Appendix D - Implementation Target 5.1 - Care Coordination

HSD will monitor implementation of a term in all contracts with its designees to require that care coordination include identification of physical, behavioral health, and long-term care needs, and providing services to address said needs, in compliance with Section 4.4 of Centennial Care 2.0 Managed Care Organization contracts with HSD.

Co-Neutral November 15th Report: Status of Commitment as of September 1, 2021

The Co-Neutrals' findings determined that this IT was not completed by the required due date of June 1, 2021. The Co-Nuterals' stated that the State was close to finalizing the necessary documents to achieve the IT. A period for further observation was allowed for the Co-Neutrals to further assess whether the State has met this performance standard and delayed their determination until a future Co-Neutrals' report.

CYFD & HSD Actions Taken Between January 1, 2021, and May 31, 2022

The State continues to make good faith progress in this area. To comply with this deliverable, HSD needed to first clarify direction to the MCOs, and second, ensure that we have appropriate monitoring tools in place to ensure MCOs comply with the care coordination requirements.

1. **Care Coordination Direction**

On March 18, 2022, the Human Services Department (HSD) issued Letter of Direction (LOD) 69-1, outlining the requirements for Centennial Care 2.0 Managed Care Organizations (MCOs) for Children in State Custody (CISC). The LOD included the requirement for CISC to be placed in Care Coordination Level 2 and identified required training related to CISC. The LOD outlines requirements related to the Child and Adolescent Needs and Strengths (CANs) training requirements for CISC and additional provisions related to the CANS and care plan development. The following highlights some of the amended contract sections included in LOD 69-1.

Section 4.4.3 of the Medicaid Managed Care Services Agreement: Assignment to Care Coordination Levels.

> Sub-Section 4.4.3.5: Care coordination level two (2) and level three (3). The MCO shall conduct a Comprehensive Needs Assessment (CNA) (further explained in section 4.4.5 of this Agreement), utilizing motivational interviewing techniques, to determine whether the Member should be in care coordination level two (2) or three (3).

Section 4.4.9 of the Medicaid Managed Care Services Agreement: Care Plan Requirements.

Sub-Section 4.4.9.2.2 For CISC members, the MCO shall consult with the CISC's PPW as well as the CISC Member's guardian/representative when developing the comprehensive care plan (CCP).

Sub-Section 4.4.9.2.3 For CISC members, the MCO shall receive a copy of the CANS and utilize the CANS in developing the comprehensive care plan.

Section 4.4.16 of the Medicaid Managed Care Services Agreement Transition of Care Requirements.

Sub-Section 4.4.16.1.3 The MCO shall notify the assigned CYFD PPW for Protective Service (PS) involving children and youth within three (3) business days prior to transition in care for CYFD involved children/youth.

Section 4.4.18.2.4 of the Medicaid Managed Care Services Agreement.

Provide high needs population training and consultation with other care coordination staff including Members who are involved with CYFD juvenile justice services, protective services, behavioral health services, and their parents and/or kinship caretakers.

2. Tools to Monitor MCO Care Coordination

In 2021 and 2022, HSD implemented CISC Care Coordination quarterly audits and reviews to ensure the MCOs' compliance with contractual requirements as follows:

- Identify CISC that were difficult to engage, unable to reach, or refusing care coordination from the MCO.
- Ensure MCO timeliness in conducting health risk assessments and comprehensive needs assessments for CISC
- Monitor care coordinator to CISC ratios.
- Ensure that all CISC enrolled with a MCO are engaged in care coordination and receive wellness and dental care.
- Care Coordination 101 training is conducted with CYFD staff to educate on the roles and responsibilities of the MCO care coordinator.

HSD reviews the audit findings with the MCOs during the regular quarterly care coordination meetings as well as with CYFD during the bi weekly collaboration meetings. During these meetings the teams discussed barriers and solutions in connecting CISC with their MCO to receive care coordination assessments and services. The results of these audits and activities are outlined in the attached "HSD Care Coordination Audits and Activities 2021 and 2022" report.

3. Additional Care Coordination Processes and Future Recommendation

a. Background

On March 31, 2022, in response to feedback from the Co-Neutrals, the State submitted a memo to the CNs detailing the State's approach to ensuring coordination of services for CISC in both Managed Care and Fee-for- Service (FFS) Medicaid. Information from this memo will be incorporated into relevant Appendix D deliverables.

In New Mexico, the Medicaid program operates both Managed Care and Fee-for-Service components. Although there is a month-to-month variance, approximately ninety-seven percent (97%) of CISC are enrolled in managed care through a MCO and, as a result, have care coordination administrative functions available to them. Currently, care coordination participation is optional, and members enrolled in a MCO can decline to participate. In the event of member declination of services, collaboration between the member's MCO Care Coordinator and Permanency Planning Worker (PPW) can promote rapid re-engagement.

Section 4.4.1.5.1 of the Medicaid Managed Care Services Agreement states that in the event a CISC guardian/representative refuses care coordination, the MCO shall have the CISC guardian/representative sign an HSD approved care coordination declination form. If the CISC guardian/representative refuses to sign the care coordination declination form the MCO shall document such refusal in the member's file. Children 14 years or older can sign the care coordination declination from. The MCO shall contact the CISC's PPW within three (3) business days of the refusal to inform them of the refusal. The CISC will be monitored per section 4.4.4 of the agreement.

If a member refuses care coordination, they will be monitored by the MCO to determine if a need for care coordination is indicated. At that time, a Care Coordinator will reach out and attempt to re-engage the member in care coordination (Section 4.4.4. of the Medicaid Managed Care Services agreement).

Section 4.4.18.3.2 of the Medicaid Managed Care Services Agreement requires the MCO to contact the member's PPW within three days of notification of the member's involvement in CYFD and assign the member a Care Coordinator.

As of December 31, 2021 there were 2,131 CISC. 1,848 CISC were enrolled with a MCO and were eligible for care coordination services. There were a total of 283 CISC that were Native American, with 220 enrolled with a MCO and 63 enrolled in fee for service Medicaid.

Care coordination is a central tenet of Medicaid Managed Care. The Medicaid 1115 demonstration waiver defines care coordination as:

- Assessing each member's physical, behavioral, functional, and psychosocial needs;

- Identifying the specific medical, behavioral, and Long-Term-Services and Supports (LTSS) and other social support services (e.g., housing, transportation, or income assistance) necessary to meet a member's needs.
- Ensuring timely access and provision of services needed to help each member maintain or improve their physical and behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services needed to promote each member's health, safety, and welfare.

Each member enrolled with a MCO receives a standardized health risk assessment (HRA) to determine if the member requires a comprehensive needs assessment (CNA). The CNA identifies members requiring level two (2) or three (3) care coordination and is followed with the development of a comprehensive care plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members identified as needing level two (2) or three (3) care coordination are assigned a Care Coordinator who is responsible for coordinating their total care. MCOs routinely monitor claims and utilization data to identify changes in health status and high-risk members in need of a higher-level of care coordination.

Under the Balanced Budget Act of 1997, states have the authority to require most Medicaid beneficiaries to enroll in MCOs or Primary Care Case Management Programs (PCCM). States however, can only require Native Americans in Medicaid to receive services through a MCO or PCCM if the MCO or PCCM is the Indian Health Services (IHS), a tribally operated program, or an Urban Indian Health Program. States do not have authority to require Medicaid-eligible Native Americans to enroll in MCOs that are not operated by the IHS. As of March 31, 2022, there is not a tribally-operated MCO or PCCM in New Mexico. States do have the authority to require such enrollment under "section 1115" demonstration waivers or under "section 1915(b)" program waivers. Through collaborative engagement with New Mexico tribes and HSD, tribes have indicated they do not want the New Mexico Medicaid program to pursue this approach until it is the expressed will of the tribes. Individual Native Americans eligible for Medicaid do have the choice of enrolling with any participating MCO.

b. Care Coordination Recommendation

The Human Services Department (HSD) and CYFD recommend a three-pronged approach for care coordination for CISC:

1. Education on the benefit of Managed Care Medicaid;
2. Intensive Care Coordination (ICC): Wraparound Approach; and
3. Enroll all CISC in Medicaid Managed Care (Native Americans will retain option to choose FFS)

In the development of the 1115 Waiver Renewal which began in January 2022, the Medical Assistance Division (MAD) outlined two proposals related to deliverables that specifically impact New Mexico's Native American population:

1. CISC enrollment in Medicaid Managed Care; and
2. Reimbursement for Tribal Healing Services.

We have conducted several listening sessions, outlined below, with a variety of stakeholders, including designated sessions for Tribes and Pueblos. All Tribal leadership were invited to a final meeting in July 2022 where they will provide the State with direction on how to proceed with our proposals.

1115 Waiver Renewal/Medicaid MCO Procurement Stakeholder Sessions 2022	
Date	Meeting
4/26/2022	Tribal Listening Session
5/4/2022	Sister Agency and Partner Session
5/5/2022	Large Stakeholder Session
5/11/2022	Legislator Session
5/11/2022	Legislative Finance Committee (LFC), Department of Finance Administration (DFA), and Governor's Office Listening Session
5/12/2022	Tribal Meeting with Navajo Nation
5/13/2022	Tribal Meeting with Zuni and Laguna Pueblo
7/20/2022	Tribal Leadership Meeting/MAD/BHSD/CYFD/IAD
9/1/2022 – 10/31/2022	Public Comment Period, including Tribal Consultation and Public Hearings

After many tribal engagements HSD will submit the 1115 waiver application with a proposal for member directed tribal healing benefit and a proposal for a CISC MCO plan. This CISC MCO will be built with a specific focus on this population and with a focus on culturally appropriate engagement of the CISC. Because HSD is engaging in a competitive procurement for this MCO, we cannot provide additional detail at this time. At the direction of our tribal partners, Native Americans will retain the option to enroll children in custody in the CISC MCO or in FFS. HSD firmly believes that this plan design will improve the oversight, monitoring and delivery of services to CISC in line with this deliverable.

Exhibits

Appendix D - IT 5.1 MCO Letter of Direction (LOD) 69-1 Dated 02/28/2022 (Issued 3/18/2022): LOD 69-1 D IT 6.1 No Reject No Eject clean.pdf

HSD Care Coordination Audits and Activities 2021 and 2022

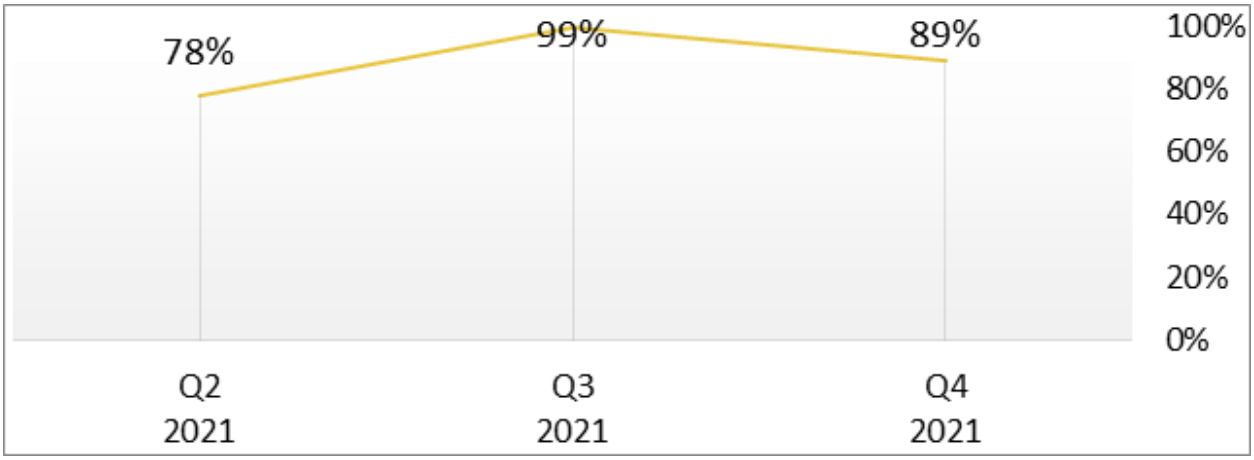
Human Services Care Coordination Children in State Custody Quarterly Audits

The Human Services Department's (HSD) Quality Bureau (QB) conducted quarterly Children in State Custody (CISC) Difficult to Engage (DTE), Unable to Reach (UTR), Refused Care Coordination (RCC), otherwise referenced as DUR audits. DUR audits ensure the MCOs are following contract and policy requirements when outreaching to CISC members enrolled with a MCO.

HSD's QB ended this quarterly audit in Q1 CY22 due to the decrease in CISC categorized as DUR and the QB having already audited all CISC DUR Member files.

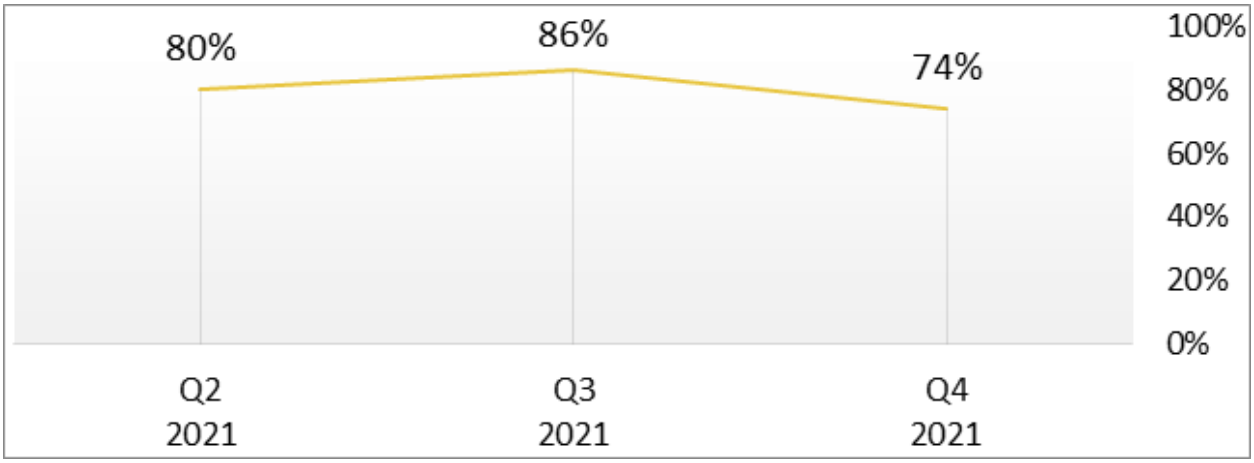
The below charts show MCO compliance with HSD contract and policy requirements for categorizing a member as DTE, UTR, or RCC.

CISC DTE Audit Results Q2 CY21 through Q4 CY21



Decreased compliance for DTE Members was attributed to inconsistent Member file documentation and incorrect categorization.
Auditors noted that some Member files listed the Member as CCL2 and as CCL5-DTE within the same Member file. Auditors also noted that some Members were listed as CCL5-DTE in the Member file; however, had not been updated in the MCO to HSD Interface file.
All findings were presented to MCOs and follow up requested.
MCOs provided responses to all findings of non-compliance, rectified any inconsistencies noted in the audited Member files, updated the MCO to HSD interface file appropriately, and conducted additional, targeted training on documentation to MCO staff.

CISC UTR Audit Results Q2 CY21 through Q4 CY21



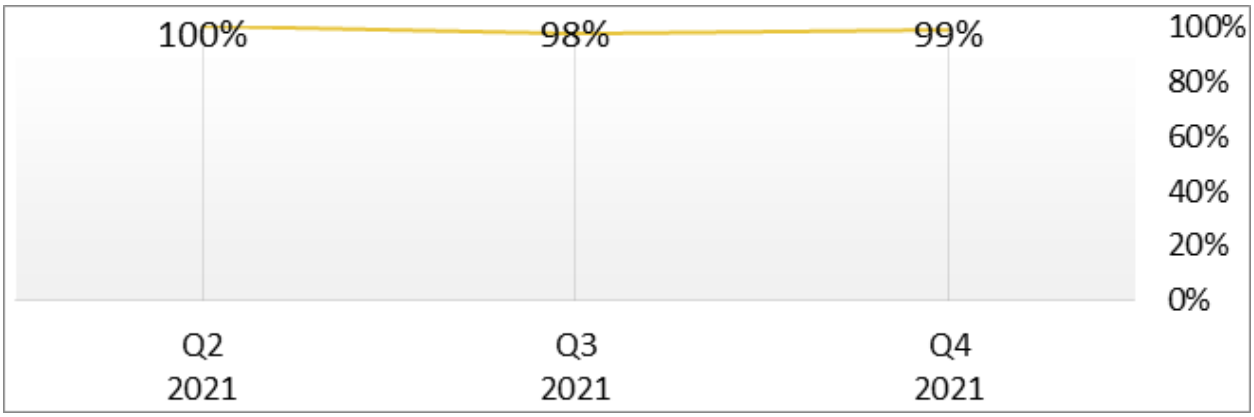
Decreased compliance for UTR Members was attributed to inconsistent Member file documentation and difficulty for auditors to determine outreach times.

Auditors noted that, in some Member files, a Member was included in the CCL0-UTR universe; however, had been reached and was engaged in Care Coordination. Auditors also noted difficulty in determining whether outreach was made per the Managed Care Services Agreement (contract) which specifies outreach must be attempted on three different days, at three different times of the day including after hours and on the weekend. This was due to time stamps in the Member files not being included for all outreach attempts.

All findings were presented to MCOs and follow up requested.

MCOs provided responses to all findings of non-compliance, rectified areas of non-compliance in the specific audited files, assured HSD that future audit universes submitted would be more thoroughly validated, provided additional information on outreach dates and times, and assured HSD that future Member files would include bookmarking of all dates and times of outreach attempts.

CISC RCC Audit Results Q2 CY21 through Q4 CY21



Any non-compliance findings for CCL4-RCC members was due to inconsistent Member file documentation. All findings were presented to MCOs and follow up requested and received. The number of CISC RCC Members have decreased significantly since Q4CY21

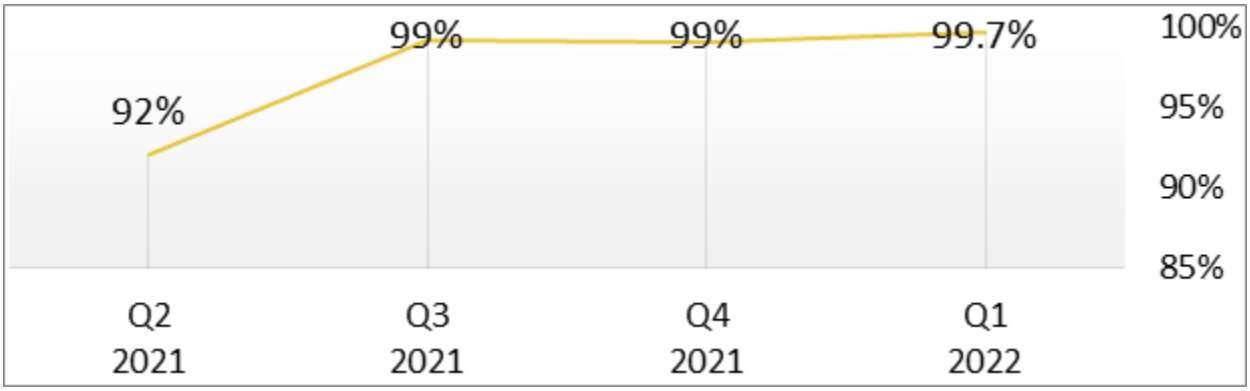
HSD's QB began conducting quarterly CISC Health Risk Assessment (HRA) and Care Coordination Level (CCL) Audits in Q2 CY21 to ensure that all CISC Members are being correctly referred to a CNA, if applicable and leveled appropriately upon completion of the CNA.

HSD's QB audits CISC Member files solely for CISC Members with Categories of Eligibility (COEs) 066 and 086.

Since Q4 CY22, all CISC 066 and 086 Members are required to be leveled as CCL2 or above.

The below charts show MCO compliance with HSD contract and policy requirements for completion of the HRA, completing the assessment within contract specified timeframes, correctly referring Members for a CNA, covering all requiring elements of a CNA, and correctly categorizing a Member as Care Coordination Level two (2) or Care Coordination Level three (3). Results from the CISC HRA and CISC CNA Audits continue to be near 100% compliance.

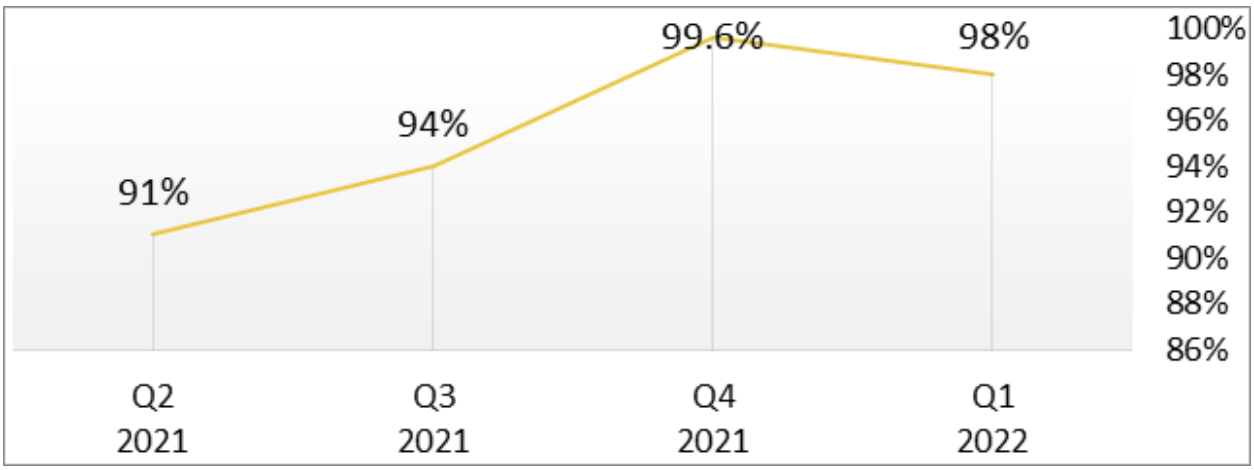
CISC HRA Audit Results Q2 CY21 through Q1 CY22



Non-compliance centered around the timeliness of the HRA or confusing documentation in the Member files.

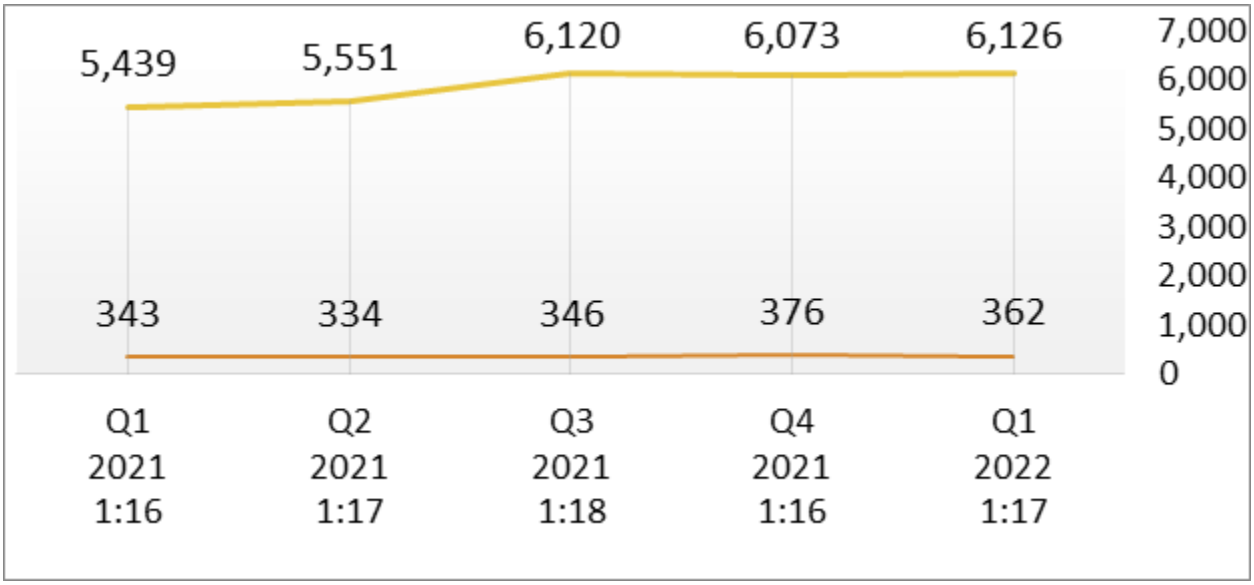
Auditors noted that in some Member files, the timeliness of the HRA, per HSD contract, was not apparent. Additionally, auditors found some HRAs listed as 'initial' though the Member was not New to Medicaid.
All findings were presented to the MCOs and follow up requested.
MCOs clarified that additional outreach was occurring for CISC Members that had previously been Unable to be Reached (CCL0-UTR), Difficult to Engage (CCL5-DTE), or had Refused Care Coordination (CCL4-RCC). A number of these Members were not New to Medicaid; however, were new to CISC categories. MCOs have added additional documentation to the Member files, per HSD's request, clarifying additional outreach for CISC CCL0, CCL4, and CCL5 Member HRAs.

CISC CCL Audit Results Q2 CY21 through Q1 CY22



Non-compliance was attributed to confusing Member file documentation.
Auditors noted, in one Member file, a list of the Member's medication that was not included in the Member's Comprehensive Needs Assessment. Auditors also noted, in one Member file, the Member reported no behavioral health related issues in one area of the assessment; however, anxiety, depression, and PTSD were reported in the same assessment.
All findings were presented to the MCOs and follow up requested.
The MCO added additional documentation concerning the Member's medications to the CNA. The MCO also clarified that Members may provide conflicting answers; however, the Member file documents the diagnosis, including those the Member may not reveal during the assessment.

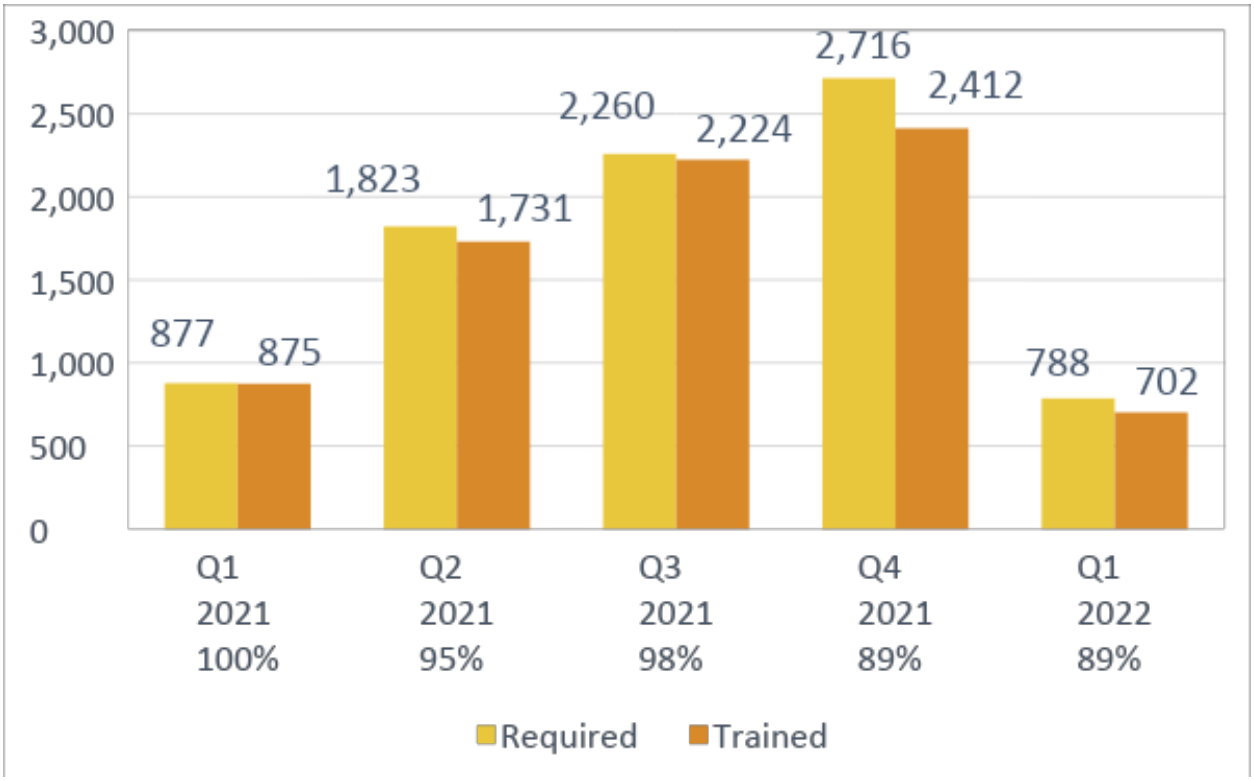
MCO Care Coordination Ratios for CISC Members



HSD's QB instituted a quarterly Staffing and Training report in Q1 CY21 to provide more comprehensive data from the MCOs on their staffing levels, required trainings, and training materials provided to staff.

The above chart details the staffing ratios of Care Coordinators to CISC Members from Q1 CY21 through Q1 CY22. As shown, the current ratio, for Q1 CY22, is one care coordinator per 17 CISC Members.

MCO Care Coordinator CISC Training



The Quarterly Staffing and Training Report includes data for the number of MCO staff that require and receive training for the CISC membership. MCOs require staff in addition to care coordinators to attend CISC training and include Peer Support Specialists, Community Health Workers, care coordination Supervisors and care coordinators. CISC trainings occur throughout the year and MCOs ensure that all staff are trained within each calendar year.

HSD's QB staff request MCO training dates for CISC trainings, attend CISC trainings, ensure that the trainings are comprehensive and follow contract and policy requirements and provide feedback to the MCOs for the attended trainings.

Care Coordination 101 Training

HSD's QB and CYFD's CISC collaborative workgroup implemented an ongoing Care Coordination 101 training designed specifically to educate CYFD staff on the roles and responsibilities of MCO Care Coordinators. CYFD included the Care Coordination 101 training in their Cornerstone Training Platform and is now requiring all CYFD Permanency Planning Workers (PPW) and Investigators to attend this training. As of Q1 CY2022 433 CYFD staff have attended this training.

Additionally, HSD's QB and CYFD collaborated on a "Roles and Responsibilities" document that outlines the assessments and touch points required by both PPW and MCO Care Coordinators. This one-page document has been provided to all PPW's and is included on the Cornerstone Training Platform.

HSD Children in State Custody Performance Measures Quarterly Audits

To ensure that all CISC enrolled with a MCO, and engaged in Care Coordination, are receiving wellness and dental care, HSD's QB in collaboration with CYFD, developed a set of five (5) performance measures (PM). The reports for CY 22 Q1 and CY 22 Q2 have been received from the MCOs. The tables below represent MCO cumulative aggregate data on the number of CISC children that have received the specified wellness and dental visits by age group. HSD's QB present the findings during the HSD/CYFD biweekly meetings, as well as during the quarterly meetings with the MCOs, to discuss any of the measures that are lagging and develop an action plan to ensure that all CISC members receiving care coordination are completing the expected wellness and dental visits. HSD expects to see the rates increase significantly as the year progresses and more CISC complete wellness and dental visits.

PM#1: The number of CISC Medicaid Members (COE 017, 037, 046, 047, 066 and/or 086), who are ages two (2) to twenty (20) years as of December 31 of the measurement year, who are enrolled with a MCO, and who have had at least one (1) dental visit during the measurement year.

CISC PM 1 - Annual Dental Visit (ADV) CY 2022			
	Numerator	**Denominator**	**MCO Aggregate Total**
Q1	**1,095**	**5,351**	**20%**
Q2	**2,175**	**5,433**	**40%**
Q3	**N/A**	**N/A**	**N/A**
Q4	**N/A**	**N/A**	**N/A**

PM#2: The number of CISC Medicaid Members (COE 017, 037, 046, 047, 066 and/or 086), who are enrolled with a MCO on or before the child's second birthday, who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

CISC PM2 - Childhood Immunization Status: Combination 3 (CIS) CY 2022			
	Numerator	Denominator	MCO Aggregate Total
Q1	73	154	47%
Q2	84	164	51%
Q3	N/A	N/A	N/A
Q4	N/A	N/A	N/A

PM#3: The percentage of CISC adolescent Medicaid Members (COE 017, 037, 046, 047, 066 and/or 086), who turn 13 years of age during the measurement year, enrolled with a MCO, and who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

CISC PM3 - Immunizations for Adolescents Combination 2 (IMA) CY 2022			
	Numerator	Denominator	MCO Aggregate Total
Q1	101	330	31%
Q2	111	336	33%
Q3	N/A	N/A	N/A
Q4	N/A	N/A	N/A

PM#4: The percentage of CISC Medicaid Members (COE 017, 037, 046, 047, 066 and/or 086), who had the following number of well child visits with a PCP during the last 15 months. The measure reports the following rates: First 15 months and 15 months to 30 months.

CISC PM 4 – Well-Child Visits in the first 15 months: Children who turned 15 months old who had six (6) or more well-child visit(s) with a PCP during the measurement year (W30) CY 2022			
	Numerator	Denominator	MCO Aggregate Total
Q1	30	104	29%
Q2	46	125	37%
Q3	N/A	N/A	N/A

Q4	**N/A**	**N/A**	**N/A**
CISC PM 4 – Well-Child Visits for Age 15 Months to 30 Months: Children who turned 30 months old and had two (2) or more well-child visit(s) with a PCP during the measurement year (W30) CY 2022			
	Numerator	**Denominator**	**MCO Aggregate Total**
Q1	**98**	**160**	**61%**
Q2	**119**	**180**	**66%**
Q3	**N/A**	**N/A**	**N/A**
Q4	**N/A**	**N/A**	**N/A**

PM#5: The percentage of CISC Medicaid Members (COE 017, 037, 046, 047, 066 and/or 086) 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The measure reports for the following age groups: 3-11 years of age, 12-17 years of age, and 18-21 years of age.

CISC PM5 - Child and Adolescent Well-Care Visits3-11 years of age (WCV) CY 2022			
	Numerator	**Denominator**	**MCO Aggregate Total**
Q1	**265**	**2,404**	**11%**
Q2	**638**	**2,459**	**26%**
Q3	**N/A**	**N/A**	**N/A**
Q4	**N/A**	**N/A**	**N/A**
CISC PM5 - Child and Adolescent Well-Care Visits 12-17 years of age (WCV) CY 2022			
	Numerator	**Denominator**	**MCO Aggregate Total**
Q1	**174**	**2,130**	**8%**
Q2	**413**	**2,175**	**19%**
Q3	**N/A**	**N/A**	**N/A**
Q4	**N/A**	**N/A**	**N/A**
CISC PM5 - Child and Adolescent Well-Care Visits18-21 years of age (WCV) CY 2022			
	Numerator	**Denominator**	**MCO Aggregate Total**
Q1	**28**	**748**	**4%**
Q2	**56**	**720**	**8%**
Q3	**N/A**	**N/A**	**N/A**
Q4	**N/A**	**N/A**	**N/A**

HSD continues to audit and monitor care coordination services provided by the MCOs for CISC engaged in care coordination. In addition to ensuring timely assessments, adequate staffing and training, HSD will continue monitoring wellness and dental visits for CISC. Through biweekly collaboration with CYFD, HSD will work to identify barriers and provide solutions to engaging CISC in care coordination and improving health outcomes for CISC.