Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2018 – 12/31/2018)
Waiver Quarter: 3/2018

December 6, 2018
New Mexico Human Services Department

Table of Contents

Section I: Introduction 5

Section II: Eligibility, Provider Access and Benefits 6

Eligibility 6

Access 6

Primary Care Provider (PCP)-to-Member Ratios 6

Geographic Access 6

Physical Health and Hospitals 6

Behavioral Health 7

Community Health Workers 9

Telemedicine 11

Transportation 12

Provider Network 12

Service Delivery 12

Utilization Data 12

Pharmacy 13

Hepatitis C (HCV) 15

Nursing Facilities (NFs) 16

Community Interveners 16

Centennial Rewards Program 16

Presbyterian Health Plan’s Agreement with UnitedHealthcare 18

UnitedHealthcare Community Plan Termination 18

Section III: Enrollment 20

Disenrollments 21

Section IV: Outreach 22

Presumptive Eligibility Program 22

JUST Health Program 23

Section V: Collection and Verification of Encounter Data and Enrollment Data 24

Enrollment Data 24

Section VI: Operational/Policy/Systems/Fiscal Development Issues 25

Program Development 25

Behavioral Health....25
MCO Initiatives....25
Blue Cross and Blue Shield of New Mexico....25
Molina Healthcare....27
Presbyterian Health Plan....28
UnitedHealthcare....29
Fiscal Issues....30
Systems Issues....30
Medicaid Management Information System Replacement....30
Section VII: Home and Community-Based Services....32
New Mexico Independent Consumer Support System (NMICSS)....32
Critical Incidents....33
Home and Community-Based Services Reporting....36
Long-Term Services and Supports (LTSS)....36
Self-Directed Community Benefit....36
Electronic Visit Verification....36
Section VIII: AI/AN Reporting....37
Access to Care....37
Section IX: Action Plans for Addressing Any Issues Identified....41
Section X: Financial/Budget Neutrality Development/Issues....42
Section XI: Member Month Reporting....43
Section XII: Consumer Issues – Complaints and Grievances....44
Section XIII: Quality Assurance/Monitoring Activity....45
Service Plans....45
NF LOC....45
External Quality Review Organization (EQRO) NF LOC....47
Care Coordination Monitoring Activities....48
Care Coordination Audits....48
Care Coordination for Super Utilizers....49
Care Coordination and EDIE....49
Care Coordination Ride-Alongs....50

Care Coordination Member Issue and Technical Assistance Calls....50
Section XIV: Managed Care Reporting Requirements....51
Customer Service....51
MCO Reporting....51
Member Appeals....51
Section XV: Demonstration Evaluation....53
Section XVI: Enclosures/Attachments....54
Section XVII: State Contacts....55
Section XVIII: Additional Comments....56
Centennial Care Member Success Story 1....56
Centennial Care Member Success Story 2....56
Centennial Care Member Success Story 3....57
Centennial Care Member Success Story 4....57

Section I: Introduction

On July 12, 2013, the Centers for Medicare and Medicaid Services (CMS) approved New Mexico's Centennial Care Program 1115 Research and Demonstration Waiver. The approval of the waiver was effective from January 1, 2014 through December 31, 2018.

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. There are approximately 659,197 members currently enrolled in the program.

The goals of the Centennial Care Program at implementation included:

- Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most effective settings;
- Ensuring that the care being purchased by the program is measured in terms of its quality and not its quantity;
- Slowing the growth rate of costs or "bending the cost curve" over time without cutting services, changing eligibility or reducing provider rates; and
- Streamlining and modernizing the program.

In the development of a modernized Medicaid program, New Mexico articulated four (4) guiding principles:

1. Developing a comprehensive service delivery system that provides a full array of benefits and services offered through the State's Medicaid program;
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
3. Increasing the emphasis on payment reforms that pay for performance rather than payment for the quantity of services delivered; and
4. Simplifying administration of the program for the State, for providers and for recipients where possible.

These guiding principles continue to steer New Mexico's Medicaid modernization efforts and serve as the foundation for the Section 1115 waiver.

The four Managed Care Organizations (MCOs) contracted with New Mexico to deliver care are:

- Blue Cross Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico (MHC)
- Presbyterian Health Plan (PHP)
- UnitedHealthcare (UHC)

Section II: Eligibility, Provider Access and Benefits

On September 1, 2018, UHC membership transitioned to PHP as a result of a Medicaid membership buy out. The transition of Medicaid membership from UHC to PHP will be noted in various sections of this quarterly report.

Eligibility

As noted in Section III of this report, there are 267,627 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment decrease of 5,466 from DY5 Q2.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through June 30, 2018. Quarterly data is available through the second quarter of calendar year 2018.

Primary Care Provider (PCP)-to-Member Ratios

The primary care provider (PCP)-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties. There are no PCP access concerns at this time. Please see Table 1 and Table 2 – PCP

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June
BCBS	1:34	1:36	1:37	1:35	1:36	1:37
MHC	1:91	1:91	1:90	1:87	1:85	1:83
PHP	1:74	1:74	1:74	1:84	1:82	1:74
UHC	1:30	1:29	1:28	1:29	1:29	1:28

Source: [MCO] PCP Report #53 Q1 & Q2 Calendar Year 2018

Geographic Access

Physical Health and Hospitals

Geographic access standards are defined as at least 90% of members are within distance standards to provider types in urban, rural, or frontier geographic areas. Please see Attachment B– GeoAccess Physical Health (PH) for New Mexico's geographical access measurements. This reporting period HSD reviewed Q2 DY5 GeoAccess data and identified the following:

- Access standards for General Hospitals, PCPs, Pharmacies and most specialties in urban, rural and frontier areas are met by all 4 MCOs.
- Dermatology, Endocrinology, Neurosurgeons, Rheumatology and Urology remain areas of provider shortages in rural and frontier areas.
    - All MCOs report improvements towards meeting access standards for rural members to Dermatology services (BCBS: +0.2%, UHC: +8.1%, MHC: +6%, PHP: +0.2%).

- All MCOs are below access standards for Neurosurgeons in rural and frontier areas;
- All MCOs are below access standards for Rheumatology in frontier areas, and two MCOs did not meet the access standard for Rheumatology in rural areas;
- Three of the four MCOs are below access standards for Endocrinology and Neurology in frontier areas;
- Three of the four MCOs are below access standards for Urology in rural areas.

Additionally, HSD monitors outliers. All but one MCO met distance standards for specific provider types in geographic areas. PHP continues make slight increases towards meeting access standards in rural areas for neurology. (85.5%, +0.2). Some of the smaller percentage gains correlate with population eligibility changes as the standard calculation is dependent upon the number of members with geographic access meeting distance requirements compared to the total number of enrolled members. With PHP adding approximately 85,500 members to its enrollment on September 1, 2018, HSD anticipates higher percentage changes in the next quarterly report. BCBS reports diminished access for FQHC-PCPs only in rural areas with a decline of 4.6% to result in 85.7% of rural members within distance. It is noted that BCBS reports 100% access for FQHCs.

HSD found many positive outliers for which one MCO was able to exceed standards while all other MCOs remain below access standards. For this quarter, each MCO has a positive outlier. BCBS remains the only MCO to exceed access standards in frontier areas for neurology (92.1%). All other MCOs are close to meeting access standards. (UHC: 88.7%, MHNM: 89.0%, PHP 84.0%). MHC is the only MCO to meet access standards in frontier areas for endocrinology at 91%. In rural areas, PHP maintains the positive outlier status with a 1.3% increase in access to urologists, with 94% within minimum distance access.

Additionally, of note this quarter:

- UHC successfully maintained access standards in frontier areas for dermatology for the 2nd quarter after over 12 quarters of being under distance access standard.
- UHC reports an increase of 13.1% resulting in 56.7 % of rural members having access to Neurosurgeons.
- MHC reports an increase of 23% resulting in 98% of urban members having access to Dermatology.

.

Behavioral Health

In DY5 Q3, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier areas through Core Service

Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient provider agencies, psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners. (See Attachment C: GeoAccess Behavioral Health Summary for MCO performance in meeting access to specific provider types.)

Rural and frontier access standards remain unmet with limited exceptions, for the following: Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs. Treatment Foster Care 1 & 2, Behavioral Management Services, Day Treatment Services, Intensive Outpatient Services, Methadone Clinics Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST). Rural access standards for Behavioral Health clinics are not met by the majority of MCOs.

With a few exceptions, none of the urban, rural and frontier access standards were met for residential treatment programs, both accredited and non-accredited, Indian Health Services and Tribal 638s providing BH, Day Treatment Services, and Rural Healthcare Clinics providing BH services.

HSD continues to be aware of the BH services that do not meet the standards due to provider shortages in New Mexico. HSD continues to work with MCOs to strengthen their relationships with providers and to increase accessibility through increased opportunities to expand use of telemedicine.

The Interdepartmental Council (IDC), made up of Children, Youth, and Families Department (CYFD) and HSD, has been processing applications and conducting site visits to continue to increase approved Intensive Outpatient Programs (IOP). CareLink New Mexico (CLNM) Health Homes also launched an additional service site July 1st. By the end of 2019, the new Health Homes are expected to serve nearly 10,000 Medicaid beneficiaries with serious mental illness (SMI) for adults and severe emotional disturbance (SED) for children and adolescents.

MCOs individually continue to work to maintain access with the current network while continually striving to build accessibility through efforts to provide innovative service delivery to their members by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available network in ways such as having a Behavioral Health provider service representatives routinely visit providers to validate practice information, respond to claims and other issues. Additionally, MCOs are looking at value-based purchasing to increase access with appointment availability and utilizing High Fidelity Wrap around services to meet member's needs. MCO Network contracting teams monitor the out of network providers from the single case agreement files to recruit additional practitioners to participate in the Behavioral network. Also, ongoing assessments by some MCOs have identified recruitment

opportunities with out of state border facilities for Inpatient BH services.

Community Health Workers

Centennial Care MCOs reported a 45% increase in members served by CHWs for DY5 Q2 from the previous reporting period. An increase of 25 CHWs was also reported for a total of 123 CHWs, employed or contracted. Please see Table 2-Summary of CHW Workforce by MCO.

Table 2 – Summary of CHW by MCOs Workforce by MCO

DY5 Q3			
Community Health Workers			
	Employed	**Contracted**	**Total**
BCBS	30	15	45
MHC	20	16	36
PHP	8	12	20
UHC	17	5	22
Totals	**75**	**48**	**123**

Source: [MCO] CHW DSIPT, Q2CY18

The most effective CHW intervention has been with members on Emergency Department (ED) education. This intervention is comprised of obtaining or updating health risk assessments (HRAs) and conducting social determinants of health screening resulting in linkages to commonly needed food assistance, utility assistance, housing, transportation, and health education, and providing alternative resources. In addition, the CHWs identify members requiring a level of care change as a result of inpatient admissions or multiple ED visits.

Housing assistance continues to be identified as the number one need, often above food assistance needs. CHWs serve members recently released from jails and prisons to provide resources and Peer Support Worker, as needed. CHW services also focus on Hep C treatment regimen support and follow up. Please see Table 3-Unduplicated Members Served by CHWs.

Table 3 - Unduplicated Members Served by CHWs

DY5 Q3 Unduplicated Members Served					
	BCBS	**MHC**	**PHP**	**UHC**	**Region Totals**
Underserved Urban	13,632	978	1,497	649	16,756
Rural	3,126	870	559	540	5,095
Frontier	751	139	190	134	1,214
MCO Totals	**17,509**	**1,987**	**2,246**	**1,323**	**23,065**

Source: [MCO] CHW DSIPT, Q2CY18

Member educational by CHWs outreach in Q2 included:

- NB3-Native American Healthy Foods Healthy Kids
- American Lung Association -Asthma Basics
- Hep C Events
- Circle of Security Parenting Series (Spanish & English)
- Container Gardening Workshop (Spanish & English)

Telemedicine
Telemedicine utilization data for Q2DY5 was reviewed and indicates that most telemedicine services provided in New Mexico are for behavioral health diagnoses (Please see Table 4 – Telemedicine Services). All MCOs maintain efforts to increase telemedicine utilization.

- BCBS initiated communication with New Mexico Primary Care Association (NMPCA) regarding telemedicine billing for Medicaid services. This resulted in a letter from NMPCA to the FQHC membership outlining Medicaid benefit services that can be provided via telehealth and billed to managed care organizations. BCBS started discussions with an urgent care center to explore in-home telehealth services.
- MHC met with several telemedicine providers to assist with telemedicine related questions. MHC contracts with behavioral health prescribers and wellness centers, with Pine Hill Clinic and First Nations having telemedicine start-up at clinics this quarter.
- Presbyterian Health Plan (PHP) offers technical assistance to providers who are interested in delivering services via telemedicine. PHP also partners with Presbyterian Health Services' (PHS) delivery system, the Presbyterian Medical Group (PMG), through a Telehealth Operations Committee to identify opportunities to improve access and capacity through expanded telemedicine offerings. Expanding utilization of video visits to reduce ED utilization has been a PHP priority initiative for the past few years.
- UHC informs their members of the options available for telemedicine through originating sites and virtual visit technology. UHC reports a continued increase in virtual visits. PHP telemedicine interventions include provider education regarding accurate coding of telemedicine services.

Table 4 - Telemedicine Services

DY5 Q2			
Number of Behavioral Health Visits			
	Urban	Rural	Frontier
BCBS	446	590	148
MHC	597	1,126	228
PHP	1,432	1,802	971
UHC	305	656	141
TOTAL	2,780	**4,174**	**1,488**

Source: [MCO] Telemedicine DSIPT, Q2CY18
*Urban numbers are for data collection only and do not count towards DSIPT goal.

Transportation

HSD monitors the administration of the non-emergency medical transportation benefit provided under managed care. HSD requires MCOs to monitor adequate access to safe and timely transportation services while ensuring the benefit is appropriately utilized for medically necessary services.

As a result of the transition of Medicaid members from UHC to PHP on September 1, 2018, PHP worked with its vendor, Superior Medical Transport (SMT) to facilitate a smooth transition for former UHC members. PHP requested and received a list of UHC members with ongoing/standing appointments. The Presbyterian Customer Service Center's (PCSC) Travel Team made reservations for these members beginning in September and through October. Other preemptive measures by PHP and SMT included, but were not limited to: implementing no mileage restrictions for transportation services provided by SMT to an appointment for medically necessary covered services; opening PHP's PCSC to member calls regarding transportation; honoring all short-term travel requests by first offering to arrange travel, or if not feasible within the required notice, providing appropriate mileage reimbursement; providing a specialized toll free number to SMT to ensure that PHP was readily available to assist SMT with any issues or concerns while they were scheduling appointments; and increasing SMT staff, vendors, and vehicles.

Provider Network

As a part of Presbyterian Health Plan's (PHP) agreement with UnitedHealthcare (UHC), UHC shared information regarding its provider network. PHP estimated that approximately 95% of providers that had contracted with UHC would also be available to UHC members during the transition period. In addition, PHP successfully contracted with Lovelace Health System to expand its network as well as to ensure continuity of care for transitioning UHC members. Of the approximate 5% of members whose PCPs were not contracted with PHP by September 1, 2018, they were offered the choice of an in-network PCP, an assigned PCP, or the option to switch to an MCO who was contracted with their current PCP.

New Mexico's documented provider shortage in several specialty areas remained consistent with previous quarters. PHP's delivery-system improvement fund initiative to expand capacity for difficult to recruit clinical professions increased the new to New Mexico providers again this quarter. Since the beginning of this initiative, a total of 34 providers were recruited. This initiative is demonstrating to have a positive impact on improving access to care for Medicaid patients. For more detail regarding this initiative, please refer to PHP Initiatives and Innovations.

Service Delivery

Utilization Data

Centennial Care key utilization and cost per unit data by programs is provided for July 2016

through June 2018. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

Pharmacy

HSD reviews the monthly MCO pharmacy reports to monitor key metrics regarding prescription claims on brand and generic drugs (Please see Table X – Percent of Pharmacy Claims for each MCO). This reporting period showed an average generic drug usage for all four MCOs of 88% and is consistent with the previous reporting period. In comparison to the last quarter, HSD identified the following:

- All MCOs had a slight decrease in generic drug utilization. BCBS had a 0.2% decrease, MHNM had a 0.5% decrease, PHP had a 0.4% decrease, and UHC had a 0.1 % decrease in generic drug utilization from the previous quarter.
- BCBS, MHNM, and PHP had a slight increase in usage of brand drugs with no generic available, while UHC remained the same from the previous reporting period.
- The overall usage of brand medication when there was no generic available averaged at 11.8% for the current reporting period with a slight increase of 0.3% from the previous reporting.
- Three MCOs had a slight increase in the use of brand drugs when there was a generic available while one remained the same. BCBS had a 0.2% increase, MHNM and UHC had a 0.1% increase, and PHP remained the same. The 0.5% average use of brand drugs when there was a generic available had a slight increase of 0.1 % from the previous reporting period.
- All MCOs continue to require medical justification for the use of a brand drug when there is a generic available. Dispense as Written (DAW) claims averaged at 0.2% with UHC having the highest number of DAW claims paid at 0.63%.

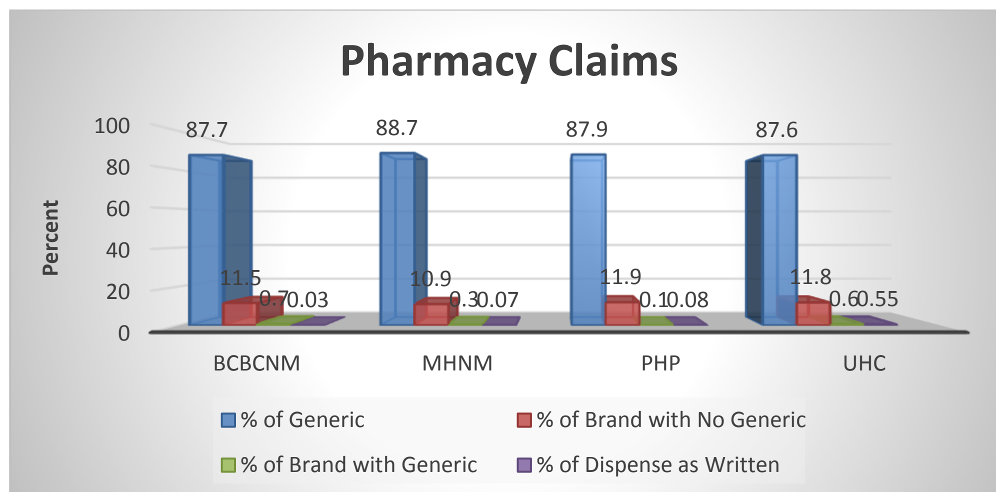
HSD issued a letter of direction (LOD) to the MCOs addressing Community Pharmacy Reimbursement. The intent of the LOD was to increase payments to the community-based pharmacies and establish standard payment methodology to help ensure that the pharmacy payment structure more realistically reflects buying power, buying volume, and price negotiating potential. A community-based Pharmacy as defined in the LOD is a pharmacy that has the following characteristics:

- Is open to the public for prescriptions to be filled, regardless of the facility or practice where the prescription was written. This includes multi-site pharmacy operations and franchises whose locations are in New Mexico;
- Is located in New Mexico or near the state border, if the border town is a primary source of prescription drugs for Centennial Care members residing in the border area;
- Is not government-owned, not hospital-owned or hospital-based, not an extension of a hospital, not owned by a corporation owning hospitals, and not an extension of a medical practice or specialty facility;

- Is not owned by a corporate chain with stores outside of New Mexico;
- Is not a mail order pharmacy; and
- Is not part of a national network of pharmacies or specialty pharmacies, including those primarily used for supplying IV admixtures.

Per the LOD, MCOs must ensure payment to community-based Pharmacies on the Maximum Allowed Cost (MAC) for ingredient cost generic drugs that it is no lower than the current National Average Drug Acquisition Cost (NADAC) listed for the National Drug Code (NDC) for the drug item. Dispensing fees will be paid in accordance with the terms of the applicable pharmacies' contracts. When NADAC is not available, the MAC must be no lower than the published Wholesaler's Average Cost (WAC) listed for the NDC + 6%, The WAC must come from a published national pharmacy pricing source such as Medi-Span or First Data Bank that is not associated with the MCO or PBM. Additionally, the LOD directed MCOs to cover flu shots, including the booster-enhanced flu shots when prescribed for 65 and older and for other conditions per CDC seasonal recommendations.

Table 5 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M6CY18, M7CY18, M8CY18

Hepatitis C (HCV)

During DY5 Q3, HSD reviewed MCO Q2DY5 data submitted on the HCV delivery system improvement performance target (DSIPT) reporting template. HSD is monitoring the number of unduplicated members requesting HCV treatment for Q2DY5 as well as similar numbers for direct antiviral agent prescription approvals and dispensing by both members' liver fibrosis stages and HCV genotypes. All MCOs have exceeded their treatment target for Q2.

Each MCO has implemented their own comprehensive plan to expand HCV screening, case finding and develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico. For Q2DY5 the following was reported:

- BCBS started a draft for a HCV Provider Incentive Program. Their tentative plan was to implement the provider training incentive first. The partnership that BCBS established with Tricore labs in the previous quarter will enhance BCBS's capability to support the provider incentive program.
- MHC continues to implement a Pay for Performance (P4P) incentive for the initiation and completion of Hepatitis C virus treatment. MHC conducts outreach to three Provider groups each month and reported to have 6 provider groups who participated in their P4P incentive program in Q2. Provider groups selected for outreach include those who may need assistance with: 1) process improvements concerning Member treatment; 2) appropriate documentation for HCV medication requests; and 3) a clearer understanding of treatment grids.

Additionally, MHC conducts outreach to provider groups who are interested in hosting HCV testing events through their collaboration with the Chronic Liver Disease Foundation.

- PHP analyzed laboratory data to identify members with positive viral load and/or genotype as part of their comprehensive plan to expand HCV case finding and screening efforts. PHP has dedicated nurse navigators and midlevel providers to increase screening and treatment efforts. Outreach efforts are underway and members are being identified for treatment.
- UHC incentivizes their contracted providers for screening all at-risk populations, including substance use disorders, populations with high risk sexual behavior and baby boomers. UHC's care coordinators are also given lists of patients that meet screening recommendations with the expectation that they will outreach to encourage the members to have a Hepatitis C screening test.

Nursing Facilities (NFs)

In DY5 Q3, HSD continues to monitor the MCOs' efforts to address nursing facility claims issues. HSD has been very pleased with the outcomes of these meetings and the nursing facilities have expressed their satisfaction with the MCO's resolution of claims issues.

Community Interveners

In DY 5 Q2, four Centennial Care members received Community Intervener (CI) services as illustrated below. The MCOs provide education to their care coordinators to assist in identifying members that meet the criteria for the CI service. The MCOs also provided assistance to CI providers when needed regarding billing issues. Please see Table 6 – Community Intervener Services Utilization DY5 Q2.

Table 6 – Community Intervener Services Utilization DY5 Q2

MCO	# of Members Receiving	Total # of CI Hours Provided	Claims Billed Amount
BCBS	1	12	$84
MHC	0	0	$0
PHP	1	57	$1,231
UHC	2	140	$909
Total	**4**	**209**	**$2,440**

Source: [MCO] Utilization Management Report #41, Q2CY18

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date, 694,455 distinct members, or 68.4% of all enrollees, have earned at least one reward. Since the launch of Centennial Rewards, members have earned points totaling a value of $57.6 million.

Of that amount $14.5 million have been redeemed for a cumulative redemption rate of about 25%. Points expire at the end of the year after the year in which they were earned. Table 7 – Health Behaviors Rewarded shows the healthy behaviors rewarded and each behavior's value. It includes the maximum dollar value available for each activity; reward value by activity and the total earned rewards.

Table 7 – Healthy Behaviors Rewarded

Eligibility Activities	Reward Value in Points, by Activity	Reward Value in $, by Activity	Total Rewards Earned by Activity in $
Asthma Management	600	$60	$ 30,195
Bipolar Disorder Management	600	$60	$ 54,255
Bone Density Testing	350	$35	$ 1,155
Healthy Smiles Adults	250	$25	$ 392,600
Healthy Smiles Children	350	$35	$ 873,320
Diabetes Management	600	$60	$ 171,600
Healthy Pregnancy	1000	$100	$ 68,900
Schizophrenia Management	600	$60	$ 61,955
Health Risk Assessment (HRA)	100	$10	$ 110
Other (Appeals and Adjustments)	N/A	N/A	$ 31,075
Step-Up Challenge	250	$25	$ 36,550
Totals	**N/A**	**N/A**	**$ 1,721,715**

Presbyterian Health Plan's Agreement with UnitedHealthcare
PHP successfully completed negotiations with UHC to acquire its full Medicaid membership as of September 1, 2018. To make the transition as seamless as possible for members, PHP established a phone line at its Customer Service Center specifically for UHC transitioning members in addition to its existing phone lines; implemented extended hours for the transition line; extended employment offers to all of UHC's 340 care coordinators and assigned the new hires to the same members they had worked with when they were with UHC in order to facilitate continuity of care; utilized the Centennial Care 2.0 Transition Management Agreement (TMA) as a guideline for service transitions from UHC to PHP including honoring prior authorizations; and, instituted many additional precautionary measures to manage the transition of approximately 85,500 members over the 2018 Labor Day weekend.

UnitedHealthcare Community Plan Termination
During DY5 Q3, United Health Care Community Plan (UHC) terminated its participation in the Centennial Care Medicaid Program. The transition of UHC's Centennial Care members took place as of midnight on August 31, 2018 and included a thirty-day run out period to establish a steady state communication channel between UHC and PHP clinical teams to manage transition of Care (TOC) requests.

In compliance with section 7.6.3.9 of the Managed Care Services Agreement between UHC and the State of New Mexico, on August 21, 2018 UHC submitted a Centennial Care Termination Plan to HSD for review and approval. UHC will provide on-going updates to ensure they are aligned with the termination/closure expectations defined in Section 7.6.8.3.16 of the Managed Care Services Agreement which include, but are not limited to, the following:

- UHC will identify key UHC staff to support the run out of the Managed Care Service Agreement and ensure there is adequate staffing in all member service areas throughout the transition process. They will also develop a provider communication strategy to communicate with their provider network about this transition and ensure there is an efficient and orderly transition of its members.
- UHC will maintain claims processing functions necessary for a minimum of twelve (12) months to complete adjudication of claims and up to two (2) years for I/T/U claims. They will comply with all duties and or obligations incurred prior to the actual termination date of the agreement, including but not limited to the appeal process as described in section 4.16.3 of the managed care services agreement.
- UHC will abide by all contractual reporting requirements and meet all filing deadlines of reports concerning their operations during the term of the agreement and will outline this in their Termination Plan.
- UHC will submit an update to their Termination Plan every thirty (30) days to HSD describing how they have completed its continuing obligations under the Managed Care Services Agreement.

HSD will continue to follow-up and direct UHC as necessary through the run out of their termination plan. Upon completion of their Termination plan, UHC will submit to HSD a final report describing how UHC fulfilled its termination plan responsibilities.

Section III: Enrollment

Centennial Care enrollment indicates a decrease in enrollment in all populations except SSI and Related Dual and 217 Like Group Dual with the Expansion population remaining stable. The majority of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in the table below.

The following table outlines all enrollment activity under the demonstration. The enrollment counts include unique enrollees, not member months. Please note that these numbers reflect current enrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of the reporting quarter. Since members change eligibility and thus MEGs during the year, the only way to give an unduplicated count for the quarter and YTD is to look at the last month a client was in the MEG within the period. For that reason, the unduplicated total for YTD could be less than a prior quarter.

Table 8 – Enrollment DY5 Q3

Demonstration Population	Total Number Demonstration Participants DY5 Q2 Ending June 2018	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**364,225**	**464,868**
FFS	42,038	65,624
Molina	111,550	146,416
Presbyterian	118,000	171,292
UnitedHealthcare	27,182	6,011
Blue Cross Blue Shield	65,455	75,525
Population 2 – SSI and Related – Medicaid Only	38,451	42,484
FFS	2,466	3,873
Molina	11,445	12,914
Presbyterian	12,503	18,100
UnitedHealthcare	5,066	571
Blue Cross Blue Shield	6,971	7,026
Population 3 – SSI and Related – Dual	36,161	38,545
FFS	0	200
Molina	7,081	7,672
Presbyterian	7,122	21,622
UnitedHealthcare	14,892	1,772
Blue Cross Blue Shield	7,066	7,279
Population 4 – 217-like Group – Medicaid Only	353	493
FFS	86	204
Molina	51	59
Presbyterian	60	161
UnitedHealthcare	98	5
Blue Cross Blue Shield	58	64
Population 5 – 217-like Group - Dual	4,096	4,066
FFS	0	30
Molina	836	877
Presbyterian	792	2,076
UnitedHealthcare	1,514	210
Blue Cross Blue Shield	954	873
Population 6 – VIII Group (expansion)	267,627	278,516
FFS	28,742	38,474
Molina	69,223	71,855
Presbyterian	69,666	95,207
UnitedHealthcare	36,497	10,186
Blue Cross Blue Shield	63,499	62,794

Disenrollments

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

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

Table 9 – Disenrollment Counts DY5 Q3

Disenrollments	Total Disenrollments During DY5 Q2
Row Labels	
Population 1 – TANF and Related	**7,364**
FFS	767
Molina	2,364
Presbyterian	2,010
UnitedHealthcare	675
Blue Cross Blue Shield	1,548
Population 2 – SSI and Related – Medicaid Only	**365**
FFS	39
Molina	101
Presbyterian	84
UnitedHealthcare	57
Blue Cross Blue Shield	84
Population 3 – SSI and Related – Dual	**474**
Molina	104
Presbyterian	94
UnitedHealthcare	173
Blue Cross Blue Shield	103
Population 4 – 217-like Group – Medicaid Only	**6**
FFS	4
Molina	0
Presbyterian	1
UnitedHealthcare	1
Blue Cross Blue Shield	0
Population 5 – 217-like Group - Dual	**76**
Molina	15
Presbyterian	14
UnitedHealthcare	32
Blue Cross Blue Shield	15
Population 6 – VIII Group (expansion)	**8,585**
FFS	1,005
Molina	2,273
Presbyterian	2,209
UnitedHealthcare	1,104
Blue Cross Blue Shield	1,994
TOTAL	**16,870**

Section IV: Outreach

In DY5 Q3, HSD Outreach and Education staff participated in statewide outreach activities and events:

1. HSD participated in the Centennial Care 2.0 readiness activities: reviewing three Managed Care written proposals and participated in each MCO's on-site readiness review.
2. HSD scheduled and arranged for ten statewide Centennial Care 2.0 public information Attendees included providers, advocates, and members.
3. HSD Outreach and Education staff Long Term Services & Supports Bureau staff, presented Centennial Care 2.0 Waiver changes, at the New Mexico Association of Home & Hospice Care 2018 third quarter conference in Albuquerque.
4. Current MCOs participated in community events across the state providing enrollment opportunities and educating the public about Centennial Care. MCOs attended numerous Medicaid enrollment activities, health fairs and community events comprised of people with disabilities, senior citizens, children and families, Native Americans and other populations.

Table 10 - Schedule of Community Events DY5 Q3

Event Type	Event Location and Date	Audience and Topics
NM Assoc. of Home & Hospice Care 2018 Third Quarter	Albuquerque, NM Thursday 8/2/2018	NM Adult Protective Services requested a Centennial Care overview presentation for their new employees during their annual training of their state-wide APS call center staff.

Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's outreach efforts. With over 635 active certified Presumptive Eligibility Determiners (PEDs) state-wide, Medicaid application assistance is available in even the most remote areas of the state.

PEDs are employees of participating hospitals, clinics, FQHCs, IHS Facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some NM State Agencies (NM Department of Health, NM Children Youth and Families Department and the NM Department of Corrections).

PEDs continue to provide application assistance state-wide. In DY5Q3, PEDs:

- Granted 646 PE approvals*
- Submitted Medicaid applications for 5,221 individuals
  - Resulted in 4,468 ongoing Medicaid approvals

*99.6 % of all PEs granted in this reporting period also had an ongoing application submitted

JUST Health Program

PEDs who are employees of the NM Department of Corrections, County Jails, or Detention Centers participate in the PE Program through the Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) program. The JUST Health program allows for the automated data transfer of information for Medicaid eligible or enrolled individuals who are incarcerated in New Mexico. Individuals who are Medicaid-enrolled have their benefits suspended after 30 days of incarceration. Benefits are reinstated upon the individual's release from incarceration which allows immediate access to care. Individuals who are not Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply. Application assistance is provided by PEDs at the correctional facilities.

HSD has added enhanced care coordination activities for incarcerated individuals within the 1115 waiver renewal application submitted to CMS. In 2019, each MCO will be required to have a dedicated position for justice-involved transitions, including releases that occur on weekends and after hours. Each MCO will be required to work with the facilities to begin care coordination activities prior to an incarcerated individual's release.

It is HSD's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, BH appointments, etc.) upon release.

In DY5 Q3, HSD has established the Centennial Care a JUST Health workgroup. The workgroup includes representatives from State and County Correctional facilities, Managed Care Organizations, County governments, State agencies, provider organizations and other stakeholders. The goal of the workgroup is to create processes and procedures that can be utilized and adapted to work for all correctional facilities state-wide.

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

Encounter Data

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

Enrollment Data

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

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

Program Development

The proposed revision of the Managed Care Policy Manual that will be effective January 1, 2019 was sent out for public comment. HSD is reviewing and responding to the comments received and revising the policy manual as necessary.

In preparation for implementation of Centennial Care 2.0, HSD conducted an extensive readiness review of the three CC 2.0 MCOs that included a comprehensive desk audits and onsite readiness reviews for all 2.0 MCOs. The areas reviewed include but are not limited to behavioral health services, benefits, care coordination, program integrity, finance, long term services and support, member education and outreach, operations, provider network, quality, reporting, systems and value-based purchasing.

HSD conducted trainings for the CC 2.0 MCOs with a focus on the newly selected MCO. The trainings conducted included: an overview of 1915(c) Home and Community Based Service Waiver Programs, benefits; claims; physical health programs; pharmacy; national correct coding initiative (NCCI); nursing facility level of care (NFLOC); setting of care (SOC); fair hearings; Indian Health Services (IHS); Medicaid EHR incentive program; and others. HSD has also offered extensive technical assistance to all MCOs in preparation for a smooth transition of members effective January 1, 2019.

Behavioral Health

Please refer to Attachment E: Behavioral Health Collaborative CEO Report for an update on Behavioral Health activities.

MCO Initiatives

Blue Cross and Blue Shield of New Mexico

Children Youth and Families Department (CYFD) Intervention Pilot Program

As the number of reports for abuse and neglected children continue to rise statewide, BlueCross BlueShield of New Mexico (BCBS) has partnered with the Children Youth and Families Department (CYFD), Protective Services Division (PSD) to provide an intervention community resource through care coordination services for families during the investigation phase.

Currently in the state of New Mexico, there are over 2,400 children in out-of-home placements. All Managed Care Organizations work with these children and provide services. This BCBS pilot works in the investigations phase when children can remain in the home with their parents, guardians, or family members. In this phase, BCBS collaborates with the CYFD

investigations team to provide resources for the family to maintain permanency, safety, and well-being of the children involved. BCBS provides community partner access to behavioral health (BH), substance use treatment, medication management, individual therapy resources, and referrals. This is accomplished through understanding each family's need by completing a Comprehensive Needs Assessment (CNA) to ensure the family has the resources they need to preserve family relations and stability.

In order to see this pilot become more successful statewide, BCBS plans to identify specific care coordinators assigned to assist CYFD investigators for continuity of care to members and CYFD support. These Care Coordination teams will be matched by CYFD geographic regions to maintain contact with the county office managers and supervisors. In doing this, it will ensure communication is ongoing and will simplify the number of BCBS staff the CYFD staff have to engage with. It will also ensure referrals are fluid and processes are simplified for the overworked and understaffed CYFD offices. BCBS also plans on attending CYFD staff meetings to present any updates and answer any questions.

Amazon Echo Dot Pilot

In 2018, BCBS is piloting a program using Amazon Echo Dots for Centennial Care Members. The pilot program will target Members who have signs of memory loss or have been diagnosed with dementia, and who are receiving limited Long-Term Services and Supports, not including those receiving daily in-person services. Members enrolled in the pilot program will receive an Amazon Echo Dot, which require the Member to have Wi-Fi access and a device with an internet browser. The member will simply need to state "Alexa - Call my BCBS Care Coordinator."

BCBS Care Coordinators and Community Health Workers will assist Members in programming the Echo Dot to have "Alexa" remind Members to perform key activities at set times during the day or on specific dates. Some of these activities will include, but are not limited to: taking medications, drinking water, preparing and eating meals, attending provider appointments, etc.

BCBS plans on monitoring the outcome of this pilot through scheduled visits with the member, a program to install the Echo device, conducting week 1 and week 3 follow-ups with the member, and monthly follow-ups with the member for 6 months.

Providing families with the Echo Dot will potentially alleviate some of the burden from family members or caretakers by providing monthly, weekly and daily reminders.

Telehealth Grant Program

New Mexico is the fifth largest state in land mass, but 36th in population in the United States. There are many rural and frontier areas of the state with limited access to behavioral health care services. To address this challenge, BCBS is expanding telemedicine services in New Mexico, specifically in the rural and frontier areas of the state.

BCBS has awarded seven grants to community based behavioral health providers to develop or expand telemedicine services for members living in rural or frontier counties. The grant funding can be used for start-up costs to include equipment, supplies, software, licenses, internet connection/speed, associated fees, training, etc. The providers include prescribers, counselors/therapists, substance use disorder providers treating opioid and other drug dependence and applied behavior analysis providers who treat autism spectrum disorders. Awards were made to the providers because of their response to BCBS's request for applications for the grant funding. Applications were reviewed, and awards were made based on the provider's plan for expanding needed services to members living in rural and frontier areas, as well as the sustainability and growth potential of their development or expansion of telemedicine services.

Reserving Appointment Slots with Behavioral Health Providers
Access to behavioral health providers in New Mexico can be very challenging, especially for members who have urgent needs and who are not currently seeing a behavioral health provider. In addition, many behavioral health providers struggle with the high percentage of Medicaid members who miss appointments, usually without any notice. To help alleviate these problems, BCBS is developing an initiative to reserve appointment slots with behavioral health providers for members who have an urgent need, as well as those members stepping down from higher levels of care.

This initiative will focus on reserving appointment slots with prescribers or counselors/therapists, targeting providers who provide telemedicine services as well as office services. BCBS will work collaboratively in filling the slots and helping ensure members attend their appointment. For example, if a BCBS care coordinator or peer support worker is working with a member with an urgent need, they can schedule the member with a provider that has a reserved slot, and then accompany the member to the appointment if needed. If the member attends the appointment, the provider will submit a claim as usual so that the encounter can be tracked and recorded.

Molina Healthcare
Molina has developed referral and review processes to provide care to members with complex needs.

- The Quality Improvement (QI) and Population Health Department has set up a referral system that allows Healthcare Services care coordination staff to refer members to the QI nurse specialists who could benefit by talking with a nurse. Patients who have forgotten their medication instructions or who don't understand how to use their blood glucose equipment are examples of the situations where referrals are made. Nurses work directly with the member or on 3-way calls with the member and care coordinator during a home visit to provide education and training.
- The QI and Population Health Department has also developed a process for QI nurses to continuously review and evaluate members in the top five percent cost/risk

cohort to identify those best suited for Medical Rounds. In Rounds, a team of BH and PH providers evaluate the members' situations and make recommendations for team-based care.

Presbyterian Health Plan

A continuing initiative in Q3 DY5 is PHP's delivery system improvement fund plan (DSIF) to expand the provider network capacity by attracting providers to relocate to New Mexico. Providers selected for recruitment are those who have historically been difficult to recruit and retain, and newly graduating providers who might otherwise move out of state. PHP's areas of focus include: behavioral health – addiction medicine, allergy/asthma specialists, pediatric subspecialties, dermatology, and primary care physicians in rural areas. In an effort to increase provider capacity, PHP's strategies include, but are not limited to: growing the workforce via an accredited educational fellowship with academic sponsorship for behavioral health specialties; offering provider incentives such as quality specialty pay; reimbursing travel expenses for providers in active recruitment; increasing attendance for PHP recruiters to conferences held for specific specialties; and, training PCPs in asynchronous dermatology visits which encompass services that are amenable to treatment that are now beyond the scope of primary care. PHP developed measures to quantify system-wide access improvements for new to New Mexico providers. Please refer to Attachment F – DSIF 2018 Performance Measures map for new to New Mexico providers. A count of the 34 New Mexico provider types added to the delivery system because of this initiative are provided below in Table 11 – PHP Delivery System Funds Reinvestment Plan. For practice locations, see Attachment F – Delivery System Improvement Fund 2018 Performance Measures map, Q1-Q3 Report.

Table 11 - PHP Delivery System Funds Reinvestment Plan

	Q1	Q2	Q3
APC - ADDICTIONS CONSULTANT			1
APC - ADDICTIONS MEDICINE CL		3	
APC - FAMILY MEDICINE	1		2
DO - FAMILY MEDICINE	1		1
MD - FAMILY MEDICINE	1		2
MD - INTERNAL MEDICINE	1	1	
MD - PEDIATRICS	1	1	
MD - PEDS ENDOCRINOLOGY	1		
MD - PEDS HEMATOLOGY/ONCOLOGY		2	
MD - PEDS INTENSIVIST	1		
MD - PEDS NEWBORN HOSPITALIST		1	
MD - PEDS SURGERY		1	
MD - PEDS URGENT CARE		3	
MD - PSYCHIATRIC HOSPITALIST		1	
MD - PULMONARY			1
MIDLEVEL - FAMILY MEDICINE	1		
MIDLEVEL - PEDS HEMATOLOGY/ONCOLOGY		1	
MIDLEVEL - PEDS URGENT CARE	1		
MIDLEVEL - PSYCHIATRIC NURSE PRAC	1		
MIDLEVEL - PSYCHOLOGIST	1		
PSYCHOLOGIST			2
Quarter Sub-total	**11**	**14**	**9**
Grand Total			**34**

Additional PHP Provider Network Team innovations this quarter include the following:

- Implemented a small group Patient Centered Medical Home (PCMH) with First Nations. Developed a small group PCMH for groups with membership of a minimum of 1,000 members or less. A standard PCMH is 2,000 or more.
- PHP is in the final stages of implementation for developing and offering Native American Health and Wellness Services for I/T/U and IHS 638 Tribal facilities and providers. This offering will include services such as: traditional herbal remedies, sweat lodge groups and drumming circles.
- PHP is rolling out a provider incentive packet to incent providers to offer: after hours care and urgent care services to reduce emergency room utilization; Fecal/Colorectal Immunochemical Test (FIT) testing to ensure members are receiving appropriate screenings at appropriate times; and, lab services performed by in-state providers to keep New Mexico providers viable. This program was expanded to include Grants and Roswell providers.

UnitedHealthcare

UHC successfully transitioned approximately 86,000 members to Presbyterian Health Plan and coordinated critical member and clinical information to ensure membership impact was

minimal. UHC partnered with our vendors and internal stakeholders to implement and expedite data feeds, aligned with the New Mexico TMA.

UHC communicated the acquisition timeline and requirements with all vendors and major sub-contractors, in order to obtain requested transition information for previous years and provide supplemental reports throughout September to ensure all data was captured for dates of service through August 31 (formal date of termination for UHC Centennial Care).

UHC submitted its contractual termination plan to HSD for review on September 21, 2018 and will provide on-going updates to ensure UHC is aligned to the termination/closure expectations defined in Section 7.6.8.3.16 of the Managed Care Services Agreement.

Fiscal Issues

During DY5 Q3, capitation payments were reprocessed for the January to June period because of rates update to account for additional programmatic change, changes to the medical and non-medical components to account for material changes in the enrolled populations, and a change to the premium assessments. These changes were identified in the revised rate certification letters dated June 11, 2018 and submitted to CMS on August 17, 2018. The effects of those changes resulted in higher PMPM for all MEGs in quarter 3 of DY 5 compared to those PMPMs reported for quarter 2 of DY 5.

Systems Issues

HSD continues to implement reporting for analysis and oversight. HSD and the MCOs work together to address any concerns or make any necessary system changes on either side. There is a process in place to identify, track, research and resolve any issues that may arise.

Medicaid Management Information System Replacement

HSD's planning for replacement of its current legacy Medicaid Management Information System (MMIS) began some time ago, and activity for this effort continued to progress in DY5 Q3. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the Department of Health (DOH), Children Youth and Families Department (CYFD), and the Aging and Long-Term Services Department (ALTSD). These three departments have participated in RFP development and replacement planning. HSD is currently in the process of drafting a GSA with CYFD and is in the final stages of the GSA with ALTSD for qualifying activities to receive MMISR funding. The GSA with DOH has been approved. For overview and status please reference Table 12: Overview of status for MMSIR Modules.

Table 12 – Overview of status for MMISR Modules

Module	Description	Status	Date
IV&V	Independent Verification and Validation service (incl. document review, risk assessment, mitigation plan)	Contracted	Aug 2016
System Integrator	Infrastructure for Connectivity, Interoperability, Standards and Security; Enterprise Service Bus, Master Indices, Identity Management, and Legacy Data Conversion; Project Integration Management for all other modules; Data definition and Interface standards	Contracted	March 2018
Data Services	Data Tools and Trainings; Analytics; Reporting ; Business Intelligence; Enterprise Data Warehouse	Pending contract approval	Ongoing
Quality Assurance	Program integrity; Third-Party Liability (TPL) Detection, Avoidance and Recovery; Fraud Detection and Reporting Audit and Hearing Coordination; Quality Reporting, RAC	Procurement process	Ongoing
Benefit Management Services	Case/ Care management; Member and provider management; Utilization management; Pharmacy benefits management; Benefit Plan management	Pending release	
Financial Services	Claims processing; payments; financial activities (including account payable, account receivable, financial reporting, budgeting)	Sent to CMS	
Unified Portal Consolidated Customer Service Center			

Section VII: Home and Community-Based Services

New Mexico Independent Consumer Support System (NMICSS)

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

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

ADRC Coordinators provide over the phone counseling in care coordination, which is the process for assisting the client in describing their situation/problem. 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 ALTSD provides quarterly reports to HSD regarding the ADRC Caller Profile Report and Care Transitions Program Data.

ALTSD provides quarterly reports to HSD including the ADRC Caller Profile Report and Care Transitions Program Data. Please see Table 13 – ADRC Call Profiler Report DY5 Q2 and Table 14 – ADRC Care Transition Program Report DY5 Q3 below.

Table 13 – ADRC Call Profiler Report DY5 Q3

Topic	# of Calls
Home/Community Based Care Waiver Programs	2,589
Long Term Care/Case Management	2
Medicaid Appeals/Complaints	8
Personal Care	467
State Medicaid Managed Care Enrollment Programs	13
Medicaid Information/Counseling	1,284

Table 14 – ADRC Care Transition Program Report DY5 Q3

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		242	
Medicaid Education/Outreach	3,361		
Nursing Home Intakes		91	
**LTSS Short-Term Assistance			283

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

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

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

Critical Incidents

HSD continues to meet quarterly with the MCOs' Critical Incident workgroup in an effort to provide technical assistance. The workgroup also supports the Behavioral Health Services Division in the delivery of Behavioral Health (BH) incident reporting protocols to providers. BH protocols have been implemented by HSD/BHSD to improve reporting accuracy as well as establish guidelines for the types of BH providers who are required to report.

During DY5 Q3, a total of 6,168 Critical Incident Reports (CIRs) were filed for Centennial Care members in the areas of physical health, behavioral health, and self-directed community benefit services. One hundred percent of all CIRs received through the HSD Critical Incident web portal are reviewed. HSD continues to provide technical assistance to the MCOs when providers are non-compliant in reporting CIRs.

During DY5 Q3, a total of 421 deaths were reported. Of those deaths reported, 399 were reported as natural or expected deaths while 19 deaths were reported as unexpected and 3 deaths were reported as suicides. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

All CIRs require follow-up and may include a medical record review or a request for records

from the Office of the Medical Investigator (OMI) to determine cause of death. MCOs have internal processes on follow-up for all member deaths.

During DY5 Q3, a total of 3,865 critical incidents were categorized as Emergency Services. Of those, 194 were reported by BH providers and 318 were associated with self-directed members. This demonstrates an upward trend in the number of incidents categorized as Emergency Services when compared to DY5, Q2 (3,797), DY5, Q1 (3,685), DY4, Q4 (2,690), DY4, Q3 (2,692), DY4, Q2 (2,910) and DY4, Q1 (3,172). The MCOs continue to identify the use of Emergency Services as the highest critical incident type reported by volume for members with a reportable category of eligibility. Please see Table 15 – Critical Incident Types by MCO – Centennial Care below.

Table 15 – Critical Incident Types by MCO – Centennial Care

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	58	1.09%	83	1.55%	123	2.303%	44	0.82%	308	5.77%
Death	87	1.63%	93	1.74%	108	2.022%	96	1.80%	384	7.19%
Natural/Expected	82		91		100		93		366	
Unexpected	4		2		7		3		16	
Suicide	1		0		1		0		2	
Elopement/Missing	3	0.06%	15	0.28%	11	0.206%	1	0.02%	30	0.56%
Emergency Services	585	10.95%	722	13.52%	1,497	28.028%	549	10.28%	3,353	62.78%
Environmental Hazard	19	0.36%	12	0.22%	40	0.749%	23	0.43%	94	1.76%
Exploitation	16	0.30%	4	0.07%	26	0.487%	23	0.43%	69	1.29%
Law Enforcement	16	0.30%	30	0.56%	28	0.524%	15	0.28%	89	1.67%
Neglect	114	2.13%	122	2.28%	665	12.451%	113	2.12%	1,014	18.99%
Total	**898**	**16.81%**	**1,081**	**20.24%**	**2,498**	**46.77%**	**864**	**16.18%**	**5,341**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	11	2.65%	38	9.157%	26	6.265%	1	0.24%	76	18.31%
Death	3	0.72%	11	2.651%	3	0.723%	0	0.00%	17	4.10%
Natural/Expected	2		10		1		0		13	
Unexpected	1		1		1		0		3	
Suicide	0		0		1		0		1	
Elopement/Missing	0	0.00%	5	1.205%	4	0.964%	0	0.00%	9	2.17%
Emergency Services	6	1.45%	133	32.048%	43	10.361%	12	2.89%	194	46.75%
Environmental Hazard	1	0.24%	1	0.241%	6	1.446%	0	0.00%	8	1.93%
Exploitation	0	0.00%	4	0.964%	3	0.723%	0	0.00%	7	1.69%
Law Enforcement	4	0.96%	11	2.651%	8	1.928%	3	0.72%	26	6.27%
Neglect	6	1.45%	36	8.675%	32	7.711%	4	0.96%	78	18.80%
Total	**31**	**7.47%**	**239**	**57.59%**	**125**	**30.12%**	**20**	**4.82%**	**415**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	5	1.21%	3	0.73%	12	2.91%	3	0.73%	23	5.58%
Death	1	0.24%	4	0.97%	12	2.91%	3	0.73%	20	4.85%
Natural/Expected	1		4		12		3		20	
Unexpected	0		0		0		0		0	
Suicide	0		0		0		0		0	
Elopement/Missing	0	0.00%	2	0.49%	0	0.00%	0	0.00%	2	0.49%
Emergency Services	28	6.80%	30	7.28%	238	57.77%	22	5.34%	318	77.18%
Environmental Hazard	2	0.49%	0	0.00%	2	0.49%	0	0.00%	4	0.97%
Exploitation	1	0.24%	1	0.24%	7	1.70%	0	0.00%	9	2.18%
Law Enforcement	2	0.49%	0	0.00%	6	1.46%	0	0.00%	8	1.94%
Neglect	1	0.24%	2	0.49%	22	5.34%	3	0.73%	28	6.80%
Total	**40**	**9.71%**	**42**	**10.19%**	**299**	**72.57%**	**31**	**7.52%**	**412**	**100.00%**

Home and Community-Based Services Reporting

In DY5 Q3, HSD continued to compile and analyze the on-site validation and participant surveys with Community Benefit providers and members. HSD continues to update the Statewide Transition Plan milestones as required by CMS.

Long-Term Services and Supports (LTSS)

In DY5 Q3, HSD conducted ride-alongs with the MCO care coordinators to observe and monitor care coordination interactions and member assessment and interviewing practices. For more information regarding the ride-alongs, please see section XIII – Quality Assurance/Monitoring Activities.

All Centennial Care members enrolled with UHC as of August 31, 2018, transitioned to PHP effective September 1, 2018. HSD held frequent meetings with PHP to monitor the transition of LTSS members and their community benefit service authorizations to ensure continuity of care. Some issues with the transition of Personal Care Services authorizations in the EVV system were identified and resolved. HSD used the lessons learned with this MCO transition to update and improve the EVV system to ensure that PCS authorizations are transitioned more efficiently during the Centennial Care 2.0 implementation.

Self-Directed Community Benefit

In DY5 Q3, HSD continued to meet with PHP and monitor the quality and outcomes of transitioning all members to in-house Support Brokers and two external SB agencies. HSD is also working closely with PHP to monitor any SDCB specific transition issues related to the UHC to PHP transition described above.

Electronic Visit Verification

In DY5 Q3, HSD continued meetings with the MCOs and their EVV Vendor, First Data, for the implementation of EVV for self-directed personal care services in order to meet the requirements of the Cures Act. MCOs continued to solicit member input through their regular Member Advisory Board meetings and through a SDCB member survey.

In regard to ABCB EVV that is already fully implemented, the MCOs and their contractor, First Data began working to implement system upgrades to ensure the smooth transition of members' PCS authorizations from one MCO to another during the Centennial Care 2.0 transition.

Section VIII: AI/AN Reporting

Access to Care

I/T/Us are concentrated near or on Tribal land where many Native Americans live and receive services. Native Americans in Centennial Care may access services at IHS and Tribal 638 clinics at any time. Approximately 53, 900 Native Americans are enrolled in Centennial Care. Data from the MCOs show:

- 97% access to care for Native Americans in rural and frontier areas for physical health
- 97.9% access to care for Native Americans in rural and frontier areas for behavioral health

Contracting Between MCOs and I/T/U Providers

The MCOs continue to reach out to Indian Health Service (IHS) and Tribal 638 health providers, as well as Tribal programs to develop agreements. Some of the MCOs have contracts with Navajo Area IHS. The MCOs treat the non- contracted I/T/Us as if they are contracted for services rendered to their MCO members. For several of the MCOs, services rendered at any non-contracted I/T/U are considered contracted/in network for members. There is ongoing outreach to I/T/U programs for reimbursement for telemedicine, peer support recovery programs, Community Health Representative (CHR) services, and non-emergency medical transportation. Several MCOs have been working with Tribal CHR programs to develop a customized process to reimburse them for their services to MCO members.

Ensuring Timely Payment for All I/T/U Providers

Two of the four MCOs met timely payment requirements at 98% for claims processed and paid within 15 days of receipt. (The contract standard is for 95% of claims to be processed and paid within 15 days of receipt.) For claims processed and paid within 30 days of receipt, none of the MCOs met this standard. They range was 84% to 98.4%. (The contract standard is 99% of claims will be processed and paid within 30 days of receipt.)

Table 16 – Native American Advisory Board (NAAB) meetings for DY5 Q3

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Albuquerque Main Library Albuquerque, NM 07/26/2018	**Issue:** A member asked how to earn Centennial Reward (CR) points. **Response:** The BCBS Ombudsman had a conference call with the CR representative and resolved the issue for this member. Member is now enrolled and earning Centennial Rewards. **Issue:** Member has a disabled son, but MCO wouldn't give her any information about his plan. **Response:** The BCBS Ombudsman reviewed case and found that there was an alert several months back allowing her to speak on her son's behalf when she calls the MCO. Issue was resolved. **Issue:** There were several transportation issues brought up during the meeting with Logisticare.

MHC	Zuni Wellness Center Zuni Pueblo, NM June 20, 2018	Molina Healthcare members were informed that if qualified services are rendered at IHS, they will need to call the 800 number to manually redeem their Centennial Care Rewards points since IHS claims billing system is different. **Issue:** A member stated their grandson has an addiction and would like to know how Peer Support Services can help her with her grandson. **Response:** The Peer Support Supervisor provided his business card so that her grandson may contact him, even if he is not a Molina Healthcare member. After receiving several questions about that status of Molina Healthcare in 2019, the Native American Affairs Manager informed members that Molina Healthcare was not selected to be an MCO for Centennial Care 2.0 starting January 1, 2019. Molina Healthcare will continue to provide Medicaid coverage until the end of
PHP	Jicarilla Health Center Dulce, NM 08/03/2018	Presbyterian (PHP) met with about six members at their Native American Advisory Board meeting. They discussed care coordination, the Presbyterian Financial Assistance program, Centennial Care Rewards, and introduced the PHP Ombudsman. The DME provider, HME, was present for the meeting as well. No concerns.
UHC		UHC did not have a Native American Advisory Board meeting for Quarter 3.

HSD's Native American Technical Advisory Committee (NATAC) Update
At the NATAC meeting held on September 24, 2018, NM Medicaid presented on Centennial Care 2.0 and the proposed program changes effective 01/01/2019. Open enrollment starts October 1 and runs through November 30, 2018.

There was also an update on the federal match for services received through an I/T/U. NATAC presented the Native American Data Report which is analyzed quarterly for Native Americans receiving MCO services. There was a discussion regarding Community Health Representative (CHR) and how HSD will collaborate with the MCOs to improve CHR utilization.

Update on implementation of the federal reinterpretation of guidance for services received through IHS/Tribal Facilities

- **Albuquerque Area IHS (AAIHS) and the University of NM Hospital (UNMH)**
  UNMH will see if they can go back and identify claims prior to April 1, 2018 and resubmit for the 100% FMAP since CMS (Jeffrey Branch) said we could go back. UNM met with their IT team and reported that it would involve a great deal of effort and time for a few claims. UNMH is also working with a couple of Tribal 638s on a CCA.
- **Navajo Area IHS (NAIHS) and UNMH**
  Navajo Area IHS and staff from UNMH have worked diligently over the past several weeks on a go live date to start billing the 100% federal match with attachment code 09. Everything is in place to have a go live date of 12/01/2018. This includes all of the IHS providers in Navajo Area (Crownpoint, Shiprock, Gallup and their associated clinics).
  - According to UNM, the CCA has been approved by UNMH. They will be moving forward with system configuration that is required to process identified claims for the 100% federal match with NAIHS.
- **Albuquerque Area IHS (AIHS) and Presbyterian Healthcare Services (PHS)**
  PHS-IHS signed the Care Coordination Agreement Amendment 1, which claims have been submitted to HSD and encompasses all PHS facilities in New Mexico.
- **Navajo Area IHS and PHS**
  Navajo Area IHS will be working with PHS on developing a CCA in the future, once the UNM-NAIHS system configuration is completed.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment G: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

Q3 DY5 reflects the CY 2018 rate adjustments for programmatic change, changes to the medical and non-medical components to account for material changes in the enrolled populations, and a change to the premium assessments as provided to CMS on August 17, 2018. The PMPM for DY 5 is lower compared to DY 4 for MEGs 1and 2; the PMPM for DY 5 is higher than those of DY 4 for MEGs 3 to 6 (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY 5 is 29.2% below the budget neutrality limit (Table 5.4) based on three quarters of payments.

Section XI: Member Month Reporting

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

Table 17 – Member Months DY5 Q3

Number of client by Population Group and MC	
	2018
	Q3
Population 1 – TANF and Related	**1,086,544**
FFS	122,015
MC	
Molina	335,691
Presbyterian	380,504
UnitedHealthcare	54,911
Blue Cross Blue Shield	193,423
Population 2 – SSI and Related – Medicaid Only	**114,906**
FFS	7,353
MC	
Molina	34,227
Presbyterian	42,326
UnitedHealthcare	10,312
Blue Cross Blue Shield	20,688
Population 3 – SSI and Related – Dual	**106,032**
MC	
Molina	20,727
Presbyterian	35,290
UnitedHealthcare	29,489
Blue Cross Blue Shield	20,526
Population 4 – 217-like Group – Medicaid Only	**1,056**
FFS	267
MC	
Molina	155
Presbyterian	260
UnitedHealthcare	199
Blue Cross Blue Shield	175
Population 5 – 217-like Group - Dual	**11,896**
MC	
Molina	2,444
Presbyterian	3,722
UnitedHealthcare	3,000
Blue Cross Blue Shield	2,730
Population 6 – VIII Group (expansion)	**742,764**
FFS	76,101
MC	
Molina	193,896
Presbyterian	225,978
UnitedHealthcare	70,024
Blue Cross Blue Shield	176,765

Section XII: Consumer Issues – Complaints and Grievances

A total of 1,110 grievances were filed by Centennial Care members in DY5 Q3. An overall trend cannot be established when compared to DY5 Q3 (850), DY5 Q1 (891), DY4 Q4 (871), DY4 Q3 (1,184), DY4 Q2 (1,058) and DY 4 Q1 (968).

Non-emergency ground transportation continues to constitute the largest member grievance code reported with 572 (51.53%) of the total grievances received. An overall upward trend is demonstrated when compared to DY5 Q2 (442), DY5 Q1(414), DY4 Q4 (414), DY4 Q3 (487), DY4 Q2 (332) and DY4 Q1 (274). Transportation Grievances in Section II of this report provides the MCOs' efforts to address transportation grievances under the guidance of HSD.

Other Specialties was the second top member grievance code filed with a total of 72 (6.48%) grievances. An overall trend cannot be established when compared to DY5 Q2 (51), DY5 Q1 (101), DY4 Q4 (45), DY4 Q3 (61), DY4 Q2 (84) and DY4 Q1 (109).

There were 466 (41.99%) variable grievances filed during DY5 Q3. Of those, each MCO reported unique grievances that do not provide data to establish a trend. HSD is monitoring these grievances to identify specific trends.

Table 18 – MCO Grievances DY5 Q3

MCO Grievances DY5 Q3 (July - September 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	293	26.40%	239	21.53%	367	33.06%	211	19.01%	**1,110**	100.00%
Top Two Prmary Member Grievance Codes										
Transportation Ground Non-Emergency	222	20.00%	47	4.23%	208	18.74%	95	8.56%	**572**	51.53%
Other Specialties	5	0.45%	0	0.00%	23	2.07%	44	3.96%	**72**	6.48%
Variable Grievances	66	5.95%	192	17.30%	136	12.25%	72	6.49%	**466**	41.99%

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD 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 DY5 Q3.

Table 19 – Service Plan Audit Results DY5 Q3

Member Records	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	120	120	110	
BCBS	30	30	30	
MHC	30	30	30	
PHP	30	30	30	
UHC	30	30	20	
Percent of files with personalized goals matching identified needs	100%	100%	100%	
BCBS	30	30	30	
MHC	30	30	30	
PHP	30	30	30	
UHC	30	30	30	
Percent of service plans with hours allocated matching needs	100%	100%	100%	
BCBS	30	30	30	
MHC	30	30	30	
PHP	30	30	30	
UHC	30	30	20	

NF LOC

HSD reviews Nursing Facility High LOC denials and Community Benefit NF LOC denials on a quarterly basis to ensure the denials were appropriate and comply with NF LOC criteria.

Table 20 – Nursing Facility LOC Audit Results DY5 Q3

MCO High NF LOC denied requests (and downgraded to Low NF)	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	15	12	11	
BCBS	5	4	2	
MHC	0	0	0	
PHP	5	5	5	
UHC	5	3	4	
HSD Reviewed Results	**DY5 Q1**	**DY5 Q2**	**DY5 Q3**	**DY5 Q4**
Number of member files that met the appropriate level of care criteria	15	12	11	
BCBS	5	4	2	
MHC	0	0	0	
PHP	5	5	5	
UHC	5	3	4	
Percent of MCO level of care determination accuracy	100%	100%	100%	

Table 21 – Community Benefit NF LOC Audit DY5 Q3

Community Benefit denied NF LOC requests	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	25	25	25	
BCBS	5	5	5	
MHC	10	10	10	
PHP	5	5	5	
UHC	5	5	5	
Number of member files that met the appropriate level of care criteria determined by the MCO	25	25	25	
BCBS	5	5	5	
MHC	10	10	10	
PHP	5	5	5	
UHC	5	5	5	
Percent of MCO level of care determination accuracy	100%	100%	100%	

HSD agreed with all NFLOC decisions for Quarter 3; however, four of the files submitted for review were outside of the sample criteria. Of the five sample files submitted by BCBS for High NF, three did not qualify as a High NF Level of Care request. Additionally, one of the five samples submitted by UHC did not qualify as a HNF Level of Care request. HSD will continue to follow up with the MCOs to ensure that selected samples match requested criteria for future audits. MHC did not have any HNF denials in Q3 and an additional five files for Community Benefit were reviewed. All NFLOC decisions were appropriate and complied with NFLOC criteria. UHC only submitted denials for July and August of DY5 Q3 as their membership was transitioned to PHP on September 1,2018.

External Quality Review Organization (EQRO) NF LOC

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

Table 22 – EQRO NF LOC Review Results DY5 Q3

Facility Based	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
High NF Determination				
Number of member files audited	**23**	**22**	**23**	
BCBS	4	3	5	
MHC	7	6	6	
PHP	7	11	7	
UHC	5	2	5	
Number of member files the EQRO agreed with the determination	**22**	**22**	**19**	
BCBS	3	3	5	
MHC	7	6	6	
PHP	7	11	6	
UHC	5	2	2	
%	**96%**	**100%**	**83%**	
BCBS	75%	100%	100%	
MHC	100%	100%	100%	
PHP	100%	100%	86%	
UHC	100%	100%	40%	
Low NF Determination				
Number of member files audited	**85**	**106**	**134**	
BCBS	23	29	41	
MHC	20	26	36	
PHP	20	21	35	
UHC	22	30	22	
Number of member files the EQRO agreed with the determination	**85**	**102**	**122**	
BCBS	23	29	37	
MHC	20	25	31	
PHP	20	21	33	
UHC	22	27	21	
%	**100%**	**96%**	**91%**	
BCBS	100%	100%	90%	
MHC	100%	96%	86%	
PHP	100%	100%	94%	
UHC	100%	90%	95%	
Community Based				
Number of member files audited	**156**	**176**	**198**	
BCBS	39	44	54	
MHC	39	44	54	
PHP	39	44	54	
UHC	39	44	36	
Number of member files the EQRO agreed with the determination	**152**	**176**	**192**	
BCBS	39	44	51	
MHC	39	44	51	
PHP	35	44	54	
UHC	39	44	36	
%	**97%**	**100%**	**97%**	
BCBS	100%	100%	94%	
MHC	100%	100%	94%	
PHP	90%	100%	100%	
UHC	100%	100%	100%	

MCO High NF determinations decreased to 83% in Q3 for EQRO agreement with determinations. The Low NF determinations also decreased from 96% in Q2 to 91% for EQRO agreement in Q3. Community Based determinations also decreased in Q3 to 97% for EQRO agreement, from 100% in DY5Q2. Issues identified included incomplete supporting documentation and information outside of the expected date range. HSD will follow up with the MCOs regarding the identified cases and will continue to provide technical assistance as needed.

During DY5 Q3, HSD followed up on EQRO determination disagreements identified in the previous quarter. The EQRO audit in DY5 Q2 initially indicated five denial determinations, one for MHC and four for UHC; however, after further review of the determination disagreements for DY5 Q2, the number of disagreements was changed to three for UHC. HSD determined that one determination disagreement by the EQRO, an approval of Low NF LOC by UHC was appropriate and met criteria for Low NF. Feedback was provided to the EQRO and the decision was changed and the data in the EQRO-NF LOC table above has been updated to reflect this change.

HSD reviewed MHC's NF LOC determination disagreement for DY5 Q2 and requested additional information or documentation supporting the NF LOC decision and plans to improve the accuracy of determinations. MHC provided additional documentation and noted that going forward MHC would ensure that submitted documentation is within the expected date range and if not, staff would contact the facility for updated information to complete the determination.

HSD will continue to monitor the EQRO audit of MCO NF LOC determinations and identify and address any trends and provide technical assistance as needed.

Care Coordination Monitoring Activities

Care Coordination Audits

HSD continues to evaluate the MCO internal action plans (IAPs). Technical Assistance calls and increased communication between the MCOs and HSD have resulted in high compliance rates for consecutive quarters. In DY5 Q3, HSD completed an audit of BCBS reported internal IAP audit results related to Transitions of Care revealing that these action steps were successfully completed and further reporting from BCBS was inactivated for these Action Steps. Additionally, HSD conducted an audit of two IAP Action Step results from MHC which resulted in the inactivation of an IAP Action Step related to Transition of Care and an Action step related to completing back up and disaster plans. HSD notes that PHP has completed 3 consecutive quarters with compliance over 80% for multiple Action Steps related to Transition of Care in DY5 Q3 and anticipates conducting audits during DY5 Q4. With the transition of UHC members to PHP in DY5 Q3, Action Steps and Recommendations will not continue for UHCs IAP. HSD will conduct regular audits of any areas of concern and continue evaluating compliance with current IAPs.

Care Coordination for Super Utilizers
HSD continues to evaluate the progress of targeted care coordination with the top Emergency Department (ED) utilizers for each MCO. Originally this project included 35 members from each MCO. Over the past 35 months, some members have lost Medicaid eligibility or are no longer with the MCO. HSD monitors the efforts by care coordinators to engage members, provide alternatives to excessive ED usage and connect members with needed services. HSD tracks the number of ED visits and reviews next steps to reduce the incidence of ED visits and how supplemental community assistance can complement the services provided by the care coordinator. HSD has seen an overall decrease in ED use among project participants of 30.9% from the projects inception in DY2 Q3 to DY5 Q3. HSD has observed that all MCOs have gone beyond standard contract-required touchpoints to address the members' needs including housing assistance, peer support, nutritional needs assistance, treatment center admissions and collaboration with both internal and external partners. Housing insecurity remains an issue across the state with numerous project members homeless or at risk of homelessness. Several of the Super Utilizer participants who have received housing assistance have shown a substantial decline in ED use and increased use of community resources. The collaboration with Peer Support Specialists and Community Health Workers has increased contact with project members who are chronically difficult to engage.

Care Coordination and EDIE
The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical metadata. Because of the notification, the provider has information in hand before seeing the patient. This allows the provider to act and to influence health care outcomes.

Due to the increased use of EDIE, MCOs have reported they are gathering data that has allowed them to better assist those members utilizing the ED, rapidly engaging those members with emergent needs and connecting difficult to engage members with care coordinators. Care coordinators participating in the Care Coordination Super Utilizer Project, have reported building relationships with ER staff that assist them in recognizing those members receiving care coordination. Currently 33 of 38 hospitals are online and fully integrated with the remaining 5 in progress to go live by 2019. The EDIE committee is seeing progress in adding over 15 hospitals in the Texas Panhandle where New Mexico residents often access services.

Work continues on integrating the Veteran's Administration Hospital as well as those medical facilities within the Indian Health Services. A Care Manager User Group is being established for users within New Mexico to share best practices and promote increased use of the system. Development of additions to EDIE for the inclusion of Behavioral Health case notes will target ED clinicians in their recommendations. Currently, users are being tracked and contract metrics analyzed for where targeted training and follow-up will be beneficial. HSD regularly attends the bi—monthly committee meetings to support this collaborative program.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY5 Q3, HSD staff attended "ride-alongs" with BCBS and PHP. HSD specifically focused on members receiving Home and Community Based waiver services and utilizing self-direction as their setting of care. During both "ride-alongs", HSD staff observed open, patient, empathetic and professional care coordinators using a member-centric process to conduct annual CNAs. HSD staff observing the CNA process noted a team approach with guardians, support brokers, caregivers and family members. HSD observed that care coordinators followed contract requirements including the administration of the Community Benefit Services Questionnaire (CBSQ). The Quality Bureau Care Coordination Unit meets quarterly with HSD's Long-Term Services and Supports Bureau who also attend "ride-alongs" and share best practices observed and any concerns that may need to be addressed with the MCOs.

Care Coordination Member Issue and Technical Assistance Calls

The Quality Bureau's Care Coordination Unit (CCU) participates in monthly member calls with all MCOs to address issues concerning members with special behavioral or physical health needs. CCU has also previously conducted technical assistance (TA) calls on an as needed basis with all the MCOs to discuss various issues related to care coordination. In DY5 Q3, CCU joined with HSD's Centennial Care Contracts Bureau staff to conduct regularly scheduled monthly calls with the MCO's Care Coordination subject matter experts. Items for discussion included member enrollment, member engagement, and contractual requirements for timeliness and reporting. CCU began conducting regular calls with BCBS in September 2018 and PHP beginning in October 2018. CCU also plans to schedule a regular monthly call with WSCC beginning in Quarter 1 2019.

Section XIV: Managed Care Reporting Requirements

Customer Service

In DY5 Q3, all MCOs met call center metrics (abandonment rate, speed of answer and wait time) for customer services lines, member services, provider services, nurse advice line and the utilization management line. Please see Attachment H: Customer Service Summary.

MCO Reporting

During DY5 Q3, HSD Subject matter experts conducted Technical Assistance (TA) Calls with each of the four MCOs. The MCOs also submitted Self-Identified Error Resubmission (SIER) requests for report corrections. Two SIERs were submitted during DY5 Q3. Both the TA Calls and the submission of the SIERs allow HSD and MCO Subject Matter Experts (SMEs) to provide clarification and direction for MCO reporting inaccuracies.

Report Revisions

During DY5 Q3, HSD subject matter experts continue to work with Mercer to revise selected reports in preparation for Centennial Care 2.0. There are currently 20 reports that are being revised. HSD revised reports to streamline elements, improve monitoring, incorporate requirements of the managed care final rule, and include new CC 2.0 changes.

Member Appeals

A total of 780 member appeals were filed by Centennial Care members in DY5 Q3. This demonstrates a decrease when compared to 944 in DY5 Q2, an overall trend cannot be established when compared to member appeals received in DY5 Q1 (869), DY4 Q4 (876), DY4 Q3 (1,043), DY4 Q2 (1,000) and DY4 Q1 (1,013). Of those 780 appeals, 694 (88.97%) were standard member appeals and 86 (11.03%) were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner.

Denial or limited authorization of a requested service remains the top member appeal code reported with 681 (87.31%) of the total appeals received. This demonstrates a decrease when compared to 758 in DY5 Q2, an overall trend cannot be established when compared to DY5 Q1 (716), DY4 Q4 (697), DY4 Q3 (834), DY4 Q2 (822), and DY4 Q1 (873).

Reduction of a previously authorized service was the second top member appeal code with a total of 49 (6.28%) member appeals. This remained the same when compared to 49 in DY5 Q2, an overall downward trend is demonstrated when compared to DY5 Q1 (61), DY4 Q4 (54), DY4 Q3 (79), DY4 Q2 (110), and DY4 Q1 (81).

There were 50 (6.41%) variable appeals in DY5 Q3. Of those, each MCO reported unique appeals during the quarter that do not provide enough information to establish a trend. All MCOs have complied with the policies and procedures regarding members’ exhaustion of the

Grievance and Appeal System prior to requesting a State Fair Hearing.

Table 23 – Member Appeals DY5 Q3

MCO Appeals DY5 Q3 (July - September 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	133	17.05%	147	18.85%	335	42.95%	79	10.12%	**694**	88.97%
Number of Expedited Member Appeals	55	7.05%	11	1.41%	3	0.39%	17	2.18%	**86**	11.03%
Total	188	24.10%	158	20.26%	338	43.33%	96	12.31%	**780**	100%
Top Two Primary Member Appeal Codes										
Denial or limited authorization of a requested service	150	19.23%	142	18.21%	307	39.36%	82	10.51%	**681**	87.31%
Reduction of a previously authorized service	9	1.15%	25	3.21%	12	1.54%	3	0.38%	**49**	6.28%
Variable Appeals	29	3.72%	-9	-1.15%	19	2.43%	11	1.41%	**50**	6.41%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continued in DY5 Q3. During this quarter, discussions between Deloitte and HSD occurred for the purposes of working through measure level analyses, confirming data and analysis approach. Activities conducted during this quarter were centered around DY4 data collection review and analysis which will be included in the Final Evaluation Report.

The Final Evaluation Report format will be consistent with the Interim Evaluation Report and contain the final conclusions regarding the effectiveness of the waiver with respect to the established goals of the program. Deloitte continues to meet with HSD regularly to assess Final Report status, gather report content feedback, and identify and review analysis issues or risks associated with the project plan.

Preliminary observations from DY3 to DY4 indicate an increase of 0.6% of members who meet Nursing Facility Level of Care (NF LOC) and are receiving Home and Community Based Services (HCBS). The percentage of members who meet NF LOC and are receiving HCBS increased 3.5% compared to the 2013 baseline. The AARP's annual report for 2017, State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers, reports that New Mexico ranks third in the nation for its investment in long-term supports and services.

Planned activities for DY5 Q4 will focus on the continued assessment of DY4 information; drafting the fully assembled Final Evaluation report for HSD leadership review and continuing to discuss and review comments on the Final Evaluation Report content.

Section XVI: Enclosures/Attachments

Attachment A: Budget Neutrality Monitoring Spreadsheet
Attachment B: GeoAccess PH Summary
Attachment C: GeoAccess BH Summary
Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment E: Behavioral Health Collaborative CEO Report
Attachment F: PHP DSIF 2018 Performance Measures map
Attachment G: MCO Action Plans
Attachment H: Customer Service Summary

Section XVII: State Contacts

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

Section XVIII: Additional Comments

The following are member success stories from the Centennial Care MCOs who have had positive experiences with care coordination and other unique aspects of Centennial Care.

Centennial Care Member Success Story 1

On September 13, 2018, Presbyterian's Customer Service Center (PCSC) received an email from one of our new care coordinators, Cristan, who came to Presbyterian during the UHC transition. Cristan went to see one of our Centennial member with a complex condition. Cristan noticed that the member's caregiver was not around. Cristan asked the member where her caregiver was, and the member told Cristan that she hasn't had a caregiver since the end of August.

Cristan called the agency, and the agency said that they had not received an authorization for continuation of services. Cristan reached out to PCSC, and Sandra, a Centennial Customer Service representative, assisted Cristian. Sandra understood the urgency of the situation. Sandra reached out to multiple departments, and the provider, to find ways to assist the member. Sandra contacted the member and provided the member with an update.

On September 14, 2018, Sandra called Cristan and stated that the agency had been contacted and the member had a caregiver assigned. Cristan was impressed by Sandra's customer service and her prompt response. Sandra could have given Cristan the information, but instead she took ownership and arranged everything herself. The member called Cristan several minutes later stating her caregiver was there to assist her.

Cristan reflected on his new co-worker, "Working with Sandra for less than 24 hours has made me feel like she is on my side, that she takes issues to heart, and most importantly, that she cares. I am so happy to be part of the Presbyterian team and look forward to this new relationship."

Centennial Care Member Success Story 2

A Member with a history of complex behavioral health conditions and inpatient stays had struggled with severe anxiety and had difficulty going out into her community to receive care. This significantly affected the Member's quality of life. When the Care Coordinator was assigned to and met with the Member, she initially had difficulty engaging the Member and establishing rapport. Since that first meeting the Care Coordinator has successfully fostered a strong and supportive relationship with the Member. As a result, the Member has felt supported and encouraged to become more independent as exemplified by the following accomplishments:

- Completion of Hepatitis C treatment,
- Recertified her Medicaid Supplemental Security Income eligibility with the Care Coordinator's assistance,
- Established care with a new dental provider.

She has also developed the confidence to begin advocating for herself to make sure her behavioral and physical health needs are met. The member has expressed her gratitude to the Care Coordinator and the MCO.

Centennial Care Member Success Story 3

Member stated that prior to moving to Gallup he had weighed 399 pounds and had 7 heart attacks. With the help of Care Coordination, Member is now at a healthy weight of 170 pounds. Member's functioning levels have increased and member is now independent with all Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs). Member exercises for 1 hour a day at the local senior center in the weight room. Member drives himself to the senior center, to Walmart, to the laundry and other locations in Gallup, NM. Member walks to nearby communities of Church Rock (14.4 miles round trip) and Red Rock (18.6 miles one way) of New Mexico, walks to the Senior Center across town, and walks to the nearest laundry mat. Member is now independent in his mobility and his Care Coordinator (CC) continues to encourage him to exercise, eat healthy, and maintain his medical appointments. Member reports that his medications have also decreased. Member was previously receiving his care in Crownpoint, NM and he did not have a regular PCP. Member stated that when he moved to Gallup, NM with the assistance of CC, the member obtained a regular PCP. Member states that having a regular PCP is part of his success. Member is happy with his current lifestyle. Member does not qualify for NFLOC after 08/31/2018 as he has regained independence in ADLs/IADLs with regular PCP care, exercise, diet, and compliance with prescribed medication.

Centennial Care Member Success Story 4

On August 27, 2018, one MCO saw a fulfillment of a dream come true for one of their members. A member in the Self-Directed Waiver program, had been working hard with his Care Coordinator, on his needs for community integration and participation. He was paralyzed in his early twenties, and as a result, has been bed or wheel chair bound since. Standing upright had not been feasible; not until August 27th when an approved special standing chair was delivered to his home. The member can now navigate his rural community of Maxwell, enjoy the outdoors and the nature reserve, participate in outings without sitting the entire time, and overall has more freedom and mobility than he has experienced in over a decade. Hats off to the care coordinator who worked diligently with our medical officers to process this request and subsequent support information for approval.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet
- PMPM Analysis

DY 5

Start Date: 01/01/2018

End Date: 12/31/2018

Quarter 3

Start Date:1/01/2018

End Date: 6/30/2018

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01 TANF & Related	DY 01 Cost Estimates	DY1 YTD - Actuals [2]	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	4,621,656	5,092,636	4,623,475	5,132,359	3,331,550
PMPM	$ 385.80	$ 329.15	$ 400.77	$ 344.32	$ 416.32	$ 338.83	$ 432.47	$ 328.59	$ 449.25	$ 316.44
Dollars	$ 1,823,911,159	$ 1,486,827,065	$ 1,948,487,793	$ 1,533,703,631	$ 2,090,074,424	$ 1,565,965,980	$ 2,202,434,150	$ 1,519,238,854	$ 2,305,734,126	$ 1,054,248,212

MEG02 SSI & Related - Medicaid Only	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	508,700	497,958	513,736	494,529	518,976	493,577	524,737	487,798	530,824	346,167
PMPM	$ 1,763.90	$ 1,656.68	$ 1,842.83	$ 1,785.35	$ 1,925.21	$ 1,757.24	$ 2,008.00	$ 1,729.87	$ 2,094.34	$ 1,708.41
Dollars	$ 897,298,062	$ 824,959,005	$ 946,727,393	$ 882,906,438	$ 999,138,707	$ 867,331,883	$ 1,053,669,000	$ 843,827,281	$ 1,111,724,897	$ 591,396,585

MEG03 SSI & Related - Dual Eligible	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	373,823	428,025	380,215	435,140	386,831	447,801	393,832	443,071	401,197	321,409
PMPM	$ 1,780.77	$ 1,333.20	$ 1,857.34	$ 1,342.70	$ 1,937.21	$ 1,361.23	$ 2,020.51	$ 1,272.28	$ 2,107.39	$ 1,279.72
Dollars	$ 665,692,378	$ 570,643,867	$ 706,189,973	$ 584,263,216	$ 749,372,219	$ 609,558,793	$ 795,742,098	$ 563,711,424	$ 845,479,241	$ 411,312,858

MEG04 "217 Like" Medicaid Only	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	5,841	2,799	5,898	2,382	5,959	2,987	6,025	3,797	6,095	2,710
PMPM	$ 4,936.92	$ 2,380.16	$ 5,090.46	$ 2,347.27	$ 5,248.77	$ 2,538.07	$ 5,412.01	$ 3,302.07	$ 5,580.32	$ 3,330.67
Dollars	$ 28,834,295	$ 6,662,076	$ 30,025,379	$ 5,591,208	$ 31,274,952	$ 7,581,210	$ 32,605,551	$ 12,537,970	$ 34,009,571	$ 9,026,104

MEG05 "217 Like" Dual Eligible	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	27,935	26,895	28,413	27,063	28,907	31,866	29,430	40,409	29,981	34,717
PMPM	$ 1,776.90	$ 3,226.87	$ 1,853.31	$ 3,143.68	$ 1,933.00	$ 2,884.14	$ 2,016.12	$ 2,791.40	$ 2,102.81	$ 2,808.23
Dollars	$ 49,637,569	$ 86,786,741	$ 52,657,285	$ 85,077,407	$ 55,877,183	$ 91,905,888	$ 59,334,769	$ 112,797,734	$ 63,043,435	$ 97,493,217

MEG06 VIII Group - Medicaid Expansion	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	1,632,968	1,887,728	1,788,895	2,748,632	1,800,808	3,078,074	1,763,748	3,143,890	1,773,299	2,259,804
PMPM	$ 577.87	$ 454.25	$ 607.34	$ 477.42	$ 638.31	$ 443.01	$ 670.87	$ 441.47	$ 705.08	$ 474.96
Dollars	$ 943,638,928	$ 857,505,477	$ 1,086,464,733	$ 1,312,253,505	$ 1,149,478,718	$ 1,363,622,028	$ 1,183,239,734	$ 1,387,944,913	$ 1,250,319,546	$ 1,073,322,390

MEG08 Uncompensated Care Pool	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
Total Allotment	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 67,294,973	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,324	$ 68,889,323	$ 34,444,664

MEG09 Hospital Quality Improvement Incentive Pool	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
Total Allotment	$ -	$ -	$ 2,824,462	$ 2,824,462	$ 5,764,727	$ 7,359,077	$ 8,825,544	$ 8,825,541	$ 12,011,853	$ -

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

2.) Expenditures as reported on the CMS-64 Schedule C, FFY18 Quarter 4. Report pulled on 11/13/2018.

Q3DY5 Attachment B- GeoAccess PH Q2 Calendar Year 2018 (April 1 - June 31, 2018)

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%	100.0%	100.0%	100.0%
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	99.9%
FQHC - PCP Only	100.0%	94.6%	100.0%	100.0%	85.7%	98.9%	100.0%	99.5%	96.3%	97.8%	94.0%	98.7%
PH - Standard 2												
Cardiology	99.2%	99.1%	98.0%	99.0%	99.7%	99.6%	100.0%	99.6%	99.9%	99.8%	100.0%	99.8%
Certified Nurse Practitioner	99.2%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%
Certified Midwives	99.2%	100.0%	98.0%	99.1%	100.0%	100.0%	100.0%	93.4%	99.9%	99.8%	100.0%	98.6%
Dermatology	72.6%	93.8%	98.0%	99.0%	65.5%	64.2%	69.0%	78.0%	81.8%	91.5%	93.0%	84.8%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	95.8%	93.8%	98.0%	99.0%	62.8%	66.6%	74.0%	73.7%	76.7%	85.3%	91.0%	87.5%
ENT	99.2%	99.0%	98.0%	99.0%	91.1%	98.4%	92.0%	99.3%	94.8%	97.0%	92.0%	98.1%
FQHC	100.0%	94.6%	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%	99.1%	98.0%	98.3%	97.0%	98.2%	99.4%	99.0%	99.0%	97.9%
Neurology	99.1%	93.8%	98.0%	99.0%	97.8%	90.5%	94.0%	85.5%	92.1%	88.7%	89.0%	84.0%
Neurosurgeons	99.2%	99.0%	98.0%	99.0%	40.7%	56.7%	65.0%	76.4%	70.2%	75.7%	87.0%	87.1%
OB/Gyn	99.2%	99.1%	98.0%	99.1%	99.9%	99.8%	100.0%	99.6%	99.8%	100.0%	100.0%	99.8%
Orthopedics	99.2%	99.0%	98.0%	99.1%	99.7%	99.7%	100.0%	100.0%	99.7%	99.3%	98.0%	98.5%
Pediatrics	100.0%	99.1%	98.0%	100.0%	99.6%	98.9%	100.0%	99.9%	99.9%	100.0%	100.0%	100.0%
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.2%	99.1%	98.0%	99.2%	99.3%	99.2%	100.0%	99.6%	99.9%	93.5%	100.0%	99.9%
Rheumatology	94.4%	93.8%	98.0%	99.0%	69.3%	92.0%	91.0%	87.7%	81.4%	88.2%	88.0%	86.1%
Surgeons	99.2%	99.1%	98.0%	99.1%	69.3%	100.0%	100.0%	100.0%	99.9%	99.8%	100.0%	99.9%
Urology	99.1%	99.0%	98.0%	98.9%	81.2%	77.7%	82.0%	94.0%	92.8%	91.5%	93.0%	96.3%
LTC - Standard 2												
Personal Care Service Agencies (PCS) - delegated	98.2%	100.0%	100.0%	100.0%	90.4%	98.7%	100.0%	99.8%	99.9%	100.0%	100.0%	100.0%
Personal Care Service Agencies (PCS) - directed	99.2%	100.0%	100.0%	100.0%	99.0%	98.7%	100.0%	99.8%	99.9%	100.0%	100.0%	100.0%
Nursing Facilities	95.2%	94.0%	92.0%	100.0%	99.8%	98.7%	99.0%	98.8%	99.9%	99.9%	100.0%	100.0%
General Hospitals	99.2%	99.1%	98.0%	99.1%	99.3%	99.5%	100.0%	99.4%	99.9%	99.8%	100.0%	99.9%
Transportation	99.2%	100.0%	100.0%	97.8%	95.1%	98.9%	100.0%	99.9%	99.9%	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.

Meets Standard | Does Not Meet

Standard 2	Urban				Rural				Frontier			
	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP
Accredited Residential Treatment Center (ARTC)	88.8%	82.2%	90.0%	85.7%	32.3%	83.9%	27.0%	51.3%	67.5%	100.0%	68.0%	73.2%
Assertive Community Treatment (ACT)	83.6%	99.1%	83.0%	95.8%	32.2%	16.2%	50.0%	43.0%	29.8%	7.4%	71.0%	74.0%
Behavioral Management Services (BMS)	99.2%	99.1%	97.0%	99.1%	43.6%	90.9%	36.0%	53.9%	68.6%	98.0%	74.0%	87.0%
Community Mental Health Center (CMHC)	99.2%	99.1%	98.0%	96.3%	98.3%	98.8%	100.0%	99.8%	91.9%	100.0%	100.0%	99.8%
Core Service Agency (CSA)	99.0%	99.0%	92.0%	99.1%	99.4%	96.1%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%
Day Treatment Service	62.5%	73.9%	56.0%	76.4%	28.7%	31.9%	28.0%	43.2%	62.5%	68.6%	48.0%	62.2%
FQHC- BH	100.0%	100.0%	100.0%	100.0%	100.0%	90.4%	86.0%	91.3%	100.0%	100.0%	100.0%	100.0%
FreeStanding Psychiatric Hospital	88.9%	97.8%	90.0%	85.7%	22.3%	35.1%	17.0%	35.2%	67.5%	90.4%	68.0%	71.3%
General Hospital with Psychiatric Units	93.5%	97.0%	90.0%	96.0%	77.5%	71.5%	79.0%	80.8%	80.3%	69.7%	82.0%	81.6%
Indian Health Services and Tribal 638	72.9%	72.7%	90.0%	77.5%	56.6%	63.1%	96.0%	67.4%	82.6%	85.1%	98.0%	86.7%
Intensive Outpatient Services	94.8%	99.1%	64.0%	96.3%	71.1%	75.7%	82.0%	88.1%	96.0%	92.3%	83.0%	99.7%
Licensed Independent Behavioral Health Practitioners	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Methadone Clinics (METH)	94.3%	93.6%	91.0%	96.2%	42.1%	36.4%	38.0%	62.9%	76.6%	77.2%	76.0%	80.5%
Multi-Systematic Therapy(MST)	94.0%	99.1%	92.0%	95.9%	44.4%	83.9%	57.0%	67.5%	73.6%	94.6%	71.0%	77.5%
Non-Accredited Residential Treatment Center (NARTC)	62.5%	91.8%	56.0%	64.2%	50.2%	76.6%	70.0%	53.0%	57.4%	88.1%	77.0%	80.5%
Outpatient Provider Agencies	99.3%	100.0%	98.0%	100.0%	89.1%	100.0%	99.0%	100.0%	99.6%	100.0%	100.0%	100.0%
Partial Hospital Program	26.3%	94.2%	34.0%	21.4%	1.5%	90.9%	12.0%	4.7%	8.5%	98.0%	11.0%	6.4%
Psychiatrists	100.0%	100.0%	100.0%	99.90%	99.9%	100.0%	100.0%	100.0%	99.9%	100.0%	98.0%	99.9%
Psychologists (inc Subscribing)	100.0%	100.0%	98.0%	99.9%	95.2%	100.0%	100.0%	97.3%	99.9%	100.0%	100.0%	99.9%
RHC (BH)	0.0%	.o7	0.0%	.o1%	9.1%	16.1%	36.0%	16.5%	18.3%	62.0%	26.0%	27.2%
Suboxone Certified MDs	99.3%	99.1%	98.0%	100.0%	88.9%	92.8%	100.0%	93.3%	96.0%	94.6%	100.0%	99.1%
Treatment Foster Care I & II(TFC)	94.2%	98.9%	92.0%	96.0%	52.5%	73.7%	63.0%	71.1%	81.4%	88.3%	91.0%	88.9%
Inpatient Psychiatric Hospitals	98.7%	98.7%	98.0%	98.7%	46.2%	73.8%	80.0%	80.9%	67.5%	94.3%	86.0%	85.2%

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 2016 - June 2017**	**July 2017 - June 2018**	**July 2016 - June 2017**	**July 2017 - June 2018**
Inpatient (Admissions)	92.3	96.0	$ 9,111	$ 8,922
Inpatient (Days)	398.8	415.0	$ 2,109	$ 2,064
Practitioner / Physician (Services)	8,345.1	8,556.1	$ 67	$ 68
Emergency Department (Visits)	540.7	586.0	$ 340	$ 356
Outpatient (Visits)	1,438.3	1,501.9	$ 268	$ 280
Pharmacy (Scripts)	4,897.6	4,946.4	$ 63	$ 63
Other (Services)[1]	8,994.9	8,889.2	$ 59	$ 57

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**July 2016 - June 2017**	**July 2017 - June 2018**	**July 2016 - June 2017**	**July 2017 - June 2018**
Brand	13.5%	12.4%	$ 341	$ 372
Generic	85.0%	86.1%	$ 18	$ 18
Other Rx[2]	1.5%	1.5%	$ 94	$ 96

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 2016 - June 2017**	**July 2017 - June 2018**	**July 2016 - June 2017**	**July 2017 - June 2018**
Inpatient (Admissions)	75.9	76.1	$ 15,154	$ 15,650
Inpatient (Days)	499.0	637.9	$ 2,305	$ 1,866
Practitioner / Physician (Services)	8,838.4	9,010.5	$ 78	$ 78
Emergency Department (Visits)	649.9	698.6	$ 476	$ 506
Outpatient (Visits)	2,232.3	2,189.7	$ 301	$ 316
Pharmacy (Scripts)	10,022.7	9,792.5	$ 77	$ 76
Other (Services)[1]	9,919.6	10,170.8	$ 65	$ 64

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	**July 2016 - June 2017**	**July 2017 - June 2018**	**July 2016 - June 2017**	**July 2017 - June 2018**
Brand	11.0%	10.5%	$ 567	$ 580
Generic	87.2%	87.6%	$ 15	$ 15
Other Rx[2]	1.8%	1.9%	$ 86	$ 93

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 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Inpatient (Admissions)	251.8	243.5	$ 2,699	$ 2,807
Inpatient (Days)	1,488.2	1,442.8	$ 457	$ 474
Nursing Home (Days)	343,554.2	320,530.1	$ 34	$ 36
Personal Care (Services / hr.)	752,849.9	739,129.1	$ 15	$ 15
Outpatient (Visits)	5,134.2	4,890.6	$ 129	$ 146
Pharmacy (Scripts)	1,660.7	1,287.7	$ 27	$ 18
HCBS (Services)	5,850.4	6,402.2	$ 130	$ 141
Other (Services)[1]	44,395.5	41,862.0	$ 46	$ 46

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Brand	21.0%	20.9%	$ 93	$ 61
Generic	76.7%	76.3%	$ 8	$ 5
Other Rx[2]	2.3%	2.8%	$ 60	$ 53

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 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Inpatient (Admissions)	352.2	334.8	$ 18,239	$ 17,332
Inpatient (Days)	2,407.6	2,356.7	$ 2,668	$ 2,462
Nursing Home (Days)	15,707.9	18,066.5	$ 176	$ 159
Personal Care (Services / hr.)	738,183.4	726,609.0	$ 15	$ 15
Outpatient (Visits)	7,517.1	7,638.3	$ 441	$ 462
Pharmacy (Scripts)	43,448.4	42,346.1	$ 91	$ 85
HCBS (Services)	12,162.0	13,386.6	$ 100	$ 92
Other (Services)[1]	64,378.4	64,307.9	$ 83	$ 84

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Brand	12.7%	12.2%	$ 580	$ 558
Generic	85.0%	85.4%	$ 19	$ 17
Other Rx[2]	2.3%	2.4%	$ 79	$ 83

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 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Inpatient (Admissions)	250.3	199.6	$ 9,118	$ 8,011
Inpatient (Days)	1,548.4	1,200.7	$ 1,474	$ 1,332
Nursing Home (Days)	9,913.4	6,966.2	$ 12	$ 18
Personal Care (Services / hr.)	48.0	135.3	$ 11	$ 15
Outpatient (Visits)	6,622.4	6,549.4	$ 220	$ 271
Pharmacy (Scripts)	14,307.7	14,516.0	$ 110	$ 132
HCBS (Services)	325,747.0	296,151.7	$ 99	$ 93
Other (Services)[1]	57,999.6	55,950.9	$ 51	$ 51

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Brand	13.7%	14.8%	$ 551	$ 676
Generic	83.1%	82.2%	$ 37	$ 34
Other Rx[2]	3.2%	3.0%	$ 111	$ 138

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 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Inpatient (Admissions)	77.8	69.3	$ 4,482	$ 4,210
Inpatient (Days)	475.8	415.3	$ 733	$ 703
Practitioner / Physician (Services)	9,929.6	8,867.8	$ 26	$ 24
Emergency Department (Visits)	664.5	673.0	$ 153	$ 165
Outpatient (Visits)	2,996.8	2,867.0	$ 127	$ 126
Pharmacy (Scripts)	1,647.0	1,423.0	$ 40	$ 28
Other (Services)[1]	9,693.9	9,201.6	$ 89	$ 97

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Brand	21.4%	23.4%	$ 144	$ 74
Generic	76.4%	74.1%	$ 11	$ 12
Other Rx[2]	2.2%	2.5%	$ 59	$ 57

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 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Inpatient (Admissions)	39.1	40.5	$ 979	$ 1,259
Inpatient (Days)	108.7	125.5	$ 352	$ 406
BH Practitioner (services)	174.9	250.5	$ 124	$ 114
Core Service Agency (Services)	229.0	231.2	$ 104	$ 115
BH outpatient / clinic (Services)	2,507.7	3,320.3	$ 66	$ 56
Pharmacy (Scripts)	1,847.8	1,748.9	$ 57	$ 58
Residential Treatment Center (days)	90.7	84.4	$ 1,039	$ 1,117
Other (Services)[1]	141.3	131.8	$ 57	$ 51
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2016 - June 2017	July 2017 - June 2018	July 2016 - June 2017	July 2017 - June 2018
Brand	6.1%	7.0%	$ 424	$ 443
Generic	93.9%	93.0%	$ 33	$ 29
Other Rx[2]	0.0%	0.0%	$ -	$ -

Notes:

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

Behavioral Health Collaborative CEO Report

October 11, 2018

1. **SAMHSA Grant Awards**
   The following organizations will be receiving a grant award from the Substance Abuse and Mental Health Services Administration:

   Announcement Number: SM-18-015
   Announcement Name: State Opioid Response Grants
   Grantee Organization: NM DEPARTMENT OF HUMAN SERVICES
   Award Amount: $5,307,273 annually for two years

   Announcement Number: SM-17-008
   Announcement Name: Promoting Integration of Primary and Behavioral Health Care
   Grantee Organization: NM DEPARTMENT OF HUMAN SERVICES
   Award Amount: $2,000,000 annually for five years

   Announcement Number: SM-18-013
   Announcement Name: Assertive Community Treatment Grants
   Grantee Organization: NM DEPARTMENT OF HUMAN SERVICES
   Award Amount: $678,000 annually for five years

   Announcement Number: TI-18-016
   Announcement Name: Tribal Opioid Response Grants
   Grantee Organization: PUEBLO OF TAOS
   Award Amount: $85,115.00

   Announcement Number: TI-18-016
   Announcement Name: Tribal Opioid Response Grants
   Grantee Organization: OHKAY WINGEH
   Award Amount: $87,045.00

   Announcement Number: SM-18-017
   Announcement Name: Native Connections
   Grantee Organization: OHKAY WINGEH
   Grantee City: Ohkay Owingeh
   Award Amount: $236,663.00

   Announcement Number: TI-18-016
   Announcement Name: Tribal Opioid Response Grants
   Grantee Organization: FIVE SANDOVAL INDIAN PUEBLOS, INC.
   Award Amount: $772,946.00

   Announcement Number: SM-18-017
   Announcement Name: Native Connections
   Grantee Organization: FIVE SANDOVAL INDIAN PUEBLOS, INC.
   Grantee City: Rio Rancho
   Award Amount: $250,000.00

Announcement Number: SM-18-017
Announcement Name: Native Connections
Grantee Organization: PUEBLO OF ACOMA
Grantee City: Acoma Pueblo
Award Amount: $250,000.00

Announcement Number: SM-17-004
Announcement Name: INDIGENOUS - PROJECT LAUNCH
Grantee Organization: PUEBLO OF ACOMA
Grantee City: Acoma Pueblo
Award Amount: $366,775.00

Announcement Number: SM-18-006
Announcement Name: Project AWARE - State Education Agency
Grantee Organization: PUEBLO OF SAN FELIPE
Grantee City: San Felipe Pueblo
Award Amount: $1,351,881.00

Announcement Number: SM-17-006
Announcement Name: Zero Suicide
Grantee Organization: PUEBLO OF SAN FELIPE
Grantee City: San Felipe Pueblo
Award Amount: $400,000.00

Announcement Number: SP-18-008
Announcement Name: Strategic Prevention Framework - Partnerships for Success
Grantee Organization: ALBUQUERQUE AREA INDIAN HEALTH BOARD
Grantee City: Albuquerque
Award Amount: $500,000.00

Announcement Number: SP-16-004
Announcement Name: HIV CBI
Grantee Organization: ALBUQUERQUE AREA INDIAN HEALTH BOARD
Grantee City: Albuquerque
Award Amount: $282,354.00

Announcement Number: SM-18-017
Announcement Name: Native Connections
Grantee Organization: FIRST NATIONS COMMUNITY HEALTHSOURCE, INC.
Grantee City: Albuquerque
Award Amount: $250,000.00

Announcement Number: SM-18-017
Announcement Name: Native Connections
Grantee Organization: ZUNI YOUTH ENRICHMENT PROJECT, THE
Grantee City: Zuni
Award Amount: $249,994.00

Announcement Number: SM-18-012
Announcement Name: Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis
Grantee Organization: COUNTY OF BERNALILLO
Grantee City: Albuquerque
Award Amount: $400,000.00

Announcement Number: SM-16-011
Announcement Name: Assisted Outpatient Treatment (AOT)
Grantee Organization: CITY OF ALBUQUERQUE
Grantee City: Albuquerque
Award Amount: $957,625.00

Announcement Number: TI-18-008
Announcement Name: SAMHSA Treatment Drug Courts
Grantee Organization: BERNALILLO COUNTY METROPOLITAN COURT
Grantee City: ALBUQUERQUE
Award Amount: $399,974.00

Announcement Number: SP-19-009
Grantee Organization: NATIONAL LATINO BEHAVIORAL HEALTH ASSOCIATION, THE
Grantee City: Cochiti Lake
Award Amount: $500,000.00

Announcement Number: TI-18-012
Announcement Name: Targeted Capacity Expansion Hispanic/Latino Center of Excellence for Substance Use Disorder Treatment and Recovery Program
Grantee Organization: NATIONAL LATINO BEHAVIORAL HEALTH ASSOCIATION, THE
Grantee City: Cochiti Lake
Award Amount: $400,000.00

Announcement Number: TI-18-014
Announcement Name: Providers Clinical Support System- Universities
Grantee Organization: UNIVERSITY OF NEW MEXICO HEALTH SCIS CTR
Grantee City: Albuquerque
Award Amount: $150,000.00

Announcement Number: TI-17-009
Announcement Name: GBHI
Grantee Organization: ST. LUKE'S HEALTH CARE CLINIC, INC.
Grantee City: Las Cruces
Award Amount: $400,000.00

Announcement Number: TI-17-007
Announcement Name: PPW
Grantee Organization: SANTA FE RECOVERY CENTER, INC.
Grantee City: Santa Fe
Award Amount: $523,117.00

Announcement Number: SP-18-002
Announcement Name: Drug-Free Communities (DFC) Support Program – New
Grantee Organization: SOUTHWEST CENTER FOR HEALTH INNOVATION
Grantee City: SILVER CITY
Award Amount: $125,000.00

2. **National Safety Council Opioid Report**
The National Safety Council recently released a report assessing state progress in addressing the opioid crisis. The Council prescribes six key actions that states should take to combat the opioid epidemic. NM was recognized as *one of only three states* (along with Nevada and Rhode Island) to have taken all six actions. The key actions are:
- Mandating prescriber education
- Implementing opioid prescribing guidelines
- Integrating prescription drug monitoring programs into clinical settings
- Improving data collection and sharing
- Treating opioid overdose
- Increasing availability of opioid use disorder treatment

3. **Strategic Plan for Children's Behavioral Health**
In an effort to develop the BH Collaborative Children's Strategic Plan, CYFD conducted a series of focus groups, where more than 70 people were interviewed, and presented to the BH Collaborative in July 2018. On September 25, 2018, the BH Collaborative and CYFD hosted a Children's Behavioral Health Strategic Plan Convening, with 98 participants in attendance. Participants included the CYFD Cabinet Secretary and Division leadership from BHS, PS, JJS, and ECS; HSD BHSD and Medicaid; DOH; PED; Legislative Finance Committee; community and cultural partners; family members and advocates; youth advocates; behavioral health providers; Managed Care Organizations; and other key stakeholders. Presenters from HSD/BHSD, CYFD, DOH, PED, NM Voices for Children, El Puente, and the NM Black History Organizing Committee shared invaluable data on the current state of children and families in NM. The Convening included important voices from youth, families, and the NM Behavioral Health Providers Association as well as a presentation on the federal Family First Prevention Services Act. The Convening concluded with cross-sector conversations that generated opportunities for collaborating on existing and new initiatives.

The ideas and suggestions generated from the conversations will feed the BH Collaborative Children's Strategic Plan. Updates on progress will be distributed to an email list serve comprised of Convening participants and will be provided at the BH Collaborative quarterly meetings.

4. **National Recovery Month**
NM celebrated National Recovery Month throughout September with tremendous success. Recovery Month is a national observance dedicated to educating Americans that substance use treatment and mental health services can enable those with a mental and/or SUD to live healthy and rewarding lives. Recovery Month celebrates the gains made by those in recovery and reinforces the positive message that: behavioral health is essential to overall health; prevention works; treatment is effective; and people can and do recover. This year's theme was "Join the Voices for Recovery: Invest in Health, Home, Purpose, and Community." Communities all over the state hosted celebratory events filled with shared recovery stories, positive energy, and

hope for the future. Many thanks to everyone who participated and helped make possible these inspiring community events!

5. **Medicaid BH Rule and Policy Manual**
The Medicaid Behavioral Health Rule, with its accompanying Behavioral Health Policy and Billing Manual, is under leadership review. It aligns all policy with Children, Youth and Family Department policy, and contains many key changes developed with input from providers as well as State Departments. Promulgation is now expected early next year. Staff at MAD, BHSD and CYFD are currently working to prepare a Supplement to fill the gap until the rule is promulgated.

6. **Administrative Services Organization (ASO)**
Falling Colors, Inc. (FC), is now in its second year as the Administrative Services Organization (ASO) for the BH Collaborative. In the first year of operations, the ASO was able to assist with 2,567 provider payments, with an average day-to-payment of less than 6 days and with all payments 100% on time. The ASO was able to process 149,371 claims with a 91% acceptance rate. 197 provider contracts were executed with a total of $44,471,184 paid to providers. $711,902 was recouped from 29 providers for Medicaid covered individuals that were billed to Non-Medicaid funds. The ASO continues to provide outreach and training for providers and has resolved 4,689 support tickets through FY18.
*Source- FC ASO Status Report

7. **Behavioral Health Investment Zones (BHIZ)**
BHIZs were established in 2016 in two NM counties, Rio Arriba and McKinley, based on high incidence of deaths attributable to drugs, alcohol and suicide: Each county has created its own plan, based on strategic priorities.

Rio Arriba County BHIZ: Rio Arriba County Opiate Use Reduction (OUR) Network continues to serve and track clients. OUR Network case managers made approximately 2,000 outreach contacts and provided intensive case management over 200 clients in FY 2018. The range of services provided included MAT, detox, residential, recovery support, medical care, transport, housing, legal assistance and behavioral health care. OUR Network agencies have begun entering data into the web portal. Monthly care coordination meetings are being held to jointly staff shared clients, and to discuss issues with the VPR/portal. The evaluation team was able to pull data from the Pathways HIT to compile the annual report for the first time, and has been able to evaluate the use of the VPR with recommendations for the developers on improvements designed to tailor the HIT for use with SUDs.

Rio Arriba has focused in this quarter on developing Law Enforcement Assisted Diversion (LEAD, or pre-arrest diversion) in partnership with the Rio Arriba Sheriff's Office, the Española Police Department and Santa Fe County. It hired a LEAD coordinator, and began developing protocols to divert individuals into intensive case management prior to arrest maintaining fidelity to the evidence-based model. A funding proposal for LEAD funding was submitted to the McCune Foundation and the U.S. Bureau of Justice Assistance. A team consisting of Rio Arriba Health and Human Services (RAHHS), Judge Lidyard, the DA, the Public Defender, RASO and EPD has been meeting twice per month, and resolutions supporting LEAD have been passed by Rio Arriba County and the City of Española.

The City of Española has moved forward with efforts to pass a housing ordinance in anticipation of developing a tax credit affordable housing project. In addition, OUR Network continues to distribute Naloxone in partnership with member organization, Santa Fe Mountain Center. Las Cumbres Community Services is providing home visiting and intensive case management for pregnant women and the families of small children. El Centro Family Health has begun using their interface between their VPR and Pathways. Rio Arriba is providing case management for Las Clinicals Del Norte, a new network partner, increasing their effectiveness and network access to MAT. Ninety-one percent of Network clients received two or more services within 30 days of intake in the final six months of the fiscal year, more than twice the legislative target.

Successful referrals from the jail into treatment increased over 1,000% during the previous fiscal year from four referrals in 2017 to forty-one, and 79% percent had either completed or remained in treatment the second half of the fiscal year, an increase of 29% from the first half of the year.

Rio Arriba has also realized the importance of changing community perception of SUD so that it is understood to be a chronic illness and not a criminal offense. OUR Network has developed a media campaign designed to build empathy and support for SUDs sufferers and their families, as well as awareness of treatment options. With the help of Sancre Productions five TV-ad length professionally produced videos have been created featuring local actors and scenes. The NM Community Foundation is acting as the campaign's fiscal agent, enabling us to seek corporate sponsors. The Rio Arriba Community Health Council kicked off OUR Network's "New Normal" campaign at its annual health fair. The fair included over 100 vendors, a lowrider competition, and free bands and food. Hundreds of second-fourth graders were bused in from surrounding schools for a free concert by the nationally renowned band Ozomatli, while high schools students from Rio Arriba and Taos Counties were bused in for a career fair. Events culminated in a free public concert on the evening of August 17th featuring the bands Divino, Strings Attached, Nosotros and Ozomatli. Approximately 4,000 people attended events throughout the day.

The overdose death rate in Rio Arriba County has dropped 30% since the inception of the BHIZ. While figures are not out yet for the current year, it appears that the OD death rate may show a small improvement again in the current year.

McKinley County BHIZ: McKinley County BHIZ had many successes this quarter which include a continuation application for the Prevention Alcohol Related Deaths grant. Nihzhoozhi Center Inc. (NCI) also coordinated and hosted a Red Ribbon Relay run with various community providers and clients. The run focused and celebrated sobriety.

- This quarter July to August (September data will be available in October), NCI provided counseling session to 169 unduplicated clients. There were 69 group sessions held at NCI with over 1,848 social detox clients in attendance.
- The City of Gallup in collaboration with the McKinley County Health Alliance completed strategic planning for Health Priorities. Plans will be finalized in by the end of the year.
- Hosted a team building retreat for NCI Treatment staff.
- Completed a Motivational Interviewing Coaching and Skill building training for NCI Staff. All treatment staff are competent in Motivational Interviewing. We are starting to see an increase in interest and applications for treatment.
- Hosted the City's Indigenous Peoples Commission meeting. The Commission will work on Indigenous Peoples concerns and solutions.

- Collaborated with Rehoboth McKinley Christian Health Care Services and Gallup Indian Medical to provide a Motivational Interviewing training to 25 health care providers. GIMC is working to implement the Zero Suicide Initiative.

8. **CareLink NM BH Health Homes (CLNM)**

Twelve BH Health Homes are now operating throughout NM to coordinate an array of physical and behavioral health services for Medicaid-eligible individuals with Serious Mental Illness and Severe Emotional Disturbance. Many of these individuals are also living with complex chronic conditions such as diabetes, high blood pressure, and chronic pulmonary disease, as well as co-occurring substance use disorders. Providers are: UNM Hospital Clinics and NM Solutions in Bernalillo County; Presbyterian Medical Services and Kewa Pueblo Health Corporation in Sandoval County; Mental Health Resources in four locations in Curry, Roosevelt, De Baca and Quay counties; Guidance Center of Lea County; and Hidalgo Medical Services in two locations in Grant and Hidalgo counties.

CLNM providers are comprised of Federally Qualified Heath Centers, Core Service Agencies, Behavioral Health Agencies (BHA), and a Tribal 638 Health Center. Some were already providing both physical and BH services and some have developed agreements with outside providers to form integrated multi-disciplinary teams. HSD is collaborating with CYFD to implement High Intensity Wraparound to serve an anticipated 200 of the most vulnerable children and adolescents with SED, many of whom have been in out-of-state residential treatment centers. Providers implementing Wraparound are the Guidance Center of Lea County and Mental Health Resources in Portales. Because of the complexity of BH challenges in youth recommended for Wraparound, facilitator to youth ratios do not exceed 1:10, and Wraparound facilitators participate in a mandated 18-month training and mentoring process conducted by CYFD Behavioral Health staff. As of mid-September, 51 children and youth were receiving High Intensity Wraparound.

Data collection for return on investment analyses and federally-mandated reporting has begun for the second year of the two original Health Homes sites in Farmington and Clovis and an oversight/monitoring process is being implemented to help assess quality of Health Home services and to develop practice improvement strategies with providers.

9. **Clinical Curriculum Development Initiative**

Since the fall, 2017, BHSD has been partnering with the faculty in NM State University's Departments of Social Work and Counseling Psychology, the University of Texas-El Paso's Social Work Department and La Clinica De Familia's (LCDF) BH program in a Clinical Curriculum Development Initiative. The purpose of the Initiative is to co-design and deliver training materials for the Master's level students in these schools. Over the last few years, BHSD's training experts in *Clinical Reasoning and Case Formulation* have been sharing these materials with our clinical practitioners across NM.

Our experts, Ray Foster and Kate Gibbons, have restructured the *Clinical Reasoning and Case Formulation* 2-day training into a modular format suitable for classroom use. We believe the materials, in the newly restructured modular format, will be more useful for their Master's Social Work and Counseling Psychology Programs. As co-designers, the participants will experience the content and then strategize opportunities for delivery of the materials. We plan to establish a Task Force to continue learning about its use, improvement and effectiveness. This

initiative will introduce these materials to Masters level students to strengthen their skills and strategies to be applied during their practicum field placements and/or after graduation when working in behavioral health treatment agencies.

Our newest partners are the Social Work and the Counseling Departments at Western New Mexico University. They have become our fastest "early adopters!" Starting in October 2018, the Social Work Department will offer an on-line course in *Clinical Reasoning & Case Formulation*, taught by our experts. The eight week course will be offered twice to both social work and to counseling students. In addition, the materials will be incorporated into the teaching of the Pre-Practicum and Practicum courses for the Counseling Program. We will be consulting with their Chair to development measures of competency of the student participants. Delivering the materials for distance learners will offer us another opportunity to modify the tools as needed and make the material available to a broader audience of student.

In early Spring, we anticipate engaging with additional universities to determine their interest in partnering on this curriculum in their programs.

10. Consortium for Behavioral Health Training and Research (CBHTR)

One of the main activities this quarter has been planning the NM Behavioral Health Workforce Summit for Oct. 25, 2018. This is a collaborative effort among several providers, educators and others across the state. In addition to establishing and finalizing the agenda, securing speakers and all logistics, CBHTR is partnering with CYFD's Youth in Transition program to ensure that youth are integrated into the entire day. This is particularly important given what we know about our aging BH workforce in the state. The Division of Community Behavioral Health at UNM has extended an offer to hire an LCSW to expand capacity, through clinical supervision, to increase the number of independently licensed professionals in NM and to improve quality of service provision. This LCSW will also enhance our ability to offer workforce trainings throughout the state. CBHTR has also brought on another interdisciplinary supervisor. Currently, CBTHR-licensed professionals now provide supervision to approximately 20 LMSWs monthly, three of whom have completed their required hours in the last quarter. CBHTR has also worked with the NM Office of Peer Recruitment and Engagement (OPRE) to obtain continuing education credits and create a pipeline to encourage certified peer support workers to take comprehensive community support services (CCSS) training to increase their employability statewide. A CCSS training in Albuquerque with 35 participants from 11 agencies was completed late this quarter.

11. Crisis Triage Centers (CTC)

A CTC is a health facility that is licensed by DOH with programmatic approval by BHSD and CYFD. CTCs provide stabilization of BH crises and detox management, either in a 23 hour outpatient or a 24/7 short-term residential setting. They will provide emergency BH triage, evaluation, and admission, on a voluntary basis. CTCs may serve individuals 14 years of age or older who meet admission criteria. DOH has been working with BHSD and CYFD to draft the licensing regulations for CTCs. Following an amendment in SB220 this last Legislative Session, DOH has revised its previously posted rule on CTCs to cover both residential and outpatient forms of CTCs and held a public hearing on the adoption of the new rule. The final rule will be published following the DOH Secretary's review of changes following public comments. Meanwhile, Medicaid's BH rule that includes payment mechanisms for services provided by CTCs is expected to be promulgated early next year. A Supplement is being developed to fill the

gap until rule promulgation.

12. Naloxone Pharmacy Technical Assistance

BHSD's Office of Substance Abuse Prevention (OSAP) has contracted with the Southwest CARE Center (SCC) under the Opioid STR grant to provide technical assistance to NM pharmacies reimbursed by Medicaid to dispense naloxone for 100 pharmacy trainings over the two-year grant period, to be completed by September 2019. On-site technical assistance has focused on increasing patient/customer access to naloxone, increasing the number of pharmacies carrying and dispensing naloxone, and reducing pharmacy barriers to dispensing and billing for the medication. The two-hour, onsite training provides both pharmacists and pharmacy technicians with CEUs.

On August 1st, SCC pharmacists trained all pharmacy staff at the Haven Behavioral Hospital of Albuquerque. Pharmacy staff at this location are hoping to increase naloxone distribution to patients participating in their intensive outpatient program for opioid use disorder. On August 16th, SCC pharmacists conducted a naloxone training at To'hajiilee Navajo Health Center in To'hajiilee, NM. Pharmacy staff, clinic staff, and members of the community were in attendance. During this first quarter, SCC dispensed 70 Narcan® kits to 12 NM pharmacies previously trained under the program for patients without Medicaid or insurance.

13. Network of Care (NOC)

The NM BH Network of Care (NMNOC) is operating as the official website for the BH Collaborative. This website can be accessed at: http://www.newmexico.networkofcare.org/mh/

For the period of July 01, 2018 to September 30, 2018 there were total of 42,507 site visits. This is an increase of 5159 visits or 7% from last quarter. Average visits per day are 477 and 1032 page views so visitors are navigating through at least 2-3 pages per visit and spending an average of 7:39 minutes on the site. 16,295 visits are coming from mobile phone devices.

The top five keyword searches were: Substance abuse, Depression, Health Care, Housing, and Employment The overall top six web page views: Home, Residential Treatment Facilities, Find Services, OPRE, Southwest Horse Power, Inc., and NM Opioid STR. The top five agencies for web page views were: Southwest Horse Power, Inc., Courageous Transformations, Samaritan Counseling Center of Albuquerque, UNM Hospital Programs for Children and Adolescents, and Alternative House Inc/La Posada Halfway House

Development for the Opioid STR pages continues with an emphasis on reviewing and updating content as the program grows and evolves, i.e. more training videos. There have been a few meetings with the STR Public Relations Monthly Team participants, and the group seems to be warming up to the areas of cross promotion and support with messaging around treatment, recovery, prevention and stigma. Some focus areas are:

- Recovery Month has been a big opportunity for shared promotions especially on NOC, OPRE (newsletter and facebook) and A Dose of Reality.
- We are just beginning to look at how to leverage efforts around database development and upkeep.

- The OPRE communications and promotions are starting to be picked up by other groups. A Dose of Reality often reposts the OPRE recovery stories, jobs and trainings to their social networks.
- Strategic areas on NOC have been targeted to link to A Dose of Reality, and this development will happen right away.
- We are working to collaborate more with DOH and DOT and hope to have some mutually supportive efforts.

The OPRE section on NOC will have the new sidebar navigation design (like the STR pages) development should be live by mi- October including an area for CPSWs to post resumes. For the first time, OPRE is sending out a print and email communication to the NOC database of Behavioral Health Organization to solicit support for the CPSW Pre-Req Hours and asking these organizations to be part of the OPRE database of locations for peers to work and get their hours required for certification.

14. New Mexico Crisis and Access Line (NMCAL)

As of August 31st, NMCAL has answered a total of 38,489 calls this calendar year. This includes 16,866 crisis calls, 4,175 NM calls from the National Suicide Prevention Lifeline (NSPL), 9,908 calls for the Peer-to-Peer Warm Line, and 7,540 after-hours calls forwarded from NM's Core Service Agencies (CSAs).

Bernalillo, Curry, Taos, Santa Fe, and Sandoval counties had the highest numbers of callers on the crisis line, with Dona Ana and San Juan Counties being the next top utilizers. Anxiety, suicide, situational stress, and depression were the top four presenting issues. While suicide was not always the presenting issue on a crisis line call, concerns related to suicide were reported on 29.9% of the calls. In August, 16.3% of crisis line callers reported concerns related to drug and/or alcohol use impacting their lives. For the Peer-to-Peer Warmline, the top concern identified is “mental health” at 89.2% in August, with “relationships” at 3.4% being the next highest reported challenge.

NMCAL now offers a texting services for its Warmline, in an effort to reach more youth, and has produced a flyer that describes how the service works. In addition, NMCAL has joined with HSD-BHSD and providers across the State to expand its focus to Opioid Use Disorders by providing specialized OUD training to all Crisis Line Counselors and Warm Line Peer Support staff. NMCAL has also partnered with the Dose of Reality, NM’s social media opioid campaign, to promote NMCAL’s availability. NMCAL is operated by ProtoCall Services, Inc. and is funded by BHSD.

15. Office of Peer Engagement (OPRE)

The Office of Peer Recovery and Engagement is continuing with the positive momentum from the close of FY18. OPRE has completed two CPSW trainings since July 1, 2018 and is proud to announce a total of 380 CPSWs in our state currently. In an effort to improve the peer workforce, OPRE will institute new requirements effective January 1, 2019:

- Documented 40 hours of work/volunteer experience before sitting for the CPSW Exam.
- Improved vetting of CPSW applicants via improved interviewing process and letter of reference requirement.

OPRE was successful in utilizing State Targeted Response (STR) grant funding to place Certified Peer Support workers in two new settings: the Taos County Correctional Facility and Christus St.

Vincent Behavioral Health Unit. Both Peers are doing extremely well early on and have made a big impact on their respective facilities. STR funds will continue to be used to present MAT/OUD to Peers across the state as a free CEU opportunity and to organize and facilitate a proposed statewide "Peer Summit."

OPRE has and will continue to support the efforts of CYFD in ongoing development and implementation of the Family Peer Support Program, Youth Peer Support Program and the Adult Family Peer Endorsement.

Forensic Peer training: 25 new CPSWs were recently trained and certified in the SAMHSA sanctioned Forensic Peer Training, August 28-30, 2018. This was a very emotional and unifying training, led by Liz Woodley and Lester Othal of the Pennsylvania Mental Health Consumers' Association. OPRE staff looks forward to future contributions from those who received the training and is thankful for their unique qualities and perspectives.

OPRE continues to be active in presenting information as needed in forums such as the Psychosocial Rehabilitation Association of New Mexico annual conference, Tribal Leadership Summit, and State, City and County committee meetings.

And finally, the OPRE-funded Wellness Centers are alive and well in providing supports in their respective communities and are proudly Peer run and Peer led:

- Hozho Center provides recovery services and support meetings for residents in the Gallup NM area.
- Inside Out is a staple of support in Espanola, NM providing food and clothing banks and technical assistance with resumes, registrations and applications.
- Healing Circle in Shiprock, NM specializes in tradition healing practices, Native Women's supports and assistance.
- Mental Health Association provides much needed transitional housing services, supports and referrals to those discharged from New Mexico Behavioral Health Institute in Las Vegas, NM.
- Carton County Grassroots Behavioral Health provides a lifeline of services to those in one of the most rural counties of New Mexico.
- Forward Flag/Straight Scoop for Vets provides a much needed outlet and resources for our veterans via the newly opened Veteran's Wellness Center in Albuquerque and the Veteran's "Coffee Bunker," a mobile unit reaching Veteran's across our state.

16. Opioid Crisis State Targeted Response Grant (Opioid STR)

The goals of this initiative are to increase the number of Opioid Treatment Providers (OTPs) and Office-Based Opioid Treatments (OBOTs), increase the availability of qualified staff and programs to address the needs of persons with Opioid Use Disorder (OUD), and improve access to services for individuals with OUD. The NM Opioid STR Initiative is framed around a centralized hub/regional hub model that will utilize the expertise of regional institutions and community agencies already providing services and integrate them with the newly trained providers and a centralized training hub that is able to coordinate and disseminate trainings and best practice efforts around the state. There are currently over 30 regional hub/community partners participating in the initiative.

August Highlights:

- STR Central Hub presented on the NM Opioid STR Initiative: Innovative Hub & Spoke Approach at the 2018 National Association for Rural Mental Health (NARMH) in New Orleans, 8/23/18 – 8/26/18.
- Motivational Interviewing (MI) and Community Reinforcement Approach (CRA) trainings scheduled for October and November in Las Cruces and Espanola.
- PK Public Relations working with Patrick Stafford at DOH Las Cruces to create messaging for Provider Anti-Stigma Campaign

Performance Activities & Accomplishments:

Treatment Update:

In August, our partners have attended the following trainings:

- ECHO series for Counselors & Social Workers – 40 attendees
- ECHO series for CHWs, CPSWs, & MAs – 4 attendees
- ECHO series for Integrated Psychiatry & Addiction – 6 attendees
- MSG LC4 Matrix Training – 30 attendees

Overdose Reversals:

- During the month of August, a total of 19 reversals were reported from Inside Out and Grants County Fire and Rescue Department.

The STR grant also supports prevention activities, which complement efforts supported by the PDO grant (see below). Since July 1st, 2017 OSAP has coordinated multiple meetings, trainings, and Narcan distribution with key stakeholders throughout the state representing tribal communities, law enforcement agencies, fire departments, health councils, detention centers, behavioral health providers, youth and adult shelters, and local governments.

- As of September 2018, the number of kits distributed has totaled 5,790 with 2,792 people being trained and 35 reported reversals due to grant-funded Narcan being deployed.
- STR-funded Narcan is currently being provided to New Mexico Corrections Department for dispensing to inmates upon their release from state correctional facilities.

Data Outcomes – Year 2 (as of August 2018)	Cumulative	Initiative Goals
1) Other workforce trainings (# people)	127	Various Training Partners
2) Naloxone workforce training (# people)	430	Bernie Lieving
TOTAL WORKFORCE TRAINED	**557**	**130**
3) Naloxone community training (# people)	278	Inside Out & Serenity Mesa
4) Naloxone kits distributed to community	341	Inside Out & Serenity Mesa
5) Naloxone kits distributed to workforce	1730	SW CARE & Bernie Lieving
TOTAL KITS DISTRIBUTED	**2349**	**9,000 kits**
6) Recovery Support Services (# people)	685	520 per year
7) MAT Treatment (# people)	123	330 per year
8) Reported OD Reversals	25	

17. Opioid Treatment Programs (OTP)

There are sixteen Opioid Treatment Programs (OTPs) operating in NM, serving approximately 6200 patients. Of these, nine are located in Albuquerque, including a courtesy dosing clinic at the Metropolitan Detention Center. Clinics are also located in Belen, Santa Fe, Espanola, Farmington, Las Cruces, Roswell, and Rio Rancho. There are currently six provider organizations that have submitted applications to open clinics in Albuquerque (1) Bernalillo (2), Espanola (1), Santa Fe (1) and Gallup (1). Applications are under various stages of completion. Sites in Albuquerque, Santa Fe and Espanola are expected to open in early 2019.

Statute now requires clinics dispensing methadone or narcotic replacement to provide patients with education on opioid overdose and the safe use of Naloxone in the prevention of opioid overdose deaths. To comply with this new requirement, Dr. Joanna Katzman and Monica Moya Balasch from the UNM Pain Center/STR Project continue to provide Naloxone trainings and technical support to the existing OTPs.

The Central Registry provides OTP clinics with a database to ensure that patients are not duel enrolled. Efforts to automate the process whereby clinics would no longer require staff to manually upload patient information are underway. This is another step toward providing real time data to clinics through use of the Central Registry.

Updates to NMAC 7.32.8 Opioid Treatment Programs are underway and will be sent for public comment upon completion.

18. PAX Good Behavior Game

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

FY19 implementation, begun in July, consists of two projects: the first is a continuation of efforts with the FY16, FY17 and FY18 participating schools, and the second begins a new implementation with Bureau of Indian Education schools in collaboration with the NM Indian Affairs Department.

Beginning in August 2018, 10 school districts continued implementing PAX GBG. These districts participated in an initial teacher training to ensure new teachers received the training: Aztec Municipal School District (3 schools, 65 classrooms) with the school also contributed their own funds to help ensure all staff at their three elementary schools were trained; Bloomfield School District (1 school, 4 classrooms); Chama Valley Independent School District (2 schools, 4 classrooms); Ch’ooshgai Community School (1 school, 7 classrooms); Cobre Consolidated School District (3 schools) training date to be determined; Deming School District (6 schools, 37 classrooms-- some district funds were used to support additional staff to be trained); Espanola Public Schools (11 schools, 12 classrooms); Farmington Municipal School District (6 schools, 31 classrooms); Santa Fe Public Schools had an expansion using district funds adding 10 schools since May 2018 (14 schools, 100 classrooms) with a training scheduled on October 29th, 2018 to

support school-wide implementation ; Socorro Consolidated Schools (3 schools, 18 classrooms); and Tucumcari School District (1 school, 4 classrooms). A total of 286 teachers have been trained since August 2018, reaching 5,049 students across the state to date.

Evaluation data was collected August and September 2018, in the form of pre- and post-implementation "spleem" counts, student social competence evaluations, and teacher burnout surveys. Spleems are off-task or inattentive behaviors that are identified and counted discretely by trained observers, known as PAX Partners. The social competence evaluation includes an 8-point scale that measures self-regulation in each student. Core classroom teachers have filled out a survey on each of their students. Teachers also completed a survey on stress and burnout measuring scales related to personal accomplishment and emotional exhaustion.

An outreach effort has been occurring to expand PAX GBG to other communities in the state, reaching Las Cruces Public Schools and Roswell Public Schools. Strategic planning meetings were held with PAXIS Lead Trainer Claire Richardson throughout August and September. Booster sessions for each district are being planned and coordinated. The following dates are confirmed: Aztec Municipal Schools on October 15th, Bloomfield School District on October 3rd, Chama Valley Independent School District on October 19th, Ch'ooshgai Community School on October 10th, Santa Fe Public Schools on October 13th and November 3rd. Socorro Consolidated Schools had their Booster on August 9th for previously trained staff, and Tucumcari School District on October 12th. We are still in process of coordinating Boosters for Cobre Consolidated School District, Deming School District and Farmington Municipal School District. Meetings with administrators have been scheduled to coincide with Booster trainings to ensure Administrators best support their teachers in implementation.

New and streamlined data instruments were created to assist all staff in completing data in a timely and effective manner. PAX Partner in-person and zoom call meetings and support has occurred on an ongoing basis to clarify Partner role responsibilities and troubleshoot and brainstorm partnering issues as they arise. PAX Partners are overseeing the data collection process in each of their school buildings for all data collection methods. A PAX Partner Training for current and newly recruited schools will be held in Santa Fe on November 13th and 14th, 2018.

Indigenous PAX**:** Each of the three major New Mexico Tribal groups (Pueblos, Navajo Nation, and the Apache tribes) have been approached for participation, with the intent to create three distinct Native projects. The Tribal Liaison conducted outreach this quarter with Ch'ooshgai Community School, Jemez/Zia Education Collaborative, Pueblo of Acoma and Jicarilla Apache, and Santo Domingo/Cochiti Pueblos.

Ch'ooshgai Community School: Residential and middle school staff were trained September 21st. Seven core classroom teachers, 24 special education teachers and three administrators were trained, reaching 114 students; a booster session will be provided on October 10, 2018. **Jemez/Zia Education Collaborative:** Additional Indigenous PAX presentations are scheduled at the Education Collaborative Meeting for July 19th in Jemez with Collaborative retreat conducted on September 21st. Initial teacher training for Jemez and Zia schools is targeted for October 26th.

Pueblo of Acoma: Contact has been made with Gil Sanchez, Principal of the new Haaku Community Academy School and Tribal Secretary, David Malie. A request has been made to present to the tribal Council in October.
Jicarilla Apache: Request was submitted to Levi Pesata, Jicarilla Apache President, to present Indigenous PAX to the school board this winter.
Santo Domingo/Cochiti Pueblos: Keres Language Teachers have requested teacher training and have been invited to attend the October 26th training at Jemez.

The following 11 schools (mixture of Bureau of Indian Education (BIE)/Tribal Schools/Public Schools with high enrollment of tribal youth) have been approached for participation and are in various stages of communication regarding participation: Acoma Pueblo Schools, Cubero Elementary School, Jicarilla Apache School, Laguna Elementary School, Mescalero Apache School, Pueblo of Isleta Elementary School, San Felipe Pueblo Elementary School, San Ildefonso Day School, Sky City Community School, Taos Community School, Tohatchi Elementary School, Wingate Elementary School, Tohaali' Community School, and Zia and Jemez Education Collaborative. Some of these communities have been approached and have scheduled presentations and meetings to further discussed PAX and bringing it to their communities.

19. Prevent Prescription Drug /Opioid Overdose-Related Deaths Grant (PDO)

BHSD's OSAP successfully applied for and received SAMHSA's $1 million annual award for five years: *Grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO),* which began September 1, 2016. The purpose of the grant is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

<u>Overall Grant Update</u>

All Federal grant carryover activities by Rio Arriba, Santa Fe, Dona Ana, and Bernalillo County have been completed and data will be coming in at the end of September to chronicle the work that was conducted. The counties continue to distribute naloxone in their respective areas. The Metropolitan Detention Center/Resource Re-entry Center (MDC/RRC) has completed data collection training, purchased Narcan and is finalizing the distribution process out of the RCC. Between July 2017 through August 2018, 2,267 individuals received opioid overdose prevention and Narcan training, 5,705 Narcan kits were distributed, and 25 overdose reversals were reported.

<u>PDO Advisory Council</u>

The PDO Advisory Council is conducting monthly meetings to provide guidance, recommendations, and oversight over the PDO grant and sub-grantees. The meetings focus on providing updates on the county distribution plans, reviewing PDO membership and scope, and assessing additional needs. This quarter, the PDO Advisory Council met July 13, August 3, and September 7. Local distribution success stories were shared. Presentations were provided on medical practitioner barriers to providing MAT in New Mexico (July 13), the 2017/2018 PAX Good Behavior Game Implementation (August 3), and the PDO Opioid Recognition and Response Trainings in Spanish (September 7).

Contracted Providers
The 3 grantee recipients (Bernalillo County Community Health Council, Santa Fe Prevention Alliance, Dona Ana County Health and Human Services) are continuing the expansion phase by increasing local capacity to distribute Narcan. The counties are actively engaging local agencies and offering training and naloxone with the intention of targeting the priority populations of people who use opioids/heroin, layperson "first responders", local county jails, drug courts and jail diversion programs, programs that service high-risk youth who use prescription opioids/heroin, homeless shelters and homeless services programs, drug treatment programs, local law enforcement and fire departments, faith-based organizations, etc.

Bernalillo County Community Health Council (BCCHC):
BCCHC has distributed 1,461 Narcan kits and trained 1,011 individuals to respond to an overdose as of the end of August 2018. BCCHC has established training and/or distribution to the following agencies:

- Youth Development, Inc
- NMCD Probation & Parole
- Albuquerque Police Department
- New Season Central NM Treatment Center
- Copper Pointe Church
- Gordon Bernell Charter School
- First Nations Wellness Center
- Serenity Mesa
- Duke City Recovery Toolbox
- New Mexico Corrections Department
- Bernalillo County Sheriff's Office
- Church of the Good Shepherd
- Bernalillo County Community Health Council
- Feria de Salud Free Clinic Outreach
- First Nations Wellness Center
- New Season Treatment Clinic
- South Valley Celebration Day
- UNM Hospital ED
- MATS Detox Services

Dona Ana County Health and Human Services (DACHHS):
DACHHS has distributed 2,431 Narcan kits and trained 716 individuals, and reported 13 opioid reversals as of the end of August 2018. DACHHS has established training and/or distribution to the following agencies:

- St. Luke's Health Care Center
- Doña Ana County Detention Center
- Mesilla Valley Community of Hope
- Morning Light Counseling Center
- New Mexico Department of Vocational Rehabilitation, Las Cruces
- American Medical Response
- ALT Recovery Group
- Las Cruces Fire Department
- NMSU Police Department

- Las Cruces Police Department
- Alcoholics Anonymous/Narcotics Anonymous
- Burrell College of Osteopathy
- Sunland Park Police Department
- Cedar Hills Church of the Cross
- Kilby Motel
- Serenity Counseling
- Southern New Mexico Homeless Providers Coalition
- Project OPEN
- La Clinica De Familia
- Third Judicial District Court (Drug Court)
- Peak Behavioral Health
- Security Concepts
- Mesilla Marshals
- Unified Prevention (UP!) Coalition
- Union Pacific Police Department
- Forensic Intervention Consortium of Dona Ana
- New Mexico Corrections Department
- New Mexico Mounted Patrol
- Esperanza Guidance Services
- Ben Archer Health Center
- AARP
- Dierson Charities
- Doña Ana County Health and Human Services
- Hatch Police Department
- Mountain View Regional Medical Center
- New Mexico Caregivers Coalition
- Rio Grande Re-entry Council
- Reclaim Wellness
- Southern New Mexico Promatora Committee
- United States Border Patrol
- Animal Service Center of the Mesilla Valley
- Memorial Medical Center Family Practice

Santa Fe Prevention Alliance (SFPA):
SFPA has distributed 1,813 Narcan kits and trained 440 individuals, and reported 27 opioid reversals as of the end of August 2018. SFPA has established training and/or distribution to the following agencies:

- The Life Link
- Santa Fe Fire Department Overdose Follow up Project
- NM 1st Judicial Court
- Pojoaque Police Dept.
- Santa Fe County Reentry Specialist El Centro Family Medicine
- NMCD Mental Health Team
- Edgewood Senior Center
- Santa Fe Police Department

- Santa Fe County Juvenile Detention Facility
- Solace Crisis Treatment Center
- Santa Fe County Adult Detention Facility
- Hoy Recovery Program
- Las Clinicas Del Norte
- Carlos Vigil Middle School
- Santa Fe Recovery Center
- El Centro Family Medicine
- Barrios Unidos
- Mesa Vista Wellness
- Santa Fe County DWI Program
- YouthWorks
- Santa Fe County Community Services Department
- Santa Fe Public Schools Adelante Program
- Tranquilla Inn
- Desert Chateau Inn
- Thunderbird Inn
- Cactus Centro
- First Choice Community Health Center
- Probation/Parole Division
- Southwestern College
- SF Fire Dept. MIHO
- Christus St. Vincent Regional Medical Center Emergency Department
- Espanola Public Schools
- Rio Arriba County Health and Human Services
- NM Attorney General
- Las Cumbres Community Services
- Santa Fe Therapist Networking Group
- Southwest CARE Center
- Meow Wolf
- Susan's Liquor Store
- Rio Arriba County Adult Center
- Espanola Hospital
- Santa Fe County Community Center

PDO Media Subcommittee
The PDO media campaign is ongoing and continues to utilize advertising strategies, media strategies, social media, and a user-friendly website providing information to the public about overdose prevention and naloxone use. The media campaign has enhanced the websites and social media platforms to be user friendly and to increase visibility regarding overdose prevention and naloxone, while destigmatizing overdoses. The website has been updated to offer an English and Spanish version for site visitors. The media campaign developed mini-campaigns focused on spreading awareness of opioid abuse prevention (prescription and/or illicit drugs), of the various statistics related to Opioid Use Disorder (OUD), the path of treatment and recovery, and to encourage opioid users (licit and illicit) and friends/family to keep naloxone on-hand in order to potentially save a life. Social media campaigns have focused on addressing

OUD and overdose death by running a campaign titled Humans of New Mexico on Facebook and Instagram. The filming of a Spanish naloxone training video has been completed and will soon be made available for communities to use.

20. Prevention "Partnership for Success" Grant (PFS 2015)

BHSD's OSAP has been awarded this SAMHSA grant of $1.68 annually for 5 years ($8 million total) to address underage drinking and youth prescription drug abuse. Nine providers were awarded contracts in November 2015: Chaves, Cibola, Curry, and Roosevelt counties, and the five schools of the NM Higher Education Prevention Consortium (NMHEPC) - NMSU in Las Cruces, NM Tech in Socorro, San Juan College in Farmington, UNM in Albuquerque, and the Institute for American Indian Arts (IAIA) in Santa Fe.

Eight of the nine PFS 2015 funded providers (Chaves, Cibola, Curry, and Roosevelt counties, and four of the five schools of the NMHEPC (NMSU in Las Cruces, NM Tech in Socorro, San Juan College in Farmington, and UNM in Albuquerque) have completed all Strategic Prevention Framework trainings: Coalition Development, Community Needs Assessment, Community Capacity & Readiness, Strategic Planning & Evidence Based Practices, and Evaluation.

Since August 2017, 8 of t 9 sites have been implementing prevention strategies. In December 2017, the NMHEPC identified the Institute for American Indian Arts (IAIA) in Santa Fe as the 5th school to participate in the PFS 2015 grant. In May 2018 they collected data for the New Mexico Community Survey that was used in their needs assessment to prioritize issues for prevention efforts. They received assessment training in August 2018 and submitted the first part of their assessment report at the end of September. IAIA will continue to receive SPF trainings and technical assistance support to develop a strategic plan.

Throughout the quarter, providers received technical assistance (TA) via monthly webinars and in-person visits. To date, webinar topics have included working with school substance abuse policies, engaging community leaders with prevention efforts, an overview of prevention resources, completing the SAMHSA federal reporting requirement (Community Level Instrument), utilizing social media, conducting Town Halls, and the fourth degree felony law for providing alcohol to minors. In-person TA was provided to New Mexico State University (NMSU), University of New Mexico (UNM), New Mexico Tech, and the Institute for American Indian Arts (IAIA). These TA visits focused on the strategic prevention framework, publicizing party patrols in a University setting, and developing medical provider guides for prescribing opioids.

All PFS 2015 sites received carry over funds from federal fiscal year 2017. In this quarter, PFS15 providers utilized these funds to attend intensive social media workshops and conduct two town halls; one on prescription opioid misuse and another on underage drinking. Also in this quarter, PFS 2015 providers submitted their annual OSAP Final Year and Quality Improvement Reports highlighting their progress for each strategy.

<u>State Epidemiological Outcomes Workgroup: SEOW</u>

The SEOW met three times this quarter. On July 19th, the group had a presentation from the Department of Health (DOH) on the results from the 2017 Youth Risk and Resiliency Survey. On August 16th, CYFD and DOH presented on findings from the 2017 Reconnecting Youth Survey conducted in Santa Fe County. On September 21st, the UNM Prevention Research Center

presented on Youth Suicide Risk and Resiliency Factors. The SEOW is conducting a series of data literacy trainings in four regions of the state. The first two trainings were on September 10th in Santa Fe and September 24th in Roswell. These have been well attended by OSAP providers, Health Council coordinators, and DWI directors. Future trainings will be held on October 23rd in Albuquerque and November 29th in Las Cruces.

21. Screening, Brief Intervention, Referral to Treatment Grant (SBIRT)

In August 2013, SAMHSA awarded BHSD with a five-year, $10 million grant to implement SBIRT. SBIRT services integrate behavioral health within primary care and community health care settings. Each medical partner site universally screens adult patients 18 years old or over, at a minimum, on an annual basis to identify those at-risk of or those who have a substance use disorder.

The pre-screen, Healthy Lifestyle Questionnaire (HLQ), includes questions from evidence-based screening tools, such as the AUDIT 10 (screens for alcohol), DAST (screens for drug), and PHQ-9 (screens for depression). The HLQ pre-screen score identifies when a patient is considered positive for NM SBIRT, at risk of having or has substance misuse and/or a co-occurring disorder. The HLQ also includes questions that identify if an individual is at risk of having or has depression, anxiety, and/or trauma. Although the NM SBIRT grant is specific to addressing substance use, screening includes mental health questions to better serve patients' needs.

The following are the seven NM SBIRT medical partner sites and locations: White Sands Family Medical Practice, Alamogordo; Aspen Medical Center, Santa Fe; Christus St. Vincent Entrada Contenta, Santa Fe; Christus St. Vincent Family Medicine Center, Santa Fe; First Nations Community Health Source Zuni Clinic, Albuquerque; Santa Fe Indian Hospital, Santa Fe; and UNM Hospital, Albuquerque.

NM SBIRT has made significant progress since the project's inception. By grant's end, on July 31, 2018, a total of 49,663 screens were conducted with 44,235 individuals screened. There have been 27,901 negative screens and 21,761 positive screens. The positive screens were categorized as needing Brief Interventions (BI), Brief Treatment (BT), or Referral to Treatment (RT) based on the screen scores. Of those screened, 38% screened for as BI, 49% screened BT, and 7% screened RT. NM SBIRT has conducted 8,584 SBIRT Positive BIs; 4,203 Mental Health BIs; served 8,465 individuals with therapy, and referred 263 individuals to treatment services and 1,089 clients to various services, such as case management or family support services.

Post grant, the following five NM SBIRT medical partner sites and locations that remain operational are: White Sands Family Medical Practice, Alamogordo; Aspen Medical Center, Santa Fe; Christus St. Vincent Entrada Contenta, Santa Fe; First Nations Community Health Source Zuni Clinic, Albuquerque; and Santa Fe Indian Hospital, Santa Fe. UNM Hospital, Albuquerque, has hired two permanent part-time SBIRT employees specifically to meet the federal requirements for SBIRT services for Trauma Surgical patients at all Level One Trauma Centers, nationally. The Life Link is assisting with the training for these new UNMH designated SBIRT employees.

NM SBIRT services were included in the Section 1115 Waiver application, which will allow for SBIRT Medicaid billing codes upon approval by CMS and active in January 2019. Services rendered by the existing NM SBIRT sites served as the model of SBIRT to define Medicaid codes.

All primary care clinics, hospitals and emergency departments throughout New Mexico will be eligible for site certification and SBIRT certification for their site staff in accordance with the SBIRT Medicaid 1115 Waiver guidelines.

At the most recent site visit in preparation for the NM SBIRT grant end, Christus St. Vincent administrative staff expressed a desire to have SBIRT in all of their locations once the Medicaid Waiver takes effect in January 2019. The Life Link is also in communications with administrators from Albuquerque Presbyterian Hospital Services who wish to have SBIRT services in their hospital Emergency Department. Additionally, Indian Health Services in Gallup has also reached out to The Life Link expressing their interest in SBIRT training for SBIRT services at their location.

22. Strategic Prevention Framework for Prescription Drugs Grant (SPF Rx)

BHSD's OSAP successfully applied for and received SAMHSA's competitive *Strategic Prevention Framework for Prescription Drugs (SPF Rx)*, which provides $371,616 award per year for five years beginning September 1, 2016. The purpose of the grant is to raise awareness about the dangers of sharing medications, and promote collaboration between states, pharmaceutical and medical communities to understand the risks of over-prescribing to youth and adults; bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and users in a targeted community of high need; and promote increased incorporation of Prescription Monitoring Program (PMP) data into state and community level needs assessments and strategic plans.

The grantee's sub-recipient, the Bernalillo County Community Health Council (BCCHC), completed the Strategic Prevention Framework trainings last quarter. Their strategic plan approved on October 24, 2017 and for implementation began in November. Technical assistance was provided to support BCCHC in planning and implementation for three new pilot strategies being implemented in Bernalillo County: HERO TRaILS, Boot Camp Translation (BCT) and a social media campaign targeting youth.

During this quarter, BCT-related events were held July 8, July 23, August 19 and September 8. The final BCT event is scheduled for September 29. Technical assistance, support and training were held during this quarter on July 6, 11, 17, 23, August 6, 11, 20, 24, September 10, 19 and 25.

In addition to Boot Camp Translation, the BCCHC team has been providing academic detailing on the safe prescribing of opioids to providers in Bernalillo County. Twelve sessions were done with 8 family physicians, 3 physician assistants, and 1 nurse practitioner as well as 10 pharmacy education visits were done this quarter. On September 18, one of the full-time preventionists attended a provider handbook TA training and planning session with other preventionists working on the same strategy in different counties. Planning is underway for the provider handbook and the parent handbook.

BCCHC lost their senior experienced preventionist last quarter but were able to hire a full-time staff preventionist in July to fill the position. Additional support and TA was provided to keep moving the project along while getting the new preventionist up to speed to co-facilitate BCT meetings. The new preventionist received SPF trainings on July 30 and September 6. Additionally, a temporary preventionist was hired in September to fill-in for one of the full-time preventionists now on maternity leave.

23. Supportive Housing

A subcommittee of the Collaborative's Housing Leadership Group (HLG) worked with the Technical Assistance Collaborative (TAC) to finalize the New Mexico Supportive Housing Plan: 2018-2023. The five-year plan sets ambitious goals and lays out concrete, achievable strategies. The Strategic Plan was presented to and approved by the Collaborative at the January 2018 meeting. BHSD's Supportive Housing Coordinator has begun meetings in July 2018 with the HLG and all stakeholders to execute implementation of the plan; the next meeting is scheduled for September 19, 2018.

HSD continues discussion with the Center for Medicaid Services (CMS) on inclusion of a supportive housing benefit in Centennial Care 2.0 for Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program. The benefit will include pre-tenancy and tenancy sustaining supports provided by peers of Linkages service providers. Linkages serves individuals with serious mental illness, who are homeless or precariously housed, extremely low income, and functionally impaired.

An additional $100,000 was approved for permanent supportive housing in the state budget during the 2018 legislative session. BHSD is determining how best to utilize the additional funds.

Housing Supports, Health, and Recovery for Homeless Individuals Grant (HHRHI)

This three-year $5.4 million SAMHSA-funded grant program successfully completed its final year, ending September 29, 2018. The program operated in Santa Fe, Bernalillo, & Dona Ana counties and provided permanent supportive housing for chronically homeless individuals with SUD, SMI, or co-occurring SUD and SMI. HHRHI incorporated the use of peers in the recovery model, and integrated the evidence-based practices of Permanent Supportive Housing, Supported Employment, Seeking Safety, and Motivational Interviewing into project implementation. During the last few months of the grant, carryover funds were used to develop a permanent supportive housing training curriculum for peers.

24. Treat First Learning Community

Various Design Teams within the Treat First Learning Community are developing contributions to improving BH practice. Three examples are:

Interdisciplinary Teaming in Behavioral Healthcare:

The Design Team on Teaming developed a "White Paper on Teaming". This material has been included as an Appendix in the newest Medical Assistance Policy and Procedure Manual and formed part of the conceptual logic for including interdisciplinary teaming as a service. Highlights of the White Paper include:

- Definition of Teaming
- The 6 C's of Teaming:
    - Communication
    - Coordination
    - Collaboration
    - Consensus
    - Commitment
    - Contribution
- Core Concepts of Teaming:

  - Shared Decision-Making
  - Common Purpose
  - Unity of Effort
- Teaming as a Central Practice Function
- Considerations for Teaming
  - Teaming Supports Shared Decision Making
  - Teaming is an Engine for Case-Level Learning and Action
  - Teaming is a Process, Not an Event
  - Teaming Should Be Person-Centered
  - Team Formation: Effective Teaming Requires the Right People
  - Team Functioning: Effective Teaming Supports Ongoing Collaborative Problem Solving
  - Team Coordination: Effective Teaming Requires Leadership
  - Effective Team Meetings Require Preparation, Facilitation, and Follow-Up
- Facilitation
- Service Planning and Follow-Up
- Challenges that May Thwart or Disrupt Effective Teaming

<u>Clinical Supervision Implementation Guide:</u>
One of the Design Teams is targeted on Clinical Supervision. As a contribution to the Practice Community, the Team has developed a Clinical Supervision Implementation Guide. Completion is anticipated for early September. It is designed to be a practical tool for community-based providers in NM. And it offers a way for communication and discussion among clinicians as they seek support from their colleagues on clinical supervision issues. The Guide will be available in the MAD Policy & Procedure Manual, the New Mexico Network of Care. In addition, it will have a prominent page on the New Mexico Behavioral Health Provider Association website where clinicians will be able to participate in clinical discussions and make practice contributions to the Guide.

Some of the content highlights include:
- Overview of Clinical Supervision principles, practice, expectations and functions
- The Practice Wheel: Functions in integrated care.
- The Clinical Supervision Experience:
  - Supervision relationship
  - Rights and Responsibilities
  - Supervision agreements and Learning Plan
  - Supervision Log
  - Preparation Worksheet
  - Models of Supervision
  - Supervision Bridging Session Form
- Therapist Evaluation Checklist
- Supervisory Competency Self-Assessment
- Case Discussion Guide for Reflective Practice.
- Annotated references to Licensing and Credentialing Boards' materials.

Treat First Talks:

Another of the Design Teams of providers is building a training program to help new provider organizations learn about Treat First, its philosophy, expectations, tips of implementation and its benefits. The program will also be useful for existing agencies to train their new staff and for orienting new sites where they are expanding the program. The Team has taken a lively, multi-media approach to sharing the ideas and experiences from across the current Treat First providers. MAD will be releasing its revised Rules and a BH Clinical Policy Manual which cites this training as a required part for becoming a Treat First provider. A website www.treatfirst.org is being built to facilitate training. Providers will be able to export the materials into their own e-learning agency platforms. Completion of the modules for the website is expected by November 1st.

Delivery System Improvement Fund
2018 Performance Measures

Q1-Q3 Report
through September 30, 2018

Report Date: October 31, 2018

4 new providers in Española

18 new providers in Albuquerque

4 new providers in Santa Fe

2 new providers in Belen

1 new provider in Clovis

1 new provider in Capitan

4 new providers in Socorro

Numbers are cumulative for Q1-Q3

DY5 Q3 ATTACHMENT G: MCO Action Plans

Quarter 3 DY2

MHC		
Q3DY2		
Action Plan #1	Implementation Date	Completion Date
Regulatory Reports	07/27/15	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

MHC has engaged Corporate IT, the Enterprise Project Management Office, and other key resources to complete a priority 1, "State Remediation Report Project." This project was actively sponsored at the highest executive levels within the company. Twenty-four state reports were identified in this project.

MHC's State Remediation Report Project prioritized reports 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 State Remediation Report Project was completed 09/30/16. Transition work was been completed on the reports that were still open items as of 09/30/16, including Report 3, 55 and 45. During the current reporting period, all open items, with the exception of Report 3, were closed.

For Report #3, MHC continued to take action to ensure data integrity and to refine the database infrastructure. Further logic changes are still in development. Testing has been delayed; finalization is now anticipated by August, 2017.

As of 09/20/17, testing for Report #3 was successful with no issues detected. It is anticipated that this item will be closed following the data run and submission for Q3.

This item remains open. Manual interventions are still required to generate the report. To reduce the potential for errors, MHC continues to work on programming solutions that will minimize these interventions.

03/31/18 – MHC closed this item 01/17/18. Configuration has been completed, and no issues were detected.

Quarter 3 DY3

UHC		
Q3DY3		
Action Plan #1	Implementation Date	Completion Date
HSD Care Coordination Audit	09/01/16	In Progress

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
09/30/16 – 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.

12/01/16 – Improvement activities for each audit finding is submitted monthly. Of the seven items, three are complete and the four others are in progress. Random sample reviews guide areas of focus for continued improvement efforts.

04/05/17 – HSD provided UHC with two recommendations and seven action steps focused on ensuring positive health outcomes resulting from Care Coordination activities. Quarterly updates are due to HSD from the MCOs on the 15th of the month following the end of quarter. In addition the MCOs meet individually with HSD on a monthly basis to review progress as well as to identify barriers. UHC has several quality improvement initiatives utilizing its new clinical care system, CommunityCare. In 2017, UHC has placed an emphasis on internal auditing, staff education, training and feedback, utilizing system generated goals as a starting point for developing measurable goals for the member and having current medication and service data readily available in the CommunityCare system. UHC has also developed a Corporate Adherence Report to measure adherence to contract metrics.

07/15/17 – UHC is meeting quarterly with the Quality Bureau at HSD for in-person meetings. HSD has provided positive feedback related to UHC care coordination efforts. Meetings will continue through 2017.

10/09/17 – HSD and UHC exchanged positive feedback and comments at their quarterly meeting with the Quality Bureau regarding ongoing Care Coordination performance improvement efforts.

1/15/18 - Q4CY17 Internal Action Plan (IAP) submitted to HSD

2/6/18 - The Health Services team met with HSD and reviewed the quarterly IAP information. UHC received recommendations in regards of ongoing improvement of the care coordination documentation based on the report outcome. HSD added Nursing Home Transition documentation elements to the quarterly IAP, for which UHC received clarifications on the newly added elements. During the meeting, HSD also announced 3 elements are on the IAP are

deactivated effectively immediately. Since the action plan was initiated in 2015, there are total of 2 recommendations and 11 action steps (4 TOC action steps newly added in Q4CY17).

3/31/18 – Two (2) recommendations and 4 action steps are closed

BCBS

Q3DY3		
Action Plan #1	Implementation Date	Completion Date
HSD Care Coordination Audit	07/19/16	In progress

Description

HSD conducted an audit on care coordination documentation in November 2015. The audit examined Care Coordination processes 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

07/19/16 – 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.

12/30/16 –BCBS continues to address HSD findings to improve care coordination processes and documentation. BCBS continues to update HSD on the progress made on a monthly basis.

03/31/17 – BCBS continues to update HSD on progress made to improve care coordination processes and documentation. Future updates will be provided to HSD quarterly and will encompass information on ongoing internal audits, summarizing the scope (sample/universe), methodologies (record review, ride along/observations, etc.), measurable results and ongoing actions steps based on BCBS internal findings.

06/30/17 –BCBS's internal audits demonstrate improvement in care coordination processes and documentation. Audit activities have validated the following: disaster and back-up plans have been included in the member records, appropriate behavioral health referrals have been made and documented in the member records and multi-disciplinary teams have been involved in managing members with complex physical health and/or behavioral health care needs. BCBS will continue to educate and train staff on proper documentation in order to ensure positive health outcomes as a result of improved care coordination activities.

09/30/17 – BCBS's self-auditing and monitoring continues. Additional education was completed by 09/30/2017. BCBS continues to conduct multi-disciplinary rounds to manage complex physical health and/or behavioral health care needs.

12/31/17 – BCBS continues to identify members with physical health (PH) and behavioral health (BH) needs for co-management. Members identified with complex BH needs are assigned to a Peer Support Specialist who uses their life experiences to assist members in managing their complex needs and encourage participation in care coordination. Additionally, BCBS is in the process of revising its transition of care documentation to improve the monitoring of members reintegrating into the community from the nursing facility, while ensuring a successful transition occurs.

03/31/18 – BCBS continues to focus on ensuring staff is appropriately managing member needs when reintegrating into the community from the nursing facility and the co-managed process for physical and behavioral health members. Additionally, BCBS has revised the Standard Operating Procedure (SOP) for 1915(c) waiver members to ensure that members enrolled in waiver categories who have a Comprehensive Needs Assessment indicating that they meet criteria for Care Coordination Level 2 (CCL2) or Care Coordination Level 3 (CCL3) are assigned to CCL2 or CCL3. The SOP was implemented and staff has been trained on this process to ensure adherence to the process.

06/29/18 –BCBS's Care Coordination team continues to provide training to staff on the completion of Comprehensive Care Plans (CCP) to ensure records contain detailed disaster plans and back-up plans as well as meet the member's identified needs. The revised Standard Operating Procedure was implemented on 6/28/18 to include expectations for completing the CCP within State deadlines. In addition, BCBS updated a tasking tool to ensure their care coordination team completes contractual care coordination touch-points as required. Weekly Dashboard Compliance meetings are being held to discuss compliance rates, including Comprehensive Needs Assessment (CNA) and Health Risk Assessment (HRA) compliance to ensure data is captured and remediation activities occur as necessary. In an effort to improve BCBS's ability to capture data, Job Aids and tasking tools continue to be evaluated and updated. These aids and tools are reviewed with the care coordination team and staff during weekly staff meetings. Additionally, BCBS implemented a new Transition of Care Plan on 2/27/18 and trained staff to utilize the plan on members residing in a nursing facility and reintegrating into the community. The plan ensures that BCBS is capturing all pertinent information for members to secure a safe transition into the community.

09/30/2018 – BCBS's Care Coordinators (CCs) continue to identify member BH diagnoses through the CNA and HRA assessments as well as through claims data to make appropriate referrals to address BH needs. Consistent monitoring continues with monthly member file audits completed by unit managers to ensure disaster plan compliance as well as BH diagnosis and referral. In February 2018, a new Transition of Care Plan (TOC) was created and all CCs were trained. The new template was designed to include all required elements to document member's transition from a nursing facility as well as address the members Medicaid eligibility. Consistent monitoring

continues with monthly member file audits completed by unit managers to ensure TOC plans are thoroughly completed. The CNA and HRA Tasking tool has been in production for two months and the expected improvement in metrics for CNA and HRA will be reported in coming weeks. All unit managers use a CNA dashboard report as a tool to ensure that CCs are meeting CNA and HRA compliance. Performance measures have been implemented for all BCBS CCs. BCBS utilizes additional support to improve CNA and HRA metrics as evidenced through BH liaisons located in all BH facilities and providers that follow members while inpatient at all BH out of home placements. Peer Support staff are also located in shelters and encourage care coordination for those members that they are engaged with.

Quarter 3 DY4

MHC

Q3 DY3 reported in Q3 DY4		
Action Plan #2	Implementation Date	Completion Date
HSD Care Coordination IAP	07/16	In progress

Description

Following an HSD desk audit, MHC developed and implemented an IAP to: 1) improve and standardize the documentation in members' case files, and 2) create a process for multidisciplinary review and identification of intervention strategies for members with BH issues who refuse treatment.

The IAP included the development of a file documentation template and extensive training of Care Coordinators in file documentation processes. MHC measures progress through quarterly review of a random sample of files. MHC also implemented Physical and Behavioral Health Co-Managed Rounds for members refusing BH services

Status

As of the 3rd quarter, MHC reports progress in consistent and complete file documentation of disaster and back up plans, next steps for members, and member reassessments. The results of the sample reviews are shared with Supervisors for feedback to Care Coordinators.

A workflow has been developed for members seen in inpatient multidisciplinary rounds to be followed in MHC's outpatient co-managed rounds. Care Coordinators are educated on the importance of motivational interviewing and medication adherence. The recommendations of Medical Directors and Pharmacists are clearly documented in the member's file.

3/31/18 In Q4, HSD provided MHC with new recommendations for its care coordination action plan. HSD continues to monitor MHC progress in 1) the development of inter-rater reliability controls for Care Coordination consistency;2) addressing gaps in discharge planning and documenting transitions of care;3) back-up and disaster planning;,4) improving the file documentation of Behavioral Health (BH) Diagnoses; 5) the development of processes and strategies for members with BH needs who refuse treatment.

6/30/18 MHC continued to monitor care coordination activities as recommended by HSD, and documented sustained progress in 1) back up and disaster planning; 2) the completion of multi-disciplinary team reviews for members with BH needs who refuse treatment; 3) ensuring that a Comprehensive Needs Assessment was completed prior to nursing facility discharge; and 4) completion and file documentation of the Transition of Care plan for members moving from a nursing facility to the community.9/30/18 MHC continued to perform internal audits as recommended by HSD and documented improvement in 1) Identifying the source of a behavioral health diagnosis and plans to address potential needs; and 2) Transition of Care plans with complete demographic information, and eligibility status. **Quarter 4 DY4**

UHC

Q4 DY4		
Action Plan #2	Implementation Date	Completion Date
Provider Experience CAP	11/09/17	In progress

Description

Concerns of the increase in claims projects and reprocessing of claims, and an increase in provider service call center volume.

Status

UHC submitted an Internal Plan of Correction (ICAP) that included a self-identification that their current network training curriculum is inconsistent amongst provider facing teams. United has stated there are opportunities to align talking points to define; their UnitedHealthcare network voice, align reporting resources and tool kits to help mitigate issues proactively, align escalation channels to expedite provider claims resolution turnaround time, and align provider engagement strategies to define their United network voice.

UHC has initiated the following:

11/17/17 - Work groups are in progress

11/27/17 - Process of documenting a road map

12/13/17 - UHC Network contracting tool is completed and will be deployed to Network teams

12/15/17 - Develop oversight process and owners for Contract Data Variance Reporting.

12/15/17 - Align Network training and system access levels to facilitate research and ensure provider expectations can be managed throughout the resolution process.

12/15 17 - UHC has defined and aligned education around provider portal availability and functionality.

12/15/17 - UHC has aligned provider education forums (Expo's, Town Halls, and administrative advisory committees). Establish 2018 schedule of events

UHC Operation teams will continue to evaluate during regularly scheduled Operations Meetings.

4/4/18 - Provider Experience CAP entered steady-state in Q1 2018; two-part demonstration of Network enhancements and Claims oversight processes were shared with our Contract Managers and state partners acknowledged decreased provider escalations at the state level. Additional analysis of call center statistics shows a decrease in call volume, month-to-month in provider services queues as noted in Report 2 analysis. [Recommendation to deploy activities into steady-state model to maintain progress received on 2/21]

iCAP closed in Q1 and improvement efforts have been sustained through Medicaid contract termination on 8/31/2018.

UHC

Q4 DY4

Action Plan #3	Implementation Date	Completion Date
Encounter CAP	11/10/17	In progress

Description

UHC has initiated a self-directed ICAP to address claims issues and to be proactive in the reduction of incorrect claims denials.

Status

Some of the remediation action taken by UHC to correct these issues included the following:

11/22/17 - Built oversight dashboard

12/08/17 - PRPK logic update in process. Will eliminate manual adjudication and insure greater payment accuracy

12/30/17 - Establish weekly claim performance per provider type – weekly reporting to allow for proactive feedback to providers.

12/29/17 - Review and validate processing SOP's for accuracy to minimize review escalations. Coordinate oversight of DEFECTS and CEAP (pre-payment) audits identifying processing errors.

12/29/17 - Automate claims processing versus overturn claims payment reports to target appeals/adjustments that were overturned as a result of claims inappropriately processed or adjusted.

12/30/17 - UHC established a weekly claims performance per provider type – weekly reporting to allow for proactive feedback to providers.

UHC states they have changed to proactive monitoring, formalized reviews via standing bi-monthly meeting with the health plan operations team for CPEWS (Care Provider Early Warning System) and CEAP (pre-payment) audits on the various provider types for the high volume denial codes.

UHC Operations leadership Team informed HSD they will continue to monitor these items through

their regularly scheduled Operations meeting and reports will be reviewed in bi-weekly Claims / Ops meetings.

3/16/18 - Added standing agenda item to bi-weekly systems call to manage state and UHC technical updates required to deploy a claim edit

4/2/18 - Strategy finalized. Combination of upfront claims denials, provider education and claims resubmission to insure minimal provider abrasion

4/6/2018 - Conducted Project to correctly identify denied claims versus zero paid claims and project was deployed on 4/6/18

4/8/18 - Built oversight dashboard and demonstrated to HSD on 4/8/18

4/30/18 - Evaluating opportunities for further provider education.

UHC Operations leadership Team informed HSD they will continue to monitor these items through their regularly scheduled Operations meeting and reports will be reviewed in bi-weekly Claims/Ops meetings.

6/8/18 IT work continues, deployment date of 6/30 delayed to 7/28 to allow for additional provider education, mitigating provider abrasion. Additional requirements provided 6/8: Added to work and aiming to deliver with original requirements 7/28.

ICAP closure submitted to HSD on 8/7/2018. UHC deployed claims edits and completed all tasks outlined in plan. Phase 2 of the Cures Act was scheduled for deployment on 9/1.

However, this was rescinded due to acquisition of UHC Medicaid membership by Presbyterian Health Plan. Phase 2 Cures Act-related edits were only applicable to claims with DOS after 9/1. UHC had no active membership to receive DOS.

Quarter 1 DY5

BCBS		
Q1 DY5		
Action Plan #3	Implementation Date	Completion Date
Americans with Disabilities	01/01/2018	In progress

Act (ADA) and Cultural Compentency Indicators in Online Provider Finder and Printed Directory

Description
The BCBS online provider directory and provider finder does not currently include certain ADA indicators and does not indicate if a provider has completed provider cultural competence training.

Status

03/31/2018 – The ADA indicators are targeted to be incorporated into the online provider finder and hard copy provider directory effective 06/01/2018. An Enterprise-wide initiative is currently being worked through to include provider training detail related to cultural competency and the current deployment target date is 09/29/2018.

06/29/2018 – The ADA/Physical Disability Accommodations have been fully implemented and are included in BCBS's online and printed Provider Directories. ADA indicators were loaded into provider records and will continue to be captured by BCBS as providers submit this information. BCBS will ensure that this information is up to date and accurate for members. As part of BCBS's Enterprise-wide initiative, Provider Services is reviewing previous provider training related to cultural competency to make adjustments as necessary and is still on target for 09/29/2018.

09/30/2018 –The ADA indicators have been loaded into BCBS's provider records. This project will be an ongoing effort to ensure BCBS has the most accurate and up to date information from providers. BCBS's Network Services is finalizing the Cultural Competency training deck that will be available to providers in the fourth quarter of 2018. Provider indicators reflecting completion of cultural competency training will be updated on a monthly basis in the online provider finder once the provider has completed their training.

Quarter 2 DY5

PHP

Q2 DY5		
Action Plan #1	Implementation Date	Completion Date
NIA Improvement Plan	06/27/2018	In progress

Description

An issue was identifed with NIA, PHP's delegated Utilization Management (UM) vendor for radiologic services. NIA's affiliated vendor was not mailing letters in a timely manner.

Status

06/27/2018 PHP notified NIA of the required improvement plan. NIA will complete the initial plan of correction provided by PHP and return it to PHP within 10 days. NIA will identify a second method to notify members of decisions in addition to letter mailing. NIA will work with its mail vendor to mail letters timely and to provide mail dates to NIA who will document these dates in its system and monitor timeliness. NIA will identify appropriate control processes for mailing and ensure the secondary notification process is in place should the letter notification fail or be delayed. Lastly, NIA will identify a process to be able to identify the true mailing dates to ensure accuracy of reporting and to be able to assess member impacts.

09/30/2018: PHP is monitoring NIA's compliance.

Quarter 3 DY5

BCBS		
Q3 DY5		
Action Plan #1	Implementation Date	Completion Date
Retroactive Medicare and and Medicaid Explansion Population	05/09/2018	In progress

Description

When enrollment was retroactively terminated for members on the Medicaid Expansion (Category of Eligibility 100), BCBS was recouping payment of claims that were previously paid. HSD provided clarification that despite enrollment being terminated, if capitation is left in place, the claims should be left paid.

Status

09/30/2018 – BCBS has implemented interventions to override the existing system logic to ensure claims previously paid remain paid for these members. Most impacted providers have been repaid. BCBS is working with two providers on the claim submissions and adjustments.

BCBS		
Q3 DY5		
Action Plan #2	Implementation Date	Completion Date
Implementation of July 2018 Rate Increases	09/06/2018	In progress

Description

BCBS received and signed rate sheets in June 2018, which outlined rate increases for providers, by provider type with specific associated increases for an effective date of July 1, 2018. BCBS did not complete all system configurations by July 1, 2018. As a result, some Behavioral Health, Nursing Facility, Assisted Living Facility, and Adult Day Health providers did not receive correct reimbursement beginning July 1, 2018.

Status

09/30/2018 – BCBS implemented a remediation plan in September 2018 to complete the remaining system configurations and claims adjustments for impacted providers. The remaining system configurations for Behavioral Health providers were completed on August 20, 2018, on September 4, 2018 for Nursing Facility providers, and on September 12, 2018 for Assisted Living Facilities and Adult Day Health providers. Claims adjustments for Behavioral Health and Nursing Facility providers were completed on September 28, 2018 and the remaining claims adjustments for Assisted Living Facilities and Adult Day Health providers are expected to be completed by

October 10, 2018. BCBS has been working with providers impacted and communicating progress.

PHP		
Q3 DY5		
Action Plan #1	Implementation Date	Completion Date
DentaQuest Improvement Plan	03/01/2018	09/11/2018

Description

DentaQuest's Provider Services Call Center stats and requirements for 2nd Quarter 2018 through May 2018.

Status

DentaQuest was not meeting contractual requirements set forth in the Medicaid Managed Care Services Agreement. DentaQuest encountered long hold times due to their remote staff encountering technical issues that took them the first two weeks of May to resolve. The issues were with their remotes and their various network providers (ATT, Comcast) not synching well with their systems and upgrades to their MBPS to resolve the issue.

PHP reviewed DQ's Phone Summary for 3Q2018 (June 2018 through August 2018) and DQ's Addendum to Policy 400.001 and found the results had improved, and it is now in compliance. Closed.

PHP		
Q3 DY5		
Action Plan #2	Implementation Date	Completion Date
DentaQuest Improvement Plan	07/02/2018	07/18/2018

Description

PHP's IT Auditor requested DentaQuest Problem Management Module for their Service Desk Portal and was unable to obtain it.

Status

DentaQuest implemented a Problem Management Module within ServiceNow, which went into effect 7/2/18 and provided a screen shot to demonstrate compliance. DentaQuest integrated the new process and is using it within specific IT departments with no reported incidents since integration.

Q3 2018 Attachment H: Customer Service Summary (June 1 - August 31, 2018)

MCO CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			BCBS			MHC			PHP			UHC		
		CONTRACT STANDARD	**JUN**	**JUL**	**AUG**	**JUN**	**JUL**	**AUG**	**JUN**	**JUL**	**AUG**	**JUN**	**JUL**	**AUG**
Member Services	Number of Calls Received - All Queues		9,523	10,015	11,397	8,856	9,186	10,972	11,404	12,235	14,272	5,782	6,131	7,313
	Number of Calls Answered - All Queues		9,345	9,862	11,186	8,810	9,105	10,833	11,171	12,033	14,072	5,752	6,078	7,262
	Percent of Calls Abandoned	**< 5%**	1.9%	1.5%	1.9%	0.5%	0.9%	1.3%	2.0%	1.7%	1.4%	0.5%	0.9%	0.7%
	Percent of Calls Answered within 30 Seconds	**85%**	93%	94%	89%	97%	96%	91%	86%	87%	87%	94%	87%	89%
	Average Wait Time	**< 2 minutes**	0.2	0.2	0.3	0.1	0.1	0.2	0.3	0.3	0.3	0.1	0.3	0.2
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nurse Advice Line	Number of Calls Received - All Queues		501	533	536	1,132	1,103	1,080	1,836	1,881	1,961	269	248	318
	Number of Calls Answered - All Queues		500	529	535	1,125	1,099	1,071	1,802	1,848	1,929	267	248	316
	Percent of Calls Abandoned	**< 5%**	0.2%	0.8%	0.2%	0.6%	0.4%	0.8%	1.9%	1.8%	1.6%	0.7%	0.0%	0.6%
	Percent of Calls Answered within 30 Seconds	**85%**	96%	96%	96%	98%	99%	98%	96%	97%	97%	97%	99%	93%
	Average Wait Time	**< 2 minutes**	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.6	0.5	0.4
Provider Services	Number of Calls Received - All Queues		9,378	9,616	10,972	9,900	9,525	10,884	2,708	2,834	3,292	7,944	7,830	8,828
	Number of Calls Answered - All Queues		9,129	9,421	10,685	9,856	9,470	10,757	2,698	2,813	3,275	7,926	7,808	8,788
	Percent of Calls Abandoned	**< 5%**	2.7%	2.0%	2.6%	0.4%	0.6%	1.2%	0.4%	0.7%	0.5%	0.2%	0.3%	0.5%
	Percent of Calls Answered within 30 Seconds	**85%**	94%	94%	90%	99%	99%	95%	88%	92%	90%	97%	93%	92%
	Average Wait Time	**< 2 minutes**	0.2	0.1	0.3	0.1	0.1	0.1	0.3	0.2	0.2	0.2	0.1	0.1
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
UM Line	Number of Calls Received - All Queues		7,148	6,901	7,459	3,395	3,683	3,965	1,553	1,684	1,956	2,448	2,393	2,637
	Number of Calls Answered - All Queues		7,021	6,791	7,290	3,334	3,636	3,882	1,548	1,679	1,951	2,426	2,357	2,598
	Percent of Calls Abandoned	**< 5%**	1.8%	1.6%	2.3%	1.8%	1.3%	2.1%	0.3%	0.3%	0.3%	0.9%	1.5%	1.5%
	Percent of Calls Answered within 30 Seconds	**85%**	91%	93%	90%	96%	95%	95%	91%	91%	90%	94%	91%	91%
	Average Wait Time	**< 2 minutes**	0.3	0.2	0.4	0.4	0.4	0.5	0.1	0.2	0.1	0.2	0.2	0.2

Source: [MCO] Report 2, M6-M8 CY18