solved and that recurrence of the problems is judged to be improbable. HSD shall be notified of all lock-in removals.

50) **Section 4.22.3 of the Contract is amended and restated to read as follows:**

4.22.3 The CONTRACTOR monitors the potential for abuse or overuse of services and require that a Member visit a certain pharmacy provider when Member compliance or drug-seeking behavior is suspected. Prior to placing the Member on pharmacy lock-in, the CONTRACTOR shall inform the Member and/or his or her Representative of the intent to lock-in. The CONTRACTOR's Grievance procedure shall be made available to the Member being designated for pharmacy lock-in. The pharmacy lock-in shall be reviewed and documented by the CONTRACTOR and reported to HSD every quarter. The Member shall be removed from pharmacy lock-in when the CONTRACTOR has determined that the compliance or drug-seeking behavior has been resolved and the

recurrence of the problems is judged to be improbable. HSD shall be notified of all lock-in removals.

51) **Section 6.1.2 of the Contract is amended and restated to read as follows:**

6.1.2 The CONTRACTOR shall accept the capitation payment received each month as payment in full by the HSD for all services provided to enrollees covered under this agreement and the administrative costs incurred by the CONTRACTOR in providing or arranging for such services. Unless otherwise specified in this agreement, any and all costs incurred by the CONTRACTOR in excess of the capitation payment shall be borne in total by the CONTRACTOR.

52) **Section 6.1 of the Contract is amended to add the following new Section 6.1.7:**

6.1.7 By signature on this Agreement, the Contractor explicitly agrees that this section shall not independently convey any inherent rights, responsibilities or obligations, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by the Contractor. In the event that the rates certified by the state's actuary and approved by CMS are different from the rates included with this Agreement, the Contractor agrees to participate in a reconciliation process with HSD to bring capitation payments to the Contractor in line with the approved rates.

53) **Section 6.3.2 of the Contract is amended and restated to read as follows:**

6.3.2 HSD shall pay the CONTRACTOR for services rendered to Medicaid Members in I/T/Us. HSD will reimburse the CONTRACTORS based on Encounters that have cleared all systems edits in the Medicaid Management Information System (MMIS) per quarter. HSD will cross reference the "Payments to I/T/Us", each quarter; however the Encounters paid and accepted by HSD will supersede or take preference if there is a difference between paid Encounters versus the report required by HSD to report I/T/U expenditures.

54) **Section 6.6 and 6.6.1 of the Contract is amended and restated to read as follows:**

6.6 Changes in the Capitation Payment Rates

6.6.1 The capitation rates awarded with this Agreement shall be effective for the term of this Agreement. The capitation rates may be adjusted based

on factors such as changes in the scope of work, CMS requiring a modification of the 1115(a) Waiver if now or amended federal or State statutes or regulations are implemented, inflation, significant changes in the demographic characteristics of the Member population, or the disproportionate enrollment selection of the CONTRACTOR by Members in certain rate cohorts, or in the event that the rates certified by the state's actuary and approved by CMS are different from the rates included with this Agreement. Any changes to the rates shall be actuarially sound and implemented pursuant to Section 6.1.6 or 6.1.7 of this Agreement.

55) **Section 7.2.8.1 of the Contract is amended to add the following new Section 7.2.8.1.34:**

7.2.8.1.34 Electronic Visit Verification (EVV)

56) **Section 7.3.4 of the Contract is amended and restated to read as follows:**

Item #2:

Program Issues

Failure to comply with Encounter submission as described in Section 4.19 of this Agreement

Penalty

Monetary penalties up to two percent (2%) of the CONTRACTOR's Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction

IN WITNESS WHEREOF, the parties have executed this amended and restated contract as of the date of signature by the Human Services Department.

CONTRACTOR

By: [redacted] Date: 4/15/16

Title: VP Medicaid Ops, Centene Care CEO

STATE OF NEW MEXICO

By: [redacted] Date: 5/11/16

Brent Ernest, HSD Cabinet Secretary

By: [redacted] Date: 4/29/16

Danny Sandoval, HSD CFO

THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

By: [redacted] Date: 5/11/16

Title: Secretary HSD

By: [redacted] Date: 5-16-16

Title: Secretary CYFD

By: [redacted] Date: 5/17/16

Title: Secretary - DOH

Approved as to Form and Legal Sufficiency:

By: [redacted] Date: 5/6/16

Christopher Collins, HSD Chief Legal Counsel

The records of the Taxation and Revenue Department reflect that the CONTRACTOR is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross Receipts and compensating taxes.

TAXATION AND REVENUE DEPARTMENT

ID Number: 02-445429-00-0

By: [redacted] Date: 5-13-16

Q3DY3 ATTACHMENT H: MCO Action Plans

Quarter 3 DY2

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.

June 2016 - Self-Directed Report #4 and Agency-Based Community Benefit Report #9 have been completed and removed from Report Remediation Project.

July 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, however these are every changing based on reporting instructions and requirements provided by

HSD. The data dictionaries will also be used to cross-reference other reports that encompass similar data requests.

The State Remediation Report Project has completed as of 9/30/16. Transition work has been completed on the reports that were still open items as of 9/30/16, including Report 3, 55 and 45. The Analytics team was de-briefed and items such as code walk-through, RRD walk-through, and lessons learned were discussed.

The reports included in this report project are broken down by Waves

WAVE A: 4 Reports, 100% complete

WAVE B: 4 Reports, 100% complete

2 Reports removed from Report Remediation Project and moved to MHNM Analytics for logic and report design.

1 Report 90% complete and awaiting HSD approval of final template

WAVE C: 5 Reports removed from Report Remediation Project and moved to MHNM Analytics for logic and report design.

WAVE D: 2 Reports removed from Report Remediation Project and moved to MHNM Analytics for logic and report design.

Quarter 1 DY3

UHC

Q1DY3		
Action Plan #1	Implementation Date	Completion Date
Myers & Stuaffer Audit	3/24/16	Closed – Moved to a DCAP

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. 5/26/16 – HSD is transitioning this internal corrective action plan to a directed corrective action plan (DCAP) which includes additional areas of concern resulting from the Myers & Stauffer audit. 8/18/16 – Please see CMS notification and DCAP attachment.

Quarter 2 DY3

BCBSNM

Q2DY3		
Action Plan #1	Implementation Date	Completion Date
Myers and Stauffer Audit	02/04/16	In progress

Description

BCBSNM is actively addressing Myers and Stauffer audit findings and recommendations.

Status

1. Conducting provider training and education on how to properly submit late charges on inpatient hospital claims. 06/29/16 – BCBSNM anticipates that training activities will be completed in approximately five months. Anticipated completion is end of 2016.
2. Returning claims to providers with blank Present on Admission (POA) indicators so the proper POA indicator can be included. 06/29/16 – BCBSNM creating coding and system upgrade request.
3. Defining standards and routinely monitoring contract loading timelines. 6/29/16 – Inventory and monitoring process for application loading into BCBSNM's system is in progress. Anticipated completion is end of 2016.
4. Activities are ongoing. Anticipated completion date is on target for December 2016.

UHC

Q2DY3		
Action Plan #2	Implementation Date	Completion Date
Reporting	05/03/16	In process

Description

A previous internal action plan was completed in February 2016. This plan is to complete design reviews of state reports. UHC identified areas of the reporting process, to review, in its effort to ensure accurate reporting.

Status

7/7/16 – A reporting summit was held with report owners to identify any gaps and areas for process improvements. Quality review documents are being developed. 10/4/16 – Reviews are in progress with business owner and analytics team. Clinical reports were prioritized to ensure that there are no disruptions of state reporting in anticipation of UHC's migration to a new clinical platform due to launch on 10/1/16. UHC completed an evaluation of its reporting inventory to account for all state reports including those that are ad hoc or required by some other means beyond the state contract (e.g. Letters of Direction (LODs).

Quarter 3 DY3

PHP

Q3DY3		
Action Plan #1	Implementation Date	Completion Date
EQRO Audit Results	07/15/16	In progress

Description

For all areas where PHP's scored less than 80% in the individual categories PHP will develop an internal corrective action plan.

Status

PHP awaits the final Report for the EQRO Compliance Audit Report. PHP will work with HSD to ensure the requirement was to develop separate transition of care documents and not additional entries for transition in the member's care coordination plans.
PHP will begin an internal CAP while we await the draft EQRO Compliance Audit Report.

- Areas to address are Transition of Care and Care Coordination.

PHP

Q3DY3		
Action Plan #2	Implementation Date	Completion Date
DentaQuest Claims Audit	07/15/16	12/31/16

Description

During PHP's 6/23/16 annual audit of DentaQuest the Claims Auditor identified the issue with claims timeliness and accuracy. Both measures were missing goal by 1% to 3%.

Status

DentaQuest's Claims CAP will be reported to Delegation Oversight Committee on 10/12/16.
DentaQuest is required to submit an updated CAP to PHP every 30 days.

UHC

Q3DY3		
Action Plan #3	Implementation Date	Completion Date
HSD Care Coordination Audit	09/01/16	In process

Description

HSD conducted an audit on care coordination documentation in November 2015. Outcomes were favorable and indicated significant improvement in continued documentation efforts specific to care coordination activities.

Status

9/30/16 – A summary report was provided to HSD on UHC's internal activities specific to the action plan that is in place to continue improvement on care coordination documentation. The internal action plan was also updated and submitted.

BCBSNM

Q3DY3		
Action Plan #4	Implementation Date	Completion Date
HSD Care Coordination Audit	07/29/16	In process

Description
HSD conducted an audit on care coordination documentation in November 2015. The audit examined Care Coordination process and documentation completeness through a sample file review of members with a Care Level 2 or 3. The final report from HSD indicated 12 findings/recommendations identified.

Status
7/29/16 – A summary report was provided to HSD specific to BCBS's internal actions related to HSD's findings as well as continued quality improvement for care coordination.

BCBSNM

Q3DY3		
Action Plan #5	Implementation Date	Completion Date
Members with HSD Mailing Address	07/29/16	In process

Description
BCBSNM is implementing logic to suppress mailings only when the HSD physical address is provided.

Status
9/7/16 – The converter update to accommodate these situations is currently in process.

BCBSNM

Q3DY3		
Action Plan #6	Implementation Date	Completion Date
Non-Native American PA Criteria for ITU and Tribal 638 providers	09/30/16	In process

Description
It was determined that Prime Therapeutics systems were configured to require a PA for non-Native American members that get services from a ITU and Tribal 638 providers. Also, the 2-year timely filing limit was not correctly configured for these same situations.

Status
9/30/16 – Prime therapeutics is currently developing system edits to correct these two situations. These system updates are currently scheduled to go into production on 12/1/16. Interim solutions have been put into place to ensure claims are adjudicated.

HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

August 18, 2016

Bill Brooks, Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
1301 Young Street, Room 833
Dallas, TX 75202

RE: Notice of UnitedHealthcare (UHC) Directed Corrective Action Plan (DCAP)

Dear Mr. Brooks:

In 2015, the New Mexico Human Services Department, Medical Assistance Division (HSD/MAD) engaged Myers and Stauffer LLC, Certified Public Accountants to assist with the monitoring and review of the Centennial Care Managed Care Organizations (MCOs) related to the following program areas: claims adjudication, prior authorization, provider credentialing, and provider contract loading. An on-site review conducted by Myers and Stauffer included review of complaints, appeals and grievances; health plan compliance; program integrity; and subcontractor/delegated services monitoring. On February 2, 2016, UHC was provided with the Myers and Stauffer draft audit report and an opportunity to respond to the audit findings and recommendations. UHC's response, received February 29, 2016, was included in the final Myers and Stauffer audit report dated March 10, 2016.

As a result of the deficiencies identified in the Myers and Stauffer audit report, HSD/MAD is implementing a DCAP with UHC. The following outline the areas of non-compliance that are included in the DCAP:

- Subcontractor oversight and delegated services monitoring, and
- Claims payment and claims adjudication process including prior authorization process.

HSD/MAD will notify UHC in writing when individual items in the DCAP have been closed and will notify both UHC and CMS when the entire DCAP has been closed. Should UHC fail to meet any established due dates, an internal referral for possible assessment of monetary penalties will be initiated.

Sincerely,

[redacted]

Nancy Smith-Leslie, Director

Attachment: Directed Corrective Action Plan

cc: Dina Payne, CMS, 1115 Project Officer
Ford Blunt, CMS, Dallas Regional Office
Charles Milligan, CEO, UHC

UnitedHealthcare (UHC) **Directed Corrective Action Plan (DCAP)**	Response Due to HSD	Date Response Received	Status Open or Closed
Subcontractor/Delegated Services Monitoring			
1.) UHC should outline a plan to capture complete and accurate credentialing data in its system and provide a timeline to HSD for implementing this change. Such data is needed to effectively calculate and monitor credentialing timeliness. UHC should take the necessary steps to capture the date of provider application and credentialing. UHC should be able to demonstrate compliance with HSD's 45-calendar day requirement related to the timely credentialing of providers. UHC should improve the quality and completeness of credentialing data retained in the UHC system. Complete and accurate data is necessary in order to monitor UHC and delegated vendor compliance with HSD credentialing requirements. (pgs. 38-39, UHC Final Report)	8/5/2016	8/5/2016	**OPEN**
2.) UHC's main provider reporting system only contains current credentialing cycle information. Therefore, many of the credentialing and recredentialing dates were the same. UHC had an analyst spend a few days assembling as much original credentialing information as possible, but there was information still missing. UHC stated most of the blanks were attributed to providers for which credentialing was delegated. (pg. 10, UHC Final Report)	8/5/2016	8/5/2016	**OPEN**
Claims Payment and Claims Adjudication Process (Including Prior Authorization Process)			
3.) There were claims manually priced by UHC that Myers and Stauffer identified as overpayments. Myers and Stauffer attempted to obtain methodology and details used to price these claims; however, this information was not provided by UHC. Additional testing should be performed on these claims and the results should be reported to the Department for review. (pg. 11, UHC Final Report) Pricing details or other supporting documentation was not provided by UHC; therefore, 11 issues were not resolved thus identified as mispayments. Myers and Stauffer did not identify any underpayments by UHC during the testing periods. As shown in Table 6, mispayments totaled $86,614.42. UHC failed to provide pricing methodology on 10 claims; therefore these claims were determined to be overpayment of $85,414.42. (pg. 29, UHC Final Report) Additional testing should be performed on these claims and the results should be reported to the Department for review. (pg. 11, UHC Final Report)	8/5/2016	8/5/2016	**OPEN**
4.) Prior Authorization issues accounted for 21% of the hospital claim denials for UHC. Based on the high volume of claim denials for "Requires Notification/Plan not Notified," Myers and Stauffer recommend UHC review their policies and procedures on notification/prior authorization requests, submissions, and processing. UHC should also conduct provider training and education on how to properly request and submit prior authorizations on inpatient hospital claims. (pg. 30, UHC Final Report)	8/5/2016	8/5/2016	**OPEN**
5.) The average daily claims volume received is three thousand (3,000) for hospital claims and six thousand (6,000) for physician's claims. The average auto-adjudication rate is 40%. Sixty percent of claims are touched by processors. Inpatient claims review is a highly manual process which can result in delays in payment. Ninety percent of clean claims are processed within thirty (30) calendar days. Ninety percent of clean claims are processed within 90 calendar days. (pg. 16, UHC Final Report)	8/5/2016	8/5/2016	**OPEN**

UnitedHealthcare (UHC) **Directed Corrective Action Plan (DCAP)**	Response Due to HSD	Date Response Received	Status Open or Closed
6.) Myers and Stauffer noted that UHC had approximately 53% of denied claims in the claims universe during the three sample periods. UHC should continue to monitor and submit their denials and reports on claims adjudication to HSD. (pg. 40, UHC Final Report)	8/5/2016	8/5/2016	**OPEN**

7.3.2.1 - If HSD determines that the CONTRACTOR is not in compliance with one or more requirements in this Agreement, HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP)). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as notice for sanction in the event HSD determines that sanctions are also necessary.

7.3.4, #4 - Failure to complete or comply with CAPs/DCAPs - .12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.

* 7.3.2.6 - If HSD staff is required to spend more than 10 hours or more per week monitoring a CAP(s) or DCAP(s), HSD will provide notice to the CONTRACTOR that the CONTRACTOR must contract with a third party either designated by HSD or approved by HSD to oversee the CONTRACTOR's compliance with the CAP(s) or DCAP(s).

UHC shall reimburse HSD for the Myers and Stauffer expenditures related to this DCAP.