# Centennial Care Waiver Demonstration

## Section 1115 Quarterly Report
## Demonstration Year: 5 (1/1/2018 – 12/31/2018)
## Waiver Quarter: 2/2018

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New Mexico Human Services Department

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## Section I: Introduction

On July 12, 2013, the Centers for Medicare and Medicaid Services (CMS) approved New Mexico's Centennial Care Program 1115 Research and Demonstration Waiver. The approval of the waiver 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 656,708 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

### Eligibility

As noted in Section III of this report, there are 273,093 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment increase of 4,904 from DY5 Q1.

### Access

Throughout this report, the most current monthly and quarterly data available is through March 31, 2018. unless otherwise noted.

#### *Primary Care Provider (PCP)-to-Member Ratios*

The 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 currently.

**Table 1 – PCP-to-Member Ratios by MCO**

| | Jan | Feb | Mar |
|---|---|---|---|
| BCBS | 1:34 | 1:36 | 1:37 |
| MHC | 1:91 | 1:91 | 1:90 |
| PHP | 1:74 | 1:74 | 1:74 |
| UHC | 1:30 | 1:29 | 1:29 |

Source: [MCO] PCP Report #53, Q1CY18

### Geographic Access

#### *Physical Health and Hospitals*

The geographic access standard is defined as at least 90% of members residing within distance requirements to provider types in urban, rural, or frontier geographic areas. See Attachment B: GeoAccess Physical Health Summary for MCO performance in meeting access to specific provider types.

All four MCOs maintained 90% or above access compliance with distance requirements to general hospitals, federally qualified health centers (FQHCs), PCPs, pharmacies and most specialties in urban, rural and frontier areas. MCOs actively seek to contract with border area providers to improve overall access for members and to address the shortage of specialty providers throughout New Mexico. In the previous quarter, all MCOs remained below the access standard for neurosurgeons in rural and frontier areas. All MCOs remained below the access standard for rheumatologists in frontier areas, and two MCOs did not meet the access standard in rural areas. Three of four MCOs were below the access standard for urologists in rural areas. Access to dermatologists, endocrinologists and neurologists in frontier areas were reported below 90% by three MCOs. BCBS and MHC did not meet access standards for dermatologists, which is consistent with previous quarters.

HSD remains focused on outliers where all but one MCO met distance standards for specific provider types in geographic areas. Access issues may be remedied by transportation to the nearest provider and telemedicine services which have generally been increasing because of

delivery system improvements. At least one MCO specifically targets access to dermatologists through recruitment and retention efforts and another MCO specifically targets access to neurology services through telemedicine initiatives. Single case agreements are also permitted for providers who may not want to contract, including in-state providers, whenever possible; border area providers, providers within 100 miles of New Mexico's borders that are considered "in-state" for reimbursement purposes; and, out-of-state providers as necessary to ensure members receive medically necessary covered services which may not be available in-state. PHP is close to meeting the 90% access standard in rural areas for neurology (85.3%).

Of note this quarter, UHC successfully gained access standards in frontier areas for dermatology for the first time in more than 12 quarters. Two MCOs report significant changes in rheumatology in rural areas. BCBS reports a decrease of 8.5%. PHP reports a decrease which falls slightly below the access standard (89.1%). Conversely, one MCO reports significant increases in two geographical areas for neurosurgeon services. PHP reports an increase in member access of 13.5% in rural areas and 12.8% in frontier areas.

HSD found many positive outliers for which one MCO was able to exceed the standard while all other MCOs remain below the access standard. For this quarter, each MCO achieved a positive outlier status. UHC is a positive outlier as the only MCO to meet access standards in frontier areas for dermatology (91.6%) with an increase of 5.9%. BCBS, with slight improvements over last quarter, was the only MCO to exceed access standards in frontier areas for neurology (92.4%). MHC was the only MCO to meet access standards in frontier areas for endocrinology with slight improvements (91%). PHP is a positive outlier in that it meets the 90% standard for distance requirements to urologists in rural areas.

***Behavioral Health***

In DY5 Q2, 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.

However, 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 Health 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 to areas not meeting access standards through increased opportunities to expand use of telemedicine and Project ECHO. 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). Five new BH providers launched CareLink New Mexico (CLNM) Health Home services on April 1st and a sixth will implement services July 1st, bringing the total number of implementations to eight. By the end of 2019, the new Health Homes are expected to serve nearly 10,000 Medicaid beneficiaries with serious mental illness for adults (SMI) and severe emotional disturbance (SED) for children and adolescents.

MCOs individually work to maintain access with the current network while continually striving to build accessibility through efforts to provide innovative service delivery to their members and by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available 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.

***Community Health Workers***

Centennial Care MCOs reported a 23% increase in members served by CHWs for DY5 Q1. For this period, a total of 98 CHWs, are employed or contracted. CHWs work in a variety of settings such as clinics, emergency rooms, paramedic units, and community food banks, with titles that include Peer Support Specialists, Member Navigators and Community Health Representatives. CHW certification is available through the NM Department of Health. Please see Table 2 – Summary of CHW Workforce by MCO.

**Table 2 – Summary of CHW Workforce by MCO**

| **DY5 Q2** | | | |
|---|---|---|---|
| **Community Health Workers** | | | |
| | **Employed** | **Contracted** | **Total** |
| **BCBS** | 27 | 15 | 42 |
| **MHC** | 20 | 0 | 20 |
| **PHP** | 8 | 12 | 20 |
| **UHC** | 11 | 5 | 16 |
| **Totals** | **66** | **32** | **98** |

Source: [MCO] CHW DSIPT, Q1CY18

CHW interventions include assistance with primary care physician (PCP) appointments, appropriate use of emergency room for physical and behavioral health care, contact with over utilizers and/or those who utilize the ER for non-emergent reasons, timely pre-natal and post-partum care, completion of health risk assessments (HRAs), social determinants of health screening with linkages to commonly needed food assistance, utility assistance, housing, transportation, and health education. Examples of CHWs supports include keeping an appointment calendar, appointment reminders, how to create a list of questions or needs for members to share with their PCPs, creating a family budget, on-going health literacy support and translation services.

A CHW team has begun a food bank pilot called the Health Food Center to assist members to access healthy food and attend on-site healthy cooking classes. The pilot includes the availability of a dietician to members. CHWs are being integrated into an addiction recovery-specific workforce in a clinical behavioral health setting, with a pilot called The Healthy Way. The CHWs in this pilot are Peer Support Specialists who will support members with mental health conditions and addiction recovery needs. MCOs also report that CHWs play an important role for members transitioning from incarceration back to the community by providing linkages to community services such as transportation, food assistance, employment and legal services.

The focused areas for the CHW initiative outreach to Medicaid members is the underserved urban, rural, and frontier areas of New Mexico. Please see Table 3 – Unduplicated Members Served by CHWs.

**Table 3 - Unduplicated Members Served by CHWs**

| DY5 Q2<br>Unduplicated Members Served | | | | | |
|---|---|---|---|---|---|
| | **BCBS** | **MHC** | **PHP** | **UHC** | **Region Totals** |
| **Underserved Urban** | 5286 | 1045 | 1550 | 714 | 8595 |
| **Rural** | 1107 | 773 | 703 | 664 | 3247 |
| **Frontier** | 480 | 120 | 195 | 95 | 890 |
| **MCO Totals** | **6873** | **1938** | **2448** | **1473** | **12732** |

Source: [MCO] CHW DSIPT, Q1CY18

Educational outreach in Q1 included:

- Diabetes & Managing Weight
- Medical Benefits & Services- Educational Events
- Cooking for Health
- Cooking for Health- Kids
- HealthPlex Fitness Classes
- Let’s Cook

***Telemedicine***

In DY5 Q2, telemedicine utilization data for Q1 was reviewed. Consistent with previous reporting periods, the data indicates that most telemedicine services provided in New Mexico are for behavioral health diagnoses (Please see Table 4 – Telemedicine Services). Overall there is in an increase in telemedicine utilization among all MCOs from the previous reporting period. BCBS and UHC both had a slight decrease in urban utilization from the previous quarter but both MCOs report increases in rural and frontier utilization. PHP had a decrease in rural utilization from DY4Q4 to DY5Q1, however PHP reported an increase in urban and frontier utilization. MHC reported increased utilization among urban, rural and frontier. BCBS reported the use of telemedicine for dermatology and optometry (eye exams) visits and indicated that they would like to see an increase in eye exams being done through telemedicine especially for diabetic screening. MHC remains dedicated to educating providers on beginning a telemedicine program and resolving claims issues brought forward by telemedicine providers. Additionally, MHC works closely with their care coordinator staff to inform them of providers who utilize telemedicine so that they can also inform members. PHP's telemedicine interventions include provider education regarding accurate coding of telemedicine services. PHP offers technical assistance to providers who are interested in delivering services via telemedicine. UHC informs members of the options available for telemedicine through originating sites and virtual visit technology. UHC marketing activities include educating members and training providers on the benefits of telehealth.

**Table 4 - Telemedicine Services**

| DY5 Q1 | | | |
|---|---|---|---|
| Behavioral Health | | | |
| | Urban | Rural | Frontier |
| **BCBS** | 287 | 506 | 135 |
| **MHC** | 596 | 1,120 | 234 |
| **PHP** | 1,338 | 1,587 | 801 |
| **UHC** | 219 | 619 | 107 |
| **TOTAL** | 2,440 | **3,832** | **1,277** |

Source: [MCO] Telemedicine DSIPT, Q1CY18

*Urban numbers are for data collection only and do not count towards DSIPT goal.

***Transportation***

In DY5 Q2, HSD monitored 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. MCOs monitor transportation grievances as part of their subcontractor oversight activities. MCOs work with transportation subcontractors to address

issues resulting in grievances. For additional detail regarding transportation grievances, please see Section XII: Consumer Issues – Complaints and Grievances.

**Provider Network**

New Mexico's documented provider shortage in several specialty areas remain consistent with previous quarters. However, during the reporting period, PHP expanded system-wide provider capacity for difficult to recruit and retain clinical professionals, particularly in rural areas. This effort specifically focuses on traditionally difficult to recruit and retain provider specialists, who are currently out-of-state, and will be *new* as New Mexico providers. For an expanded description of this initiative, please refer to Section VI: PHP Initiatives.

**Service Delivery**

***Utilization Data***

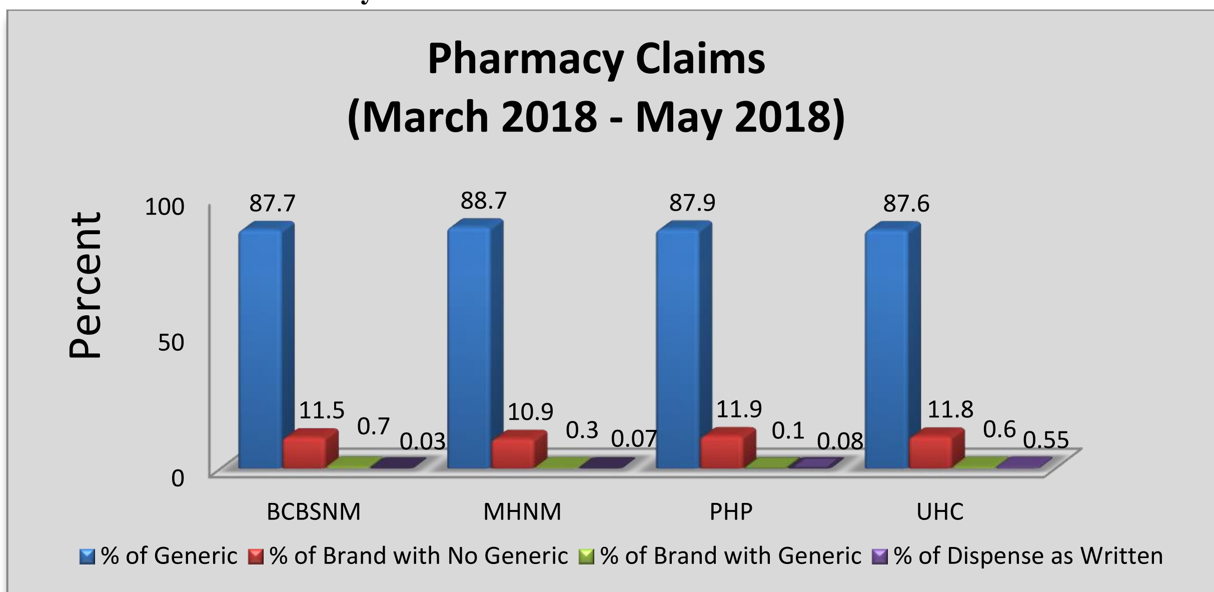
Centennial Care key utilization and cost per unit data by programs m is provided for April 2016 through March 2018. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

***Pharmacy***

HSD reviews and monitors key metrics in monthly MCO pharmacy reports regarding prescription claims on brand and generic drugs (Please see Table 5 – 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:

- Of the MCOs, BCBS and MHC had a slight decrease of 0.2% in generic drug utilization while the other two, PHP and UHC, had a slight increase in generic drug utilization from the previous quarter.
- BCBS and MHC, had a slight increase in usage of brand drugs with no generic available, while PHP and UHC had a slight decrease since the last reporting period in the usage of brand drugs with no generic available.
- The overall usage of brand medication when there was no generic available averaged at 11.5% for the current reporting period with no change from the previous reporting.
- All MCOs require medical justification for the use of a brand drug when there is a generic available. Dispense as Written (DAW) claims averaged at 0.18% with UHC having the highest number of DAW claims paid at 0.55%.

**Table 5 – Percent of Pharmacy Claims for Each MCO**




Source: [MCO] Pharmacy Report #44, M3CY18, M4CY18, M5CY18

***Hepatitis C (HCV)***

During DY5 Q2, HSD reviewed MCO Q1CY5 data submitted on the revised HCV delivery system improvement performance target (DSIPT) reporting template. As reported in Q1, the revised reporting cycle transitioned from a monthly report to a quarterly report and captures both qualitative and quantitative data related to the requirements set forth in a Letter of Direction (LOD) issued in DY4 Q4. HSD is monitoring the number of unduplicated number of members requesting HCV treatment for DY5 Q1 as well as similar numbers for direct antiviral agent prescription approvals and dispensing by both members' liver fibrosis stages and HCV genotypes.

In DY5 Q1, BCBS partnered with Tricore labs to identify members receiving confirmatory testing for HCV and provided this list of members to their care coordination team for outreach. BCBS is also running internal lab data to identify members with confirmatory HCV labs. Also, BCBS established a relationship with the Department of Health to discuss data sharing, which will assist in additional case findings. To implement care coordination services and HCV linkage to care when incarcerated members are released, BCBS began discussions with the NM Department of Corrections. BCBS has annual reminders for providers and members about HCV screening and the importance of HCV treatment.

PHP developed a comprehensive plan to expand HCV screening efforts that includes:

- Utilization of demographic/geographic mapping to identify underserved HCV dense areas;
- Health fairs scheduled for 2018 and 2019 to include onsite rapid HCV testing;
- Training seminar to educate CHWs and care coordinators on current screening guidelines;

- Development of screening questions for care coordinators as they interview incarcerated patients nearing release from New Mexico prisons; and,
- Electronic medical record notifications alert providers and identify high risk age group populations to provide recommend testing procedures.

An HCV screening training packet has been created and will be distributed to PHP contracted providers. PHP has also established a provider incentive program, which is anticipated to be implemented in Q2 or Q3. The MCO will pay an incentive for providers who receive HCV training through UNM Project ECHO, initiate treatment for HCV positive members, or complete treatments for HCV positive members.

***Nursing Facilities (NFs)***

In DY5 Q2, HSD continued to monitor the MCOs' efforts to address nursing facility (NF) claims issues. HSD also continued to work with Myers and Stauffer on the claims payment audit for NFs.

***Community Interveners***

In DY5 Q1, three Centennial Care members received Community Intervener (CI) services as illustrated below. The MCOs provided 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 Q1.

**Table 6 – Community Intervener Services Utilization DY5 Q1**

| MCO | # of Members Receiving CI | Total # of CI Hours Provided | Claims Billed Amount |
|---|---|---|---|
| BCBS | 1 | 4 | $25 |
| MHC | 0 | 0 | $0 |
| PHP | 1 | 49 | $1,231 |
| UHC | 1 | 172 | $1,075 |
| **Total** | **3** | **225** | **$2,331** |

Source: [MCO] Utilization Management Report #41, Q1CY18

***Centennial Rewards Program***

All Centennial Care members are eligible for Centennial Rewards and to date, 683,228 distinct members, or 69% 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. Points expire at the end of the year after the year in which they were earned. Table 7 shows the healthy behaviors rewarded and each behavior's value. It includes the maximum dollar value available for each activity, the total dollars earned.

**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 | $ 39,495 |
| Bipolar Disorder Management | 600 | $60 | $ 69,275 |
| Bone Density Testing | 350 | $35 | $ 3,675 |
| Healthy Smiles Adults | 250 | $25 | $ 605,475 |
| Healthy Smiles Children | 350 | $35 | $ 1,590,925 |
| Diabetes Management | 600 | $60 | $ 343,500 |
| Healthy Pregnancy | 1000 | $100 | $ 99,300 |
| Schizophrenia Management | 600 | $60 | $ 39,865 |
| Health Risk Assessment (HRA) | 100 | $10 | $ 380 |
| Other (Appeals and Adjustments) | N/A | N/A | $ 26,830 |
| Step-Up Challenge | 250 | $25 | $ 52,275 |
| **Totals** | **N/A** | **N/A** | **$ 2,870,995** |

## 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. Most of Centennial Care members are enrolled in TANF and Related with Group VIII being the next largest group as reflected in Table 8 – Enrollment DY5 Q2 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 Q2**

| Demonstration Population | Total Number Demonstration Participants DY5 Q2 Ending June 2018 | Current Enrollees (Rolling 12-month Period) |
|---|---|---|
| **Population 1 – TANF and Related** | **370,175** | **471,999** |
| FFS | 43,113 | 66,569 |
| Molina | 115,566 | 149,875 |
| Presbyterian | 119,086 | 145,707 |
| UnitedHealthcare | 27,868 | 33,878 |
| Blue Cross Blue Shield | 64,542 | 75,970 |
| **Population 2 – SSI and Related – Medicaid Only** | **38,724** | **44,527** |
| FFS | 2,526 | 4,152 |
| Molina | 11,659 | 13,523 |
| Presbyterian | 12,556 | 13,644 |
| UnitedHealthcare | 5,139 | 5,856 |
| Blue Cross Blue Shield | 6,844 | 7,352 |
| **Population 3 – SSI and Related – Dual** | **36,075** | **39,510** |
| FFS | 0 | 274 |
| Molina | 7,108 | 7,863 |
| Presbyterian | 6,985 | 7,540 |
| UnitedHealthcare | 15,057 | 16,431 |
| Blue Cross Blue Shield | 6,925 | 7,402 |
| **Population 4 – 217-like Group – Medicaid Only** | **374** | **528** |
| FFS | 106 | 227 |
| Molina | 54 | 57 |
| Presbyterian | 56 | 75 |
| UnitedHealthcare | 100 | 104 |
| Blue Cross Blue Shield | 58 | 65 |
| **Population 5 – 217-like Group - Dual** | **3,895** | **3,777** |
| FFS | 0 | 33 |
| Molina | 805 | 835 |
| Presbyterian | 731 | 714 |
| UnitedHealthcare | 1,484 | 1,402 |
| Blue Cross Blue Shield | 875 | 793 |
| **Population 6 – VIII Group (expansion)** | **273,093** | **286,598** |
| FFS | 29,379 | 38,840 |
| Molina | 72,324 | 75,036 |
| Presbyterian | 69,832 | 67,343 |
| UnitedHealthcare | 38,168 | 41,226 |
| Blue Cross Blue Shield | 63,390 | 64,153 |

**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 disenrollments are attributed to loss of eligibility and death. Please see Table 9 – Disenrollment Counts DY5 Q2.

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 Q2**

| Disenrollments | Total Disenrollments During DY5 Q2 |
|---|---|
| **Row Labels** | |
| **Population 1 – TANF and Related** | **7,787** |
| FFS | 921 |
| Molina | 2,384 |
| Presbyterian | 2,146 |
| UnitedHealthcare | 773 |
| Blue Cross Blue Shield | 1,563 |
| **Population 2 – SSI and Related – Medicaid Only** | **352** |
| FFS | 29 |
| Molina | 103 |
| Presbyterian | 96 |
| UnitedHealthcare | 54 |
| Blue Cross Blue Shield | 70 |
| **Population 3 – SSI and Related – Dual** | **562** |
| Molina | 123 |
| Presbyterian | 123 |
| UnitedHealthcare | 191 |
| Blue Cross Blue Shield | 125 |
| **Population 4 – 217-like Group – Medicaid Only** | **4** |
| FFS | 1 |
| Molina | 2 |
| Presbyterian | 1 |
| UnitedHealthcare | 0 |
| Blue Cross Blue Shield | 0 |
| **Population 5 – 217-like Group - Dual** | **67** |
| Molina | 10 |
| Presbyterian | 21 |
| UnitedHealthcare | 22 |
| Blue Cross Blue Shield | 14 |
| **Population 6 – VIII Group (expansion)** | **9,254** |
| FFS | 1,147 |
| Molina | 2,430 |
| Presbyterian | 2,303 |
| UnitedHealthcare | 1,259 |
| Blue Cross Blue Shield | 2,115 |
| **TOTAL** | **18,026** |

## Section IV: Outreach

In DY5 Q2, HSD Outreach and Education staff participated in a variety of outreach activities and events:

- Centennial Care overview to the NM Aging & Long-Term Services Department, Adult Protective Services Division call-center.
- Participated in the annual Mental Health Awareness Day and Community Health Fair. More than 1,000 community members attended, and many were provided with information regarding behavioral health services, long-term care services, and the Centennial Care Rewards program.
- Participated in the Gallup, NM Woman's Health Fair and provided Medicaid program information and answered a variety of Medicaid related questions.

All four MCOs participated in a wide variety of community events across the state providing enrollment opportunities and educating the public about Centennial Care. MCOs attended numerous Medicaid enrollment events, health fairs and community events. Attendees included people with disabilities, senior citizens, children and families, Native Americans, and other populations. Please see Table 10 – Schedule of Community Events DY5 Q2.

**Table 10 - Schedule of Community Events DY5 Q2**

| Event Type | Event Location and Date | Audience and Topics |
|---|---|---|
| NM Aging & Long-Term Services Dept. – Adult Protective Services | Albuquerque, NM<br>Tuesday 4/4/18 | NM Adult Protective Services requested a Centennial Care overview presentation for their new employees during their annual state-wide APS training for the call center staff. |
| 2018 Mental Health Awareness Day | Albuquerque, NM<br>Downtown Civic Plaza<br>Tuesday May 22, 2018 | Sponsored by the City of Albuquerque and Bernalillo County. HSD provided Medicaid program information and answered a variety of Medicaid related questions. |
| Women's Health Fair | Gallup, NM<br>Saturday 6/9/18 | NM Rep. Lundstrom requested HSD Outreach and Applicant enrollment assistance at the Gallup Women's Health Fair. HSD provided Medicaid program information and answered a variety of Medicaid related questions. |

### Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's outreach efforts. With over 505 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).

In DY5 Q2, HSD PE Program staff conducted PED refresher trainings on "Non-Citizen/Immigrant Eligibility". The trainings ensure that all PEDs have the most up to date information regarding the NM PE Program. All PEDs were required to complete a training session in DY5 Q2 to retain their PE certifications. Those who did not complete the PED refresher training were suspended until a full PED certification training is completed.

PEDs continue to provide application assistance state-wide. In DY5 Q2, PEDs:

- Granted **491** PE approvals*
- Submitted applications for **4,928** individuals
- Which resulted in **4,247** ongoing Medicaid approvals

*84.73% 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 and 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 programs allows for the automated data transfer of information regarding the incarceration status of individuals 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.

JUST Health PEDs also participated in the "Non-Citizen/Immigrant" training that was developed in this reporting period.

## 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 monthly 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 monthly 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 monthly 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

HSD began revision of the Managed Care Policy Manual that will be effective January 1, 2019. This revision will add a new section to the policy manual to cover pharmacy. The addition will include direction and expectations on the implementation of the MCO's pharmacy benefit. Items covered in the pharmacy section include Preferred Drug List and Formulary Requirements; Treatment Guidance for Chronic Hepatitis C Virus (HCV) Infection, Community Pharmacy Reimbursement, MCO Participation in the Drug Utilization Review (DUR) Board and Submission of a DUR Annual Report, MCO requirements regarding the Drug Rebate Analysis and Management System (DRAMS) and drug rebate dispute resolution, and MCO Compliance with the Pharmacy Benefit Manager Regulation Act.

### 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*

As an additional component to the BCBS Community Paramedicine Program, BCBS has partnered with American Medical Response (AMR) to pilot the use of remote monitoring tools within the existing BCBS Community Paramedicine program.

Throughout this pilot, AMR has utilized a remote monitoring platform called Life365. Each member is provided with a Samsung Galaxy Tablet, which is pre-loaded with Life365 software. Using a Bluetooth connection, data is gathered through the member's assigned medical devices such as blood pressure cuffs, scales, pulse oximeters and blood glucose monitors. When vitals, blood pressure, weight, oxygen saturation and blood glucose readings are taken from these prescribed devices, the tablet will automatically receive the reading and then send to the community paramedic (CP).

This functionality allows for the CP to remotely monitor daily vitals including those that have not taken their vitals. The CP can log in anytime to view this information and reach out to members who may not be checking their vitals and provide a gentle reminder of the importance of regularly completing these vital checks.

#### *Molina Healthcare*

Molina carried out a wide range of innovative activities to identify, treat, and provide services to members with chronic Hepatitis C virus (HCV) infection: During this quarter Molina:

- Formalized a partnership with the Chronic Liver Disease Foundation to provide screening, laboratory testing, and treatment services to members at two Behavioral Health treatment facilities in Albuquerque and Santa Fe;
- Collaborated with the NM Department of Health for the secure exchange of member level information to increase the percentage of HCV Members receiving treatment;
- Collaborated with the NM Department of Corrections to establish HCV treatment options for members after discharge to ensure continuity of care;
- Linked HCV members with Community Health Workers, who provided information and resources for housing and transportation; and
- Expanded the number of practitioners treating chronic HCV with the execution of six provider incentive contracts.

***Presbyterian Health Plan***
New in DY5 Q2 is PHP's delivery system improvement plan to expand provider network capacity by attracting providers to relocate to New Mexico. Specific providers selected for recruitment are those who have been historically been difficult to recruit and retain. 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.

Other new innovations include the design and implementation of Small Group PCMHs (Patient Centered Medical Homes). PHP is developing a small group of PCMHs for providers with membership of a minimum of 1,000 members or less. The Standard PCMH is for 2,000 members or more. PHP is also developing an offering of Native American Health and Wellness Services for I/T/Us, IHS 638 Tribal facilities and providers. This offering will include services such as traditional herbal remedies, sweat lodge groups, and drumming circles.

Previously reported was the PHP and Isleta Presbyterian Medical Group (PMG) Clinic collaboration to develop a community health worker (CHW) pilot with the Pediatric, Internal Medicine and Family Practice clinics. This pilot is proving successful in connecting with PHP Centennial Care members who are seen at the PMG Isleta clinic. The CHW can connect with multiple family members at once to see how PHP can best meet the social determinants of health needs of the family. In the month of May, the CHW touched 176 individuals representing 79 different homes by meeting with them during their visits to the clinic. The CHW connected

members with food and housing resources as well as assisted with translation services and completing forms for community services. The staff at the clinic acknowledges the valuable resources the CHW brings to the team. PHP is training other CHWs to provide back up for this valuable resource.

Other notable updates from previously reported initiatives and innovations are as follows:

- PHP's partnership with CYFD and All Faiths to deliver WRAP around services for the targeted population has resulted in decreased lengths of stay for those members seeking out of home care through the involvement of the WRAP team.

- PHP's Helping to Engage and Link to Providers (HELP) team's engagement techniques for members who have been difficult to reach or engage in care coordination has resulted in a 30% decrease of members that PHP was previously unable to engage from November 2017 to June 2018.

The most recent Town Hall Efforts, which occur quarterly and where PHP's Provider Network Management meet with providers throughout the state for a variety of trainings and discussion, continues with an addition of webinar availability. The most recent webinar was June 19 with 35 participants and June 21 with 33 participants. The quarter three Town Hall is scheduled for the northern region of New Mexico.

***UnitedHealthcare***

UHC executed Value Based Contracts with several Behavioral Health providers. UHC is engaged with the NM Hospital Association's new VBC Task Force. Teams from UHC including contracting, health services, quality, and others are partnering with this Task Force, which in turn is working with the state's hospitals to develop competencies to shift toward VBC.

UHC assisted 2,316 members at statewide Member Days, Resource Center in Shiprock, and at Storefronts in Gallup and Las Cruces. The prevalent touchpoints and inquiries involved completion of HRAs, assistance with scheduling transportation, mileage reimbursement requests, and fulfillment of Value Added Benefits. In Q2, UHC also launched its Haircuts for the Homeless project, providing over 540 haircuts across Bernalillo County at community shelters which include the Albuquerque Indian Center, HopeWorks, and Albuquerque Hope & Recovery.

**Fiscal Issues**

During DY5 Q2, reconciliation payments and recoupments were made for IHS, retroactive eligibility, hepatitis C, patient liability and risk corridor for calendar years (CY) 2016 and 2017. The net effect of the patient liability reconciliations for CY 2016 is an increase in expenditures and affects the per member per month (PMPM) for Medicaid eligibility group (MEG) 2 of DY 3. For MEG 6, retroactive and risk corridor reconciliations result in a net decrease to the expenditure affecting PMPM for DY 3 and retroactive and hepatitis C reconciliations affect the PMPM for DY 4.

**Systems Issues**
HSD continues to implement reporting for analysis, monitoring and oversight which include encounter accuracy reports, a lag report for comparisons of financials (claims) to encounters, and MCO payment reconciliations reports. 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 Q2. The replacement MMIS will be a true Enterprise system. 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 Governmental Service Agreement (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.

The first module of the State's Framework for MMIS Replacement, the System Integrator, is in process. The contract has been finalized and the contractor has begun work on the project.

The RFP for the second module, the Enterprise Data Services RFP, was released on April 17, 2017. HSD is currently in an active procurement process. Contract negotiations have been completed for Data Services and the contract is in the final stage for signature.

CMS has approved the RFP for the third module, Quality Assurance. The Quality Assurance RFP was released on March 16, 2018 and proposals came in on May 16, 2018. HSD is currently in an active procurement process to select a vendor.

HSD has begun development of the RFP for the fourth module, Benefit Management Services. This RFP involved meetings with all stakeholders, questionnaires for input, review of other states' procurements and contracts, as well as information from the current fiscal agent contract for requirements gathering. CMS has approved this RFP.

Work continues with the development of the RFP for the fifth module, Financial Services. Some work with stakeholders, questionnaires, and requirements gathering from other states has been initiated. Further work will be done as areas are identified that require additional input from stakeholders.

The module previously referenced as Population Health has been renamed Outcomes Based Management. The components that were part of the Population Health module have been transitioned to the Outcomes Based Management module to better align with the other modules.

Deloitte is currently working on the changes to implement the provisions for Real Time Eligibility (RTE) in the E&E system. These changes were previously approved by CMS.

An Implementation Advanced Planning Document Update (IAPD-U) was submitted to CMS on June 5, 2018.

## 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 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.

The ADRC coordinators provide phone counseling in care coordination, which is the process for assisting the client in describing his/her issue. ADRC staff offer options, coordinate New Mexico's aging and disability service systems, provide objective information and assistance, and empower people to make informed decisions.

ALTSD provides quarterly reports to HSD including the ADRC Caller Profile Report and Care Transitions Program Data. Please see Table 11 – ADRC Call Profiler Report DY5 Q2 and Table 12 – ADRC Care Transition Program Report DY5 Q2 below.

**Table 11 – ADRC Call Profiler Report DY5 Q2**

| Topic | # of Calls |
|---|---|
| Home/Community Based Care Waiver Programs | 2,825 |
| Long Term Care/Case Management | 7 |
| Medicaid Appeals/Complaints | 22 |
| Personal Care | 408 |
| State Medicaid Managed Care Enrollment Programs | 6 |
| Medicaid Information/Counseling | 1,580 |

**Table 12 – ADRC Care Transition Program Report DY5 Q2**

| Counseling Services | # of hrs | # of Nursing Home Residents | # of Contacts |
|---|---|---|---|
| Transition Advocacy Support Services | | 257 | |
| Medicaid Education/Outreach | 2,888 | | |
| Nursing Home Intakes | | 167 | |
| **LTSS Short-Term Assistance | | | 242 |

*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 lead member of the NMICSS, the ALTSD Care Transition Bureau (CTB) provides assistance to Medicaid beneficiaries enrolled in Centennial Care and receiving long-term services and supports (institutional, residential and community based) in navigating and accessing covered healthcare services and supports. CTB staff serve 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 the system. CTB staff also monitor to ensure that identified services are provided by the MCO, MCO subcontractors and other community provider agencies. The main purpose of the CTB 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 preferences, values and individual circumstances.

CTB reported an increase in Short Term Assistance (STA) referrals due to Centennial Care MCOs providing referrals for individuals transitioning from Medicaid to Medicare due to age or disability.

CTB managers participated in Presbyterian Health Care MCOs annual training. CTB staff trained care coordinators and other participants on Short Term Assistance, the ADRC and Care Transition Services. Approximately 300 Presbyterian employees were in attendance. CTB staff provided training to approximately 200 Blue Cross Blue Shield MCO staff to learn about the ADRC and CTB services and programs.

**Critical Incidents**

HSD continues to meet quarterly with the MCOs' Critical Incident workgroup to provide technical assistance. The workgroup also supports the Behavioral Health Services Division (BHSD) 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 Q2, a total of 5,823 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.

During DY5 Q2, a total of 431 deaths were reported. Of those deaths reported, 396 were reported as natural or expected deaths while 28 deaths were reported as unexpected and seven 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 Q2, a total of 3,797 critical incidents were categorized as Emergency Services. Of those, 262 were reported by BH providers and 288 were associated with self-directed members. This demonstrates an upward trend in the number of incidents categorized as Emergency Services when compared to DY5 Q1 (3,685), DY4 Q4 (2,690), DY4 Q3 (2,692), DY4 Q2 (2,910) and DY4 Q1 (3,172). 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 13 – Critical Incident Types by MCO – Centennial Care below.

**Table 13 – Critical Incident Types by MCO – Centennial Care**

| Critical Incident Types by MCO - Centennial Care | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Critical Incident Types | BCBS | | Molina | | Presbyterian | | UHC | | Total | |
| | # | % | # | % | # | % | # | % | # | % |
| Abuse | 51 | 1.04% | 119 | 2.42% | 88 | 1.79% | 77 | 1.56% | 335 | 6.81% |
| Death | 95 | 1.93% | 91 | 1.85% | 83 | 1.69% | 126 | 2.56% | 395 | 8.03% |
| Natural/Expected | 88 | | 85 | | 74 | | 120 | | 367 | |
| Unexpected | 6 | | 3 | | 9 | | 6 | | 24 | |
| Suicide | 1 | | 3 | | 0 | | 0 | | 4 | |
| Elopement/Missing | 4 | 0.08% | 7 | 0.14% | 11 | 0.22% | 4 | 0.08% | 26 | 0.53% |
| Emergency Services | 502 | 10.20% | 806 | 16.38% | 1,141 | 23.19% | 798 | 16.22% | 3,247 | 65.98% |
| Environmental Hazard | 3 | 0.06% | 8 | 0.16% | 16 | 0.33% | 29 | 0.59% | 56 | 1.14% |
| Exploitation | 12 | 0.24% | 23 | 0.47% | 18 | 0.37% | 52 | 1.06% | 105 | 2.13% |
| Law Enforcement | 11 | 0.22% | 29 | 0.59% | 15 | 0.30% | 18 | 0.37% | 73 | 1.48% |
| Neglect | 116 | 2.36% | 115 | 2.34% | 272 | 5.53% | 181 | 3.68% | 684 | 13.90% |
| **Total** | **794** | **16.13%** | **1198** | **24.34%** | **1,644** | **33.41%** | **1,285** | **26.11%** | **4,921** | **100.00%** |

| Critical Incident Types by MCO - Behavioral Health | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Critical Incident Types | BCBS | | Molina | | Presbyterian | | UHC | | Total | |
| | # | % | # | % | # | % | # | % | # | % |
| Abuse | 5 | 0.95% | 78 | 14.74% | 36 | 6.81% | 7 | 1.32% | 126 | 23.82% |
| Death | 2 | 0.38% | 9 | 1.70% | 2 | 0.38% | 7 | 1.32% | 20 | 3.78% |
| Natural/Expected | 2 | | 7 | | 1 | | 5 | | 15 | |
| Unexpected | 0 | | 0 | | 1 | | 2 | | 3 | |
| Suicide | 0 | | 2 | | 0 | | 0 | | 2 | |
| Elopement/Missing | 3 | 0.57% | 5 | 0.95% | 3 | 0.57% | 0 | 0.00% | 11 | 2.08% |
| Emergency Services | 13 | 2.46% | 204 | 38.56% | 34 | 6.43% | 11 | 2.08% | 262 | 49.53% |
| Environmental Hazard | 0 | 0.00% | 0 | 0.00% | 2 | 0.38% | 1 | 0.19% | 3 | 0.57% |
| Exploitation | 1 | 0.19% | 1 | 0.19% | 1 | 0.19% | 0 | 0.00% | 3 | 0.57% |
| Law Enforcement | 2 | 0.38% | 9 | 1.70% | 4 | 0.76% | 1 | 0.19% | 16 | 3.02% |
| Neglect | 10 | 1.89% | 50 | 9.45% | 18 | 3.40% | 10 | 1.89% | 88 | 16.64% |
| **Total** | **36** | **6.81%** | **356** | **67.30%** | **100** | **18.90%** | **37** | **6.99%** | **529** | **100.00%** |

| Critical Incident Types by MCO - Self Directed | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Critical Incident Types | BCBS | | Molina | | Presbyterian | | UHC | | Total | |
| | # | % | # | % | # | % | # | % | # | % |
| Abuse | 3 | 0.80% | 10 | 2.68% | 9 | 2.41% | 6 | 1.61% | 28 | 7.51% |
| Death | 5 | 1.34% | 2 | 0.54% | 4 | 1.07% | 5 | 1.34% | 16 | 4.29% |
| Natural/Expected | 4 | | 2 | | 4 | | 4 | | 14 | |
| Unexpected | 0 | | 0 | | 0 | | 1 | | 1 | |
| Suicide | 1 | | 0 | | 0 | | 0 | | 1 | |
| Elopement/Missing | 2 | 0.54% | 1 | 0.27% | 1 | 0.27% | 0 | 0.00% | 4 | 1.07% |
| Emergency Services | 29 | 7.77% | 54 | 14.48% | 165 | 44.24% | 40 | 10.72% | 288 | 77.21% |
| Environmental Hazard | 0 | 0.00% | 0 | 0.00% | 2 | 0.54% | 1 | 0.27% | 3 | 0.80% |
| Exploitation | 1 | 0.27% | 2 | 0.54% | 2 | 0.54% | 2 | 0.54% | 7 | 1.88% |
| Law Enforcement | 1 | 0.27% | 0 | 0.00% | 2 | 0.54% | 3 | 0.80% | 6 | 1.61% |
| Neglect | 4 | 1.07% | 3 | 0.80% | 11 | 2.95% | 3 | 0.80% | 21 | 5.63% |
| **Total** | **45** | **12.06%** | **72** | **19.30%** | **196** | **52.55%** | **60** | **16.09%** | **373** | **100.00%** |

**Home and Community-Based Services Reporting**
In DY5 Q2, 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 Q2, HSD continued to conduct ride-alongs with the MCO care coordinators to observe and monitor care coordination interactions and interviewing practices. For more information regarding the ride-alongs, please see Section XIII – Quality Assurance/Monitoring Activities.

**Self-Directed Community Benefit**
In DY5 Q2, 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.

**Electronic Visit Verification**
In DY5 Q2, HSD continued meetings with the MCOs and their EVV Vendor, First Data, for the planning of implementation of EVV for self-directed personal care services. The MCOs began to solicit member input thorough their regular Member Advisory Board meetings and sent information about EVV to their Support Brokers.

## Section VIII: AI/AN Reporting

**Access to Care**
Indian Health Service, tribally operated facility/programs, and Urban Indian clinics (I/T/Us) are concentrated near or on Tribal land where many Native Americans live and receive services. Approximately 51,000 Native Americans are enrolled in Centennial Care. Data from the four Centennial Care MCOs shows for physical health and behavioral health there is 98% access to care for Native Americans in rural and frontier areas. This is a 5% increase for Physical and Behavioral Health from the previous quarter.

**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 provider agreements. Some of the MCOs have contracts with Navajo Area HIS providers. Some of the MCOs consider services rendered at any non-contracted I/T/U as 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. Some MCOs have been working with Tribal CHR programs to develop a process to reimburse them for their services to the MCO members.

**Ensuring Timely Payment for All I/T/U Providers**

The MCOs met timely payment requirements 98% of the time for claims being processed and paid within 15 days of receipt and 99% of claims being processed and paid within 30 days of receipt.

**Table 14 – Native American Advisory Board (NAAB) meetings for DY5 Q2**

| MCO | Date of Board Meeting | Issues/Recommendations |
|---|---|---|
| BCBS | Gallup Community Services Center<br>Gallup, NM<br><br>April 18, 2018 | **Issue**: The question was asked if you lose your member ID card, can you get a new one?<br><br>**Response**: You can call the toll-free number for BCBS and request a new card. (BCBS staff assisted member after the meeting.)<br><br>**Issue:** What is the timeframe to call ahead for transportation?<br><br>**Response:** You need to call 72 hours in advance to arrange transportation.<br><br>**Issue:** Can this (Medicaid) insurance be used out of state?<br><br>**Response:** Only in emergency situations. For other services, you will need to call Customer Service ahead of time because it might not be covered. |
| MHC | Zuni Wellness Center<br>Zuni Pueblo, NM<br><br>June 20, 2018 | Members were informed that Molina Healthcare will continue to provide Medicaid coverage until the end of 2018 and that they were not selected to be a MCO under Centennial Care 2.0.<br><br>**Issue:** A person asked how to get a care coordinator.<br><br>**Response:** Molina explained the Health Risk Assessment (HRA) process and how a care coordinator gets assigned. |
| PHP | New Mexico Cancer Center<br>Gallup, NM<br><br>April 20, 2018 | **Issue**: A member indicated he had trouble getting transportation to an appointment and ended up walking.<br><br>**Response**: PHP made sure the member had the right number to call for future appointments. They also explained how to file a complaint if he chose to.<br><br>**Issue:** A member asked how to change their enrollment status with Medicaid if they need to.<br><br>**Response**: PHP replied they can call Conduent or go to their Patient Benefits Coordinator (PBC) at IHS. |
| UHC | Farmington Marriot Courtyard<br>Farmington, NM<br><br>June 7, 2018 | UHC informed the group that they were not selected for Centennial Care 2.0 and are appealing the decision. |

| | | |
|---|---|---|
| | | However, they are operating business as usual in the meantime.<br><br>**Issue**: Member had a comment about a transportation vendor not showing up on time and asked for the rules regarding an attendant going with the member to appointments.<br><br>**Response**: Logisticare (transportation provider) went over the guidelines for members to bring an attendant with them to appointments. |

**HSD's Native American Technical Advisory Committee (NATAC) Update**

The NATAC meeting took place on June 2018 and the following issues were discussed:

1. An update on the 1115 Waiver renewal with CMS;
2. HSD shared the Centennial Care 2.0 outreach events planned for the fall of this year;
3. An update on the federal match for services received through an I/T/U; and
4. Various data regarding Native Americans in managed care were presented.

**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 and AAIHS completed testing of transmission of referrals, discharge documents and claims submissions with the attachment code. UNMH began submitting claims with the attachment code in April.
- **Navajo Area IHS (NAIHS) and the University of NM Hospital (UNMH)**
  The NAIHS Care Coordination Agreement (CCA) is being reviewed by legal at UNMH. UNMH is working with Navajo Area to have a similar data exchange system to what was implemented with Albuquerque Area IHS. UNMH has received a list of service units within the Navajo Area.
- **Albuquerque Area IHS (AIHS) and Presbyterian Healthcare Services (PHS)**
  PHS is awaiting signatures on the CCA from AAIHS legal department for Amendment 1. The Amendment adds all PHS providers in New Mexico to the CCA. The referral process is in place as well as the discharge report back to the referring IHS provider.

## Section IX: Action Plans for Addressing Any Issues Identified

See Attachment F: MCO Action Plans

**Section X: Financial/Budget Neutrality Development/Issues**

DY5 Q2 reflects the CY 2018 rates as provided to the Centers for Medicare and Medicaid Services (CMS) on January 4, 2018. The PMPM for DY 5 is lower compared to DY 4 for MEGs 1 to 4; the PMPM for DY 5 is higher than those of DY 4 for MEGs 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 31.9% below the budget neutrality limit (Table 5.4) based on two 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 15 – Member Months DY5 Q2**

| Number of client by Population Group and MC | |
|---|---|
| | 2018 |
| | Q2 |
| **Population 1 – TANF and Related** | **1,105,849** |
| **FFS** | 125,983 |
| | |
| **MC** | |
| Molina | 347,511 |
| Presbyterian | 358,301 |
| UnitedHealthcare | 82,648 |
| Blue Cross Blue Shield | 191,406 |
| **Population 2 – SSI and Related – Medicaid Only** | **115,667** |
| **FFS** | 7,597 |
| | |
| **MC** | |
| Molina | 34,786 |
| Presbyterian | 37,428 |
| UnitedHealthcare | 15,424 |
| Blue Cross Blue Shield | 20,432 |
| **Population 3 – SSI and Related – Dual** | **105,964** |
| **MC** | |
| Molina | 20,799 |
| Presbyterian | 20,485 |
| UnitedHealthcare | 44,421 |
| Blue Cross Blue Shield | 20,259 |
| **Population 4 – 217-like Group – Medicaid Only** | **1,096** |
| **FFS** | 313 |
| | |
| **MC** | |
| Molina | 155 |
| Presbyterian | 165 |
| UnitedHealthcare | 301 |
| Blue Cross Blue Shield | 162 |
| **Population 5 – 217-like Group - Dual** | **11,267** |
| **MC** | |
| Molina | 2,348 |
| Presbyterian | 2,098 |
| UnitedHealthcare | 4,316 |
| Blue Cross Blue Shield | 2,505 |
| **Population 6 – VIII Group (expansion)** | **758,307** |
| **FFS** | 78,411 |
| | |
| **MC** | |
| Molina | 202,108 |
| Presbyterian | 193,880 |
| UnitedHealthcare | 107,031 |
| Blue Cross Blue Shield | 176,877 |

## Section XII: Consumer Issues – Complaints and Grievances

A total of 850 grievances were filed by Centennial Care members in DY5 Q2. This presents a slight decrease when compared to member grievances received in DY5 Q1 (891). An overall trend cannot be established when compared to DY4 Q4 (871), Q3 (1,184) Q2 (1,058) and Q1 (968).

Non-emergency ground transportation continues to constitute the largest member grievance code reported with 442 (52%) of the total grievances received. This presents an increase when compared to 414 in DY5 Q1. An overall upward trend is demonstrated when compared to DY4 Q4 (414), Q3 (487), Q2 (332) and 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 51 (6%) grievances. An overall downward trend is demonstrated when compared to DY5 Q1 (101), DY4 Q4 (45), Q3 (61), Q2 (84) and Q1 (109).

There were 357 (42%) variable grievances filed during DY5 Q2. 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. Please see Table 16 – MCO Grievances DY5 Q2 below.

**Table 16 – MCO Grievances DY5 Q2**

| MCO Grievances<br>DY5 Q2 (April - June 2018) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **MCO** | **BCBS** | | **MHC** | | **PHP** | | **UHC** | | **Total** | |
| Member Grievances | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | % |
| Number of Member Grievances | 247 | 29.06% | 176 | 20.71% | 178 | 20.94% | 249 | 29.29% | **850** | 100.00% |
| | | | | | | | | | | |
| Top Two Prmary Member Grievance Codes | | | | | | | | | | |
| Transportation Ground Non-Emergency | 167 | 19.65% | 40 | 4.70% | 104 | 12.24% | 131 | 15.41% | **442** | 52.00% |
| Other Specialties | 23 | 2.71% | 0 | 0.00% | 0 | 0.00% | 28 | 3.29% | **51** | 6.00% |
| | | | | | | | | | | |
| Variable Grievances | 57 | 6.70% | 136 | 16.00% | 74 | 8.71% | 90 | 10.59% | **357** | 42.00% |

## Section XIII: Quality Assurance/Monitoring Activity

### Service Plans

HSD randomly reviews service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures that the MCOs appropriately allocate and implement the services identified in the member's Comprehensive Needs Assessment (CNA), and that the member's goals are identified in the care plan. There were no identified concerns in DY5 Q2. Please see Table 17 – Service Plan Audit Results DY5 Q2 below.

**Table 17 – Service Plan Audit Results DY5 Q2**

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

### 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. Please see Table 18 – Nursing Facility LOC Audit Results DY5 Q2 below and Table 19 – Community Benefit NF LOC Audit DY5 Q2.

**Table 18 – Nursing Facility LOC Audit Results DY5 Q2**

| MCO High NF LOC denied requests (downgraded to Low NF) | DY5 Q1 | DY5 Q2 | DY5 Q3 | DY5 Q4 |
|---|---|---|---|---|
| Number of member files audited | 15 | 12 | | |
| BCBS | 5 | 4 | | |
| MHC | 0 | 0 | | |
| PHP | 5 | 5 | | |
| UHC | 5 | 3 | | |
| **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 | | |
| BCBS | 5 | 4 | | |
| MHC | 0 | 0 | | |
| PHP | 5 | 5 | | |
| UHC | 5 | 3 | | |
| Percent of MCO level of care determination accuracy | 100% | 100% | | |

**Table 19 – Community Benefit NF LOC Audit DY5 Q2**

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

HSD agreed with all NFLOC decisions for DY5 Q2; however, three of the files submitted for review were outside of the sample criteria. Of the five sample files submitted by UHC for High NF, two did not qualify as a High NF Level of Care request. Additionally, one of the five samples submitted by BCBS 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 Q2 and an additional five files for Community Benefit were reviewed. All NFLOC decisions were appropriate and complied with NFLOC criteria.

**External Quality Review Organization (EQRO) NF LOC**

The EQRO for HSD reviews a random sample of MCO NF LOC determinations every quarter. Please see Table 20 – EQRO NF LOC Review Results DY5 Q2 below.

**Table 20 – EQRO NF LOC Review Results DY5 Q2**

| Facility Based | DY5 Q1 | DY5 Q2 | DY5 Q3 | DY5 Q4 |
|---|---|---|---|---|
| **High NF Determination** | | | | |
| Number of member files audited | **23** | **22** | | |
| BCBS | 4 | 3 | | |
| MHC | 7 | 6 | | |
| PHP | 7 | 11 | | |
| UHC | 5 | 2 | | |
| Number of member files the EQRO agreed with the determination | **22** | **22** | | |
| BCBS | 3 | 3 | | |
| MHC | 7 | 6 | | |
| PHP | 7 | 11 | | |
| UHC | 5 | 2 | | |
| % | **96%** | **100%** | | |
| BCBS | 75% | 100% | | |
| MHC | 100% | 100% | | |
| PHP | 100% | 100% | | |
| UHC | 100% | 100% | | |
| **Low NF Determination** | | | | |
| Number of member files audited | **85** | **106** | | |
| BCBS | 23 | 29 | | |
| MHC | 20 | 26 | | |
| PHP | 20 | 21 | | |
| UHC | 22 | 30 | | |
| Number of member files the EQRO agreed with the determination | **85** | **101** | | |
| BCBS | 23 | 29 | | |
| MHC | 20 | 25 | | |
| PHP | 20 | 21 | | |
| UHC | 22 | 26 | | |
| % | **100%** | **95%** | | |
| BCBS | 100% | 100% | | |
| MHC | 100% | 96% | | |
| PHP | 100% | 100% | | |
| UHC | 100% | 87% | | |
| **Community Based** | | | | |
| Number of member files audited | **156** | **176** | | |
| BCBS | 39 | 44 | | |
| MHC | 39 | 44 | | |
| PHP | 39 | 44 | | |
| UHC | 39 | 44 | | |
| Number of member files the EQRO agreed with the determination | **152** | **176** | | |
| BCBS | 39 | 44 | | |
| MHC | 39 | 44 | | |
| PHP | 39 | 44 | | |
| UHC | 39 | 44 | | |
| % | **97%** | **100%** | | |
| BCBS | 100% | 100% | | |
| MHC | 100% | 100% | | |
| PHP | 90% | 100% | | |
| UHC | 100% | 100% | | |

MCO High NF determinations improved to 100% in DY5 Q2 for EQRO agreement for determinations. The Low NF determinations decreased from 100% in DY5 Q1 to 95% for EQRO

agreement in Q2. Community Based determinations improved in DY5 Q2 to 100% for EQRO agreement, an improvement from 97% in DY5 Q1. Only two of the MCOs, MHC and UHC, had denial determinations in DY5 Q2. HSD reviewed the NF LOC determination disagreements from EQRO audits for DY5 Q2 and agreed with the EQRO findings. Issues identified included conflicts in 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.

Additionally, HSD reviewed five NF LOC determination disagreements for DY5 Q1 with the MCOs, four for PHP and one for BCBS. HSD requested clarification for discrepancies identified in audit documentation, status updates on the identified members, and plans to improve the accuracy of determinations.

BCBS provided clarification for one identified discrepancy on the member's notification form which indicated LNF while supporting documentation indicated HNF. Per BCBS, an incorrect notification form was inadvertently provided for this audit. The corrected form was sent by the MCO to the facility but was not included with the submitted audit documentation. BCBS noted that the member's file has the correct notification form that was submitted to the facility on file and provided a copy to HSD with their clarification. BCBS stated that they have updated their internal job aids to ensure that any communications have the correct approval information and accurate communications are submitted.

PHP also provided clarification for four identified discrepancies in member files and provided status updates for the members. For the four files, information regarding Activities of Daily Living (ADL) deficits from the CNA did not match information in supporting documentation provided in the audit packet which indicated additional ADL deficits. PHP noted that these documents provided additional detail regarding ADLs. Per PHP, the NFLOC Supplemental Assessment and NFLOC Summary provided further clarification of ADL deficits due to the members' health condition and based on this additional information, PHP found that these members met NF LOC criteria.

PHP noted that their NF LOC Summary Note and NF LOC Supplemental Assessment are not embedded within the Comprehensive Needs Assessment (CNN). The NF LOC Summary Note and NF LOC Supplemental Assessment are conducted after the CNA and are designed to detail the member's functional needs in relation to their deficits in Activities of Daily Living. As such, not all the information pertaining to the member's functional limitations is provided at the time the Care Coordinator is documenting within the CNA.

PHP stated that they will continue to summarize all objective observations and member's statements from the CNA, NFLOC Summary Note and NFLOC Supplemental Assessment within their Reviewer template, ensuring that all documentation is comprehensive and cohesive to validate that the member will meet NF LOC. PHP also noted that they will provide further training to all staff to ensure that correct documentation is entered within all assessments.

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 and conducted technical assistance calls with MCOs in DY5 Q2 to assist them in understanding what specific points of compliance HSD is requesting. MHC has reported three quarters of over 85% completion rate for back-up and disaster planning. BCBS has met requirements for 2 consecutive quarters addressing its transition of care plans for nursing home to community transitions as well as conducting timely home assessments after discharge. In addition to MCOs auditing member files for transition of care documentation and care coordination level determinations, HSD added Action Steps in DY5 Q2 to monitor member files for compliance with consistency in CNA and comprehensive care plan (CCP) timeliness and member participation.

***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, leaving 87 active members in the project. 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 a decrease in ED use among project participants ranging from a 26% decrease among BCBS and UHC members to 34% decrease for PHP members and a 61% decrease from MHC members. 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. For example, one member had 50 ED visits in a previous quarter. With the added support of care coordination and housing arrangements, this member now has a PCP and has reduced use of the ED to 10 ED visits in the most recent quarter. Other members, with the extra support of their care coordinators, have shown a vast decline in ED usage, engaged with peer support and community connectors and communicated to their care coordinators that their outlook has significantly improved.

***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 with a total of 37 hospitals currently participating in the program statewide, 31 of which are complete and fully integrated. Three more are progressing forward to a completion date in DY5. 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 take action 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. Onsite visits to 26 of the 31 completed hospitals have occurred with targeted training, refreshers, technical assistance and support. Targeted training of MCO staff is being developed and technical issues are being addressed.

***Care Coordination Ride-Alongs***
HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY5 Q2, HSD staff attended "ride-alongs" with MHC and BCBS. 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 CAN process noted a team approach with guardians, support brokers, caregivers and family members. HSD observed that care coordinators were in compliance with contract requirements including the administration of the Community Benefit Services Questionnaire (CBSQ).

## Section XIV: Managed Care Reporting Requirements

### Customer Service

In DY5 Q2, 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 G: Customer Service Summary.

### MCO Reporting

During DY5 Q2, each of the four MCOs had Technical Assistance (TA) Calls with HSD subject matter expects and submitted Self-Identified Error Resubmission (SIER) requests for report corrections. Both the TA Calls and the submission of the SIER's allow HSD and MCO Subject Matter Experts (SMEs) to provide clarification and direction for MCO reporting inaccuracies. Reports from MCOs in Q2 have been timely and HSD continues to see a decline in MCOs report extension requests, with no extension requests made for DY5 Q1 reports.

#### *Report Revisions*

During DY5 Q2, HSD subject matter experts continue to collaborate with Mercer and the MCO's to make report revisions to select reports. There are currently 23 reports that are being revised in preparation for Centennial Care 2.0. HSD revises reports to streamline elements, improve monitoring, and incorporate requirements of the managed care final rule.

### Member Appeals

A total of 944 member appeals were filed by Centennial Care members in DY5 Q2. Although this demonstrates an increase when compared to 869 in DY5 Q1, an overall trend cannot be established when compared to member appeals received in DY4 Q4 (876), Q3 (1,043), Q2 (1,000) and Q1 (1,013). Of those 944 appeals, 834 (88.34%) were standard member appeals and 110 (11.65%) 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 758 (80.30%) of the total appeals received. Although this presents an increase when compared to 716 in DY5 Q1, an overall downward trend is demonstrated when compared to DY4 Q4 (697), Q3 (834), Q2 (822), and Q1 (873).

Reduction of a previously authorized service was the second top member appeal code with a total of 49 (5.19%) member appeals. This demonstrates a decrease when compared to 61 in DY5 Q1, an overall downward trend is demonstrated when compared to DY4 Q4 (54), Q3 (79), Q2 (110), and Q1 (81) in DY4.

There were 137(14.51%) variable appeals in DY5 Q2. 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. Please see Table 21 – Member Appeals DY5 Q2 below.

**Table 21 – Member Appeals DY5 Q2**

| MCO Appeals DY5 Q2 (April - June 2018) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **MCO** | **BCBS** | | **MHC** | | **PHP** | | **UHC** | | **Total** | |
| Member Appeals | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | % |
| Number of Standard Member Appeals | 122 | 12.92% | 212 | 22.46% | 359 | 38.02% | 141 | 14.94% | **834** | 88.35% |
| Number of Expedited Member Appeals | 59 | 6.25% | 4 | 0.42% | 5 | 0.53% | 42 | 4.45% | **110** | 11.65% |
| Total | 181 | 19.17% | 216 | 22.88% | 364 | 38.56% | 183 | 19.39% | **944** | 100% |
| | | | | | | | | | | |
| Top Two Primary Member Appeal Codes | | | | | | | | | | |
| Denial or limited authorization of a requested service | 143 | 15.15% | 167 | 17.69% | 319 | 33.79% | 129 | 13.67% | **758** | 80.30% |
| Reduction of a previously authorized service | 0 | 0.00% | 49 | 5.19% | 0 | 0.00% | 0 | 0.00% | **49** | 5.19% |
| | | | | | | | | | | |
| Variable Appeals | 38 | 4.02% | 0 | 0.00% | 45 | 4.77% | 54 | 5.72% | **137** | 14.51% |
| Empty Variables | | | | | | | | | **0** | 0.00% |

**Section XV: Demonstration Evaluation**

Progress under the Centennial Care 1115 Waiver Evaluation work plan continued in DY5 Q2. Activities conducted during this quarter were devoted to DY4 data collection for review and analysis to be included in the Final Evaluation Report. Deloitte and HSD discussions focused on the development of timelines, measure-specific reporting methodologies, and data source changes.

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 further refine the timeline for the Final Evaluation Report, discuss data to be included and provide responses to outstanding questions, as well as identify and review any analysis issues or risks.

Preliminary observations from DY3 to DY4 indicate an increase for members accessing mental health services across all age cohorts. The rates for 50% medication compliance for people with asthma increased across three out of four age cohorts from DY3 to DY4.

Planned activities for DY5 Q3 will focus on the collection and assessment of DY4 information and drafting measure-level write-ups as final DY4 data is collected and reviewed to be included in the Final Evaluation Report.

## 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: MCO Action Plans
Attachment G: Customer Service Summary

## Section XVII: State Contacts

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

A PHP member in Southern New Mexico was identified as an individual who used the Emergency Room (ER) frequently. The member had visited the ER 11 times in 2018. For over two years, there were multiple attempts to connect with the member through phone calls, letters, provider outreach, and unannounced home visits. All attempts were unsuccessful. Due to the extensive amount of ER use, the member was flagged to have real-time notifications of ER visits via the Pre-Manage system (see also MCO Initiatives under Presbyterian Health Plan in the DY5 Q1 report). The ER that the member visited frequently had not been participating with the EDIE program until quite recently.

After the ER began to participate in the EDIE program, a real-time alert of an ER visit was received by PHP's care coordination team. A CHW was deployed to go to the Emergency Room to meet with the member. The CHW spent over an hour with the member to understand the member's needs and to develop a rapport with the member. The member initially agreed to work only with the CHW and refused care coordination. A few days later, PHP received another notification of an ER visit. Again, the CHW was able to meet the member in the ER to assist the member with needs.

Over time, the CHW was able to work with the member toward goals such as visiting a PCP for the first time in almost two years. The member also agreed to meet a care coordinator with the CHW present. The member agreed to complete a CNA and is now engaged in care coordination and is working with the CHW to address multiple ongoing healthcare needs.

**Centennial Care Member Success Story 2**

A House that Became a Home - A BCBS Community Health Worker (CHW) began working with a family several months ago. Collaboration between care coordinators, advocates, CHWs, and other agencies was vital. The CHW's primary goal was to assist the family in locating housing that would accommodate the family of eleven, nine of which were children. The family consisted of two households that lived in two separate apartments. The new home would bring the two families together, under the same roof. The family was new to the culture, and traditions of living in the United States and with this newness came many unknowns. The children were attending schools, seeing doctors, dentists, therapists, and dealing with the tragedy of their father who has been unable to provide them with the support that the family needed, due to an accident that disabled him. The care coordinators, advocates, and CHWs came together to address the needs of the family. The family had been living in a second floor, two-bedroom apartment. This situation was difficult for the family. It was a small place and it meant carrying the youngest of the family up and down the stairs. Although, the family was going through a time of learning and

struggling, they remained positive, and willing to do all that was asked of them. Mom carried the load and did it with courage, and tenacity. Her determination to see her family through this difficult time of struggle provided her with the valor to move ahead in seeking a better life for her family. The CHW alongside the family advocates worked diligently together to locate suitable housing for the family. The family had been on the Section 8 Public Housing list for some time. The CHW immediately connected with a Section 8 representative and was instrumental in placing this family with adequate housing. The CHW worked closely with the Section 8 representative on a consistent basis through phone calls, and agency visits in hopes that the process of assisting the family would be a smooth transition and the assigned home would be adequate for the family's needs. The CHW received notification from the Section 8 representative that a five-bedroom home was being remodeled, would be handicapped accessible ready, and the family was first on the waiting list. The remodeling took time, but then came the day – it was ready! The CHW immediately advised the advocates and the family who expressed excitement and relief that the family would finally have a home that would be sufficient to meet their needs. The home contains five bedrooms, is counter wheelchair accessible, shower handicapped accessible, it has ramps that will allow easy entrance into the home and has a small yard where the children can be outside. It was only a few months or so after the initial contact from the Section 8 representative that the family moved into their new home. Many agencies, people in the community and friends have reached out to support the family. It has proven how positive forces can come together and bring hope to a family that is no longer in a strange land, but amongst neighbors, family, and friends. The family has turned this house into their home.

**Centennial Care Member Success Story 3**

Shortly before a Molina member transferred to a new care coordinator, his Personal Care Services (PCS) hours had been reduced and he did not understand why. The new care coordinator spent time explaining to the member the reasons for the decrease and describing the member's right to appeal the decision. The member was grateful and thanked the care coordinator.

This conversation with his care coordinator inspired the member to take more responsibility for managing his health care. The member diligently attended all scheduled appointments and worked with his provider to learn more about his conditions and make changes to improve his health. Six months after the conversation, the care coordinator reported that the member had improved and had made a new goal to no longer require Personal Care Services. The member also found a part time job that accommodated his limitations. The member can find satisfaction in being able to work a few days a week.

**Centennial Care Member Success Story 4**

A UHC member has struggled for years with depression and anxiety; she had found herself in a situation where she had just let everything go. She soon found herself in desperate need of assistance but wasn't sure where to turn. Her home was in such disarray that she knew that she

would not pass her HUD inspection. This intensified her anxiety and depression. When life would get overwhelming the member would become severely depressed, then suicidal, and usually ended up hospitalized. This time, care coordination was there to help her manage her symptoms without hospitalization. The member's UHC care coordinator contacted a church that the member belonged to and asked them for assistance. The UHC care coordinator spoke with the member to obtain permission before putting into place a plan of care with her congregation. With the member as lead, the team picked a date on the calendar and asked members of this church to volunteer their time and assist the member in getting her home ready for her HUDD inspection. The member had a lot of trouble doing this because she was embarrassed about the state of her home. The member reschedules a few times, but she knew she was running out of time and HUDD was not going to reschedule any more. She needed constant encouragement and support during this time; she would make statements like "I just need to go to the hospital". Her UHC care coordinator would talk her through this saying "if you think you really need to go to the hospital I will take you." Then the member would think about it and say, "I can't run from things because that is how I got here in the first place". The UHC care coordinator worked through this time together. This process was over the period of 6-8 months. The member finally agreed on a Saturday. On the day of the big event the crew showed up with 4 trucks, 2 huge dump trailers, gloves, cleaning supplies, trash bags, and over 20 volunteers. The UHC care coordinator stayed with the member and assisted in clean-up efforts with the volunteer group. The event lasted over 8 hours. The UHC care coordinator also pulled resources in the community to purchase a couch for the member. The member stated she was just so grateful; she could see her floor and walk without climbing over things. The day was filled with all kinds of emotion, but this was a great success.

**DY5 Q2 Attachment B- GeoAccess PH Q1 2018 (January 1 - March 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% | 100.0% | 100.0% | 100.0% | 99.9% | 100.0% | 97.9% | 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% | 94.7% | 100.0% | 100.0% | 90.3% | 99.1% | 100.0% | 99.4% | 97.5% | 97.7% | 94.0% | 98.9% |
| **PH - Standard 2** | | | | | | | | | | | | |
| Cardiology | 99.2% | 99.1% | 98.0% | 99.1% | 99.7% | 99.5% | 100.0% | 99.7% | 99.8% | 99.8% | 100.0% | 99.9% |
| Certified Nurse Practitioner | 99.2% | 100.0% | 100.0% | 100.0% | 99.7% | 100.0% | 100.0% | 100.0% | 99.8% | 100.0% | 100.0% | 100.0% |
| Certified Midwives | 99.2% | 100.0% | 98.0% | 99.1% | 100.0% | 99.8% | 100.0% | 94.0% | 99.8% | 99.8% | 100.0% | 98.8% |
| Dermatology | 72.2% | 93.9% | 75.0% | 99.0% | 65.7% | 56.1% | 63.0% | 77.8% | 81.8% | 91.6% | 87.0% | 85.3% |
| Dental | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Endocrinology | 95.8% | 93.9% | 98.0% | 99.0% | 62.8% | 67.9% | 75.0% | 85.5% | 76.9% | 85.4% | 91.0% | 87.5% |
| ENT | 99.2% | 99.0% | 98.0% | 99.0% | 91.4% | 98.5% | 92.0% | 99.4% | 95.0% | 97.0% | 92.0% | 98.3% |
| FQHC | 100.0% | 94.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Hematology/Oncology | 99.1% | 99.0% | 98.0% | 99.2% | 98.0% | 98.2% | 98.0% | 98.2% | 99.5% | 97.7% | 99.0% | 97.9% |
| Neurology | 99.2% | 93.9% | 98.0% | 99.0% | 97.8% | 90.9% | 94.0% | 85.3% | 92.4% | 88.3% | 89.0% | 84.0% |
| Neurosurgeons | 99.2% | 99.0% | 98.0% | 99.0% | 40.7% | 43.6% | 65.0% | 76.0% | 70.3% | 73.2% | 88.0% | 87.2% |
| OB/Gyn | 99.0% | 99.1% | 98.0% | 99.1% | 99.9% | 99.8% | 100.0% | 99.7% | 99.8% | 99.9% | 100.0% | 99.9% |
| Orthopedics | 99.2% | 99.0% | 98.0% | 99.1% | 99.7% | 99.5% | 100.0% | 99.6% | 99.7% | 99.9% | 98.0% | 98.7% |
| Pediatrics | 100.0% | 99.1% | 98.0% | 100.0% | 99.6% | 100.0% | 100.0% | 99.9% | 99.8% | 100.0% | 100.0% | 100.0% |
| Physician Assistant | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.8% | 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% | 99.7% | 99.8% | 93.6% | 98.0% | 100.0% |
| Rheumatology | 94.3% | 93.9% | 98.0% | 99.0% | 69.3% | 92.0% | 91.0% | 89.1% | 81.7% | 88.1% | 88.0% | 87.3% |
| Surgeons | 99.2% | 99.1% | 98.0% | 99.2% | 99.9% | 99.8% | 100.0% | 99.6% | 99.9% | 99.8% | 100.0% | 99.9% |
| Urology | 99.1% | 99.0% | 98.0% | 99.0% | 81.4% | 89.9% | 81.0% | 92.7% | 92.8% | 94.4% | 96.0% | 95.7% |
| **LTC - Standard 2** | | | | | | | | | | | | |
| Personal Care Service Agencies (PCS) - delegated | 95.1% | 100.0% | 100.0% | 100.0% | 99.8% | 98.6% | 100.0% | 99.6% | 99.8% | 100.0% | 100.0% | 100.0% |
| Personal Care Service Agencies (PCS) - directed | 98.1% | 100.0% | 100.0% | 100.0% | 90.5% | 98.6% | 100.0% | 99.6% | 98.1% | 100.0% | 100.0% | 100.0% |
| Nursing Facilities | 99.2% | 94.1% | 94.0% | 97.0% | 99.1% | 98.6% | 99.0% | 99.4% | 99.8% | 99.9% | 100.0% | 100.0% |
| | | | | | | | | | | | | |
| General Hospitals | 99.2% | 99.0% | 98.0% | 99.1% | 99.4% | 98.1% | 100.0% | 99.4% | 99.8% | 99.3% | 100.0% | 99.5% |
| Transportation | 99.2% | 100.0% | 100.0% | 97.7% | 95.0% | 98.8% | 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.

## DY5 Q2 BH Geo Access

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) | 88.4% | 82.2% | 90.0% | 85.2% | 32.3% | 83.9% | 27.0% | 54.60% | 67.7% | 100.0% | 68.0% | 72.4% |
| Assertive Community Treatment (ACT) | 61.9% | 99.0% | 83.0% | 96.4% | 19.9% | 83.7% | 50.0% | 49.30% | 45.3% | 92.7% | 71.0% | 74.2% |
| Behavioral Management Services (BMS) | 87.0% | 99.1% | 97.0% | 99.1% | 19.7% | 90.8% | 36.0% | 58.70% | 51.3% | 97.9% | 74.0% | 86.6% |
| Community Mental Health Center (CMHC) | 93.7% | 73.3% | 98.0% | 78.5% | 69.9% | 32.0% | 100.0% | 48.50% | 96.0% | 68.1% | 100.0% | 63.2% |
| Core Service Agency (CSA) | 100.0% | 99.0% | 92.0% | 96.8% | 79.0% | 75.8% | 100.0% | 89.50% | 88.7% | 92.1% | 100.0% | 99.8% |
| Day Treatment Service | 61.0% | 99.0% | 57.0% | 98.8% | 28.6% | 83.9% | 28.0% | 71% | 35.6% | 94.7% | 48.0% | 77.0% |
| FQHC- BH | 99.1% | 100.0% | 100.0% | 100.0% | 83.0% | 100.0% | 86.0% | 100% | 85.5% | 100.0% | 100.0% | 100.0% |
| FreeStanding Psychiatric Hospital | 88.5% | 99.1% | 90.0% | 99.2% | 41.3% | 98.7% | 17.0% | 99.90% | 67.7% | 100.0% | 68.0% | 99.9% |
| General Hospital with Psychiatric Units | 21.4% | 93.8% | 90.0% | 99.1% | 36.0% | 98.7% | 79.0% | 99.90% | 76.6% | 100.0% | 82.0% | 100.0% |
| Indian Health Services and Tribal 638 | 72.6% | 100.0% | 90.0% | 100.0% | 56.8% | 90.3% | 96.0% | 92.20% | 82.1% | 100.0% | 98.0% | 100.0% |
| Intensive Outpatient Services | 72.7% | 97.7% | 65.0% | 85.2% | 55.7% | 35.3% | 82.0% | 40.60% | 63.5% | 90.1% | 83.0% | 71.0% |
| Licensed Independent Behavioral Health Practitioners | 100.0% | 97.0% | 100.0% | 96.6% | 100.0% | 71.6% | 100.0% | 83.80% | 100.0% | 70.1% | 100.0% | 81.9% |
| Methadone Clinics (METHC) | 94.3% | 72.8% | 91.0% | 79.7% | 42.1% | 63.0% | 38.0% | 69.30% | 76.8% | 85.1% | 77.0% | 87.1% |
| Multi-Systematic Therapy(MST) | 72.0% | 93.7% | 92.0% | 96.7% | 26.1% | 36.5% | 57.0% | 67.10% | 55.6% | 77.2% | 71.0% | 81.1% |
| Non-Accredited Residential Treatment Center (NARTC) | 72.6% | 91.9% | 56.0% | 65.8% | 46.4% | 76.7% | 70.0% | 57.70% | 67.5% | 88.0% | 78.0% | 82.3% |
| Outpatient Provider Agencies | 87.0% | 100.0% | 98.0% | 100.0% | 30.6% | 100.0% | 99.0% | 100% | 45.8% | 100.0% | 100.0% | 100.0% |
| Partial Hospital Program | 93.2% | 94.2% | 34.0% | 19.3% | 26.6% | 90.8% | 13.0% | 4.70% | 64.2% | 97.9% | 11.0% | 5.3% |
| Psychiatrists | 100.0% | 100.0% | 100.0% | 99.9% | 99.9% | 100.0% | 100.0% | 100% | 99.9% | 100.0% | 98.0% | 99.9% |
| Psychologists (inc Subscribing) | 100.0% | 100.0% | 98.0% | 99.9% | 89.3% | 100.0% | 93.0% | 97.70% | 99.9% | 100.0% | 100.0% | 100.0% |
| RHC (BH) | 0.7% | 0.1% | 0.0% | 0.1% | 44.9% | 16.1% | 36.0% | 15.1 | 67.7% | 61.3% | 26.0% | 26.3% |
| Suboxone Certified MDs | 99.2% | 99.1% | 98.0% | 99.1% | 94.3% | 92.8% | 100.0% | 92.9 | 96.0% | 94.7% | 100.0% | 100.0% |
| Treatment Foster Care I & II(TFC) | 83.3% | 98.8% | 92.0% | 96.5% | 45.6% | 73.7% | 63.0% | 75.10% | 57.8% | 88.3% | 91.0% | 89.9% |
| Inpatient Psychiatric Hospitals | 98.6% | 94.2% | 98.0% | 85.4% | 81.3% | 73.9% | 80.0% | 84.0% | 85.3% | 98.7% | 86.0% | 98.8% |

**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 | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Inpatient (Admissions) | 93.9 | 93.1 | $ 9,400 | $ 8,821 |
| Inpatient (Days) | 410.2 | 407.2 | $ 2,151 | $ 2,017 |
| Practitioner / Physician (Services) | 8,484.3 | 8,384.4 | $ 68 | $ 67 |
| Emergency Department (Visits) | 544.5 | 572.9 | $ 344 | $ 349 |
| Outpatient (Visits) | 1,452.7 | 1,454.5 | $ 270 | $ 278 |
| Pharmacy (Scripts) | 4,954.7 | 4,895.1 | $ 63 | $ 65 |
| Other (Services)[1] | 9,140.2 | 8,874.3 | $ 59 | $ 57 |

| | Script Utilization | | Script Cost per Unit | |
|---|---|---|---|---|
| Pharmacy Classification | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Brand | 13.6% | 12.7% | $ 336 | $ 373 |
| Generic | 85.0% | 85.8% | $ 18 | $ 19 |
| Other Rx[2] | 1.4% | 1.5% | $ 96 | $ 95 |

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 | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Inpatient (Admissions) | 76.8 | 74.5 | $ 15,391 | $ 15,889 |
| Inpatient (Days) | 500.2 | 615.7 | $ 2,363 | $ 1,924 |
| Practitioner / Physician (Services) | 9,017.0 | 8,819.5 | $ 79 | $ 77 |
| Emergency Department (Visits) | 659.5 | 680.6 | $ 481 | $ 497 |
| Outpatient (Visits) | 2,320.4 | 2,126.1 | $ 302 | $ 314 |
| Pharmacy (Scripts) | 10,210.8 | 9,712.2 | $ 76 | $ 78 |
| Other (Services)[1] | 9,889.8 | 9,985.6 | $ 67 | $ 64 |

| | Script Utilization | | Script Cost per Unit | |
|---|---|---|---|---|
| Pharmacy Classification | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Brand | 11.0% | 10.7% | $ 561 | $ 586 |
| Generic | 87.3% | 87.4% | $ 15 | $ 15 |
| Other Rx[2] | 1.8% | 1.9% | $ 88 | $ 92 |

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 | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Inpatient (Admissions) | 254.2 | 231.2 | $ 2,784 | $ 2,798 |
| Inpatient (Days) | 1,492.8 | 1,360.0 | $ 474 | $ 476 |
| Nursing Home (Days) | 332,981.2 | 306,519.8 | $ 35 | $ 36 |
| Personal Care (Services / hr.) | 762,729.0 | 735,816.9 | $ 15 | $ 15 |
| Outpatient (Visits) | 5,172.5 | 4,712.0 | $ 125 | $ 144 |
| Pharmacy (Scripts) | 1,787.4 | 1,254.2 | $ 32 | $ 13 |
| HCBS (Services) | 5,392.2 | 6,299.0 | $ 137 | $ 136 |
| Other (Services)[1] | 44,287.3 | 42,020.9 | $ 47 | $ 44 |

| | Script Utilization | | Script Cost per Unit | |
|---|---|---|---|---|
| Pharmacy Classification | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Brand | 20.3% | 22.3% | $ 116 | $ 34 |
| Generic | 77.6% | 74.8% | $ 9 | $ 5 |
| Other Rx[2] | 2.1% | 2.9% | $ 59 | $ 52 |

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 | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Inpatient (Admissions) | 349.5 | 333.0 | $ 18,214 | $ 18,338 |
| Inpatient (Days) | 2,369.2 | 2,303.7 | $ 2,687 | $ 2,651 |
| Nursing Home (Days) | 15,369.5 | 17,235.8 | $ 184 | $ 155 |
| Personal Care (Services / hr.) | 758,519.2 | 713,176.0 | $ 15 | $ 15 |
| Outpatient (Visits) | 7,499.9 | 7,501.0 | $ 435 | $ 467 |
| Pharmacy (Scripts) | 43,934.6 | 41,969.3 | $ 92 | $ 90 |
| HCBS (Services) | 12,081.0 | 12,963.7 | $ 102 | $ 95 |
| Other (Services)[1] | 65,047.6 | 62,978.7 | $ 84 | $ 84 |

| | Script Utilization | | Script Cost per Unit | |
|---|---|---|---|---|
| Pharmacy Classification | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Brand | 12.7% | 12.4% | $ 578 | $ 581 |
| Generic | 85.0% | 85.2% | $ 19 | $ 18 |
| Other Rx[2] | 2.2% | 2.4% | $ 81 | $ 82 |

Notes:

*1 - Other services include dental, transportation, vision.*

*2 - Other Rx includes diabetic supplies*

## Key Utilization / Cost per Unit Statistics by Major Population Group

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

| | Utilization (per 1,000 Members) | | Cost per Unit | |
|---|---|---|---|---|
| Service Grouping | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Inpatient (Admissions) | 231.8 | 219.2 | $ 8,738 | $ 9,186 |
| Inpatient (Days) | 1,270.9 | 1,460.1 | $ 1,594 | $ 1,379 |
| Nursing Home (Days) | 10,666.8 | 8,595.2 | $ 12 | $ 14 |
| Personal Care (Services / hr.) | 48.0 | 125.7 | $ 11 | $ 15 |
| Outpatient (Visits) | 6,519.2 | 6,466.6 | $ 207 | $ 254 |
| Pharmacy (Scripts) | 14,111.8 | 14,227.1 | $ 107 | $ 130 |
| HCBS (Services) | 338,047.0 | 295,457.9 | $ 101 | $ 94 |
| Other (Services)[1] | 57,432.6 | 56,639.4 | $ 50 | $ 52 |

| | Script Utilization | | Script Cost per Unit | |
|---|---|---|---|---|
| Pharmacy Classification | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Brand | 13.7% | 14.6% | $ 502 | $ 673 |
| Generic | 83.2% | 82.3% | $ 42 | $ 34 |
| Other Rx[2] | 3.1% | 3.1% | $ 118 | $ 126 |

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 | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Inpatient (Admissions) | 77.0 | 70.4 | $ 4,298 | $ 4,234 |
| Inpatient (Days) | 479.9 | 437.0 | $ 690 | $ 682 |
| Practitioner / Physician (Services) | 9,729.8 | 9,049.8 | $ 26 | $ 24 |
| Emergency Department (Visits) | 666.9 | 636.4 | $ 150 | $ 161 |
| Outpatient (Visits) | 3,025.9 | 2,746.4 | $ 124 | $ 128 |
| Pharmacy (Scripts) | 1,647.5 | 1,405.7 | $ 43 | $ 23 |
| Other (Services)[1] | 9,957.2 | 9,150.4 | $ 92 | $ 109 |

| | Script Utilization | | Script Cost per Unit | |
|---|---|---|---|---|
| Pharmacy Classification | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Brand | 20.8% | 23.6% | $ 161 | $ 56 |
| Generic | 77.2% | 73.9% | $ 11 | $ 11 |
| Other Rx[2] | 2.1% | 2.5% | $ 60 | $ 53 |

Notes:

*1 - Other services include dental, transportation, vision.*

*2 - Other Rx includes diabetic supplies*

## Key Utilization / Cost per Unit Statistics by Major Population Group

| Behavioral Health Services - All Populations (PH, OAG, LTSS) | | | | |
|---|---|---|---|---|
| | Utilization (per 1,000 Members) | | Cost per Unit | |
| Service Grouping | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Inpatient (Admissions) | 37.3 | 40.0 | $ 990 | $ 1,219 |
| Inpatient (Days) | 104.6 | 122.4 | $ 353 | $ 398 |
| BH Practitioner (services) | 166.4 | 234.9 | $ 129 | $ 117 |
| Core Service Agency (Services) | 242.1 | 220.5 | $ 103 | $ 110 |
| BH outpatient / clinic (Services) | 2,351.7 | 3,158.4 | $ 70 | $ 56 |
| Pharmacy (Scripts) | 1,865.6 | 1,789.2 | $ 57 | $ 57 |
| Residential Treatment Center (days) | 93.6 | 85.7 | $ 1,037 | $ 1,063 |
| Other (Services)[1] | 145.6 | 130.7 | $ 60 | $ 51 |

| | Script Utilization | | Script Cost per Unit | |
|---|---|---|---|---|
| Pharmacy Classification | Apr 16 - Mar 17 | Apr 17 - Mar 18 | Apr 16 - Mar 17 | Apr 17 - Mar 18 |
| Brand | 5.9% | 6.6% | $ 417 | $ 440 |
| Generic | 94.1% | 93.4% | $ 34 | $ 30 |
| Other Rx[2] | 0.0% | 0.0% | $ - | $ - |

Notes:

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

*2 - Other Rx includes diabetic supplies*

# Behavioral Health Collaborative CEO Report

**July 12, 2018**

1. **State Opioid Response (SOR) Grant**
   SAMHSA is providing a total $930 million nationally in additional one-time only funding through SOR Grants as it continues its efforts to address the opioid crisis. This funding aims to address the opioid crisis by increasing access to evidence-based, medication-assisted treatment; reducing unmet treatment need; and reducing opioid-related overdose deaths. SAMHSA will award the grants to states and territories in support of their ongoing efforts to provide prevention, treatment, and recovery support services. State and territories will use the grants to design and implement plans which specifically meet their needs within a two year project period. Fifteen percent of the total funds are set-aside to provide extra support to ten states that have been hardest hit by the crisis, according to a specific formula. NM is not among those states eligible for the 15% set-aside. The good news is that NM will be receiving $5.2 million in SOR funding in each of the next two years for a total of $10.4 million. State applications outlining the proposed use of funds must be submitted to SAMHSA by August 13th. BHSD and CYFD, in concert with UNM, are drafting the application.

2. **Delta Center Grant**
   The New Mexico Primary Care Association (NMPCA) has received a $240,000 two year grant to implement value-based revenue models based on pay for performance, pre-established quality indicators, and integrated primary care and behavioral health services. The NMPCA has engaged the New Mexico Behavioral Health Providers Association (NMBHPA) as a grant recipient partner on the project, and the two Associations will collaborate on incorporating both behavioral health and primary care interventions and outcome measures. The grantee, the Delta Center for a Thriving Safety Net, received funding for this project from the Robert Wood Johnson Foundation. The four goals of the project are:

   - Build internal capacity of state associations via Value-based Purchasing and Contracting Vision and Strategy Development, board and staff engagement, learning organization practices, and sustainability planning
   - Build policy and advocacy capacity to advance value-based payment and care at state level
   - Foster collaboration between primary care and behavioral health at state level
   - Build capacity to provide TA and training to advance value-based payment and care at provider level.

   Maggie McCowen and Brian Serna will participate on the grant team with the NMPCA, along with additional NMBHPA members TBD interested in serving as advisory committee to the project.

3. **NM BH Provider Guide**
   A NM BH Provider Guide is being developed to bring together, in one place, the information that is relevant to current and interested providers and stakeholders. This guide is intended for several audiences. It is most specifically written to give current providers of publicly-funded BH services a global picture of the environment within which these services are administered, and

more importantly, answers to common questions and links to many detailed documents that address more technical issues. It is not itself a technical document.

It is also intended to provide potential new individual and provider organizations with a sense of the scope of services, sources of funding, contracting and payment mechanisms, and oversight expectations for publicly-funded behavioral health. With the growth of more local – city, county and regional – BH systems, this guide may also serve as a support for expansion planning and integration with the larger state system. Finally, the document has been written to be accessible to an informed public, policy makers, advocates for expansion and improvement of a broad range of human services, private funding entities, and others with an interest in BH issues.

Such a guide is, of necessity, reflective of the point in time at which it is written. There has been a great deal of planned and unexpected change in publicly-funded BH over the past decade, but the guidance and direction by NM BH leaders has not varied greatly from a progressive and evidence-based foundation over that time, and new programming has intentionally addressed gaps and disparities that have been identified and examined. This guide will be updated as significant changes occur.

Some highlights of the Guide include:

- An overview of the NM BH service system;
- The structure of BH at the state level - highlights of state agencies roles and responsibilities;
- A description of service supported by major payers;
- Presentation of major administrative rules and supporting clinical and other policies: what they are and how to find them; and
- Provider contracting and state oversight.

The final Guide will be presented at the October BH Collaborative quarterly meeting.

**4. Medicaid BH Rule, Policy Manual and Rate Changes**

The Medicaid Behavioral Health Rule, with its accompanying Behavioral Health Policy and Billing Manual, is currently under leadership review. It is scheduled for publication for comment in the August/September time frame with an effective date of no later than January 1, 2019. 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.

The Medicaid fee-for-service fee schedule was posted for public comment on June 1, 2018. Responses to received commentary will be published in July with an effective date for changes to reimbursement of July 1, 2018. It includes rate increases made possible through legislative appropriation.

**5. Administrative Services Organization (ASO) Transition**

Falling Colors, Inc. (FC), is the current Administrative Services Organization (ASO) for The BH Collaborative, and is the payer of last resort for adult BH services funded by BHSD and CYFD. Services for members covered under Medicaid benefits must be billed to the Managed Care Organization (MCOs) or Fee for Service (FFS) Medicaid. Likewise, services covered by other third-party payers, whether public or private, must be billed to the appropriate payer(s).

Services covered by Medicaid or other payers that have been billed inappropriately to FC but paid, are being recouped. Also, non-Medicaid funds cannot be used to offset the unpaid portion of billing by another payer, such as deductibles, co-pays, or amounts exceeding treatment limits. The auditing of payments for non-Medicaid services is occurring on an ongoing basis. BHSD and CYFD conducted the first round of provider recoupments for clients that were found to be eligible for Medicaid, and the BHSD savings totaled $555,302.89 for SFY18 services through May. BHSD was able to appropriately reallocate those funds intended for the uninsured. CYFD recouped $74,840.54 over the same period.

6. **Adolescent Substance Use Reduction Effort (ASURE)**

CYFD's BHS is a recipient of a 4-year, $760,000 per year grant award from SAMHSA. CYFD's BHS used the State Youth Treatment Planning Grant (SYT-P) to institute an Interagency Council termed the Adolescent Substance Use Reduction Taskforce (ASURT). The Taskforce will be reconvened in July, 2018. Currently, Youth Support Services (YSS) is being implemented in Bernalillo County, Rio Rancho, Santa Fe, Espanola, Las Cruces, and Los Lunas. Beginning July 1st BHS will add Farmington, Hobbs, and the Butterfly Healing Center of 8 Northern Indian Pueblos in Taos. Training will continue to focus on development of the YSS Life Skills Coach model, focused on developing coaching skills as transformative interactive skill building.

The primary recipients of this service are intended to be youth and young adults at risk or already engaged in the justice system, or who have active SUD and/or co-occurring MH disorders. BHS worked with the Praed Foundation, the developers of the Child and Adolescent Needs and Strengths (CANS) to develop the YSS Youth Support Assessment, titled the YSA/CANS. This tool will allow for aggregated data collection through both the CANS and the YSA/CANS. BHS will also work to host the Praed Foundation to train clinicians on the use of CANS and also as trainers for implementation of CANS. The Global Appraisal of Individual Needs Short Screen (GAIN-SS) and the Adolescent Engagement and Satisfaction Questionnaire (AESQ) are also being administered. The GAIN-SS has data that indicates a very high accuracy of identification of issues, and all tools are being used at multiple points to actively measure progress.

BHS will implement a Seven Challenges Brief 7 training for all ASURE providers currently implementing the Seven Challenges and will work to adapt both Motivational Interviewing and the Community Reinforcement and Family Training (CRAFT) as entry-level workforce trainings to encourage youth and young adults practicing the YSS Life Skills Coaching to develop para-professional skills to increase competencies and employability. This training will roll out in November or December of 2018 at all YSS sites across the state.

7. **Behavioral Health Investment Zones (BHIZ)**

Behavioral Health Investment Zones were established in 2016 in two NM counties: Rio Arriba and McKinley. 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. Outcomes-based contracts to providers were issued for the first time in 2018. Despite not starting the contracts until February, OUR Network providers were able to meet most of their targets. Rio Arriba focused on developing jail diversion at multiple intercept points: a re-entry specialist was added to the jail serving inmates upon release, and a case manager was dedicated to the Sheriff to pilot Law Enforcement Assisted Diversion into case management in lieu of arrest. Rio Arriba has formed a partnership with the District Attorney,

Law Office of the Public Defender, Espanola Police Department, Rio Arriba County Sheriff and Santa Fe County LEAD to develop the criteria and protocols to implement LEAD with fidelity to the evidence-based model. In addition, OUR Network continues to distribute Naloxone in partnership with member organization, Santa Fe Mountain Center.

Intensive Case Management has been added for pregnant women and families of small children through Las Cumbres Community Services. El Centro Family Health installed an interface between their VPR and Pathways. It was completed on June 15th, enabling them to use the web portal to jointly manage shared clients in the coming fiscal year. Rio Arriba is providing case management for Las Clinicas Del Norte, a new network partner, increasing their effectiveness and network access to MAT. Eighty-two percent of Network clients received two or more services within 30 days of intake.

Successful referrals from the jail into treatment have increased over 500% as of April from four referrals the previous year to twenty-one, and 50% had either completed or remained in treatment at the time of the report. OUR Network case managers made approximately 2,200 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 BH care.

With the help of Sancre Productions, five TV-ad length professionally developed videos have been produced featuring local actors. The NM Community Foundation is acting as the campaign's fiscal agent, enabling us to seek corporate sponsors. Rio Arriba has secured two nationally known bands, Nosotros and Ozomatli, to play at a free public concert on August 17h at Northern NM College in conjunction with the Rio Arriba Community Health Council Health Fair to kick off the campaign. The event will feature a career fair for high schools students throughout Rio Arriba and Taos Counties.

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 includes a presentation and tour of NCI to the Legislative Finance Committee. The BHIZ also presented to Congressional staff from Udall, Heinrich and Ben Ray Lujan's Offices.

- This quarter, April to May (June data will be available in July), NCI provided counseling sessions to 56 unduplicated clients and Case Management to 15 clients. There were 48 group sessions held at NCI with over 844 social detox clients in attendance (data missing from one counselor).
- Rehoboth McKinley Christian Health Care Services (RMCHCS) offered 589 adult education hours for clients in its 90-day treatment program who were seeking their GED.
- RMCHCS case management services were provided to 35 clients in the 90-day treatment program. Fifty clients enrolled in the 120-work rehab program and gained a minimum of three employment skills. Ten clients were placed in permanent employment.
- The City of Gallup, in collaboration with Gallup McKinley County Schools, hosted a Trauma Informed Care training with 46 local providers, Ethics with 28 providers, and a 12 Core Functions of Substance Abuse Therapy training with 28 providers. The City of Gallup will also

be hosting a cultural competence training and Social Determinates of Health Training in June.

- The City of Gallup is collaborating with the local Gallup Indian Medical, District Attorney's Office, Magistrate Judges, Public Defenders Office and Administration office of the Courts to bring a drug court to our community in FY20.

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

Five new BH providers launched CLNM Health Home services on April 1st and a sixth implemented services July 1st, bringing the total number of implementations to 8. By the end of 2019, the new Health Homes are expected to serve nearly 10,000 Medicaid beneficiaries with SMI/SED. The 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 three locations in 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, and a Tribal 638 Health Center. Some were already providing both physical and BH services and some have been developing 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.

The CMS State Plan Amendment has been submitted and follow-up questions are being addressed with CMS. Data collection for return on investment analyses and federally-mandated reporting has begun, and an oversight/monitoring process is being developed to help assess quality of Health Home services and to develop practice improvement strategies with providers.

**9. Consortium for Behavioral Health Training and Research (CBHTR)**

The SAMHSA/NAADAC NM Youth Workforce Forum occurred on April 14. This statewide event was a collaboration between numerous partners including ENMU-R, NMHU, NMSU, WNMU and UNM. It spotlighted the need for and benefits of addictions and mental health careers. The programming was live-streamed to partner schools and attracted between 80-100 high school and college students. Each site also had exhibitors – providers and other agencies – which whom youth could speak.

The event inspired the planning of a youth track for the upcoming NM Behavioral Health Workforce Summit slated for Oct. 25, 2018. Several workgroups, representing stakeholders around the state, met this quarter to begin discussing the overarching theme and content to ensure the summit is meaningful for attendees. Team members are also identifying youth to participate in planning this daylong event. Clinical supervision remains a high priority. We have added another interdisciplinary supervisor to the team. The goal is to increase the number of independently licensed professionals in NM and to improve quality of service provision. CBTHR-licensed professionals now provide supervision to approximately 23 LMSWs monthly. This

quarter that represents close to 100 hours of group or individual time. Finally, CBHTR provided one two-day Comprehensive Community Support Services training in Albuquerque, which served 25 staff from Five Sandoval, San Felipe; Albuquerque Healthcare for the Homeless; Circle of Life; BHSD and UNM ASAP, UPC, and Forensic services.

**10. 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 review of public comments. Meanwhile, Medicaid's BH rule that includes payment mechanisms for services provided by CTCs is also expected to be promulgated this year.

**11. Clinical Curriculum Development Initiative**

Since the fall, 2017, the BHSD has been partnering with the faculty in New Mexico 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!" This fall, the Social Work Department will offer an on-line course in *Clinical Reasoning & Case Formulation*, taught by our experts. 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.

**12. Forensics**

In the first 9 months of FY18, forensics providers rendered 1061 competency evaluations. In a first phase data analysis project the following has been found: Males are referred for and evaluated more often than females; ethnic identity Latino/ Hispanic plus another identity is the

most frequently evaluated; followed by white ethnic identity; almost half of the evaluations occur within 30 days of receiving the report; 74% of evaluations were returned to the court within 20 days of the evaluation; 69% of reports were delivered to court within 90 days of the order; however, 321 reports were delivered to the court between 91-500 days of the order being issued; and 51% were found competent. During this period, 540 individuals were deemed competent, while another 518 were found to be incompetent. Phase two of analysis will begin in the next quarter.

13. **Intensive Outpatient Programs (IOP)**
The Interdepartmental Council (IDC), made up of CYFD & BHSD representation in communication with the Medical Assistance Division of HSD (MAD), has been processing applications and conducting site visits. This quarter two provider organizations have received their final approval, and one has received provisional approval. Two provider organizations are working with the IDC on findings revealed during a final site survey. Four additional provider organizations are in the initial application process.

A retrospective review of all providers, approved for IOP, is occurring to determine when follow up site visits will be conducted. IDC is developing a learning community for providers rendering IOP, to create a space for providers to discuss challenges, barriers and successes in the provision of IOP services.

14. **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 June 23rd, SCC hosted a Naloxone Awareness booth for the New Mexico Pharmacists Association at Isleta Resort & Casino. They advertised the program, received feedback from the community, and conducted needs assessments for naloxone.

During this fourth quarter, SCC dispensed 109 Narcan® kits to 22 NM pharmacies previously trained under the program for patients without Medicaid or insurance. For the first year of the STR grant, SCC distributed a total of 339 kits to previously trained pharmacies and trained two new pharmacies.

15. **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/.

Development of the BH NOC is ongoing. Organizations and/or individuals can now submit requests to post job vacancies, community events, or other public information relevant to those seeking behavioral health services. Requests should be submitted to

**HELP.NMNOC@state.nm.us**.

Under the Opioid STR grant, the site has been expanded to include specific information on Opioid Use Disorder and Medication Assisted Treatment. Providers can now find vital resources, treatment information and training opportunities. Development for the STR pages for year two of the grant will include implementing new functionality including: Mobile Search Function and increased targeted search words in search drop-down to include MAT services. Collaboration efforts among STR partners to share information and cross-promote is underway.

The Office of Peer Recovery and Engagement will be reformatting the section on OPRE for more ease in information and layout.

For FY2019, 3 major projects are anticipated:

- Trilogy and ProtoCall services will be working collaboratively to study and potentially improve on navigating NMNOC's community resources.
- BHSD will have the contractor work with Trilogy and OSAP on migrating its website content to NMNOC.
- BHSD is examining the potential installation of OpenBeds (a national in-patient bed registry).

For the period of April 01, 2018 to June 30, 2018, there were 37,348 total visits, up from 20,121 during the previous quarter**.** The top five keyword searches were: depression, substance abuse, health care, employment, and housing. The overall top five web page views were: Home, Find Services, Residential Treatment Facilities, OPRE, and Community Mental Health Agencies. The top five provider organizations for web page views were: Amancer Community Counseling Center, UNM Hospital Programs for Children and Adolescents, Connection Recovery Support Group, Alternative House Inc./La Posada Halfway House, and Courageous Transformations.

The NM Department of Veterans Affairs posts information for veterans, family members, active-duty personnel, reservists, members of the NM National Guard, employers, service providers, and the community at large. This site is available at: http://newmexico.networkofcare.org/Veterans/

The NM Department of Aging and Long Term Services posts information for seniors and people with disabilities. This site is available at: http://newmexico.networkofcare.org/aging/

**16. New Mexico Crisis and Access Line (NMCAL)**

As of May 31st, NMCAL has answered a total of 22,941 calls this year. This includes 9,937 crisis calls, 2,268 NM calls from the National Suicide Prevention Lifeline (NSPL), 5,805 calls for the Peer-to-Peer Warm Line, and 4,931 after-hours calls forwarded from NM's Core Service Agencies (CSAs).

Anxiety, situational stress, suicide, and depression were the top four presenting issues. Bernalillo, Curry, Santa Fe, and Dona Ana counties had the highest numbers of callers, with San Juan and Sandoval counties being the next top utilizers. For the Peer-to-Peer Warmline, the top concern identified is "mental health" at 90.9%, with "relationships" at 3.1% being the next highest reported challenge.

NMCAL continues to report successful stabilization of the caller at an average rate of 96.2%. The Peer to Peer Warm Line is reporting 97.8% of callers feeling supported during the call. Very few calls are transferred from the Warmline to the Crisis Line.

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.

**17. NM Service Members, Veterans, & Families (SMVF) In-State Policy Academy**

The SMVF Technical Assistance Center (SMVF TA Center) has been working with state and territory teams, providing technical assistance and training to Policy Academy graduates and supporting the engagement of new states and territories in the process. The NM In-State Policy Academy was convened by the NM Department of Veterans Services under the direction of the Governor on June 21-22, 2016. Following the June Leadership Brief, the NM team has started a campaign to identify existing NM resources and assess those that have a mission to help the NM SMVF population.

The New Mexico Department of Veteran Services (DVS) continues to meet with local city and county probation/parole officers to ensure they are aware of the behavioral health resources available to their parolees. The proposed MOU between DVS and the Corrections Department has been signed and DVS personnel will be attending training to be able to gain access into the state facilities to identify those veterans that are coming up to be released and to determine what services they might need once they transition out of incarceration. The training will be conducted on July 12 and will include background checks for DVS personnel. In concert with SAMHSA, the New Mexico Department of Health Suicide Prevention Coordinator and DVS have started an initiative in Santa Fe to identify community partners that can assist with reducing veteran suicides in Santa Fe.
SAMHSA staff visited Santa Fe and held a two-day Veterans Crisis Mapping Virtual Academy examining the resources in the Santa Fe community that could assist in this effort. There will be a follow-up session with SAMHSA to provide technical assistance to the Santa Fe team in helping to solidify the action plan and guide intervention efforts.

**18. Office of Peer Engagement (OPRE)**

OPRE wrapped up the year completing eight CPSW trainings across NM and is proud to announce that our State has a total of 340 CPSWs. In an effort to improve the peer workforce, OPRE will soon institute new requirements:

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

OPRE was successful in implementing State Targeted Response (STR) grant funding in incorporating new chapters in the CPSW training manual covering the topics of Opiate Use Disorder (OUD), Medication Assisted Treatment (MAT), and Mental Health Disorders. STR funds were also used to present MAT/OUD to Peers across the state as a free CEU opportunity. OPRE

in year two of STR projects will be issuing endorsements of CPSWs in hospital and correctional settings, as well as, outpatient treatment settings. In addition, OPRE will be convening a statewide "Peer Summit."

OPRE has partnered with CYFD in the development and implementation of a Family Peer Support program, training and certification which will offer a continuum of support for those in need, both for individuals who suffer and their immediate caretakers.

Train-the-Trainer: 11 new CPSWs were recently trained and certified to deliver the Peer Support week-long training. OPRE staff looks forward to their contributions 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, NASC Tribal Leadership Summit, and State, City and County committee meetings.

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;
- Inside Out is a staple of support in Espanola providing food and clothing banks and technical assistance with resumes, registrations and applications.
- Healing Circle in Shiprock specializes in tradition healing practices, and Native Women's supports and assistance;
- Mental Health Association provides much needed transitional housing services, supports and referrals to those discharged from the Behavioral Health Institute in Las Vegas;
- Carton County Grassroots Behavioral Health provides a lifeline of services to those in one of the most rural counties ; and
- 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.

**19. 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 20 regional hub/community partners participating in the initiative.

Performance Activities & Accomplishments:

- 13 Opioid Treatment Programs across the state have received training in Opioid Overdose and Naloxone Education.
- Several overdose reversals across the state have been reported to Bernie Lieving, STR Overdose Prevention Coordinator/Trainer.
- Inside Out OUT/MAT Trainings for CPSWs were completed:

- 4/13 in Santa Fe with 24 participants
    - 4/20 in Las Cruces with 11 participants
    - 4/27 in Santa Fe with 9 participants
    - 4/28 in Gallup with 11 participants
- Rio Arriba HHS held medication education fairs that served 240 individuals. Fairs were conducted in the following communities: Espanola, Ohkay Owingeh, Santa Clara, Alcalde, and Dixon.
- Santa Fe Recovery Center hosted a Seeking Safety Training on 4/26/18 with 28 participants.
- Santa Fe Prevention Alliance, in partnership with Santa Fe County, hosted a MAT 360 Conference on 4/14/18 with 108 participants.
- Year 2 scopes of work for regional hubs and partners are being finalized.
- Several new partners will be added in Year 2, to include San Miguel County Adult Detention Center and Santa Fe Mountain Center.
- A total of 809 new patients have been added to MAT and 1,480 have been referred to recovery support services. Total workforce trained is 1,138.

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.

Naloxone distribution under the STR grant has focused on training first responders throughout the state while increasing access to the medication. After the completion of Year 1, the number of kits distributed has totaled 3,006 with 1,184 trainings being conducted, 1,871 people being trained and 13 reported reversals due to grant funded Narcan being deployed.

**20. Opioid Treatment Programs (OTP)**

There are sixteen Opioid Treatment Programs (OTPs) operating in NM, serving approximately 5,549 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.

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 have conducted Naloxone trainings for OTPs and are currently providing technical assistance as needed.

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 near completion and will be sent out for public comment in the near future.

21. **PAX Good Behavior Game**

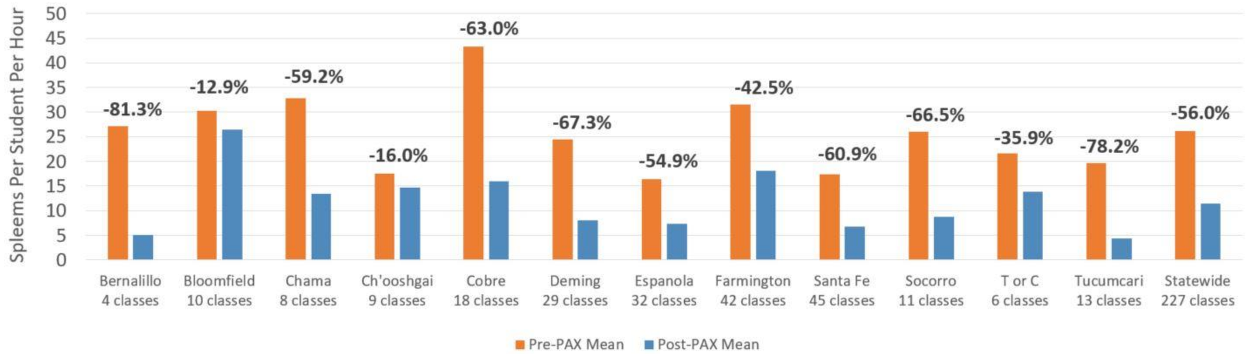
The PAX Good Behavior Game (PAX GBG) has been found to reduce disruptive behaviors, hyperactivity, and emotional symptoms. Its long-term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, 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.

FY18 implementation, begun last July, consists of two projects: the first is a continuation of efforts with the FY16 and FY17 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 2017, 12 school districts continued implementing PAX GBG. These districts participated in an initial teacher training to ensure new teachers received the training: Bernalillo Public School District (4 schools, 7 classrooms), Bloomfield School District (1 school, 3 classrooms), Chama Valley Independent School District (2 schools, 9 classrooms), Ch'ooshgai Community School (1 school, 9 classrooms), Cobre Consolidated School District (3 schools, 13 classrooms), Deming School District (4 schools, 45 classrooms), Espanola Public Schools (11 schools, 29 classrooms), Farmington Municipal School District (6 schools, 46 classrooms), Santa Fe Public Schools (4 schools, 21 classrooms), Socorro Consolidated Schools (3 schools, 13 classrooms), Truth or Consequences Public Schools District (1 school, 17 classrooms), and Tucumcari School District (1 school, 9 classrooms). A total of 217 teachers have been trained since August 2017, reaching 4,340 students across the state.

Evaluation data was collected between March and May 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. Spleems per student per hour had a statistically significant decrease of 56.5% statewide over the school year. The social competence evaluations provide information about changes in students' social skills and emotional regulation. Students' social competence scale scores had a statistically significant rise of 21.3% statewide over the school year. The teacher burnout survey assesses aspects of educator burnout such as emotional exhaustion, depersonalization, and sense of personal accomplishment. While changes in teacher burnout scales did not significantly change over the implementation period, higher fidelity when implementing PAX was associated with a modest but statistically significant drop in emotional exhaustion. Fidelity was measured using an instrument which assessed the frequency with which teachers implemented 11 key elements (kernels) of PAX GBG.

Spleems per student per hour, New Mexico, school year 2017/18




Indigenous PAX**:** Each of the three major New Mexico Tribal groups (Pueblo nations, Navajo Nation, and the Apache tribes) have been approached for participation, with the intent to create three distinct Native projects. On May 1st, a Tribal Liaison was hired to do PAX GBG outreach to Tribal communities and provide technical assistance and support for implementation. Outreach was conducted with Jemez/Zia Education Collaborative Retreat on May30-31st, Pueblo of Acoma and Jicarilla Apache on June 26th, and Santo Domingo on June 27th. Additionally, the Tribal Liaison, OSAP PAX GBG Program Manager, and Synar Coordinator presented Indigenous PAX to the Native American Behavioral Health Summit at San Felipe Pueblo on June 19th. Strategic planning meetings were held with PAX GBG developer Dr. Dennis Embry and Lead Trainer Claire Richardson on June 8th and June 14th.

Ch’ooshgai Community School, a small BIE school located in Navajo Nation, was trained November 30th. Nine core classroom teachers, six special education teachers and one administrator were trained, reaching 157 students; a booster session for teachers was provided on March 16, 2018. An Administrator Training was provided on December 18th to four additional Navajo Nation Tribal schools. 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.

**22. 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.

Overall Grant Update

A carryover request was submitted by OSAP and approved by SAMSHA during this quarter. Sub-recipients have begun to implement activities approved under the FFY17 carryover request. Rio Arriba, Santa Fe, Dona Ana, and Bernalillo County are all distributing additional naloxone in their respective areas and the distribution project with the Metropolitan Detention Center/Resource Re-entry Center (MDC/RRC) is in the final stages of preparation. Data collection training is currently being scheduled for MDC/RRC. Between July 2017 through May 2018, 1859 individuals received opioid overdose prevention and Narcan training, 4673 Narcan kits were distributed, and 19 overdose reversals were reported.

PDO Advisory Council

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 April 6, May 4, and June 1. Local distribution success stories were shared. PDO sites shared their experiences learned from the pilot period and expansion plans going forward.

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 1,095 Narcan kits and trained 775 individuals to respond to an overdose as of the end of May 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

Dona Ana County Health and Human Services (DACHHS):
DACHHS has distributed 2,191 Narcan kits and trained 577 individuals, and reported 13 opioid reversals as of the end of May 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

Santa Fe Prevention Alliance (SFPA):

SFPA has distributed 1,387 Narcan kits and trained 507 individuals, and reported 27 opioid reversals as of the end of May 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

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.

**23. 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.

As of August 2017, strategic plans were approved for 7 of the 9 sites, with the 8th site approved in April 2018. Implementation of prevention strategies have begun in 8 sites. 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. During summer and fall of 2018, IAIA will receive SPF trainings and technical assistance support to develop a strategic plan.

Throughout the quarter, providers received technical assistance (TA) via monthly webinars. To date, webinar topics have included SAMHSA Community Level Instrument requirements, 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, and conducting Town Halls. On-site TA was provided to San Juan College, New Mexico State University (NMSU), University of New Mexico (UNM), New Mexico Tech, the Institute for American Indian Arts (IAIA), Chaves County, Roosevelt County, Cibola County, and Curry County. These TA visits focused on engaging community partners, developing a logic model to utilize in planning efforts, establishing prevention systems at the local level, developing medial provider guides for prescribing opioids, and collaborating with Law Enforcement. In this quarter, all nine PFS 2015 entities conducted the NM Community Survey with the Pacific Institute for Research and Evaluation (PIRE). The NM Community Survey data will be analyzed throughout the summer and fall to gage progress on prevention outcomes.

All PFS 2015 sites received carry over funds from federal fiscal year 2017. These funds are being allocated for a series of social media workshops, public relations/media contracts at the local level, and conducting two town halls; one on prescription opioid misuse and another on underage drinking. Chaves, Cibola, and Roosevelt counties received funds in state FY18 for the public relations/media contracts. All five schools in the NMHEPC and Curry County will receive these funds in the first quarter of state FY19. All nine sites will be conducting their two town halls in the first quarter of state FY19, with carry over funds spent by September 30, 2018.

State Epidemiological Outcomes Workgroup: SEOW

During the fourth quarter, the SEOW met three times. On April 19th, the group had a presentation from PIRE on the evaluation of Project Lazarus and discussed the differences in rural vs. urban opioid use. On May 17th, NM DOH presented on the Prescription Monitoring Program (PMP) and available PMP data reports. Additionally in May, the SEOW reviewed the Opioid Prescriber Survey used to evaluate prescriber practices across the state. On June 21st, the SEOW discussed the statewide evaluation results of the PAX Good Behavior Game and reviewed appropriate methods to analyze the data.

**24. 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 BH within primary care and community health care settings. Each medical partner site universally screens adult patients 18 years old or over at least annually to identify those at-risk of or have a substance use disorder.

The pre-screen, Healthy Lifestyle Questionnaire (HLQ), includes questions from evidence based tools, such as the AUDIT 10, DAST, and PHQ-9. 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; UNM Hospital, Albuquerque.

NM SBIRT has made significant progress since the project's inception. As of June 27, 2018, a total of 48,658 screens were conducted with 43,459 individuals screened. There have been 27,337 negative screens and 21,320 positive screens. NM SBIRT has conducted 78,380 BIs; 4,122 Mental Health BIs; served 8,444 individuals with therapy, and referred 258 individuals to treatment services and 1,046 clients to various services, such as case management or family support services. 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.

**25. 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. Technical assistance for strategic planning was given by the state technical assistance provider last quarter and the plan was approved for implementation on October 24, 2017. 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. BCT is currently in full swing. TA including creating a project timeline, developing a core team to guide the project, recruiting community experts, recruiting and preparing a medical expert, prevention expert and facilitator, training the co-facilitator and planning event agendas. Zoom meetings between the TA provider and BCCHC staff were held to talk about the recruitment process and support on April 27, May 3, 7, 11, 24 and June 4. The TA provider met with the prevention expert to recruit, orient to the project and work on the presentation for community experts on May 3rd and 24th. The first core team meeting held June 8th covered expert and observer roles with background information on the project goals. The BCT Kick Off was held June 9th. Since kickoff, the TA provider has met with the core team via Zoom on June 15th and first community expert call on June 18th. TA support will continue throughout the project, which is scheduled to wrap up in September 2018.

Technical assistance was provided this quarter for implementation support of additional strategies in person on May 11th (assessing and tracking implementation progress and identifying TA needed), June 13th (BCCHC staff meeting, progress updates), June 21st (orientation to the grant), and June 22nd (scope of work review and progress/planning). Support will continue to be available throughout the project.

A BCCHC team member, preventionist and the TA provider attended the National Resource for Academic Detailing (NaRCAD) training (out of Harvard Medical School) and HERO TRaILS safe opioid prescribing training in Albuquerque. Since then, BCCHC has conducted 10 academic detailing sessions with 10 Family Medicine MDs, two Family Medicine PAs, and one Family Medicine NP. A debrief meeting was held between the BCCHC academic detailer and the TA provider on June 25th. BCCHC hired a full-time staff preventionist to fill a vacant position, restoring staffing back to two preventionists. The TA provider oriented the new staff member to the grant and the state prevention system on June 21st. BCCHC received training on conducting the New Mexico Community Survey from PIRE in January. NM Community Survey collection began in March of this quarter and came to completion in April.

26. **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 is arranging for the next meeting in July 2018 with the HLG and all stakeholders to execute implementation of the plan.

The 1115 waiver for Centennial Care 2.0 includes a supportive housing benefit 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.

<u>Housing Supports, Health, and Recovery for Homeless Individuals Grant (HHRHI)</u>
This three-year $5.4 million SAMHSA-funded grant program is in its final year, ending September 29, 2018. The program operates in Santa Fe, Bernalillo, & Dona Ana counties and provides permanent supportive housing for chronically homeless individuals with SUD, SMI, or co-occurring SUD and SMI. HHRHI incorporates the use of peers in the recovery model, and integrates the evidence-based practices of Permanent Supportive Housing, Supported Employment, Seeking Safety, and Motivational Interviewing into project implementation. Recent analysis on pre-post measures of functioning indicate a statistically significant decrease in PTSD symptoms; fewer days of serious depression, anxiety or tension, and trouble understanding, concentrating or remembering; more days prescribed psychiatric medication; and less subjective distress related to psychiatric symptoms. Data from the HHRHI evaluation was be presented at the upcoming New Mexico Public Health Association Annual Conference in April. Service providers for HHRHI have been pursuing sustainability measures over the course of the grant in order to continue services once federal funding ends.

27. **Treat First Learning Community**

Various Design Teams within the Treat First Learning Community are developing contributions to improving behavioral health practice. Two examples are:

<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 is developing 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 will offer a way for communication and discussion among clinicians as they seek support from their colleagues on clinical supervision issues.

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.

**DY5 Q1 ATTACHMENT F: 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

| *BCBSNM* | | |
|---|---|---|
| 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 –BCBSNM continues to address HSD findings to improve care coordination processes and documentation. BCBSNM continues to update HSD on the progress made on a monthly basis.

03/31/17 – BCBSNM 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 BCBSNM internal findings.

06/30/17 –BCBSNM'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. BCBSNM 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 – BCBSNM's self-auditing and monitoring continues. Additional education was completed by 09/30/2017. BCBSNM continues to conduct multi-disciplinary rounds to manage complex physical health and/or behavioral health care needs.

12/31/17 – BCBSNM 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, BCBSNM 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 – BCBSNM 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, BCBSNM 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 –BCBSNM'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, BCBSNM 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 BCBSNM'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, BCBSNM 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.

**Quarter 3 DY4**

*PHP*

Q2 DY4

| Action Plan #2 | Implementation Date | Completion Date |
|---|---|---|
| EQRO Encounter Validation Audit | 09/01/2017 | 6/30/2018 |

*Description*

Items listed in the EDV audit require correction – reconciliation process improvements; medical record information; file format improvement

*Status*
September 2017 – PHP is waiting for the final report and has asked for specific issues that the auditors found as noncompliant in order to effectively implement corrective action plans (CAPs). For instance, in its rebuttal PHP questioned the reporting that 50% of medical records failed. PHP requested specific data from the auditor such that PHP can work with its network of providers to correct.

December 2017 - PHP understands that many of the issues identified were also issues of process and all MCOs along with HSD will be working on solutions. PHP also understood that the final report had been published on the HSD website and have retrieved this final report. PHP will be developing specific responses to the issues identified and determining if these issues were: 1) related to start up in 2014 and have sense been corrected; 2) part of an HSD/MCO solution that needs to be developed; or 3) items that are very specific to PHP and need to be addressed - these will be put in a work plan and reported on next quarter.

March 2018 - PHP carefully reviewed the items listed in the audit results. Many issues that had been identified by the EQRO were remediated and are now resolved. All items will be documented and closed by the end of Q2.

June 2018 – This action plan is now closed; however, PHP will reopen any areas that HSD identifies as requiring follow up.

| *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.

**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]

*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.

**Quarter 1 DY5**

*BCBS*

| Q1 DY5 | | |
|---|---|---|
| Action Plan #3 | Implementation Date | Completion Date |
| Americans with Disabilities Act (ADA) and Cultural Compentency Indicators in Online Provider Finder and Printed Directory | 01/01/2018 | In progress |

*Description*
The BCBSNM 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 BCBSNM's online and printed Provider Directories. ADA indicators were loaded into provider records and will continue to be captured by BCBSNM as providers submit this information. BCBSNM will ensure that this information is up to date and accurate for members. As part of BCBSNM'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.

**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.

DY5 Q2 Attachment G: Customer Service Summary (March 1 - May 31, 2018)

## MCO CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

| | | CONTRACT STANDARD | BCBS | | | MHC | | | PHP | | | UHC | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | MAR | APRIL | MAY | MAR | APRIL | MAY | MAR | APRIL | MAY | MAR | APRIL | MAY |
| Member Services | Number of Calls Received - All Queues | | 10,659 | 10,265 | 9,741 | 10,786 | 10,012 | 9,440 | 12,865 | 12,400 | 12,073 | 6,774 | 6,436 | 6,406 |
| | Number of Calls Answered - All Queues | | 10,525 | 10,118 | 9,629 | 10,734 | 9,990 | 9,405 | 12,612 | 12,165 | 11,864 | 6,734 | 6,419 | 6,383 |
| | Percent of Calls Abandoned | < 5% | 1.3% | 1.4% | 1.1% | 0.5% | 0.2% | 0.4% | 2.0% | 1.9% | 1.7% | 0.6% | 0.3% | 0.4% |
| | Percent of Calls Answered within 30 Seconds | 85% | 96% | 95% | 94% | 98% | 99% | 98% | 86% | 88% | 87% | 92% | 95% | 97% |
| | Average Wait Time | < 2 minutes | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.1 | 0.3 | 0.3 | 0.3 | 0.1 | 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% |
| Nurse Advice Line | Number of Calls Received - All Queues | | 656 | 603 | 545 | 1,523 | 1,368 | 1,280 | 2,042 | 2,033 | 1,942 | 249 | 225 | 242 |
| | Number of Calls Answered - All Queues | | 651 | 601 | 544 | 1,505 | 1,353 | 1,271 | 1,995 | 1,995 | 1,905 | 246 | 223 | 240 |
| | Percent of Calls Abandoned | < 5% | 0.8% | 0.3% | 0.2% | 1.2% | 1.1% | 0.7% | 2.3% | 1.9% | 1.9% | 1.2% | 0.9% | 0.8% |
| | Percent of Calls Answered within 30 Seconds | 85% | 85% | 98% | 99% | 97% | 97% | 99% | 96% | 98% | 98% | 93% | 91% | 92% |
| | Average Wait Time | < 2 minutes | 0.2 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.3 | 0.1 | 0.0 | 0.5 | 0.6 | 0.2 |
| Provider Services | Number of Calls Received - All Queues | | 9,995 | 9,615 | 10,159 | 11,927 | 10,753 | 10,499 | 2,842 | 2,910 | 2,851 | 9,462 | 8,562 | 8,100 |
| | Number of Calls Answered - All Queues | | 9,855 | 9,455 | 9,979 | 11,896 | 10,735 | 10,466 | 2,824 | 2,897 | 2,824 | 9,415 | 8,532 | 8,083 |
| | Percent of Calls Abandoned | < 5% | 1.4% | 1.7% | 1.8% | 0.3% | 0.2% | 0.3% | 0.6% | 0.4% | 0.9% | 0.5% | 0.4% | 0.2% |
| | Percent of Calls Answered within 30 Seconds | 85% | 96% | 95% | 95% | 99% | 99% | 99% | 88% | 89% | 88% | 93% | 94% | 97% |
| | Average Wait Time | < 2 minutes | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.1 | 0.3 | 0.3 | 0.3 | 0.1 | 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 | | 7,815 | 7,352 | 7,854 | 3,967 | 3,856 | 3,594 | 1,607 | 1,595 | 1,712 | 2,504 | 2,501 | 2,578 |
| | Number of Calls Answered - All Queues | | 7,645 | 7,229 | 7,675 | 3,875 | 3,792 | 3,469 | 1,598 | 1,590 | 1,701 | 2,465 | 2,482 | 2,560 |
| | Percent of Calls Abandoned | < 5% | 2.2% | 1.7% | 2.3% | 2.3% | 1.7% | 3.5% | 0.6% | 0.3% | 0.6% | 1.6% | 0.8% | 0.7% |
| | Percent of Calls Answered within 30 Seconds | 85% | 88% | 88% | 88% | 95% | 96% | 96% | 88% | 91% | 91% | 89% | 93% | 95% |
| | Average Wait Time | < 2 minutes | 0.3 | 0.3 | 0.3 | 0.4 | 0.4 | 0.5 | 0.2 | 0.1 | 0.2 | 0.4 | 0.2 | 0.2 |

*Source: [MCO] Report 2, M3-M5 CY18*