Centennial Care Waiver Demonstration

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

June 11, 2018
New Mexico Human Services Department

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Section I: Introduction

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

Launched on January 1, 2014, Centennial Care places New Mexico among the leading states in the design and delivery of a modern, efficient Medicaid program. There are approximately 670,000 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 268,189 enrollees in the Group VIII (expansion) who are in Centennial Care. This is an enrollment decrease of 2,895 from DY4 Q4.

Access

Throughout this report, unless otherwise noted, the most current monthly data available is through February 2018. Quarterly data is available through the fourth quarter of 2017.

Primary Care Provider (PCP)-to-Member Ratios

The PCP-to-member ratio standard of 1:2,000 was met by all MCOs in urban, rural, and frontier counties. PHP's PCP-to-Member ratio was improved in the last quarter of 2017 when an agreement with UNM added approximately 200 additional PCPs to PHP's provider network. There are no PCP access concerns at this time.

Table 1 – PCP-to-Member Ratios by MCO

Table X: PCP-to-Member Ratios by MCO												
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
BCBS	1:39	1:39	1:40	1:38	1:38	1:38	1:35	1:35	1:36	1:34	1:35	1:36
MHC	1:102	1:102	1:102	1:100	1:99	1:99	1:98	1:96	1:94	1:94	1:94	1:97
PHP	1:88	1:88	1:86	1:87	1:86	1:84	1:83	1:81	1:82	1:74	1:74	1:74
UHC	1:30	1:30	1:30	1:29	1:29	1:29	1:28	1:28	1:27	1:28	1:28	1:29
Source: [MCO] PCP Report #53, Q4CY17												

Geographic Access

Physical Health and Hospitals

Geographic access standards were met by all MCOs for general hospitals, federally qualified health centers (FQHCs), PCPs, pharmacies and most specialties in urban, rural and frontier counties. This means that at least 90% of members are within distance standards to provider types in specific geographic areas (i.e. urban, rural, or frontier). Please see Attachment B: GeoAccess PH Summary.

New Mexico has a shortage of specialty providers throughout the state, and MCOs actively seek to contract with border area providers to improve overall access for members. In DY4 Q4, all MCOs remained below access standards for dermatology and neurosurgeons in rural and frontier areas. All MCOs remained below access standards in rheumatology in frontier areas, and BCBS was the only MCO that did not meet the rheumatology access standard for rural members. In rural areas, three of the four MCOs were below access standards for urology. In frontier areas, three of the four MCOs did not meet access for endocrinology and neurology. Consistent with previous quarters, BCBS and MHC did not meet access standards for dermatology in urban areas. PHP was able to meet access standards for dermatology in urban areas, because of Presbyterian Healthcare Services, a not-for-profit healthcare "system," that maintains its own medical group (Presbyterian Medical Group). UHC was also able to meet access standards for

dermatology in urban areas, because its smaller enrollment of members does not necessitate as many specialty providers as the other MCOs in order to meet access requirements.

HSD continues to focus on outliers where all but one MCO met distance standards for specific provider types in geographic areas. For this period, BCBS remains the only MCO below access standards in rural areas for rheumatology (77.8%). PHP is close to meeting access standards in rural areas for neurology (85.3%). Access issues may be remedied by transportation to the nearest provider and telemedicine services which have generally been increasing as a result of delivery system improvements. Single case agreements are permitted for providers who may not want to contract with MCOs to ensure members receive medical necessary services.

Of note this quarter, PHP successfully met access standards in two rural county categories: hematology/oncology (98.6%) and certified nurse midwives (93.9%). In the previous quarter, PHP was close to meeting access standards for both specialties with 88.8% and 89.9% respectively. MHC and PHP both met access standards for rheumatology in rural areas, MHC with 91% and PCP (96.8%). In the previous quarter, both MCOs were close to meeting access standards for rheumatology with 85% and 85.2%.

HSD found many positive outliers for which one MCO was able to exceed standards while all other MCOs remain below access standards. PHP is a positive outlier as compared to other MCOs by being the only MCO to meet access standards in rural areas for urology (92.8%). BCBS was the only MCO to exceed access standards in frontier areas for neurology (92.1%). Another positive outlier is MHC who was the only MCO to meet access standards in frontier areas for endocrinology (91%).

Behavioral Health

In DY5 Q1, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions 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.

However, rural and frontier access standards remain unmet with limited exceptions, for the following-- Freestanding Psychiatric Hospitals, General Hospitals with psychiatric units and partial hospital programs, , Treatment Foster Care 1 & 2, Behavioral Management Services, Day Treatment Services, Intensive Outpatient Services, Methadone Clinics Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST)

Rural access standards for Behavioral Health clinics are not met by the majority of MCOs.

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

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

MCOs build accessibility 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 vist providers to validate practice information, respond to claims and other issues. Please see Attachment C: GeoAccess BH Summary.

Community Health Worker

The Community Health Worker (CHW) initiative continues outreach to Medicaid members in underserved urban, rural, and frontier areas of New Mexico. In DY5 Q1, an increase of two employed CHWs was reported by the MCOs. The Q1 total is 91 CHWs who are employed and contracted by Centennial Care MCOs. CHWs, in some settings, are called Peer Support Specialists, Member Navigators, and Community Health Representatives. CHW certification is available through the NM Department of Health. Please see Table 2 – Summary of CHW Workforce.

Table 2 – Summary of CHW Workforce by MCO

DY5 Q1			
Community Health Workers			
	Employed	Contracted	Total
BCBS	13	15	28
MHC	22	0	22
PHP	14	4	18
UHC	11	12	23
Totals	**60**	**31**	**91**

Source: [MCO] CHW DSIPT, Q4CY17

CHW interventions include assisting members with primary care physician (PCP) appointments, preventative care, education, health literacy, completing health risk assessments (HRAs), post emergency room/hospital follow up and translation. The highest level of interventions in Q1 included PCP appointments and transportation. CHWs also assist members in acute facilities to complete HRAs and educate them about benefits, and appropriate use of the emergency room. According to information reported by MCOs, CHWs attended meetings alongside members after a Behavioral Health hospitalization and provided medication adherence education and support with follow-up with Behavioral Health provider appointments. Increasingly, CHWs attend recovery support group meetings with members to provide additional support. Maternal health outreach with CHW involvement improved outcomes with increased pre and post-partum care. CHWs also serve incarcerated members returning to the community and who are in need of

medical care, linkages to food assistance, utility assistance, housing, and transportation. Please see Table 3 – Unduplicated Members Served by CHWs.

Table 3 – Unduplicated Members Served by CHWs

DY5 Q1 Unduplicated Members Served					
	BCBS	**MHC**	**PHP**	**UHC**	**Region Totals**
Underserved Urban	4601	1451	721	640	7413
Rural	159	1204	460	574	2397
Frontier	53	231	136	95	515
MCO Totals	**4813**	**2886**	**1317**	**1309**	**10325**

Source: [MCO] CHW DSIPT, Q4CY17

Educational outreach in Q1 included:

- Diabetes & Managing Weight
- Medical Benefits & Services Educational Events
- Cooking for Health

Telemedicine

In DY5 Q1, telemedicine utilization data for Q4 was reviewed. Consistent with previous reporting periods, the data indicates that most telemedicine services provided in New Mexico are for behavioral health diagnoses (Please see Table 4 – Telemedicine Services). All MCOs continue to provide technical assistance to providers and promote the use of technology to allow members to have access to telemedicine services. BCBS reports working with large in-state providers of telehealth specialty services to make sure rural and frontier primary care physicians are aware of their availability. MHC expanded access to specialty services through telemedicine by contracting with three behavioral health prescriber groups and by linking these behavioral health prescriber groups with contracted clinics that are in need of their services. PHP partners with the Presbyterian Healthcare Services delivery system through a Telehealth Operations Committee to identify opportunities to improve access and capacity through expanded telemedicine offerings. UHC began a marketing campaign to better educate its members and held town hall meetings and training sessions with providers on the benefits of telehealth.

Table 4 - Telemedicine Services

DY4 Q4			
Behavioral Health			
	Urban	**Rural**	**Frontier**
BCBS	298	439	117
MHC	312	791	186
PHP	1,141	1,680	734
UHC	244	421	58
TOTAL	1,995	**3,331**	**1,095**

Source: [MCO] Telemedicine DSIPT, Q4CY17
*Urban numbers are for data collection only and do not count towards Delivery System Improvement Performance Target (DSIPT) goal.

Transportation

In DY5 Q1, HSD continued to monitor the administration of the non-emergency medical transportation benefit provided under managed care. HSD requires MCOs to monitor adequate access to safe and timely transportation services while ensuring the benefit is appropriately utilized for medically necessary services. In DY5 Q1, the MCOs provided oversight of transportation contractors through monthly reporting, grievance reports, call center audits, joint operational meetings, and corrective action. For additional detail regarding grievances, please see Section XII: Consumer Issues – Complaints and Grievances.

Provider Network

New Mexico continues to experience a provider shortage; however, the overall provider network remained consistent with previous quarters. During DY4 Q4, HSD monitored MCOs' compliance in maintaining an adequate and efficient provider network by: tracking and trending new and terminated providers, member-to-provider ratios, the number of providers with panels and/or practices that are open and closed to new members, the number of single case agreements, and the transition of members to new providers when a provider or agency was suspended or terminated.

Service Delivery

Utilization Data

Centennial Care key utilization and cost per unit data by overall program as well as by specific program is provided for CY16 to CY17. Please see Attachment D: Key Utilization/Cost per Unit Statistics by Major Population Group.

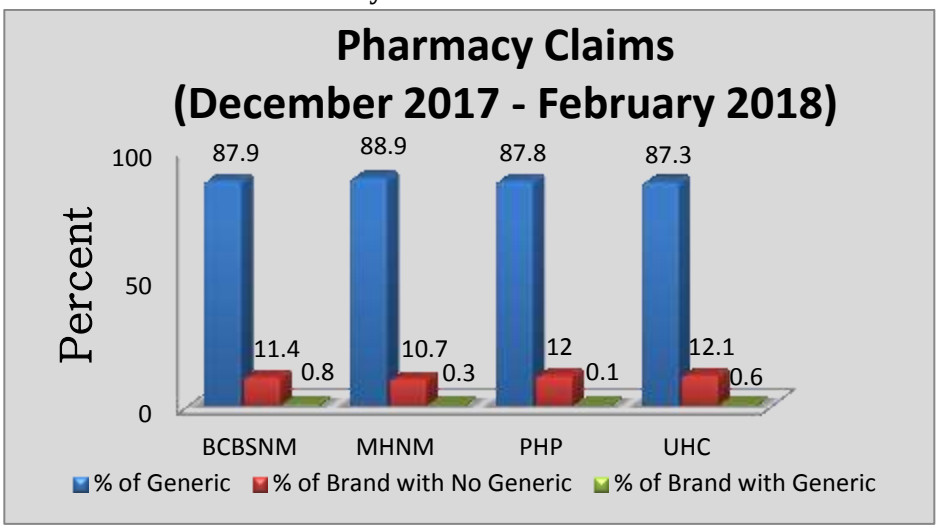
Pharmacy

HSD reviews the monthly MCO pharmacy report to identify trends in prescription claims for brand and generic drugs (Please see Table 5 – Percent of Pharmacy Claims for each MCO). This reporting period showed an average generic drug usage for all four MCOs of 88%, an increase

from 87.4% in the previous reporting period. In comparison to the last quarter, HSD identified the following:

- All MCOs showed an increase, from the previous quarter, in generic drug utilization and usage of brand drugs when no generic is available.
- All MCOs had a decrease, from the previous quarter, in usage of brand drugs with no generic available, with MHNM having a noticeable decrease of 10.7% from 12%.
- The overall usage of brand medication when there was no generic available averaged 11.6%.
- Use of brand drugs when there was a generic available remained the same for three of the MCOs. BCBS had an increase in the use of brand drugs and resulted in an overall average of 0.5% for all MCOs.
- All four MCOs continue to require medical justification for use of a brand drug when there is a generic drug available.

Table 5 – Percent of Pharmacy Claims for Each MCO



Source: [MCO] Pharmacy Report #44, M12CY17, M1CY18, M2CY18

During DY5 Q1, HSD issued a Letter of Direction (LOD) to the MCOs to address community pharmacy reimbursement. The intent of the LOD is to increase reimbursement to the community-based pharmacies to ensure that the pharmacy payment structure more realistically reflects buying power, buying volume, and price negotiating potential. Effective April 1, 2018, the LOD directed the MCOs to ensure that the Maximum Allowed Cost (MAC) for ingredient cost for generic drugs for community-based pharmacies is no lower than the current National Average Drug Acquisition Cost (NADAC) listed for the National Drug Code (NDC) for the drug item.

MCOs are expected to reflect the change in reimbursement policy in their contracts with providers. The increase being implemented is in addition to the MCOs' existing reimbursement rates as of January 1, 2018 and MCOs should apply the increases associated with the LOD, without offsetting the reductions elsewhere. The LOD included a list of 91 community-based

pharmacies, mostly in New Mexico or very close to the New Mexico border. A Community-Based Pharmacy is a pharmacy that has the following characteristics:

- Is open to the public for prescriptions to be filled, regardless of the facility or practice where the prescription was written. This includes multi-site pharmacy operations and franchises whose locations are in New Mexico;
- Is located in New Mexico or near the state border, if the border town is a primary source of prescription drugs for Centennial Care members residing in the border area;
- Is not government-owned, not hospital-owned or hospital-based, not an extension of a hospital, not owned by a corporation owning hospitals, and not an extension of a medical practice or specialty facility;
- Is not owned by a corporate chain with stores outside of New Mexico;
- Is not a mail order pharmacy; and
- Is not part of a national network of pharmacies or specialty pharmacies, including those primarily used for supplying IV admixtures.

Hepatitis C (HCV)

During DY5 Q1, HSD revised the HCV delivery system improvement performance target (DSIPT) reporting template. In addition, the reporting cycle was transitioned from a monthly report to quarterly report. The revised reporting template collects both qualitative and quantitative data related to the requirements set forth in a LOD issued in DY4 Q4. The quantitative data allows HSD to monitor the running number of unduplicated number of patients requesting HCV treatment for the calendar year as well as similar numbers for direct antiviral agent prescription approvals and dispensing by both members' liver fibrosis stages and HCV genotypes. The template also provided the MCOs with a formula to estimate their respective DSIPT treatment target. The qualitative data collects information about the MCOs efforts to develop a provider incentive plan, a comprehensive outreach plan, a comprehensive plan to expand HCV case finding and screening efforts, as well as a comprehensive plan to expand HCV screening efforts to conform to USPSTF/CDC/AASLD/IDSA guidelines.

Nursing Facilities

In DY5 Q1, HSD continued to monitor the MCOs' efforts to address nursing facility (NF) claims issues through regularly scheduled meetings with the MCOs and their NF provider network. HSD also continued to work with Myers and Stauffer on the audit of MCOs' claims payments to NFs. The audit is focused on the MCO processing of crossover claims, denial of payment for preauthorized services, and accuracy of payment rates for retroactive rate changes.

Community Interveners

In DY4 Q4, two Centennial Care members received Community Interveners (CI) services as illustrated below. There were a total of five members who used CI services in 2017. The MCOs provide education to their Care Coordinators to assist in identifying members that meet the criteria for the CI service.

Table 6 – Community Intervener Services Utilization DY4 Q4

MCO	# of Members Receiving CI	Total # of CI Hours Provided	Claims Billed Amount
BCBS	0	0	$0
MHC	0	0	$0
UHC	1	176	$1,050
PHP	1	29	$719
Total	**2**	**205**	**$1,769**

Centennial Rewards Program

All Centennial Care members are eligible for Centennial Rewards and to date, 677,475 distinct members, or 72% of all enrollees, have earned at least one reward. Since the launch of Centennial Rewards, members have earned points totaling a value of $49.7 million. Of that amount $12.3 million have been redeemed for a cumulative redemption rate of about 25%. Points expire at the end of the year after the year in which they were earned. Table 7 shows the healthy behaviors rewarded and each behavior's value. It includes the maximum dollar value available for each activity, the total dollars earned, and the amount redeemed.

Table 7 – Healthy Behaviors Rewarded

Eligibility Activities	Reward Value in Points, by Activity	Reward Value in $, by Activity	Total Rewards Earned by Activity in $	Total Rewards Redeemed by Activity in $
Asthma Management	600	$60	$ 1,250,940	$ 437,539
Bipolar Disorder Management	600	$60	$ 1,477,650	$ 386,660
Bone Density Testing	350	$35	$ 69,790	$ 15,428
Healthy Smiles Adults	250	$25	$ 10,880,525	$ 2,225,796
Healthy Smiles Children	350	$35	$ 24,294,305	$ 6,683,107
Diabetes Management	600	$60	$ 5,953,820	$ 1,636,333
Healthy Pregnancy	1000	$100	$ 1,579,000	$ 409,262
Schizophrenia Management	600	$60	$ 737,890	$ 166,384
Health Risk Assessment	100	$10	$ 4,394,320	$ 1,127,030
Step-Up Challenge			$ 599,375	$ 523,176
Other (Appeals and Adjustments)	N/A	N/A	$ 690,653	$ 427,433
Totals		**N/A**	**$ 51,928,268**	**$ 14,038,148**

Section III: Enrollment

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

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

Table 8 – Enrollment DY5 Q1

Demonstration Population	Total Number Demonstration Participants DY5 Q1 Ending March 2018	Current Enrollees (Rolling 12-month Period)
Population 1 – TANF and Related	**368,464**	**471,395**
FFS	39,740	59,103
Molina	117,888	153,353
Presbyterian	119,483	148,066
UnitedHealthcare	27,934	34,381
Blue Cross Blue Shield	63,419	76,492
Population 2 – SSI and Related – Medicaid Only	**38,723**	**44,918**
FFS	2,267	3,776
Molina	11,854	13,879
Presbyterian	12,633	13,878
UnitedHealthcare	5,171	5,934
Blue Cross Blue Shield	6,798	7,451
Population 3 – SSI and Related – Dual	**35,883**	**39,183**
FFS	0	265
Molina	7,047	7,765
Presbyterian	6,818	7,372
UnitedHealthcare	15,235	16,549
Blue Cross Blue Shield	6,783	7,232
Population 4 – 217-like Group – Medicaid Only	**266**	**510**
FFS	10	193
Molina	50	67
Presbyterian	49	73
UnitedHealthcare	106	109
Blue Cross Blue Shield	51	68
Population 5 – 217-like Group - Dual	**3,565**	**3,460**
FFS	0	31
Molina	754	762
Presbyterian	635	625
UnitedHealthcare	1,401	1,341
Blue Cross Blue Shield	775	701
Population 6 – VIII Group (expansion)	**268,189**	**287,337**
FFS	25,620	33,722
Molina	73,253	77,705
Presbyterian	68,214	67,439
UnitedHealthcare	38,712	42,985
Blue Cross Blue Shield	62,390	65,486

Disenrollments

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

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

Table 9 – Disenrollment Counts DY5 Q1

Disenrollments	Total Disenrollments During DY5 Q1
Row Labels	
Population 1 – TANF and Related	**6,550**
FFS	753
Molina	2,034
Presbyterian	1,844
UnitedHealthcare	606
Blue Cross Blue Shield	1,313
Population 2 – SSI and Related – Medicaid Only	**468**
FFS	25
Molina	140
Presbyterian	143
UnitedHealthcare	68
Blue Cross Blue Shield	92
Population 3 – SSI and Related – Dual	**482**
Molina	86
Presbyterian	79
UnitedHealthcare	213
Blue Cross Blue Shield	104
Population 4 – 217-like Group – Medicaid Only	**2**
FFS	1
Molina	0
Presbyterian	0
UnitedHealthcare	0
Blue Cross Blue Shield	1
Population 5 – 217-like Group - Dual	**84**
Molina	19
Presbyterian	17
UnitedHealthcare	31
Blue Cross Blue Shield	17
Population 6 – VIII Group (expansion)	**8,282**
FFS	1,100
Molina	2,117
Presbyterian	2,077
UnitedHealthcare	1,125
Blue Cross Blue Shield	1,863
TOTAL	**15,868**

Section IV: Outreach

In DY5 Q1 HSD staff assisted the Medicaid Member call-center with troubleshooting numerous MCO enrollment issues and recognizing trends in found errors, following the move of the MCO enrollment functionality from Omnicaid to ASPEN, which was implemented during DY4 Q4.

All four MCOs participated in a wide variety of community events across the state providing enrollment opportunities and educating the public about Centennial Care. MCOs attended numerous Medicaid enrollment events, health fairs and community events comprised of people with disabilities, senior citizens, children and families, Native Americans and other populations.

Presumptive Eligibility Program

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

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

In DY5 Q1, HSD PE Program staff has been preparing PED refresher trainings to ensure that all PEDs have the most up to date information regarding the NM PE Program. The next scheduled training will be the "Non-Citizen/Immigrant Eligibility Training for Presumptive eligibility Determiners." All PEDs will be required to complete a training session in DY5 Q2 to retain their PE certifications.

PEDs continue to provide application assistance state-wide. In DY5Q1, PEDs:

- Granted **703** PE approvals*
- Submitted applications for **6,568** individuals
- Which resulted in **5,631** ongoing Medicaid approvals

*98.1% of all PEs granted in this reporting period also had an ongoing application submitted

JUST Health Program

PEDs who are employees of the NM Department of Corrections and County Jails or Detention Centers participate in the PE Program through the Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) program.

The JUST Health programs allows for the automated data transfer of information regarding the incarceration status of individuals in New Mexico. Individuals who are Medicaid-enrolled have

their benefits suspended after 30 days of incarceration. Benefits are reinstated upon the individual's release from incarceration which allows immediate access to care. Individuals who are not Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply. Application assistance is provided by PEDs at the correctional facilities.

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

Procurement for Centennial Care 2.0 MCOs
HSD conducted a procurement process in late 2017 to select MCOs for the second phase of Centennial Care ("2.0") beginning January 1, 2019. A Request for Proposals (RFP) was released on September 1, 2017. Proposals were submitted by eight MCOs by the November 3, 2017 deadline. Evaluation and scoring was done by HSD in November and December, resulting in the selection of three MCOs for the contract award, which was announced in January 2018. Four non-awarded MCOs subsequently submitted protests following the award announcement.

Documents related to the procurement, including the RFP and protests, can be found at: http://www.hsd.state.nm.us/Centennial_Care_RFP.aspx.

Indian Managed Care Entity RFI
HSD issued a Request for Information (RFI) on January 25, 2018 soliciting information and interest in establishing an Indian Managed Care Entity for New Mexico Native American Medicaid Members. Three responses were received by the March 1 deadline, which HSD reviewed for consideration and further discussion.

Documents related to the RFI, including submissions and responses, can be found at: http://www.hsd.state.nm.us/LookingForInformation/open-rfps.aspx.

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
Based on the difficulties of living with asthma or COPD, throughout DY5 Q1, BCBS initiated a partnership with Albertsons Markets to offer health education classes, at no charge, to BCBS Community Centennial Care members. The objective of these classes is to help members better understand breathing conditions.

The classes are between 60 - 90 minutes long and they will provide BCBS Community Centennial Care members with the option to:

1. Learn from an Albertsons Market pharmacist about:
    - Causes of asthma and COPD
    - Symptoms of asthma and COPD
    - Management of asthma and COPD

2. Better understand how to take inhaled medications. The pharmacist will show them the best techniques and common mistakes using demonstration inhalers.
3. Be part of a question and answer session.
4. Receive education materials at no charge, including:
    - Asthma/COPD booklet
    - Water bottle

The classes are scheduled to begin June 16, 2018 and will be held at numerous Albertsons Market locations. Members will be notified of these classes through member communications that have been approved by HSD.

Molina Healthcare

Santa Fe Fire Department Pilot Program - As previously reported, collaboration with the City of Santa Fire Department (SFFD) targets members with complex care coordination needs who are also high utilizers of 911 services. The objective is to engage these members, who could not be contacted by other means, and re-establish relationships with care coordinators. During the current reporting period, additional planning occurred in preparation for a April 1, 2018 start date.

Ten MHC members will be mutually identified each quarter. SFFD attempts to make contact with the members. Once contact is established, the member is assigned an SFFD lead and a substance abuse history and health issues assessment are completed. The lead is responsible for making appointments and connecting the member to services. The member is reintroduced to the MHC Care Coordinator and a warm transfer is accomplished.

Outcome metrics include the utilization patterns including Emergency Department, Inpatient, and Physical Health (PCP) encounters, and the engagement rate of members sent for SFFD interventions, and subsequent continued engagement in Care Coordination thereafter.

Presbyterian Health Plan

PHP is tracking initiatives described in earlier progress reports. In addition to reporting new initiatives, PHP will provide periodic updates for ongoing activities such as: offering in-house support broker services for self-directed members; using "Pre-Managed" reports for care coordination to quickly identify members who require follow up after emergency department visits; care coordinators embedded in pediatric primary care provider offices with a high volume of high risk pediatric members; and, many other pilots and activities previously presented.

New in DY5 Q1, PHP and the Isleta Presbyterian Medical Clinic collaborated to develop a CHW pilot within the Pediatric, Internal Medicine, and Family Practice clinics. The pilot, called "Healthy Way," focuses on screening members for social determinants of health (SDOH). Members who screen positive for SDOH are offered support and linkages to community

resources and services. The clinic's support staff and the providers are also able to submit direct referrals and/or call on the support of the CHW when needs are identified.

Also new in DY5 Q1 is PHP's delivery system improvement plan to expand provider network capacity by attracting providers to relocate to New Mexico. Specific providers selected for recruitment are those who have been historically difficult to recruit and retain. PHP's areas of focus include: behavioral health – addiction medicine, allergy/asthma, pediatric subspecialties, dermatology, and primary care physicians in rural areas. In an effort to increase provider capacity, PHP strategies include, but are not limited to: growing the workforce via an accredited educational fellowship with academic sponsorship for behavioral health specialties; offering provider incentives such as quality specialty pay; reimbursing travel expenses for providers in active recruitment; increasing attendance to conferences held for specific specialties; and, training PCPs in asynchronous dermatology visits which encompass visits that are amenable to treatment that are now beyond the scope of primary care. PHP is developing measures to quantify the results of its efforts including improved member access for the specialties and subspecialties identified.

UnitedHealthcare

One of the great innovations reported by UHC's Network team stemmed from an HSD mandate to establish routine Provider Forum calls to address provider claims and other issues. UHC reports the initiation of their provider forums are co-led by the network team and the health plan. The pilot for this model was hospitals: they had concerns that were escalated to HSD (around claims, credentialing, authorizations). To assist with the resolution of these issues, HSD mandated that UHC host regularly scheduled forums to hear and resolve the hospitals' and other provider issues. UHC reports a significant improvement by conducting these forums and provide the following examples of steps taken to remain focused in the area:

- All of the concerns are tracked and worked, and each month UHC reports-out and closes outstanding issues. Individual hospitals and the hospital association participate, and UHC also invites HSD staff to observe. UHC states this approach has been a huge success – they hold themselves accountable and providers see traction on their concerns,
- Following that success, UHC initiated similar approaches with the nursing home industry, I/T/Us, and behavior health providers.

These forums continue to be successful for UHC and have not only allowed UHC to address and correct past issues but also allowed the opportunity to identify and act on developing issues as they occur.

Fiscal Issues

During DY5 Q1, cost settlement with the schools and IHS payments were made for calendar year (CY) 2016 and retroactive capitation adjustments for newborns were made for CYs 2016 and 2017. These payments affect the per member per month (PMPM) for MEG 1 for DY3 and DY4. Capitation adjustments were also made for a change in the setting of care for individuals in

institutional nursing facilities for CYs 2016 and 2017. These capitation adjustments affected the PMPM of MEGs 2 to 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. The issues that were identified as part of the transition of enrollment from the Medicaid Management Information System (MMIS) to the Eligibility and Enrollment (E&E) system, have been researched and resolved. 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 legacy MMIS began some time ago, and activity for this effort progressed in DY5 Q1. The replacement MMIS will be a true Enterprise system, so HSD has actively engaged the DOH, CYFD, and the Aging and Long-Term Services Department (ALTSD). These three departments have participated in RFP development and replacement planning. HSD is currently in the process of drafting a GSA with CYFD and is in the final stages of the GSA with ALTSD for qualifying activities to receive MMISR funding; the GSA with DOH has been approved.

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

The RFP for the next module of the Framework, the Enterprise Data Services RFP, was released on April 17, 2017. Proposals came in on June 21, 2017, and HSD is currently in an active procurement process. Contract negotiations have begun for Data Services and the contract is in the final stages.

CMS has approved the third module RFP for Quality Assurance. The Quality Assurance RFP was released on March 16, 2018 and proposals are due May 16, 2018.

HSD has begun development of the RFP for the fourth module, Benefit Management Services. This RFP involved meetings with all stakeholders, questionnaires for input, review of other states' procurements and contracts, as well as information from the current fiscal agent contract. This information is being gathered for requirements development and will be vetted through the stakeholder review process for comment prior to submission to CMS. The expectation is to submit the RFP to CMS in April 2018.

Once the Benefit Management Services RFP is submitted to CMS for review, work will continue with the development of the RFP for the fifth module, Financial Services. Some work with stakeholders, questionnaires, and requirements gathering from other states has already been started. Further work will be done as areas are identified that require additional input from stakeholders.

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

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

An Implementation Advanced Planning Document Update (IAPD-U) was submitted and approved by CMS and an update will be submitted in the coming months.

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 ALTSD Aging & Disability Resource Center (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.

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

ALTSD provides quarterly reports to HSD including the ADRC Caller Profile Report and Care Transitions Program Data.

Table 10 – ADRC Call Profiler Report DY5 Q1

Topic	# of Calls
Home/Community Based Care Waiver Programs	3,263
Long Term Care/Case Management	9
Medicaid Appeals/Complaints	9
Personal Care	188
State Medicaid Managed Care Enrollment Programs	17
Medicaid Information/Counseling	1,538

Table 11 – ADRC Care Transition Program Report DY5 Q1

Counseling Services	# of hrs	# of Nursing Home Residents	# of Contacts
Transition Advocacy Support Services		171	
Medicaid Education/Outreach	1,672		
Nursing Home Intakes		73	
**LTSS Short-Term Assistance			156

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

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

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

CTB hired a Regional Counseling Program Manager to manage the Short-Term Assistance (STA) Program. The STA Program has seen an increase in assisting individuals from last quarter due to Medicaid MCOs providing referrals for individuals transitioning from Medicaid to Medicare due to age or disability needs.

Critical Incidents

HSD continues to meet quarterly with the MCOs' Critical Incident (CI) workgroup in an effort to provide technical assistance. The workgroup supports the Behavioral Health Services Division in the delivery of BH incident reporting protocols to providers. The protocols will be used by BH providers to improve accuracy of information reported and to establish guidelines for the types of BH providers who are required to report.

During DY5 Q1, a total of 5,644 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 CI web portal are reviewed. HSD continues to direct the MCOs to provide technical assistance when providers are non-compliant.

During DY5 Q1, a total of 561 deaths were reported. Of the 561 deaths reported, 457 deaths were reported as natural or expected deaths, 100 deaths were reported as unexpected and four suicides were reported. All deaths reported through the critical incident system are reviewed by HSD and the MCOs.

All CIRs require follow up and may include a medical record review or a request for records from the Office of the Medical Investigator (OMI) to determine a cause of death. MCOs have internal processes on follow-up for all member deaths.

During DY5 Q1, a total of 3,685 critical incidents were reported for Emergency Services. Of those Emergency Services reports, 217 were reported by Behavioral Health providers and 288 were associated with self-directed members. This demonstrates an upward trend in the use of Emergency Services when compared to DY4 Q4 (2,690), DY4 Q3 (2,692), DY4 Q2 (2,910) and

DY4 Q1 (3,172). MCOs continue to identify the use of Emergency Services as the highest critical incident type reported by volume for members with a reportable category of eligibility.

Table 12 – Critical Incident Types by MCO – Centennial Care

Critical Incident Types by MCO - Centennial Care										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	41	0.85%	90	1.87%	92	1.91%	71	1.48%	294	6.11%
Death	125	2.60%	121	2.52%	101	2.10%	166	3.45%	513	10.66%
Natural/Expected	109		80		85		157		431	
Unexpected	16		41		15		8		80	
Suicide	0		0		1		1		2	
Elopement/Missing	3	0.06%	5	0.10%	9	0.19%	1	0.02%	18	0.37%
Emergency Services	670	13.93%	812	16.88%	877	18.23%	821	17.07%	3,180	66.10%
Environmental Hazard	12	0.25%	16	0.33%	28	0.58%	27	0.56%	83	1.73%
Exploitation	13	0.27%	19	0.39%	19	0.39%	41	0.85%	92	1.91%
Law Enforcement	14	0.29%	33	0.69%	27	0.56%	18	0.37%	92	1.91%
Neglect	107	2.22%	98	2.04%	141	2.93%	193	4.01%	539	11.20%
Total	**985**	**20.47%**	**1,194**	**24.82%**	**1,294**	**26.90%**	**1,338**	**27.81%**	**4,811**	**100.00%**

Critical Incident Types by MCO - Behavioral Health										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	10	2.22%	50	11.09%	43	9.53%	7	1.55%	110	24.39%
Death	5	1.11%	11	2.44%	3	0.67%	3	0.67%	22	4.88%
Natural/Expected	1		4		1		0		6	
Unexpected	4		7		2		2		15	
Suicide	0		0		0		1		1	
Elopement/Missing	1	0.22%	2	0.44%	4	0.89%	0	0.00%	7	1.55%
Emergency Services	15	3.33%	163	36.14%	25	5.54%	14	3.10%	217	48.12%
Environmental Hazard	0	0.00%	2	0.44%	2	0.44%	0	0.00%	4	0.89%
Exploitation	1	0.22%	3	0.67%	2	0.44%	0	0.00%	6	1.33%
Law Enforcement	5	1.11%	8	1.77%	10	2.22%	0	0.00%	23	5.10%
Neglect	6	1.33%	39	8.65%	8	1.77%	9	2.00%	62	13.75%
Total	**43**	**9.53%**	**278**	**61.64%**	**97**	**21.51%**	**33**	**7.32%**	**451**	**100.00%**

Critical Incident Types by MCO - Self Directed										
Critical Incident Types	BCBS		Molina		Presbyterian		UHC		Total	
	#	%	#	%	#	%	#	%	#	%
Abuse	5	1.31%	3	0.79%	13	3.40%	9	2.36%	30	7.85%
Death	2	0.52%	4	1.05%	11	2.88%	9	2.36%	26	6.81%
Natural/Expected	2		2		8		8		20	
Unexpected	0		2		2		1		5	
Suicide	0		0		1		0		1	
Elopement/Missing	0	0.00%	0	0.00%	2	0.52%	0	0.00%	2	0.52%
Emergency Services	30	7.85%	39	10.21%	171	44.76%	48	12.57%	288	75.39%
Environmental Hazard	0	0.00%	0	0.00%	3	0.79%	0	0.00%	3	0.79%
Exploitation	0	0.00%	0	0.00%	7	1.83%	2	0.52%	9	2.36%
Law Enforcement	1	0.26%	5	1.31%	3	0.79%	0	0.00%	9	2.36%
Neglect	1	0.26%	1	0.26%	11	2.88%	2	0.52%	15	3.93%
Total	**39**	**10.21%**	**52**	**13.61%**	**221**	**57.85%**	**70**	**18.32%**	**382**	**100.00%**

Home and Community-Based Services Reporting

In DY5 Q1, HSD began compiling and analyze the on-site validation and participant surveys with Community Benefit providers and members. HSD also continued to update the Statewide Transition Plan milestones as required by CMS.

In DY5 Q1, the LTC Workgroup met to discuss the following agenda items:

- Ride-along feedback from HSD to the MCOs that included recommendations for best practice care coordination interviewing techniques.

HSD conducted Assisted Living Facility (ALF) training to the MCOs to clarify requirements for timeliness of member transitions and authorizations of ALF services.

Self-Directed Community Benefit

In DY5 Q1, HSD continued to meet monthly with PHP to discuss the transition of PHP's Self-Directed Community Benefit (SDCB) members to its in-house Support Brokers (SB) or to one of the two contracted external SB agencies. During the reporting period, PHP began quality auditing with the SBs and early results are promising. Overall, the transition has been a success for PHP and their SDCB members. HSD will continue to monitor the quality outcomes of this project.

Electronic Visit Verification

In DY5 Q1, HSD began to conduct meetings with the MCOs and their EVV Vendor, First Data for the implementation of EVV for the self-directed personal care services. HSD has directed the MCOs to work together with First Data and the SDCB Fiscal Management Agency in order to meet the required January 2019 start date. In DY5 Q2, the MCOs will continue to seek stakeholder input and involve SBs and members in the EVV roll-out for self-directed personal care services.

Section VIII: AI/AN Reporting

Access to Care

Indian Health Service, Tribally operated facility/programs, and Urban Indian clinics (I/T/Us) are concentrated near or on Tribal land where many Native Americans live and receive services. Data from the four Centennial Care MCOs shows for physical health there is 98% access to care for Native Americans in rural areas and 99% access to care for Native Americans in frontier areas. For behavioral health there is a 98% access for Native Americans in rural areas and 99% access for Native Americans in frontier areas.

Contracting Between MCOs and I/T/U Providers

The MCOs continue to work on developing contracts with I/T/Us. One MCO has begun to work with Community Health Representative (CHR) programs to develop agreements. The MCOs currently have agreements with Tribal entities for HRA completion, translation, transportation, health education, audiology, optical, extended hour services, tribal behavioral health services, recovery services, and Wellness Centers.

Ensuring Timely Payment for All I/T/U Providers

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

Table 13 – Native American Advisory Board (NAAB) meetings for DY5 Q1

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Zuni Tribal Conference Center Zuni, NM March 22, 2018	**Issue**: How do we know if an HRA has already been completed? **Response**: We can have a care coordinator check in our system to see if the member's HRA is completed. **Issue:** Sometimes appointments come unexpected. How can I give 72-hour notice to book transportation in that case? **Response:** It is possible to get urgent care transportation by calling Logisticare. This will depend on availability. **Issue:** I completed my HRA but my husband didn't. I asked if I could do the HRA for him and they told me no. Since that time he has not completed an HRA. **Response:** If you do not have Power of Attorney for your husband, you do not have legal permission to do the HRA for him.

MHNM	Native American Community Academy Albuquerque, NM March 7, 2018	There was a question about the reimbursement rate from Secure Transportation. The rate is .45 cents per mile not .50 cents per mile. Another member stated that her grandson has an addiction and would like to know more about peer support services. The peer support worker at the meeting provided his card to the grandmother and asked that her grandson contact him, even if he is not a Molina Healthcare member.
PHP	Pueblo of Zuni Tribal Headquarters Zuni, NM March 9, 2018	**Issue:** How can I switch my MCO? **Response**: Member was given Native American FAQs on switching MCOs as well as information on open enrollment beginning October, 2018. **Issue**: How can I get a care coordinator? **Response**: The member or family member can request a care coordinator. You can contact the member services call center at Presbyterian. **Issue:** How can I get a ramp for my home? **Response:** Your care coordinator can you help you with home modifications. She will begin the process with an assessment and help you with the process.
UHC	Future Foundation Family Center Grants, NM March 14, 2018	**Issue**: Do members receive mileage reimbursement if they go to the ER? **Response**: Yes, they can receive mile reimbursement if they call the same day to receive a Trip Number for the ER visit. **Issue:** Do you have to receive verification once someone is discharged from the hospital? **Response:** No, you do not need any verification once being discharged.

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

The NATAC meeting took place on March 19, 2018. The Medicaid Director provided an update to the Committee of the three MCOs that have been selected for Centennial Care 2.0. She also informed the Committee of the release of a Request for Information (RFI) in January 2018 regarding an Indian Managed Care Entity (IMCE). The MAD Native American Liaison went over Medicaid data for Native Americans in Centennial Care.

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

- During DY5 Q1, the care coordination agreement (CCA) between the University of New Mexico Hospital (UNMH) and the Albuquerque Area Indian Health Services (AAIHS) progressed as follows:
    - Billing staff finalized the requirements to identify relevant claims;
    - All logic and testing is complete;
    - UNMH and AAIHS completed two preliminary audits;
    - Progress on a second CCA between UNMH and the Navajo Area IHS (NAIHS) included a legal review by NAIHS of the proposed CCA; and
    - A third partnership, Presbyterian Healthcare Services and AAIHS have a fully executed CCA. Presbyterian is working on a flow chart for the proposed process with AAIHS.

Section IX: Action Plans for Addressing Any Issues Identified

See Attachment F: MCO Action Plans

Section X: Financial/Budget Neutrality Development/Issues

DY5 Q1 reflects the CY 2018 rates as provided to CMS on January 4, 2018. The PMPM for DY5 is lower compared to DY4 for MEGs 1, 2, and 3; the PMPM for DY5 is higher than those of DY4 for MEGs 4, 5 and 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 DY5 is 35.8% below the budget neutrality limit (Table 5.4) based on one quarter of payments.

Section XI: Member Month Reporting

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

Table 14 – Member Months DY5 Q1

Number of Clients by Population Group and MC	
	2018
Row Labels	Q1
Population 1 – TANF and Related	**1,108,827**
FFS	**121,250**
MC	**987,577**
Molina	356,199
Presbyterian	360,005
UnitedHealthcare	82,993
Blue Cross Blue Shield	188,380
Population 2 – SSI and Related – Medicaid Only	**115,715**
FFS	**6,887**
MC	**108,828**
Molina	35,421
Presbyterian	37,724
UnitedHealthcare	15,477
Blue Cross Blue Shield	20,206
Population 3 – SSI and Related – Dual	**105,573**
MC	**105,573**
Molina	20,790
Presbyterian	20,049
UnitedHealthcare	44,901
Blue Cross Blue Shield	19,833
Population 4 – 217-like Group – Medicaid Only	**858**
FFS	**57**
MC	**801**
Molina	160
Presbyterian	159
UnitedHealthcare	319
Blue Cross Blue Shield	163
Population 5 – 217-like Group - Dual	**10,304**
MC	**10,304**
Molina	2,191
Presbyterian	1,833
UnitedHealthcare	4,070
Blue Cross Blue Shield	2,210
Population 6 – VIII Group (expansion)	**755,947**
FFS	**73,858**
MC	**682,089**
Molina	206,939
Presbyterian	190,833
UnitedHealthcare	109,390
Blue Cross Blue Shield	174,927

Section XII: Consumer Issues – Complaints and Grievances

A total of 891 grievances were filed by Centennial Care members in DY5 Q1. Although this presents a slight increase when compared to member grievances received in DY4 Q4 (871), an overall downward trend is demonstrated when compared to Q3 (1,184) Q2 (1,058) and Q1 (968). Non-emergency ground transportation continues to constitute the largest number of grievances reported with 414 (46.46%) of the total grievances received. This remained the same when compared to 414 in DY4 Q4. An overall trend cannot be established when compared to DY4 Q3 (487) Q2 (332) and Q1 (274). Transportation Grievances in Section II of this report provides the MCOs' efforts to address transportation grievances under the guidance of HSD.

The second top grievance filed was Other Specialties with a total of 101 grievances (11.34%) which demonstrates an overall upward trend when compared to DY4 Q4 (45), Q3 (61), Q2 (84) and Q1 (109).

There were 376 (42.20%) variable grievances filed during DY5 Q1. Of those, each MCO reported unique grievances that do not provide data to establish a trend. HSD is monitoring these grievances to identify specific trends.

Table 15 – MCO Grievances DY5 Q1

MCO Grievances DY5 Q1 (January - March 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Grievances	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Member Grievances	205	23.01%	182	20.43%	198	22.22%	306	34.34%	**891**	100.00%
Top Member Grievances										
Transportation Ground Non-Emergency	122	13.69%	80	8.98%	63	7.07%	149	16.72%	**414**	46.46%
Other Specialties	38	4.26%	0	0.00%	7	0.79%	56	6.29%	**101**	11.34%
Variable Grievances	45	5.05%	102	11.44%	128	14.37%	101	11.34%	**376**	42.20%

Section XIII: Quality Assurance/Monitoring Activity

Service Plans

HSD randomly reviews service plans to ensure that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures that the MCOs appropriately allocate and implement the services identified in the member's Comprehensive Needs Assessment (CNA), and that the member's goals are identified in the care plan. There were no identified concerns in DY5 Q1.

Table 16 – Service Plan Audit Results DY5 Q1

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

NF LOC

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

Table 17 – Nursing Facility LOC Audit Results DY5 Q1

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

Table 18 – Community Benefit NF LOC Audit DY5 Q1

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

HSD was in agreement with all NF LOC decisions for DY5 Q1. MHC did not have any HNF denials in Q1 and an additional 5 files for Community Benefit were reviewed. All NF LOC decisions were appropriate and complied with HSD's NF LOC criteria.

External Quality Review Organization (EQRO) NF LOC

The EQRO for HSD reviews a random sample of MCO NF LOC determinations every quarter to ensure compliance with HSD's NF LOC criteria.

Table 19 – EQRO NF LOC Review Results DY5 Q1

Facility Based	DY5 Q1	DY5 Q2	DY5 Q3	DY5 Q4
High NF Determination				
Number of member files audited	**23**			
BCBS	4			
MHC	7			
PHP	7			
UHC	5			
Number of member files the EQRO agreed with the determination	**22**			
BCBS	3			
MHC	7			
PHP	7			
UHC	5			
%	**96%**			
BCBS	75%			
MHC	100%			
PHP	100%			
UHC	100%			
Low NF Determination				
Number of member files audited	**85**			
BCBS	23			
MHC	20			
PHP	20			
UHC	22			
Number of member files the EQRO agreed with the determination	**85**			
BCBS	23			
MHC	20			
PHP	20			
UHC	22			
%	**100%**			
BCBS	100%			
MHC	100%			
PHP	100%			
UHC	100%			
Community Based				
Number of member files audited	**156**			
BCBS	39			
MHC	39			
PHP	39			
UHC	39			
Number of member files the EQRO agreed with the determination	**152**			
BCBS	39			
MHC	39			
PHP	39			
UHC	39			
%	**97%**			
BCBS	100%			
MHC	100%			
PHP	90%			
UHC	100%			

The MCO High NF determinations continue to average 96% compliance in DY5 Q1 for EQRO agreement of determinations which equaled the percentage of High NF determinations in DY4

Q4. The Low NF determinations increased in Q1to 100% from an average of 98% in DY4 Q4 for EQRO agreement. The EQRO agreed with 97% of the Community Based determinations, a slight decrease from 98% in DY4 Q4. HSD reviewed all five NF LOC determinations where the EQRO and MCO determinations did not align for DY5 Q1 and HSD was in agreement with all EQRO findings. Issues identified included conflicts in documentation and incomplete information from the MCO. HSD will follow up with the MCOs regarding the identified cases and will continue to provide technical assistance as needed.

Care Coordination Monitoring Activities

Care Coordination Audits

HSD continues to evaluate the MCO internal action plans and met with each MCO in February 2018 to discuss action steps going forward for the Transition of Care audit conducted in DY4 Q3 and the Care Coordination Level of Care (CCL) Audit conducted in DY4 Q4. HSD found with the transition of care audit that member files did not consistently contain all required information such as Medicaid eligibility status, disaster plan or identification of physical health, behavioral health or community needs. The results of these audits prompted HSD to issue additional action steps and recommendations to the MCOs which will be monitored throughout DY5. In addition, MCO internal action plans were updated to include internal monitoring of care coordination level determinations through audits and staff training.

HSD has implemented a quarterly Ad Hoc report for DY5 focusing on member enrollment, member engagement and care coordination timeliness that will allow HSD staff to track and trend the data.

Care Coordination for Super Utilizers

HSD continues to evaluate the progress of targeted care coordination with the top Emergency Department (ED) utilizers for each MCO. Originally this project included 35 members from each MCO. Over the past 32 months some members have lost Medicaid eligibility for one reason or another leaving 92 active members currently in the project. HSD monitors this effort on a monthly basis. HSD tracks the number of ED visits, reviews next steps of care coordinators to reduce the incidence of ED visits by their members and how supplemental community assistance can complement the services provided by the care coordinator. HSD met with the MCOs in February 2018 to review data since the inception of the project to discuss what challenges care coordinators encounter in working with super utilizers and look at best practices that have been successful for lowering ED usage. HSD shows a 45% decrease over the tenure of this project in ED use among project participants. DY5 Q1 has shown this trend continuing.

All of the MCOs have made a concerted effort to go beyond standard touchpoints for these members and have engaged them in ways that have affected their wellbeing in all areas of their lives. Care Coordinators have assisted with obtaining housing for homeless members,

collaborated with Community Health Workers to deliver food boxes to members facing food insecurity, and arranged to meet with a member at their detox center and utilized a triage team approach. All of these efforts have contributed to member wellbeing and in turn lower ED use.

Care Coordination and EDIE

The Emergency Department Information Exchange (EDIE) is a MCO collaborative effort utilized to promote appropriate ED utilization. EDIE was launched in July of 2016 with additional hospitals and emergency facilities joining this effort throughout 2017. EDIE allows the MCOs to increase the impact of their existing care coordination resources by automatically aggregating a full census of all ED and inpatient admissions, transfers, observations and discharges. EDIE is directly integrated with the hospital Electronic Medical Record (EMR), which automatically alerts EDIE. EDIE then identifies the patient and references visit history, even if key information is missing from the patient's hospital record. If a visit triggers a pre-set criterion, EDIE notifies the provider within seconds. Notifications to the provider contain visit history, diagnoses, prescriptions, guidelines, and other clinical metadata. As a result of the notification, the provider has information in hand before seeing the patient. This allows the provider to take action and to influence health care outcomes. Due to the increased use of EDIE, MCOs have reported data that has allowed them to better assist those members utilizing the ED, rapidly see those members with emergent needs and connect difficult to engage members with care coordinators. HSD regularly reviews how EDIE can assist those care coordinators working with members in the Super Utilizer project. Care Coordinators have reported building relationships with ER staff that assist them in recognizing those members receiving care coordination. Targeted training of MCO staff is being developed and technical issues are being addressed. As the program grows EDIE will become more valuable to the MCOs and in turn the member.

Care Coordination for Incarcerated Individuals

In DY5 Q1, HSD met with staff from 3 MCOs to discuss policy, procedure and best practices used at The Santa Fe County Detention Center (SFCDC). UHC, PHP and BCBS have collaborated with Santa Fe County to provide care coordination to those incarcerated members that are transitioning back into the community. The SFCDC made this program a priority and have certain staff trained to assist with each MCO's unique processes. In DY5 Q1 BCBS had 573 members incarcerated at SFCDC with 142 expressing an interest in care coordination. UHC had 415 members at SFDC with 51 interested in care coordination and PHP had 273 members at SFCDC with 23 interested in care coordination. HSD discussed with UHC, BCBS, PHP and SFCDC how best practices could be implemented in other facilities across the state. SFCDC has agreed to present their policies and procedures, and best practices at a future HSD sponsored event.

Care Coordination Ride-Alongs

HSD continues to conduct "ride-alongs" with MCO care coordinators on a quarterly basis. In DY5 Q1, HSD staff attended a ride along with UHC and PHP. HSD staff observed the different interview styles of care coordinators, the CNA process and whether it best addressed the member's needs, whether all pertinent questions were asked and whether the resources and services most needed by the member were provided.

HSD found that care coordinators showed great empathy for their members and that their activities were in compliance with contract requirements including the administration of the Community Benefit Services Questionnaire (CBSQ). Care coordinators, naturally, have a variety of interviewing techniques and skill level. HSD strives to have the CNA process as member centric as possible, focused on the information needed and to serve as a building block in the development of the relationship between the member and the MCO care coordinator.

Section XIV: Managed Care Reporting Requirements

Customer Service

In DY5 Q1, all MCOs met call center metrics (abandonment rate, speed of answer and wait time) for the customer services lines, member services, provider services and the utilization management line.

Metrics were met for the nurse advice line for each month in Q1 by all MCOs with the exception of one metric (percent of calls answered within 30 seconds). BCBS reported a staff shortage for December, January and February and did not meet this metric. New nurse advice line staff have been hired to mitigate the staffing shortage. Please see Attachment G: Customer Service Summary.

MCO Reporting

In the DY5 Q1, the MCOs continued the Technical Assistance (TA) Calls and the Self-Identified Error Resubmission. These two processes allow HSD and MCO Subject Matter Experts (SMEs) to provide clarification and direction on MCO reporting inaccuracies. Reports from MCOs in Q1 have been timely and HSD continues to see a decline in MCOs report extension requests, with two extension requests made in DY5 Q1.

Report Revisions

During DY5 Q1, HSD report reviewers submitted proposed revisions for each of their respective reports, in preparation for Centennial Care 2.0. HSD revises reports to streamline elements, improve monitoring, and incorporate requirements of the managed care final rule.

Member Appeals

A total of 869 member appeals were filed by Centennial Care members in DY5 Q1. This demonstrates a consistent downward trend when compared to member appeals received in DY4 Q4 (876), Q3 (1,043), Q2 (1,000) and Q1 (1,013). Of those 869 appeals, 744 (85.62%) were standard member appeals and 125 (14.38%) were expedited member appeals. All MCOs processed acknowledgement notices in a timely manner. Denial or limited authorization of a requested service remains the reason for member appeals reported with 716 (82.39%) of the total appeals received. Although this presents an increase when compared to 697 in DY4 Q4, an overall downward trend is demonstrated when compared to Q3 (834), Q2 (822), and Q1 (873) in DY4.

The second top reason for member appeals was the reduction of a previously authorized service with a total of 61 (7.02%) member appeals. This demonstrates a slight increase when compared to 54 in DY4 Q4, an overall downward trend is demonstrated when compared to Q3 (79), Q2 (110), and Q1 (81) in DY4.

There were 92 (10.59%) variable appeals in DY5 Q1. Of those, each MCO reported unique appeals during the quarter that do not provide enough information to establish a trend. All MCOs

have complied with the policies and procedures regarding members' exhaustion of the Grievance and Appeal System prior to requesting a State Fair Hearing.

Table 20 – Member Appeals DY5 Q1

MCO Appeals DY5 Q1 (January - March 2018)										
MCO	**BCBS**		**MHC**		**PHP**		**UHC**		**Total**	
Member Appeals	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	%
Number of Standard Member	91	10.47%	165	18.99%	346	39.82%	142	16.34%	**744**	85.62%
Number of Expedited Member	70	8.05%	12	1.38%	6	0.69%	37	4.26%	**125**	14.38%
Total	161	18.52%	177	20.37%	352	40.51%	179	20.60%	**869**	100%
Top Member Appeals										
Denial or limited authorization of a requested service	145	16.69%	140	16.11%	317	36.48%	114	13.11%	**716**	82.39%
Reduction of a previously authorized service	2	0.23%	36	4.14%	8	0.92%	15	1.73%	**61**	7.02%
Variable Appeals	14	1.61%	1	0.12%	27	3.11%	50	5.75%	**92**	10.59%

Section XV: Demonstration Evaluation

Progress under the Centennial Care 1115 Waiver Evaluation work plan continues throughout DY5 Q1 with activities centered on the collection of outstanding DY4 data as well as preliminary data for DY5. Deloitte and HSD discussions focused on the development of timelines and deliverables for DY5, reporting activities, and report content and structure of the Final Evaluation Report.

The Final Evaluation Report format will be consistent with the Interim Evaluation Report and contain the final conclusions on the effectiveness of the waiver with respect to the established goals of the program. Deloitte continues to meet with HSD regularly to further refine the work plan, discuss data and data questions, as well as identify and review any analysis issues or risks.

Section XVI: Enclosures/Attachments

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

Section XVII: State Contacts

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

Section XVIII: Additional Comments

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

Centennial Care Member Success Story 1

A community health worker (CHW) embedded in a clinic practice has been collaborating with providers to assist members with social determinants of health. Providers at the clinic are responding to the vital role of CHWs and are identifying members who may benefit from the support of a CHW. Providers are allowing the embedded CHW time to meet with members individually in the exam room.

Recently, a member screened positive for housing insecurity. The CHW met with the member and encouraged the member to follow up on a Housing and Urban Development (HUD) application that was submitted several years prior. The member was ambivalent about contacting the agency because the member reported that she has been on the wait list for many years. The member ultimately contacted HUD and due to her change in health status, the member was able to advance on the waiting list. With the CHW's support and coaching, the member was able to advocate for herself. The member now has a better chance of obtaining permanent housing due to the Section 8 lottery opening in Bernalillo County in April.

Centennial Care Member Success Story 2

A member attended Member Day at Albuquerque Healthcare for the Homeless. The member approached a Member Representative for assistance with a lost Member ID card. The Member Representative immediately contacted Member Services and ordered a replacement card. The member also requested assistance with a Social Security benefit question. The Member Representative assisted by pointing him in the right direction. The member stated he had not collected his SSI benefits for nearly 6 years as he's been homeless and without a permanent address. The Member Representative provided the member with contact information for the nearest Social Security Administration Office as well as Legal Aid. In addition, the Member Representative assisted the member with finding a new PCP and setting up a dental appointment. Lastly, the Member Representative assisted with filling out the paperwork for housing on site and with obtaining a no cost telephone, so he would be able to communicate with his advocates. As a result of the resources that were provided, the member was able to have his SSI benefits reinstated and is pursuing permanent housing. The member has expressed that he is very appreciative of the Member Representative's willingness to listen and be responsive to him.

Centennial Care Member Success Story 3

A member was referred to the care coordinator while inpatient at an Albuquerque hospital. The member was homeless and suffering from alcohol induced pancreatitis, diabetes, hepatitis C, hypertension, and depression. Once he was discharged, the member transitioned to another facility where he continued his detox program before moving to a nursing facility to recover physically. As the member prepared to move back into the community, the care coordinator

worked with Clinical Health Worker and Housing Specialist in addressing his needs and becoming self-sufficient.

During the member's in-person assessment, the member talked about the success of his results with the resources provided. He found a PCP, was clean and sober and motivated to move forward in life, and had obtained a temporary job. At the member's quarterly assessment, he reported he had a one bedroom apartment, had completed his training with Work Force Connections, and was going to start a new job in two weeks.

Centennial Care Member Success Story 4

A member was in the Lubbock hospital when the care coordinator received his referral. He had a self-inflected gunshot wound under his chin and has been a drug addict most of his life. The case worker and discharge planners were not having luck with finding him a placement; a residential treatment facility would not take him because he had a trach collar and a peg tube. A rehab nursing facility would not take him because of his history of drug abuse, his multiple suicide attempts and because he was actually under arrest at the time of his injury. The only alternative was to send him home if possible and get his family to agree. The care coordinator set up specialized equipment for him at home and made an appointment with a counselor at a mental health agency. The care coordinator also made appointments with a PCP, because he did not have one and they would not discharge without one. Additionally, the care coordinator scheduled an appointment with a CNP who specializes and prescribes BH medication, and referred him to a BH care coordinator. The member was discharged on February 22, 2018 and for the following month had numerous problems with his trach tubing/cleaning supplies and liquid nutrition as he cannot eat by mouth. With persistent follow up, the care coordinator was able to assist in getting the member all needed supplies and liquid nutrition. The member has met with his new therapist multiple times as well as with a psychiatrist, new PCP and the BH Nurse Practitioner. The member's family has reported that he is doing remarkably well considering his challenges.

Attachment B - GeoAccess PH Summar

Meets Standard | Does Not Meet

	Urban				Rural				Frontier			
PH - Standard 1	**BCBS**	**UHC**	**MHC**	**PHP**	**BCBS**	**UHC**	**MHC**	**PHP**	**BCBS**	**UHC**	**MHC**	**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%	97.7%	100.0%	99.1%
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	99.9%
FQHC - PCP Only	100.0%	94.5%	100.0%	100.0%	90.4%	99.1%	93.0%	99.6%	97.4%	97.7%	93.0%	98.8%
PH - Standard 2												
Cardiology	99.2%	99.1%	98.0%	99.0%	99.7%	99.5%	100.0%	99.6%	99.8%	99.9%	100.0%	99.8%
Certified Nurse Practitioner	99.2%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%
Certified Midwives	99.1%	100.0%	98.0%	99.1%	91.1%	99.8%	100.0%	93.9%	99.8%	97.7%	100.0%	98.7%
Dermatology	71.4%	93.7%	75.0%	99.0%	56.9%	56.1%	64.0%	70.5%	74.6%	85.7%	88.0%	77.9%
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	95.6%	93.7%	98.0%	99.0%	62.7%	67.9%	75.0%	85.6%	76.6%	85.2%	91.0%	87.2%
ENT	99.1%	99.1%	98.0%	99.0%	91.4%	98.5%	92.0%	99.5%	94.9%	97.1%	92.0%	98.1%
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	99.1%	99.1%	98.0%	99.1%	97.9%	98.2%	98.0%	98.6%	99.4%	99.1%	99.0%	97.9%
Neurology	99.1%	93.7%	98.0%	99.0%	97.8%	90.9%	95.0%	85.3%	92.1%	88.7%	89.0%	83.9%
Neurosurgeons	99.1%	99.1%	98.0%	99.0%	39.8%	43.6%	65.0%	62.5%	70.3%	73.4%	88.0%	74.4%
OB/Gyn	99.0%	99.1%	98.0%	99.1%	99.9%	99.8%	100.0%	99.6%	99.7%	100.0%	100.0%	99.8%
Orthopedics	99.2%	99.1%	98.0%	99.1%	99.7%	99.5%	100.0%	99.6%	97.3%	99.4%	98.0%	98.6%
Pediatrics	100.0%	99.1%	98.0%	100.0%	99.6%	100.0%	100.0%	99.9%	99.8%	100.0%	100.0%	100.0%
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.2%	99.1%	98.0%	99.2%	99.3%	99.2%	99.0%	99.6%	99.8%	93.6%	94.0%	100.0%
Rheumatology	94.2%	93.7%	98.0%	99.0%	77.8%	92.0%	91.0%	96.8%	81.4%	88.3%	88.0%	87.5%
Surgeons	99.2%	99.1%	98.0%	99.2%	99.9%	99.8%	100.0%	99.6%	99.9%	100.0%	100.0%	99.9%
Urology	99.1%	99.1%	98.0%	99.0%	81.4%	89.9%	82.0%	92.8%	92.7%	94.2%	93.0%	99.5%
LTC - Standard 2												
Personal Care Service Agencies (PCS) - delegated	98.0%	100.0%	100.0%	100.0%	90.4%	98.7%	100.0%	99.7%	99.8%	100.0%	100.0%	100.0%
Personal Care Service Agencies (PCS) - directed	99.1%	100.0%	100.0%	100.0%	99.0%	98.7%	100.0%	99.6%	99.8%	100.0%	100.0%	100.0%
Nursing Facilities	94.9%	94.0%	94.0%	97.1%	99.8%	98.7%	99.0%	99.5%	99.8%	97.5%	100.0%	99.9%
General Hospitals	99.1%	99.0%	98.0%	99.1%	99.3%	99.5%	100.0%	99.3%	99.8%	99.9%	100.0%	99.4%
Transportation	99.2%	100.0%	100.0%	97.7%	94.7%	98.9%	100.0%	99.9%	99.9%	100.0%	100.0%	100.0%

nd - no data

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

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

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

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

DY5 Q1 BH Geo Access

Meets Standard | Does Not Meet

Standard 2	Urban				Rural				Frontier			
	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP	BCBSNM	UHC	MHC	PHP
Freestanding Psychiatric Hospitals	88.4%	97.4%	90.0%	85.3%	41.3%	52.5%	17.0%	40.4%	67.9%	90.0%	68.0%	71.2%
General Hospitals with psychiatric units	78.3%	98.5%	90.0%	96.5%	64.2%	71.6%	80.0%	83.6%	64.2%	81.0%	82.0%	81.9%
Partial Hospital Programs	93.0%	94.5%	34.0%	19.1%	26.5%	90.5%	13.0%	4.8%	64.3%	97.9%	12.0%	5.5%
Accredited Residerntial Treatment Centers (ARTC)	88.3%	82.1%	90.0%	85.3%	32.2%	83.7%	27.0%	54.2%	67.9%	100.0%	68.0%	72.5%
Non-Accredited Residential Treatment Center & Group Homes	72.1%	91.9%	56.0%	66.1%	46.5%	76.9%	71.0%	57.4%	67.7%	88.0%	78.0%	82.2%
Treatment Foster Care I & II	83.1%	98.8%	92.0%	96.4%	45.5%	73.7%	64.0%	74.9%	58.0%	88.3%	91.0%	89.8%
Core Service Agencies	100.0%	93.9%	92.0%	99.1%	79.3%	98.6%	100.0%	100.0%	88.6%	100.0%	100.0%	100.0%
Community Mental Health Centers	93.6%	99.1%	98.0%	99.2%	63.5%	98.6%	100.0%	99.9%	4.0%	100.0%	100.0%	99.9%
Indian Health Service and Tribal 638s providing BH	72.2%	72.8%	90.0%	79.9%	56.2%	62.7%	96.0%	68.7%	82.3%	85.0%	98.0%	87.1%
Outpatient Provider Agencies	86.9%	100.0%	98.0%	100.0%	30.4%	100.0%	99.0%	100.0%	46.1%	100.0%	100.0%	100.0%
Agencies providing Behavioral Mgmt. Srvs.	86.9%	99.1%	97.0%	99.1%	19.6%	90.5%	36.0%	58.5%	51.6%	97.9%	74.0%	86.7%
Agencies providing Day Treatment Services	60.5%	72.0%	57.0%	78.7%	28.6%	32.1%	28.0%	48.2%	35.7%	67.9%	48.0%	63.0%
Agencies providing Assertive Community Treatment	61.4%	99.0%	84.0%	96.3%	19.8%	83.6%	50.0%	49.0%	45.5%	92.9%	71.0%	74.5%
Agencies providing Multi-Systemic Therapy	71.6%	99.0%	92.0%	98.7%	26.1%	83.7%	57.0%	70.7%	55.7%	94.8%	71.0%	77.4%
Intensive Outpatient Services	72.3%	99.0%	65.0%	96.8%	55.8%	76.0%	83.0%	89.4%	63.6%	92.0%	83.0%	99.8%
Methadone Clinics	94.2%	93.8%	91.0%	96.7%	42.2%	36.7%	39.0%	66.7%	73.5%	77.1%	77.0%	81.0%
FQHCs providing BH services	99.1%	100.0%	100.0%	100.0%	83.0%	90.1%	86.0%	92.1%	85.8%	100.0%	100.0%	100.0%
Rural Health Clinics providing BH Services	0.07%	0.07%	0.0%	0.10%	45.3%	16.5%	36.0%	15.5%	67.9%	61.6%	26.0%	26.4%
Psychiatrists	100.0%	100.0%	100.0%	99.9%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	99.9%
Psychologists	100.0%	100.0%	99.0%	99.9%	89.4%	100.0%	93.0%	94.3%	99.9%	100.0%	100.0%	99.9%
Suboxone certified MDs	99.2%	99.1%	100.0%	99.1%	93.2%	93.0%	100.0%	93.2%	96.0%	94.8%	100.0%	99.9%
Other Licensed Independent BH practioners	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Inpatient Psychiatric Hospitals	98.6%	98.6%	98.0%	98.8%	81.1%	73.8%	80.0%	83.8%	85.6%	94.2%	86.0%	85.6%

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.

Behavioral Health Collaborative CEO Report

April 12, 2018

- **Behavioral Health Legislation**
  The following behavioral health-related bills were passed in the 2018 Legislative Session and signed into law:

  House Bill 19 Judiciary Committee Substitute (HB 19jcs) – This is an omnibus crime bill that creates requirements for correctional facilities and HSD to implement an inmate recidivism reduction transition program. Section 1 of HB 19jcs requires that a correctional facility:

  a) Inform HSD when an eligible individual is incarcerated.
  b) Facilitate, with assistance from HSD, eligibility determinations for Medicaid during incarcerated individuals' incarceration or upon release.
  c) Notify HSD upon an eligible individual's release.
  d) Facilitate HSD's or its contractor's provision of care coordination pursuant to Section 2.

  In addition, upon written request of a county, HB 19jcs would require HSD to provide a BH screening tool to facilitate screenings, as well as, provide technical assistance, training and certification of county jail presumptive eligibility determiners to a county jail.

  Section 2 of HB 19jcs requires:

  a) Correctional facilities to ensure that each inmate of that correctional facility is screened for BH within 30 days of incarceration in that facility.
  b) Correctional facilities to offer a qualifying inmate the opportunity to enroll in Medicaid in accordance with Section 27-2-12.22 NMSA 1978.
  c) To the extent allowed by federal law or waiver agreement, care coordinators employed by Medicaid MCOs shall link inmates who are enrolled in a Medicaid managed care program to care coordination prior to the inmate's release.
  d) HSD shall provide information to correctional facilities seeking Medicaid care coordination for qualifying inmates.

  House Bill 35 - Currently 46% of the liquor excise tax flows to the Local DWI Grant Fund, but this was scheduled to drop to 41.5% on July 1, 2018. HB 35 directs 45% of the tax proceeds permanently to the fund, plus another 5% to support drug courts. HB 35 also creates a Drug Court Fund.

  House Bill 40 – Requires information on strangulation in domestic abuse to be included in the curriculum of each basic law enforcement training class. Domestic abuse incident training is a component of in-service training that certified police officers must take each year.

  House Bill 139 – Amends a section of the Controlled Substances Act exempting prescription drugs that the U.S. FDA has approved that contain marijuana or a marijuana derivative. It also adds a section that exempts certain activities regarding marijuana derivatives from arrest, prosecution or penalty.

House Bill 140 – Permits taxpayers the option of donating part or all of an income tax refund to the NM Housing Trust Fund, beginning with the returns for the 2018 tax year.

Senate Bill 1 – The Nurse Licensure Compact's provisions will apply to all licensed nurses who practice in the states or jurisdictions who become parties to the compact. The updated compact addresses the expanded mobility and new practice modalities in the nursing profession by providing for uniformity of nurse licensure requirements. It provides for exchange of information between party states, and provides opportunities for interstate practice by nurses who meet the uniform licensure requirements while still holding a nurse accountable for meeting practice laws in the home state.

Senate Bill 11 – Identically amends several state laws governing health insurance to establish guidelines for step therapy for prescription drug coverage. Psychotropic drugs are exempt from step therapy guidelines.

Senate Bill 29 – Revises the name, structure and duties of the agency to the Overdose Prevention and Pain Management Advisory Council (currently called the Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council). It also adds to members to the Council, including the Human Services Department, and clarifies its duties.

Senate Bill 61 – Makes it a third-degree felony to commit the crime of suffocation or strangulation against a household member. It provides definitions for the terms "suffocation" and "strangulation" within the Family Violence Protection Act, the Crimes Against Household Members Act, and the Abuse and Neglect Act.

Senate Bill 193 – Authorizes the NM Finance Authority to issue and sell State Office Building Tax Revenue Bonds in an amount not to exceed $20 million (plus costs for issuance) for construction of a building in Bernalillo County to be operated by CYFD.

Senate Bill 220 – Amends the Public Health Act to allow a Crisis Triage Center (CTC) to be physically part of an inpatient hospital and to provide outpatient stabilization.

- **NM Youth Workforce Forum**
  The NAADAC NM Youth Work Force Forum will be held at UNM Domenici Education Center, North, 3rd Floor, 1001 Stanford Dr. NE, Albuquerque, NM and live-streamed to partner satellite sites at Eastern New Mexico University-Roswell, New Mexico Highlands University, New Mexico State University and Western New Mexico University. The forum is sponsored by a grant from SAMHSA to the National Association for Addictions Professionals (NAADAC) to the NM Behavioral Health Collaborative. UNM's Department of Psychiatry and Behavioral Sciences, Division of Community Behavioral Health has been organizing and will host the event to educate high school and undergraduate college students about BH careers. Youth-informed programming includes learning about the teenaged/young adult brain, a panel discussion with BH professionals, exhibitors from BH provider organizations, free food, and door prizes. The event is Saturday, April 14 from 1-5 pm and is free to all who wish to attend. For more information or to register, visit https://naadac.org/newmexico-workforce-forum

- **US HHS, Office of Inspector General Study on Access in NM**
  In May, 2017, the HHS Office of Inspector General (OIG) received a Congressional request to study the accessibility of BH services within Medicaid managed care plans. The Office of Evaluation and

Inspections (OE&I), Region II, which conducts evaluations of programs within HHS is planning to examine five States, including NM. BHSD is cooperating with the OE&I in their process of designing this study to inform the study's scope and methodology. The study is estimated to take twelve months. The OIG is requesting data to support its evaluation of the availability of BH services in NM's Medicaid MCOs.

- **BH Collaborative's Next Strategic Plan: Improving the Well-Being of NM's Children**
  CYFD will be leading a conversation across a wide variety of systems and stakeholders on how to the shift the current service paradigm towards improving the well-being of NM's children. Initial planning is underway to identify the principles, values, and models that could help the participants frame future efforts. Stakeholders from public health, primary care, local government, special education, juvenile justice, workforce licensing bodies will join with treatment providers, local advocates and funders to explore new strategies. The kick-off planning event is set for the Fall.

- **Medicaid Behavioral Health Rule**
  The new Medicaid BH rule consolidates all BH service definitions for Medicaid services into a single rule with an accompanying BH Policy Manual. New services included in the 1115 Waiver renewal application will be contained in the rule, with a January 1, 2019 effective date. Among the driving principles for the new rule are simplifying requirements and removing administrative barriers for providers. The hearing to repeal the old DOH BH Rule was convened on March 29, 2018.

- **Intensive Outpatient Programs (IOP)**
  The Interdepartmental IOP Council, made up of staff from CYFD & BHSD, in collaboration with the MAD, has been processing applications and conducting site visits. Three agencies had final site visits this quarter and one provider is in the initial review phase. The Council has successfully mapped out and streamlined the application, as well as, the process for review and approval. A retrospective review of all provider organizations approved for IOP is occurring to determine when follow-up site visits will be conducted. Approved IOP provider organizations will have annual site visits to ensure ongoing maintenance of fidelity to the selected evidence-based practice. A flow chart of the IOP Approval Process is attached to this report.

- **Certified Family Peer Support**
  CYFD began implementation of its Family Peer Support Worker (FPSW) training in March, 2018. FPSWs are primary caregivers who have "lived-experience" of being actively involved in raising a child who experiences BH challenges. This includes young people with neurobiological differences. FPSWs have experience navigating child-serving systems and have received specialized training to support and empower other families who are raising children with similar experiences. CYFD's BHS collaborated with the national Family-Run Executive Director Leadership Association (FREDLA) to purchase its Parent Peer Support (PPS) Practice Model curriculum for Family Peer Support Workers, Supervisors, and Train-the-Trainers. CYFD's BHS collaborated with the NM Credentialing Board for BH Professionals (NMCBBHP) for FPSW certification, to include the protocols for training, coaching, ethics, exams, and re-certification. The first FPSW exam will occur in the Spring of 2018.

- **Administrative Services Organization (ASO) Transition**
  BHSD and CYFD has been working with the ASO on a process for ensuring that Non-Medicaid funds are used for only clients that do not have insurance coverage. BHSD has created rules for the

BHSDSTAR database to run reports on services covered by the Medicaid program, as well as, covered under Non-Medicaid funds. The intent is to ensure that services are paid for by the appropriate entity. The ASO has created a tracking mechanism for BHSD/CYFD, Providers, and the ASO to monitor the claims and create a central point for providers and the State to resolve claims issues in a real time environment. BHSD/CYFD is expecting to see non-Medicaid savings as a result of this process.

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

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

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

- **Behavioral Health Day 2018**
  The BH Day at the Legislature celebration was initiated on January 16th at the Lodge at Santa Fe with a Behavioral Health Day Summit. The theme was *Prevention Works* and the summit included:
  - Over 30 exhibitors showcasing their prevention programs.
  - Star Awards to individuals or programs from local communities throughout NM for their work in prevention. Twelve Stars recipients, two Lifetime Achievement winners, two Special Awardees, and one John Henry Award winner were honored.
  - Training was conducted on Suicide Prevention, PAX Good Behavior Games, Legislation 101, and Naloxone Administration.

  BH Day at the Legislature was held on the following day on January 17th. Fourteen exhibitors lined the Capitol Rotunda which was filled with hundreds of participants. At the Legislative ceremony,

individuals and programs were honored by their respective Legislators. They were also introduced on the floor of the State Senate.

- **Behavioral Health Investment Zones (BHIZ)**
  Behavioral Health Investment Zones were established in 2016 in two NM counties: Rio Arriba and McKinley. Each county has created its own plan, based on strategic priorities.

  Rio Arriba County (RAC) is using the Pathways web portal to case manage SUD clients. The Espanola Police Department and Rio Arriba Sheriff's Office continue to distribute Narcan and have requested advanced Crisis Intervention training for qualified officers. In 2018, Rio Arriba switched to outcome-based contracts for all agencies subcontracting through BHIZ funding, paying them for production of specific outcomes rather than unit of service or deliverables. Rio Arriba is funding a case manager through Las Cumbres Community Services, to case manage pregnant women and women with small children. The Santa Fe Recovery Center is admitting pregnant women with SUD and their children, and has agreed to accept Opiate Use Reduction (OUR) Network referrals.

  RAHHS is at the center of an effort to create a national Community Care Coordinators' Learning Network to test the use of the Pathways Care Coordination model with Opioid Use Disorder. The collaboration includes participation from CMS and the Georgia Health Policy Institute of Georgia State University, as well as communities in Washington State, Oregon, Georgia, Ohio and Wisconsin.

  The Rio Arriba Sheriff's Office and Espanola Police Department have committed to participating in a Law Enforcement Assisted Diversion pilot in Rio Arriba County. Narcan continues to be distributed at the Rio Arriba Detention Center upon release. Santa Fe Mountain Center and Southwest Care Center have been testing inmates for Hepatitis C through the efforts of the re-entry specialist funded through BHIZ.

  McKinley County (MC) BHIZ: McKinley County BHIZ had many successes this quarter which include the approval by the City Council to form an Indigenous Peoples Commission. This Commission includes four Navajo community members, one Zuni tribal member and one city employee. The group will advise the City Council and community concerning matters of cultural diversity, fairness, equal opportunity, and respect for indigenous peoples and cultures. Other successes include:

  - This quarter, January to February (March data will be available in April), Nihzhoozhi Center Inc. (NCI) provided counseling sessions to 72 unduplicated clients and Case Management to 15 clients. There were 46 group sessions held at NCI with over 1,117 social detox clients in attendance.
  - Rehoboth McKinley Christian Health Care Services (RMCHCS) offered 942 adult education hours for clients in their 90-day treatment program who were seeking their GED.
  - RMCHCS case management services were provided to 162 clients in the 90-day treatment program and to 51 clients from the 120 program. Sixty clients enrolled in the 120-work rehab program gained a minimum of 3 employment skills and 4 clients were placed in permanent employment.
  - The City of Gallup in collaboration with Gallup McKinley County Schools hosted a Motivational Interviewing training with 41 local providers.
  - The City collaborated with local providers to bring in a Community Reinforcement and Family Training (CRAFT), an intervention geared to help families aid their loved ones in recognizing the

need for treatment. The City will be bringing an Ethics and an additional Motivational Interviewing training in the next quarter.
  - The City collaborated with the County to approve an ordinance in January 2018 that mirrored the City's ordinance passed in July 2017, which prohibits alcohol sales before 10:00am (changed from 7:00am).

- **CareLink NM Health Homes (CLNM)**
  Six providers will implement CLNM Health Home services on April 1st, with a seventh slated to launch on July 1st. By the end of 2019, the new Health Homes are expected to serve nearly 10,000 Medicaid beneficiaries with SMI/SED. The providers are:
  - UNM Hospital Clinics and NM Solutions in Bernalillo County;
  - Presbyterian Medical Services and Kewa Pueblo Health Corporation in Sandoval County;
  - Mental Health Resources in three locations in Roosevelt, De Baca and Quay Counties;
  - Guidance Center of Lea County; and
  - Hidalgo Medical Services in two locations in Grant and Hidalgo counties.

  Providers are a mix of Federally Qualified Heath Centers, Core Service Agencies, Behavioral Health Agencies, and one Tribal 638 Health Center. Some already provided a mix of physical and BH services, and some will be developing agreements with outside providers to form integrated multi-disciplinary teams. Through a collaboration with CYFD, two of the Health Homes will use high intensity wraparound to serve an anticipated 200 of the most vulnerable children and adolescents with SED. Health Homes that will be implementing Wraparound are the Guidance Center of Lea County and Mental Health Resources in Portales. The final site visit with UNM was held on April 5th, and training and follow-up activities continue.

  The CMS State Plan Amendment has been submitted with a retroactive date of 4/1/18. Elements of the CLNM data collection and reporting system are continuing to be developed and refined.

- **Consortium for Behavioral Health Training and Research (CBHTR)**
  In addition to ongoing projects focused on workforce education and development, CBHTR provided three Comprehensive Community Support Service (CCSS) trainings. This rehabilitative service focuses on those whose BH impairs their ability to function independently in their communities. The training included:
    - UNM Hospitals, Kewa Pueblo Health Corporation, and Isleta Behavioral Health Services;
    - Two on-site trainings, in Las Cruces and Espanola, included agencies representing St. Luke's Health Care Clinic, New Mexico Family Services, Mesilla Valley Community of Hope (Veterans Services), Dona Ana County, La Clinica and Circle of Life.

  Clinical supervision is critical to increase the number of independently licensed professionals in NM and to the quality of service provision. CBTHR licensed professionals provide supervision to approximately 21 LMSWs monthly, representing well more than 100 hours each quarter. In addition, CBHTR researches workforce policies and issues at the request of various professional boards. This quarter, these activities included creating a summary and presenting on other states' policies regarding inactive status licenses for the NM Board of Social Work Examiners.

- **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, including outpatient stabilization and short-term residential stabilization in a residential rather than institutional setting. They provide emergency

behavioral health triage, evaluation, and admission up to 24 hours a day, 7 days a week 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, which are now complete. Following an amendment in SB220 this Legislative Session, DOH has revised it's previously posted rule on CTCs to cover both residential and outpatient forms of CTCs and will publish and hold a public hearing on the adoption of the new rule shortly. Meanwhile, Medicaid's BH rule that includes payment mechanisms for services provided by CTCs is also expected to be promulgated this Spring.

- **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 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.

  During this quarter, SCC was able to dispense 150 Narcan® kits to 22 NM pharmacies previously trained under the program for patients without Medicaid or insurance. On March 20th, a SCC pharmacist trained two pharmacists and two pharmacy technicians at Smith's Pharmacy in Santa Fe. More trainings are being discussed with Smith's.

- **Network of Care (NOC)**
  The NM BH Network of Care (NMNOC) is operating as the official website for the BH Collaborative. This website can be accessed at: http://www.newmexico.networkofcare.org/mh/. Development of the BH NOC is ongoing. BHSD has a new independent contractor, to assist with the management of NMNOC postings and information. Organizations and/or individuals can now submit requests to post job vacancies, community events, or other public information relevant to those seeking behavioral health services. Requests should be submitted to **HELP.NMNOC@state.nm.us.**

  Under the Opioid STR grant, the site was expanded to include specific information on Opioid Use Disorder and Medication Assisted Treatment. Providers can now find vital resources, treatment information and training opportunities.

  For FY2019, 3 major projects are anticipated:
  - Trilogy and ProtoCall services will be working collaboratively to study and potentially improve on navigating NMNOC's community resources.
  - BHSD will have the contractor work with Trilogy and OSAP on migrating its website content to NMNOC.
  - BHSD is examining the potential installation of OpenBeds (a national in-patient bed registry).

  For the period of January 01, 2018 to March 30, 2018, there were total visits: **20,121.** The top five keyword searches were: substance abuse, depression, housing, health care, and crisis. The top five provider organizations for web page views were: UNM, Amancer, Samaritan Counseling Center of Albuquerque, Valle del Sol, and Courageous Transformations Inc.

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

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

- **New Mexico Crisis and Access Line (NMCAL)**
  NMCAL, operated by ProtoCall Services, Inc. and funded by BHSD, is celebrating five years of aiding New Mexicans in finding the help, services, and support for BH crises. Since it began operating, the hotline has received nearly 115,000 crisis calls through NMCAL, the National Suicide Prevention Lifeline (NSPL), The Rio Grande Gorge Bridge, and Core Service Agencies, as well as more than 25,000 Peer-to-Peer Warmline calls, resulting in 185,373 hours spent talking to callers from all counties throughout the state.

  Since NMCAL launched, underserved populations in all counties are being reached, including 62% of callers who are not enrolled in BH services and 53% of callers who have Medicaid or no insurance. To support the recovery process, callers are referred and encouraged to participate and engage in community support services beyond the call. Partnerships are built through collaborative efforts that NMCAL and HSD-BHSD coordinate with state, county, city, and local social service agencies, community associations and coalitions, schools, healthcare facilities and emergency rooms, public safety and correctional facilities, as well as fire, EMT and law enforcement. Bernalillo County dispatches 911 callers in unincorporated areas of Bernalillo County to transfer to NMCAL .

  Starting in January of this year, the Warmline expanded to include texting services to reach more youth. Most recently, NMCAL has joined with HSD-BHSD, and providers across the State, expanding its focus to better support addressing the Opioid crisis by providing specialized 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.

- **NM Service Members, Veterans, & Families (SMVF) In-State Policy Academy**
  The NM In-State Policy Academy was convened by the NM Department of Veterans Services (DVS) under on June 21-22, 2016. DVS continues to meet with local city and county probation/parole officers to ensure they are aware of the BH resources available to their parolees. A MOU between DVS and the Corrections Department has been signed and it allow DVS personnel to actively engage with incarcerated veterans as they enter the system, as well as, be notified when veterans are close to being released. This allows DVS to ascertain what services the veteran might need upon release and ensure there is a plan for how the veteran will access the particular service.

  This month, DVS joined forces with the city of Albuquerque to participate in the SAMHSA Mayor's Challenge to end Veteran Suicide. Seven cities were selected from around the nation to participate in a pilot initiative aimed at finding strategies to end the number of veteran suicide. A diverse team of 10 from Albuquerque traveled to Washington, DC March 13-16 to work on the beginnings of a collaborative plan on how to put prevention strategies in place to combat the veteran suicide problem. SAMHSA will be conducting a follow-up visit in support of the Mayor's Challenge in May to assess the team's efforts and provide assistance where needed.

- **Opioid Crisis State Targeted Response Grant (Opioid STR)**
  The goals of this initiative are to increase the number of Opioid Treatment Providers (OTPs) and Office-Based Opioid Treatments (OBOTs), increase the availability of qualified staff and programs to address the needs of persons with Opioid Use Disorder (OUD), and improve access to services for individuals with OUD. The NM Opioid STR Initiative is framed around a centralized hub/regional hub model that will utilize the expertise of regional institutions and community agencies already providing services and integrate them with the newly trained providers and a centralized training hub that is able to coordinate and disseminate trainings and best practice efforts around the state. There are currently over 20 regional hub/community partners participating in the initiative.

  Performance Activities & Accomplishments:
  - BHSD and STR Admin are working on completing Year 2 Scopes of Work for Regional Hubs and community partners.
  - Two tribal summits were well attended and a great success. The Espanola Summit had 94 participants and the Farmington Summit had 39 participants.
  - Five DATA Waiver Trainings and 8 Safer Opioid Trainings have been held to date.
  - Six OTPs have been trained in OUD Education and Naloxone Distribution.
  - A total of 353 new patients have been added to MAT and 1158 have been referred to recovery support services.

  The STR grant also supports prevention activities, which complement efforts supported by the PDO grant (see below). Since July 1st, 2016 the Overdose Prevention Education Coordinator (OPEC) has trained 647 unduplicated individuals and distributed 1501 two-dose kits of Narcan nasal spray. Trainings have been provided to agencies in 16 of the 29 STR-targeted counties. Five reversals have been reported this quarter and an overdose response educational video was produced.

  Other prevention activities include contracts with:
  - Inside Out: 215 replacements kits of Narcan were ordered and 364 people were trained.
  - Serenity Mesa: 85 replacements kits of Narcan were ordered and 106 people were trained.
  - Southwest Care Center: 245 replacements kits of Narcan were ordered.
  - Holy Cross Hospital experienced barriers with implementation of their Scope of Work and as a result requested an expansion of their activities to include distribution out of additional areas within the hospital.

- **Opioid Treatment Programs (OTP)**
  There are sixteen Opioid Treatment Programs (OTPs) operating in NM, serving approximately 5,549 patients. Of these, nine are located in Albuquerque, including a courtesy dosing clinic at the Metropolitan Detention Center. Clinics are also located in Belen, Santa Fe, Espanola, Farmington, Las Cruces, Roswell and Rio Rancho.

  There are currently six provider organizations that have submitted an application to open a new clinic. All applications are under various stages of review. Locations identified for these prospective clinics include Albuquerque (2), Espanola (2), and Santa Fe (1) and Gallup (1).

  In an ongoing effort to provide support to NM OTPs in adhering to HB370, which requires agencies operating a federally certified program to dispense methadone or narcotic replacement as part of a detoxification/maintenance treatment and to provide patients with education on opioid overdose and the safe use of Naloxone in the prevention of opioid overdose deaths, Dr. Joanna Katzman and

Monica Moya Balasch from the UNM Pain Center/STR Project have conducted six Naloxone trainings to OTPs at the following locations:

- ABQ Health Services – Monroe location
- ABQ Health Services – Montano location (RR Health Services staff also trained)
- Albuquerque Treatment Services
- Courageous Transformations
- Recovery Services of NM – Roswell
- NM Treatment Services – Farmington

An additional three trainings have been scheduled with NM Treatment Services in Espanola and Santa Fe, and UNM Addictions & Substance Abuse Programs.

- **PAX Good Behavior Game**

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

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

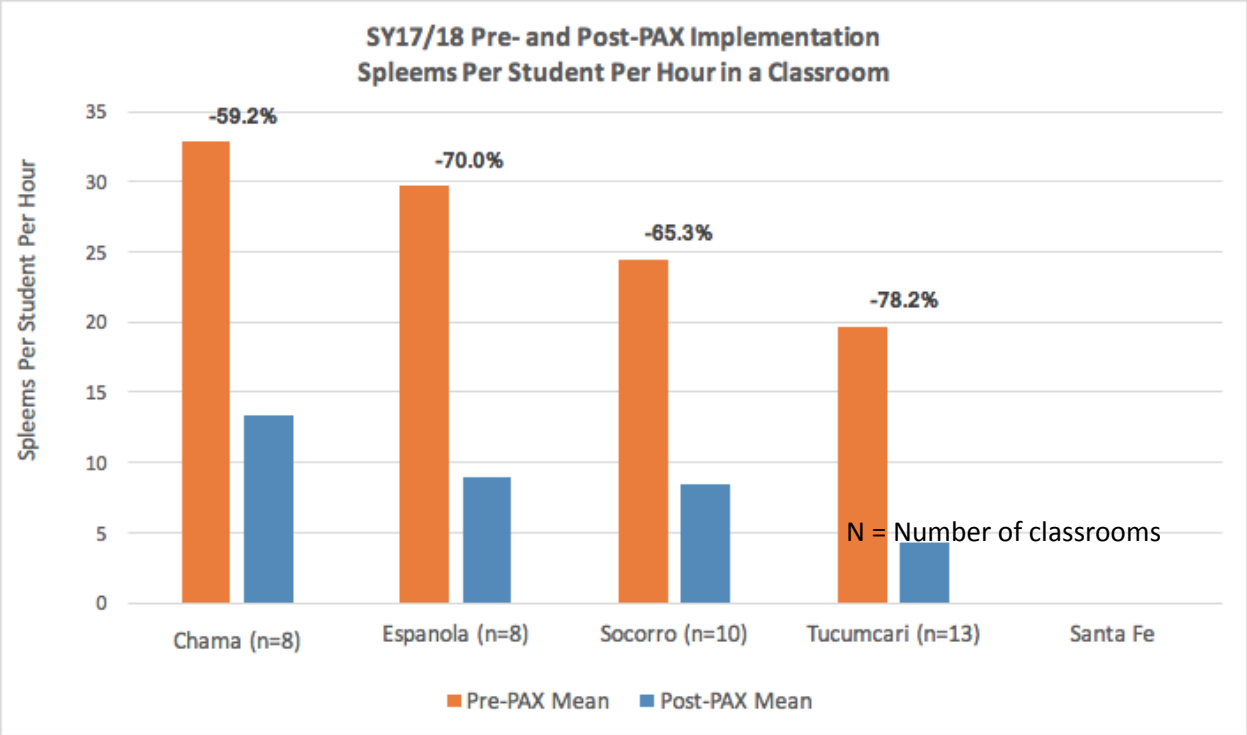
Eleven (11) school districts continued implementing PAX GBG during the 2017-2018 academic year. The new activity within these districts to expand and enhance implementation efforts included an initial teacher training to ensure that newly hired teachers (to account for staff turnover) and other interested teachers received the training: Bernalillo Public School District (4 schools, 7 classrooms), Bloomfield School District (1 school, 5 classrooms), Chama Valley Independent School District (2 schools, 5 classrooms), Cobre Consolidated School District (3 schools, 15 classrooms), Deming School District (4 schools, 45 classrooms), Espanola Public Schools (11 schools, 29 classrooms), Farmington Municipal School District (6 schools, 46 classrooms), Santa Fe Public Schools (4 schools, 21 classrooms), Socorro Consolidated Schools (3 schools, 13 classrooms), Truth or Consequences Public Schools District (1 school, 17 classrooms), and Tucumcari School District (1 school, 9 classrooms). A total of 212 teachers have been trained since August 2017, impacting 4,090 students across the state.

Between October 2017 and March 2018, Booster Trainings were held with 11 school districts and 346 teachers/classrooms affecting 7,457 students (including teachers trained in this current school year, as well as in previous years).

Overall, 9,328 students (unduplicated count) were impacted by a PAX GBG training or booster session, and its resulting PAX GBG classroom environment, during the current school year.

Pre- and post-data were collected about students' disruptive behaviors (counts of non-attentive and off-task behaviors—"spleems") from a sample of four school districts in fall 2017 and in March 2018 in order to assess short-term results--Chama Valley Independent Schools, Espanola Public Schools,

Socorro Consolidated Schools, and Tucumcari Schools. Other districts' post-test data will be collected nearer the end of the school year. The outcome of this evaluation effort across the four districts was a reduction in disruptive behaviors by a range of 59.2% to 78.2%, as shown in the graph below.



Indigenous PAX**:** Each of the three major New Mexico Tribal groups (Pueblo nations, Navajo Nation, and the Apache tribes) have been approached for participation, with the intent to create three distinct Native projects. Ch'ooshgai Community School, a small BIA school located in Navajo Nation, was trained November 30th. Nine core classroom teachers, six special education teachers and one administrator were trained, reaching 157 students; a booster session for teachers was provided on March 16, 2018. An Administrator Training was provided on December 18th to four additional Navajo Nation Tribal schools. The following 11 schools (mixture of Bureau of Indian Education (BIE)/Tribal Schools/Public Schools with high enrollment of tribal youth) have been approached for participation and are in various stages of communication regarding participation: Taos Community School, Mescalero Apache School, Tohatchi Elementary School, Wingate Elementary School, Tohaali' Community School, San Felipe Pueblo Elementary School, San Ildefonso Day School, Santo Domingo Elementary School, Pueblo of Isleta Elementary School, Laguna Elementary School, Sky City Community School, and Cubero Elementary School.

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

and distribution of naloxone to first responders.

Overall Grant Update

A carryover request was submitted by OSAP and approved by SAMSHA during this quarter. OSAP has identified activities under this carryover request that will support naloxone distribution in the three contracted counties and Metropolitan Detention Center (MDC), to the data management system and website, and to an expansion of activities focused specifically on Rio Arriba County. OSAP and MDC are finalizing the Scope of Work that will focus on providing naloxone and training to inmates being released into the community. This will increase much needed access to naloxone and education for a vulnerable population often at high risk of overdose death.

PDO Advisory Council

The PDO Advisory Council is conducting monthly meetings to provide guidance, recommendations and oversight over the PDO grant and sub-grantees. The meetings focus on providing updates on the county distribution plans, reviewing PDO membership and scope, and assessing additional needs. This quarter, the PDO Advisory Council met January 5, February 9, and March 2. Local distribution success stories were shared. PDO sites shared their experiences learned from the pilot period and expansion plans going forward.

Contracted Agencies

The 3 agencies (Bernalillo County Community Health Council, Santa Fe Prevention Alliance, Dona Ana Health and Human Services) are currently in an expansion phase in which they are looking to increase their local capacity, building on the success from the pilot phase. 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 915 Narcan kits and trained 544 individuals to respond to an overdose as of the end of February 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

Dona Ana County Health and Human Services (DACHHS):

DACHHS has distributed 1605 Narcan kits and trained 365 individuals to respond to an overdose as of the end of February 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

<u>Santa Fe Prevention Alliance (SFPA):</u>

SFPA has distributed 903 Narcan kits and trained 410 individuals to respond to an overdose as of the end of February 2018. SFPA has established training and/or distribution to the following agencies:

- 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

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 is also developing three mini campaigns that will focus on treatment, recovery and eliminating discrimination toward people with opioid use disorders.

- **Prevention "Partnership for Success" Grant (PFS 2015)**

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

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

As of August 2017, strategic plans were approved by OSAP for 7 of the 9 sites and implementation of prevention strategies began. Due to changes in fiscal agents, Cibola County was delayed in the SPF process and will complete its strategic plan to begin implementation in January 2018. After a school in the NMHEPC withdrew in June 2017, the Consortium began the recruitment process for a replacement in August. In December 2017, the NMHEPC identified the Institute for American Indian Arts (IAIA) in Santa Fe to participate in the PFS 2015 grant. During spring and summer of 2018, IAIA will receive SPF trainings and technical assistance support to develop a strategic plan.

Throughout the quarter, providers received technical assistance (TA) via monthly webinars. To date, webinar topics have included SAMHSA Community Level Instrument requirements, working with school substance abuse policies, engaging community leaders with prevention efforts, and an overview of prevention resources. On-site TA was provided to San Juan College, NMSU, New Mexico Tech, Chaves County, Roosevelt County, and Curry County. These TA visits focused on engaging community partners and developing a logic model to utilize in planning efforts. All nine PFS 2015 entities received training on conducting the NM Community Survey from the Pacific Institute for Research and Evaluation (PIRE) in January. The NM Community Survey collection began in early March and will come to completion on April 28th.

Beginning in November 2017, the NM Statewide Epidemiological and Outcomes Workgroup (SEOW) began connecting with Federal sub-grantees via a monthly SEOW bulletin. This was introduced as a tool to provide access to key resources and summary documents that result from the monthly convening of the SEOW. The first bulletin was an overview of strategies to address opioid misuse, overdose, and treatment. The January bulletin covered strategies to address underage drinking and drinking and driving as well as introduced sub-grantee communities to the DOH substance abuse epidemiologists. The March 2018 bulletin covered strategies to address underage drinking and drinking and driving as well as introduce sub-grantee communities to the DOH substance abuse epidemiologists.

- **Screening, Brief Intervention, Referral to Treatment Grant (SBIRT)**
  In August 2013, SAMHSA awarded BHSD with a five year, $10 million grant to implement SBIRT. SBIRT services integrate BH within primary care and community health care settings. Each medical partner site universally screens adult patients 18 years old or over at least annually to identify those at-risk of or have a substance use disorder.

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

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

  NM SBIRT has made significant progress since the project's inception. As of March 28, 2018, a total

of 45,642 screens were conducted with 40,965 individuals screened. There have been 25,704 negative screens and 19,937 positive screens. NM SBIRT has conducted 7,676 BIs; 3,877 Mental Health BIs; served 8,027 individuals with therapy, and referred 229 individuals to treatment services and 915 clients to various services, such as case management or family support services. NM SBIRT services were included in the Section 1115 Waiver application, which will allow for SBIRT Medicaid billing codes upon approval by CMS and active in January 2019.

- **Strategic Prevention Framework for Prescription Drugs Grant (SPF Rx)**

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

  The grantee's sub-recipient, the Bernalillo County Community Health Council (BCCHC), completed the Strategic Prevention Framework trainings last quarter. Technical assistance for strategic planning was given by the state technical assistance provider last quarter and the plan was approved for implementation on October 24, 2017. Technical assistance was provided this quarter for three new pilot strategies being implemented in Bernalillo County: HERO TRAILS, Boot Camp Translation and a robust social media campaign targeting youth. TA was provided on the follow dates: January 25, January 31, February 21, February 23, March 7, and March 29. Support will continue to be available throughout the project via on-site visits, webinars, phone and email.

  BCCHC received training on conducting the New Mexico Community Survey from the Pacific Institute for Research and Evaluation (PIRE) in January. New Mexico Community Survey collection began in March of this quarter and will come to completion on April 28.

  During this quarter, the Statewide Epidemiological & Outcomes Workgroup (SEOW) continued reviewing the most recent research on strategies to prevent prescription painkiller misuse and opioid overdose prevention to include recommendations from the CDC and SAMHSA.

- **Supportive Housing**

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

  The 1115 waiver for Centennial Care 2.0 includes a supportive housing benefit for Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program. The benefit will include pre-tenancy and tenancy sustaining supports provided by peers at Linkages service providers.

Linkages serves individuals with serious mental illness, who are homeless or precariously housed, extremely low income, and functionally impaired.

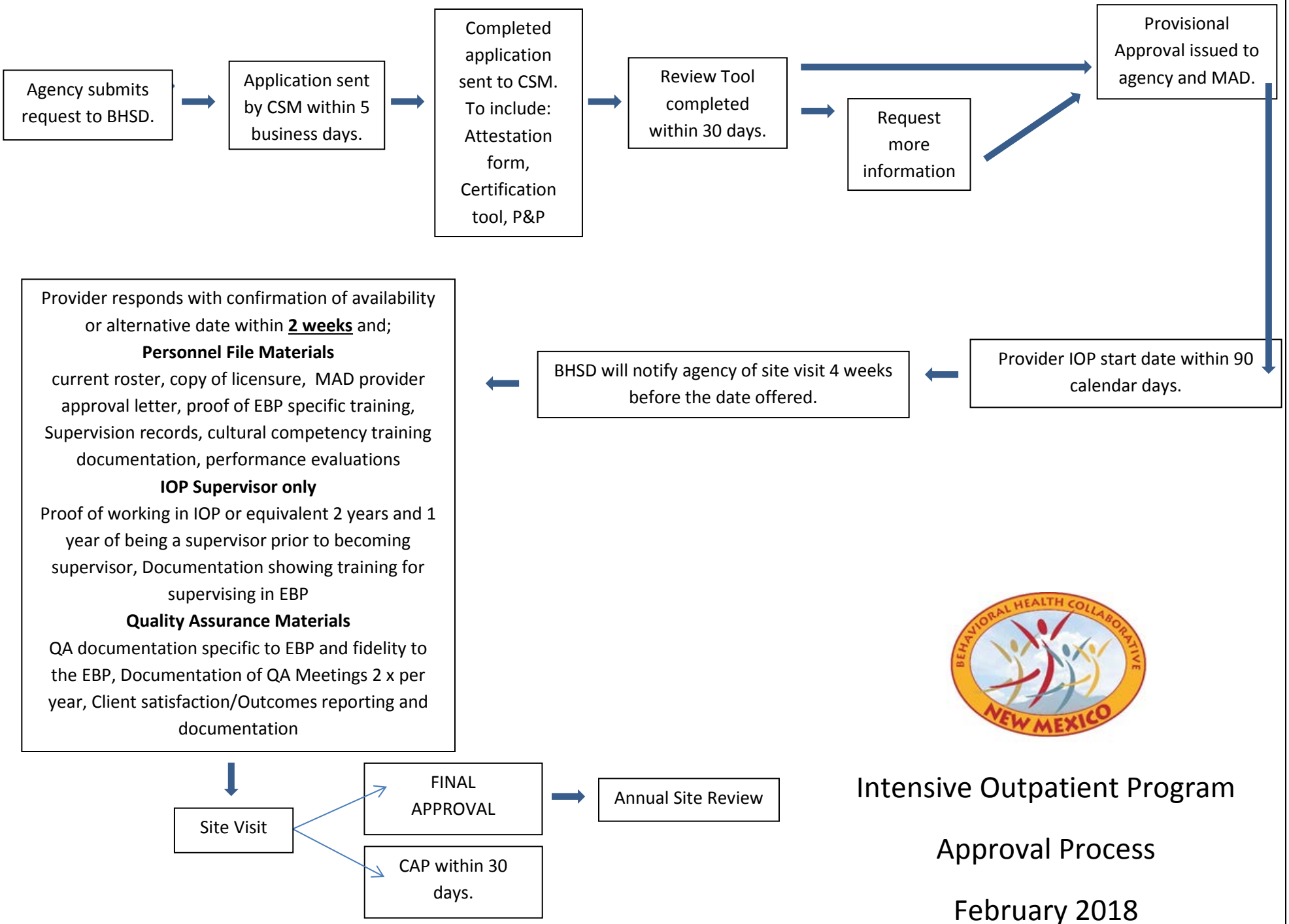
An additional $100,000 was approved for permanent supportive housing in the state budget during the 2018 legislative session. BHSD is determining how best to utilize the additional funds.

Housing Supports, Health, and Recovery for Homeless Individuals Grant (HHRHI)
This SAMHSA-funded grant program completed second year of implementation on September 29, 2017 and has now entered its final year. The program operates in Santa Fe, Bernalillo, & Dona Ana counties and provides permanent supportive housing for chronically homeless individuals with SUD, SMI, or co-occurring SUD and SMI. HHRHI incorporates the use of peers in the recovery model, and integrates the evidence-based practices of Permanent Supportive Housing, Supported Employment, Seeking Safety, and Motivational Interviewing into project implementation. Recent analysis on pre-post measures of functioning indicate a statistically significant decrease in PTSD symptoms; fewer days of serious depression, anxiety or tension, and trouble understanding, concentrating or remembering; more days prescribed psychiatric medication; and less subjective distress related to psychiatric symptoms. Data from the HHRHI evaluation will be presented at the upcoming New Mexico Public Health Association Annual Conference in April.

- **Treat First**
  "Treat First" is an innovative approach to clinical practice improvement. Starting as a pilot with six provider organizations, it has expanded to 15 children and adult serving providers in multiple sites. It is a coordinated effort across BHSD, MAD, and CYFD. The organizing principle has been to ensure a timely and effective response to a person's needs as a first priority. It was structured as a way to achieve immediate formation of a therapeutic relationship while gathering needed historical, assessment and treatment planning information over the course of a small number of therapeutic encounters. One of the primary goals has been to decrease the number of "no shows" for the next scheduled appointment because their need was not met upon initial intake.

  2,258 clients were served during this 6 month period. Adults rated the Treat First sessions very positively (i.e., 34 out of a maximum of 40 points). They indicated that the sessions covered what they wanted, felt connected to the therapist and overall, thought their work together was good. Youth were even more pleased with their Treat First sessions (i.e., 18. out of a maximum of 20 points.) They felt listened to, got to talk about what they wanted, felt good about the session work and felt positive about their next connection. Overall, 33% (751) of the clients were able to have their needs met and not need more treatment after four visits. There was a 14.6% "No Show" rate which varied across providers. Two thirds (57%) of clients showed for their scheduled appointments and the remaining clients rescheduled during that period.

  In November, 2017 the Treat First Learning Community discussed what areas of clinical practice needed improvement. They identified four areas in which they wanted to recommend solutions for practice improvement. From February through mid-April, participants volunteered to work on the "Design Teams" addressing teaming, clinical supervision, SUD, and *e*stablishing a Treat First University. On April 25, 2018, participants from the Design Teams will be bringing their recommendations to the Learning Community for further discussion and development.



Intensive Outpatient Program

Approval Process

February 2018

BEHAVIORAL HEALTH SERVICES

YOUTH SATISFACTION SURVEY

2017

cyfd

New Mexico Children,
Youth & Families Department

HIGHLIGHTS

For 2017, we continued surveys of youth in Juvenile Justice Facilities (162), but changed the community target groups to include youth new to the system by surveying shelter residents (43) and youth transitioning to adulthood in our Healthy Transitions program plus members of LUVYANM (34).

Young Adult Characteristics

Gender Identity:

36% Female

58% Male

1% Trans.

1 % Other

Age: 32% 18 to 21

46% 16 to 18

17% 12 to 16

5% No Ans.

Race / Ethnicity:

56% Hispanic

20% White

10% Native

8% Afric/Am

6% Other

This report shows young adult perceptions of state funded mental health and substance abuse services in New Mexico.

For young adults in all cohorts:

- **85% said they participated in their own treatment.**
- **82% said staff spoke to them in a way they understood.**
- **77% said that staff respected their families religious / cultural beliefs**
- **75% said that they helped choose their treatment goals and that staff treated them with respect.**

Lowest score: Only 59% felt that the people helping them stuck with them no matter what.

Regarding Managed Care Organizations:

- **Young adults rated United Health the best for behavioral health services at 80%. However, it is probable that United's high score is an artifact of their very low number of participants (n=5). Molina (n=32) had the highest score for the other MCOs at 31% Excellent.**
- **Young adults rated United the best in effectiveness of behavioral health services at 80%. However, it is probable that United's high score is an artifact of their very low number of participants (n=5). Blue Cross / Blue Shield (n=22) had the highest score for the other MCOs at 73%.**

Regarding education and legal involvement

With the addition of youth placed in shelter to the survey this year, these data points are not comparable to previous years.

At each survey since 2013, progressively fewer young adults had been arrested in the previous six months. The addition of youth placed in shelter as a survey cohort will skew this number for comparative purposes as shelter is used as an alternative to detention.

Youth Survey 2017

Of 34 young adults surveyed about satisfaction with community-based behavioral health:

Young Adult Characteristics

Gender Identity:

59% Female

32% Male

3% Other

Age:

18% 18 to 21

32% 16 to 18

46% 12 to 16

Race / Ethnicity:

46% Hispanic

33% White

9% Native

4% Afric/Am.

- **♥ 97% said they received services that were right for them**
- **♥ 97% said behavioral health staff treated them with respect**
- **♥ 97% said behavioral health staff spoke with them in ways they understood**
- **♥ 96% said behavioral health staff respected their family's spiritual beliefs**
- **♥ 91% were satisfied with the services they received**
- **♥ 91% believed that people helping them stuck with them no matter what**
- **♥ 91% said they got the help they wanted**
- **♥ 90% said behavioral health staff were sensitive to their cultural/ethnic background**

Youth Survey 2017

HOW DOES THIS COMPARE TO PREVIOUS YEARS?

COMMUNITY		2016		2015	2014	2013
Youth Satisfaction with Services: Statewide		**Strongly Agree/Agree**				
Overall, I am satisfied with the services I received.	↑	91.4%	↓	85.0%	NO DATA AVAILABLE	85.8%
I helped to choose my services.	↑	82.8%		71.0%		63.7%
I helped to choose my treatment goals.	↑	87.1%	↓	81.0%		85.8%
The people helping me stuck with me no matter what.	↑	91.4%	↓	84.0%		85.0%
I felt I had someone to talk to when I was troubled.		87.1%	↑	87.0%		85.0%
I participated in my own treatment.	↓	88.2%		91.0%		90.3%
I received services that were right for me.	↑	96.8%	↓	84.0%		88.3%
The location of services was convenient for me.	↑	82.8%	↓	76.0%		79.6%
Services were available at times that were convenient for me.	↑	83.9%	↓	76.8%		85.8%
I got the help I wanted.	↑	91.4%	↓	87.7%		91.2%
I got as much help as I needed.		86.0%	↓	85.7%		86.7%
Staff treated me with respect.	↑	96.8%	↓	88.0%		94.7%
Staff respected my family's religious/spiritual beliefs.	↑	95.7%	↓	84.8%		92.9%
Staff spoke with me in a way that I understood.	↑	96.8%		92.9%		92.9%
Staff was sensitive to my cultural/ethnic background.	↑	90.3%	↓	87.9%		91.1%

HOW EFFECTIVE DO YOUNG ADULTS THINK THEIR BEHAVIORAL HEALTH SERVICES ARE?

Youth Satisfaction with Services: Statewide		2016		2015	2014	2013
COMMUNITY		**Strongly Agree/Agree**				
I am better at handling daily life.	↑	89.2%	↓	86.0%	NO DATA AVAILABLE	88.5%
I get along better with family members.	↑	80.6%	↓	78.8%		79.6%
I get along better with friends and other people.	↑	88.2%	↓	87.8%		89.3%
I am doing better in school and or work.	↑	88.2%	↑	83.9%		80.4%
I am better able to cope when things go wrong.	↓	79.6%	↑	81.0%		78.6%
I am satisfied with my family life right now.	↓	75.3%	↑	85.0%		82.9%

Youth Survey 2017

RATING OF BEHAVIORAL HEALTH CARE BY MANAGED CARE ORGANIZATION

Molina											
Rating		**2016**	**%**		**2015**	**%**		**2014**	**%**	**2013**	**%**
Not so good		1	3.1%		1	4.4%		NO DATA AVAILABLE			
Okay	↓	5	15.2%		5	21.7%					
Good	↓	10	30.3%		11	47.8%					
Excellent	↑	14	42.4%		6	26.1%					
		n=33	**100.0%**		**n=23**	**100.0%**		**n=54**	**100.0%**		**100.0%**

Presbyterian											
Rating		**2016**	**%**		**2015**	**%**		**2014**	**%**	**2013**	**%**
Not so good	↓	0	0.0%		1	4.4%		NO DATA AVAILABLE			
Okay	↑	4	12.12%		3	13.0%					
Good	↑	14	42.4%		8	34.8%					
Excellent	↓	15	45.4%		11	47.8%					
		n=33	**100.0%**		**n=23**	**100.0%**		**n=54**	**100.0%**		**100.0%**

United											
Rating		**2016**	**%**		**2015**	**%**		**2014**	**%**	**2013**	**%**
Not so good		0	0.0%		0	0.0%		NO DATA AVAILABLE			
Okay	↑	2	100.0%		1	50.0%					
Good	↓	0	0.0%		1	50.0%					
Excellent		0	0.0%		0	0.0%					
		n=2	**100.0%**		**n=2**	**100.0%**		**n=2**	**100.0%**		**100.0%**

Blue Cross / Blue Shield											
Rating		**2016**	**%**		**2015**	**%**		**2014**	**%**	**2013**	**%**
Not so good		0	0.0%		0	0.0%		NO DATA AVAILABLE			
Okay	↓	2	16.6%		9	36.0%					
Good	↑	4	33.3%		8	32.0%					
Excellent	↑	6	50.0%		8	32.0%					
		n=12	**100.0%**		**n=25**	**100.0%**		**n=9**	**100.0%**		**100.0%**

Youth Survey 2017

SATISFACTION WITH BEHAVIORAL HEALTH SERVICES BY MCO

For responses of Agree and Strongly Agree only.	Molina (n=30)			Presbyterian (n=33)		
		2016	2015		2016	2015
Overall, I am satisfied with the services I received	↑	100.0%	73.9%	↑	87.9%	69.6%
I helped to choose my services.	↑	90.0%	65.2%	↑	84.8%	73.9%
I helped to choose my treatment goals.	↑	100.0%	73.9%	↓	81.8%	87.0%
The people helping me stuck with me no matter what.	↑	93.3%	78.3%	↓	90.9%	95.7%
I felt I had someone to talk to when I was troubled.	↓	83.3%	87.0%	↑	93.9%	91.3%
I participated in my own treatment.	↑	96.7%	82.6%	↓	87.9%	91.3%
I received services that were right for me.	↑	100.0%	82.6%	↑	97.0%	82.6%
The location of services was convenient for me.	↑	83.3%	73.9%	↑	81.8%	69.6%
Services were available at times that were convenient for me.	↑	90.0%	73.9%	↑	78.8%	73.9%
I got the help I wanted.	↑	93.3%	82.6%	↑	97.0%	95.5%
I got as much help as I needed.	↑	86.7%	77.3%	↓	84.8%	100%
Staff treated me with respect.	↑	96.7%	82.6%	↑	97.0%	95.7%
Staff respected my family's religious/spiritual beliefs.	↑	100.0%	87.0%	↑	93.9%	87.0%
Staff spoke with me in a way that I understood.	↑	100.0%	82.6%		100.0%	100.0%
Staff was sensitive to my cultural/ethnic background.	↑	93.3%	82.6%	↑	90.9%	0%
		n=30			n=33	

For responses of Agree and Strongly Agree only.	United (n=2)			BC / BS (n=12)		
		2016	2015		2016	2015
Overall, I am satisfied with the services I received	UNABLE TO CALCULATE	50.0%	50.0%	↓	75.0%	88.0%
I helped to choose my services.		50.0%	50.0%	↓	66.7%	80.0%
I helped to choose my treatment goals.		100.0%	50.0%	↓	83.3%	92.0%
The people helping me stuck with me no matter what.		100.0%	50.0%	↓	75.0%	80.0%
I felt I had someone to talk to when I was troubled.		100.0%	50.0%	↓	66.7%	84.0%
I participated in my own treatment.		100.0%	50.0%	↓	83.3%	96.0%
I received services that were right for me.		100.0%	50.0%	↑	91.7%	84.0%
The location of services was convenient for me.		50.0%	50.0%	↓	83.3%	88.0%
Services were available at times that were convenient for me.		100.0%	50.0%	↑	91.7%	80.0%
I got the help I wanted.		100.0%	50.0%	↓	75.0%	91.7%
I got as much help as I needed.		100.0%	50.0%	↓	75.0%	83.3%
Staff treated me with respect.		100.0%	50.0%	↓	91.7%	92.0%
Staff respected my family's religious/spiritual beliefs.		50.0%	50.0%	↑	91.7%	83.3%
Staff spoke with me in a way that I understood.		100.0%	100.0%	↓	91.7%	95.8%
Staff was sensitive to my cultural/ethnic background.		50.0%	0.0%	↑	91.7%	87.5%
		n=2			n=12	

Youth Survey 2017

EFFECTIVENESS OF BEHAVIORAL HEALTH SERVICES BY MCO

For responses of Agree and Strongly Agree only.	Molina (n=30)			Presbyterian (n=33)		
		2016	2015		2016	2015
I am better at handling daily life.	↑	86.7%	82.6%	↓	87.9%	91.3%
I get along better with family members.	↑	76.7%	69.6%	↑	84.8%	82.6%
I get along better with friends and other people.	↑	93.3%	69.6%	↓	81.8%	95.7%
I am doing better in school and or work.	↓	86.7%	91.3%	↑	93.9%	91.3%
I am better able to cope when things to wrong.	↓	70.0%	82.6%	↓	90.9%	82.6%
I am satisfied with my family life right now.	↓	63.3%	78.3%	↑	84.8%	78.3%
		n=30			n=33	
	United (n=2)				BC / BS (n=12)	
	UNABLE TO CALCULATE	2016	2015		2016	2015
I am better at handling daily life.		100.0%	50.0%	↓	83.3%	84.0%
I get along better with family members.		100.0%	50.0%	↓	75.0%	100.0%
I get along better with friends and other people.		100.0%	50.0%	↓	91.7%	96.0%
I am doing better in school and or work.		100.0%	50.0%	↑	91.7%	79.2%
I am better able to cope when things to wrong.		100.0%	50.0%	↓	83.3%	92.0%
I am satisfied with my family life right now.		100.0%	50.0%	↓	75.0%	92.0%
		n=2			n=12	

SCHOOL ATTENDANCE OF YOUNG ADULTS SURVEYED...

How often were you absent from school during the last month of school?										
Absences	2017		2016		2015		2014		2013	
	#	%	#	%	#	%	#	%	#	%
1 day or less	61	37.70%	39	43.30%	41	42.70%	61	35.90%	98	43.00%
2 days	8	4.90%	7	7.80%	10	10.40%	19	11.20%	19	8.30%
3 to 5 days	15	9.30%	11	12.20%	3	3.10%	37	21.80%	36	15.80%
6 to 10 days	6	3.70%	3	3.30%	11	11.50%	7	4.10%	11	4.80%
More than 10 days	11	6.80%	4	4.40%	13	13.50%	11	6.50%	7	3.10%
Do not remember	29	17.90%	17	18.90%	5	5.20%	21	12.40%	44	19.30%
Not in school	28	17.30%	9	10.00%	13	13.50%	14	8.20%	13	5.70%

The percentage of young adults surveyed with a day or less of school absences has remained fairly consistent since 2013.

After a significant drop in 2016, 2017 saw a return to the increases seen in 2014 and 2015 for the number of young adults surveyed with 10 or more school absences (11). This is probably an artifact of adding youth placed in shelter as a survey cohort.

Youth Survey 2017

HOW LONG HAVE THE YOUNG ADULTS IN THE COMMUNITY HAD BEHAVIORAL HEALTH SERVICES?

	2016		2015	
Length (Duration) of Behavioral Health Services	Total	Percent	Total	Percent
No Response	1	1.1%	6	6.0%
Less than 1 month	7	7.5%	14	14.0%
1-2 months	9	9.7%	11	11.0%
3-5 months	12	12.9%	11	11.0%
6 months to 1 year	20	21.5%	18	18.0%
More than 1 year	44	47.3%	40	40.0%
	93	**100.0%**	**100**	**100%**

SIGNIFICANTLY MORE YOUNG ADULTS SURVEYED IN 2016 HAD BEEN IN TREATMENT FOR SIX (6) MONTHS OR LONGER (69%), AS COMPARED TO 2015 (58%). SIGNIFICANTLY FEWER SURVEYED IN 2016 (7.5%) HAD BEEN IN TREATMENT LESS THAN A MONTH COMPARED TO 2015 WHEN 14% HAD LESS THAN A MONTH OF BEHAVIORAL HEALTH SERVICES

WHERE HAVE THE YOUNG ADULTS IN THE COMMUNITY BEEN LIVING IN THE PAST 6 MONTHS?

Type Of Living Situation	2016 Percent	2015	2014 Percent	2013 Percent
With one or both parents	36.9%	NO DATA AVAILABLE	80.0%	53.8%
With another family member	19.0%		35.0%	22.3%
Foster Home	6.0%		9.0%	6.9%
Therapeutic foster home	1.8%		3.0%	1.9%
Crisis shelter	1.8%		4.0%	0.76%
Homeless shelter	3.6%		3.0%	0.38%
Group Home	3.0%		9.0%	3.5%
Residential treatment center	3.0%		7.0%	10.8%
Hospital	6.0%		10.0%	3.8%
Local jail or detention facility	4.2%		6.0%	39.6%
Runaway/homeless/on the streets	4.8%		5.0%	7.3%
Other	6.0%		1.0%	8.5%
No response	4.2%		0.0%	0.0%

Note: Respondents could answer yes to more than one type of living situation.

Youth Survey 2017

LEGAL INVOLVEMENT OF YOUNG ADULTS SURVEYED...

In the last month, did you get arrested by the police?															
2017				2016				2015				2014			
Yes	%	No	%	Yes	%	No	%	Yes	%	No	%	Yes	%	No	%
22	13.6%	139	85.8%	1	1.1%	91	97.8%	2	2.0%	98	98%	9	5.3%	161	94.7%
In the last month, did you go to court for something you did?															
2017				2016				2015				2014			
Yes	%	No	%	Yes	%	No	%	Yes	%	No	%	Yes	%	No	%
30	18.5%	128	79.0%	4	4.3%	88	94.6%	3	3.0%	97	97.0%	16	9.5%	153	90.5%

At each survey since 2013, progressively fewer young adults had been arrested in the previous six months. The addition of youth placed in shelter as a survey cohort will skew this number for comparative purposes as shelter is used as an alternative to detention.

What has been most helpful?

- ♥ *One on one sponsor believed in me*
- ♥ *Always having someone to talk to*
- ♥ *Being able to speak my mind*
- ♥ *Able to trust someone to listen*
- ♥ *Learning to use a breath chart*
- ♥ *Better able to communicate*
- ♥ *Learning how to control my anger*
- ♥ *Learning coping skills*

What would improve services?

- ♠ *A safe ride system to get to appointments*
- ♠ *Better access to services*
- ♠ *Being able to go to therapy more often*
- ♠ *Faster processes and services*
- ♠ *Finding a way to help my Mom*
- ♠ *If school would understand my situation*
- ♠ *If services were closer*
- ♠ *More checking from medical provider*

For more information regarding the Youth Satisfaction Survey, please contact: Kristin Jones, CYFD Behavioral Health Services.

Kristin.Jones@state.nm.us - (505) 827-8008

DY5 Q1 ATTACHMENT F: MCO Action Plans

Quarter 3 DY2

MHC

Q3DY2

Action Plan #1	Implementation Date	Completion Date
Regulatory Reports	07/27/15	In progress

Description

Identify errors in report submission data. Ensure analyses address trends and details of report activity. Perform a quality review of report data and analyses prior to submission to HSD.

Status

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

MHC's State Remediation Report Project prioritized reports by "waves." Each report listed now has a data dictionary, which is part of the normalization process and is a well-established industry standard for Data Modeling based on Business Rules and Modeling.

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

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

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

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

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

Quarter 3 DY3

UHC

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

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

Status
09/30/16 – A summary report was provided to HSD on UHC's internal activities specific to the action plan that is in place to continue improvement on care coordination documentation. The internal action plan was also updated and submitted.

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

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

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

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

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

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

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

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

BCBSNM

Q3DY3

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

Description

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

Status

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

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

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

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

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

12/31/17 – BCBSNM continues to identify members with physical health (PH) and behavioral health (BH) needs for co-management. Members identified with complex BH needs are assigned to

a Peer Support Specialist who uses their life experiences to assist members in managing their complex needs and encourage participation in care coordination. Additionally, BCBSNM is in the process of revising its transition of care documentation to improve the monitoring of members reintegrating into the community from the nursing facility, while ensuring a successful transition occurs.

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

~~**Quarter 4 DY3**~~

~~***BCBSNM***~~

~~Q4DY3~~

~~Action Plan #2~~	~~Implementation Date~~	~~Completion Date~~
~~HCM CareNet Remediation Plan~~	~~11/01/16~~	~~10/10/17~~

~~*Description*~~

~~Collaborating with CareNet (new vendor) to ensure completed HRAs are loaded into the Aerial medical management platform. Confirming IT Oversight/Monitoring to ensure process does not negatively impact scheduling and completing of CNAs for New Mexico Centennial Care members who require a CNA.~~

~~*Status*~~

~~11/19/16 – Detailed data path flow analysis between systems completed and touch points identified.11/23/16 – Determined why HRA data had not been loaded to the Aerial system. Pending – BCBSNM's Information Technology is currently instituting a production failure monitoring and oversight process.~~

~~03/31/17 – An enterprise issue has been identified and the HRA's completed by the vendor are consistently being entered in the healthcare management system in an automated manner. BCBSNM has identified a short and long term solution to ensure the HRA is loaded into the system. The preliminary implementation of the short term solution is a manual process and the long term solution will be a fully automated process to load records into the system.~~

~~06/30/2017 – BCBSNM has submitted a funding request internally to support a diagnostic tool to monitor and report on data feeds between all data path touch points and resolve the issues or problems between each data system. There is a manual work around to monitor data from the CareNet system to Aerial system; however, beginning in May 2017, BCBSNM will conduct member HRAs rather than CareNet.~~

09/30/17 – Interventions are now approximately 95% complete. BCBSNM will be revising one standard operating procedure to reflect the internal process and requirements. Additionally, performance metrics are being monitored to assure performance levels are met and maintained. Anticipated date of completion is October 2017.

12/31/2017 – HRA's continue to be performed internally. Standard operating procedures have been finalized to reflect internal process and requirements.

Quarter 2 DY4

PHP

Q2DY4		
Action Plan #1	Implementation Date	Completion Date
EQRO Audit Results – 2016		
Audit conducted in 2017	07/2017	12/2017

Description

Determine if there is a need to have two care plans for transitioning members – a Comprehensive Care Plan (CCP) and a Transition Plan as separate documents to satisfy Health Insight Auditors

Status

July 2017 – Separate Transition plans are an issue. PHP seeks guidance and final determination of having multiple care plans (CCP and Transition of Care plan) instead of one integrated CCP which includes transition items from HSD. Auditors and PHP do not agree on a process for these efforts. At the quarterly meeting, the Quality Bureau Chief stated that the Transition of Care plan may be located within the CCP provided that it is in a dedicated section of the plan and clearly identified as a Transition of Care Plan.

November 2017 – PHP will work on Transition of Care plan documentation.

December 2017 – Separate and well labeled documents have been created to ensure that the Transition Plans are highlighted.

Quarter 3 DY4

PHP

Q2 DY4		
Action Plan #2	Implementation Date	Completion Date
EQRO Encounter Validation Audit	09/01/2017	In progress

Description

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

Status

September 2017 – PHP is waiting for the final report and has asked for specific issues that the auditors found as noncompliant in order to effectively implement corrective action plans (CAPs). For instance, in its rebuttal PHP questioned the reporting that 50% of medical records failed. PHP requested specific

data from the auditor such that PHP can work with its network of providers to correct.

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

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

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.

Quarter 4 DY4

BCBS

Q1 DY4

Action Plan #~~23~~	Implementation Date	Completion Date
Encounter Accuaracy Remediation Plan	07/19/17	~~In progress~~2/08/18

Description

The Human Services Department (HSD) communicated its intent to enforce encounter accuracy requirements in accordance with the Medicaid Managed Care Services Agreement, PSC: 13-630-8000-0021, section 4.19.2.2.13 effective with the quarter beginning July 1, 2017 and ending September 30, 2017. BCBSNM developed an internal action to address encounter types that exceeded the 3% denial rate during the quarter.

Status

07/19/17 – An Encounters Process Flow was created by BCBSNM to map all data processing points from claim processing to encounter validation, and through encounter submission to HSD.

10/01/17 – Denied encounters from the 3rd Quarter were identified and resubmitted through the BCBSNM Encounter Quality System enhanced logic for resubmissions at an 85% acceptance status.

01/04/2018 – Performance metrics continue to be monitored to assure performance levels are met and maintained at no more than 3% error rate.

03/31/2018 - BCBSNM retained a denial error rate of less than 3% through Q4CY17. Inpatient was 2.06%, Dental was 1.32%, and Non-Inpatient and Professional were 2.48%. Error rate trend continues to meet the requirement for Q12018.

~~*PHP*~~

~~Q1 DY4 reported in Q4 DY4~~

~~Action Plan #4~~	~~Implementation Date~~	~~Completion Date~~
~~Internal Audit Pay~~	~~02/2017~~	~~12/2017~~

~~*Description*~~

~~PHP conducted an internal Audit of our Pay Hold process to ensure adequate processes and controls were in place when pay hold direction was received from HSD.~~

~~*Status*~~

~~Compliance audited processes, owner, and controls. Ensured latest Pay Holds were processed properly. Audit was closed when the updated policies and procedures were published in the Presbyterian Electronic Library. An audit will be conducted again when a new, more automated~~

~~process is implemented by the Special Investigation Unit for Pay Hold.~~

UHC

Q4 DY4

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

Description

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

Status

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

UHC has initiated the following:

11/17/17 - Work groups are in progress

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

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

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

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

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

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

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

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

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UHC

Q4 DY4

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

Description

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

Status

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

11/22/17 - Built oversight dashboard

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

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

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

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

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

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

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

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

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

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

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

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

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

Quarter 1 DY5

BCBS
Q1 DY5

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

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

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

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Attachment G: Customer Service Summary (December 1, 2017- February 28, 2018)

MCO CALL CENTER STANDARDS AND PERFORMANCE MEASURES

			Meets Standard						Does Not Meet					
			BCBS			MHC			PHP			UHC		
		CONTRACT STANDARD	DEC	JAN	FEB	DEC	JAN	FEB	DEC	JAN	FEB	DEC	JAN	FEB
Member Services	Number of Calls Received - All Queues		8,389	13,125	10,265	11,445	15,877	11,494	10,560	16,187	12,870	6,862	8,869	6,916
	Number of Calls Answered - All Queues		8,244	12,841	10,077	11,388	15,603	11,468	10,348	15,882	12,647	6,850	8,803	6,879
	Percent of Calls Abandoned	< 5%	1.7%	2.2%	1.8%	0.5%	1.7%	0.2%	2.0%	1.9%	1.7%	0.2%	0.7%	0.5%
	Percent of Calls Answered within 30 Seconds	85%	90%	88%	90%	99%	89%	99%	87%	87%	87%	98%	92%	92%
	Average Wait Time	< 2 minutes	0.3	0.3	0.2	0.1	0.3	0.0	0.3	0.3	0.3	0.0	0.2	0.1
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nurse Advice Line	Number of Calls Received - All Queues		691	864	682	1,636	2,150	1,637	1,944	2,351	2,128	220	318	278
	Number of Calls Answered - All Queues		674	841	665	1,618	2,126	1,632	1,886	2,282	2,063	218	316	276
	Percent of Calls Abandoned	< 5%	2.5%	2.7%	2.5%	1.1%	1.1%	0.3%	3.0%	2.9%	3.1%	0.9%	0.6%	0.7%
	Percent of Calls Answered within 30 Seconds	85%	83%	81%	76%	97%	97%	98%	93%	93%	94%	94%	93%	93%
	Average Wait Time	< 2 minutes	0.3	0.3	0.4	0.1	0.1	0.1	0.2	0.4	0.2	0.0	0.3	0.2
Provider Services	Number of Calls Received - All Queues		8,478	10,975	9,562	10,623	13,246	11,817	2,621	3,131	2,774	8,422	9,768	8,515
	Number of Calls Answered - All Queues		8,287	10,704	9,388	10,596	13,178	11,800	2,591	3,102	2,751	8,403	9,752	8,509
	Percent of Calls Abandoned	< 5%	2.3%	2.5%	1.8%	0.3%	0.5%	0.1%	1.1%	0.9%	0.8%	0.2%	0.2%	0.1%
	Percent of Calls Answered within 30 Seconds	85%	89%	89%	91%	99%	94%	100%	87%	87%	88%	96%	97%	96%
	Average Wait Time	< 2 minutes	0.3	0.3	0.2	0.1	0.2	0.0	0.3	0.3	0.3	0.2	0.1	0.1
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
UM Line	Number of Calls Received - All Queues		5,885	7,531	7,005	3,373	3,764	3,852	1,335	1,504	1,515	2,353	3,012	2,538
	Number of Calls Answered - All Queues		5,777	7,379	6,857	3,278	3,718	3,791	1,332	1,498	1,508	2,333	2,973	2,504
	Percent of Calls Abandoned	< 5%	1.8%	2.0%	2.1%	2.8%	1.2%	1.6%	0.2%	0.4%	0.5%	0.8%	1.3%	1.3%
	Percent of Calls Answered within 30 Seconds	85%	92%	91%	87%	94%	96%	95%	89%	89%	87%	90%	94%	91%
	Average Wait Time	< 2 minutes	0.2	0.2	0.2	0.6	0.2	0.4	0.2	0.2	0.2	0.5	0.4	0.5

Source: [MCO] Report 2, M12 CY17-M1, M2 CY18