Centennial Care Waiver Demonstration

Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2018 – 12/31/2018)
Waiver Quarter: 4/2018

March 7, 2019
New Mexico Human Services Department

Table of Contents

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 269,896 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment decrease of 2,269 from DY5 Q3.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through December 31, 2018. Quarterly data is available through the fourth quarter of calendar year 2018.

Primary Care Provider (PCP)-to-Member Ratios

The primary care provider (PCP)-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier areas. Noted in last quarter's progress report, UnitedHealthcare (UHC) members were acquired by and transitioned to Presbyterian Health Plan (PHP) on September 1, 2018. The significant increase in enrollment, approximately 65,500 members, impacted PHP's PCP-to-Member ratio. Still well within the 1:2,000 standard, PHP ensured that transitioning members would seamlessly retain their existing PCPs, or PHP would reach out to the member to assist in selecting an in-network provider. For additional information regarding PHP's primary provider network and the UHC transition, please refer to the Provider Network section of this report.

Because UHC no longer has members, a PCP-to-Member ratio was not calculated beginning in September 2018, and "no data" (nd) or not applicable is an accurate report. Please see Table 1: PCP-to-Member Ratios by MCO.

Table 1 – PCP-to-Member Ratios by MCO

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
BCBS	1:34	1:36	1:37	1:35	1:36	1:37	1:32	1:33	1:35
MHC	1:91	1:91	1:90	1:87	1:85	1:83	1:83	1:82	1:81
PHP	1:74	1:74	1:74	1:84	1:82	1:74	1:73	1:72	1:97
UHC	1:30	1:29	1:28	1:29	1:29	1:28	1:26	1:26	nd
Source: [MCO] PCP Report #53, Q3CY18									

Geographic Access

Physical Health and Hospitals

Geographic access performance standards require that at least 90% of members reside within defined distances to provider types in urban, rural, and frontier geographic areas. Please see Attachment B –GeoAccess Physical Health (PH) for New Mexico MCOs' geographic access performance.

Also of note, regarding MCO performance for geographic provider access this quarter, are the following points.

- MCO performance for access to general hospitals, PCPs, pharmacies and most specialties in urban, rural and frontier areas were met.
- Geographic access for dermatology, endocrinology, rheumatology, and urology services as well as access to neurosurgeons were, and continue to be, limited due to provider shortages in rural and frontier areas.
- Blue Cross Blue Shield of New Mexico (BCBS) reported 72.9% of urban members have access to dermatology. This is a slight improvement (+0.3%) as compared to last quarter. BCBS was the only MCO not meeting distance requirements for dermatology in urban areas. BCBS met geographic access to "FQHC- PCP Only" for rural members after having dropped below the performance standard last quarter.
- MHNM maintained a significant increase of urban members with access to dermatology services as reported in quarter two (+23%).
- BCBS and PHP met distance requirements for neurology services in frontier areas. MHNM is the only MCO to have met distance requirements for endocrinology (91%) in frontier areas.
- PHP's access percentages fluctuated somewhat during the UHC transition period. PHP established processes to ensure continuity of care and access for existing and transitioning members. For a description of PHP's transition process, please refer to the Provider Network section of the report.

Behavioral Health

In DY5 Q4, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier areas through Core Service Agencies (CSA), Community Mental Health Centers (CMHC), Outpatient provider agencies, psychiatrists, psychologists, Suboxone certified MDs, and other licensed independent behavioral health practitioners. (See Attachment C: GeoAccess Behavioral Health Summary for MCO performance in meeting access to specific provider types.)

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

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

HSD continues to be aware of the BH services that do not meet the standards due to provider shortages in New Mexico. MCOs continue to work to strengthen their relationships with the existing BH providers in their networks meeting routinely with them and with the State. The efforts to continue to increase accessibility through increased opportunities to expand use of telemedicine, maintain open panels, and expand reimbursement for extended hours have all been collaborated on.

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). The addition of CareLink New Mexico (CLNM) Health Homes also increased accessibility for Medicaid beneficiaries with serious mental illness (SMI) for adults and severe emotional disturbance (SED) for children and adolescents.

MCOs individually continue to work to maintain access with the current network while continually striving to build accessibility through efforts to provide innovative service delivery to their members by utilizing care coordinators, family and peer supports and Community Health Workers (CHWs). MCOs support their available network in ways such as having a Behavioral Health provider service representatives routinely visit providers to validate practice information, respond to claims and other issues. Additionally, MCOs are looking at value-based purchasing to increase access with appointment availability and utilizing High Fidelity Wrap around services to meet member's needs. MCO Network contracting teams monitor the out of network providers from the single case agreement files to recruit additional practitioners to participate in the Behavioral network. Also, ongoing assessments by some MCOs have identified recruitment opportunities with out of state border facilities for Inpatient BH services. It is also notable that MCOs continue to frequently be contracted with the entire available network for some services such as all approved Inpatient Psychiatric Hospitals and General BH Acute Hospitals in New Mexico although access standards are not met. The MCOs utilize additional border resources to provide members with access to services.

Community Health Workers

Centennial Care MCOs reported a 15% increase in members served by Community Health Workers (CHWs) from the previous reporting period. An increase of 21 CHWs was also reported for a total of 144 CHWs, employed or contracted. Please see Table 2 – Summary of CHW Workforce by MCO.

Table 2 – Summary of CHW Workforce by MCO

DY5 Q4			
Community Health Workers			
	Employed	**Contracted**	**Total**
BCBS	34	15	49
MHNM	19	0	19
PHP	40	1	41
UHC	20	15	35
Totals	**113**	**31**	**144**

Source: [MCO] CHW DSIPT, Q3CY18

Housing continues to be the number one social determinate of health need in quarter three, with food access unchanged as the number two request. CHWs are involved in working with members to regain personal documents such as birth certificates and social security cards to assist with applications for housing and other resources.

CHWs also obtain or update HRAs for members who have had an inpatient hospital admission or multiple Emergency Department visits, as well as link members with PCP appointments, prenatal and postpartum care, area wellness centers, detox resources and support in recovery, homeless shelter resources, and behavioral health facilities, including post discharge and follow-up resources. CHW services also focus on Hepatitis C treatment regimen support and follow up. Please see Table 3: Unduplicated Members Served by CHWs.

Table 3-Unduplicated Members Served by CHWs

DY5 Q4 Unduplicated Members Served					
	BCBS	**MHNM**	**PHP**	**UHC**	**Region Totals**
Underserved Urban	9,634	718	1,376	916	**12,644**
Rural	2,569	522	500	1,965	**5,556**
Frontier	643	84	153	704	**1,584**
MCO Totals	**12,846**	**1,324**	**2,029**	**3,585**	**19,784**

Source: [MCO] CHW DSIPT, Q3CY18

Educational outreach in Q3 included:

- NB3-Native American Healthy Foods Healthy Kids
- Head to Toe Healthy Kids Initiative
- American Lung Association-Asthma Basics
- St. Joseph's Children's Program- Parenting Classes
- Trumbull Resource Center-Toddler Safety Seat Education
- Roadrunner Food Bank-Health Foods Classes
- NM Legal Aid-Legal Topics Classes
- Health Education for Native Communities -Jicarilla, Zuni Pueblo, Taos Pueblo, Pine Hill Navajo Tribal 638, Alamo Navajo Tribal 638 & Ohkay Owingeh Pueblo

Telemedicine

MCOs reported increases in telemedicine services for rural and frontier areas of New Mexico in Q4DY5. MCOs reported the following efforts to increase telemedicine utilization.

- BCBS promoted the use of technology during the quarter, providing seven grants to New Mexico behavioral health provider groups ranging from $10,000-$15,000 to increase member access to telemedicine services. Tele-dermatology was made available through a primary care provider group. Promotion of telemedicine services was conducted at New Mexico Behavioral Health Provider Association meetings and a Provider Quick Reference Guide for telemedicine and newsletter was posted to the BCBS provider website.
- Molina Healthcare (MHNM) added Milagro Community Care providers to the Border Area Mental Health provider group increasing access to telemedicine services in the southeast cities of New Mexico, Silver City and Deming, both are located in.
- PHP focused on provider education, technical assistance, and telemedicine specific billing this quarter.
- UHC informed members of telemedicine services available through virtual visit technology and originating site location information.

Most telemedicine services are for members with behavioral health diagnoses. Please see Table 4 – Telemedicine Number of Behavioral Health Visits.

Table 4 - Telemedicine Services

DY5 Q4			
Number of Behavioral Health Visits			
	Urban	Rural	Frontier
BCBS	528	499	149
MHNM	549	1,014	148
PHP	1,938	2,324	1,160
UHC	194	523	135
TOTAL	**3,209**	**4360**	**1592**

Source: [MCO] Telemedicine DSIPT, Q3CY18

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

Transportation

To facilitate the ease of access, PHP and its transportation vendor SMT completed a trial run of online scheduling for non-emergency medical transportation for member appointments. PHP asked some of its Consumer Advisory Committee members to be part of the pilot program. Members responded positively to the enhanced scheduling option. Go-live for the program is January 1, 2019, and PHP aims to have utilization information by end of Q1CY19. The option for scheduling by telephone remains available to members as well.

Provider Network

During the last quarter of the year, HSD focused on Centennial Care 2.0 transition planning including member transitions, provider adequacy and network development. While HSD began transition planning in June 2017, with a thorough review and revision of its Transition Management Agreement (TMA), transition monitoring and deliverables continued through the quarter. Documents, due dates, and timelines were closely tracked by HSD to ensure continuity of care and services, facilitating a smooth transition for
New Mexico Medicaid members. Upon Go-Live of Centennial Care 2.0, on January 1, 2019, if a member's provider is determined to be out-of-network, all transition authorizations will be honored for a duration of 60–90 days depending on the service and in accordance with the TMA. In addition, the member's health needs and longevity with the provider will be reviewed by the receiving MCO to explore the potential for a single case agreement, the possibility of contracting with the provider, or assistance with a transition to a new provider as appropriate. To ensure continuity of care for members who do not want to switch providers, when their providers remain out-of-network for the receiving MCO, members will have an opportunity to switch MCOs. HSD monitored the complete list of MCO contracted and re-contracted weekly throughout the quarter and into 2019.

Service Delivery

Utilization Data

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

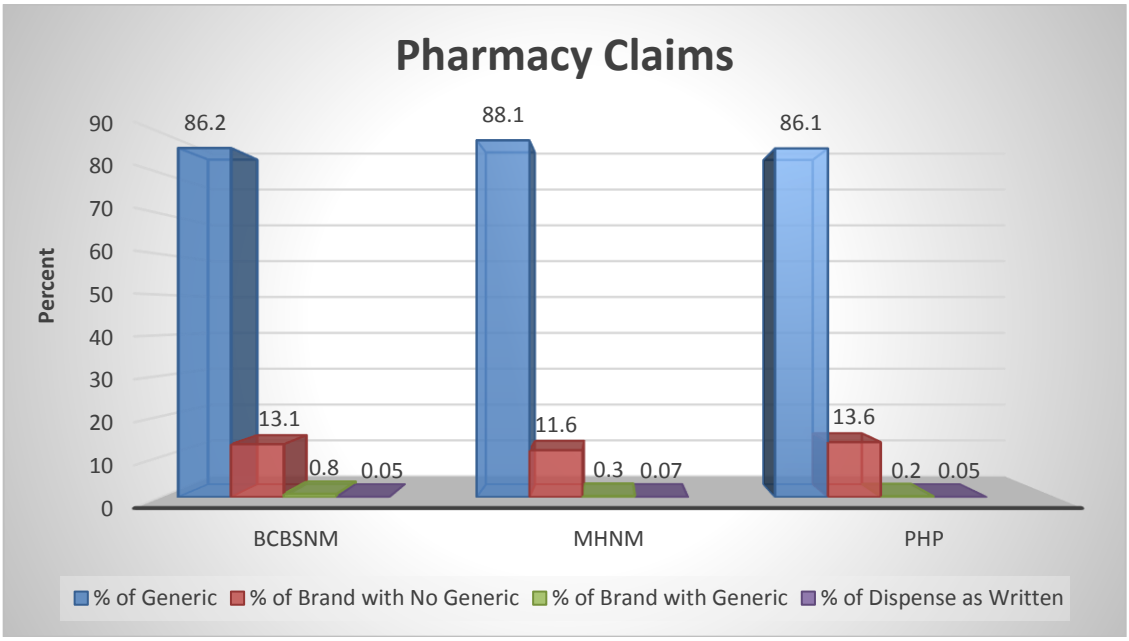
Pharmacy

HSD evaluates monthly MCO pharmacy reports to monitor key metrics regarding prescription claims on brand and generic drugs. Please refer to Table 5 – Percent of Pharmacy Claims for each MCO. This reporting period showed an average generic drug usage for all three MCOs of 87% which is a 1 percentage point decrease from the previous reporting period. In comparison to the last quarter, HSD identified the following:

- All MCOs had a slight decrease in generic drug utilization. BCBS had a 1.5 percentage point decrease, MHNM had a 0.6 percentage point decrease, and PHP had a 1.8 percentage point decrease in generic drug utilization from the previous quarter.

- All MCOs had an increase in usage of brand drugs with no generic available. BCBS had a 1.6 percentage point increase, MHNM had a 0.7 percentage point increase, and PHP had a 1.7 percentage point increase from the previous reporting period.
- The overall usage of brand medication when there was no generic available averaged 12.8 percentage points for the current reporting period with a 1 percentage point increase from the previous reporting period.
- BCBS AND PHP had a slight increase of 0.1 percentage point in the use of brand drugs when there was a generic available; MHNM remained the same. The 0.4% average use of brand drugs when there was a generic available had a slight decrease of 0.1 percentage point from the previous reporting period.
- All MCOs continue to require medical justification for the use of a brand drug when there is a generic available. Dispense as Written (DAW) claims averaged at 0.06% with MHNM having the highest number of DAW claims paid at 0.07%.

Table 5 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M9CY18, M10CY18, M11CY18

Hepatitis C (HCV)

During DY5 Q4, HSD reviewed MCO Q3DY5 data submitted on the HCV delivery system improvement performance target (DSIPT) reporting template. HSD is monitoring the number of unduplicated members requesting HCV treatment for Q3DY5 as well as similar numbers for direct antiviral agent prescription approvals and dispensing by both members' liver fibrosis stages and HCV genotypes.

Each MCO has implemented their own comprehensive plan to expand HCV screening, case finding and develop a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico. For Q3DY5 the following was reported:

- BCBSNM identified a large provider group which is interested in participating in the incentive program and is working on the finalized details. It is BCBS' intention to include incentives for provider training, starting patients on treatment and ensuring patients complete treatment.
- MHNM's comprehensive plan to expand HCV case finding and screening efforts are multi-faceted and consists of the following: 1) partnering with the Chronic Liver Disease Foundation to host HCV screening events at addiction treatment facilities; 2) establishment of a HCV database that tracks screening results, diagnosis based on laboratory results, and HCV medication treatment; and 3) monthly review of HCV database to identify members who have been screened, but were subsequently lost to follow-up, for outreach by our care coordinator team.

- PHP established a provider incentive plan to expand the number of practitioners treating chronic HCV in New Mexico, including incentive for receiving Hepatitis C training through UNM Project ECHO; incentives for initiating treatment for Hepatitis C positive members; and incentives for completion of treatments for Hepatitis C positive members.
- UHC implemented a comprehensive plan to expand HCV case finding and screening efforts by engaging shared value-based care (VBC) partners and to other practices throughout the state for member outreach. Care coordinators were also given lists of patients that meet screening recommendations with the expectation that they will outreach to encourage the members to have a Hepatitis C screening test.

Nursing Facilities (NFs)

In DY 5, Q4, HSD received the final audit report from Myers and Stauffer related to claims adjudicated for the period of July 2016 through June 2017 by the Centennial Care MCOs. MCOs were given an opportunity to review the draft report and offer additional documents and feedback. The final report included findings and recommendations for changes to MCO policies and procedures. HSD is working with MCOs to ensure policies and procedures are updated.

Community Interveners

In DY5 Q3, five Centennial Care members received Community Intervener (CI) services as illustrated below. The MCOs provide education to their care coordinators to assist in identifying members that meet the criteria for the CI service. The MCOs provide technical assistance to CI providers when needed regarding billing issues. Please see Table 6 – Community Intervener Services Utilization DY5 Q3.

Table 6 – Community Intervener Services Utilization DY5 Q3

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims paid
BCBSNM	1	6	$38
MHNM	0	0	$0
PHP	3	29	$734
UHC	1	20	$ 125
Total	**5**	**55**	**$897**

Source: [MCO] Utilization Management Report #41, Q3CY18

Centennial Rewards Program

Centennial Care members are eligible for Centennial Rewards and to date, 714,199 distinct members, or 70.7% of all enrollees, have earned at least one reward. Since the launch of

Centennial Rewards, members have earned points totaling a value of $60.3 million. Of that amount $15.4 million have been redeemed for a cumulative redemption rate of about 26.6%. Points expire at the end of the year after the year in which they were earned. The table below shows the healthy behaviors rewarded and each behavior's value. It includes the maximum dollar value available for each activity, the total dollars earned, the amount redeemed, and the associated percentage of redemption by activity. Please see Table 7 – Healthy Behaviors Rewarded.

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	$ 20,055
Bipolar Disorder Management	600	$60	$ 26,135
Bone Density Testing	350	$35	$ 1,295
Healthy Smiles Adults	250	$25	$ 306,425
Healthy Smiles Children	350	$35	$ 444,815
Diabetes Management	600	$60	$ 104,400
Healthy Pregnancy	1000	$100	$ 52,400
Schizophrenia Management	600	$60	$ 11,195
Health Risk Assessment (HRA)	100	$10	$ 40
Other (Appeals and Adjustments)	N/A	N/A	$ 43,780
Step-Up Challenge	250	$25	$ 32,075
Totals	**N/A**	**N/A**	**$ 1,042,615**

UnitedHealthcare Community Plan Termination

HSD sent out the Award Notification of the Centennial Care 2.0 RFP process to all the Managed Care Organizations (MCOs) on January 19, 2018. United Healthcare Care (UHC) was not awarded selection in Centennial Care 2.0 and began the transition process. During its transition, UHC entered into an agreement with Presbyterian Health Plan (PHP) and made plans to transition all UHC Centennial Care 1.0 membership to PHP after August 31, 2018. UHC submitted a Centennial Care 1.0 Decommission/Termination Plan to HSD on August 15, 2018 as required by and outlined in section 7.6.8 of the Managed Care Services Agreement and its Centennial Care 1.0 membership was transferred to PHP on September 1, 2018. UHC was advised by HSD regarding its continued contractual obligations for reporting and claims management requirements under the Transition Management Agreements and Transition Management section 7.6.8 of the Managed Care Services Agreement. UHC is current in all transition management requirements and continues to work though claims processing. HSD will continue to work with UHC on its contractual obligations through the remainder of 2019.

Molina Healthcare Plan Termination

HSD sent out the Award Notification of the Centennial Care 2.0 RFP process to all Managed Care Organizations (MCOs) on January 19, 2018. MHNM was not awarded a contract for Centennial Care 2.0 and began the transition process. MHNM entered into Transition Management Agreements with HSD and the selected Centennial Care 2.0 MCOs on May 14, 2018.

MHP submitted a Centennial Care 1.0 Termination Plan to HSD on March 15, 2018 as required by and outlined in section 7.6.8 of the Managed Care Services Agreement. MHP's Centennial Care 1.0 membership was transferred to the 2.0 Centennial Care MCOS on January 1, 2019. MHP was advised by HSD regarding its continued contractual obligations for reporting and claims management requirements under the Transition Management Agreements and Transition Management section 7.6.8 of the Managed Care Services Agreement. MHP is current in all its transition management requirements.

Section III: Enrollment

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

The following table outlines all enrollment activity under the demonstration. The enrollment counts include unique enrollees, not member months. Please note that these numbers reflect current enrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of the reporting quarter. Since members change eligibility and thus MEGs during the year, the only way to give an unduplicated count for the quarter and YTD is to look at the last month a client was in the MEG within the period. For that reason, the unduplicated total for YTD could be less than a prior quarter. Please see Table 8: Enrollment DY5 Q4.

Table 8 – Enrollment DY5 Q4

Demonstration Population	Total Number Demonstration Participants DY5 Q4 Ending December 2018	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**361,557**	**461,482**
FFS	38,918	61,662
Molina	108,047	141,292
Presbyterian	145,448	173,879
Blue Cross Blue Shield	69,144	80,064
Population 2 – SSI and Related – Medicaid Only	38,260	42,045
FFS	2,445	3,751
Molina	11,138	12,914
Presbyterian	17,414	12,312
Blue Cross Blue Shield	7,283	7,382
Population 3 – SSI and Related – Dual	36,113	38,217
FFS	0	149
Molina	6,998	7,488
Presbyterian	21,517	21,790
Blue Cross Blue Shield	7,598	7,548
Population 4 – 217-like Group – Medicaid Only	310	504
FFS	57	214
Molina	51	58
Presbyterian	137	159
Blue Cross Blue Shield	65	70
Population 5 – 217-like Group - Dual	4,162	4,101
FFS	0	20
Molina	798	863
Presbyterian	2,242	2,136
Blue Cross Blue Shield	1,122	925
Population 6 – VIII Group (expansion)	269,896	287,446
FFS	28,695	38,228
Molina	66,664	70,378
Presbyterian	106,984	99,362
Blue Cross Blue Shield	67,553	65,803

Disenrollments

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

HSD continues to monitor disenrollment and any potential issues. Validation checks are run periodically to identify any potential gaps in enrollment. Any issues that are identified or reported are researched and addressed. Please see Table 9: Disenrollment Counts DY5 Q4.

Table 9 – Disenrollment Counts DY5 Q4

Disenrollments	Total Disenrollments During DY5 Q4
Row Labels	
Population 1 – TANF and Related	**5,063**
FFS	484
Molina	1,509
Presbyterian	1,960
Blue Cross Blue Shield	1,110
Population 2 – SSI and Related – Medicaid Only	**291**
FFS	26
Molina	75
Presbyterian	120
Blue Cross Blue Shield	70
Population 3 – SSI and Related – Dual	**473**
Molina	104
Presbyterian	94
Blue Cross Blue Shield	103
Population 4 – 217-like Group – Medicaid Only	**8**
FFS	2
Molina	1
Presbyterian	3
Blue Cross Blue Shield	2
Population 5 – 217-like Group - Dual	**86**
Molina	9
Presbyterian	55
Blue Cross Blue Shield	22
Population 6 – VIII Group (expansion)	**6,784**
FFS	773
Molina	1,656
Presbyterian	2,720
Blue Cross Blue Shield	1,635
TOTAL	**12,705**

Section IV: Outreach

In DY5 Q4, HSD Outreach and Education staff participated in statewide outreach activities and events:

- Presented Centennial Care 2.0 changes to the New Mexico Aging & Long-Term Services Department's Aging & Disability Resource Center staff from around the state.
- Participated in the Centennial Care 2.0 readiness activities and conducted additional on-site visits for two MCO Member call-centers with a secondary location site and new call-center staff.
- Current MCOs participated in community events across the state providing enrollment opportunities and educating the public about Centennial Care. MCOs attended numerous Medicaid enrollment activities, health fairs and community events comprised of people with disabilities, senior citizens, children and families, Native Americans and other populations.

Please see Table 10: Schedule of Community Events DY5 Q4

Table 10 - Schedule of Community Events DY5 Q4

Event Type	Event Location and Date	Audience and Topics
NM Aging & Long-Term Services Department, Aging &	Santa Fe, NM Wednesday 12/19/2018	NM Aging & Long Term Services Department requested a Centennial Care 2.0 overview presentation for their state-wide Aging & Disability Resource Center staff.

Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's outreach efforts. With over 627 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 Q4, HSD PE Program staff updated the PE Certification trainings to reflect the

changes in the PE and on-going YESNM-PE application tool. The changes encompassed eligibility updates and manage care organization changes that were implemented as part of the 1115 waiver effective 01/01/2019.

PEDs continue to provide application assistance state-wide. In DY5Q4, PEDs:

- Granted 636 PE approvals*
- Submitted applications for 4,888 individuals
    - Resulted in 4,076 ongoing Medicaid approvals

*99.9% 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 program allows for the automated data transfer of information for Medicaid eligible or enrolled individuals who are incarcerated in New Mexico. Individuals who are Medicaid-enrolled have their benefits suspended after 30 days of incarceration. Benefits are reinstated upon the individual's release from incarceration which allows immediate access to care. Individuals who are not Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply. Application assistance is provided by PEDs at the correctional facilities.

HSD has added enhanced care coordination activities for incarcerated individuals to the 1115 waiver application submitted to CMS. Each MCO will be required to have a dedicated position for justice-involved transitions, including releases that occur on weekends and after hours. Each MCO will be required to work with the facilities to begin care coordination activities prior to an incarcerated individual's release. It is HSD's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, BH appointments, etc.) upon release.

In DY5, Q4, HSD continues the Centennial Care JUST Health workgroup. The workgroup includes representatives from State and County Correctional facilities, Managed Care Organizations, County governments, State agencies, provider organizations and other stakeholders. The goal of the workgroup is to create processes and procedures that can be utilized and adapted to work for all correctional facilities state-wide.

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

Encounter Data

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

Enrollment Data

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

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

Program Development

In preparation for implementation of Centennial Care 2.0, HSD worked with the Managed Care Organizations (MCOs) selected for 2.0 as well as the MCO whose contract would terminate in December 2018. Requirements were developed for the coordination and smooth transition of high-risk members and vulnerable populations. HSD conducted weekly calls with the MCOs to monitor the transition of these members, while ensuring continuity of care, the transfer of member files, care coordinator engagement, and collaboration between the MCOs.

HSD will have staff on-site at the new MCO, Western Sky Community Care (WSCC) for the first week of Centennial Care 2.0 to assist WSCC staff with the transition. HSD will also conduct daily calls with the Centennial Care 2.0 MCOs beginning January 3, 2019, to monitor activities including, but not limited to the following:

- Pharmacy claims and payment;
- Transportation utilization and grievances;
- Call center performance for the member services, provider services, utilization management, and nurse advice lines;
- Member enrollment, including care coordination level assignment and engagement efforts;
- Care coordination timely completion of Comprehensive Needs Assessments (CNAs);
- Nursing Facility Level of Care (NF LOC) determinations;
- Personal Care Service (PCS) claims payment and cash advances; and
- Utilization management (prior authorizations) for physical health, behavioral health, community benefits, durable medical equipment, and pharmacy.

Transition monitoring will continue and Transition Management Agreement (TMA) deliverables will be provided and tracked by HSD into early 2019 to ensure continuity of care and MCO compliance.

In DY5 Q4, HSD finalized Amendment #1 to the CC 2.0 contract. In this amendment, HSD requires new initiatives and worked to clarify definitions and expectations for the Managed Care Organizations (MCOs). Initiatives in the CC 2.0 Amendment #1 include but are not limited to:

- Increased thresholds for many of the Delivery Systems Improvement Performance Targets;
- Increased requirements for nursing facilities and those members meeting a nursing facility level of care;
- Clarified Care Coordination measures for members including but not limited to:
    - Members with co-morbid conditions;
    - Cognitive defects;
    - Poly-pharmaceutical use, defined as use of six or more medications from different drug classes or simultaneous use of three or more medications from the same drug

class;
    - Requiring assistance with two or more activities of daily living;
    - Members classified as difficult to engage.
- Supportive Housing programs targeting an increased population, including but not limited to:
    - Members with serious mental illness;
    - Chronic substance use disorders;
    - High emergency department usage;
    - High inpatient utilization;
    - Crisis stabilization;
    - Funding and direction for School Based Health Centers;
    - Implementation of a Federally Qualified Health Center (FQHC) residency pilot program, to be approved by HSD;
    - New requirements for pharmacy and provider payments and Spread Pricing methodology with required reporting on these initiatives to HSD;
- Initiatives to provide oversight and monitoring of the use of controlled substances including opioids, including but not limited to:
    - Implementation of a task force to develop a standard monitoring program for controlled substance utilization;
    - Monitoring of opioid drug use and poly-drug use in order to detect the potential for drug overdose;
    - Coverage of naloxone without prior authorization or quantity limits;
    - Establishment of a critical incident review committee;
    - Implementing Self-Directed Community Benefit (SDBC) measures to provide assistance and services to those who meet a nursing facility level of care but are able and willing to live in the community
- Quality Assurance initiatives including but not limited to:
    - Value Based Purchasing (VBP) initiatives to reward providers based on quality and improved outcomes rather than volume or services, initiatives require demonstration on how VBP programs improve member outcomes and quality scores;
    - Establishment of a critical incident review committee and reporting on annual dental visits and control of high blood pressure

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
Inpatient Behavioral Health Bundled Case Rates and Value Based Purchasing

BCBSNM has introduced a new reimbursement model to two high volume inpatient behavioral health providers in the state. The new reimbursement model includes paying providers a bundled case rate for each inpatient admission with a primary psychiatric diagnosis. Providers can share savings if the facility reduces their overall readmission rate and percentage of members who have follow-up appointments with a behavioral health provider within seven days of discharge.

The current reimbursement methodology for inpatient psychiatric providers is a negotiated per diem rate, or flat rate that is paid for every day a member is authorized for payment by BCBSNM. This requires the provider and BCBSNM to not only review the medical necessity of the admission, but also to do ongoing concurrent reviews throughout the stay to determine medical necessity. With the change to a bundled case rate, the provider will be paid a flat amount for the inpatient stay, no matter how long or short the stay is (with a stop loss provision if the stay is exceedingly long). The case rate will be slightly higher than the average amount providers are currently getting paid for an admission. With the case rate, the provider is only required to do a medical necessity review upon admission and is no longer required to do concurrent medical necessity reviews. This approach frees up resources for both the provider and BCBSNM to focus on aftercare arrangements and discharge planning.

The bundled case rate approach that allows providers and BCBSNM to focus on setting up strong discharge and aftercare plans are expected to help ensure members are seen soon after discharge, which has proven to be a significant factor in preventing readmissions within 30 days of discharge. Since a reduction of readmissions would have a financial impact on providers, this reimbursement model would share savings with BCBSNM as well from the reduced readmissions. The outcome of this reimbursement model is expected to significantly improve member outcomes while generating moderate savings.

Urgent Care Telemedicine Services in Member Homes

Telemedicine services that members can access from their home have been available for several years to members who have non-urgent healthcare needs and who have access to equipment (e.g., computer or smart phone) that provides real-time audio and visual. This standard telemedicine service can often treat members very effectively and efficiently; however, there are times that members require more of a "hands-on" approach. For example, a telemedicine provider is typically not able to obtain member's vital signs (e.g., blood pressure, pulse, breathing, etc.), and if a provider thinks it's necessary, the member is referred to an urgent care or emergency room. In addition, some members do not have the necessary equipment to access telemedicine services from their home.

BCBSNM has been working with an urgent care provider on a new telemedicine service model that addresses these limitations of the standard telemedicine visit. This urgent care telemedicine model includes sending a paramedic to the member's home. The paramedic would take the member's vital signs and collect other basic information that is typically done by a nurse in an office or urgent care setting. The paramedic then initiates a telemedicine call with the urgent care provider who is at the urgent care center ("distant site") by portable telemedicine equipment, which the paramedic sets up in the home. The member successfully has their telemedicine visit with the urgent care provider.

The urgent care provider is reimbursed for the telemedicine urgent care visit at the same rate as if the member was seen at the urgent care center, plus an additional fee for the telemedicine "originating site" fee. Members can set up these urgent care telemedicine visits either online or by phone. This urgent care telemedicine service will be available for members in the first quarter of 2019.

Difficult to Engage Program

In early 2019, BCBSNM is piloting a new initiative called the Difficult to Engage (DTE) Program with the intention to increase care coordination engagement with the DTE and Unable to Reach (UTR) population. The purpose of the DTE Program is to locate and establish contact with members whom BCBSNM has not been able to reach through traditional channels and engage them in care coordination. BCBSNM recognizes that some DTE/UTR members have mental/behavioral health disorders, substance abuse issues, or a psychosis when left untreated, may lead to a higher risk of self-harm, harm to others, or increase in Emergency Department (ED) and/or Hospitalization utilization. BCBSNM's strategy is to develop a team that has unique training and background to engage with difficult members and develop a relationship in order help move them towards care coordination. This team will consist of DTE care coordinators who will be able to complete assessments and triage any urgent issues before assigning the member to a care coordinator. Once assigned, the care coordinator will resume care coordination activities with the member.

Initially, the project will launch in the Metro and Las Cruces area based on the highest concentration of population, ED/Hospitalization usage, homelessness, and DTE/UTR data. BCBSNM will expand the program and eventually cover all of New Mexico as BCBSNM's capacity increases.

Benefits of the DTE Program include:

- Improving member relationship and participation in care coordination
- Improving treatment outcome
- Reducing unnecessary ED/Hospital utilization
- Improving healthcare utilization
- Decreasing unnecessary medical expense
- Reducing closure rates
- Decreasing unnecessary strain upon health facilities through care coordination

By having a team dedicated to reaching out to these difficult to engage members, BCBSNM is extending its healthcare reach and closing the gap to ensure every member has an opportunity to participate in care coordination and receive the treatment they need.

Molina Healthcare Community Paramedicine

Molina Healthcare partnered with American Medical Response (AMR) and Las Cruces Fire Department (LCFD) with the objective to improve the triple aim of better health, better care and lower costs. Both vendors conducted home visits/outreach to targeted Members providing assessments and education to reduce gaps in care.

Continuous Quality Improvement – Pre and Post-Partum HEDIS

The QI and Population Health Department maintained the Motherhood Matters program, assisting women to obtain the education and services needed for a healthy pregnancy. Services may include prenatal education materials, coordination with social services, and/or case management by a nurse. Expecting mothers can receive 1,000 points ($100) in Centennial Rewards for completion of their maternity screening with a Care Coordinator to identify any additional support or assistance that may be needed. Following delivery, Members who complete their postpartum visit between three (3) and eight (8) weeks after delivery are eligible to receive a reward gift card.

Health Home – CareLink NM

As of 12/31/2018, Molina had 746 members opted-in to Health Homes across the state. The QI and Population Health Department identifies and refers members who qualified for a Health Home.

Quality Improvement PMs – Provider Outreach/Partnerships

- 2 high volume groups participated in a cost-containment program for high risk members (mPACT):
    - Targeted 10% PMPM cost reduction over 12 months;
    - Both provider groups exceeded the targeted reduction;
    - $2.7 M in cost savings was achieved; and
    - 50% of cost savings was shared back to the provider groups.
- Continued to provide education about quality initiatives and health education programs at Member Advisory Board meetings in collaboration with the Member Engagement Department and Native American Affairs.
- Continued to review best practices for improved performance measure rates for targeted Provider Engagement Team (PET) visits at First Choice Community Health Clinic, Clinica la Esperanza, Las Cruces Physician Services, La Clinica de Familia, Presbyterian Medical Services and Lovelace.

Quality Improvement/Member Engagement

Member Engagement hosted **5** Member Advisory Board Meetings in the 4th quarter. The meetings were for Marketplace, Medicare and Centennial Care members and were held in Albuquerque, Upper Fruitland and Las Cruces NM. Topics included self-help tools such as MyMolina Portal and HealthInHand App; other topics included Members' Rights & Responsibilities, Members' Appeals & Grievance process, role and responsibilities of the Ombudsman Care Coordination and Community Benefits. Members were also informed about Health Education Programs such as Quit for Life, Motherhood Matters, National Diabetes Prevention Program, My Chronic Disease and Centennial Rewards. To focus on Behavioral Health, Members were educated about the Peer Support Program and provided with the number for the NM Crisis Line as an additional resource.

Presbyterian Health Plan

PHP finalized an agreement with the Navajo Nation Shiprock Service Unit CHR/Outreach Program to provide community outreach services. The agreement covers the State of New Mexico, part of San Juan County, and the Shiprock Agency.

PHP continues the rollout of their Provider Incentive Program with its next target being the Farmington/Bloomfield area of the state. PHP looks to have this incentive program completed by the end of the first quarter of 2019.

Staff expansion

The Population Health Management Community Health Worker (CHW) team added 8 new CHW FTEs and 4 new Certified Peer Support Worker (CPSW) FTEs and 1 CHW supervisor FTE to the current population health management (PHM) team of 9 CHWs and 1 Manager. The additional staff allows the team to cover a greater number of counties in the southern and northern parts of the state, including the northwest part of New Mexico. The identified member behavioral health needs are addressed more effectively with adding CPSWs to the team. A high percentage of members who are identified with social needs, emergency department (ED) overutilization and physical health care gaps have underlying behavioral health and substance abuse disorders.

Development of Questionnaires & Tools for Care Plans in JIVA

PHP's previous social determinants of health (SDOH) needs questionnaire was updated to reflect evidence-based questions from the "Health Leads Social Needs Screening Toolkit" into the new medical management system, JIVA. Social needs identified during the screening process then trigger a care plan item with suggested goals and interventions based on the Community Health Worker's scope of work as defined by the New Mexico Department of Health Community Health Worker board. Additionally, by identifying needs that require CHW/PSW intervention and documenting the outcome of the intervention in a care plan format, outcomes data can more easily be gathered and measured for future program enhancements.

Fiscal Issues

During DY5 Q4, underwriting gain recoupment for capitation rates for calendar year 2016 reduced the PMPM for MEG 1 of DY 3. The health insurance providers fee payments and recoupments for retroactive eligibility and hepatitis C reconciliations resulted in a higher PMPM for MEG 1 and 6 of DY 4. The health insurance providers fee payment and patient liability reconciliation payments contribute a higher PMPM for MEG 2 of DY 4. For DY 5, the capitation payments reflected the rates update to account for additional programmatic change, changes to the medical and non-medical components to account for material changes in the enrolled populations, and a change to the premium assessments. These changes were identified in the revised rate certification letters dated June 11, 2018 and submitted to CMS on August 17, 2018. The effects of those changes continued to contribute to higher PMPMs for all MEGs in quarter 4 of DY 5 compared to those PMPMs reported for quarter 3 of DY 5.

Systems Issues

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

Medicaid Management Information System Replacement

HSD's planning for replacement of its current legacy Medicaid Management Information System (MMIS) began some time ago, and activity for this effort continued to progress in DY5 Q4. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the Department of Health (DOH), Children Youth and Families Department (CYFD), and the Aging and Long-Term Services Department (ALTSD). These three departments have participated in RFP development and replacement planning. For overview and status please reference Table 12: Overview of status for MMSIR Modules.

Table 12 - Overview of status for MMSIR Modules

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

Section VII: Home and Community-Based Services

New Mexico Independent Consumer Support System (NMICSS)

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

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

ADRC Coordinators provide over the phone counseling in care coordination, which is the

process for assisting the client in describing their situation/problem. ADRC staff offers options, coordinates New Mexico's aging and disability service systems, provides objective information and assistance, and empowers people to make informed decisions. The ALTSD provides quarterly reports to HSD regarding the ADRC Caller Profile Report and Care Transitions Program Data. Please see Table 11: ARDC Call Profiler Report DY5 Q4 and Table 12: ADRC Care Transition Program Report DY5 Q4.

Table 11 – ADRC Call Profiler Report DY5 Q4

Topic	# of Calls
Home/Community Based Care Waiver Programs	1,927
Long Term Care/Case Management	3
Medicaid Appeals/Complaints	4
Personal Care	226
State Medicaid Managed Care Enrollment Programs	13
Medicaid Information/Counseling	702

Table 12 – ADRC Care Transition Program Report DY5 Q4

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		159	
Medicaid Education/Outreach	3418		
Nursing Home Intakes		72	
**LTSS Short-Term Assistance			160

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

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

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

The CTB provides education of the program and transition referrals to new nursing facility staff. The CTB is working closely with the MCOs to identify ways to work collectively to increase referrals and provide advocacy to additional residents in the transition process.

The CTB supervisors and bureau chief met with incoming Medicaid Centennial Care 2.0 MCO, Western Sky Community Care. The meeting provided introductions to discuss programs the ALTSD/ADRC serve and how to work collaboratively with Medicaid recipients in the transition process.

Critical Incidents

HSD continues to meet quarterly with the MCOs' Critical Incident workgroup in an effort to provide technical assistance. The workgroup also supports the Behavioral Health Services Division (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.

United Healthcare (UHC) data is not reflected in the DY5 Q4 report. UHC coordinated with Presbyterian to transfer its Medicaid membership on September 1, 2018. HSD continues to monitor the transition to ensure continuity of care for Medicaid members. UHC provides HSD with a weekly update regarding the single death investigation which currently remains open. This investigation remains open and pending a report from of the Office of the Medical Investigator.

During DY5 Q4, a total of 5,523 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 with reporting requirements.

During DY5 Q4, a total of 494 deaths were reported. Of those deaths reported, 471 were reported as natural or expected deaths while 71 deaths were reported as unexpected and one death was reported as a suicide. 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 to determine cause of death. MCOs have internal processes regarding follow-up for all member deaths.

During DY5 Q4, a total of 3,544 critical incidents were categorized as Emergency Services. Of those, 171 were reported by BH providers and 255 were associated with self-directed members. This demonstrates a downward trend in the number of incidents categorized as Emergency Services when compared to DY5 Q3 (3,865), DY5 Q2 (3,797), DY5 Q1 (3,685). 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 Incidents Types by MCO – Centennial Care.

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	28	0.58%	74	1.53%	126	2.60%	0	0.00%	228	4.70%
Death	132	2.72%	85	1.75%	277	5.71%	0	0.00%	494	10.19%
Natural/Expected	120		79		233		0		432	
Unexpected	12		6		43		0		61	
Suicide	0		0		1		0		1	
Elopement/Missing	1	0.02%	8	0.16%	8	0.16%	0	0.00%	17	0.35%
Emergency Services	582	12.00%	720	14.85%	1,816	37.44%	0	0.00%	3,118	64.29%
Environmental Hazard	15	0.31%	18	0.37%	44	0.91%	0	0.00%	77	1.59%
Exploitation	13	0.27%	14	0.29%	49	1.01%	0	0.00%	76	1.57%
Law Enforcement	17	0.35%	18	0.37%	31	0.64%	0	0.00%	66	1.36%
Neglect	118	2.43%	123	2.54%	533	10.99%	0	0.00%	774	15.96%
Total	**906**	**18.68%**	**1060**	**21.86%**	**2,884**	**59.46%**	**0**	**0.00%**	**4850**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	4	1.17%	20	5.85%	18	5.26%	0	0.00%	42	12.28%
Death	2	0.58%	8	2.34%	12	3.51%	0	0.00%	22	6.43%
Natural/Expected	2		7		9		0		18	
Unexpected	0		1		3		0		4	
Suicide	0		0		0		0		0	
Elopement/Missing	0	0.00%	3	0.88%	2	0.58%	0	0.00%	5	1.46%
Emergency Services	13	3.80%	111	32.46%	47	13.74%	0	0.00%	171	50.00%
Environmental Hazard	0	0.00%	2	0.58%	2	0.58%	0	0.00%	4	1.17%
Exploitation	1	0.29%	3	0.88%	6	1.75%	0	0.00%	10	2.92%
Law Enforcement	4	1.17%	6	1.75%	11	3.22%	0	0.00%	21	6.14%
Neglect	10	2.92%	23	6.73%	34	9.94%	0	0.00%	67	19.59%
Total	**34**	**9.94%**	**176**	**51.46%**	**132**	**38.60%**	**0**	**0.00%**	**342**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	1	0.30%	5	1.51%	7	2.11%	0	0.00%	13	3.93%
Death	5	1.51%	2	0.60%	20	6.04%	0	0.00%	27	8.16%
Natural/Expected	5		1		15		0		21	
Unexpected	0		1		5		0		6	
Suicide	0		0		0		0		0	
Elopement/Missing	0	0.00%	1	0.30%	0	0.00%	0	0.00%	1	0.30%
Emergency Services	34	10.27%	31	9.37%	190	57.40%	0	0.00%	255	77.04%
Environmental Hazard	0	0.00%	0	0.00%	4	1.21%	0	0.00%	4	1.21%
Exploitation	1	0.30%	2	0.60%	2	0.60%	0	0.00%	5	1.51%
Law Enforcement	3	0.91%	1	0.30%	7	2.11%	0	0.00%	11	3.32%
Neglect	0	0.00%	4	1.21%	11	3.32%	0	0.00%	15	4.53%
Total	**44**	**13.29%**	**46**	**13.90%**	**241**	**72.81%**	**0**	**0.00%**	**331**	**100.00%**

Home and Community-Based Services Reporting

In DY5 Q4, HSD completed its analysis of 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 Q4, 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.

HSD continued to hold meetings with PHP to discuss and resolve any transition issues for members who transitioned from UHC as described in the previous quarterly report. PHP resolved all Personal Care Services authorizations related issues, and no new issues were reported during the quarter.

In October 2018, HSD began meeting with each of the MCOs on a weekly basis in anticipation of the implementation of Centennial Care 2.0 and the transition of LTC members between MCOs. In addition, the following long-term care areas were monitored by HSD through weekly reporting from the MCOs:

- LTC service authorization information file transfers amongst MCOs to ensure no break in services occurred with transitioning members;
- Self-Directed member transitions from one MCO to another;
- Development of Western Sky Community Care's LTC provider network; and
- Timely processing of NF LOC determinations.

Self-Directed Community Benefit

In DY5 Q4, HSD met regularly with the SDCB fiscal management agency (FMA) and the MCOs to develop and implement system changes needed for the Centennial Care 2.0 new initiatives such as:

- Start-Up Goods as a new service;
- Increased Respite hour limit from 100-300;
- Limits on certain services for new SDCB members;
- Non-Medical Transportation procedure code changes; and
- Continuous NF LOC.

Electronic Visit Verification

In DY5 Q4, HSD continued planning activities with the MCOs and their EVV Vendor, First Data, for the implementation of EVV for self-directed personal care services. MCOs continued to solicit member input through their regular Member Advisory Board meetings. The SDCB EVV member survey was closed on December 31, 2018, and HSD is analyzing the data that will drive policy decisions in early 2019.

Section VIII: AI/AN Reporting

Access to Care

I/T/Us are concentrated near or on Tribal land where many Native Americans live and receive services. Native Americans in Centennial Care may access services at IHS and Tribal 638 clinics at any time. Approximately 53,891 Native Americans are enrolled in Centennial Care. Data from the MCOs this quarter is consistent with the previous quarter showing:

- 97.5% access to care for Native Americans in rural areas and 98.4% in frontier areas for physical health
- 97.5% access to care for Native Americans in rural areas and 98.4% in frontier areas for behavioral health

Contracting Between MCOs and I/T/U Providers

Since the last quarterly report, UnitedHealthcare members transitioned to Presbyterian Health Plan effective September 1, 2019. The remaining MCOs BCBS, Molina and Presbyterian Health Plan continue to reach out to Indian Health Service (IHS) and Tribal 638 health providers, as well as Tribal programs to develop agreements. Some of the MCOs have contracts with Navajo Area IHS. The MCOs treat the non-contracted I/T/Us as if they are contracted for services rendered to their MCO members. For several of the MCOs, services rendered at any non-contracted I/T/U are considered contracted/in-network for members. There is ongoing outreach to I/T/U programs for reimbursement for telemedicine, peer support recovery programs, Community Health Representative (CHR) services, and non-emergency medical transportation. Several MCOs continue to work with Tribal CHR programs to develop a customized process to reimburse them for their services to MCO members.

Ensuring Timely Payment for All I/T/U Providers

Two of the four MCOs met timely payment requirements for claims processed and paid within 15 days of receipt. The contract standard is for 95% of claims to be processed and paid within 15 days of receipt. For claims processed and paid within 30 days of receipt, none of the MCOs met this standard. The range was 88% to 96% and the contract standard is 99% of claims will be processed and paid within 30 days of receipt. Please see Table 14: Native American Advisory Board (NAAB) meetings for DY5 Q4.

Table 14 – Native American Advisory Board (NAAB) meetings for DY5 Q4

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	PMS Farmington Community Health Center Farmington, New Mexico October 17, 2018	**Issue**: A member asked if all her prescriptions could be sent to the pharmacy. **Response**: BCBS Ombudsman responded that behavioral health prescriptions will be limited. **Issue:** A member asked the difference between home health services and personal care services. **Response:** BCBS stated home health services are for short term acute conditions. Personal Care Services (PCS) are for chronic conditions requiring long-term care. A member needs to qualify for PCS based on Activities of Daily Living (ADL).
MHC	Five Sandoval Indian Pueblos, Inc. Rio Rancho, New Mexico September 12, 2018	There have been some changes to the Motherhood Matters program. One major change Molina informed the group about is a $20 Walmart gift card in lieu of a car seat upon completion of the program. **Issue:** What is the difference between an emergency room (ER) visit and an urgent care visit? **Response:** Molina provided examples of the difference and explained when each one should be used. **Issue:** What is the status of Molina Healthcare in 2019? **Response:** Molina informed members that Molina Healthcare was not selected to be an MCO for Centennial Care 2.0 starting January 1, 2019. Molina Healthcare will continue to provide Medicaid coverage untilthe end of 2018.

PHP	CHR Conference Room Mescalero, New Mexico October 19, 2018	**Issue:** A lot of members don't know anything about care coordination. **Response:** PHP had care coordinators at the meeting who explained what care coordination is andhow care coordinators can help members. It starts with a health risk assessment. **Issue:** PHPs transportation vendor, SMT, does not offer mileage reimbursement. SMT denied member transportation because they needed to find a doctor closer to Ruidoso. **Response:** SMT does not approve or deny transportation. If the travel distance is exceeded, then SMT reaches out to the PHP travel team to give a determination. **Issue:** Diabetic patients are being told they can't eat or drink in the transportation vendor's car. **Response:** For medical issues it is allowed, but the member is asked to bring the meal in a sealed container. There is also a handout for transportation in the packet.
UHC	Farmington Marriott Courtyard Farmington, New Mexico June 7, 2019	The meeting began with UHC informing the group that UHC's bid was denied for Centennial Care 2.0. UHC remains dedicated to its members and the partnerships. They will be operating business as usual. **Issue:** Transport providers are not showing up on time. **Response:** Minutes don't indicate response, but the transportation vendor was at the meeting. **Issue:** What the rules are if a member needs an attendant to assist the member? **Response:** It must be medically necessary and transportation vendor will provide the form.

HSD's Native American Technical Advisory Committee (NATAC) Update
At the NATAC meeting December 10, 2018, the NM Medicaid deputy director presented an update on Centennial Care 2.0 and changes that are effective 01/01/2019.

There was also an update on the federal match for services received through an IHS/Tribal 638 facility. NATAC presented the Native American Data Report which is analyzed quarterly for Native Americans receiving MCO services. There was a Community Health Representative (CHR) update and an Income Support Division (ISD) update.

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 continues to bill for the FMAP for FFS members as well as Native Americans in an MCO referred by IHS. UNMH is in the final stages of having a CCA in place with two Tribal 638 facilities.

- **Navajo Area IHS (NAIHS) and UNMH**
  The CCA between UNMH and Navajo Area IHS was signed 09/26/2018. UNMH began billing for claims 12/01/2018 after a system configuration that was required to process identified claims for the 100% federal match with NAIHS.

- **AAIHS and Presbyterian**
  Presbyterian began claiming the FMAP for services referred by IHS 05/01/2018. Currently they are only identifying claims for FFS members.

- **NAIHS and Presbyterian**
  The CCA discussions were on hold during the federal shutdown since key players with NAIHS were unable to be on the calls. The first conference call between NAIHS and Presbyterian was 01/30/2019. Presbyterianasked NAIHS to research the volume of referrals NAIHS is sending to Presbyterian providers before a second meeting is scheduled.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment F: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY5 Q4 reflects the continued impact of the CY 2018 rate adjustments for programmatic change, changes to the medical and non-medical components to account for material changes in the enrolled populations, and a change to the premium assessments as provided to CMS on August 17, 2018. The PMPM for DY 5 is lower compared to DY 4 for MEGs 1and 2; the PMPM for DY 5 is higher than those of DY 4 for MEGs 3 to 6 (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY 5 is 28.1% below the budget neutrality limit (Table 5.4) based on four 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. Please see Table 15: Member Months DY5 Q4.

Table 15 – Member Months DY5 Q4

Number of client by Population Group and MC	
	2018
	Q4
Population 1 – TANF and Related	**1,081,476**
FFS	112,859
MC	
Molina	327,246
Presbyterian	436,815
Blue Cross Blue Shield	204,556
Population 2 – SSI and Related – Medicaid Only	**114,388**
FFS	7,354
MC	
Molina	33,563
Presbyterian	51,974
Blue Cross Blue Shield	21,497
Population 3 – SSI and Related – Dual	**106,121**
MC	
Molina	20,658
Presbyterian	63,591
Blue Cross Blue Shield	21,872
Population 4 – 217-like Group – Medicaid Only	**996**
FFS	252
MC	
Molina	153
Presbyterian	402
Blue Cross Blue Shield	189
Population 5 – 217-like Group - Dual	**12,014**
MC	
Molina	2,368
Presbyterian	6,519
Blue Cross Blue Shield	3,127
Population 6 – VIII Group (expansion)	**750,077**
FFS	74,318
MC	
Molina	189,286
Presbyterian	298,831
Blue Cross Blue Shield	187,642

Section XII: Consumer Issues – Complaints and Grievances

A total of 763 grievances were filed by Centennial Care members in DY5 Q4. This demonstrates a decrease when compared to member grievances received in DY5 Q3 (1,114). An overall trend cannot be established when compared to DY5 Q2 (850) and DY5 Q1 (891).

Non-emergency ground transportation continues to constitute the largest member grievance code reported. The total number of grievances received was 399. This demonstrates a decrease when compared to 572 in DY5 Q3. An overall trend cannot be established when compared to DY5 Q2 (442) and DY5 Q1(414). 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 48 grievances reported. This demonstrates a decrease when compared to 72 in DY5 Q3. An overall trend cannot be established when compared to DY5 Q2 (51) and DY5 Q1 (101).

There were 316 variable grievances filed in Q4 of DY5. 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 Q4.

Table 16 – MCO Grievances DY5 Q4

MCO Grievances DY5 Q4 (October - December 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	277	36.30%	60	7.86%	372	48.76%	54	7.08%	**763**	100.00%
Top Two Prmary Member Grievance Codes										
Transportation Ground Non-Emergency	186	24.38%	20	2.62%	193	25.29%	0	0.00%	**399**	52.29%
Other Specialties	18	2.36%	0	0.00%	7	0.92%	23	3.01%	**48**	6.29%
Variable Grievances	73	9.57%	40	5.24%	172	22.55%	31	4.06%	**316**	41.42%

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD reviews service plans to ensure the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs appropriately allocate and implement the services identified in the member's CNA, and that the member's goals are identified in the care plan. There were no identified concerns in DY5 Q4. Please see Table 17: Service Plan Audit Results DY5 Q4.

Table 17 – Service Plan Audit Results DY5 Q4

Member Records	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	**120**	**120**	**110**	**90**
BCBSNM	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**20**	**N/A**
Percent of files with personalized goals matching identified needs	**100%**	**100%**	**100%**	**100%**
BCBSNM	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**30**	**N/A**
Percent of service plans with hours allocated matching needs	**100%**	**100%**	**100%**	**100%**
BCBSNM	**30**	**30**	**30**	**30**
MHC	**30**	**30**	**30**	**30**
PHP	**30**	**30**	**30**	**30**
UHC	**30**	**30**	**20**	**N/A**

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 Q4 and Table 19: Community Benefit NF LOC Audit DY5 Q4.

Table 18 – Nursing Facility LOC Audit Results DY5 Q4

MCO High NF LOC denied requests (and downgraded to Low NF)	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	15	12	11	10
BCBSNM	5	4	2	5
MHC	0	0	0	0
PHP	5	5	5	5
UHC	5	3	4	N/A
HSD Reviewed Results	**DY5 Q1**	**DY5 Q2**	**DY5 Q3**	**DY5 Q4**
Number of member files that met the appropriate level of care criteria	15	12	11	10
BCBSNM	5	4	2	5
MHC	0	0	0	0
PHP	5	5	5	5
UHC	5	3	4	N/A
Percent of MCO level of care determination accuracy	100%	100%	100%	100%

Table 19 – Community Benefit NF LOC Audit DY5 Q4

Community Benefit denied NF LOC requests	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
Number of member files audited	25	25	25	17
BCBSNM	5	5	5	5
MHC	10	10	10	7
PHP	5	5	5	5
UHC	5	5	5	N/A
Number of member files that met the appropriate level of care criteria determined by the MCO	25	25	25	16
BCBSNM	5	5	5	4
MHC	10	10	10	7
PHP	5	5	5	5
UHC	5	5	5	N/A
Percent of MCO level of care determination accuracy	100%	100%	100%	94%

HSD agreed with all NFLOC decisions for Quarter 4 for MHC and PHP. HSD agreed with all but one BCBS decision, a Community Benefit NF LOC denial. Documentation in the CNA indicated that member met criteria for LNF; however, the member was denied NF LOC by Utilization Management (UM) staff. HSD followed up with BCBS regarding this discrepancy and BCBS confirmed that decision to deny NF LOC by the UM reviewer was inaccurate. A new CNA was conducted on 1/10/19 and the new determination resulted in the member being approved for PCS. BCBS also noted that the UM reviewer who completed this review had been coached regarding this issue and general reminder will be provided to their NF LOC review team to ensure NF LOC decisions accurately reflect ADL information captured in documentation.

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 Q4.

Table 20 – EQRO NF LOC Review Results DY5 Q4

Facility Based	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
High NF Determination				
Number of member files audited	**23**	**22**	**23**	**48**
BCBSNM	4	3	5	16
MHC	7	6	6	15
PHP	7	11	7	17
UHC	5	2	5	-
Number of member files the EQRO agreed with the determination	**22**	**22**	**19**	**37**
BCBSNM	3	3	5	10
MHC	7	6	6	10
PHP	7	11	6	17
UHC	5	2	2	-
%	**96%**	**100%**	**83%**	**77%**
BCBSNM	75%	100%	100%	63%
MHC	100%	100%	100%	67%
PHP	100%	100%	86%	100%
UHC	100%	100%	40%	-
Low NF Determination				
Number of member files audited	**85**	**106**	**134**	**77**
BCBSNM	23	29	41	26
MHC	20	26	36	26
PHP	20	21	35	25
UHC	22	30	22	-
Number of member files the EQRO agreed with the determination	**85**	**102**	**122**	**64**
BCBSNM	23	29	37	22
MHC	20	25	31	20
PHP	20	21	33	22
UHC	22	27	21	-
%	**100%**	**96%**	**91%**	**83%**
BCBSNM	100%	100%	90%	85%
MHC	100%	96%	86%	77%
PHP	100%	100%	94%	88%
UHC	100%	90%	95%	-
Community Based				
Number of member files audited	**156**	**176**	**198**	**156**
BCBSNM	39	44	54	53
MHC	39	44	54	49
PHP	39	44	54	54
UHC	39	44	36	-
Number of member files the EQRO agreed with the determination	**152**	**176**	**192**	**154**
BCBSNM	39	44	51	52
MHC	39	44	51	48
PHP	35	44	54	54
UHC	39	44	36	-
%	**97%**	**100%**	**97%**	**99%**
BCBSNM	100%	100%	94%	98%
MHC	100%	100%	94%	98%
PHP	90%	100%	100%	100%
UHC	100%	100%	100%	-

MCO High NF determinations decreased to 77% in Q4 for EQRO agreement with determinations. The Low NF determinations also decreased from 91% in Q3 to 83% for EQRO agreement in Q4. Community Based determinations increased in Q4 to 99% for EQRO agreement, from 97% in DY5Q3. Issues identified included incomplete supporting documentation and information outside of the expected date range. HSD will follow up with the MCOs regarding the identified cases and will continue to provide technical assistance as needed.

During DY5 Q4, HSD also followed up on EQRO determination disagreements identified in the previous quarter. The EQRO audit in DY5 Q3 indicated three determination disagreements for PHP, seven for BCBS and eight for MHC. HSD requested clarification for discrepancies identified in audit documentation, status updates on the identified members, and plans to improve the accuracy of determinations.

PHP provided clarification for three identified discrepancies. For one file, PHP provided clarification for an initial LNF approval and noted that the updated information was requested from the Nursing Facility after member's discharge. This updated information from the Minimum Data Set (MDS) indicated that member correctly met initial LNF. PHP noted that the member discharged safely to the community and is now accessing self-directed community benefits. For another file, PHP also provided clarification for a HNF approval for therapies and noted that this member had been properly approved for HNF for the certification period. For the last discrepancy, PHP acknowledged that the physician's order utilized for NF LOC approval was not correct and indicated that going forward they would ensure orders are appropriate for the type of NF LOC request. PHP noted that they will submit a communication form as necessary to ensure that all required documentation is current and accurate.

MHC provided clarification for discrepancies in eight audit files. For one file, MHC noted that the CNA was completed by staff at the health home and was not included in the audit packet for review. MHC also provided clarification for two files for the same member, MHC provided clarification for both the initial LNF request and the continued stay request for LNF, identifying additional supporting elements for the member meeting LNF criteria in both files. For another file, clarification was provided regarding member's eligibility and approval period for NF LOC.- MHC also addressed one file which did not have additional documentation supporting a NF LOC decision. MHC notes that, based on the available documentation, LNF should have been denied. For three remaining audit files, MHC provided clarification regarding the physician's orders for NF LOC and provided additional supporting documentation. In response to all the identified discrepancies, MHC noted that new staff had been re-trained regarding correct NF LOC procedures and required documentation needed for review.

BCBS addressed discrepancies identified in seven audit files. For two audit files, BCBS provided corrected and missing documentation from the original submissions. For another file, BCBS provided clarification that the member's file from November 2017 was incorrectly placed in the NF LOC review universe for DY5 Q3. BCBS also addressed documentation that was outside the expected date range for another audit file. For the three remaining audit files, BCBS provided clarification regarding the physician's orders for NF LOC and provided additional supporting documentation. In follow up to all the identified discrepancies, BCBS indicated that UM staff will be retrained around the specific requirements of a complete, accurate and timely NF LOC packet submission. BCBS noted that if the facility fails to submit the required documentation, UM staff will provide technical assistance to the facility and will institute the Communication Form process to obtain the necessary elements; if documentation is not provided within the prescribed timeframe, a NFLOC technical denial will be issued.

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

Care Coordination Monitoring Activities

Care Coordination Audits

HSD continues to evaluate the MCO internal action plans (IAPs). Technical Assistance calls and increased communication between the MCOs and HSD have resulted in high compliance rates for consecutive quarters. In DY5 Q4, HSD completed audits of BCBS, MHC's and PHP's reported IAP audit results. HSD completed audits for BCBS, MHC PHP relating to Behavioral Health needs, Transition of Care plans, care coordination level determinations for 1915 (c) waivers members, care coordination level determinations for Dual Eligible Special Needs (DSNP and high Emergency Department (ED) usage members. HSD revealed that the MCOs had successful completion of 13 of 15 internal audits. HSD has requested BCBS continue to audit two action steps quarterly to comply with contract requirements. HSD added an action step for BCBS related to an EQRO finding related to language in Notice of Adverse Benefits determination letters. HSD will continue to conduct regular care coordination audits and evaluate compliance with current IAPs.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top ED utilizers for each MCO. Originally this project included 35 members from each MCO. Over the past 42 months, some members have lost Medicaid eligibility or are no longer with their original MCO. HSD monitors the efforts by care coordinators to engage members, provide alternatives to excessive ED usage and connect members with needed services. HSD tracks the number of ED visits and reviews next steps to reduce the incidence of ED visits. HSD analyzes how supplemental community assistance can complement the services provided by the care coordinator. DY5 Q4 was the final quarter of the project. HSD began extensive analysis of the final data submitted on project members. Data received monthly by each MCO is validated through HSD's PRISM data base. Due to the claims lag, final ED visit counts for DY5 Q4 cannot be validated until DY6 Q2 therefore HSD will continue to follow the current active participants through claims data through DY6 Q2. Chronic homelessness, substance abuse and behavioral health needs have contributed to high ED utilization. HSD recognizes that all MCOs have gone beyond contract required touchpoints for these members by assisting them with housing, nutritional assistance, treatment center admissions, behavioral health support and collaborating with internal and external partners for member success. HSD has seen a 37% decrease in ED visits, per member per month, since the projects inception in DY2 Q3. Through targeted, consistent outreach by Care Coordinators, Peer Support Specialists and Community Health Workers, members receiving these services have shown substantial decline in ED usage.

Care Coordination and EDIE

The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED admissions, 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 then references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical metadata. Because of the notification, the provider has information in hand before seeing the patient. This allows the provider to act 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. As of DY5 Q4, 33 of 38 hospitals in New Mexico are fully integrated online with the remaining 5 in progress to go live by 2019. The Care Manager User Group was established in 2018 for users within New Mexico to share best practices while promoting increased use of the system. HSD continues to attend the bi-monthly committee meetings to support this collaborative program.

Care Coordination Ride-Alongs

HSD conducted "ride-alongs" with BCBS and PHP care coordinators in October and November 2018 to observe Agency-Based and Self-Directed Community Benefit members' comprehensive needs assessments in the home setting. Over the waiver period, HSD has provided feedback gleaned from the ride-alongs, and observed care coordination improvements by experiencing MCO care coordination efforts first hand. HSD will continue to conduct regular ride-alongs with each of the Centennial Care 2.0 MCOs each quarter to ensure that all MCO requirements are being met.

Care Coordination Member Issue and Technical Assistance Calls

The CCU participates in monthly member issue calls with the MCOs to address issues concerning members with special behavioral or physical health needs. Additionally, the CCU participates in TA calls with the MCOs to discuss various issues related to care coordination. The CCU participated in weekly high utilizer calls with MHC and bi-weekly with PHP in DY5 Q4. Calls focused on warm transfers for members needing highly focused care coordination engagement when changing MCOs.

HSD conducted reviews of care coordination enrollment, engagement and timeliness completion reports submitted by all MCOs throughout DY5. These internal reviews resulted in closer oversight by HSD in all data submitted to the Quality Bureau care coordination unit. Standardized methodology was developed by the unit and discussed at monthly TA calls in DY5 Q4. Items for discussion included HRA and CNA completion, member enrollment, member engagement, and contractual requirements for timeliness. HSD will implement a revised care coordination report in DY6 Q1. HSD will continue to conduct regularly scheduled calls with all the MCOs.

Section XIV: Managed Care Reporting Requirements

Customer Service

In Q4 DY5, 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. The MCOs reported an overall 23% increase in the number of calls received in quarter three due to the transition to Centennial Care 2.0 and questions about changes for enrollment. Please see Attachment X: Customer Service Summary.

MCO Reporting

HSD continued technical assistance (TA) calls with the MCOs regarding report issues and accepting Self-Identified Error Resubmissions (SIERs). These two processes allow HSD and MCO subject matter experts to clarify data requirements and correct any data inaccuracies. Reports from MCOs in Q2 have been timely, and HSD notes minimal report extension requests from MCOs. Four extension requests made for Q4DY5 reports.

Report Revisions

HSD subject matter experts collaborate with Mercer, also an HSD contractor, and MCOs to make report revisions to select reports. There are currently 14 reports that are undergoing the revision process. Three report revisions were completed during Q4DY5. HSD revises reports to streamline data elements, improve monitoring, and incorporate requirements of the managed care final rule.

Member Appeals

A total of 737 member appeals were filed by Centennial Care members in DY5 Q4. This demonstrates a decrease when compared to 780 in DY5 Q3. An overall downward trend is demonstrated when compared to member appeals received in DY5 Q2 (944) and DY5 Q1 (869). Of the 737 appeals filed, 89% were standard member appeals and 11% 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. The total number of appeals received was 660. This demonstrates a decrease when compared to 681 in DY5 Q3. An overall downward trend is demonstrated when compared to DY5 Q2 (758) and DY5 Q1 (716).

Denial in whole of a payment for a service was the second top member appeal code with a total of 43 member appeals reported. This demonstrates an increase when compared to 34 in DY5 Q3. An overall trend cannot be established when compared to DY5 Q2 (48) and DY5 Q1 (34).

There were 34 variable appeals filed in Q4 of DY5. 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 Q4.

Table 21 – Member Appeals DY5 Q4

MCO Appeals DY5 Q4 (October - December 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member Appeals	123	16.68%	79	10.71%	453	61.47%	1	0.14%	**656**	89.00%
Number of Expedited Member Appeals	76	10.31%	3	0.41%	1	0.14%	1	0.14%	**81**	11.00%
Total	199	27.00%	82	11.13%	454	61.60%	2	0.27%	**737**	100%
Top Two Primary Member Appeal Codes										
Denial or limited authorization of a requested service	172	23.34%	81	10.99%	404	54.81%	3	0.41%	**660**	89.55%
Denial in whole of a payment for a service	9	1.22%	0	0.00%	34	4.61%	0	0.00%	**43**	5.83%
Variable Appeals	18	2.44%	1	0.13%	16	2.17%	-1	-0.13%	**34**	4.61%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continued in DY5 Q4. Deloitte and HSD finalized Amendment 5 of the contract to cover the period January 1, 2019, through June 30, 2019. The activities completed during this quarter were centered around HSD's review of the draft Final Evaluation Report. Discussions were held to address measure-level data changes and clarify report content. Discussions were also held with subject matter experts at HSD to review specific measures, relevant data, and methodology. Deloitte will continue to meet with HSD on a weekly basis to assess Final Report status and gather report content feedback as it becomes available.

Preliminary observations for DY4 indicate the following:

- For both physical health and behavioral health visits, the use of telemedicine has increased from 2,160 in the baseline year to 26,046 in DY4.
- There was a favorable decrease in the ratio of members to providers of 20.4% from DY1 to DY4. This decrease was impacted by the influx of participating providers, which increased by approximately 13,000 from DY1 to DY4.
- Member satisfaction with their personal doctor increased in all three population cohorts from baseline to DY4, increasing 1% for the adult population, 1% for the child general population, and 2% for the children with chronic conditions population. DY4 satisfaction rates exceeded national averages for children with chronic conditions and the child general population, and satisfaction for adults was equivalent to the national average.

Planned activities for DY6 Q1 will focus on the development of the DY5 Annual Report and HSD's approval of the Final Evaluation Report for submission to CMS. This includes review and discussion of the fully assembled Final Evaluation report for HSD leadership as well as discussion and review with Deloitte of the comments on the Final Evaluation Report content.

Section XVI: Enclosures/Attachments

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

Section XVII: State Contacts

HSD State Name and Title	Phone	Email Address	Fax
Nicole Comeaux Director HSD/Medical Assistance Division	505-827-7703	Nicole.Comeaux@state.nm.us	505-827-3185
Megan Pfeffer Acting, Deputy Director HSD/Medical Assistance Division	505-827-7722	Megan.Pferffer@state.nm.us	505-827-3185
Jason Sanchez Deputy Director HSD/Medical Assistance Division	505-827-6234	JasonS.Sanchez@state.nm.us	505-827-3185
Kari Armijo Deputy Director HSD/Medical Assistance Division	505-827-1344	Kari.Armijo@state.nm.us	505-827-3185
Linda Gonzales Deputy Director HSD/Medical Assistance Division	505-827-6222	Linda.Gonzales@state.nm.us	505-827-3185

Section XVIII: Additional Comments

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

Centennial Care Member Success Story 1

On Friday, December 7, 2018, a PHP Presbyterian Downtown Hospital Emergency Department (ED) based Community Health Worker (CHW) contacted a Certified Peer Support Worker (CPSW) team member regarding a woman he spoke with during an intervention at the ED. She was in the ED for alcohol withdrawals, including delirium tremors. The member was in active withdrawal and experiencing homelessness. The CPSW and ED based CHW spoke with her throughout the day and attempted to find an alternative shelter for her on discharge, rather than returning to Joy Junction, which she stated was "chaotic." The CPSW spoke with Barrett House foundation, and Barrett House located a respite bed available and attempted to get her discharged to them. However, this option was unavailable due to her being in active withdrawal. The CPSW spoke with the Metropolitan Assessment and Treatment (MATS) detox program, and the staff was able to secure her a spot there for further detox. The CPSW and CHW managed to find some funds and paid for an Uber ride to MATS upon discharge. They followed her to MATS in their own vehicles, where they helped her sign in to the facility. The CPSW left the member his business card and requested that she call and keep him informed of her status.

On Monday, December 10, 2018, the member called the CPSW around 11 a.m. to say that MATS had moved her into Turquoise Lodge, which she feels is "much nicer." She was doing well there and expressed a desire to finish the 7-day program, and possibly a 30-day stay after that. The CPSW continued his contact with her during the 7-day program and the member decided to stay for the 30-day program with the encouragement of the CPSW. The member stated that she feels the CHW and CPSW "are miracles" and thanked them for their support. They shared that they want her to succeed and find joy in her life again. As of December 26, 2018, the member remains at Turquoise Lodge and continues to participate in her rehabilitation. The CPSW visits her at the facility at least weekly.

Centennial Care Member Success Story 2

A young member has been in residential treatment three times in the past four years, and in a shelter three times as well. He had a lot of conflict with his mother and was generally not compliant with medication. The Behavioral Health Care Coordinator has been working with him for the past three and a half years, and he has really turned his life around. He has been successfully living independently, is working, going to school, maintaining a better relationship with his mother, and attending behavioral health services regularly. He has been successful and stable enough that he was offered the opportunity to step down from Care Coordination, but he reports that he really appreciates the relationship he has with his Care Coordinator and wants to continue working with her.

Centennial Care Member Success Story 3

Member is a 41-year old female who has been diagnosed with Epilepsy/seizure disorder, osteoarthritis, chronic migraines, vertigo, chronic pain, generalized weakness, chronic fatigue, blood clots, hyperlipidemia, hypothyroidism, hypertension, asthma, depression, anxiety schizoaffective disorder, thrombosis of retinas, and varicose veins of lower extremities. Member lives alone and she has one brother in Las Cruces and doesn't have any other surviving family members. The Care Coordinator (CC) started working with the Member at the end of June 2018 and during the first contact with the member, the CC found out that the member was a high Emergency Department and Behavioral Health inpatient utilizer. This Member had been approved for 25 hours a week of Personal Care Services (PCS) but was not receiving the services due to not being able to keep caregivers. Care Coordinator contacted the PCS Agency, Ambercare, and through collaborated efforts the Member was able to get her brother to become her paid caregiver. She has been utilizing PCS consistently since July and her personal needs are being met. The Member has learned to become more involved in managing her health and is more compliant with medications and medical appointments. Member receives Behavioral Health Care Coordination (BH CC), completes weekly counseling sessions and participates in the Psychosocial Rehabilitation program through La Clinica de Familia. The last Behavioral Health inpatient admission the Member had was on 6/27/2018. Member continues to make progress with the support of her Physical Health Care Coordinator (PH CC), BH CC, counselor and psychiatrist. The Member is becoming more confident and is understanding her conditions and the services and resources available to her.

Centennial Care Member Success Story 4

Member is a 57-year-old male who had a stroke in November 2017. The stroke paralyzed member's left side and his speech. Member had been residing in a nursing facility and CM began to work with member and his family in March, 2018. Through speaking with member's POAs/sisters and visiting member, he expressed a desire to go home and was becoming depressed with being in a nursing facility beyond skilled treatment for rehabilitation. CM began to work with POAs to help navigate and educate member's treatment with providers and general support during member's recovery process.

Member did experience further medical complications related to his stroke and went back to rehabilitation and then more skilled nursing. Once member stabilized medically, CM began to work with member's POAs/sisters to establish community benefits for member and educate the POAs on these benefits. Member needed 24-hour support/monitoring for his ADLs, so his family could work during the day and care for him in the evening.

In November 2018, member was finally ready to return home with his supports in place. CM visited member a month later, when he was back home. Member was extremely happy and grateful to be back in his own home with his family. Member and family expressed gratitude that member was able to qualify for PCS, ERS, Respite, and CTS to make it possible for him to be back at home. When CM was leaving member's home, POA hugged CM and thanked CM for all of the help and support with member and making it possible for him to be home with his family.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet

- PMPM Analysis

DY 5

Start Date: 01/01/2018

End Date: 12/31/2018

Quarter 4

Start Date:10/01/2018

End Date: 12/31/2018

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01 TANF & Related	DY 01 Cost Estimates	DY1 YTD - Actuals [2]	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	4,621,656	5,092,636	4,623,475	5,132,359	4,417,957
PMPM	$ 385.80	$ 329.15	$ 400.77	$ 344.33	$ 416.32	$ 335.69	$ 432.47	$ 341.58	$ 449.25	$ 318.94
Dollars	$ 1,823,911,159	$ 1,486,841,131	$ 1,948,487,793	$ 1,533,729,677	$ 2,090,074,424	$ 1,551,445,667	$ 2,202,434,150	$ 1,579,268,876	$ 2,305,734,126	$ 1,409,054,435

MEG02 SSI & Related - Medicaid Only	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	508,700	497,958	513,736	494,529	518,976	493,577	524,737	487,798	530,824	460,906
PMPM	$ 1,763.90	$ 1,656.68	$ 1,842.83	$ 1,785.40	$ 1,925.21	$ 1,756.97	$ 2,008.00	$ 1,734.17	$ 2,094.34	$ 1,716.86
Dollars	$ 897,298,062	$ 824,959,005	$ 946,727,393	$ 882,930,360	$ 999,138,707	$ 867,198,591	$ 1,053,669,000	$ 845,926,780	$ 1,111,724,897	$ 791,312,991

MEG03 SSI & Related - Dual Eligible	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	373,823	428,025	380,215	435,140	386,831	447,801	393,832	443,071	401,197	429,569
PMPM	$ 1,780.77	$ 1,333.20	$ 1,857.34	$ 1,342.70	$ 1,937.21	$ 1,361.24	$ 2,020.51	$ 1,272.95	$ 2,107.39	$ 1,286.37
Dollars	$ 665,692,378	$ 570,643,867	$ 706,189,973	$ 584,263,216	$ 749,372,219	$ 609,566,681	$ 795,742,098	$ 564,005,217	$ 845,479,241	$ 552,584,591

MEG04 "217 Like" Medicaid Only	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	5,841	2,799	5,898	2,382	5,959	2,987	6,025	3,797	6,095	3,500
PMPM	$ 4,936.92	$ 2,380.16	$ 5,090.46	$ 2,347.27	$ 5,248.77	$ 2,538.07	$ 5,412.01	$ 3,298.31	$ 5,580.32	$ 3,428.98
Dollars	$ 28,834,295	$ 6,662,076	$ 30,025,379	$ 5,591,208	$ 31,274,952	$ 7,581,210	$ 32,605,551	$ 12,523,688	$ 34,009,571	$ 12,001,420

MEG05 "217 Like" Dual Eligible	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	27,935	26,895	28,413	27,063	28,907	31,866	29,430	40,409	29,981	47,108
PMPM	$ 1,776.90	$ 3,226.87	$ 1,853.31	$ 3,143.68	$ 1,933.00	$ 2,884.14	$ 2,016.12	$ 2,791.74	$ 2,102.81	$ 2,838.94
Dollars	$ 49,637,569	$ 86,786,741	$ 52,657,285	$ 85,077,407	$ 55,877,183	$ 91,905,888	$ 59,334,769	$ 112,811,332	$ 63,043,435	$ 133,736,825

MEG06 VIII Group - Medicaid Expansion	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals [2]	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
MMs [1]	1,632,968	1,887,728	1,788,895	2,748,632	1,800,808	3,078,074	1,763,748	3,143,890	1,773,299	3,014,736
PMPM	$ 577.87	$ 454.27	$ 607.34	$ 477.43	$ 638.31	$ 442.84	$ 670.87	$ 451.10	$ 705.08	$ 480.16
Dollars	$ 943,638,928	$ 857,530,333	$ 1,086,464,733	$ 1,312,288,319	$ 1,149,478,718	$ 1,363,091,603	$ 1,183,239,734	$ 1,418,200,426	$ 1,250,319,546	$ 1,447,565,532

MEG08 Uncompensated Care Pool	DY 01 Cost Estimates	DY1 YTD - Actuals	DY 02 Cost Estimates	DY2 YTD - Actuals	DY 03 Cost Estimates	DY3 YTD - Actuals [2]	DY 04 Cost Estimates	DY4 YTD - Actuals [2]	DY 05 Cost Estimates	DY5 YTD - Actuals [2]
Total Allotment	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 67,294,973	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,324	$ 68,889,323	$ 51,666,996

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

Notes:

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

2.) Expenditures as reported on the CMS-64 Schedule C, FFY19 Quarter 1. Report pulled on 1/31/2019.

Q4DY5 Attachment B - GeoAccess PH Q3 Calendar Year 2018 (July 1 - September 30, 2018)

Meets Standard | Does Not Meet

	Urban				Rural				Frontier			
PH - Standard 1	**BCBSNM**	**UHC**	**MHNM**	**PHP**	**BCBSNM**	**UHC**	**MHNM**	**PHP**	**BCBSNM**	**UHC**	**MHNM**	**PHP**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	99.9%	100.0%	99.8%	100.0%	99.9%
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%	94.5%	100.0%	100.0%	90.3%	98.9%	100.0%	98.9%	97.2%	97.9%	94.0%	98.9%
PH - Standard 2												
Cardiology	99.3%	99.1%	98.0%	99.0%	99.7%	99.5%	100.0%	99.7%	99.9%	99.8%	100.0%	99.7%
Certified Nurse Practitioner	99.3%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%
Certified Midwives	99.2%	100.0%	100.0%	99.1%	100.0%	99.8%	100.0%	94.1%	99.9%	97.7%	100.0%	94.1%
Dermatology	72.9%	93.7%	98.0%	99.0%	65.5%	64.2%	69.0%	76.8%	81.8%	94.7%	95.0%	76.8%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	95.9%	93.7%	98.0%	99.0%	62.4%	66.5%	76.0%	71.7%	76.8%	85.5%	91.0%	71.7%
ENT	99.2%	99.1%	98.0%	98.9%	90.9%	98.5%	92.0%	99.1%	94.8%	97.1%	92.0%	99.1%
FQHC	100.0%	94.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/Oncology	99.2%	99.1%	98.0%	99.1%	98.0%	98.3%	96.0%	98.3%	99.5%	99.1%	100.0%	98.3%
Neurology	99.2%	93.7%	98.0%	99.0%	97.8%	90.5%	96.0%	91.8%	92.0%	88.9%	89.0%	91.8%
Neurosurgeons	99.2%	99.1%	98.0%	98.9%	40.6%	56.9%	65.0%	74.9%	70.2%	76.3%	87.0%	74.9%
OB/Gyn	99.0%	99.1%	98.0%	99.1%	99.9%	99.8%	100.0%	99.7%	99.8%	99.9%	100.0%	99.7%
Orthopedics	99.3%	99.1%	98.0%	99.1%	99.7%	99.7%	100.0%	100.0%	99.8%	99.6%	98.0%	100.0%
Pediatrics	100.0%	99.1%	98.0%	100.0%	99.6%	98.8%	100.0%	99.9%	99.9%	100.0%	100.0%	99.9%
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.2%	99.1%	98.0%	99.2%	99.9%	99.7%	100.0%	99.7%	99.9%	99.8%	100.0%	99.7%
Rheumatology	94.6%	93.7%	98.0%	99.0%	69.4%	92.0%	91.0%	86.9%	81.3%	88.1%	88.0%	86.9%
Surgeons	99.3%	99.1%	98.0%	99.1%	99.9%	100.0%	100.0%	100.0%	99.9%	99.8%	100.0%	100.0%
Urology	99.2%	99.1%	98.0%	98.9%	89.5%	90.3%	85.0%	93.1%	94.3%	94.4%	97.0%	93.1%
LTC - Standard 2												
Personal Care Service Agencies (PCS) - delegated	98.3%	100.0%	100.0%	100.0%	90.7%	98.8%	100.0%	99.8%	99.9%	100.0%	100.0%	100.0%
Personal Care Service Agencies (PCS) - directed	99.3%	100.0%	100.0%	100.0%	99.0%	98.8%	100.0%	99.8%	99.9%	99.9%	100.0%	100.0%
Nursing Facilities	95.3%	93.9%	92.0%	93.8%	99.8%	98.8%	99.0%	99.4%	99.9%	99.9%	100.0%	99.9%
General Hospitals	99.2%	99.1%	98.0%	99.1%	99.3%	99.5%	100.0%	99.3%	99.9%	99.8%	100.0%	99.9%
Transportation	100.0%	100.0%	100.0%	97.3%	100.0%	98.9%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%

nd - no data

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

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

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

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

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)	89.1%	ND	90.0%	98.8%	32.7%	ND	27.0%	55.1%	67.3%	ND	68.0%	73.3%
Assertive Community Treatment (ACT)	84.0%	ND	83.0%	95.8%	31.8%	ND	50.0%	48.5%	70.1%	ND	71.0%	76.3%
Behavioral Management Services (BMS)	99.2%	ND	97.0%	99.1%	43.2%	ND	36.0%	46.8%	68.5%	ND	74.0%	86.9%
Community Mental Health Center (CMHC)	99.2%	ND	98.0%	96.3%	98.3%	ND	100.0%	99.8%	92.0%	ND	100.0%	99.8%
Core Service Agency (CSA)	99.0%	ND	92.0%	99.1%	99.4%	ND	100.0%	99.8%	100.0%	ND	100.0%	100.0%
Day Treatment Service	37.0%	ND	56.0%	76.3%	71.6%	ND	28.0%	42.9%	63.0%	ND	47.0%	62.3%
FQHC- BH	100.0%	ND	100.0%	100.0%	100.0%	ND	100.0%	91.2%	100.0%	ND	100.0%	100.0%
FreeStanding Psychiatric Hospital	89.2%	ND	90.0%	85.7%	22.2%	ND	17.0%	34.9%	67.3%	ND	68.0%	70.9%
General Hospital with Psychiatric Units	93.6%	ND	90.0%	96.0%	68.3%	ND	79.0%	74.9%	80.5%	ND	82.0%	81.7%
Indian Health Services and Tribal 638	72.9%	ND	90.0%	77.4%	57.2%	ND	96.0%	67.3%	82.8%	ND	99.0%	86.9%
Intensive Outpatient Services	94.9%	ND	64.0%	96.3%	71.2%	ND	82.0%	88.1%	95.7%	ND	83.0%	99.7%
Licensed Independent Behavioral Health Practitioners	100.0%	ND	100.0%	100.0%	100.0%	ND	100.0%	100.0%	100.0%	ND	100.0%	100.0%
Methadone Clinics (METH)	94.4%	ND	91.0%	96.2%	41.6%	ND	39.0%	62.7%	76.5%	ND	76.0%	80.7%
Multi-Systematic Therapy(MST)	94.2%	ND	92.0%	95.9%	44.0%	ND	57.0%	67.5%	73.4%	ND	71.0%	77.4%
Non-Accredited Residential Treatment Center (NARTC)	62.8%	ND	55.0%	64.2%	50.1%	ND	70.0%	52.7%	57.7%	ND	77.0%	80.7%
Outpatient Provider Agencies	99.3%	ND	98.0%	100.0%	88.9%	ND	99.0%	100.0%	94.7%	ND	100.0%	100.0%
Partial Hospital Program	26.3%	ND	34.0%	21.5%	1.5%	ND	12.0%	4.7%	8.4%	ND	11.0%	6.5%
Psychiatrists	100.0%	ND	100.0%	99.90%	99.9%	ND	100.0%	100.0%	99.8%	ND	98.0%	99.9%
Psychologists (inc Subscribing)	100.0%	ND	98.0%	99.9%	95.4%	ND	100.0%	97.3%	99.9%	ND	100.0%	99.9%
RHC (BH)	0.0%	ND	0.0%	0.o1%	8.9%	ND	36.0%	16.5%	18.1%	ND	26.0%	27.3%
Suboxone Certified MDs	99.3%	ND	98.0%	99.2%	88.5%	ND	98.0%	93.2%	95.8%	ND	100.0%	100.0%
Treatment Foster Care I & II(TFC)	94.4%	ND	92.0%	95.9%	52.8%	ND	63.0%	74.7%	81.3%	ND	91.0%	90.6%
Inpatient Psychiatric Hospitals	89.2%	ND	98.0%	85.3%	32.7%	ND	80.0%	75.6%	67.3%	ND	86.0%	85.8%

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.

ND indicates no data due to United HealthCares membership transition to Presbyterian Health plan.

ENTENNIALCARE

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	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Inpatient (Admissions)	92.2	96.8	$ 9,254	$ 8,907
Inpatient (Days)	402.7	416.3	$ 2,119	$ 2,072
Practitioner / Physician (Services)	8,282.0	8,610.7	$ 67	$ 69
Emergency Department (Visits)	539.0	587.4	$ 345	$ 362
Outpatient (Visits)	1,430.0	1,524.7	$ 272	$ 281
Pharmacy (Scripts)	4,829.3	4,964.8	$ 64	$ 62
Other (Services)[1]	8,966.4	9,110.6	$ 58	$ 57

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Brand	13.3%	12.2%	$ 356	$ 370
Generic	85.2%	86.3%	$ 18	$ 18
Other Rx[2]	1.5%	1.5%	$ 94	$ 94

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	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Inpatient (Admissions)	74.5	77.4	$ 15,119	$ 15,563
Inpatient (Days)	492.4	657.8	$ 2,287	$ 1,832
Practitioner / Physician (Services)	8,784.8	9,110.2	$ 77	$ 79
Emergency Department (Visits)	655.3	705.3	$ 484	$ 517
Outpatient (Visits)	2,176.8	2,220.0	$ 303	$ 318
Pharmacy (Scripts)	9,839.9	9,864.8	$ 77	$ 76
Other (Services)[1]	9,974.7	10,277.6	$ 64	$ 65

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Brand	10.9%	10.4%	$ 574	$ 583
Generic	87.2%	87.8%	$ 15	$ 15
Other Rx[2]	1.9%	1.9%	$ 86	$ 93

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies

ENTENNIALCARE

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	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Inpatient (Admissions)	253.1	244.8	$ 2,816	$ 2,475
Inpatient (Days)	1,528.7	1,382.7	$ 466	$ 438
Nursing Home (Days)	349,999.4	315,659.7	$ 33	$ 37
Personal Care (Services / hr.)	743,062.5	740,672.0	$ 15	$ 15
Outpatient (Visits)	5,109.3	4,942.1	$ 132	$ 147
Pharmacy (Scripts)	1,511.8	1,246.4	$ 23	$ 18
HCBS (Services)	6,131.7	6,403.5	$ 129	$ 144
Other (Services)[1]	44,631.5	41,378.5	$ 45	$ 46

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Brand	21.6%	20.1%	$ 74	$ 63
Generic	76.0%	77.1%	$ 7	$ 5
Other Rx[2]	2.4%	2.8%	$ 60	$ 50

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	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Inpatient (Admissions)	342.2	329.3	$ 18,231	$ 17,438
Inpatient (Days)	2,357.5	2,310.3	$ 2,646	$ 2,486
Nursing Home (Days)	16,518.8	17,820.0	$ 166	$ 169
Personal Care (Services / hr.)	723,521.3	732,615.5	$ 15	$ 15
Outpatient (Visits)	7,543.4	7,627.7	$ 446	$ 478
Pharmacy (Scripts)	42,860.6	42,792.3	$ 90	$ 83
HCBS (Services)	13,216.9	13,742.8	$ 96	$ 91
Other (Services)[1]	63,848.4	64,399.1	$ 84	$ 85

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Brand	12.6%	12.0%	$ 578	$ 556
Generic	85.0%	85.6%	$ 18	$ 17
Other Rx[2]	2.4%	2.3%	$ 79	$ 83

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies

ENTENNIALCARE

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	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Inpatient (Admissions)	246.0	199.8	$ 9,247	$ 8,329
Inpatient (Days)	1,545.9	1,240.5	$ 1,472	$ 1,342
Nursing Home (Days)	9,640.8	7,718.2	$ 14	$ 20
Personal Care (Services / hr.)	81.5	81.2	$ 14	$ 15
Outpatient (Visits)	6,586.3	6,669.3	$ 221	$ 282
Pharmacy (Scripts)	14,331.8	14,682.6	$ 113	$ 134
HCBS (Services)	312,027.4	301,366.1	$ 97	$ 91
Other (Services)[1]	58,412.7	55,409.7	$ 53	$ 50

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Brand	14.1%	14.6%	$ 584	$ 695
Generic	82.7%	82.5%	$ 33	$ 34
Other Rx[2]	3.2%	2.9%	$ 115	$ 136

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	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Inpatient (Admissions)	76.9	70.3	$ 4,655	$ 4,475
Inpatient (Days)	498.0	433.4	$ 719	$ 726
Practitioner / Physician (Services)	10,019.3	8,737.7	$ 26	$ 25
Emergency Department (Visits)	662.6	696.4	$ 155	$ 163
Outpatient (Visits)	2,982.4	2,887.4	$ 126	$ 131
Pharmacy (Scripts)	1,663.3	1,418.1	$ 39	$ 27
Other (Services)[1]	9,608.8	9,102.9	$ 90	$ 107

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Brand	21.9%	23.4%	$ 129	$ 77
Generic	75.8%	74.1%	$ 12	$ 11
Other Rx[2]	2.3%	2.4%	$ 60	$ 59

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies

ENTENNIALCARE

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	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Inpatient (Admissions)	39.8	42.0	$ 1,041	$ 1,251
Inpatient (Days)	112.9	129.4	$ 367	$ 406
BH Practitioner (services)	196.9	254.3	$ 120	$ 113
Core Service Agency (Services)	223.2	240.1	$ 106	$ 122
BH outpatient / clinic (Services)	2,698.0	3,395.2	$ 63	$ 57
Pharmacy (Scripts)	1,830.1	1,716.4	$ 56	$ 61
Residential Treatment Center (days)	87.9	79.1	$ 1,057	$ 1,216
Other (Services)[1]	137.5	134.2	$ 54	$ 51

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	October 2016 - September 2017	October 2017 - September 2018	October 2016 - September 2017	October 2017 - September 2018
Brand	6.2%	7.4%	$ 429	$ 450
Generic	93.8%	92.6%	$ 31	$ 30
Other Rx[2]	0.0%	0.0%	$ -	$ -

Notes:

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

Behavioral Health Collaborative CEO Report

October 11, 2018

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. CareLink NM BH Health Homes (CLNM)

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

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

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

9. Clinical Curriculum Development Initiative

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

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

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

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

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

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

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

11. Crisis Triage Centers (CTC)

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

gap until rule promulgation.

12. Naloxone Pharmacy Technical Assistance

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

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

13. Network of Care (NOC)

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

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

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

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

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

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

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

14. New Mexico Crisis and Access Line (NMCAL)

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

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

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

15. Office of Peer Engagement (OPRE)

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

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

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

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

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

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

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

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

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

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

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

August Highlights:

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

Performance Activities & Accomplishments:

Treatment Update:

In August, our partners have attended the following trainings:

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

Overdose Reversals:

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

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

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

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

17. Opioid Treatment Programs (OTP)

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

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

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

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

18. PAX Good Behavior Game

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Overall Grant Update</u>

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

<u>PDO Advisory Council</u>

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

Contracted Providers

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

Bernalillo County Community Health Council (BCCHC):

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

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

Dona Ana County Health and Human Services (DACHHS):

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

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

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

Santa Fe Prevention Alliance (SFPA):

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

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

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

PDO Media Subcommittee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. Supportive Housing

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

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

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

<u>Housing Supports, Health, and Recovery for Homeless Individuals Grant (HHRHI)</u>

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

24. Treat First Learning Community

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

<u>Interdisciplinary Teaming in Behavioral Healthcare:</u>

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

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

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

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

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

Treat First Talks:

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

Q4DY5 ATTACHMENT F: MCO Action Plans

Quarter 3 DY3

BCBS

Q3DY3

Action Plan #1	Implementation Date	Completion Date
HSD Care Coordination Audit	07/19/16	12/31/2018

Description

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

Status

07/19/16 – A summary report was provided to HSD specific to BCBS's internal actions related to HSD's findings as well as continued quality improvement for care coordination.

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

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

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

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

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

into the community from the nursing facility, while ensuring a successful transition occurs.

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

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

09/30/2018 – BCBS's Care Coordinators (CCs) continue to identify member BH diagnoses through the CNA and HRA assessments as well as through claims data to make appropriate referrals to address BH needs. Consistent monitoring continues with monthly member file audits completed by unit managers to ensure disaster plan compliance as well as BH diagnosis and referral. In February 2018, a new Transition of Care Plan (TOC) was created and all CCs were trained. The new template was designed to include all required elements to document member's transition from a nursing facility as well as address the members Medicaid eligibility. Consistent monitoring continues with monthly member file audits completed by unit managers to ensure TOC plans are thoroughly completed. The CNA and HRA Tasking tool has been in production for two months and the expected improvement in metrics for CNA and HRA will be reported in coming weeks. All unit managers use a CNA dashboard report as a tool to ensure that CCs are meeting CNA and HRA compliance. Performance measures have been implemented for all BCBS CCs. BCBS utilizes additional support to improve CNA and HRA metrics as evidenced through BH liaisons located in all BH facilities and providers that follow members while inpatient at all BH out of home placements. Peer Support staff are also located in shelters and encourage care coordination for

those members that they are engaged with.

12/31/2018 – BCBS considers this action plan complete but will work diligently to equip staff with the appropriate tools and training to meet member needs and regulatory requirements on an ongoing basis. In this effort, two staff trainings were held on 12/13/18 and 12/14/18 for the proficient use of the CNA and HRA tasking tool, which is used to monitor compliance with assessment completion. Another training was conducted on 12/21/18 for appropriate care coordination assignment. BCBS has created a Care Coordination Compliance Report that is slated to be implemented by 1/31/19. This Report will be utilized by Managers and Care Coordinators alike to determine coming due compliance touchpoints. Transition of Care has been an area of high importance to BCBS. On 11/14/18 and 11/15/18, trainings were completed for community reintegration timeliness requirements and the proper use of the Transition of Care Plan.

BCBS completed a detailed disaster and back-up plan training on 12/19/18 with applicable staff. During the training, the audit tool that is used to audit for completeness was reviewed with the Care Coordinators, so they are aware of the elements scored when the plans are audited. BCBS's care coordinators review the disaster and back-up plans with the member and update the plan as the member's needs change. These new and reviewed plans will be audited to assess the effectiveness of the training.

BCBS uses a variety of sources to obtain behavioral health diagnoses such as: HRA, CNA, health summary, medical records, claim reports, case notes, provider input, family/caretaker, and interdisciplinary team (IDT) input. BCBS's new health management platform is structured to automatically send members with behavioral health diagnoses to a work que for behavioral health review and follow-up as needed. Care Coordinators will also use this information to work collaboratively with the member to identify resources available, decide if co-management or behavioral health consultation is needed, help with any IDT team staffing, and help develop a Comprehensive Care Plan that addresses the member's behavioral health needs. The Care Coordinator and IDT will work with the member to identify urgent issues and decide if referrals are needed to ensure a positive outcome.

Quarter 3 DY4

MHC

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

Description

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

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

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

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

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

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

12/30/18 MHC continued to perform internal audits as recommended by HSD and documented continued improvement in the percentage of files containing source of BH diagnosis and plans to address potential needs.

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	12/31/2018

Description

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

Status

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

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

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

12/31/2018 – BCBS considers this action plan closed as the ADA/Physical Disability Accommodations have been fully implemented in the online Provider Finder and printed provider directories since July of 2018. BCBS will collect and update data in the online Provider Finder and printed directories on an ongoing basis to ensure new providers reflect any accommodations as well any accommodation changes for providers in the network. The Cultural Competency training deck has been updated and posted on BCBS's website as of December 2018. As providers complete the training and attest to the completion, BCBS will include a provider indicator reflecting this completion in the online Provider Finder and the online directory will be updated on a monthly basis.

Quarter 3 DY5

BCBS

Q3 DY5		
Action Plan #1	Implementation Date	Completion Date
Retroactive Medicare and and Medicaid Explansion Population	05/09/2018	12/31/2018

Description

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

Status

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

12/31/2018 – BCBS considers this action plan closed. As of 12/12/2018, all claims for the remaining two impacted providers have been adjusted and payment has been reissued.

BCBS

Q3 DY5		
Action Plan #2	Implementation Date	Completion Date
Implementation of July 2018 Rate Increases	09/06/2018	10/09/2018

Description

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

Status

09/30/2018 – BCBS implemented a remediation plan in September 2018 to complete the remaining

system configurations and claims adjustments for impacted providers. The remaining system configurations for Behavioral Health providers were completed on August 20, 2018, on September 4, 2018 for Nursing Facility providers, and on September 12, 2018 for Assisted Living Facilities and Adult Day Health providers. Claims adjustments for Behavioral Health and Nursing Facility providers were completed on September 28, 2018 and the remaining claims adjustments for Assisted Living Facilities and Adult Day Health providers are expected to be completed by October 10, 2018. BCBS has been working with providers impacted and communicating progress.

12/31/2018 – BCBS considers this action plan closed. On 10/09/2018, the final claim adjustments for the July 2018 rate increases were completed.

Quarter 4 DY5

BCBS

Q4 DY5

Action Plan #1	Implementation Date	Completion Date
External Quality Review Organization 2015 and 2016 Compliance Audit	12/31/2018	In progress

Description

BCBS to evaluate policies and procedures to ensure medical directors are utilizing "easily understood language" in Adverse Benefit Determination letters, per Section 4.12.15 of the Medicaid Managed Care Services Agreement and as set forth in 42 CFR § 438.10 (d)(6)(i). BCBS will audit member files for documentation of compliance and monitor progress.

Status

12/31/2018 – BCBS identified an opportunity to refine Adverse Benefit Determination letters, so medical directors are using consistent and easily understood language. In February 2017, BCBS developed base template language that was made available for medical directors to use as a tool for letter completion. These base templates have been updated and enhanced since 2017. In June 2017 the BCBS Audit & Accreditation team instituted Utilization Management audits and the criteria for these audits have evolved over time and the formal evaluation of Flesch-Kincaid score was added in 2018. BCBS is conducting audits to ensure 6th grade or below reading level is applied to the letters. The December 2018 audits are targeted to be completed by 01/31/2019.

BCBS

Q4 DY5

Action Plan #2	Implementation Date	Completion Date
Care Coordination Activities	12/31/2018	In progress

Description
BCBS had not met contractual timeliness measures for certain care coordination activities.

Status
12/31/2018 – BCBS identified that the following areas required improvement: Compliance of Care Coordination Activities (Timeliness and Clinical Appropriateness) with Health Risk Assessments (HRA), Comprehensive Needs Assessments (CNA), and Nursing Facility Level of Care Determinations (NF LOC); staff training evaluation and effectiveness plan; reporting of care coordination data; and burndown plan for assessment backlogs. BCBS's Compliance department will monitor the actions that are required to close each open issue. As of 1/1/19, 12,504 HRAs have been completed, which eliminates the identified HRA backlog. Collaboration continues with BCBS's Reporting team to ensure data integrity of member files and the capturing of HRA completions. Additional staff have been hired to assist in HRA completion.

PHP		
Q4 DY5		
Action Plan #3	Implementation Date	Completion Date
Care Coordination Activities	12/20/2018	In progress

Description
Vision Service Plan - Claims Improvement Plan

Status
HSD requires a 98% technical accuracy for claims processed. Audit findings are in the rebuttal phase; however, PHP believes an Improvement Plan is necessary.

PHP		
Q4 DY5		
Action Plan #4	Implementation Date	Completion Date
Care Coordination Activities	12/20/2018	In progress

Description
Vision Service Plan - A&G Improvement Plan

Status
PHP's Appeals &Grievances Auditor indicated that VSP did not provide a copy of their A&G Policies & Procedures that is a requirement of the audit. The audit is in the rebuttal phase; however, PHP believes an Improvement Plan is necessary.

PHP		
Q4 DY5		
Action Plan #4	Implementation Date	Completion Date
Care Coordination Activities	12/20/2018	In progress

Description
Vision Service Plan - IT Improvement Plan

Status
Several required IT documents were not provided by VSP, and therefore, an Improvement Plan was requested. VSP provided the IT documents, which were sent to PHP's IT auditor for review and response. An update will be provided next quarter.

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.