CENTENNIAL CARE 2.0 DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 10 (1/1/2023 – 12/31/2023)
Quarter 2 of 2023

November 22, 2023

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INTRODUCTION

The State of New Mexico primarily operates its Medicaid and Children's Health Insurance Program (CHIP) under a federal 1115 demonstration waiver authorized by the US Centers for Medicare & Medicaid Services (CMS). Referred to as Centennial Care since 2014, the demonstration authorizes the comprehensive managed care delivery system, the Home and Community-Based Services (HCBS) Community Benefit (CB) program and several transformative pilot initiatives that serve most of the State's Medicaid beneficiaries.

On December 14, 2018, CMS approved Centennial Care 2.0, New Mexico's 1115 demonstration waiver, the next iteration of Centennial Care. Centennial Care 2.0, effective January 1, 2019 through December 31, 2023, features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care, pharmacy, behavioral health services, institutional services, and HCBS.

In Centennial Care 2.0, the state continues to advance successful initiatives pursued under Centennial Care while implementing new, targeted initiatives to address specific gaps in care, and improve healthcare outcomes for its most vulnerable members. Key initiatives include:

- Improving continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, increasing utilization of preventive services, and promoting administrative simplification and fiscal sustainability of the Medicaid program;
- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continuing the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;

- Building upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplifying administrative complexities and implementing refinements in program and benefit design.

The Centennial Care 2.0 Managed Care Organizations (MCOs) are:

- BlueCross BlueShield of New Mexico (BCBS);
- Presbyterian Health Plan (PHP); and
- Western Sky Community Care (WSCC).

Status of Key Dates:

TOPIC	KEYDATE	STATUS
Quality Strategy	Final Quality Strategy posted to HSD website on September 1, 2022.	Final copy submitted to CMS on October 26, 2022.
Substance Use Disorder (SUD) Implementation Plan	Approved by CMS on May 21, 2019.	Approved by CMS on May 21, 2019.
Evaluation Design Plan	Submitted to CMS on June 27, 2019.	Approved by CMS on April 3, 2020.
SUD Monitoring Protocol	Submitted to CMS on July 31, 2019.	Approved by CMS on July 21, 2020.
1115 Demonstration Amendment #2	Submitted to CMS on March 1, 2021.	Approved by CMS on March 28, 2023.
1115 Demonstration Amendment #2 Letter Amendment	Submitted to CMS on December 30, 2021.	Approved by CMS on March 28, 2023.
New Mexico Turquoise Care 1115 Waiver Renewal Application	Submitted to CMS on December 15, 2022.	CMS Completeness Letter received on December 29, 2022. Federal Comment Period occurred December 29, 2022 through January 28, 2023. Under CMS review.

SMI/SED Implementation Plan	Due to CMS June 26, 2023.	Submitted to CMS 6/26/2023.
SMI/SED Monitoring Protocol	Due to CMS August 25, 2023.	In progress.
COVID-19 Draft Summative Evaluation Report	Due to CMS September 4, 2023.	In progress.
Centennial Care 2.0 Amended Evaluation Design	Due to CMS September 25, 2023.	In progress.

ITEMS APPROVED BY CMS DURING DY10 AND CURRENT ACTIVITIES

New Mexico Centennial Care 2.0 Waiver Amendment #2

CMS approved New Mexico's request to amend its 1115 demonstration entitled, New Mexico Centennial Care 2.0 (Project Number 11-W00285/6) effective March 28, 2023 through December 31, 2023 providing the following authorities:

- Federal Financial Participation (FFP) for inpatient, residential and other services provided to otherwise-eligible Medicaid beneficiaries while they are short-term residents in Institutions for Mental Diseases (IMD) for diagnoses of Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). FFP will become available once CMS approves New Mexico's SMI/SED Implementation plan, which is currently due June 26, 2023.
- FFP for improvements to New Mexico's Home and Community Based Services (HCBS), including the increase of enrollment limits for the Community Benefit program and increase in service limits for Community Transition and Environmental Modification services.
- FFP and expenditure authority for the implementation of a High-Fidelity Wrap Around (HFW) Intensive Care Coordination Benefit.

New Mexico's request for federal match to establish Graduate Medical Education (GME) grant programs was not approved and CMS will continue to work with the state on the policy parameters for workforce initiatives.

New Mexico provided formal written acknowledgement of the award and acceptance of CMS' Standard Terms and Conditions (STCs) on April 27, 2023.

Updates for Q2 CY2023
In accordance with the STCs, New Mexico is developing performance metrics for SMI, HFW, and expansion of HCBS enrollment to propose to CMS for its monitoring reports. Additionally, New Mexico submitted its SMI/SED Implementation Plan to CMS on June 26, 2023.

ITEMS UNDER CMS REVIEW SINCE DY9 AND CURRENT ACTIVITIES

New Mexico Turquoise Care 1115 Waiver Renewal
New Mexico's current 1115 demonstration waiver, Centennial Care 2.0 will expire on December 31, 2023. Building upon the strong foundation created by Centennial Care, the Human Services Department (HSD) submitted a 5-Year 1115 demonstration waiver renewal application to CMS on December 15, 2022 for an anticipated effective date of January 1, 2024. Through the demonstration renewal, New Mexico introduced its new demonstration name, **Turquoise Care**, which will be effective through December 31, 2028. New Mexico received CMS' Completeness Letter on December 29, 2022 with notice that the application was posted on Medicaid.gov for a 30-day federal comment period as required by 42 CFR 431.416(b). The renewal application remains under CMS review.

As New Mexico prepared its waiver renewal application, it held several stakeholder engagements to obtain valuable input on the current Centennial Care 2.0 Medicaid program and innovations that could be explored as part of the 1115 demonstration renewal. A formal public comment period was held from September 6, 2022 through October 31, 2022 providing opportunities to health care and social service providers, Tribal leadership, Indian Health Services, Tribal Nations, Tribal health providers, Urban Indian healthcare providers, Managed Care Organizations, hospitals and health systems, medical associations, community-based organizations, members of the public, and others to provide feedback on HSD's draft Medicaid 1115 Waiver Renewal Application. Public comments were welcomed by mail, email, public hearing, and Tribal Consultation. Two public hearings and one Tribal Consultation was held to obtain verbal feedback. The following table lists stakeholder engagements that occurred throughout the process:

Date	Meeting
April 26, 2022	Tribal Listening Session
May 4, 2022	Sister Agency and Partner Session
May 5, 2022	Large Stakeholder Session
May 11, 2022	Legislator Session
May 11, 2022	Legislative Finance Committee (LFC), Department of Finance Administration (DFA), and Governor's Office Listening Session

May 12, 2022	Tribal Meeting with Navajo Nation
May 13, 2022	Tribal Meeting with Zuni and Laguna Pueblo
July 18, 2022	Virtual Tribal Listening Session
July 19, 2022	Virtual Tribal Listening Session
July 21, 2022	Virtual Tribal Listening Session
September 30, 2022	Public Hearing
October 7, 2022	Public Hearing
October 14, 2022	Tribal Consultation

New Mexico received a total of 82 individual comments through the various channels provided for public comment. These included 66 submissions by email, 6 submissions captured in public hearings, and 10 submissions received at both the public hearings and by email. Comments were submitted by self-advocates and family members, advocacy organizations, and professional and provider organizations focused on health and social services. Comments spanned suggestions, questions, concerns, and support. All feedback was taken into consideration as the State prepared its final renewal application for CMS submission. Responses to public comments were also posted to the State's dedicated webpage.

The demonstration renewal's vision and goals are predicated on HSD's overall mission and goals for providing health and human services to New Mexicans:

In alignment with HSD's mission, Turquoise Care's goals and initiatives center on improving core health outcomes and attending to the social and economic determinants of health, particularly centered on addressing the needs of the State's historically underserved populations. HSD's vision is that every New Mexico Medicaid member has high-quality, well-coordinated, person-centered care to achieve their personally defined health and wellness goals. To advance on these opportunities and move closer to our vision, HSD will operate a data-driven Medicaid program that measures quality based on population health outcomes. To support this vision, the Turquoise Care waiver is constructed around three goals:

1. Build a New Mexico health care delivery system where every Medicaid member has a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person – their physical, behavioral, and social drivers of health.
2. Strengthen the New Mexico health care delivery system through the expansion and implementation of innovative payment reforms and value-based initiatives.
3. Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives.

Turquoise Care has targeted initiatives focused on the following populations:

- Prenatal, postpartum, and members parenting children, including children in state custody;
- Seniors and members with long-term services and supports (LTSS) needs;
- Members with behavior health conditions;
- Native American members; and
- Justice-involved individuals.

These five populations were selected as target populations given their experiences with societal inequities, disproportionately high demand for health supports and services, and disparities they have experienced within the State of New Mexico. As such, many of the key waiver and expenditure authorities, and pilot programs have been created to support these populations to ensure they receive equitable care.

The current programs within the Centennial Care 2.0 waiver will continue and/or expand under the renewal. These include:

- Continued authorization of New Mexico's Managed Care delivery system;
- Continued Medicaid coverage and benefits for all current eligibility groups, including expansion of enrollment for children up to age six;
- Expansion of Community Benefit slots for Home and Community-Based Services (HCBS);
- Expanded Centennial Home Visiting Pilot Programs; and
- Expanded access to Supportive Housing.

In addition, several new programs will be launched under the renewal:

- Medicaid Services for High-Need Justice-Involved populations 30 days before release;
- Chiropractic Services Pilot;
- Member-Directed Traditional Healing Benefits for Native Americans;
- Enhanced Services and Supports for Members in need of Long-Term Care;
- Environmental Modifications Benefit Limit Increase;
- Transition Services Benefit Limit Increase;
- Home-Delivered Meals Pilot Programs;
- Addition of a Closed-Loop Referral System;
- Medical Respite for Members Experiencing Homelessness;
- Graduate Medical Education (GME) funding and technical assistance for new and/or expanded primary care residency programs; and
- Additional support for rural hospitals.

The Medicaid 1115 demonstration waiver in New Mexico is one key component of the overall vision for a person-centered Medicaid delivery system that strives to improve population health. New Mexico will utilize multiple authorities and modify Managed Care Organization (MCO) responsibilities through the MCO contracts to strengthen existing successful programs while adding new initiatives that align with the State's goals for Turquoise Care. Additionally, as the state finalized its renewal application, several groundbreaking approvals in other states, notably Massachusetts, Oregon, Arkansas, and Arizona, were released. These approvals detail significant investments in health-related social needs and workforce solutions through financing mechanisms that would support the vision and goals of Turquoise Care. As CMS reviews New Mexico's Waiver Renewal Application, the State is working to develop additional proposals to leverage the new policies announced through these approvals. New Mexico and CMS will determine the appropriate mechanism to submit additional proposals.

CMS and New Mexico have established biweekly meetings to review the Turquoise Care Waiver Renewal proposals and address questions.

Updates for Q2 CY2023

CMS has informed New Mexico of its intent to extend the existing Centennial Care 2.0 waiver to allow the state and CMS additional time to review and negotiate the state's demonstration application submitted December 15, 2022. New Mexico was advised that CMS is prioritizing the following proposals for an effective approval date of January 1, 2024:

1. Provide Continuous Enrollment for Children up to Age Six;
2. Expand Home and Community-Based Services Community Benefit (CB) Enrollment Opportunities through Additional Waiver Slots;
3. Expand the Centennial Home Visiting Program;
4. Chiropractic Services Pilot; and

5. Legally Responsible Individuals as Providers of Home and Community-Based Services Community Benefit Services.

CENTENNIAL CARE 2.0 POST AWARD FORUMS

On April 15, 2019, HSD provided an update of the implementation of Centennial Care 2.0 to the Medicaid Advisory Committee (MAC), which serves as the post award forum meeting. HSD has presented progress reports on the Centennial Care 2.0 waiver at all subsequent MAC meetings. All MAC meetings have a public comment opportunity. On August 8, 2022, HSD provided an update on the 1115 demonstration renewal, as part of a months-long stakeholder engagement process on the renewal.

During the May 8, 2023 MAC meeting the following topics were addressed in support of the Centennial Care 2.0 waiver and Medicaid 1115 demonstration waiver renewal:

- Leadership update, which included an announcement of recent departures and acting roles.
- Public Health Emergency (PHE) update, which included information on the following: unwinding efforts; overview of renewals; recertification process during unwinding; FY23 Renew NM Campaign update; Medicaid unwinding state comparison; and outreach outcomes.
- beWellnm updates, which included information on the unwinding plan and unwinding outreach and marketing campaign.
- Legislative updates, which included information on Senate Bill (SB) 7 – Rural Healthcare Delivery Fund and SB16 – Creation of Health Care Authority.
- Rate Increase in accordance with House Bill (HB) 2, which included updates on the following: legislative appropriation; provider rate benchmarking study and preliminary benchmarking – phase 1; and general fund overview and state activities.
- FY22, FY23, and FY24 Budget Overview with 4-month Maintenance of Effort (MOE) Unwinding, which included updates on the following: Medicaid budget expenditures; Medicaid budget revenues; and Federal revenue supporting Medicaid program
- Enrollment projection update related to 4-month MOE redeterminations (May 2023), which included information on the following: NM Medicaid enrollment projection FY22; NM Medicaid enrollment projection FY23; NM Medicaid enrollment projection FY24; NM Medicaid Managed Care enrollment FY22; NM Medicaid Managed Care enrollment FY23; and NM Medicaid Managed Care Enrollment FY24.
- Medicaid Dashboards, which included information on the following: current and previous 12 months of 2021 and 2022 data; data run-out through December 2022; general observations for managed care enrollment, medical costs, and service categories; Community Benefit Personal Care Services (PCS) and Home and

Community-Based Services expenses and continuous shift in setting of care utilization; and behavioral health service observations for enrollment, expenditures, and service categories.

- MCO Procurement and 1115 Demonstration Waiver updates, which included information on the following: CMS' approval of the state's Centennial Care 2.0 Waiver Amendment #2, including effective date and authorized authorities; and Turquoise Care 1115 Waiver Renewal timeline.
- Behavioral Health workforce Medicaid update on Kevin S. Settlement, which included information on the following: HSD's and CYFD's collaboration on workforce development; Evidence Based Practices; Community Based Mobile Crisis Intervention Services; Children's Mobile Response and Stabilization Services; State Plan Amendment Process and public comment opportunities; High Fidelity Wraparound; and implementation activities.
- CMS notice of proposed rulemaking, which included information on the following proposed rules: Deferred Action for Childhood Arrivals (DACA) eligibility; Medicaid access; and managed care.

An opportunity to provide public comment on the progress of the demonstration was provided and no comments were received. To date, HSD has not received public comments related to the progress of the Centennial Care 2.0 Demonstration. All stakeholder feedback gathered at the MAC as well as other public forums have been used to monitor the Centennial Care 2.0 waiver and inform the development of the Turquoise Care renewal request. Following is a listing of MAC meeting dates that have occurred since the approval of the Centennial Care 2.0 waiver:

- April 15, 2019
- December 16, 2019
- January 27, 2020
- April 27, 2020
- August 3, 2020
- November 2, 2020
- January 19, 2021
- May 10, 2021
- August 9, 2021
- November 8, 2021
- January 24, 2022
- May 16, 2022
- August 8, 2022
- November 21, 2022

- February 13, 2023
- May 8, 2023

MAC committee members, interested parties, and members of the public receive advance meeting notice through New Mexico's dedicated webpage. Additionally, New Mexico issues meeting placeholders and invites to MAC committee members and interested parties. Following each meeting, New Mexico posts to its dedicated webpage all meeting materials including the agenda, presentation, Medicaid dashboards, budget projections, and meeting minutes.

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: QUARTER 2 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	3/31/2023 ENROLLMENT	6/30/2023 ENROLLMENT	PERCENT INCREASE / DECREASE Q1
BlueCross BlueShield of New Mexico (BCBS)	300,126	282,822	-5.8%
Presbyterian Health Plan (PHP)	429,360	405,333	-5.6%
Western Sky Community Care (WSCC)	93,940	91,157	-3.0%

Source: Medicaid Eligibility Reports, March 2023 and June 2023

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment and expenditure data by programs for April 2021 – March 2023 is available in Attachment A to this report.

MCO Enrollment

In aggregate, MCO enrollment increased by 4% from the previous to current period. This increase is comprised of the following:

- 5% increase in Physical Health enrollment.
- 2% increase in Long-Term Services and Supports enrollment.
- 1% increase in Other Adult Group enrollment.

Enrollment levels are expected to decline as a result of member dis-enrollments that began May 1, 2023. Enrollment graphs in Attachment A illustrate a decrease for the most recent month, which is mostly due to retroactivity not yet accounted for at the cutoff date of the enrollment data (i.e., March 31, 2023). Historically, this decrease in the last month changes to an increase in subsequent quarter due to additional runout.

MCO Per Capita Medical Costs:

In aggregate, total MCO per capita medical costs decreased by 1% from the previous to current period. This consists of a 2% decrease to non-pharmacy services and an 8%

increase to pharmacy services.

On a dollar basis, higher enrollment levels, partially offset by the decrease in per capita medical costs, are driving the 3% year over year increase in total medical expenses.

CENTENNIAL CARE TO CENTENNIAL CARE 2.0

CENTENNIAL REWARDS

The Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors. Beginning in DY10, New Mexico modified its 2023 Rewards Program as illustrated below.

Reward Activity	Age Requirement	2023 Modification
Address Update (supports PHE unwinding efforts)	Any	Added new reward activity
Adult Primary Care Provider (PCB) Checkup – Complete annual PCP wellness checkup	Ages 20+	Age requirement changed from Ages 22+ to 20+
Antidepressant Medication Management - Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	Added new reward activity
Breast Cancer Screening (BCS) – Complete mammogram	Ages 50-74	Added new reward activity
Cervical Cancer Screening (CCS) – • Ages 21-64: Cervical cytology (pap test) • Ages 30-64 high-risk women: HPV test and/or pap test	Ages 21-64	Added new reward activity
Childhood immunizations (CIS) – Complete immunization series	Age 2	Added new reward activity
Child & Adolescent Well-Care Visit - Complete annual wellness checkup with a PCP or an OB/GYN Bonus: Adolescent Immunization Series – Complete adolescent immunization series by 13th birthday	Ages 3-21	Added new reward activity
COVID-19 Vaccine or Booster – Complete COVID-19 vaccine or booster	All ages, as advised by CDC	No change
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	No change

Diabetes HbA1C Test – Completion of HbA1C Test • Bonus: Diabetes HbA1C Control – Attain HbA1c control (<8%)	Ages 10-75	Reward activity eliminated
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75	No change
Flu Shot - Receive flu vaccine	Ages 6 months+	No change
Follow-up After Emergency Dept. Visit for Mental Illness – Complete follow-up visit within 30 days of emergency department visit for mental illness or intentional self-harm diagnoses	Ages 6+	Reward activity eliminated
Follow-up After Hospitalization for Mental Illness - Complete follow-up visit within 30 days of hospitalization for mental illness or intentional self-harm diagnoses	Ages 6+	Reward activity eliminated
1st Prenatal Care Visit – Complete prenatal care visit in the first trimester or within 42 days of enrollment	All ages	No change
Postpartum Visit – Complete postpartum care visit between 7 and 84 days after delivery	All ages	No change
Schizophrenia Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	Reward activity eliminated
Smoking/Vaping Prevention – Complete vaping/smoking prevention learning module	Age under 18	Added new reward activity
Step-Up Challenge (FCHAL-SU-3)– Successfully complete 3-week Step-Up Challenge	Ages 10+	Added new reward activity
Well-Baby Checkups – Complete up to six well-child visits with a PCP during the first 15 months of life and up to two well-child visits with a PCP between 16-30 months of life • Bonus: Complete all eight well-child visits with a PCP between 0-30 months of life	0-30 months	No change

Centennial Rewards Participation

As of DY10 Q2 there are 838,260 Centennial Care members participating in the Centennial Rewards Program. Registering for the Centennial Rewards program is not required to participate in the program but is required for reward redemption. Quality improvement and participation trends are demonstrated in the table below.

Table 2: Centennial Rewards

CENTENNIAL REWARDS				
	July - September 2022	October - December 2022	January - March 2023	April - June 2023
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	159,246	120,552	192,588	234,766
Number of Members Newly Registered in the Rewards Program this Quarter	5,416	6,609	4,345	4,497
Number of Members Who Redeemed Rewards this Quarter**	30,754	49,202	21,939	30,608

*Only includes rewards earned THIS quarter.
**Redeemed rewards could have been earned in any of the previous 24 reporting months.
Source: Finity Quarter 2 Report

Following is a summary of DY10 Q2 observations:

- Percentage of Medicaid Enrollees Participating in the Rewards Program this Quarter
    - Member participation has increased quarter over quarter throughout the life of the rewards program, reaching an all-time high in Q2 2023 of 76.4%.
- Number of Medicaid Enrollees Receiving a Centennial Care Reward Service this Quarter
    - This measure is typically highest at the beginning of the year as the majority of members have gaps-in-care at that time. This trend is in line with previous years.
- Number of Members Newly Registered in the Rewards Program this Quarter
    - Members only need to register to redeem rewards. Registration is typically lowest in the first half of the year as members save their reward points to spend when they have more buying power or during the holidays. This trend is consistent with previous years.
- Number of Members Who Redeemed Rewards this Quarter
    - In line with registration trends, reward redemptions are typically lowest in the first half of the year as members save their reward points to spend when they have more buying power or during the holidays. Earned rewards expire December 31st of the following year (e.g., rewards earned in 2023 expire on December 31, 2024). Rewards can be redeemed anytime during that period.

Centennial Care Rewards Multimedia Campaigns

In DY10 Q2, Finity conducted the below multimedia campaigns to encourage members to keep their preventive appointments, receive vaccinations, and complete targeted condition management activities that align with state performance, including Legislative Finance Committee (LFC) and HEDIS measures. All multimedia communications align with HSD's strategic goals and promote the healthy activities that members are eligible to complete to earn rewards and close gaps-in-care.

Adolescent Immunization Campaign: Designed to encourage members ages 9 to 18 to complete their Adolescent Immunization vaccine series. Currently, there isn't a reward associated with this campaign. Texts and emails were sent in April.

- 24K texts sent in Q2 2023
- 25K emails sent in Q2 2023

Child Dental Campaign: Designed to encourage members between the ages of 2 and 20 to go in for their dental visits. This reward is earned through claims verification. Members earn $30 or 300 points for completing their visit. Texts and emails were sent in May.

- 75K texts sent in Q2 2023
- 66K emails sent in Q2 2023

Monthly Redemptions Campaign: Designed to notify members who have earned rewards that they have points to spend in the Centennial Rewards Catalog on essential items like oximeters, thermometers, cleaning supplies, diapers, nursing supplies, kitchen items, and more. Texts and emails were sent April through June 2023. This is an ongoing campaign and Q2 2023 results are provided below:

- 484K texts sent in Q2 2023
- 361K emails sent in Q2 2023

Well-Baby Immunization Campaign: Designed to encourage parents/guardians to complete immunizations for their babies ages 0-30 months. Campaign texts and emails were sent in June 2023. This is an ongoing campaign and DY10 Q2 results are provided below:

- 46K texts sent in Q2 2023
- 10K emails sent in Q2 2023

Women's Cancer Screening Campaign: Designed to encourage eligible members to complete breast and cervical cancer screenings. Campaign texts and emails were sent in June 2023. This is an ongoing campaign and DY10 Q2 results are provided below:

- 126K texts sent in Q2 2023
- 86K emails send in Q2 2023

Additional Key Statistics through DY10 Q2 2023:

- Member participation in DY10 Q2 2023 reached an all-time high of over 76.4.%.
- In DY10 Q2 2023, members earned $4.8M in rewards from 348K activity completions, which is up over 16% from Q1 2023.
- In Q2 2023, members redeemed $998K on health items from the rewards catalog.
- Cumulative dollars earned over DY10 Q1 & Q2 2023 is up 12% from DY9 Q1 & Q2 2022.

Enhanced Customer Satisfaction Survey: Finity enhanced the Centennial Rewards member satisfaction survey in 2021 by adding new questions that were approved by HSD. New Mexico identified a reporting error with its DY10 Q1 2023 submission and is providing corrected results for DY10 Q1 below. The table also illustrates DY10 Q2 survey results. Consistent with previous reporting, survey response rates increase quarter over quarter within the calendar year as rewards and redemptions increase.

Table 3: Centennial Rewards Customer Satisfaction Survey

Centennial Rewards Customer Satisfaction Survey												
	DY9 Q3			DY9 Q4			DY10 Q1			DY10 Q2		
	# OF RESPONDENTS 3,340			# OF RESPONDENTS 3,961			# OF RESPONDENTS 1,759			# OF RESPONDENTS 2,981		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Centennial Care?	98%	2%	n/a	97%	3%	n/a	97%	3%	n/a	96%	4%	n/a
Are you satisfied with your doctor?	89%	4%	7% I don't have a doctor	88%	4%	8% I don't have a doctor	87%	4%	9% I don't have a doctor	88%	4%	8% I don't have a doctor
Are you satisfied with your health plan?	96%	4%	n/a	96%	4%	n/a	97%	3%	n/a	95%	5%	n/a
Are you satisfied with the help provided by your care coordinator?	85%	7%	9% I don't have a care coordinator	90%	8%	2% I don't have a care coordinator	92%	7%	1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator

Source: Finity Quarter 2 Report

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ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

The following tables outline quarterly enrollment and disenrollment activity under the demonstration.

The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment and disenrollment 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.

Most disenrollments for this quarter are attributed to loss of eligibility, members moving out of state, and death. In DY10 Q1, New Mexico refined its reporting by including two months of available disenrollment data for the quarter. Due to the lag in data available each quarter, New Mexico will refresh its previous reporting each quarter to include the complete three months of data and analyses. This quarter, New Mexico is refreshing its disenrollment data for DY10 Q1 to include three months of data and is providing preliminary data for DY10 Q2, which includes two months of available data. In DY10 Q3, New Mexico will refresh its disenrollment data for DY10 Q2 to include three months of data and will provide its preliminary disenrollment data for DY10 Q3 including the available two months of data.

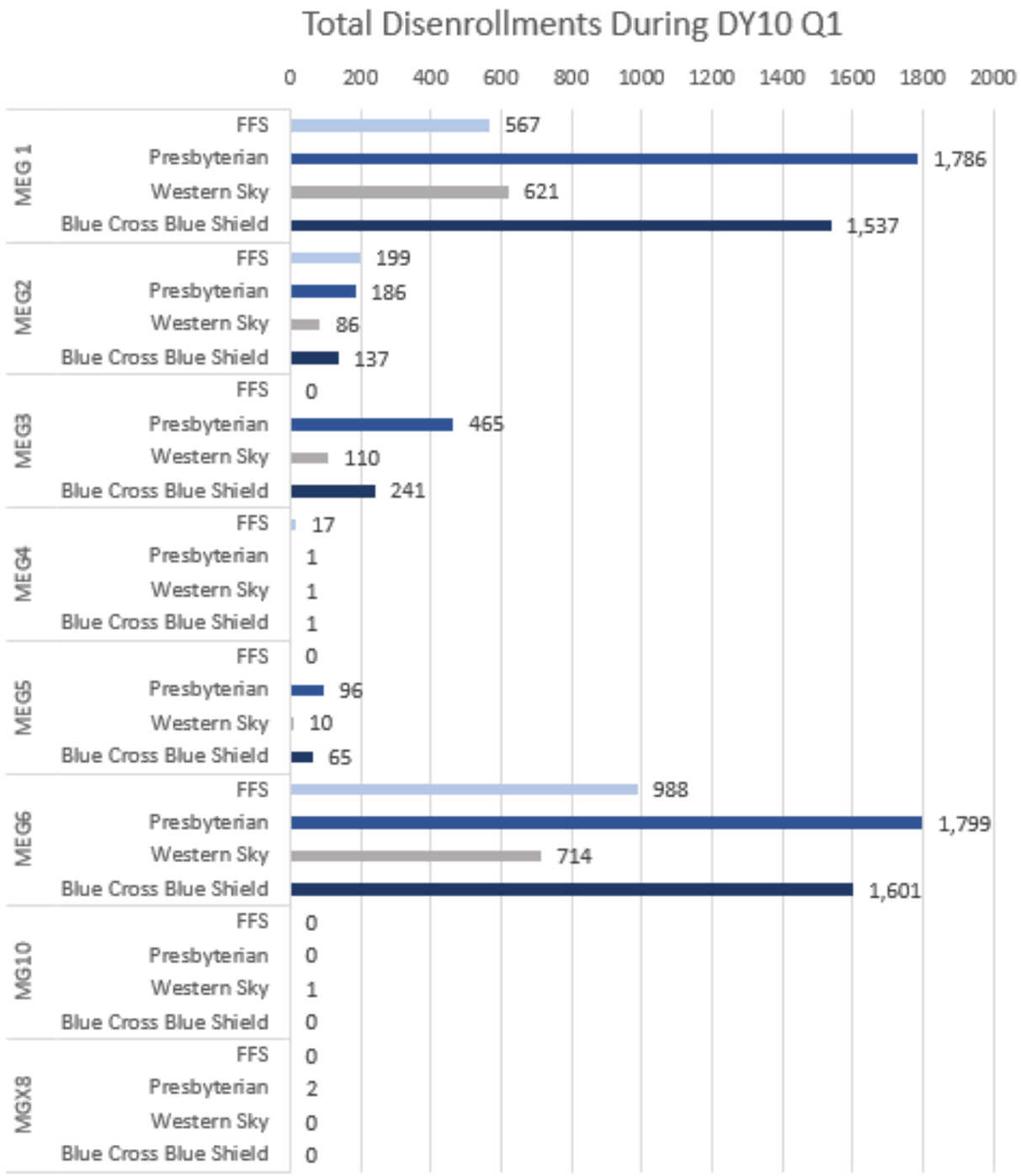
Due to Public Health Emergency (PHE) regarding Coronavirus (COVID-19), HSD meets the Maintenance of Effort (MOE) statutory requirements to receive the 6.2% increased Federal Medical Assistance Percentage (FMAP) by ensuring individuals are not terminated from Medicaid if they were enrolled in the program as of March 18, 2020, or become enrolled during the emergency period, unless the individual voluntarily terminates eligibility. The PHE ended on May 11, 2023 and the MOE continuous eligibility ended March 31, 2023. New Mexico began its unwinding activities in March 2023 and terminations began May 1, 2023. As a result of unwinding activities, New Mexico has observed increases in disenrollments, which are reflected in the preliminary data below. Specifically, disenrollments in MEG1 (TANF and Related) and MEG6 (Category of Eligibility 100) have notable increases.

Refreshed DY10 Q1 Data

Demonstration Population		Total Number Demonstration Participants DY10 Q1 Ending March 2023	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY10 Q1 (Jan-Mar 2023)
Population MEG1 - TANF and Related	0-FFS	33,101	37,077	567
	Presbyterian	229,751	217,495	1,786
	Western Sky	45,687	44,427	621
	Blue Cross Blue Shield	152,117	144,746	1,537
	Summary	**460,656**	**443,745**	**4,511**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,297	2,526	199
	Presbyterian	20,912	20,805	186
	Western Sky	4,075	4,088	86
	Blue Cross Blue Shield	12,788	12,681	137
	Summary	**40,072**	**40,100**	**608**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Presbyterian	22,813	23,853	465
	Western Sky	3,918	4,212	110
	Blue Cross Blue Shield	11,688	12,289	241
	Summary	**38,419**	**40,354**	**816**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	138	184	17
	Presbyterian	103	106	1
	Western Sky	14	15	1
	Blue Cross Blue Shield	74	77	1
	Summary	**329**	**382**	**20**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Presbyterian	3,210	3,474	96
	Western Sky	558	600	10
	Blue Cross Blue Shield	2,481	2,633	65
	Summary	**6,249**	**6,707**	**171**
Population MEG6 - VIII Group (expansion)	0-FFS	25,351	35,721	988
	Presbyterian	130,872	146,318	1,799
	Western Sky	37,247	41,514	714
	Blue Cross Blue Shield	106,466	117,954	1,601
	Summary	**299,936**	**341,507**	**5,102**
Population MG10 - IMDSUD Group	0-FFS	11	40	0
	Presbyterian	222	613	0
	Western Sky	35	97	1
	Blue Cross Blue Shield	129	373	0
	Summary	**397**	**1,123**	**1**
Population MGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Presbyterian	425	1,185	2
	Western Sky	95	307	0
	Blue Cross Blue Shield	339	925	0
	Summary	**859**	**2,417**	**2**
Summary		**846,917**	**876,335**	**11,231**

Source: Enrollee Counts Report

Refreshed DY10 Q1 Data



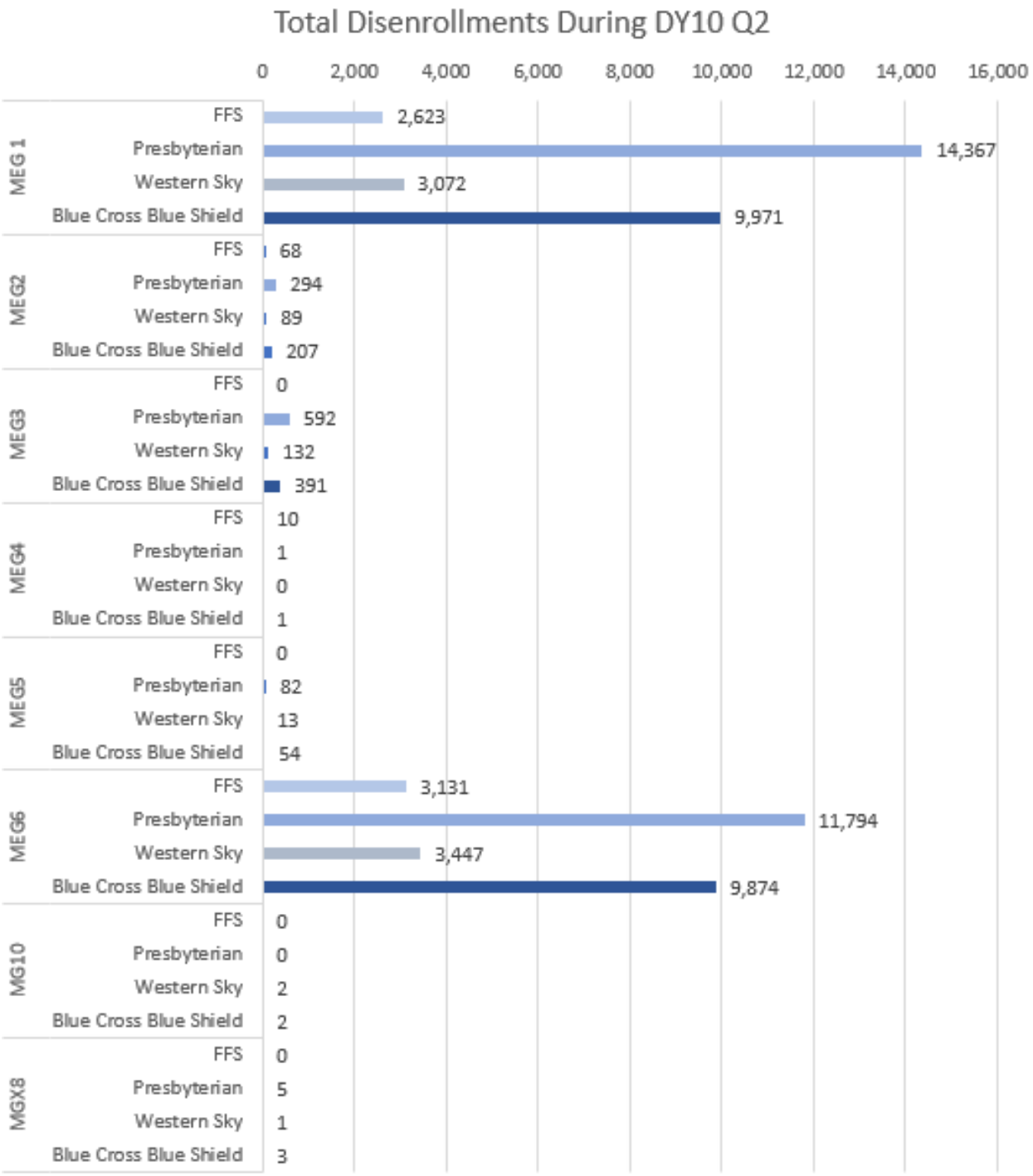
Source: Enrollee Counts Report

Preliminary DY10 Q2 Data

Demonstration Population		Total Number Demonstration Participants DY10 Q2 Ending June 2023	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY10 Q2 (Apr-May 2023)
Population MEG1 - TANF and Related	0-FFS	34,416	37,077	2,623
	Presbyterian	222,178	217,495	14,367
	Western Sky	44,605	44,427	3,072
	Blue Cross Blue Shield	147,242	144,746	9,971
	Summary	**448,441**	**443,745**	**30,033**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,352	2,526	68
	Presbyterian	20,971	20,805	294
	Western Sky	4,084	4,088	89
	Blue Cross Blue Shield	12,889	12,681	207
	Summary	**40,296**	**40,100**	**658**
Population MEG3 - SSI and Related - Dual	0-FFS	7	0	0
	Presbyterian	22,650	23,853	592
	Western Sky	3,965	4,212	132
	Blue Cross Blue Shield	11,630	12,289	391
	Summary	**38,252**	**40,354**	**1,115**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	224	184	10
	Presbyterian	106	106	1
	Western Sky	12	15	0
	Blue Cross Blue Shield	72	77	1
	Summary	**414**	**382**	**12**
Population MEG5 - 217-like Group - Dual	0-FFS	7	0	0
	Presbyterian	3,173	3,474	82
	Western Sky	557	600	13
	Blue Cross Blue Shield	2,410	2,633	54
	Summary	**6,147**	**6,707**	**149**
Population MEG6 - VIII Group (expansion)	0-FFS	29,397	35,721	3,131
	Presbyterian	139,432	146,318	11,794
	Western Sky	39,131	41,514	3,447
	Blue Cross Blue Shield	111,797	117,954	9,874
	Summary	**319,757**	**341,507**	**28,246**
Population MG10 - IMDSUD Group	0-FFS	7	40	0
	Presbyterian	98	613	0
	Western Sky	18	97	2
	Blue Cross Blue Shield	71	373	2
	Summary	**194**	**1,123**	**4**
Population MGX8 - IMDSUD VIII Group	0-FFS	7	0	0
	Presbyterian	215	1,185	5
	Western Sky	82	307	1
	Blue Cross Blue Shield	225	925	3
	Summary	**529**	**2,417**	**9**
Summary		**854,030**	**876,335**	**60,226**

Source: Enrollee Counts Report
January 1, 2019 – December 31, 2023

Preliminary DY10 Q2 Data



Source: Enrollee Counts Report

4

OUTREACH/ INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY10 Q2	In DY10 Q2, the Human Service Department (HSD), Medical Assistance Division (MAD), continued to provide coaching, outreach and educational activities through webinars to Presumptive Eligibility Determiners (PEDs) in the Presumptive Eligibility (PE) and Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) programs to help PEDs better assist their clients in the completion of Medicaid eligibility applications, both online and telephonically. HSD staff provide a monthly newsletter called “PED Medicaid Monthly,” which is electronically sent to active PEDs. The newsletter provides updates on HSD programs, policy changes, YESNM-PE system updates, tips and audit reminders for PEDs. The newsletter features a PED Hero section to allow active PEDs to nominate and feature one of their own. HSD also provided online PE certification and refresher demo training sessions for prospective and current PEDs. HSD staff participated in BeWellNM enrollment events assisting New Mexicans in applying for healthcare coverage and answering general Medicaid questions related to the end of the PHE for individuals and families. HSD staff continue to participate in HSD’s COVID-19 Vaccination Workgroup and a DOH COVID Provider Update Workgroup. The purpose of these meetings is to communicate and discuss COVID-19 vaccine efforts, upcoming statewide events, review federal guidelines, and outline operational procedures during the PHE.

5

COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

The MCOs submit encounters daily and/or weekly to stay current with encounter submissions, including encounters that are or not accepted by HSD. HSD meets regularly with the MCOs to address specific issues and to provide guidance. HSD regularly monitors encounters by comparing encounter submissions to financial reports to ensure completeness. HSD monitors encounters by extracting data monthly to identify the accuracy of encounter submissions and shares this information with MCOs. HSD extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. Based on the most recent quarterly data extracted, the MCOs are compliant with encounter submissions and there are no issues or findings to report for the encounter and enrollment data.

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

6

OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments through DY10 Q2 reflect the Centennial Care 2.0 rates effective for the period from January 1, 2023 through December 31, 2023. The rates are developed with efficiency, utilization, trends, prospective program changes, and other factors as described in the rate certification reports; the rate certification reports for January 1 through December 31, 2023 were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 21, 2022.

During DY10 Q2, financial payments were made for University of New Mexico Medical Group (UNMMG) directed payment, University of New Mexico Hospital (UNMH) directed payment, health care quality surcharge (HCQS), a recoupment for penalty for failure to report for CY 2021, and capitation reconciliation payments. The financial payments for UNMMG, UNMH, and HCQS partially contributed to the PMPM increase for MEG 1 of DY9 and DY10. Similarly, the financial payments for UNMMG, UNMH, and capitation reconciliation payments partially contributed to the Per Member Per Month (PMPM) increase for MEGs 2 and 6 of DY9 and DY10. For MEG 4, payment and member month adjustments contributed to the increase in PMPM for DY8 and DY9.

The payments related to the PHE due to the COVID-19 pandemic was $27.1 million during CY2022. In addition, expenditures and member months for substance use disorder in an institution for mental diseases (SUD IMD) were reported for DY6 to DY10 for both fee-for-service and managed care.

SYSTEM ISSUES

There are no system issues to report for this quarter.

COVID-19 PUBLIC HEALTH EMERGENCY (PHE), UNWINDING, and NEW MEXICO WILDFIRE EMERGENCY (NMWE)

On January 31, 2020 the Health and Human Services Secretary, Alex M. Azar II, declared a public health emergency for the United States to aid the nation's healthcare community in responding to the 2019 novel coronavirus also known as COVID-19. This declaration is retroactive to January 27, 2020. To help meet the needs of the nation during the ongoing COVID-19 pandemic, U.S. Health and Human Services (HHS) Secretary Xavier Becerra

renewed the COVID-19 PHE declaration for COVID-19 on February 9, 2023 and the Biden administration announced their intent to end the COVID-19 PHE effective May 11, 2023, providing states and territories with 60 days' advance notice of the PHE termination.

Following is a chronology of the renewals to date:

Historically the Maintenance of Effort (MOE) for Medicaid enrollment has been tied to the PHE declaration; however, with the passing of the Consolidation Appropriations Act of 2023 in December 2022, the MOE and the PHE were decoupled, and both had different end dates. The PHE ended on May 11, 2023 and the MOE continuous eligibility ended March 31, 2023. New Mexico began its unwinding activities in March 2023 and terminations began May 1, 2023. CMS provided states with three different options to begin unwinding activities, and New Mexico elected to begin activities in March 2023. New Mexico will use all 12 months of the unwinding period and will prioritize members that are expected to be financially ineligible based on existing system data and analyses. On February 15, 2023, New Mexico submitted its State Renewal Distribution Report (baseline report) and PHE Unwinding Configuration and Testing Plan to CMS. During New Mexico's 12-month unwinding period, it will submit a monthly report to CMS by the 8th of each month. To date, New Mexico has submitted unwinding reports to CMS through June 2023.

As states resume normal eligibility and enrollment operations following the end of the Families First Coronavirus Response Act (FFCRA) Medicaid continuous enrollment condition, CMS is working closely with state agencies and other stakeholders to identify ways to efficiently renew eligible individuals and reduce churn. There has been a substantial volume of eligibility caseload work, coupled with significant staffing shortages, causing many states to face substantial operational and system challenges. To support states facing these challenges and to protect eligible beneficiaries from inappropriate coverage losses during the unwinding period, on June 30, 2023, CMS encouraged states to request authority under Section 1902(e)(14)(A) of the Social Security Act, in limited circumstances, to implement temporary 1902(e)(14)(A) strategies. New Mexico has obtained approval on several temporary 1902(e)(14)(A) strategies and is thoughtfully considering additional strategies available.

In response to the COVID-19 PHE and unwinding efforts, HSD has requested and received approval for several federal waiver authorities as indicated below.

New Mexico Disaster Relief State Plan Amendments (SPAs)

HSD submitted Disaster Relief (DR) SPAs and received CMS approval. Following is a comprehensive listing of approved DR SPAs:

- Expanding the list of qualified entities allowed to do Presumptive Eligibility.
- Increasing Diagnosis-related Group (DRG) rates for ICU inpatient hospital stays by 50% and all other inpatient hospital stays by 12.4% from April 1, 2020 – September 30, 2020.
- Establishing Category of Eligibility (COE) for the COVID-19 Testing Group for the uninsured population.
- Providing Targeted Access UPL Supplemental Payments.
- Applying a Nursing Facility Rate Increase when treating fee for service COVID-19 members from April 1, 2020 – June 30, 2020.
- Increasing reimbursement for hospital stay services from April 1, 2020 – June 30, 2020.
- Increasing reimbursement to non-hospital providers for E&M codes and non-E&M codes, as well as an increase to Medicaid only procedure codes from April 1, 2020 – June 30, 2020.
- Increasing rates for services provided under the Family Infant Toddler (FIT) Program for July 1, 2020 through July 31, 2020.
- Providing Targeted Access supplemental payments for Safety-Net Care Pool (SNCP) hospitals from April 1, 2020 through December 31, 2020.
- Implementing coverage and reimbursement for COVID-19 vaccine and vaccine administration in accordance with Medicare's billing and reimbursement guidance.
- Providing reimbursement for administration of COVID-19 vaccines to homebound eligible Medicaid beneficiaries from March 15, 2021 through the end of the PHE.
- Applying a rate increase to non-emergency transportation providers from January 1, 2022 through June 30, 2022 or the end of the PHE, whichever comes first.
- Applying a nursing facility rate increase for COVID-19 members from January 1, 2022 through June 30,2022 or the end of the PHE, whichever comes first.
- Applying rate increases for ICU inpatient hospital services and for all other inpatient hospital services from January 1, 2022 through June 30, 2022 or the end of the PHE, whichever comes first.
- Implementing targeted access supplemental payments for Safety-Net Care Pool (SNCP) hospitals from January 1, 2021 through the end of the PHE.
- Implementing a temporary 15% reimbursement increase in accordance with Section 9817 of the American Rescue Plan (ARP) Act of 2021 and New Mexico's approved Spend Plan for providers of Personal Care Services (PCS) and Private Duty Nursing (PDN) under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit from May 1, 2021 to June 30, 2022, or the end of the PHE, whichever comes

first.

- Allowing hospital providers to bill and be paid for pasteurized donor human milk (PDHM) services separate from the Diagnosis-related group (DRG) and in addition to the inpatient hospital stay for infants through New Mexico Medicaid enrolled medical supply companies effective July 1, 2022.
- Implementing a rate increase for providers of Personal Care Services (PCS) and Private Duty Nursing (PDN) services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Effective July 1, 2022 through the end of the PHE, reimbursement for providers of PCS and PDN services under EPSDT will be set at the same rates as 1915(c) provider rates.

In May 2023, New Mexico submitted NM SPA 23-0007 requesting CMS' approval effective April 30, 2023 to end coverage for the COVID-19 testing group at 1902(a)(10)(A)(ii)(XXIII) of the Act as previously authorized in New Mexico Disaster SPA 20-0007.

1135 Waiver

HSD submitted an 1135 waiver and received CMS approval for the following:

- Suspending prior authorizations and extending existing authorizations.
- Suspending PASRR Level I and II screening assessments for 30 days.
- Extending of time to request fair hearing of up to 120 days.
- Enrolling providers who are enrolled in another state’s Medicaid program or who are enrolled in Medicare.
- Waiving screening requirements (i.e., Fingerprints, site visits, etc.) to quickly enroll providers.
- Ceasing revalidation of currently enrolled providers.
- Payments to facilities for services provided in alternative settings.
- Temporarily allowing legally responsible individuals to provide PCS services to children under the EPSDT benefit.

On May 11, 2023, New Mexico submitted a COVID-19 PHE 1115 Demonstration Waiver Application to CMS to continue the coverage of Legally Responsible Individuals (LRIs) as paid caregivers under the State’s EPSDT program following the expiration of 1135 waiver authority and end of PHE. New Mexico’s application remains under CMS review.

Appendix Ks

Following is a comprehensive listing of approved Appendix Ks by waiver request:

1915c Waivers (Medically Fragile, Mi Via, and Developmental Disabilities)

- Exceeding service limitations (i.e., allowing additional funds to purchase electronic devices for members, exceeding provider limits in a controlled community residence and suspending prior authorization requirements for waiver services, which are related to or resulting from this emergency).
- Expanding service settings (i.e., telephonic visits in lieu of face-to-face and provider trainings also done through telehealth mechanisms).
- Permitting payment to family caregivers.
- Modifying provider enrollment requirements (i.e., suspending fingerprinting and modifying training requirements).
- Reducing provider qualification requirements by allowing out-of-state providers to provide services, allowing for an extension of home health aide supervision with the ability to do the supervision remotely.
- Utilizing currently approved Level of Care Assessments to fulfil the annual requirement or completing new assessments telephonically.
- Modifying the person-centered care plan development process to allow for telephonic participation and electronic approval.

On April 13, 2023, New Mexico received CMS approval through an Appendix K amendment to terminate the following flexibilities effective March 31, 2023:

- Telehealth visits for occupational therapy, physical therapy, speech and language therapy, behavior support consultation, case management, consultant, and community support coordinator services, adult nursing, nutritional services, supported living, intensive medical living, community integrated employment, and customized community supports;
- Payments to relatives and legally responsible individuals for supported living, intensive medical living, community integrated employment, and customized community supports;
- Suspension of fingerprinting required for enrollment;
- Suspension to conduct a neglect investigation;
- Provision of community customized supports and employment services in the home; and
- Exceptions for home studies and family living service coordinator monthly visits via telephonic/tele-video modalities.

Additionally, flexibilities for level of care evaluations/re-evaluations were terminated and normal processes resumed effective June 30, 2023. The initiatives were terminated to return to normal operations as approved in base waivers.

1115 Demonstration Waiver for Home Community Benefit Services (HCBS)

- Expanding service settings (i.e., telephonic visits in lieu of face-face and provider trainings through telehealth mechanisms.).
- Permitting payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver.
- Modifying provider qualifications to allow provider enrollment or re- enrollment with modified risk screening elements.
- Modifying the process for level of care evaluations or re-evaluations.
- Modifying person-centered service plan development process to allow for telephonic participation and electronic approval.
- Modifying incident reporting requirements.
- Allowing for payment of services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
- Implementing retainer payments for personal care services.
- Expanding Community Benefit slots by 200, bringing the total number of slots to 5,989.

On May 11, 2023, New Mexico submitted a COVID-19 PHE 1115 Demonstration Waiver Application to CMS to continue the coverage of Legally Responsible Individuals (LRIs) as paid caregivers under the State's Community Benefit program following the expiration of Appendix K authority. New Mexico's application remains under CMS review.

1915c (Supports Waiver and Developmental Disabilities Waiver)

- Modifying provider qualifications to suspend fingerprint checks or modify training requirements.
- Modifying processes for level of care evaluations or re-evaluations.
- Temporarily modifying incident report requirements for deviations in staffing.
- Temporarily allowing for payment of services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
- Allowing flexibility of timeframes for the CMS 372, evidentiary package(s), and performance measure data collection.
- Adding an electronic method of service delivery allowing services to continue to be provided remotely in the home setting.

- Allowing an option to conduct evaluations, assessments, and person- centered service planning meetings virtually in lieu of face-to-face meetings and adjusting assessment requirements.
- Modifying incident reporting requirements.
- Clarifying the effective dates in section (f.) to temporarily increase payment rates with effective dates 3/16/20 – 9/30/20 for supportive living, intensive medical living, and family living as approved in NM.0173.R06.03.

1915c (Developmental Disabilities Waiver, Medically Fragile Waiver, Mi Via Waiver, and Supports Waiver)

- Additive to previously approved Appendix Ks, extending the anticipated end date to six months after the end of the PHE.
- In accordance with Section 9817 of the American Rescue Plan (ARP) Act of 2021 and New Mexico's approved Spend Plan, New Mexico received Appendix K approval to temporarily increase payment rates by 15% from May 1, 2021 to June 30, 2022.
- Beginning July 1, 2022, temporarily increasing Assistive Technology benefit limits from $500 to $750; increasing HCBS Environmental Modifications benefit limits from $5,000 to $6,000 every five years; and implementing various rate increases for the identified waiver services within the Appendix K.

PATIENT CENTERED MEDICAL HOMES (PCMH)

HSD's PCMH initiative continues to expand under Centennial Care 2.0 and supports HSD's commitment to improving health outcomes, improving service delivery, and reducing administrative burdens. The MCOs work with contract providers to implement PCMH programs to build better relationships between members and their care teams.

HSD receives quarterly reports from the MCOs that detail the number of members within the MCO that are paneled to a PCMH as well as the initiatives to promote participation in the PCMH service delivery model.

Table 4 below reports the total number of members paneled to a PCMH per MCO. DY10 Q1 reflects an overall aggregate increase of 12,406 members receiving care through a PCMH compared to DY9 Q4. The DY10 Q2 data will be reported in the DY10 Q3 CMS Quarterly Monitoring Report.

Table 4: PCMH Assignment

PCMH ASSIGNMENT				
Total Members Paneled to a PCMH				
	DY9 Q2	DY9 Q3	DY9 Q4	DY10 Q1
BCBS	135,065	156,969	154,635	167,746
PHP	277,943	272,903	271,339	269,447
WSCC	37,344	36,433	37,129	38,316
Percent of Members Paneled to a PCMH				
	DY9 Q2	DY9 Q3	DY9 Q4	DY10 Q1
BCBS	45.30%	51.90%	51.20%	55.30%
PHP	65.30%	63.90%	63.60%	62.80%
WSCC	42.30%	40.20%	39.80%	40.10%

Source: MCO Report #48 DY10 Q1

MCO PCMH initiatives:

BCBS: BCBS uses measures which include an array of transitions of care programs including a growing team of care coordinators, community health workers and the paramedicine program to engage members. These programs are established for outreach to members who have high emergency room utilization. Care coordinators help with transitions of care where they assist with care plans once a member returns home, finds services and resources in the member's community, help with medications after the member leaves the hospital, assists in arranging transportation to appointments, and visits with the member when they return home from the hospital. BCBS also has a community health workers program that provide home visits and well checks, arranges rides to medical appointments and provides health education after members are identified as high utilizers in the emergency room.

PHP: Throughout DY10 Q1, PHP's Value Based Purchasing (VBP) team met with PCMH groups to review quality measures, addressed ways to close member gaps, discussed ways to eliminate barriers to care, and shared best practices. In order to help reduce ER utilization rates, some groups have extended office hours to accommodate patients after 5pm, as well as provide abbreviated weekend hours for acute care. VBP Program Managers are working with PCMH groups on population health initiatives such as providing education on health equity topics which include Perinatal Health Equity, Transgender 101, Domestic Violence/Intimate partner violence, and Cultural Fluency. PHP continues to review the available patient resources with providers such as care coordination, transportation, member incentives as well as provider education on quality measure details to expand support for members.

WSCC: WSCC's Performance Improvement Team assists with developing best practice interventions that support priority measures to impact member care. WSCC's use of mPulse mobile engages members via text messaging providing education around Emergency Department (ED) visits and the importance of follow-up visits with their health care team. To ensure optimal care, WSCC conducts interdisciplinary rounds with clinical and non-clinical staff to review and assist members who are identified through claims as high utilizers, including those with hospital readmissions. WSCC's Member Connections team identifies members with greater than four ED visits within the last 30 days or who have co-existing mental health or substance use disorders or dependence, so further assistance can be provided for these members. Additionally, WSCC is facilitating the use of local community-based resources to assist with self-care of their condition(s). This group offers education on the correct use of ED services, aids with navigating the health care system, and collaborates with the member's health care team to effectively outreach to members.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities	
DY10 Q2	HSD continued to monitor MCO enrollment and member engagement through the quarterly Care Coordination Report. This report includes data related to completion of required assessments and touchpoints within contract timeframes. The DY10 Q2 report contains data from DY10 Q1. DY10 Q2 data will be reported in DY10 Q3. The MCO aggregate results show performance benchmarks of 85% were met, or exceeded, for timely completion of Health Risk Assessments (HRAs) for 'new to Medicaid' members, members with a change in health condition, Comprehensive Needs Assessments (CNAs), and Comprehensive Care Plans (CCPs). The aggregate completion rate for HRAs for 'new to Medicaid' members remained at 97% in DY9 Q4 and DY10 Q1.The aggregate completion rate for HRAs for members with a 'change in health condition' remained at 99% in DY9 Q4 and DY10 Q1. Aggregate completion percentages for CNAs for CCL2 members decreased from 94% in DY9 Q4 to 90% in DY10 Q1. Aggregate completion percentages for CNAs for CCL3 members also decreased from 91% in DY9 Q4 to 86% in DY10 Q4. MCOs stated that member driven delays were the primary driver for the decrease in timely completion of CNAs in DY10 Q1. HSD rescinded the in-person exception for CNAs in DY10 Q1, which created some member frustration. Members requested exceptions to the in-person requirements and rescheduled multiple times prior to agreeing to meet in-home, in-person. MCOs conducted additional outreach and education with members to alleviate any questions or concerns. Aggregate completion percentages of CCPs for CCL2 members decreased from 96% in DY9 Q4 to 94% in DY10 Q1. CCPs for CCL3 members decreased from 97% in DY9 Q4 to 95% in DY10 Q1. In DY10 Q1, BCBS initiated a process improvement project to streamline CCP completion, decrease the completion time, allow for more detail, and be more member centric. BCBS will provide updates on the project successes in DY10 Q2.

	The Care Coordination Report includes MCO strategies for engaging and retaining members. In DY10 Q1, MCOs reported on multiple strategies for engaging and retaining members. In DY10 Q1, MCOs reported on multiple strategies to retain engagement with members, many who have never had face to face interactions with their care coordinators due to the PHE. BCBS reinstituted driving by member homes and placing door hangers to remind members of upcoming touchpoints and visits. BCBS has also expanded their Special Beginnings Program for pregnant members, enrolling over 600 members in their Finity Baby Smart program to date. A special focus has been on Social Determinants of Health and enhancing their value-added services. PHP began an initiative with a local EMS service to outreach and provide education to members who utilize the ER for low acuity needs. These members then receive a warm transfer to PHP's Care Coordination staff. WSCC expanded their JUST Health Connect Program, which makes Wi-Fi tablets available to their members who are incarcerated. Members are able to connect and meet with their WSCC care coordinator virtually face-to-face for assessments and touchpoints prior to release. WSCC initiated a process to identify and improve drivers of consumer satisfaction with their health plan. WSCC has bi-weekly workgroups and targeted staff trainings to focus on members' Social Determinants of Health needs and review any Health Equity and Disparities identified. HSD continues to monitor strategies and interventions for all MCOs to retain and increase compliance with performance benchmarks. The table below details aggregate and individual MCO performance for DY9 Q2 through DY10 Q1. DY10 Q2 data will be reported in DY10 Q3.

Table 5 – Care Coordination Monitoring

MCO Performance Standards	DY9 Q2	DY9 Q3	DY9 Q4	DY10 Q1
HRAs for new Members	**97%**	**97%**	**97%**	**97%**
BCBSNM	98%	98%	97%	97%
PHP	96%	97%	96%	96%
WSCC	100%	100%	100%	100%
HRAs for Members with a change in health condition	**99%**	**98%**	**99%**	**99%**
BCBSNM	100%	100%	100%	99%
PHP	99%	96%	98%	98%
WSCC	100%	100%	100%	100%
CNAs for CCL2 Members	**95%**	**95%**	**94%**	**90%**
BCBSNM	90%	92%	89%	88%
PHP	98%	97%	96%	90%
WSCC	99%	99%	99.80%	99.70%
CNAs for CCL3 Members	**93%**	**93%**	**91%**	**86%**
BCBSNM	87%	88%	86%	86%
PHP	96%	95%	93%	85%
WSCC	100%	100%	100%	100%
CCPs for CCL2 Members	**95%**	**96%**	**96%**	**94%**
BCBSNM	87%	89%	88%	85%
PHP	99%	99%	99%	99%
WSCC	98%	99%	98%	96%
CCPs for CCL3 Members	**96%**	**96%**	**97%**	**95%**
BCBSNM	91%	88%	89%	86%
PHP	99%	99%	100%	99%
WSCC	97%	98%	98%	96%

Source: HSD DY10 Q1 Report #6 –Care Coordination Report
Percentages in bold are MCO aggregate of the total assessments due and completed.

In DY10 Q1, HSD discontinued monitoring the ongoing impact of the PHE and engagement of members in Care Coordination through a bi-weekly 'Telephonic In-Lieu of Face-to-Face Visits' report as a result of rescinded the in-person exception for CNAs in DY10 Q1. The report monitored compliance of the MCOs' use of telephonic and video visits for CNAs and

required touchpoints. The report identified whether MCOs were able to continue to provide Care Coordination by completing assessments and touchpoints for members telephonically.

Care Coordination Audits

In DY10 Q1, HSD monitored MCO compliance with contract and policy by continuing to conduct Care Coordination audits. These audits monitor:

- Whether members listed as Difficult to Engage (DTE), Unable to Reach (UTR) or Refused Care Coordination (RCC) have been correctly categorized: Care Coordination Categorization Audit.
- Verification that Transition of Care (TOC) plans for members transitioning from an In-Patient (IP) hospital stay or Nursing Facility (NF) to the community adequately address the members' needs, including the need for Community Benefits: Transition of Care Audit.
- Confirmation that members are being correctly referred for a Comprehensive Needs Assessment (CNA) if triggered by a completed Health Risk Assessment (HRA): Health Risk Assessment and Care Coordination Level Audit.
- Placement of members in the correct Care Coordination Level (CCL), based on information in the CNA and criteria outlined in contract: Health Risk Assessment and Care Coordination Level Audit.

HSD audits the files, reviews, and analyzes the findings, and submits reports of the findings to each MCO. Based on the audit findings and recommendations provided by HSD, the MCOs conduct additional outreach, re-assess members, and provide targeted training to Care Coordination staff.

HSD audits 15 member files per category, per MCO, for a total of 45 DTE, 45 UTR, 45 RCC, 30 HRA, 30 CCL, 30 TOC from In-Patient (IP) to community, and 30 Nursing Facility (NF) to community.

The Care Coordination Categorization Audit cadence has been changed from quarterly to annually due to achieved MCO compliance. DY10 data will be reported to CMS in DY11 Q1.

The table below details the Transition of Care (TOC) Audit results for DY10 Q1. DY10 Q2 data will be reported in DY10 Q3.

Table 6 - Transition of Care Audit

Transition of Care	DY9 Q2	DY9 Q3	DY9 Q4	DY10 Q1
In-Patient	**99%**	**91%**	**91%**	**99%**
BCBS	100%	98%	90%	97%
PHP	98%	91%	89%	99%
WSCC	100%	83%	95%	100%
Nursing Facility	**99%**	**88%**	**93%**	**96%**
BCBS	99.70%	100%	95%	98%
PHP	99%	90%	100%	100%
WSCC	97%	75%	85%	90%

Source: HSD DY10 Q1 Quarterly TOC Audits
Percentages in bold are MCO averages.

The aggregate compliance for IP to Community TOC files increased from 91% in DY9 Q4 to 99% in DY10 Q1. The aggregate compliance for NF to Community TOC audited files increased from 93% in DY9 Q4 to 96% in DY10 Q1.

HSD noted that areas that needed improvement from DY9 Q4 had improved, such as TOC Plans including all required elements and increased coordination with discharge planning teams.

Areas that needed improvement were related to:

- Insufficient or conflicting documentation;
- Post discharge assessments not including all required elements; and
- Assigned Care Coordination Levels not aligning with MCO to HSD Interface File data.

HSD provided detailed findings, reiterated contract requirements, and stressed the importance of comprehensive documentation. Additionally, HSD met with each MCO at monthly meetings and discussed the findings. BCBS' IP audit scores increased from 90% in DY9 Q4 to 97% in DY10 Q1 primarily due to improved documentation. BCBS' NF audit scores increased from 95% in DY9 Q4 to 98% in DY10 Q1 also due to improved documentation as well as timely coordination with discharge planning teams. PHP's IP audit scores increased from 89% in DY9 Q4 to 99% in DY10 Q1 due to improved documentation and the inclusion of all required elements in their TOC Plans. PHP's NF scores remained at 100% in DY9 Q4 and DY10 Q1. HSD acknowledged PHP's revised assessment templates, which were succinct and included all required elements. WSCC saw an increase in IP

scores from 95% in DY9 Q4 to 100% in DY10 Q1 and an increase in NF files from 85% in DY9 Q4 to 90% in DY10 Q1. WSCC audit scores reflected excellent documentation; however, a number of files included excessive documentation outside of the audit parameters. WSCC acknowledged the validity of audit findings and agreed to conduct additional oversight on documents included in member files to be audited prior to submission.

HSD has tracked TOC compliance through quarterly audits since DY6 Q1 and has seen significant improvement in all aspects of compliance with TOC requirements. Coordination with IP Discharge Planning teams continues to be a challenge due to the limited time members are in the IP prior to discharge. MCOs have dedicated teams assigned to hospitals in order to increase coordination and engage with members quickly. Additionally, clear and comprehensive documentation has improved significantly yet remains an area that requires continual targeted training. MCOs conduct documentation training for all staff, each quarter, as well as targeted training for staff that need additional assistance.

The table below details the Health Risk Assessment and Care Coordination Level Audit results for DY10 Q1. DY10 Q2 data will be reported in DY10 Q3.

Table 7 - Health Risk Assessment and Care Coordination Level Audit

HRA/CCL Audit	DY9 Q2	DY9 Q3	DY9 Q4	DY10 Q1
Health Risk Assessment (HRA)	**99%**	**99%**	**99%**	**95%**
BCBS	99.70%	99%	99%	99%
PHP	99%	100%	99%	100%
WSCC	99%	98%	99%	86%
Care Coordination Level (CCL)	**100%**	**96%**	**95%**	**97%**
BCBS	99.70%	100%	93%	99.70%
PHP	100%	100%	94%	99.70%
WSCC	99.60%	88%	99%	92%

Source: HSD DY10 Q1 HRA and CCL Audits
Percentages in bold are MCO averages

Results of the HRA Audit showed that the MCOs consistently met all contract requirements when completing HRAs. HSD noted that aggregate rates of compliance decreased from 99% in DY9 Q4 to 95% in DY10 Q1. BCBS remained at 99% compliance in DY9 Q4 and DY10 Q1 while PHP increased from 99% in DY9 Q4 to 100% in DY10 Q1. WSCC saw a decrease in compliance from 99% in DY9 Q4 to 86% in DY10 Q1 due to several files being

submitted either outside of the audit parameters or with an incorrect member included in the file. WSCC acknowledged the validity of the audit findings, noted an issue with their TruCare system, and ensured future audit files will have additional oversight prior to submission.

Aggregate rates of compliance for the CCL Audit increased from 95% in DY9 Q4 to 97% in DY10 Q1. Both BCBS and PHP showed increased compliance from DY9 Q4 to DY10 Q1. WSCC saw a decrease from 99% in DY9 Q4 to 92% in DY10 Q1, again primarily due to an incorrect assessment being submitted for audit. WSCC acknowledged the audit findings and requested to resubmit the correct assessment; however, HSD did not conduct an additional audit. Therefore, the audit score was unchanged.

Care Coordination CNA Ride-Alongs

HSD conducted 3 CNA ride-alongs with MCO care coordinators in DY10 Q1 to observe completion of member assessments.

HSD attended annual CNAs conducted by BCBS, PHP, and WSCC.

HSD determined whether care coordinators properly administered the Community Benefits Services Questionnaire (CBSQ) and the Community Benefits Member Agreement (CBMA) to ensure that members had appropriate access to Community Benefits.

HSD provided written feedback to the MCOs on the following findings:

- Care coordinators adhered to all contractual responsibilities in their assessments;
- Care coordinators were kind, thorough, and professional with the members;
- HSD noted care coordinators employing motivational interviewing with members;
- Care coordinators often went beyond contract requirements to assist members with locating and applying for additional resources and services; and
- Care coordinators and members were adjusting to a return to in-home, face-to-face assessments after several years of conducting them virtually. Both the care coordinators and members had positive feedback and expressed feeling an in-person assessment was beneficial.

Care Coordination HRA Ride-Alongs

HSD conducted 9 virtual HRA ride-alongs with MCO care coordinators in DY10 Q1 to observe completion of member assessments. All HRAs observed were conducted telephonically.

HSD provided written feedback to the MCOs on the following findings:

- The majority of Assessors were friendly, thorough, and professional with the members;
- Assessors often explained to members that they could request care coordination in the future if they would like assistance;
  - Assessors referred members to resources to address specific concerns;
  - Assessors provided warm handoffs to customer service staff for needs such as additional insurance cards or to care coordination staff to schedule their Comprehensive Needs Assessment; and
  - HSD noted opportunities for improvement that included:
    - Ensuring that Assessors explain the purpose of the HRA;
    - Ensuring that Assessors thoroughly explain the services available through care coordination;
    - Ensuring all contract required topics are addressed in HRA; and
    - Ensuring assessments are thorough without being overly lengthy.

Care Coordination All MCO Meetings

HSD conducts regular quarterly meetings with all MCOs to review data on member engagement, care coordination timeliness, performance analysis, and member outcomes. HSD held the DY10 Q1 Quarterly Meeting on March 22, 2023 and reviewed the below.

- Aggregate data from the following reports related to enrollment and compliance with assessment and touchpoint timeliness:
  - Care Coordination Report;
  - Children in State Custody (CISC) Report;
  - Comprehensive Addiction and Recovery Act (CARA) Report; and
  - Utilization Report.
- Aggregate data from the Care Coordination and Children in State Custody Performance Measures (CC and CISC PMs).
- Results of the DY9 Q4 audits of member categorization, HRAs, CCLs, and compliance with Transition of Care TOC requirements.
- Results of the DY9 Q4 audits of CISC HRAs and CCLs.

HSD requested the MCOs present on projects and initiatives implemented to address Social Determinants of Health (SDoH) and the effectiveness of care coordination.

- BCBS presented information related to their Member Care Fund (MCF) which is designed to align with the healthypeople.gov national plan to improve health and well-being over the next decade. The BCBS MCF targets include access to basic services, engagement in care coordination, providing continuity of care, and supporting members through various transitions. BCBS' fund directly supports a member's SDoH

by providing assistance for clothing, emergency housing, food, hygiene and wellness items, and basic health care items not covered by insurance. BCBS' Community Social Services Department includes Community Health Workers, Housing specialists, Community Paramedicine providers, and additional Value-Added Services. BCBS has provided 128 unique members, to date, with services through this program and seen increased need in DY10 Q1.

- PHP provided information on their partnerships with agencies across the state for services such as healthy food programs, pest control, home repair, diabetes management, housing needs, and utility assistance. PHP has 34 Community Health Workers and 10 Peer Support Specialists throughout the state that are trained to screen for SDoH needs and provide all available services. SDoH needs are incorporated into all of their assessments and member plans.
- WSCC presented information on their Picks Health mobile application that is available at no cost to their members and addresses social isolation and loneliness. In addition to self-screening tools, games, and a virtual companion pet, members can access a 24/7 warm line that assists the member in referrals to needs such as housing, transportation, and food. WSCC currently has 725 members engaged with this service and has taken 1,493 calls for support since go-live in DY9 Q3. WSCC also discussed their successful baby showers that bring together expectant parents for information, games, and baby supplies. WSCC is able to engage expectant parents during these events and assist them in securing all needed prenatal appointments.

HSD also meets individually with each MCO twice per quarter to address care coordination issues related specifically to their MCO. In DY10 Q1, meeting topics included:

- Discussion on the effectiveness of claims/data mining processes;
- Barriers to collaboration with Permanency Planning Workers for Children in State Custody;
- Challenges in contracting with providers for full and shared delegation care coordination;
- Discussion of the use of the Treat First Model of Care for members with a Comprehensive Addiction and Recovery Act (CARA) Plan of Care;
- Audit findings and changes to the cadence of audits;
- Additional Information from BCBS on their transportation services for Tribal communities;
- Discrepancies with PHP's and WSCC's CCLs for members accessing services through the Developmental Disabilities Waiver; and
- Discussion on the benefits and utilization of HSD's Clinical Decision Support System, PRISM.

BEHAVORIAL HEALTH

The Behavioral Health Services Division (BHSD) continues to maintain and expand critical behavioral health services established during the COVID-19 public health emergency. Telehealth continues to expand and be one of the greatest resource improvements, expanding capacity by reaching those in the most rural and frontier areas of the state.

In DY10 Q1, a total of 33,557 Medicaid Members received behavioral health services through telehealth. This quarter's total did see a slight decrease of 4.9% compared to the DY9 Q4 total of 35,297 persons served through this medium. Of those served in DY10 Q1 through telehealth, 13,559 persons reside in rural or frontier counties. This accounts for 40%of those served and is reflective of client and provider preferences and the high value of telehealth in New Mexico's rural and frontier landscapes.

Service delivery over telephonic means continues to see growth. In DY10 Q1, 22,134 members received services through this modality compared to 23,578 in DY9 Q4 which is a decrease of 1,444 people or 6.1%. As the timing of this report occurs soon after the end of the quarter, the results reported at this time are not final for telehealth or telephonic services, and will be refreshed next quarter when claim lag is no longer present; therefore, the result of those served during DY10 Q1 will likely increase. BHSD continues to evaluate which behavioral health services are appropriate to continue delivery through telephone when the public health emergency is over. This option has undoubtably been a critical link to services during the COVID-19 crisis.

All MCOs reported significant increases in telehealth services to all age groups, in urban, rural, and frontier counties, and to all populations of Serious Mental Illness (SMI), Severe Emotional Disturbance (SED), and substance use disorder (SUD) clients during the COVID-19 pandemic. As there is a draw to close from the pandemic era, the utilization of telephonic services has stabilized from their highs in 2020 through mid-2022. As telephonic utilization continues, behavioral health providers around the state continue to report qualitative improvements – a decline in no-shows and cancellations, clients less stressed because they have not had to leave their homes or children, and therapists more informed about their clients because they can see more of their lives.

TREAT FIRST

As depression, anxiety and other behavioral health needs surge from the stresses related to COVID-19, Treat First engages clients quickly in services that address their immediate needs. The 36 certified Treat First agencies have seen over 2,300 new clients during the first six months of 2023. With support from the Treat First agencies, 38.3% of these individuals were able to resolve their issues with solution focused interventions within 4

visits. The balance of those clients continued in services. The “No Show” for clients in this period was very low, only 9.4%. This is impressive particularly during the pandemic and significantly lower than before agencies started the Treat First Approach.

When youth or adults were asked how they felt their Treat First visits were going, on average, both groups felt that the sessions were working very well to address their immediate needs. Youth rated sessions at 94% and Adults at 89.2%.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an important evidence-based tool that can be used by virtually all primary care providers to identify problematic alcohol or drug use, depression, or trauma, and then refer a patient for additional treatment if appropriate. SBIRT was added to the state’s Medicaid program for the first time in 2019, and since then, BHSD has conducted expanded outreach to providers as well as state-sponsored provider trainings around the state.

In DY10 Q1, SBIRT utilization increased 6.3% to 1,596 persons served during the quarter compared to 1,501 in DY9 Q4. The increased utilization of SBIRT is also noted in DY10 Q1 when compared to the same quarter of the prior year, where 1,493 persons were served, when compared to the current results, there was a 6.9% increase from that period.

On a monthly average, 586 persons received SBIRT in DY10 Q1 with the greatest utilization occurring in March with 659 persons screened. The current utilization trend in SBIRT for DY10 is greater than any of the DY9 quarterly results thus far; however, the trend may change as seen over prior years reporting.

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

The Centennial Care 2.0 program includes new and expanded services for Medicaid recipients with Substance Use Disorder (SUD). In DY9, the State continued efforts to implement Crisis Treatment Centers (CTC). Provider-specific cost-based rates are established for 3 CTC providers in the state and are now delivering in-patient and outpatient CTC services. Expansion of CTCs continues as the state expands the 988 Crisis Now initiatives. In DY10 the State continues to explore additional models for crisis receiving and stabilization services such as a Community Crisis Partner whereas services are embedded within and emergency department or a Crisis Calming Center. A Crisis Calming Center is a space set up to be utilized when needed such as a hotel room, firehouse, or outpatient clinic.

In DY9, HSD continues to focus on expanding other services that are key to addressing SUD, such as Intensive Outpatient Services (IOP) and Comprehensive Community Support Services (CCSS).

As part of the SUD 1115 Waiver, services have been approved for specific substance abuse populations in an Institution for Mental Disease (IMD). An IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating SUD that is not part of a certified general acute care hospital. HSD has expanded coverage of recipients ages 22 through 64 to inpatient hospitalization in an IMD, for SUD diagnoses only, with criteria for medical necessity, and based on American Society of Addiction Medicine (ASAM) admission criteria. Covered services include withdrawal management (detoxification) and rehabilitation.

In DY10 Q1, the total number of persons served with a SUD in an IMD was 3,704, which is an increase of 189 persons (or 5.38%) compared to DY9 Q4. When comparing DY10 Q1 result to the same quarter of the prior year, the increased utilization also shows an increase of 88 more persons served (or 2.43%). As the latest trend for DY10 shows marginal increases compared to DY9, the results will continue to be reviewed and analyzed as the demonstration year continues.

SUD HEALTH IT

In DY10, HSD developed and maintain the necessary SUD Health IT capabilities and infrastructure to support member health outcomes and address the SUD goals of the demonstration. New Mexico SUD workgroup continues to review our Health IT plan to ensure the progress and support of each milestone.

Utilization of the New Mexico Prescription Monitoring Program (NM PMP) continues to increase the number of providers that are utilizing it with 89.52% of providers checking prescriptions, which is a 2.82% increase over the previous year at 87%. HSD continues to monitor with data as updated from the New Mexico Board of Pharmacy.

The New Mexico Fee for Service (FFS) Drug Utilization Review (DUR) conducted the DY10 Q2 meeting on April 12, 2023. Attendees included Board members and invited guests, including MCO representatives. Client counts for both FFS and MCO were reported with no significant changes in totals for FFS and MCO members and our state representative provided updates for the DUR Charter, and roles and responsibilities of board members. Active DUR newsletter reporting of the COVID, Diabetes, and Gabapentin DUR mailings were presented. The final outcomes summary for Ivermectin mailing was reported with results of significant decrease in ivermectin claims post mailing. SUPPORT ACT monitoring was presented including Metabolic Monitoring of Second-Generation Antipsychotics (SGA)

in Youth, and concurrent opioid usage with high-risk concurrent medication. Data from reporting of metabolic monitoring with antipsychotic treatment was warranted for a third quarter intervention for both adults and youth. Continued monitoring for Short Acting Bata Agonist (SABA) utilization was tabled.

Project ECHO continues to train providers, DY10 Q1 shows 163 case reviews. The number of sessions remain consistent. HSD released a Supplement to providers outlining the reimbursement opportunities to attend and continue case reviews. Additionally, advertising for these sessions continues to expand to multiple websites and list-serves (recruitment listings). In DY10 Q2, New Mexico continued to work with Project ECHO on Hepatitis C Treatment in New Mexico.

The New Mexico Bridge Project continues to expand its training on prescribing for Opioid Use Disorder (OUD) for hospital emergency departments, inpatient, and related clinics throughout the state. The New Mexico Bridge team conducts live trainings at hospitals and provides a virtual training series for hospitals and community members. The Project has engaged with 10 hospitals since its inception in 2021. These hospitals have completed various stages of engagement and implementation. These include Holy Cross Medical Center, Gallup Indian Medical Center, Socorro General Hospital, and Memorial Medical Center. These four have started prescribing buprenorphine. The other four hospitals we have begun engagement with and/or training include Plains Region Medical Center, Northern Navajo Medical Center, Gerald Champion Medical Center, University of New Mexico Hospital, Lovelace Women's Hospital, and UNM Sandoval Regional. These hospitals serve patients in/from both rural and urban settings. In the April to June 2023 timeframe, we continue to work with UNM and Socorro. Additionally, support to Lovelace Women's Hospital has been a main focus in this period. The trainings include buprenorphine initiation, responsible opioid prescribing, treatment in clinic settings, SUD and pregnancy, neurobiological basis of SUD, case reviews, toxicology updates, fentanyl updates, and more. We also presented on the NM Bridge program to a national audience on June 16th for the Substance Abuse and Mental Health Services Administration, State Opioid Response Webinar series. More information on the Project can be found here: www.nmbridge.com. We continue to reach out statewide to encourage engagement. We are scheduled to present at the upcoming New Mexico Hospital Association on Sept 27th, and we will update on the next reporting.

To further support all prescribing practitioners working with individuals with opioid use disorders and other substance use disorders, the University of New Mexico's poison center continues to provide a 24/7/365 call-in center for prescribing practitioners to assist with complex cases.

The Emergency Department Information Exchange (EDIE) is utilized by all hospitals, behavioral health homes, and managed care organizations. It contains a medication history for each registered patient and sends a real time message to all enrolled organizations as to a patient's emergency department visit. This triggers care coordinators to act on transitional services or other needed assistance.

HSD and vendors for the new MMIS continue to design and implement enhanced data analytics in 2023. Smart phone apps are part of the MMIS unified public interface (UPI). HSD and vendors for the new MMIS continue to design and implement smart phone capabilities (UPI) in 2024. This initiative will assist in retention or treatment for OUD and other SUDS. HSD and vendors for the new MMIS are also designing and implementing data services to provide analytics for public health and clinical support for providers, which is in progress.

ADULT ACCREDITED RESIDENTIAL TREATMENT CENTERS (AARTC) SERVICES

During DY10 Q2, there is one AARTC provider application currently in review awaiting pending documents to be submitted before granting approval. One application got approved, received a provisional letter, and is now under rate development. Two approved provider applications from DY9 Q4 completed their rate development process in DY10 Q2 and are now in the process of contracting with the MCOs. A total of twenty AARTCs provider applications have been approved since the onset of the AARTC provider application process (multiple providers have multiple locations).

Table 8 – AARTC Client Counts

MEDICAID CLIENT COUNTS				
PROVIDER #	**DY9 Q3**	**DY9 Q4**	**DY10 Q1**	**DY10 Q2**
716	0	0	0	0
090	69	61	65	58
037	351	309	322	343
081	12	11	14	5
589	13	9	8	5
332	48	31	26	0
049	19	28	54	21
825	5	1	30	24
896	13	3	0	0
302	105	90	105	88
60	NA	15	27	33
760	NA	11	17	14
Unduplicated Total	**635**	**569**	**668**	**591**

Source: Medicaid: Medicaid Data Warehouse & Non-Medicaid: BHSD Star/Falling Colors

There are 14 AARTC's in operation, approved to bill Medicaid. The data above identifies the total number of clients who received AARTC services during DY10 Q1 and DY10 Q2. Client counts are impacted by a claim lag of up to 120 days following the end of the recent quarter. The provider number is a unique identifier and is used to correlate the number of members seen by each provider for each quarter. Providers who were not approved to bill Medicaid for previous quarters have NA in the data field to represent this. Although 12 provider sites are represented in the chart above, provider 037 has three sites that are being represented through their 037 data. All AARTC provider sites are actively in process to receive distinct identification numbers to ensure accuracy in client counts for each site.

The utilization of the Medicaid services illustrates a decrease from 668 in DY10 Q1 to 591 in DY10 Q2 of clients served, which may be attributed to the 90-day claim lag submitted for DY10 Q1 and DY10 Q2. It is expected that numbers will fluctuate as actual counts are adjusted to account for claims lag. Further analysis is warranted to ensure counts are accurately reported and represented for those providers. The table reflects refreshed numbers in all quarters.

HSD continues discussing next steps to developing AARTC rates. Rates are being assessed by acquiring one full year of utilization by each provider with a review of expenditure data collected to determine the actual costs of operation. Three providers have completed the re-base process. Interim rates will then be adjusted to ensure AARTCs services are appropriately supported and funded.

HEALTH HOMES (HHs)

The CareLink New Mexico Health Homes (CLNM) program provides integrated care coordination services to Medicaid-eligible adults with the chronic conditions of substance use disorder (SUD) and serious mental illness (SMI), and to children and adolescents with diagnoses in the spectrum of severe emotional disturbance (SED). In addition to SMI, SUD, and SED, many members have diagnoses of co-occurring physical health conditions which drives the integrated care and "whole person" philosophy and practice. What is also indicative of whole person care is the concept of the individual as a collaborative participant in planning for care that is based on their preferences, needs, and values.

The CLNM HHs have 5 goals: 1) Promote acute and long-term health; 2) Prevent risk behavior; 3) Enhance member engagement and self-efficacy; 4) Improve quality of life for individuals with SMI/SED/SUD; and 5) Reduce avoidable utilization of emergency .department, inpatient, and residential services. These goals have guided the services within the CLNM HHs. The services are recorded in an automated system, BHSD Star, and success is measured through pre-determined parameters, HEDIS quality indicators, and

member surveys.

CareLink Health Homes (CLNM) Activities	
DY10 Q2 Activities	Health Home activities remain stable with the search for staff still very challenging. For this reason, membership has not grown. For those health homes that also served very compromised youth, they have had much success with High Fidelity Wrap Around (HFW). At this time, these services will be leaving the health homes and moving to a new program High Fidelity Wrap (HFW) that was approved in New Mexico's Medicaid 1115 Demonstration Waiver Amendment #2 under Centennial Care 2.0. This planning phase for HFW has also curtailed referrals to previously active HFW agencies. The CLNM Steering Committee has made plans to begin annual site visits to evaluate the quality of CLNM protocols, case reviews and membership through chart review, evaluation reports from CLNM's IT system, and conduct staff interviews. Where there is a decrease in statistics, CareLink NM health homes are made aware and are instituting corrective actions. Planning is underway to support Carelink NM (HH) providers in the national annual HH core set FY25 mandatory reporting requirements. Continued Evaluation is underway to replace the child/adolescent comprehensive needs assessment with the nationally recognized Child and Adolescent Needs and Strengths assessment (CANS). This will require both education for our care coordinators and a replacement for our information technology solution, BHSD Star, which was developed for health homes. Another change affecting two of our health homes is the departure of the High-Fidelity Wraparound component of their agency. These sub-sections of the HH business will become part of a larger expansion of wraparound care through the recently approved Centennial Care 2.0 Waiver Amendment #2.

Table 9: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY9 Q3 JUL - SEPT	DY9 Q4 OCT - DEC	DY10 Q1 JAN - MAR	DY10 Q2 APR - JUNE
4,222	4,125	4,211	4,102
% CHANGE	% CHANGE	% CHANGE	% CHANGE
2.67%	2.30%	2.04%	2.59%

Source: NMStar, CLNM Opt-in Report.

HIGH FIDELITY WRAP

The High-Fidelity Wraparound (HFW) benefit in Centennial Care 2.0 provides intensive care coordination services for Medicaid eligible youth with complex behavioral health needs. The HFW program serves individuals diagnosed with Severe Emotional Disturbance (SED), who have functional impairment in two or more domains identified by the Child and Adolescent Needs and Strengths (CANS) tool, who are involved in two or more systems such as special education, behavioral health, protective services, or juvenile justice, and who are at risk for an out of home placement. An individual is considered at risk if the behavior, continued uninterrupted is likely to result in an out of home placement.

The goal of the HFW program is to provide intervention to individuals with the most complex behavioral health needs to reduce the occurrence of placement in higher levels of care, detention, hospitalization, or institutionalization. HFW was approved as part of the Centennial Care 2.0 demonstration effective March 28, 2023. Since that time the NM HFW Steering Committee, including representatives from the Human Services Department (HSD) Behavioral Health Services Division (BHSD) and Medical Assistance Division (MAD) as well as the Children Youth and Families Department (CYFD) has met weekly to review HFW provider certification applications as these providers transition from other funding sources to Medicaid enrolled providers. As part of this process, the HFW Steering Committee assesses the providers' readiness and adherence to the HFW model. The HFW Steering Committee also provides support and oversight on long-term strategies of the HFW model within the state including implementation and long-term objectives.

The HFW Steering Committee reviews provider applications to ensure that agencies interested in providing HFW services meet provider requirements and adherence to the HFW model. Additionally, as part of the implementation process, HSD and CYFD are in process of developing claims data, provider level, and MCO reports to monitor program requirements including eligibility criteria outlined in STC 69 as well as provider employee requirements. Additionally, HFW treatment plans will receive clinical review through CYFD.

While New Mexico's amendment to include HFW in its Medicaid 1115 Centennial Care 2.0 waiver was pending with CMS, the state made additional progress for statewide provision of HFW and moved into Phase Two in which all children who meet HFW eligibility may receive services regardless of custody status. On April 26, 2023, CYFD-BHSD issued a statewide Provider Alert to inform the New Mexico behavioral health community that HFW was seeking to increase the number of providers in New Mexico. It is the intent of NM to make Wraparound available to all children in need of this level of intensive care coordination, regardless of child welfare involvement.

HSD and CYFD are collaborating on the development of HFW performance measures as well as data report development. We anticipate draft measures to be available in October 2023.

SUPPORTIVE HOUSING

The supportive housing benefit in Centennial Care 2.0 provides Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program pre-tenancy and tenancy services. The Linkages program serves individuals diagnosed with serious mental illness with functional impairment who are homeless or precariously housed and are extremely low-income, per the Department of Housing and Urban Development (HUD) guidelines. Extremely low income is defined as a household income that falls at or below 30% Area Median Income (AMI); AMI varies by county. HUD posts AMI Income Limits for each county of every state annually.

Linkages agencies have been able to bill Medicaid for comprehensive community support services (CCSS), but since the H0044 supportive housing services inclusion in the Centennial Care 2.0 waiver, BHSD continues to strongly encourage Linkages providers to shift to billing the supportive housing benefit directly. The H0044 benefit reimburses at a higher rate than CCSS. The Centennial Care 2.0 waiver requires that the services be provided by a certified peer support worker (CPSW) to align with the state's goals for building the peer support workforce. One Linkages provider has 9 CPSWs assigned to deliver Linkages supportive housing services. Last quarter, this provider had 8 CPSWs, but hired a 9th CPSW this quarter. This provider has actively and consistently been utilizing the H0044 code for reimbursement since October 2019. A second Linkages provider has 3 CPSW full time positions, 2 are field staff and 1 is a supervisor/manager. This provider has 1 CPSW fully dedicated to Linkages supportive housing services; however, this CPSW submitted a resignation to be effective mid-July 2023. This provider's CPSW field staff who have been assisting with Linkages services with a focus on Linkages clients/members in need of support with Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) will next quarter shift fully to Linkages service delivery upon the departure of the CPSW who resigned; this CPSW also carries the CPSW supportive housing specialty endorsement status. This second provider has been utilizing the H0044 code for reimbursement since January 2022. A third Linkages provider hired 1 CPSW fully dedicated to rendering Linkages supportive housing services and another CPSW for a Community Support Worker position with a focus on Linkages supportive housing services in April 2023. Billing began for the new CPSW hire in June 2023. Last quarter, this provider had 2 existing staff members who were scheduled for the CPSW training in May 2023; both participated and are now scheduled to take their CPSW exam in August 2023. The third provider has been utilizing the H0044 code for reimbursement since December 2021. A fourth Linkages provider hired 1 CPSW in December 2021 and has been utilizing the H0044 code for reimbursement since July 2022. The delay with billing by the fourth provider was due to an MCO system issue with the modifier codes and required provider type; issues have since been resolved. A fifth Linkages provider recruited to hire a CPSW but did not find a CPSW

for their Linkages role; therefore, this provider is not currently able to bill H0044 due to the current provider eligibility guidelines. This provider, however, has built a housing bill code in their current electronic health records (EHR) system in preparation to bill upon hire of a CPSW and/or updates to the H0044 eligibility criteria to allow for Community Support Workers or Supportive Housing Coordinator roles. The Linkages providers that have secured a CPSW to render supportive housing services relative to H0044 have also updated their agency's EHR systems to allow for appropriate documentation and revised workflows to clarify the process for H0044 delivery and billing.

The remaining Linkages providers (6) continue to consider hiring CPSW staff for Linkages programming and/or are actively seeking CPSWs to hire. In the meantime, these providers are utilizing case managers, community support workers, and/or supportive housing coordinators to render the supportive housing services. There are 11 Linkages support service providers, and the interest of all providers not yet utilizing H0044 remains high and increases with the progress made by the providers who have established H0044 reimbursement. The BHSD Supportive Housing Coordinator and Supportive Housing Coordinator-Supervisor continue to support providers and work with the BHSD MCO Contract Managers and MCOs to ensure successful processing establishment and billing of H0044. MCOs submit quarterly Ad Hoc reports with H0044 encounters data.

The Office of Peer Recovery and Engagement (OPRE) accepts CPSW training applications, and all Linkages providers have been kept informed about CPSW training opportunities and receive the OPRE monthly newsletter. Providers have been encouraged to utilize the OPRE newsletter to post their open positions and recruit CPSW staff. OPRE has a list-serv of CPSWs available to providers to verify if a potential peer hire is certified. Also, OPRE has a Supportive Housing specialty endorsement, which is an additional training for CPSWs. The available list-serv indicates if CPSWs carry this specialty endorsement, which is not required for Medicaid billing, but helpful for those CPSWs involved with supportive housing services.

HSD continues to promote the use of CPSWs to render Linkages support services; however, Linkages providers and providers of other behavioral health services have experienced continued challenges with vacancies, transition, and maintaining filled positions. Providers continue to receive information, education, and training about the value of Medicaid reimbursement through H0044 via Supportive Housing trainings, the Linkages policy manual, ongoing technical assistance (TA) from the BHSD Supportive Housing Coordinator to include monthly check-ins with each provider, and quarterly Statewide Linkages meetings. The Linkages TA developed a "Getting Started with H0044" guide, which was distributed to all Linkages providers along with data to show the potential

monetary gain that could result from billing the code. The data includes information based on varying case load capacities and has served as a very useful promotional tool. The "Getting Started with H0044" guide is disseminated upon every inquiry about H0044 and to the entire Linkages provider network at least quarterly. Lastly, Linkages provider contracts since State Fiscal Year 2022 and currently include an item specific to Medicaid and H0044.

Table 10: Medicaid Supportive Housing Utilization

MEDICAID SUPPORTIVE HOUSING UTILIZATION (January 1, 2023 – June 30, 2023)			
DY10 Q1	DY10 Q2	DY10 Q3	DY10 Q4
49	70		
Unduplicated Total - 70			

Source: MCO Ad Hoc Quarterly Reports

As a result of legislative sessions, an increase of State General Funds (SGF) for State Fiscal Years (SFY) 2021, SFY2023, and SFY2024 have been and/or shall be applied to Linkages programming. The funding increases allow HSD to expand Linkages services that are not covered by Medicaid. HSD also utilizes these funds to support rental assistance vouchers for eligible Linkages clients. Since SFY2020, there has been an increase of 236 vouchers with increased SGF. In SGF 2024, the voucher capacity is 396; the voucher capacity was 338 in SFY2023. An individual does not need to be a Medicaid member to obtain a voucher or services; however, many Linkages clients are Medicaid members. Through this quarter in SFY2023, an average of 305 vouchers were issued or filled; a filled voucher means housing has been secured.

Since SFY2021 and currently, there are 8 Linkages sites. Effective in FY2024, Linkages policy includes an update that allows for providers to serve surrounding counties beyond their service areas, which supports program coverage expansion. Increased funding for FY2024 will support increased rent costs and motel/hotel vouchers for the period between issued and filled vouchers and for households that are literally homeless.

SERIOUS MENTAL ILLNESS (SMI)/SEVERE EMOTIONAL DISTURBANCE (SED)

On March 28, 2023, CMS approved New Mexico's SMI/SED waiver amendment request to enhance access to mental health services and continue delivery system improvements for these services. New Mexico's plan provides more coordinated and comprehensive treatment of Medicaid beneficiaries with SMI and SED. This demonstration will provide the

state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI and SED while they are short-term residents in residential and inpatient treatment settings that qualify as an Institutions for Mental Diseases (IMD). It will also support state efforts to enhance provider capacity, and improve access to a continuum of SMI/SED evidence-based services at varied levels of intensity.

The goals of the SMI/SED demonstration amendment are to:

1. Reduce utilization and lengths of stay in ED among beneficiaries with SMI/SED;
2. Reduce preventable readmissions to acute care hospitals and residential settings, while awaiting mental health treatment in specialized settings;
3. Improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED, including through increased integration of primary and behavioral health care; and
5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

New Mexico's SMI/SED Implementation plan was submitted on June 25, 2023. It is currently under CMS review and responses to comments are due August 25, 2023. New Mexico also provides assurance that Federal Financial Participation (FFP) will not be claimed until CMS approves the State's SMI/SED Implementation Plan.

New Mexico is awaiting formal guidance from CMS on the required monitoring protocol; however, the monitoring protocol draft is in the final stages. The state is requesting an extension to submit the monitoring protocol. There are some final items that need to be coordinated and addressed before submission.

CENTENNIAL HOME VISITING (CHV) PROGRAM

New Mexico has encountered reporting delays and will submit its DY10 Q2 and DY10 Q3 data with its DY10 Q3 report. For reference, in DY10 Q1, the Centennial Home Visiting (CHV) program served 406 families. Following is DY10 Q1 data for each model:

Nurse Family Partnership (NFP) Model:

- University of New Mexico Center for Development and Disability (UNM CDD) NFP served a total of 80 unique families in DY10 Q1 in Bernalillo County and Valencia Counties.
- Youth Development Inc. (YDI) served 77 families in DY10 Q1 in Bernalillo, Rio Arriba, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 28 unique families in DY10 Q1 in Bernalillo County.
- ENMRSH served 27 unique families in DY10 Q1 in Curry and Roosevelt Counties.
- Taos Pueblo/Tiwa Babies served 12 unique families in DY10 Q1 in Taos County.
- MECA Therapies served 133 unique families in DY10 Q1 in Chaves, Curry, Doña Ana, Roosevelt, and Lea Counties.
- Aprendamos served 26 unique families in DY10 Q1 in Doña Ana, Sierra, and Otero Counties.
- Community Action Agency of Southern New Mexico served 25 unique families in DY10 Q1 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 10 unique families in DY10 Q1 in San Juan County.

CHV program continues steady growth in access to Medicaid members through new providers and additional service areas. Two programs are in various stages of the onboarding process.

- Day One Home Visiting Tresco has completed enrollment in NM Medicaid. They are in the process of creating contracts with the 3 MCOs. They will serve Bernalillo and Santa Fe Counties.
- Guidance Center of Lea County is in the process of enrollment with NM Medicaid. They are approved for 20 families in Lea County.

Several strategies are currently being employed to streamline the process of enrollment, credentialing, billing, and referral management. HSD is meeting regularly with the Early Childhood Education and Care Department (ECECD) to create a provider manual and process map that will live on the HSD website. The MCOs are also contributing their procedures to the process map. There are also changes to new MCO contracts that will start next year to streamline the referral process for members and there will be a rate increase for NFP agencies starting in July.

PRESUMPTIVE ELIGIBILITY PROGRAM

The New Mexico HSD Presumptive Eligibility (PE) program continues to be an important part of the State's efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some New Mexico State Agencies including the New Mexico Department of Health (DOH), New Mexico Children Youth and Families Department (CYFD), and the New Mexico Corrections Department (NMCD). Currently, there are approximately 816 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assist with on-going Medicaid application submissions.

HSD staff conduct monthly PE certification trainings for employees of qualified entities that choose to participate in the PE program. PE certification requirements include active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct "Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE)" demo trainings. During demo trainings, the PEDs have the opportunity to take a refresher training on "How To" utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit ongoing Medicaid applications. PE program staff conducted 3 PE certification trainings and 3 YESNM-PE demo refresher trainings in DY10 Q2.

HSD continues to maintain the virtual assistant program to help automate the process of adding newborns to existing Medicaid cases. The "Baby Bot" functionality utilizes our contractor, Accenture's, virtual assistant (AVA) software. AVA allows providers to start a Baby Bot chat session in YESNM-PE (Your Eligibility System in New Mexico for Presumptive Eligibility). The chat session can help facilitate adding the newborn to the Medicaid-enrolled mother's case.

YESNM-PE is only available to certified PEDs. PEDs use YESNM-PE to screen and grant approvals for PE coverage. They also use YESNM-PE to submit ongoing Medicaid applications. With Baby Bot, PEDs at hospitals, IHS/Tribal 638s and birthing centers also have the enhanced capabilities of electronically adding newborns to an existing case.

Access to the Baby Bot is available through a link located on the PED's home page in YESNM-PE. The Baby Bot platform operates as a webservice and sends the information electronically to ASPEN, HSD's eligibility system. Once the mother's eligibility has been electronically verified in ASPEN, the system automatically adds the newborn to the case. This allows immediate access to benefits for the newborn. Currently 257 active PEDs are

certified to use the Baby Bot functionality with more trainings scheduled to increase participation.

Following are descriptions for each column header in Table 11 below:

- **Newborns Submitted**
  - Overall number of submissions through Baby Bot.
- **Newborns Successfully Enrolled (and % of Newborns Successfully Enrolled)**
  - Number (and %) of newborns automatically added to an existing Medicaid case at time of submission.
- **Newborns Unsuccessfully Enrolled (and % Newborns Unsuccessfully Enrolled)**
  - Number (and %) of submissions not completed automatically; newborn added to the case via worker manual intervention.

Table 11: Medicaid-eligible newborns submitted through Baby Bot on YESNM-PE

AVA Baby Bot (April - June 2023)					
Month	Newborns Submitted through AVA	Newborns Successfully Enrolled	Newborns Unsuccessfully Enrolled - Tasks Created	% of Newborns Successfully Enrolled	% of Newborns Unsuccessfully Enrolled
April	535	358	177	67%	33%
May	772	500	272	65%	35%
June	787	521	266	66%	34%
Total	**2,094**	**1,379**	**715**	**66%**	**34%**

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY10 Q2, 67 PEDs used the Baby Bot functionality. Although the amount of PED participation during this reporting period remained about the same, we noticed a slight increase in the number of newborns added through the Baby Bot functionality. In this reporting period, staff observed a slight increase in the percentage of Newborns "Successfully Enrolled." HSD program staff continue to work with PEDs and system developers to increase the number of newborn submissions as well as the number of successful submissions through the Baby Bot.

Table 12: PE Approvals

PE APPROVALS (April - June 2023)				
Month	PEs Granted	% PE Granted with Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
April	199	98.99%	726	394
May	204	98.53%	730	308
June	235	100%	832	343
Total	**638**	**99%**	**2288**	**1045**

Source: Monthly PE001 Report from ASPEN and OmniCaid

Table 12 above outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. NM PEDs are aware of the importance of ongoing Medicaid coverage for their clients. In this reporting period we saw an increase in the number of PE approvals that also had an ongoing application submitted. In DY10 Q2, 92% of all PE approvals had an ongoing application submitted.

JUST HEALTH PROGRAM

Certified PEDs employed at the New Mexico Corrections Department (NMCD) and County Jails or Detention Centers participate in the PE Program through the Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) program.

The JUST Health program was established to ensure justice-involved individuals have timely access to healthcare services upon release from correctional facilities. To ensure this access can occur, individuals who have active Medicaid coverage at the time of incarceration do not lose their Medicaid eligibility, but rather, have their Medicaid benefits suspended after 30 days. 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 while incarcerated. Application assistance is provided by PEDs at the correctional facilities.

It is HSD's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, Behavioral Health appointments, outpatient/inpatient residential treatment for SUD) upon release. To help facilitate access to care and ensure a smooth transition from correctional facilities back out into the

communities, HSD has established the Centennial Care JUST Health workgroup. The monthly workgroup includes representatives from State and County Correctional facilities, Managed Care Organizations, County governments, State agencies, provider organizations, and other stakeholders. The goal of the workgroup is to create a transition of care with detailed processes and procedures that can be utilized and adapted to work for all correctional facilities statewide.

The following table outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. HSD observed an increase in the amount of PE applications and ongoing Medicaid applications submitted from jail or prison settings in DY10 Q2. Now that the PHE has ended and COVID-19 protocols in jails and prisons are lifted, we do expect to see the numbers of applications submitted increase over the next 2 years. The department continues to work on the relationships between the jails and prisons, and with the justice involved population. In DY10 Q2, 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 13: PE Approvals

PE APPROVALS – JUST HEATH (April - June 2023)				
Quarter	PEs Granted	% PE Granted w/ Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
April	6	100%	131	155
May	5	100%	77	70
June	5	100%	174	162
Total	**16**	**100%**	**382**	**387**

Source: Monthly PE001 Report from ASPEN and OmniCaid

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HCBS REPORTING

In accordance with Standard Terms and Conditions (STCs) outlined in Attachment A, VI – HCBS Reporting, New Mexico is providing the following required reporting elements in this section:

- A status update that includes the type and number of issues identified and resolved through the Consumer Support Program;
- Identification of critical incidents reported during the quarter;
- Systemic Community Benefit (CB) issues or problems identified through monitoring and reporting processes and how they are being addressed. Issues include but are not limited to: participant access and eligibility, participant-centered planning and service delivery, provider credentialing and/or verification, and health and welfare; and
- Information regarding self-direction of benefits.

Additionally, this section addresses the STC 43 requirement to comply with federal 1915(c) waiver assurances and other program requirements for all HCBS services, including 1915(c)-like services provided under the demonstration by having an approved Quality Improvement Strategy measuring performance indicators for the following waiver assurances:

- Administrative Authority;
- Level of Care (LOC);
- Qualified Providers;
- Service Plan;
- Health and Welfare of Enrollees; and
- Financial Accountability.

Consumer Support Program

The consumer support program is a system of organizations and state agencies that provide standardized information to beneficiaries about Centennial Care 2.0, long-term services and supports (LTSS), the MCO grievance and appeals process, and the fair hearing process.

Year to Date (YTD) and quarterly reporting are provided by the Aging and Long-Term Services Department (ALTSD), Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the broader public to access a variety of services. The type and number of issues identified and resolved through the Consumer Support Program for DY10 Q2 are listed in the tables below.

Table 14: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT April - June 2023	
TOPIC	NUMBER OF CALLS
Home/Community Based Care Waiver Programs	2,236
Long Term Care/Case Management	5
Medicaid Appeals/Complaints	4
Personal Care	5
State Medicaid Managed Care Enrollment Programs	4
Medicaid Information/Counseling	518

Source: SAMS Call Profiler Report; GSA I 7-630-8000-0001 CDA 93-778 State Fiscal Year 2023, Quarter 4 report

Table 15: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT April - June 2023			
COUNSELING SERVICES	NUMBER OF HOURS	NUMBER OF NURSING HOME RESIDENTS	NUMBER OF CONTACTS
Transition Advocacy Support Services		142	
*Medicaid Education/Outreach	2,506		
Nursing Home Intakes		80	
**LTSS Short-Team Assistance			80

*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.
Source: Care Transition Bureau (CTB) GSA I 7-630-8000-0001 CFDA 93-778 State Fiscal Year 2023, Quarter 4 report

Critical Incidents

Critical Incidents	
DY10 Q2	HSD conducts a quarterly meeting with MCOs. The goal of the quarterly meeting is to provide guidance and discuss findings of the MCO's reporting of critical incidents. The quarterly meeting was held on May 17, 2023. The primary discussion was regarding the total reports submitted under Adult Protective Services (APS) by an Agency/Provider in DY10 Q1. From an internal audit, HSD determined the majority of critical incident reports submitted to APS were unreportable for Neglect Refusing Services and Neglect Insufficient Staffing. Each MCO reported how they will better train agencies/providers on when and how to utilize the APS drop-down function with the reporting portal. A follow up to the 2022 Annual Provider Training was held on March 29, 2023. This specific training was for Agencies identified as requiring additional direction on how to report to APS and Agencies that did not attend the November trainings. HSD has initiated conducting monthly meetings with MCOs. The goal of the monthly meetings is to provide MCO specific guidance regarding HSD audit findings, address questions concerning quarterly monitoring reports, address concerns identified with critical incident reporting, and discuss any contract and policy compliance issues.

Items of discussion during the DY10 Q1 MCO monthly meetings were:

- BCBS- review of critical incident reports filed identified "No current follow-up diary entry to address Members health and safety" as a continued area of concern. A list of Critical Incident Reports (CIRs) discussed on the call were sent as a separate attachment prior to the monthly call. The total APS reports submitted under APS: Agency/Provider was also a topic of discussion. BCBS stated they will meet internally to assess items identified and develop actions to improve reporting.
- PHP- review of critical incident reports filed identified "No current follow-up diary entry to address Members health and safety" as a continued area of concern. A list of CIRs discussed on the call were sent as a separate attachment prior to the monthly call. The total APS reports submitted under APS: Agency/Provider was also a topic of discussion. PHP stated they will meet internally to assess items identified and develop actions to improve reporting.
- WSCC- review of critical incident reports filed identified "No current follow-up diary entry to address Members health and safety" as a continued area of concern. A list of CIRs discussed on the call were sent as a separate attachment prior to the monthly call. The total APS reports submitted under APS: Agency/Provider was also a topic of discussion. WSCC stated they will meet internally to assess items identified and develop actions to improve reporting.

HSD conducted daily reviews of critical incidents submitted by the MCOs and providers for the purpose of ensuring compliance with reporting requirements. HSD provided daily assistance to MCOs and providers to obtain access to the Critical Incident Reporting (CIR) Portal by establishing and/or resetting login credentials as well as deleting duplicate reports.

DY10 Q1 data was received on April 30, 2023. During DY10 Q1, a total of 34,831 CIRs were filed for Centennial Care which includes physical health (33,098), and subsets of behavioral health (884) and community benefit self-directed (849) members. In DY10 Q1, total Centennial Care critical incident reports increased 39% from DY9 Q4. In DY10 Q1, total Behavioral Health critical incident reports decreased 5% from DY9 Q4. In DY10 Q1, total Self-Directed critical incident reports increased 17% from DY9 Q4.

The tables below represent an MCO summary of the critical incident reporting for DY10 Q1. DY10 Q2 data will be received on July 30, 2023 and will be reflected in the DY10 Q3 report.

Table 16: Critical Incidents Reported

CRITICAL INCIDENTS REPORTED (DY10 Q1)															
MCO	CENTENNIAL CARE (CC)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
BCBS	10,031				161				204				10,031	161	204
PHP	21,208				667				513				21,208	667	513
WSCC	1,859				56				132				1,859	56	132
Total	33,098				884				849				33,098	884	849

Source MCO quarterly report #36

BCBS (DY10 Q1)															
Critical Incident Types	Centennial Care				Behavioral Health				Self-Directed				Year-to-date Totals		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	110				25				13				110	25	13
Death	213				2				7				213	2	7
Elopement / Missing	7				0				0				7	0	0
Emergency Services	1,739				88				111				1,739	88	111
Environmental Hazard	35				2				2				35	2	2
Exploitation	30				1				0				30	1	0
Law Enforcement	29				7				1				29	7	1
Neglect	7,868				36				70				7,868	36	70
All Incident Types	10,031				161				204				10,031	161	204

Source MCO quarterly report #36

PHP (DY10 Q1)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	167				61				12				167	61	12
Death	428				8				16				428	8	16
Elopement/ Missing	18				1				0				18	1	0
Emergency Services	6,519				459				360				6,519	459	360
Environmental Hazard	68				5				6				68	5	6
Exploitation	51				0				10				51	0	10
Law Enforcement	56				10				3				56	10	3
Neglect	13,901				123				106				13,901	123	106
All Incident Types	21,208				667				513				21,208	667	513

Source MCO quarterly report #36

WSCC (DY10 Q1)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	21				3				3				21	3	3
Death	42				1				5				42	1	5
Elopement/ Missing	4				0				1				4	0	1
Emergency Services	295				42				41				295	42	41
Environmenta l Hazard	5				0				1				5	0	1
Exploitation	16				2				2				16	2	2
Law Enforcement	13				2				4				13	2	4
Neglect	1,463				6				75				1,463	6	75
All Incident Types	1,859				56				132				1,859	56	132

Source MCO quarterly report #36

Community Benefit

In DY10, Community Benefit (CB) related projects have included: provider rate increases; continued development for the new tracking database for HSD approved Agency-Based Community Benefit (ABCB) providers; implementing waiver amendment changes; and Self-Directed Community Benefit (SDCB) program improvements. Also, HSD continued to collaborate with providers, stakeholders, and state agencies to implement initiatives approved under its American Rescue Plan Act (ARPA) HCBS Spending Plan and Narrative.

NM has identified that there are workforce shortages for Community Benefit Personal Care Services (PCS) caregivers for both Agency-Based and Self-Directed services. We are addressing this issue through the following remediations:

- Implementing rate increases for PCS and other CB services to coincide with state and local minimum wage increases, and the paid sick leave requirement for NM employees per the Healthy Workforce Act. There was another statewide minimum wage increase that occurred in January 2023. Additional rate increases

are being implemented effective July 1, 2023.
    - HSD continues to monitor MCO accountability to ensure minimum wage increases and paid sick leave requirements are met with weekly MCO report updates.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers. A 10% payment will be issued in 2023, and a 5% payment will be issued in 2024. HSD will require that providers attest that they are using the funding in accordance with the CMS approved ARPA spending plan.
- Approving higher rates for certain caregivers in rural areas on a case-by-case basis.
- One MCO issued grants to PCS agencies through the NM Association for Home Health and Hospice Care. The final report on how the grant funds were used to recruit and retain workers will be available later this year.

Under New Mexico's Waiver Amendment #2 request, HSD received CMS approval on March 28, 2023 to increase the number of CB slots by 200, bringing the total to 5,989. CMS provided the state flexibility to expand the number of slots by an additional 800 slots, bringing the total number of slots to 6,789, if the state finds that it has sufficient funding to do so. HSD continues its collaboration with CMS to determine how the total number of expanded slots should be counted and reported for ARPA and the waiver.

On March 28, 2023, HSD also received approval from CMS to increase the five-year limit for environmental modifications (e-mods) from $5,000 to $6,000. This increase was needed due to increased costs of labor and materials. HSD also received approval to increase the five-year limit for Community Transition Services (CTS) from $3,500 to $4,000. This will help members to be able to transition out of a nursing facility to a community setting. As the cost of consumer goods and housing have risen, this extra funding will help pay for household items and housing related deposits. HSD issued direction to the MCOs to implement both increases and updated the Community Benefit Services Questionnaire accordingly so that members are aware of these newly increased limits as part of the assessment process. HSD directed the MCOs to review any e-mod and CTS approvals going back to March 28, 2023 and make any necessary adjustments to Member budgets.

Electronic Visit Verification

HSD, in partnership with the MCOs, continued to operate EVV for Agency-Based Community Benefit (ABCB), SDCB, and EPSDT Personal Care Services. HSD received CMS approval for our Good Faith Effort Exemption request to CMS for Home Health Services. We anticipate implementing EVV for Home Health in January 2024 and are collaborating with the MCOs, providers, and CMS to ensure requirements are met.

For DY10 Q2, the average number of SDCB caregivers using EVV is 66.7%. HSD is continuing to offer training and technical assistance for SDCB agencies and individual employees to encourage more SDCB providers to use EVV.

ABCB EVV data for DY10 Q2 is outlined in the table below. The MCOs reported that 74.7% of the total ABCB PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder of claims were created through the Fiserv Authenticare application.

Table 19: EVV DATA

EVV DATA (April - June 2023)		
MCO	AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD	NUMBER OF TOTAL CLAIMS THIS PERIOD
BCBS	7,652	455,715
PHP	14,375	878,995
WSCC	2,015	118,740
TOTAL	24,042	1,453,450

Source: MCO Report #35 DY10 Q2, April – June 2023

Statewide Transition Plan

HSD received approval of its Statewide Transition Plan (STP) on March 10, 2023. HSD submitted its January 1, 2023 deliverable to CMS on March 29, 2023. CMS requested the additional deliverable from all states to ensure oversight of the Final Rule and Beneficiary recourse to report any concerns related to HCBS settings compliance. On May 30, 2023, CMS provided feedback to New Mexico on its January 2023 deliverable submission requesting additional detail concerning the State's complaint or grievance process, and how beneficiaries are notified that they have a right to file a complaint or grievance, and how to do so. CMS also encouraged New Mexico to include information on how it is improving beneficiary feedback processes (including case management services) in response to allegations of abuse amongst waiver participants. Additionally, HSD continues its work with CMS to finalize the 508 compliant version of its STP to post online. For the Community Benefit HCBS settings, the MCOs formed a workgroup and continue to collaborate on ongoing monitoring activities including provider training and care coordination tools. The MCOs will be auditing all settings by the end of 2023 to ensure continued compliance. They will report any findings to HSD.

MCO Internal Nursing Facility Level of Care (NF LOC) Audits

HSD requires the MCOs to provide a quarterly summary of their internal audits of NF LOC Determinations. Each MCO conducts internal random sample audits of both community-based and facility-based determinations completed by their staff based on HSD NF LOC criteria and guidelines. The audit includes accuracy, timeliness, consistency, and training of reviewers. The results and findings are reported quarterly to HSD along with any Quality Performance Improvement Plan. HSD is reporting DY10 Q1 audit results this quarter and audit findings for DY10 Q2 will be reported in DY10 Q3.

Total audits for DY10 Q1:

- BCBS conducted 102 total audits of NF LOC determinations, 18 facility-based and 84 community-based.
- PHP conducted 245 total audits of NF LOC determinations, 75 facility-based and 170 community-based.
- WSCC conducted 24 total audits of NF LOC determinations, 6 facility-based determinations and 18 community-based.

Audit results for NF LOC determinations for DY10 Q1:

- BCBS reported 100% agreement with reviewer determination for High and Low Facility Based NF LOC, and 100% agreement for Community Based NF LOC.
- PHP reported 100% agreement with reviewer determination for High and Low Facility Based NF LOCs, and 99% agreement for Community Based NF LOCs.
- WSCC reported 100% agreement with reviewer determination for High and Low Facility Based NF LOCs, and 100% agreement for Community Based NF LOCs.

Audit results for timeliness of determinations for DY10 Q1:

- BCBS reported 100% timeliness of determinations for High and Low Facility Based and 99% for Community Based NF LOCs.
- PHP reported 100% timeliness of determinations for High and Low Facility Based and Community Based NF LOCs.
- WSCC reported 93% timeliness of determinations for High and Low Facility Based and Community Based NF LOCs.

Aggregate results:

- NF LOC determinations aggregate results are 100% for High and Low Facility Based and 100% for Community Based NF LOCs.
- Timeliness of determinations aggregate results are 100% for High and Low Facility Based and 98% for Community Based.

HSD will continue to monitor the MCOs' internal audits of NF LOC determinations and identify and address any concerns.

Table 18: MCO Internal NF LOC Audits– Facility-Based

Facility-Based Internal Audits	Jan	Feb	Mar	DY10 Q1
High NF Determinations				
Total number of High NF LOC files audited	**18**	**20**	**20**	**58**
BCBSNM	3	3	3	9
PHP	15	16	16	47
WSCC	0	1	1	2
Total number of files with correct NF LOC determination	**18**	**20**	**20**	**58**
BCBSNM	3	3	3	9
PHP	15	16	16	47
WSCC	0	1	1	2
% of files with correct NF LOC determination				
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	0%	100%	100%	100%
Low NF Determinations	**Jan**	**Feb**	**Mar**	**DY10 Q1**
Total number of Low NF LOC files audited	**15**	**13**	**13**	**41**
BCBSNM	3	3	3	9
PHP	10	9	9	28
WSCC	2	1	1	4
Total number of files with correct NF LOC determination	**15**	**13**	**13**	**41**
BCBSNM	3	3	3	9
PHP	10	9	9	28
WSCC	2	1	1	4
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations	**Jan**	**Feb**	**Mar**	**DY10 Q1**
Total number of High NF LOC determinations completed within required timeframes	**18**	**20**	**20**	**58**
BCBSNM	3	3	3	9
PHP	15	16	16	47
WSCC	0	1	1	2
% of High NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	0%	100%	100%	100%
Total number of Low NF LOC determinations completed within required timeframes	**15**	**13**	**13**	**41**
BCBSNM	3	3	3	9
PHP	10	9	9	28
WSCC	2	1	1	4
% of Low NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%

Source: DY10 Q1 MCO Internal Audit Results

Table 19: MCO Internal NF LOC Audit Report – Community-Based

Community-Based Internal Audits	Jan	Feb	Mar	DY10 Q1
Total number of Community-Based NF LOC files audited	**92**	**88**	**91**	**271**
BCBSNM	28	28	28	84
PHP	58	55	57	170
WSCC	6	6	6	18
Total number with correct NF LOC determination	**92**	**88**	**91**	**271**
BCBSNM	28	27	28	83
PHP	58	55	57	170
WSCC	6	6	6	18
% with correct NF LOC determination	**100%**	**99%**	**100%**	**100%**
BCBSNM	100%	96%	100%	99%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations	**Jan**	**Feb**	**Mar**	**DY10 Q1**
Total number of Community-Based determinations completed within required	**91**	**89**	**89**	**269**
BCBSNM	28	28	28	84
PHP	58	55	57	170
WSCC	5	6	4	15
% of Community-Based determinations completed within required timeframes	**99%**	**100%**	**94%**	**98%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	96%	100%	83%	93%

Source: DY10 Q1 MCO Internal Audit Results

MCO NF LOC Determinations

Per Special Terms and Conditions (STC) 40 for New Mexico's Centennial Care 2.0 Waiver, HSD requires that the MCOs report to the state a monthly breakdown of all the NF LOC determinations/redeterminations that were conducted. This report includes the total number of NF LOC determinations completed, the number of determinations that were completed timely, and the number of assessments completed where the member did not meet LOC based on HSD NF LOC criteria.

- The aggregated Facility Based High NF LOC determination/redetermination percentage for DY10 Q1 was 83%, a decrease from DY9 Q4 of 90%.
- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY10 Q1 was 98% an increase from DY9 Q4 of 97%.
- The aggregated Community Based determination/redetermination percentage for DY10 Q1 was 98% and remained consistent with 98% reported for DY9 Q4.

HSD will continue to monitor the MCO NF LOC determinations to identify and address any trends and provide technical assistance as needed. MCO NF LOC determinations for DY10 Q2 will be reported in the DY10 Q3 report.

Table 20: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	**Jan**	**Feb**	**Mar**	**DY10 Q1**
Total number of determinations/redeterminations completed for High NF LOC requests	**61**	**119**	**107**	**287**
BCBSNM	9	41	28	78
PHP	48	68	76	192
WSCC	4	10	3	17
Total number of determinations/redeterminations that met High NF LOC criteria	**52**	**94**	**92**	**238**
BCBSNM	2	27	19	48
PHP	47	57	19	48
WSCC	3	10	2	15
% of determinations/redeterminations that met High NF LOC criteria	**85%**	**79%**	**86%**	**83%**
BCBSNM	22%	66%	68%	62%
PHP	98%	84%	93%	91%
WSCC	75%	100%	67%	88%
Low NF Determinations	**Jan**	**Feb**	**Mar**	**DY10 Q1**
Total number of determinations/redeterminations completed for Low NF LOC requests	**392**	**391**	**448**	**1,231**
BCBSNM	107	132	122	361
PHP	267	250	296	813
WSCC	18	9	30	57
Total number of determinations/redeterminations that met Low NF LOC criteria	**386**	**385**	**440**	**1,211**
BCBSNM	105	130	119	354
PHP	263	246	291	800
WSCC	18	9	30	57
% of determinations/redeterminations that met Low NF LOC criteria	**98%**	**98%**	**98%**	**98%**
BCBSNM	98%	98%	98%	98%
PHP	99%	98%	98%	98%
WSCC	100%	100%	100%	100%

Source: DY10 Q1 MCO NF LOC Determinations Report

Table 21: MCO NF LOC Determinations – Community-Based

Community Based Determinations	Jan	Feb	Mar	DY10 Q1
Total number of determinations/redeterminations completed	**2,144**	**2,135**	**2,439**	**6,718**
BCBSNM	646	641	761	2,048
PHP	1,407	1,429	1,607	4,443
WSCC	91	65	71	227
Total number of determinations/redeterminations that meet NF LOC criteria	**2,108**	**2,096**	**2,379**	**6,583**
BCBSNM	639	632	750	2,021
PHP	1,378	1,399	1,560	4,337
WSCC	91	65	69	225
% of determinations/redeterminations that meet NF LOC criteria	**98%**	**98%**	**98%**	**98%**
BCBSNM	99%	99%	99%	99%
PHP	98%	98%	97%	98%
WSCC	100%	100%	97%	99%

Source: DY10 Q1 MCO NF LOC Determinations Report.

External Quality Review Organization (EQRO) NF LOC

HSD's EQRO reviews a random sample of MCO NF LOC determinations every quarter. The EQRO conducts ongoing random reviews of LOC determinations to ensure that the MCOs are applying HSD's NF LOC criteria consistently. The EQRO provides a summary of their review to HSD monthly. Additionally, HSD monitors all determination denials identified in the EQRO review to identify issues of concern.

EQRO Monthly report summaries of determinations and denials were reviewed for Facility Based and Community Based.

In DY10 Q1:
Aggregated results for NF LOC determinations from EQRO were 100% in agreement with High NF, 100% in agreement with Low NF, and 100% in agreement for Community Based.

HSD will continue to monitor the EQRO audit of MCO NF LOC determinations to identify and address any trends and provide technical assistance as needed. NF LOC determinations for DY10 Q2 will be reported in the DY10 Q3 report.

Table 22: EQRO NF LOC Review

Facility-Based				
High NF Determination	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**18**			
BCBSNM	6			
PHP	6			
WSCC	6			
Number of Member files the EQRO agreed with the determination	**18**			
BCBSNM	6			
PHP	6			
WSCC	6			
% of Member files the EQRO agreed with the determination	**100%**			
BCBSNM	100%			
PHP	100%			
WSCC	100%			
Low NF Determination	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**36**			
BCBSNM	12			
PHP	12			
WSCC	12			
Number of Member files the EQRO agreed with the determination	**36**			
BCBSNM	12			
PHP	12			
WSCC	12			
% of Member files the EQRO agreed with the determination	**100%**			
BCBSNM	100%			
PHP	100%			
WSCC	100%			
Community-Based	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**90**			
BCBSNM	30			
PHP	30			
WSCC	30			
Number of Member files the EQRO agreed with the determination	**90**			
BCBSNM	30			
PHP	30			
WSCC	30			
% of Member files the EQRO agreed with the determination	**100%**			
BCBSNM	100%			
PHP	100%			
WSCC	100%			

Source: DY10 Q1 EQRO NF LOC Report.

Waiver Assurance Performance Measures

New Mexico has developed and initiated performance measure (PM) indicators to comply with STC requirement 43.

- Administrative Authority: HSD developed 3 performance measures to monitor the HCBS Administrative Authority. The DY10 Q2 results for PM #2 and PM #3 will be reported in New Mexico's DY10 Q3 report. Please find the following results for DY10 Q2 and PM #1.
    - PM #1: Percentage of required HCBS reports submitted timely by the MCOs.
        - Report #4, *Community Benefit* – 100% compliance
        - Report #8, *Nursing Facility Level of Care* – 100% compliance
        - Report #35, *Electronic Visit Verification* – 100% compliance
    - PM #2: Percentage of required HCBS reports submitted accurately without an MCO Self-Identified Error.
        - Report #4, *Community Benefit* – Data for DY10 Q2 is not yet available as reports are currently under review.
        - Report #8, *Nursing Facility Level of Care* – Data for DY10 Q2 is not yet available as reports are currently under review.
        - Report #35, *Electronic Visit Verification* Data for DY10 Q2 is not yet available as reports are currently under review.
    - PM #3: Percentage of required HCBS reports submitted accurately without an HSD rejection.
        - Report #4, *Community Benefit* – Data for DY10 Q2 is not yet available as reports are currently under review.
        - Report #8, *Nursing Facility Level of Care* – Data for DY10 Q2 is not yet available as reports are currently under review.
        - Report #35, *Electronic Visit Verification* – Data for DY10 Q2 is not yet available as reports are currently under review. e

- Level of Care (LOC): MCOs submit quarterly LOC reports to HSD that identify the number of initial LOCs conducted in the quarter. The information to support that the initial LOC is conducted timely is reported above under the NF LOC reporting.

- Qualified Providers: In DY9 Q2, HSD began to work on developing measures to monitor the HCBS Qualified Provider requirements. In DY9, there were a total of 304 approved Community Benefit providers. In DY10 Q1, HSD continued to receive and review applications for incoming CB providers. HSD reviews and approves all Agency-Based Community Benefit (ABCB) providers to ensure that

they meet all program requirements as outlined in Section 8 of the Managed Care Policy Manual. Providers must obtain this program approval from HSD prior to contracting with the MCOs and providing services to ABCB members. In the Self-Directed Community Benefit (SDCB), the MCOs contract with a single Fiscal Management Agency (FMA) to oversee provider enrollment. The FMA ensures that all providers meet program requirements as outlined in Section 9 of the managed Care Policy Manual. SDCB providers must meet all program requirements and be approved by the FMA prior to rendering services to SDCB members. 100% of providers meet the program requirements prior to providing services to members. HSD has directed the MCOs to begin auditing all ABCB providers and the SDCB FMA on an annual basis, starting in DY10. In DY10 Q2, the MCOs collaborated to develop a single audit tool and the tool has been approved by HSD. HSD has developed a reporting template for the MCOs to report any corrective action plans and provider terminations that occur. HSD will begin reporting these audit results in DY 11.

- Service Plan: In DY9, HSD developed 8 performance measures to monitor the HCBS Service Plan requirements. Following are the performance measures (PMs):
    - PM #1: Member's choice to receive HCBS waiver services institutional care.
    - PM #2: Member's choice of HCBS services and providers documented in a written comprehensive care plan.
    - PM #3: Member's HCBS services plan adequately addresses assessed needs.
    - PM #4: Services authorized by the MCO were delivered in accordance with the HCBS service plan including the type, scope, amount, duration, and frequency specified in the HCBS service plan.
    - PM #5: Member's service plan was revised, as needed, to address changing needs.
    - PM #6: A disaster preparedness plan specific to the member is documented.
    - PM #7: Member's eligibility start and end dates are documented.
    - PM #8: Linkages to protective services are documented.

  On a quarterly basis, HSD's EQRO validates MCO compliance with federal requirements for HCBS service plans. These reviews are conducted virtually, in real time, and include MCO care coordination staff participation. For each record in the sample, the MCO staff display pertinent information in the MCO's care

coordination systems to demonstrate compliance. Pertinent information includes, but is not limited to: the comprehensive needs assessment; HCBS service plan; back-up plan; disaster plan; progress notes; claims; and eligibility data. A total of 8 performance measures are reviewed for each record. MCO agreement/acceptance of the review determination (met or not met) for each performance measure is captured prior to the conclusion of the review. Following is a summary of DY10 monitoring results:

- Statewide, 94 records are reviewed each quarter, which began January 1, 2023.
- DY10 Q1 indicates 100% compliance across all performance measures for PHP and WSCC. BCBS indicates 94% compliance on PM #3 and PM #4, and 100% compliance for all other PMs.

HSD will continue to monitor EQRO HCBS Service Plan Review for compliance of the 8 performance measures to identify and address any trends and provide technical assistance as needed.

The tables below include a summary of the quarterly HCBS Service Plan data for DY10 Q1. The DY10 Q2 data will be reported on the DY10 Q3 CMS Quarterly Monitoring Report

Table 23: HCBS SERVICE PLAN REVIEW SUMMARY

Eligible Population and Sample Size, DY10 Q1			
MCO	Eligible Population for DY10 Q1	MCO % of Entire HCBS Population in DY10 Q1	Number of HCBS Files Reviewed for DY10 Q1
BCBS	4,684	25%	34
PHP	12,836	69%	54
WSCC	1,069	6%	6
Centennial Care	18,589	100%	94

Service Plan Review Results DY10 Q1						
Performance Measure	MCO	Total Files Reviewed	# of Files Met	# of Files Not Met	# of Files Not Applicable	% of Files Met
Member's choice to receive HCBS services versus institutional care is documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Member's choice of HCBS services and providers are documented in a written comprehensive care plan	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Member's HCBS service plan adequately addressed his/her assessed needs	BCBS	34	32	2	0	94%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	92	2	0	98%
Services authorized by the MCO were delivered in accordance with the HCBS service plan, including the type, scope, amount, duration, and frequency are specified in the HCBS service plan	BCBS	34	32	2	0	94%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	92	2	0	98%
The HCBS service plan was revised, as needed, to address changing needs	BCBS	34	5	0	29	100%
	PHP	54	17	0	37	100%
	WSCC	6	0	0	6	100%
	Statewide	94	22	0	43	100%
A disaster preparedness plan specific to the member was in the HCBS service plan and documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Member's eligibility start and end dates are documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Linkages to protective services are documented	BCBS	34	0	0	34	100%
	PHP	54	0	0	54	100%
	WSCC	6	0	0	6	100%
	Statewide	94	0	0	94	100%

Source: DY10 Q1 External Quality Review Organization (EQRO) Quarterly HCBS Service Plan Report

- Health and Welfare of Enrollees: HSD has implemented a monitoring process for assuring the health and welfare of members enrolled in HCBS through quarterly MCO reporting on established performance measures. The critical incident performance measures listed below will identify, address, and seek to prevent instances of abuse, neglect, exploitation, and unexpected death. HSD staff will

review and analyze the data to determine if the MCOs report any significant changes from previous reporting periods. HSD findings are communicated to each MCO through Monthly Quality Bureau Critical Incident calls and during the Quarterly Critical Incident Meeting.

In DY10 Q1, HSD observed the following as compared to DY9 Q4:

- PM #1: 11% increase for Neglect, 34% increase for Exploitation, and 43% decrease for Unexpected Death.
- PM #4: 24% decrease for follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents, and 14% decrease for follow up actions (safety plans, corrective action plans, etc.) included investigation and educating individuals and families was completed.
- PM #6: 37% decrease for the percentage of providers and MCO staff educated about reporting critical incidents to the HSD Portal initially at the start or at hire, and at least annually thereafter. This decrease is attributed to the Annual PCS training held by MCOs in DY9 Q4 where 86% of all contracted providers attended.
- All other performance measures demonstrated consistency or slight differences in percentages reported.

The table below is a summary of the quarterly data reported by the MCOs for DY10 Q1.

Table 24: Critical Incidents Performance Measures

Critical Incident Performance Measures (CI PM)				
CI PM	BCBS	PHP	WSCC	Total by
	Q1	Q1	Q1	Q1
The number of all substantiated critical incidents.	10,031	21,208	1,859	33,098
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #1: The percentage of substantiated critical incidents reported by category of abuse, neglect, exploitation and unexpected death:				
	Q1	Q1	Q1	Q1
1.a. Percentage of substantiated individual abuse incidents identified and reported.	1.1	0.79	1.13	1.01%
1.b. Percentage of substantiated individual neglect incidents identified and reported.	78.44	65.55	78.7	74.23%
1.c. Percentage of substantiated individual exploitation incidents identified and reported.	0.3	0.24	0.86	0.47%
1.d. Percentage of substantiated individual unexpected death incidents identified and reported.	0.35	0.31	0.7	0.45%
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #2: The percentage of substantiated critical incidents being reported within the required timeframe.				
	Q1	Q1	Q1	Q1
Percentage of substantiated critical incidents being reported within 24 hours.	93.08	86.18	93.28	90.84%
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #3: The percentage of substantiated individual critical incidents where follow up (safety plans, corrective action plans, etc.) was completed:				
	Q1	Q1	Q1	Q1
Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed.	89.46	97.08	57.77	81.44%

CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #4: The percentage of follow-up actions taken on the substantiated critical incidents on a systemic basis to prevent future incidents, such as investigation as well as educating individuals and families:				
	Q1	Q1	Q1	Q1
4.a. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents.	30.06	20.96	65.47	39.01%
4.b. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) included investigation and educating individuals and families was completed.	27.05	3.92	60.14	30.37%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #5: The percentage of the substantiated critical incidents with a referral to Adult Protective Services (APS) or Child Protective Services (CPS):				
	Q1	Q1	Q1	Q1
5.a. Percentage of substantiated individual critical incidents where referrals to APS were completed.	22.42	22.08	18.61	21.04%
5.b. Percentage of substantiated individual critical incidents where referrals to CPS were completed.	0.33	0.33	0.11	0.26%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #6: The percentage of providers and MCO staff trained on reporting critical incidents into the HSD Portal:				
	Q1	Q1	Q1	Q1
6.a The percentage of contracted providers, agencies and MCO educated about reporting critical incidents to the HSD Portal initially at the start or at hire during the reporting period.	97.6	4.97	2.74	35.10%
6.b. The percentage of contracted providers, agencies and MCO that attended the annual training and were educated about reporting critical incidents to the HSD Portal. NOTE: THIS WILL ONLY BE REPORTED ONCE A YEAR IN THE QUARTER THE ANNUAL TRAINING IS HELD.				
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #7: The percentage of substantiated critical incidents for Members with Multiple critical incidents identified and reported:				
	Q1	Q1	Q1	Q1
The percentage of substantiated Members with Multiple critical incidents identified and reported.	62.35	75.98	85.42	74.58%

Source: MCO CI PM quarterly report.

- Financial Accountability: In DY10 Q1, the EQRO began reviewing MCO claims for financial accountability to ensure that Community Benefit claims were not overpaid. New Mexico has compiled partial data for DY10 Q1 and will present data for all MCOs in the next quarterly report.
    - For DY10 Q1, NM has data for BCBS only. Of the 1,727 DY10 Q1 claims reviewed, 100% of claims were not overpaid.

8

AI/AN REPORTING

Access to Care

According to MCO Report #55, *Geographical Access Report* for Q2 2023:

- BCBSNM reported 96.5% access to behavioral health services in rural areas and 95% access to behavioral health services in frontier areas. For physical health, BCBSNM reported 96.5% in rural areas and 97.6% in frontier areas.
- PHP reported 98.4% access to behavioral health services in rural areas and 98.9% access to behavioral health services in frontier areas. For physical health, BCBSNM reported 98.4% in rural areas and 98.8% in frontier areas.
- WSCC reported 96.7% access to behavioral health services in rural areas and 100% access to behavioral health services in frontier areas. For physical health, BCBSNM reported 96.7% in rural areas and 100% in frontier areas.

Contracting between Managed Care Organizations and I/T/U Providers

Following are DY10 Q2 updates on contracting between MCOs and I/T/U providers.

MCO	Status of Contracting with MCOs
BCBS	BCBSNM continues to make outreach with intentions of pursuing contracts to applicable providers but has received little to no response back. • Pueblo of Isleta has been sent a contract and BCBSNM is awaiting a returned contract with their signature. • Nambe Pueblo contracts will be sent out soon; there are still a few items being discussed.
PHP	PHP's contracting efforts are underway with the IHS and Tribal facilities below: • Desert Visions Youth Wellness in Arizona; • Tewa Roots Society in Nambe Pueblo; and • Jemez Health Center.
WSCC	WSCC Tribal Relations team was unable to enter any new contracts this second quarter; however, Tribal Relations continues discussions with several tribal programs including: Fort Defiance Medical Center; Crownpoint Corrections Facility; Santo Domingo's Kewa Family Health and Wellness Department; Nambe Pueblo's Tewa Roots Society; and Picuris Pueblo Health Department. Responses to continued outreach to Navajo Nation IHS and Tribal programs results in a general statement of "IHS is not required to contract with Medicaid Managed Care Organizations (MCO) or private insurance payers".

Timely Payment for all I/T/U Providers, including Complaints

According to MCO Report #47, *Claims Activity Report* for Q2 2023:

- BCBSNM processed 99.6% clean claims within 15 days and 100% clean claims within 30 days.
- PHP processed 99.6% clean claims within 15 days and 100% clean claims within 30 days.
- WSCC processed 98.6% clean claims within 15 days and 100% clean claims within 30 days.

There were no reports of complaints by providers for claims reimbursement.

Native American Technical Advisory Committee (NATAC) Issues and Recommendations

In 2023 the NATAC members requested to have more control over the meeting agenda. They wanted to move away from state "updates" and focus on billable services for Tribes, the Medicaid Unwinding, and Community Health Representative (CHR) billing. Each meeting goes over these agenda items.

Following is the DY10 schedule for the Native American Technical Advisory Committee (NATAC) meetings.

Native American Technical Advisory Committee Schedule

Date	Time	Location
March 20, 2023	1:00 p.m. – 3:00 p.m.	Virtual
June 26, 2023	1:00 p.m. – 3:00 p.m.	Virtual
September 18, 2023	1:00 p.m. – 3:00 p.m.	Hybrid - in person/virtual
December 18, 2023	1:00 p.m. – 3:00 p.m.	Hybrid - in person/virtual

Native American Advisory Board Issues and Recommendations

The following table provides a summary of DY10 Q2 issues identified and recommendations made by the MCO Native American Advisory Board.

MCO	DATE	Issues/Recommendations
BCBSNM	May 4, 2023 Los Duranes Community Center Albuquerque, NM	Since this was a hybrid meeting, BCBSNM reported 2 in-person attendees and 11 attendees over the phone. **Issue:** One member asked if the traditional medicine benefit had been approved for her and her husband. **Response:** BCBSNM staff member checked and confirmed the benefit had been processed and mailed. **Issue:** A question was asked if a member could get the Walmart Delivery Service in Crownpoint, NM. **Response:** A care coordinator was assigned to the member to assist them with their questions. **Issue:** The question was asked "Will we be disqualified from SNAP now that my husband is employed?" **Response:** Member was sent the SNAP website and phone information to reach out to ISD about her SNAP question. **Issue:** Another member requested a care coordinator for her daughter to get the value-added service, *Assistance with Social Determinants of Health.* **Response:** A care coordinator was assigned to the member.
PHP	June 1, 2023 Virtual meeting	This was a virtual meeting. Four people called in for the meeting. There were no issues brought up during the meeting. Comments from the attendees were: • "I am just learning about this program. This will provide meaningful feedback to my team." • "Thank you for providing good information that I was not aware of. I will share this info with Pueblo members."
WSCC	June 1, 2023 hybrid meeting – virtual and in person at Dine College Shiprock, NM	There were 7 guests at this advisory board meeting. Here are some of the questions raised at the meeting: **Issue:** "If there is a member who has WSCC, but the caretaker doesn't, are they eligible for services?" **Response: "**The caretaker does not have to be associated with WSCC to provide services to the member." **Issue:** A community member said she is with Humana but wants to switch to WellCare/WSCC. How does she go about doing that? **Response:** "Open enrollment for Medicare is in October-December 7th. You can switch at open enrollment as long as it has not been within 3 months."

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ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE:	3/26/21
COMPLETION DATE:	Open
ISSUES	ModivCare has been placed on a corrective action plan for not meeting the contractual timeliness measures for certain Customer Service Call Center metrics and other additional contractual requirements.
RESOLUTION	Due to continued service level failures, the action plan remains open. Service Level (85% or more calls answered by a live person within 30 seconds), Nurse Advice line (85% or more calls answered by a live person within 30 seconds), Provider Services line (85% of calls answered within 30 Seconds) were all in compliance as of February and March 2022. **Closed** **DY10 Q2 update:** Plan of Action (POA) related to Call Center remains open. BCBS continues to monitor the call center stats that include: A-Leg, Provider No Shows, and Member Satisfaction. BCBS also continues to meet with ModivCare daily to discuss issues and/or concerns. For Q2 2023, ModivCare met April and May metrics for all except for A-Leg Pickups; this is due to members being discharged from substance facilities requesting short notice transportation. BCBS continues to monitor A-Leg Pickups closely. Below are the most current statistics: **June 2023:** ASA = 00:07 seconds (Met) Abandonment Rate = 0.14% (Met) Service Level = 95.9% (Met) Member Satisfaction = 94.5% (Met) A-Leg Pickup = 85.66% (**Not Met**) Provider No-Shows = 25 To reduce the number of provider no-shows, ModivCare continues to add other transportation providers to the network. BCBS is also working on adding UBER (rideshare) to ModivCare's options for transportation for those members that are ambulatory (can walk safely on their

	own to/from vehicle) and will start this service in specific counties. HSD receives bi-weekly updates and continues to carefully review the ModivCare remediation plan and progress.

BLUE CROSS BLUE SHIELD	
ACTION PLAN	DentaQuest (Quality of Care Process Improvement)
IMPLEMENTATION DATE:	7/15/22
COMPLETION DATE:	4/30/23 - CLOSED
ISSUES	A NM Medicaid member received in-office dental services that involved sedation. The member encountered respiratory difficulties, was transported to a higher level of care, and subsequently passed away. Initially, DentaQuest reviewed the medical records and determined that there were no quality-of-care concerns. BCBS' corporate office requested that DentaQuest conduct a second review on the case, due to an internal clinical review, and upon doing so, DentaQuest ultimately terminated the provider and will be reporting their findings to the National Practitioner Data Bank (NPDB) as well as the NM Dental Board. DentaQuest did not thoroughly review the medical records to identify quality-of-care concerns, and the original review of medical records and second review had markedly different outcomes. Additionally, DentaQuest did not appropriately and timely terminate the provider, resulting in potential quality-of-care concerns for NM Medicaid members.
RESOLUTION	BCBS has provided the following update in DY10 Q2. In April, BCBS closed this Plan of Action (POA). BCBS is tracking on a monthly cadence to ensure New Mexico quality teams are receiving the Quality of Care (QOC) timely. BCBS continues to meet with DentaQuest monthly. This item will be removed from the next reporting.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	PHP
IMPLEMENTATION DATE:	03/01/21
COMPLETION DATE:	In Process
ISSUES	2020 Provider Directory Audit
RESOLUTION	04/01/21 – Seven findings related to a provider directory audit were identified. The first finding was not contested, which found that the general and online provider directories did not include all information components required by

	Contract, Sections 4.14.5.1 and 4.14.5.4. The additional findings are being carefully reviewed. PHP is creating a detailed project plan to add required information to the website and to improve the quality of the information. HSD will receive updates for PHP's Provider Database Management project, which is in production and will improve the provider information required to feed the provider directory and downstream claims and encounters databases and other requirements dependent on provider information. The project plan was received by HSD on April 23, 2021. HSD accepted PHP's remediation plan and is monitoring the progress of activities. 07/06/21 – PHP's corrective action plan (CAP) is in progress. An update of the project plan was provided to the HSD Contract Manager. 10/01/21 – PHP CAP is being reviewed monthly to assess progress and resource needs. A system build is required to ensure accuracy and provider adoption to help ensure required information is updated. PHP is working on both strategies. 12/31/21 - PCP CAP is continuing to be reviewed monthly and is working on the system build and provider adoption. 02/21/22 - Final scope document completed and being presented to leadership for sign off next week. 04/04/22 - Project team had a meeting on 4/1/22 to discuss leadership feedback and questions. 05/18/22 - Project scope was approved and is moving forward. 05/20/22- HSD Project Scope Statement was approved, including Lexis Nexis Verified roster automation. PHP finalizing costs and implementation timeline. Lexis Nexis can provide the required data for the HSD deficiencies. 06/22/22 – Information Technology (IT) and internal stakeholders very nearly have the final budget and scope statement ready for signature so work can begin. 09/15/22 - VP of Finance reviewing final budget, approval pending. 12/31/2022 – Status remains unchanged. 03/31/23 - PHP is working to add fields to the Provider Directory Manager (PDM) b. PHP is working through the issue of getting data from the old claims system Facets to the new system. PHP is attempting a work around until the required fields are put into place in the new system, then that can be linked to the PDM which produces the Provider Directory.

	6/30/23: PHP continues to make progress. The required fields have been added to the Provider Directory Manager (PDM) system. The fields have been completed and approved, and they have been moved to Production in PDM. Training for all team leads is scheduled for 7/11 and 7/13 at the Cooper Center. Additionally, review of the requirements and finalization of placement and any additional filter options for these fields were completed. For the paper directory, Telehealth indicators have been added by PHP's vendor Clarity.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	Secure Transportation
IMPLEMENTATION DATE:	03/04/21
COMPLETION DATE:	In Process
ISSUES	Improvement Plan – Network Adequacy
RESOLUTION	Secure Transportation (ST) was placed on an improvement plan for the network issues. Monthly meetings will be held between ST and PHP leadership to review issues/concerns. 09/13/21 Update: Network concerns remained an issue for ST. PHP placed ST on a corrective action plan (CAP) as the issues are not resolved timely. ST will provide monthly updates on efforts to improve the network, the next update was due in October 2021. 02/15/22: ST added new providers to its network of drivers. PHP is working on increasing mileage reimbursement. Mileage reimbursement is offered at the front end of the scheduling process through care coordination to free up drivers for members who do not have supports for this option. ST is offering hiring bonuses and retention bonuses to help maintain the current network. 04/01/22: Areas that are remaining a focus of the CAP for ST. This CAP is to remain open until network adequacy is improved. Action Plan Items: • Risk Stratification – policy to identify and prioritize high risk members (dialysis, chemotherapy, radiation, pre or post operative care, surgery, high risk pregnancy related appointments and urgent care); and members at risk of being dropped by their provider for missed appointments • Network Adequacy Plan - include specifics to ensure statewide coverage including 100 miles from the NM state borders (excluding Mexico) • Recruiting Plan – include number of vehicles, candidates, and area serviced • Network Monitoring processes o Retention Plan o Incentive Plans - including incentive plans for resolving issue regarding short distance trips

	• Provider Issues – action plan to address providers regarding no-shows and those with excessive late pick-ups. 12/15/2022: ST remains on a CAP. PHP and ST developed a policy and process to improve access for critical care appointment scheduling and transportation completion that was approved by HSD. PHP is monitoring and seeing improved results. 03/28/23 - Q1CY23: This CAP has remained open for continuous monitoring of the Critical Care appointments and efforts to reduce all provider missed transportation. Critical Care appointments have been reduced significantly. There were 11 missed appointments in January and 9 missed appointments in February. Additional policy and procedures were implemented in CY22 which are directing the improvements. PHP will continue to monitor critical care appointments daily. Initiatives that are currently in progress include: per member per month (PMPM) rate review with guarantees, PHP contracting directly with Community Outreach Centers for partnering with transportation needs, and PHP contracting directly with tribal communities that offer transportation. Secure is adding additional vehicles to the fleet and looking to update correct scheduling platform/software for better performance. 6/30/23: May's report remains consistent with zero critical care trips that were unable to be scheduled and approximately 20 driver no shows/cancellations. May also had zero unable to schedule non-critical care appointments, down from 90 in April. Member no-shows have increased. PHP is working with care coordination to contact members who are missing and not cancelling appointments, specifically around critical care appointments and continued missed methadone appointments. Lyft ride share has been approved by the Public Regulation Commission (PRC). There will be a meeting with Secure and Clinical Operations to determine criteria and rollout plan.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Secure Transportation 2022 Annual Audit
IMPLEMENTATION DATE:	03/17/23
COMPLETION DATE:	Open Item
ISSUES	Secure 2022 Annual Audit noncompliance with credentialing and recredentialing process and procedures
RESOLUTION	Secure 2022 annual audit resulted in a determination of noncompliance relating to their credentialing and recredentialing process and procedures. This began in DY10 Q1 and closure is anticipated in DY10 Q3. If there are no improvements based on June 2023 data WSCC will issue monetary penalties.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Payment Error- Reprocessing and Recoupment of Payments
IMPLEMENTATION DATE:	9/20/22
COMPLETION DATE:	Open item
ISSUES	Payment Error- Reprocessing and Recoupment of Payments, Temporary Economic Recovery Payments increase for Home and Community Based Services (HCBS)
RESOLUTION	During a routine audit of payments issued through WSCC's accounts payable platform, a discrepancy was identified related to payments described in a Letter of Direction (LOD) that HSD sent to the MCOs. This LOD directed the MCOs to provide a temporary economic recovery payment increase for Home and Community Based Services. A misalignment occurred between the payable supplier ID and the amount due to the provider, creating over and under payments. WSCC is providing outreach to those providers impacted to ensure payments are issued for those providers who were underpaid, as well as working on repayment options for the providers who were issued overpayments. HSD is closely monitoring this through weekly detailed reports from WSCC. WSCC is at a 99% completion rate for underpaid providers and at a 90% completion rate for overpaid providers. There is a payment plan for the remaining 3 of 70 providers who were overpaid. The remaining 3 providers are actively working with WSCC on a payment plan. Closure is anticipated in DY10 Q3.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Secure Transportation No-Show Remediation Plan
IMPLEMENTATION DATE:	11/17/22
COMPLETION DATE:	Open item
ISSUES	Secure Transportation (Secure) has not met performance measures for driver no-shows for critical care appointments for the period beginning in July 2022.
RESOLUTION	The expectation is that driver no-shows are reduced to 1% of total monthly critical care trips. Secure provided a remediation plan to WSCC. The plan includes Secure, WSCC, and Uber Health working to gain approval for Uber Health (and other rideshare providers) to be able to operate in the state. This plan also includes initiatives with Secure senior leadership team to analyze the network and provide feedback on matching capacity to demand, discussion around reimbursement rates, and reducing the number of driver no-shows. HSD approved WSCC plans and is closely monitoring this. WSCC is waiting for the June 2023 results to determine if the metrics set for Secure were met. WSCC will issue monetary penalties if appropriate. WSCC issued a Request

	for Proposals (RFP) to expand its network of transportation providers and selected a new transportation vendor (MTM, Inc.) effective 1/1/24. Closure of the WSCC CAP for Secure Transportation is anticipated in DY10Q3.

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FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY10 Q2 reflects the capitation rates for Centennial 2.0 that were submitted to CMS on December 21, 2022. On weighted average, the CY 2023 rate is slightly lower than that of CY 2022 and fee-for-service claim payments for CY 2023 are still lagging. In addition, data run out for CYs 2022 and 2023 will continue and the PMPMs will continue to change as expenditures come in (see Attachment B – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment B – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis indicates that DY 8 is 10.8% below the budget neutrality limit (Table 8.5) through 10 quarters of payments. For DY 9, Table 9.5 shows a 7.1% below the budget neutrality limit with data through six quarters. Table 10.5 shows a 23.9% below the budget neutrality limit for DY 10 with preliminary data of two quarters.

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MEMBER MONTH REPORTING

Member Months		2023 2
MEG1	0-FFS	101,041
	Presbyterian	659,828
	Western Sky	131,769
	Blue Cross Blue Shield	435,951
	Total	1,328,589
MEG2	0-FFS	7,053
	Presbyterian	62,709
	Western Sky	12,130
	Blue Cross Blue Shield	38,440
	Total	120,332
MEG3	0-FFS	0
	Presbyterian	66,753
	Western Sky	11,539
	Blue Cross Blue Shield	34,071
	Total	112,363
MEG4	0-FFS	644
	Presbyterian	317
	Western Sky	38
	Blue Cross Blue Shield	214
	Total	1,213
MEG5	0-FFS	0
	Presbyterian	9,315
	Western Sky	1,632
	Blue Cross Blue Shield	7,078
	Total	18,025
MEG6	0-FFS	81,904
	Presbyterian	388,614
	Western Sky	109,488
	Blue Cross Blue Shield	311,829
	Total	891,835
MG10	0-FFS	7
	Presbyterian	114
	Western Sky	21
	Blue Cross Blue Shield	81
	Total	223
MGX8	0-FFS	0
	Presbyterian	257
	Western Sky	93
	Blue Cross Blue Shield	261
	Total	611
Total		2,473,191

Source: Enrollee Counts Report.

January 1, 2019 – December 31, 2023

12
CONSUMER ISSUES

GRIEVANCES

HSD receives MCO Report #37 Grievances and Appeals on a monthly basis. The report presents the MCOs response standards to ensure that grievances filed by members are addressed timely and appropriately. The report also provides information related to the summary of member grievance reason codes.

In DY10 Q2, the reports submitted by MCOs for April through June 2023 were reviewed analyzed. It was determined reports were in compliance with contractual requirements. HSD observed in DY10 Q2, the top primary member grievance code continues to be Transportation Ground Non-Emergency. The year to date total demonstrated a 0.38% decrease from DY10 Q1.

The second top primary member grievance code reported was Provider Specialist. The year to date total demonstrated an increase from DY10 Q1. The second top primary member grievance code reported is a change from Personal Care Services in DY10 Q1, and Dental in DY9 Q4 and Q3. Provider Specialist was the second top primary member grievance code in DY9 Q2 and MCO Operational Issues in DY9 Q1. The table below is a summary of the quarterly data reported by the MCOs for DY10 Q2.

Table 25: Grievances Reported

Grievances Reported (January - June 2023)														
Grievances	BCBS				PHP				WSCC				TOTAL BY QUARTER	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Number of Member Grievances	405	483			326	243			50	52			781	778
Top Two Primary Member Grievance Codes														
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER	
													Q1	Q2
Transportation Ground Non-Emergency	288	361			116	48			19	8			423	417
Personal Care Services	0	27			18	0			0	2			18	29
Variable Grievances	117	95			192	195			31	42			340	332

Source: MCO Report #37

APPEALS

HSD receives a monthly Grievances and Appeals report from the MCOs. The report presents the MCOs response standards to ensure that appeals filed by members are addressed timely and appropriately. The report also provides information related to the summary of member appeals reason codes.

DY10 Q2, the reports submitted by MCOs for April through June 2023 were reviewed and analyzed. It was determined reports were in compliance with contractual requirements. HSD observed in DY10 Q2, the top primary member appeals code continues to be Denial or limited authorization of a requested service. The year to date total demonstrated a 3% decrease from DY10 Q1.

The second top primary member appeals code reported continues to be Denial in whole of a payment for a service. The year to date total demonstrated a 17% increase from DY10 Q1.

These two primary member appeals codes have remained consistent from DY9.The table below is a summary of the quarterly data reported by the MCOs for DY10 Q2.

Table 26: Appeals Reported

Appeals Reported (January - June 2023)																
APPEALS	BCBS				PHP				WSCC				TOTAL BY QUARTER			
	Q1	Q2	Q3	Q1	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Standard Member Appeals	534	588			627	582			56	56			1,217	1,226		
Number of Expedited Member Appeals	35	29			23	28			12	11			70	68		
Top Two Primary Member Appeal Codes																
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER			
													Q1	Q2	Q3	Q4
Denial or limited authorization of a requested service	397	410			624	583			65	60			1,086	1,053		
Denial in whole of a payment for a service	165	199			15	12			0	0			180	211		
Variable Appeals	7	8			11	15			3	7			21	30		

Source: MCO Report #37

13
QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HSD's Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference the table below for 2023 MCO Advisory Board Meeting Schedules.

Table 28: 2023 MCO Advisory Board Meeting Schedules

BCBS 2023			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	03/16/2023	12:00-1:30 PM	Hybrid - Albuquerque - Metro
BCBS	04/13/2023	12:00-1:30 PM	Hybrid - Valencia or Socorro County - Central
BCBS	06/15/2023	12:00-1:30 PM	Hybrid - Albuquerque - Metro
BCBS	07/20/2023	12:00-1:30 PM	Hybrid - Albuquerque - Metro
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	09/21/2023	12:00-1:30 PM	Hybrid - Las Cruces (Dona Ana County) - Regional
BCBS	10/26/2023	12:00-1:30 PM	Hybrid - Santa Fe (Santa Fe County) - Regional
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	02/9/2023	12:00-2:00 PM	Virtual - Sandoval County Tribal Areas
BCBS	05/04/2023	12:00-2:00 PM	Hybrid - Los Duranes Community Center
BCBS	08/10/2023	12:00-2:00 PM	Hybrid - Dine Youth Shiprock Youth Complex
BCBS	11/2/2023	12:00-2:00 PM	Hybrid - Zuni Wellness Center
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	See above	See above	All above locations (SDCB included in each meeting)

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	See above	See above	All above locations (BH included in each meeting)

PHP 2023			
Meetings will be held virtually until state restrictions are lifted for in-person meetings. SDCB Subcommittee Member Advisory Board Meetings are currently on hold.			
MEMBER ADVISORY BOARD MEETING SCHEDULE (CENTRAL AREA)			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/10/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
PHP	06/02/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
PHP	09/08/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
PHP	12/06/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
STATEWIDE MEETINGS			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	TBD	TBD	TBD
PHP	TBD	TBD	TBD
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/09/2023	3:00-5:00 PM	Virtual Meeting
PHP	06/01/2023	3:00-5:00 PM	Virtual Meeting
PHP	08/31/2023	3:00-5:00 PM	Virtual Meeting
PHP	11/30/2023	3:00-5:00 PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	TBD	TBD	Meetings on Hold • Due to the low volume of self-directed members, PHP opted to fold these meetings into its broader Centennial Care 2.0 Member Advisory Board. Updates are provided at every meeting, presented by PHP's LTC Care Coordination Manager.
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/13/2023	1:00-2:30 PM	Virtual Meeting
PHP	06/07/2023	1:00–2:30 PM	Virtual Meeting

PHP	09/13/2023	1:00–2:30 PM	Virtual Meeting
PHP	12/13/2023	1:00–2:30 PM	Virtual Meeting

WSCC 2023			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	02/11/2023	10:00 AM 12:00 PM	Virtual Meeting
WSCC	05/18/2023	2:00 PM-4:00 PM	Virtual Meeting
WSCC	08/16/2023	11:00 AM- 1:00 PM	Virtual Meeting
WSCC	12/02/2023	2:00-4:00 PM	Virtual Meeting
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	04/19/2023	4:00-6:00 PM	Virtual Meeting
WSCC	10/12/2023	3:00-5:00 PM	Virtual Meeting
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	03/03/2023	11:00 AM- 1:00 PM	Virtual Meeting
WSCC	06/01/2023	4:00-6:00 PM	Virtual Meeting
WSCC	08/25/2023	11:00 AM-1:00 PM	Virtual Meeting
WSCC	12/09/2023	11:00-1:00 PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	08/16/2023	11:00 AM-1:00 PM	Virtual Meeting (Included in the MAB Presentation)
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	10/12/2023	3:00-5:00 PM	Virtual Meeting (Included in Statewide)
COMMUNITY ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	06/16/2023	3:00-4:30 PM	Virtual Meeting

Quality Assurance	
DY10 Q2	**<u>Quarterly Quality Meeting</u>** HSD holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HSD updates and guidance on required quality monitoring activities as well as relay HSD findings from the monthly, quarterly, and annual reports submitted by the MCOs. HSD's Quality Bureau, Performance Measures Unit, held the QQM for DY10 Q2 on June 28, 2023. HSD presented the MCO Performance Measure administrative data rates as of DY10 Q1, as compared to DY9 Q1 rates and the established HSD targets for DY10. In DY10 Q1, all three MCOs exceeded their respective DY10 HSD assigned target for PM #6, *Antidepressant Medication Management* and PM #7, *Initiation of Alcohol and Other Drug Dependence Treatment*. The remaining PMs are trending upward towards their respective target. HSD presented an aggregate comparison of MCO PM rates for DY10 Q1 and DY9 Q1. In comparing DY10 Q1 to DY9 Q1, MCO aggregate rates increased for 7 PMs while 3 PMs decreased. HSD observed a decrease for PM #5, *Childhood Immunization Status – Combo 3*, PM #8, *30 Day Follow-up After Hospitalization for Mental Illness*, and PM #9, *30 Day Follow-up After Emergency Department Visit for Mental Health*. Next, HSD presented MCO aggregate data results from the Monthly Performance Measure Monitoring Plan for PM #1, PM #3, and PM #5 from January through April 2023 of DY10. HSD provided common barriers the MCOs reported such as difficulty finding transportation to scheduled appointments, staffing shortages, accurate member contact information, and member refusal. MCOs discussed the actions taken to overcome these barriers. BCBS' Quality Management team calls members directly to help with transportation and appointment scheduling. BCBS is also partnering with school-based health centers to help with

	scheduling of appointments. BCBS has a dedicated wellness and education specialist that assist providers to connect with members and help maintain current contact information. BCBS helps providers with staff shortages by providing Value Based Program contracts. PHP advised they are partnering with community-based organization vans to assist with transportation and are working on encouraging providers to offer increased virtual care. PHP is also enhancing member and marketing material to improve communication and education for their members. PHP communicates using social media to educate members on the purpose and importance of well-child, immunizations, and follow-up visits. PHP is looking to implement more virtual care for providers. WSCC ensures their providers can help schedule transportation and have flexibility on what times appointments can be scheduled to align more with member schedules. WSCC uses member communication material to acknowledge baby deliveries by offering baby showers and provides outreach to border communities to assure it is safe for members to take their child to the doctor. WSCC conducts provider outreach providing support and advice and reviews metrics during regular meetings. Additionally, WSCC through Value Based Program contracts help providers with staff shortages. To ensure accurate contact information for their members, WSCC partners with a vendor who uses technology to identify alternative phone numbers. HSD provided the DY9 Hospital Directed Payment evaluation results for the University of New Mexico Hospital (UNMH). HSD's Quality Bureau collaborates with UNMH to improve hospital quality, access, and timeliness of care, with 10 metrics that focus on improved health outcomes and experiences with hospital care received at UNMH. The Quality Bureau reported that of all 10 metrics, 7 met the HSD established targets resulting in overall positive improvement.

	During the presentation, the UNMH DY9 facility rates were compared to DY9 established targets and DY6 baseline rates. The selected measures assess the effectiveness of care received by members who are hospitalized for serious health conditions, the timeliness of follow-up care, and the member's satisfaction related to communication with doctors and nurses during their hospital stay. The MCOs provided feedback on the findings presented by HSD and discussed interventions and barriers that could impact improved outcomes for members receiving care at UNMH. PHP advised the care coordination team closely monitors hospital admissions and emergency room reports. WSCC stated they rely on their transition of care team and care coordination team to ensure member discharges are safe. BCBS advised some providers are unaware their patients are admitted to the hospital or visited the emergency room and will focus on ensuring the member's PCP is aware and informed of hospital admissions. BCBS also works closely with providers of members who frequently use the emergency room for primary care to reduce emergency room use and make sure providers are addressing the member's health needs to avoid the use of an emergency room. HSD concluded the meeting with a presentation on Tracking Measures (TM), first providing an aggregate comparison of DY9 Q4 to DY8 Q4 data. Collectively, the MCO TM rates decreased from Q4 of DY8 to Q4 of DY9 for Fall Risk Management (TM #1), Diabetes Short-Term Complications Admissions (TM #2), Follow-up after Hospitalization for Mental Illness (TM #4), Long-Acting Reversible Contraceptive insertions (TM #6), Smoking and Tobacco Cessation products/services (TM #7), ED visits (TM #8) and Annual Dental Visits (TM #9). Rates improved in Q4 of DY9 compared to Q4 of DY8 for Screening for Clinical Depression (TM #3), Immunizations for Adolescents (TM #5), Outpatient visits (TM #8), Controlling High Blood Pressure (TM #10), Follow-up Care for Children Prescribed ADHD Medication - Initiation and Continuation phases (TM #11), and Child and Adolescent Well-Care Visits (TM #12).

	<u>Monthly Performance Measure Monitoring Plan</u> In DY9 Q3, HSD introduced 3 measures to the Monthly Monitoring Plan for MCOs due to the observed decline in performance measure outcome rates. Well Child Visits within the first 15 months of life, Timeliness of Prenatal Care, and Childhood Immunization Status are now monitored on a monthly basis by HSD. HSD provides the MCOs with reporting instructions and a monitoring template which is submitted monthly to HSD. The report requires the MCO to give an account of the ongoing interventions, strategies, and barriers associated with improving performance outcomes for the selected measures. This allows HSD to monitor the progress towards improving outcomes and meeting the established PM targets. HSD established an annual target rate for DY10 for PM #1 – *Well Child Visits in the First 15 Months of Life* (W30) of 65.91%. Through DY10 Month 3 (M3), the MCOs reported the following average rates: BCBS 30.40%, PHP 27.05%, and WSCC 26.16%. The DY10 HSD annual target rate for PM #3 – *Prenatal Care* (PPC) is 84.75%. Through DY10 M3, the MCOs reported the following average rates for Timeliness of Prenatal Care: BCBS 58.50%, PHP 66.71%, and WSCC 56.87%. The DY10 HSD annual target rate for PM #5 – *Childhood Immunization Status* (CIS) is 71.78%. Through DY10 M3, the MCOs reported the following average rates for Combination 3 Immunizations: BCBS 29.9%, PHP 45.44%, and WSCC 41.47%. HSD expects to see these rates increase quarter over quarter. The final determination of whether the MCOs have met the established targets is reliant on the CY 2023 annual audited HEDIS report, which will be received in June 2024.

	BCBS: **W30:** M1 25.61%; M2 30.26%; and M3 35.34%. Increase of 9.73 percentage points from M1 to M3. **Strategies and Interventions:** BCBS continues to make use of monthly Joint Operating Committee meetings with Value Based contracted provider groups where BCBS shared the importance of automatically scheduling the next well child visit upon completion of a well child visit. The expectation for each provider group is to work with BCBS quality and operations staff to reduce barriers and improve W30 rates by closing gaps that may contribute to members not being able to make their well-child visits. In addition to promoting W30, providers are encouraged to overlay the first 6 provider visits in the first 15 months of life with the immunization schedule for CIS-3. BCBS has established efforts that are currently being utilized to further promote the 6x15 overlay of the first 6 visits of the W30 measure with the CIS-3 immunization schedule with provider groups. **PPC:** M1 59.60%; M2 57.82%; and M3 58.09%. Decrease of 1.51 percentage points from M1 to M3. **Strategies and Interventions**: Joint operating committee meetings were held with Value Based Contracted (VBC) providers where lists were sent to each provider group to close PPC-TOPC gaps. BCBS Special Beginnings Maternity Care Coordination program initiated a working relationship with the vendor BabySmart while enhancing their existing relationship with vendor, Families First. Families First continues to work on its reporting capabilities to include the engagement rate. With this in mind, BCBS has compiled a series of questions geared towards better serving the members in this population and identifying key issues that will help strategies and interventions be more effective.

	CIS: M1 20.21%; M2 21.59%; and M3 48.03%. Increase of 27.82 percentage points from M1 to M3. **Strategies and Interventions**: BCBS telephonic member outreach efforts have continued to encourage parents/guardians to schedule and complete well child visits so that timely immunizations can be received by the child. BCBS Quality Department in support with the Community Outreach team continued its involvement with the Member Advisory Board (MAB) and the Native American Advisory Board (NAAB) meetings to provide education on the importance of child immunizations and well child visits. BCBS also encourages providers to provide immunizations during the first 6 provider visits in the first 15 months of life. **PHP:** **W30:** M1 21.54%; M2 27.28%; and M3 32.32%. Increase of 10.78 percentage points from M1 to M3. **Strategies and Interventions**: PHP continues ongoing telephonic outreach to members reminding them to schedule and attend recommended well-care visits. In addition, monthly mailings of Early Periodic and Screening, Diagnostic and Treatment (EPSDT) letters were also mailed out to members. Quarterly provider newsletters, informing Presbyterian Medical Group and Presbyterian Health Plan contracted providers of PHP's Baby Bonuses Gift Card Reward Program for PHP Centennial Care members, were also mailed out to PHP members. PHP Centennial Care Baby Bonuses program had 104 new eligible enrollees in March 2023; the enrollment boost helps with communication and engagement of the population. PHP conducted one presentation to Presbyterian Health Services Community Health Workers, which was Presented to the Native American Centennial Care Member Advisory Board for recommended well baby visits. PHP increased outreach to New Mexico Women, Infant and Children (NM WIC) staff and shared brochures on the PHP Baby Bonuses Gift Card Program for Centennial Care Members. PHP also attended meetings with

	Value Based Program (VBP) Clinics to present on HEDIS recommendations for this measure and to collaborate outreach to eligible members. Quarterly meetings with NM WIC and NM Children's Medical Services for increased health education on recommended well-care visits were held in addition to the other meetings mentioned. **PPC:** M1 66.79%; M2 66.67%; and M3 66.68%. Decrease of 0.11 percentage points from M1 to M3. **Strategies and Interventions**: PHP continues to work with internal departments in efforts to develop a more accurate methodology to identify pregnancy earlier so interventions have a stronger impact on pregnancy outcomes throughout New Mexico. PHP's goal is to contact members at an early stage of pregnancy to get them engaged with providers and community resources and to ensure appropriate access to care. PHP has initiated a Performance Improvement Project (PIP) around pregnancy to identify at risk members and connect them with home services with a goal of decreasing complications. PHP is also partnering with Presbyterian Medical Group (PMG) to develop a timely pregnancy identification report, which is currently in the testing phase. PHP will continue to do year-round medical record abstraction to assist with PPC improvement and monthly reviews of prospective rates will continue to track changes and focus on expected year-end results. PHP will also continue to participate in women's health related events in order to increase referrals to the Baby Benefits prenatal reward program as well as increase Baby Benefits enrollments to assist with member prenatal and postpartum appointment compliance by end of year. **CIS:** M1 43.54%; M2 49.01%; and M3 43.76%. Increase of 0.22 percentage points from M1 to M3. **Strategies and Interventions**: PHP Performance Improvement team recognizes an atypical

	decrease in the completion rate for this measure, so PHP PI is investigating the decrease in numerator with internal data teams to determine the decrease in rate. PHP continues to work on member engagement by conducting telephone reminder calls to members in this age group reminding them to complete immunizations and well-care visits. PHP is also planning coordination with the New Mexico Department of Health and University of New Mexico Health Sciences Community Health "Got Shots" campaign. PHP has increased education on this measure to staff, by increased social media posts for Flu and COVID-19 vaccination clinics, through collaboration and networking with New Mexico Women, Infant and Children offices, New Mexico Children's Medical Services Division, and Presbyterian Health Plan Provider Network Operations. PHP continues its collaboration with Presbyterian Health Plan Value Based Programs (PHP VBP) to attend pediatric and family practice clinics so they can develop member outreach plans for missed vaccinations and immunizations. **WSCC:** **W30:** M1 24.00%; M2 24.00%; and M3 30.48%. Increase of 6.48 percentage points from M1 to M3. **Strategies and Interventions:** WSCC utilizes Quality Nurses for targeted member outreach as they provide member's parents/guardians with valuable information on the importance of PCP visits and address any barriers they may be experiencing. Through steady concentrated efforts, WSCC's Quality Reporting Specialists and the VBP team have cultivated a good working relationship by holding monthly meetings with providers on a regular basis to review monthly scorecards, discussing interventions, and reviewing best practices. **PPC:** M1 56.68%; M2 56.68%; and M3 57.25%. Increase of 0.57 percentage points from M1 to M3.

	Strategies and Interventions: WSCC's Value Based Team and Provider Quality Team meets with providers monthly to remind providers of the Notification of Pregnancy (NOP) incentive. WSCC utilizes claims and lab data to identify members for outreach and the information is shared with Quality Improvement (QI) nurse teams to complete NOPs. WSCC reviews non-compliant member's claims to determine if members do in fact have data that shows they are compliant, and if they are, a chart chase is requested for medical review. WSCC refers pregnant moms to the Centennial Home Visiting (CHV) program to support pregnant moms as well as new parents and to promote maternal and infant health. WSCC attends monthly workgroup meetings with Early Childhood Education and Care Department (ECECD) and CHV providers to address any concerns that have been identified. In March 2023, WSCC had over 115 NOPs received through their claims and lab data, which proves the NOP program is being effective in getting pregnant members prenatal care in a timely manner. **CIS:** M1 40.36%; M2 40.36%; and M3 43.69%. Increase of 3.33 percentage points from M1 to M3. **Strategies and Interventions**: WSCC Value Based Team and Provider Quality Liaisons meet once a month with providers to discuss the CIS measure where the liaisons provide a list of members that are needing to close the gap in care, which eases some of the burden off the providers, who conduct outreach to members. WSCC began targeting providers to increase member compliance with the CIS measure as well as collaboratively work with providers to ensure members are receiving all vaccines within the measure. WSCC will continue to monitor the data and the rates. WSCC continues to keep in contact with providers by conducting monthly provider engagement meetings where WSCC provides provider data, member gap lists, and discusses how interventions can be used with members.

Performance Measures (PMs)

HSD Performance Measures (PMs) and targets are based on HEDIS technical specifications. Each MCO is required to meet the established performance targets. Each DY target is a result of the DY6 MCO aggregated Audited HEDIS data, calculating an average increase for each DY until reaching the DY6 Quality Compass Regional Average plus 1 percentage point. Failure to meet the HSD-designated target for individual performance measures during the DY will result in a monetary penalty based on 2% of the total capitation paid to the MCO for the agreement year.

HSD requires the MCOs to submit quarterly reports that are used to monitor the performance of each PM to determine if MCOs are on track for meeting the established target. MCOs report any significant changes as well as interventions, strategies, and barriers that impact improved performance. HSD staff will review and analyze the data to determine if the MCOs are trending towards meeting the established targets. HSD findings are communicated to the MCOs through MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meeting (QQM). HSD expects to see rates increase quarter over quarter and the final determination of whether the MCOs have met the targets is reliant on the DY10 annual audited HEDIS report, which will be received in DY11 Q2.

Below are the MCO quarterly rates and interventions for each PM and the established target for DY10.

The following PMs show results for DY10 Q1 reporting.

PM #1 (1 point) – Well-Child Visits in the First 15 Months of Life (W30)

The percentage of members who turned 15 months old during the measurement year and had 6 or more well-child visits.

DY10 target is 65.91%.

- BCBS Q1 35.34% and is 30.57 percentage points below

	the DY10 target. • PHP Q1 32.32% and is 33.59 percentage points below the DY10 target. • WSCC Q1 28.22% and is 37.69 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 33.02% and is 32.89 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS's Quality Department and Community Outreach team continued its involvement with the Member Advisory Board (MAB) and the Native American Advisory Board (NAAB); using the NAAB meetings to provide education on the importance of well child visits. BCBS sent email reminders to parents/guardians to schedule an appointment with their healthcare provider or contact BCBS for assistance with scheduling an appointment. The emails include links to educational newsletters and media for well child visits. BCBS also reached out to members telephonically to encourage parents/guardians to schedule and complete well child visits on time. Additionally, BCBS Special Beginnings Care Coordinators utilize a script that discusses both well child visits and childhood immunizations with members about what happens after delivery. BCBS continued their SMS texting campaign that reminds parents/guardians to complete a well child visit and immunizations by their child's second birthday. The text also includes the recommended vaccines for children from birth to age 2 along with aiding the parent/guardian to schedule an appointment. BCBS continues to engage provider groups through value-based contracting agreements. During monthly joint operating meetings, dashboards measuring performance goals against target goal for W30 are reviewed. The expectation for each provider group is to work with BCBS quality and operations staff to reduce barriers and improve W30 rates by closing gaps.

	• PHP launched three social media messages per month related to completing well baby visits and age-appropriate immunizations on Presbyterian Health Services (PHS) Facebook platform. Ongoing monthly Early and Periodic Screening, Diagnostic and Treatment (EPSDT) letters were mailed to 13,476 eligible members in DY10 Q1. PHP conducted telephonic outreach to eligible members and referred them to the Baby Bonuses reward program, a value-added benefit to PHP Centennial Care members. In DY10 Q1, 297 members were enrolled in the PHP Baby Bonuses rewards program. Additionally, the PHP Baby Bonuses gift card reward program brochure was shared with approximately 200 NM Department of Health Women, Infant and Children (WIC) staff members across the state. • WSCC continued the mPulse texting campaign reminding parents/guardians of members to complete well child visits. WSCC's Quality Nurses conducted daily telephonic outreach to engage non-compliant members into completing well child visits. WSCC offered members incentives for completing well child visits via My Health Pays (a WSCC branded Visa gift card) and Centennial Rewards. WSCC's Value Based Team held meetings monthly to discuss interventions, best practices, and share provider scorecards. Farmbox and WSCC continued collaboration on an incentive for members to receive a box of healthy snacks when they complete a well child visit. ***PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*** The percentage of members ages 3 through 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.

	For this measure the National Committee for Quality Assurance (NCQA) offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 62.93%.** • BCBS Q1 12.76% and is 50.17 percentage points below the DY10 target. • PHP Q1 12.42% and is 50.51 percentage points below the DY10 target. • WSCC Q1 12.12% and is 50.81 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 12.53% and is 50.40 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS health educators hosted an event at Cuidando los Ninos. The event offered physical activities for all children in attendance. During this event, age-appropriate education was provided emphasizing the importance of physical activity. Children were provided a laminated placemat with recommended meal portion sizes along with other activity books that both educate and engage each age group. In DY10 Q1 BCBS sent out 2,037 targeted emails to parents/guardians of members ages 3-17 encouraging provider visits that cover their child's height, weight, growth, exercise, nutrition, sleep, and any required vaccinations amongst other topics. A new SMS campaign is underway with new more detailed and robust messaging to parents/guardians of members highlighting the importance of a healthy Body Mass Index (BMI), tips to get kids active and a nutritious diet, and the importance of physical health counseling with their healthcare provider. BCBS continues to promote WCC performance by providing billing and coding education to providers during Value Based Contracting joint operating

	meetings. Member lists are also provided for each provider's attributed members to support WCC gap closure. • PHP launched 3 social media posts that supported member outreach efforts in this measure. PHP's Value Based Program Director provided education to providers on HEDIS recommendations regarding documentation requirements for this measure. In DY10 Q1, PHP sent 33,379 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) letters to members in this age group reminding caregivers to schedule, attend and complete well care visits and age-appropriate vaccinations, recommending one hour of physical activity per day. PHP collaborated with NM School Based Health Centers to provide Health and Wellness recommendations to engage eligible students to complete well care visits. • WSCC's Quality Reporting Specialists and Value Based Payment (VBP) team conducted monthly provider engagement meetings to ensure providers are contacting members to complete needed well care visits, including counseling for nutrition and physical activity. WSCC collaborates with providers on events to get sports physicals completed. WSCC and FarmBox also have incentives when members complete WCC visits, a box of healthy snacks along with a brochure that provides healthy recipes and ways to sustain a healthy life are sent to the member. ***PM #3 (1 point) – Prenatal and Postpartum Care (PPC)*** The percentage of member deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit as a member of the MCO in the first trimester or within 42 Calendar Days of enrollment in the CONTRACTOR's MCO.

	DY10 target is 84.75%. • BCBS Q1 58.09% and is 26.66 percentage points below the DY10 target. • PHP Q1 66.68% and is 18.07 percentage points below the DY10 target. • WSCC Q1 55.82% and is 28.93 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 62.08% and is 22.67 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS continued the Special Beginnings (SB) maternity program and offered it at no cost to the pregnant population. The SB program collaborates with vendors, Finity Baby Smart and Families First. Baby Smart offers virtual doula health coaching. Both vendors provide programs that offer services during prenatal and post-delivery. In DY10 Q2, BCBS's texting campaign included additional information and resources for expecting moms. BCBS offered Value-Added Services such as car seats to all pregnant members engaged in Special Beginnings. BCBS's Centennial Rewards program is offered to all members who maintain their prenatal appointments. Members accrue points with select health tasks and can redeem their points using the program catalog. The BCBS Clinical Value Consultants continue to collaborate with value based contracted providers, offering member gap lists for their attributed members, Indices training allowing providers to monitor gap lists, and measure compliance review using scorecards to track and trend progress towards goals identified in their contract. BCBS Special Beginnings and Tricore Labs continued to collaborate in identifying members early in their pregnancy. Thus, creating opportunity for early member identification and outreach by Special Beginnings and supporting vendor offerings. • PHP's Performance Improvement (PI) and Community Health Workers (CHW) teams continue to reach out to

	targeted members about the Baby Benefits rewards program. PI also promotes this reward program internally to the Population Health Team and to external stakeholders such as Families First and the Home Visting Network of Bernalillo County. • WSCC continued efforts to make sure prenatal visits were attended by sending bi-weekly text through mPulse reminding members that prenatal appointments are coming up. Additionally, WSCC uses mPulse to provide a direct link to Pacify which is an online application members can download to their phones and through the app have access to a 24/7 Nurse advise line, lactation consultations, and Doula support. WSCC also offers the Start Smart for your Baby (SSFB) program that offers educational materials and case management during pregnancy. ***PM #4 (1 point) – Prenatal and Postpartum Care (PPC)*** The percentage of member deliveries that had a postpartum visit on or between 7 and 84 Calendar Days after delivery. For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 67.26%.** • BCBS Q1 46.45% and is 20.81 percentage points below the DY10 target. • PHP Q1 52.79% and is 14.47 percentage points below the DY10 target. • WSCC Q1 41.95% and is 25.31 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 49.06% and is 18.20 percentage points below the DY10 target.

	MCO Strategies and Interventions: • BCBS continues to offer the Special Beginnings (SB) maternity program at no cost to pregnant members and new moms. The SB program collaborates with vendors, Finity Baby Smart and Families First that offer both prenatal and postpartum services. BCBS Quality Management Specialists perform member outreach calls to assist in scheduling postpartum visits with their provider. If a member is not reached, an unable to reach letter is mailed. BCBS through their Value-Added Services, offer a car seat and portable crib to members enrolled in SB. The Centennial Rewards program is offered to all Centennial members. Members accrue points with select health tasks such as attending their postpartum appointment and are then able to redeem their points using the program catalog. The BCBS Clinical Value Consultants continue to collaborate with value based contracted providers, offering member gap lists for their attributed members, as well as Indices training allowing providers to monitor gap lists. BCBS's SB program and Tricore Labs continued collaboration to identify members early in their pregnancy to initiate outreach and engagement by care coordination. • PHP's Performance Improvement (PI) team provides presentations and information on the Baby Benefits rewards program, including a targeted outreach to members in the program during their third trimester on the importance of postpartum visits. • WSCC sent bi-weekly text messages to remind members of their postpartum appointments, check on the member and inquire if they are experiencing any barriers accessing services. WSCC is also utilizing Pacify, a 24/7 online application that members can download to their smart phone. Through the app, members have access to the WSCC Nurse advice line, virtual lactation consultation, and Doula support. Start Smart for your Baby (SSFB) is another program WSCC

	utilizes to provide educational material to expecting mothers and provide case management for mothers during and after pregnancy. ***PM #5 (1 point) – Childhood Immunization Status (CIS): Combination 3*** The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps and rubella (MMR); 3 haemophilus influenza type B (HiB); 3 hepatitis B (HepB); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their 2nd birthday. For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 71.78%.** • BCBS Q1 48.03% and is 23.75 percentage points below the DY10 target. • PHP Q1 43.76% and is 28.02 percentage points below the DY10 target. • WSCC Q1 43.01% and is 28.77 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 45.20% and is 26.58 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS delivered text reminders to parents/guardians of members to complete well child visits and immunizations by their second birthday. The text included recommended vaccines for children from birth to age 2 and aided the parent/guardian in scheduling an appointment. A well-baby reminder email was also sent to parents/guardian of members in DY10 Q1, to schedule an appointment with their healthcare provider or contact BCBS, if members need assistance

	scheduling appointments. BCBS continues to engage provider groups during monthly joint operating meetings discussing performance and target goals for CIS. • PHP mailed 13,476 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) letters to members, as well as launched four social media posts educating members on immunizations, shot clinics and well care visits. PHP's Performance Improvement team presented to Community Health Workers, Native American Consumer Advisory Board and the NM Early Childhood Education and Care Department (ECECD) Families First home visiting programs on well-care visits and age-appropriate immunizations. • WSCC Quality nurses conduct daily outreach to noncompliant members for various measures including CIS. Quality nurses work with members to schedule appointments, educate them on the importance of immunizations and assist with overcoming barriers the members may have. The Quality and VBP teams also review member scorecards with providers, which include a list of all members on their panel that have a gap in care for immunizations. WSCC provides member gap lists to providers, which encourages providers to conduct additional member outreach to schedule members for appointments. FarmBox is another initiative WSCC is using to incentivize members. Members who complete immunizations will receive an initial box of healthy snacks from Farmbox to introduce them to the program. WSCC is partnering with Pfizer to launch the Vaccine Adherence in Kids (VAK's) program which reaches out to parents of members through automated calls, texts and postcards notifying them that immunizations are due.

	PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase The number of members age 18 years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least 180 Calendar Days (6 months) of continuous treatment with an antidepressant medication. **DY10 target is 35.61%**. • BCBS Q1 33.59% and is 2.32 percentage points below the DY10 target. • PHP Q1 40.87% and is 5.26 percentage points above the DY10 target. • WSCC Q1 35.87% and is 0.26 percentage points above the DY10 target. • MCO Aggregate: Q1 total is 37.46% and is 1.85 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS conducted a provider webinar in DY10 Q1 on Maternal Mental Health, covering depression during pregnancy and postpartum, anti-depressant medications during pregnancy, and best practices for continuous care. The webinar offered Continuing Education Credits. In collaboration with the physical health quality team, the behavioral health quality team conducted annual staff trainings educating staff on the importance and ability to identify the AMM measure. • PHP initiatives include sending educational flyers on depression symptoms, treatment, and medication adherence to member with comorbid conditions linked to high rates of depression. A member call campaign was also conducted in DY10 Q1 for counties with low AMM rates educating members on the value of staying on antidepressant medication. A pilot program for a member gift card is being assessed for counties with low AMM rates.

	• WSCC is considering a partnership with Outcomes (which is a company focused on improving patient outcomes), to educate members on medication adherence, completion of wellness exams and screenings, immunizations and managing their medical and behavioral health conditions. WSCC Pharmacists work with members to help them establish and accomplish adherence goals and reduce barriers through patient-centered, personalized interventions. There were 1,352 comprehensive medication reviews with WSCC members completed by Outcomes TM clinical pharmacists in DY10 Q1. WSCC's BH disease management nurse conducts outreach to members in the AMM measure to provide education on the importance of medication adherence for better health and help them overcome any barriers. ***PM #7 (1 point) – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation*** The total percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment. **DY10 target is 47.54%**. • BCBS Q1 43.82% and is 3.72 percentage points below the DY10 target. • PHP Q1 51.40% and is 3.86 percentage points above the DY10 target. • WSCC Q1 44.62% and is 2.92 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 47.61 and is 1.07 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS held an annual staff training on Initiation and Engagement of Alcohol and Other Drug Dependence Treatment in DY10 Q1. BCBS staff utilized the Emergency Department Information Exchange (EDIE) system to provide immediate support and connect

	members with proper follow-up treatment. In DY10 Q1, provider education trainings were held on the topic, Synthetic Opioids and Maternal Mental Health addressing topics of substance use and follow-up care. • PHP continues supporting the states effort to implement Screening, Brief Interventions, and Referral to Treatment programs in rural hospitals and emergency departments. PHP has identified geographic areas with the highest rates for lack of services to incentivize increased provider capacity. PHP continues to work to increase provider enrollment in value-based programming through the Behavioral Health Quality Incentive and Provider Quality Incentive programs by 5% each year. • WSCC's collaboration with UNM Hospital's Community Health Worker (CHW) program engages members in the emergency department which aims to increase the interaction with members who are difficult to reach. CHW's screen members for social determinants of health and refers them to WSCC for follow-up. In DY10 Q1, 30 members were screened by WSCC staff, and 62 members were engaged by UNM CHWs. WSCC's Member Connections team or a designated care coordinator assists members in scheduling follow-up appointments and overcoming challenges such as transportation and other barriers. ***PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness (FUH): 30 Day*** The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. **DY10 target is 53.80%.** • BCBS Q1 46.90% and is 6.90 percentage points below the DY10 target.

	• PHP Q1 43.08% and is 10.72 percentage points below the DY10 target. • WSCC Q1 39.91 and is 13.89 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 44.01% and is 9.79 percentage points below the DY10 target. **MCO Strategies and Interventions:** • In DY10 Q1, BCBS held their annual staff training to educate staff on the FUH 30-day measure. BCBS launched a new provider training on Maternal Mental Health which included the 30 day follow up after hospitalization and offered providers Continuing Medical Education (CME) or Continuing Education Units (CEU). BCBS continues the reserved appointment initiative providing members with one appointment for mental health therapy and one appointment for medication management needs. • PHP continues to work with inpatient facilities to contact members within 7 days of discharge with a clinical call. PHP is piloting a program to improve care coordination for BH members discharged to a nursing facility by providing clinical BH follow-up appointments at the nursing facility. • WSCC Certified Peer Support Worker (CPSW) collaborate with facility discharge planners providing a smooth transition for members completing inpatient Substance Use Disorder (SUD) treatment to continued outpatient SUD care. WSCC's specialized Member Connection team uses their lived experience with recovery from mental health and substance abuse challenges to connect with members and engage them in follow-up care, link them with community resources, assist in navigating systems and empower them to take charge of their health and recovery.

	PM #9 (1 point) – Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Day The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days of the ED visit. **DY10 target is 48.00%.** • BCBS Q1 43.26% and is 4.74 percentage points below the DY10 target. • PHP Q1 36.95% and is 11.05 percentage points below the DY10 target. • WSCC Q1 35.43% and is 12.57 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 39.35 and is 8.65 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS' quality team offered providers an educational webinar on maternal mental health and included the FUM measure where they earned continuing education credit. BCBS staff continued reaching out to members telephonically assisting with follow up care and mental health needs. A reserved appointment initiative offering mental health appointments for both therapy and medical needs continues. • PHP's value-based programs for Behavioral Health Quality Incentive Program (BQIP) BQIP and Provider Quality Incentive Program (PQIP) continued to recruit new providers, with both programs offering incentives for FUM. In DY10 Q1, PHP continued provider trainings on the importance of timely follow-up visits at a Provider Education Conference, and Behavioral Health Provider Town Hall Lunch and Learn meetings. PHP continues to increase access to telehealth psychiatric providers and offers training in behavioral telehealth certification. • WSCC continues their partnership with New Mexico

	Community Care (NMCC), a community paramedicine provider, to complete a Health Risk Assessment (HRA) for members who have a high risk for certain health conditions and are difficult to engage or not able to reach by WSCC outreach teams. The paramedicine professionals visit members' homes to connect with members face-to-face in their own environment. WSCC continues the mPulse texting program for members with high emergency department use to check-in regarding follow-up care. This program allows members to respond with any needs, which alerts their care coordinator or a member connections team member via telephone call. ***PM #10 (1 point) – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*** The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. **DY10 target is 82.78%**. • BCBS Q1 43.49% and is 39.29 percentage points below the DY10 target. • PHP Q1 44.06% and is 38.72 percentage points below the DY10 target. • WSCC Q1 35.31% and is 47.47 percentage points below the DY10 target. • MCO Aggregate: Q1 total is 42.56% and is 40.22 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS distributed a video discussing the importance of diabetes screening when prescribed antipsychotic medication in DY10 Q1. Care coordinators educated members on the importance of A1c screening in relation to their prescribed medication and encouraged them to follow up with their PCP or receive an in-home diabetes

	kit. Additionally, a provider training on bipolar disorder and the importance of diabetes screening was held in DY10 Q1. • PHP's Performance Improvement (PI) team continued cross-referencing of SSD gap-in-care lists with inpatient hospitalization records and lab results that took place during hospitalization and supplied lists to providers. PHP's medical director continued provider education for SSD and best practices regarding prescribing antipsychotics. PHP also issued A1c test kits to members. • WSCC continues to partner with Harmony Cares sending members in-home A1c test kits who are engaged via telephonic outreach and have requested an in-home kit. WSCC's Quality Improvement Nurse contacts members in the SSD measure providing education about the importance of A1c screenings when taking antipsychotic medications. Members are given the option to complete the A1c screening using an in-home test kit or through their primary care physician. In DY10 Q1, 78% of members contacted have requested an in-home test kit. Members in the SSD measure who complete their A1c screening are eligible to receive a $30 digital gift card, with 155 members eligible for the gift card in DY10 Q1. **Tracking Measures (TMs)** HSD requires the MCOs to submit quarterly reports for the Tracking Measures listed in the MCO contract. HSD Quality Bureau reviews and analyzes the reports for completeness and accuracy and to gauge positive or negative outcomes and trends. The MCOs report interventions, strategies, and barriers that impact performance outcomes. HSD's review findings are communicated to the MCOs through scheduled MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meetings (QQMs). Numbers and rates reported are cumulative from quarter to quarter for all TMs

except for TM #1, which is reported on a 12-month rolling period.

The following TMs show results for DY10 Q1 reporting.

TM #1 – Fall Risk Management

The percentage of Medicaid members 65 years of age and older with an outpatient visit with a diagnosis of a fall or problems with balance/walking and were screened by a practitioner for fall risk on the date of the diagnosis. An increase in percentage indicates improvement for this measure.

- BCBS Q1 0.01%
- PHP Q1 1.51%
- WSCC Q1 0.11%
- MCO Aggregate: Q1 total is 0.37%

MCO Strategies and Interventions:

- BCBS: Continued to educate clinicians on capturing fall risk assessment, as assessment is likely being done at each visit, but the clinicians may not be coding for it.

- PHP: Continued to provide follow-up for members who are engaged in care coordination to identify fall risk in the home, address needs related to activities of daily living, and support environmental modifications to support safety.

- WSCC: Referred members to the New Mexico Department of Health's Paths to Health fall prevention program to help members improve fall risk and promote fall prevention. WSCC educates members on the benefits of this fall prevention program.

TM #2 – Diabetes Short-Term Complications Admission Rate

Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees ages eighteen (18) and older. Reported as a rate per

	100,000 member months. A lower rate indicates improvement for this measure. • BCBS Q1 20.78 • PHP Q1 15.25 • WSCC Q1 13.21 • MCO Aggregate: Q1 total is 16.95 **MCO Strategies and Interventions:** • BCBS: Quality Improvement Department continued its collaboration with its primary dental vendor to send an educational flyer to 581 members diagnosed with diabetes, ages 18 and older that discusses the effects of diabetes on dental health, emphasize educational points such as healthy eating, annual A1c testing, and creating appointments for routine dental care. • PHP: In March 2023, phone calls were made to members identified as high risk, if they had not yet been contacted in 2023. • WSCC: Continued to partner with vendor to have at-home HbA1c kits mailed to members and have these kits sent back and completed so members have HbA1c completed timely. *TM #3 – Screening for Clinical Depression* Percentage of Medicaid enrollees ages eighteen (18) and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. An increase in percentage indicates improvement for this measure. • BCBS Q1 0.88% • PHP Q1 1.08% • WSCC Q1 0.93% • MCO Aggregate: Q1 total is 1.00%

	MCO Strategies and Interventions: • BCBS: A provider education video on how to appropriately bill for depression screening was developed and distributed in DY10 Q1. • PHP: Educational materials on the symptoms of depression and treatment for depression were provided to members with co-occurring diagnoses of diabetes or cardiovascular disease and via the Health Risk Assessment (HRA). • WSCC: Continued offering a provider incentive of $25.00 up to four times per year to non-behavioral health practitioners for administering the PHQ-9 depression screening tool (or equivalent screening tool) with WSCC members. *<u>TM #4 – Follow-up after Hospitalization for Mental Illness</u>* The percent of seven-day follow-up visits into community-based Behavioral Health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days. An increase in rate indicates improvement for this measure. • BCBS Q1 35.78% • PHP Q1 32.31% • WSCC Q1 30.08% • MCO Aggregate: Q1 total is 33.16% **MCO Strategies and Interventions:** • BCBS: Providers were offered an online training in DY10 Q1 on bipolar disorder and the importance of follow-up care and the follow-up after hospitalization measure. • PHP: The Behavioral Health Quality Incentive Programs (BQIPs) were promoted during the DY10 Q1 Provider Education Conference, and 8 provider groups enrolled in the program as a result.

	• WSCC: Continued to partner with a contracted behavioral health provider to facilitate completion of an initial telehealth assessment with members following an inpatient behavioral health stay. Members are referred for outreach and assessment by a licensed mental health clinician. Clinicians completed an initial assessment, encouraged members to engage in scheduled aftercare appointments, and connected members with community resources as needed. During the months of January and February 2023, the behavioral health provider successfully engaged 21.4% of members and completed 31 assessments. *<u>TM #5 – Immunizations for Adolescents (IMA)</u>* The percentage of adolescents thirteen (13) years of age who had one (1) dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. An increase in percentage indicates improvement for this measure. • BCBS Q1 74.58% • PHP Q1 74.64% • WSCC Q1 71.39% • MCO Aggregate: Q1 total is 74.28% **MCO Strategies and Interventions:** • BCBS: A child/teen email was sent to members in DY10 Q1 to remind parents/guardians to schedule an appointment with their healthcare provider. The email included links to educational newsletters and media for child/teen immunizations. • PHP: Performance improvement collaboration with New Mexico Alliance for School Based Heath Centers (NMASBHC) to increase health education on immunizations for School Based Health Centers statewide. • WSCC: Value Based team and Provider Quality Liaisons

	(PQLs) hold provider engagement meetings reviewing scorecards that include a list of all members that have a gap in care for immunizations. *TM #6 – Long-Acting Reversible Contraceptive (LARC)* Utilization of Long-Acting Reversible Contraceptives. The contractor shall report LARC insertion/utilization data for this measure. • BCBS Q1 182 • PHP Q1 293 • WSCC Q1 37 • MCO Aggregate: Q1 total is 512 *TM #7 – Smoking Cessation* The MCO shall report the number of successful quit attempts. The MCO shall monitor the use of smoking cessation products and counseling utilization. Total number of unduplicated members receiving smoking and tobacco cessation products/services. • BCBS Q1 1,080 • PHP Q1 1,364 • WSCC Q1 281 • MCO Aggregate: Q1 total is 2,725 **MCO Strategies and Interventions:** • BCBS: Continued Pharmaceutical Service Reimbursement Parity to increase smoking cessation counseling and efforts by pharmacies to be reimbursed for services as well as products. • PHP: Continue to promote Tobacco Cessation Disease Management nurse-led program for members ages 14 and older. Nurse Advice Line team continues to take referrals and answer questions about the program. • WSCC: Tobacco cessation interventions are discussed during care coordinators completion of Comprehensive

	Needs Assessment (CNA) with members. *TM #8 – Ambulatory Care Outpatient Visits* Utilization of outpatient visits reported as a rate per 1,000 member months. An increase in rate indicates improvement for this measure. • BCBS Q1 73.63 • PHP Q1 52.55 • WSCC Q1 68.51 • MCO Aggregate: Q1 total is 61.89 **MCO Strategies and Interventions:** • BCBS: The Emergency Department (ED) Reduction program targets members who have visited the ED more than 6 times in the last 6 months. Targeted members are contacted by a Community Health Worker (CHW) to ensure members are established with a Primary Care Provider (PCP) and to educate members on the importance of being connected to out-patient care. • PHP: Aligned multidepartment communication outreach activities to improve messaging and decrease duplication and to ensure that all members in need of outreach are contacted via an appropriate channel. • WSCC: Care Coordinators continued to assist members with finding providers, closing gaps in care, finding transportation, and receiving relevant information. *TM #8 – Ambulatory Care Emergency Department Visits* Utilization of emergency department (ED) visits reported as a rate per 1,000 member months. A lower rate indicates improvement for this measure. • BCBS Q1 9.75 • PHP Q1 7.01 • WSCC Q1 10.96 • MCO Aggregate: Q1 total is 8.44

	MCO Strategies and Interventions: • BCBS: Critical incident reports that show members with a pattern of frequent emergency department visits and who are not listed as having an assigned Care Coordinator are referred to the Care Coordination team for follow-up and assessment. • PHP: Continues to build on provider relationships to ensure members are receiving services at the appropriate level of care. • WSCC: Emergency department visit notifications from Collective Medical Technologies are used to provide outreach to members by pulling claims data and finding members who may benefit from outreach to reduce gaps in care. *<u>TM #9 – Annual Dental Visit (ADV)</u>* The percentage of enrolled members ages two (2) to twenty (20) years who had at least one (1) dental visit during the measurement year. An increase in percentage indicates improvement for this measure. • BCBS Q1 19.77% • PHP Q1 21.34% • WSCC Q1 17.30% • MCO Aggregate: Q1 total is 20.37% **MCO Strategies and Interventions:** • BCBS: Community outreach events occurred in 2 cities in DY10 Q1, where BCBS members received dental exams. • PHP: In DY10 Q1, there were 24,992 Early Periodic Screening Diagnostic and Treatment (EPSDT) letters mailed to members in the Annual Dental Visit (ADV) age group of 2 to 20 years old. • WSCC: The FarmBox program is used as an incentive

for the member to complete an ADV by providing a healthy snack box once the member's ADV has been completed and claims data has been sent to WSCC.

TM #10 – Controlling High Blood Pressure (CBP)

The percentage of members ages eighteen (18) to eighty-five (85) who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. An increase in percentage indicates improvement for this measure.

- BCBS Q1 15.92
- PHP Q1 25.39
- WSCC Q1 9.38
- MCO Aggregate: Q1 total is 19.82

MCO Strategies and Interventions:

- BCBS: In DY10 Q1, the Clinical Value Consultant team held joint operating committee meetings with multiple provider groups as part of value-based contracting arrangements to improve HEDIS measure performance, including CBP, for their membership.

- PHP: The HEDIS measure technical specifications were used to form an at-home program plan including exploring at-home blood pressure monitoring with the possibility of a future pilot program.

- WSCC: Offered health education programs for members with chronic health conditions, such as diabetes, that have comorbid complications of high blood pressure.

TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Initiation Phase: The percentage of members ages six (6) to twelve (12) newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had one follow-up visit with a practitioner with prescribing authority within 30 days of when the first ADHD medication was dispensed. An increase in rate

	indicates improvement for this measure. • BCBS Q1 45.44% • PHP Q1 28.70% • WSCC Q1 46.09% • MCO Aggregate: Q1 total is 37.29% **MCO Strategies and Interventions:** • BCBS: A provider education webinar, bipolar disorder: Assessment and Treatment, which included the ADD measure, occurred in DY10 Q1. • PHP: Collaborated with the Value-Based Programs team to increase provider enrollment in the Provider Quality Incentive Plan for the ADD measure since most prescribers who prescribe ADHD medications are PCPs. • WSCC: In 2023, PQLs are placing a greater emphasis on behavioral health measure discussions with providers, including providing each provider with a member care gap list, since contracted providers report having programs in place to conduct outreach to patients with behavioral health care gaps. *TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)* Continuation and Maintenance Phase: The percentage of members ages six (6) to twelve (12) newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at least two follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure. • BCBS Q1 57.14% • PHP Q1 36.04% • WSCC Q1 72.22% • MCO Aggregate: Q1 total is 45.54%

	MCO Strategies and Interventions: • BCBS: A member education video on the importance of medication compliance continued to be distributed in DY10 Q1. • PHP: Educated providers via the provider newsletter on the ADD measure and encouraged providers to schedule follow-up appointments before the patient leaves the office when prescribing a new ADHD medication. • WSCC: Transportation services via the vendor are available and encouraged for members who are having difficulties getting to appointments or who need transportation to get to the pharmacy to pick up prescribed medications after being discharged from a behavioral health inpatient stay. *TM #12 – Child and Adolescent Well-Care Visits (WCV)* The percentage of members three (3) to twenty-one (21) years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. An increase in percentage indicates improvement for this measure. • BCBS Q1 9.68% • PHP Q1 7.67% • WSCC Q1 8.18% • MCO Aggregate: Q1 total is 8.41% **MCO Strategies and Interventions:** • BCBS: The WCV performance measure was newly added to multiple provider group value-based contracts in DY10 Q1, making joint operating meetings possible where performance goals aimed at improving WCV rates for the provider group's membership. • PHP: Outreach efforts in DY10 Q1 included social media posts on well-care visits for all age groups in this

	measure. • WSCC: The Quality Reporting Specialists and the Value Based Payment team conducted monthly provider engagement meetings to share member gap lists and ensure providers are contacting members to complete needed well care visits. **External Quality Review** HSD holds bi-weekly meetings with the External Quality Review Organization (EQRO) to review monthly projects, provide feedback, offer support, and assess issues. This process ensures that deliverables are met and that desired outcomes are achieved within the established timeframe. The meetings facilitate identifying potential areas for improvement, reviewing and revising existing processes, and developing new strategies for optimal project performance. HSD's collaboration with the EQRO fosters a culture of continuous improvement. EQR Reviews and Validations in DY10 Q2 consisted of the below. DY8 EQR Reviews and Validations: • DY8 Validation of Network Adequacy received by HSD from the EQRO and posted to the HSD website. • DY8 Performance Improvement Projects received by HSD from the EQRO. DY9 Compliance Review policy review tools for Federal Medicaid standards were sent to the MCOs by the EQRO.

UTILIZATION

- Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for April 2021 – March 2023. Please see Attachment C: Key Utilization/cost per Unit Statistics by Major Population Group.
- The underlying utilization and unit cost data is based on paid claims with no additional estimation for claims incurred but not reported. As such, a certain level of

underreporting exists due to claims runout, especially in the most recent months of the April 2022 – March 2023 time period.

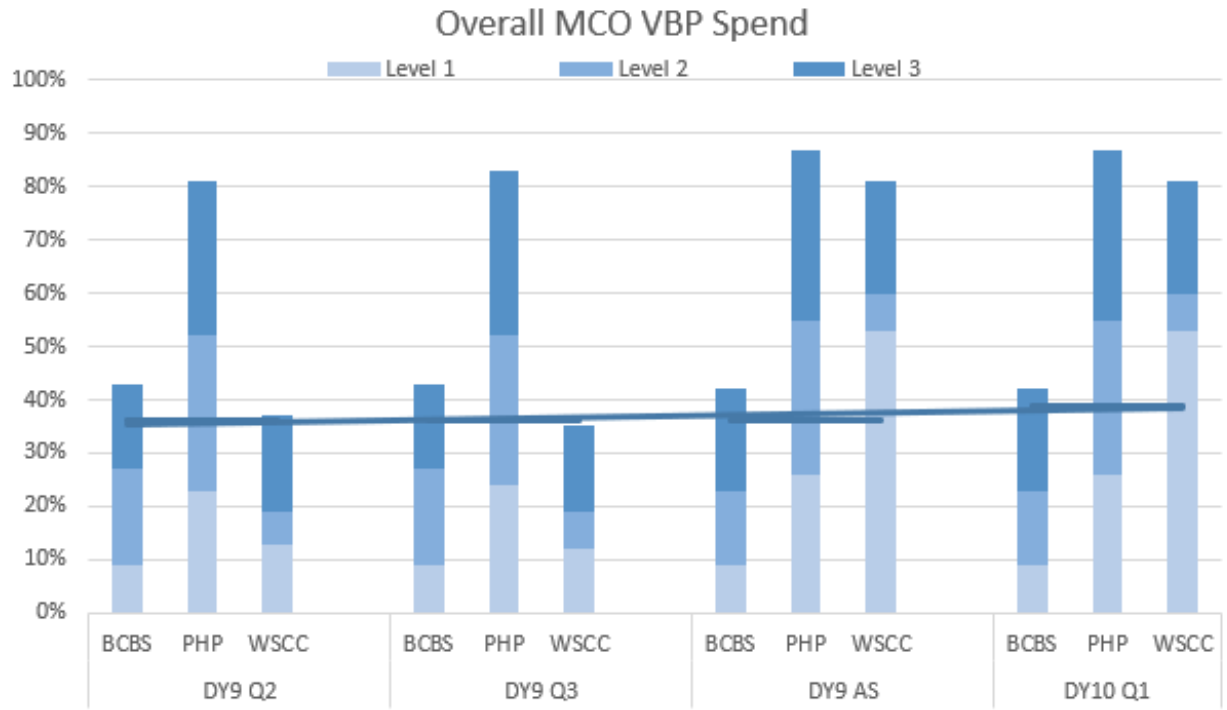
VALUE BASED PURCHASING

To support Centennial Care 2.0's value-based purchasing goals, HSD requires the MCOs to implement a Value Based Purchasing program that is based upon improved quality and/or member healthcare outcomes. To accomplish this, the MCO must meet minimum targets for 3 levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY10 requirements are as follows:

VBP Level	Level 1	Level 2	Level 3
Required Spend	13%	16%	10%
Required Provider Types	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities.	• 8% with traditional PH Providers. • 1% with Providers who are primarily BH (whose primary services are BH). • Actively build Long-Term Care Providers including nursing facilities full-risk.

For DY10 Q1, BCBS, PHP, and WSCC exceeded the required VBP spend target of 39%.

Table 27: MCO VBP Spend



Source: MCO Calendar Year (CY) 2022 Quarter 2-AS and (CY) 2023 Quarter 1 VBP Financial Reports.

LOW ACUITY NON-EMERGENT CARE (LANE)

As part of HSD's strategic goal to improve the value and range of services to members, HSD collaborates with the MCOs to reduce avoidable Emergency Room (ER) visits. HSD includes requirements in its Centennial Care 2.0 Managed Care Organization Contract that MCOs monitor usage of emergency rooms by their members and evaluate whether lesser acute care treatment options were available at the time services were provided. This results in the MCOs identifying high Emergency Department (ED)-utilizer members by monitoring data such as diagnosis codes and ER visit encounters and taking proactive steps to refer them to providers. The MCOs implement member engagement initiatives to assist in identifying member challenges through systemwide activities, including outreach by care coordinators, peer-support specialists (PSS), community health workers (CHWs), and community health representatives (CHRs) to decrease inappropriate ER utilization.

The Community Paramedicine Program is an additional outreach project supporting this effort. The program helps direct members to the right care, at the right time, and in the right setting for better health outcomes. The program is intended to reduce non-emergency medical calls, improve patient care and relieve rescue units for more life-threatening calls. The program targets members with chronic medical conditions such as diabetes and

congestive heart failure who also may face social barriers to better health, including unstable housing or unreliable transportation. In rural communities where transportation may be difficult to obtain or distance is a barrier, especially for people who are elderly or homebound, community paramedics play an important role on a patient's care team because they can also deliver basic primary care services in the patient's home without requiring them to travel to a clinic. Community paramedicine services can ensure prompt care and identify health issues that need to be escalated to another provider. Community paramedics can also facilitate communication between the patient and their primary care provider.

Because access to primary care is a key factor in reducing nonemergent Emergency Department visits, HSD is also working with graduate medical education (GME) programs to establish and/or expand existing programming, specifically in the primary care specialties of Family Medicine, General Internal Medicine, General Psychiatry, and General Pediatrics. A GME expansion 5-year strategic plan released by HSD in January 2020 estimates that 46 new primary care residents will graduate in New Mexico each year, beginning in 2025; and, the number of primary care GME programs will grow by more than 60% within the next 5 years.

BCBS' digital texting campaign sends text messages to members who have visited the ED a minimum of two times in the past 60 days, with links to help with finding a Primary Care Provider (PCP), location of the nearest Urgent Care Centers and the telephone number for the Nurse Advise Line. The current ED Reduction Program targets members who have visited the ED more than six times in the last six months. Targeted members are contacted by a Community Health Worker with a goal to ensure members are established with a PCP. Education is provided to members on the importance of being connected to out-patient care. Critical Incident reports are monitored for members that show a pattern of frequent ED visits. Members not listed as having an assigned care coordinator will be referred to care coordination for follow-up and assessment.

PHP has initiated several efforts to reduce avoidable ER visits. For ER visits that occur for members in level 2/3 care coordination, the care coordinator will assess the member for a change in condition and discuss the outcome of the ER visit. Care Coordinators provide needed follow-up and education concerning alternatives to ER and coordinate available services to avoid future ER visits. PHP ensures that members have an assigned PCP and provide education concerning the need for PCP engagement and ER alternatives, such as urgent care and utilization of the nurse advice line. Education is provided concerning transportation and assists with scheduling appointments when needed. For members who are not in level 2/3 care coordination, they are monitored through data mining to proactively

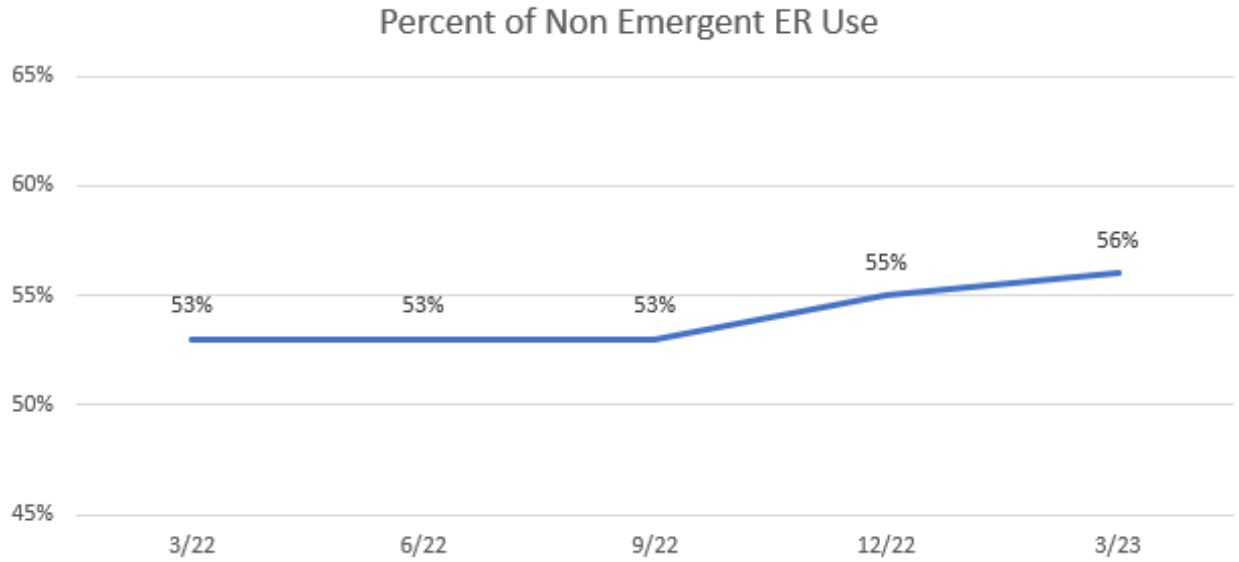
identify members who may be over-utilizing the ER or other services. PHP conducts outreach to complete an HRA for any member who is identified through data mining. PHP has an arrangement with Albuquerque Ambulance for members who are utilizing the ER for low acuity needs. Members who frequently use the ER inappropriately are referred to Albuquerque Ambulance, who provides member education concerning alternative sites of service for low acuity needs. PHP's peer support specialist team engages with members who have frequent ER utilization, typically related to substance use disorder, provide resources and support and, where possible, facilitate engagement with care coordination. The Community Health Worker team also has initiatives to address ER utilization including identifying and addressing social determinants of health (SDOH) needs that may contribute to unnecessary ER use and member education concerning alternatives to ER visits.

WSCC continues to send text messages to members that utilized the ED through their mPulse program. All WSCC members that visit the ED receive a text message to check in about follow-up care post ED visit, education about the use of primary care, versus urgent care, and emergency department, allowing members to access resources through text messages and to respond with any needs they may have. Members who respond indicating they have a need receive telephonic outreach from either their assigned care coordinator, if applicable, or from the WSCC Member Connections Team (CHWs/Peer Supports). WSCC care coordinators set alerts, when applicable, in Collective Medical to receive emails when one of their members has an ED visit, to address gaps in care, provide member education, connect members with providers, and assist with transportation or other barriers. WSCC also partners with UNM's CHW program for face-to-face emergency department outreach for WSCC members that visit the UNM EDs to engage members prior to leaving the ED and provide education and support as well as a hand off back to the WSCC team for continued follow up. WSCC also partners with Teambuilders, a community BH provider, to follow up with any member post ED visit for mental health reasons, to provide support and services. Members are also incentivized through a WSCC $30 dollar gift card for having a follow up visit within 14 days of an ED visit for substance abuse as well as educated about Centennial Rewards for members that have a follow up visit after being seen in the ED for a mental health reason. WSCC also works closely with Collective Medical to add the WSCC care coordinator's name and phone number to be viewed in the Collective Medical system by the hospital and emergency room staff so that they can connect WSCC members back to their care coordinator for support.

The percentage of emergency utilization that are considered low acuity increased from DY9 Q1 to DY10 Q1. In comparing low acuity ED visits from March of 2022 (53%) to March of 2023 (56%), the percentage of visits to the emergency department for non-emergent care increased by 3 percentage points. A lower rate indicates improvement for this measure.

The trend for this measure indicates a steady increase in the number of low acuity ED visits.

Table 28: Non-Emergent ER Use



Source: Mercer- Non-Emergent Emergency Room Utilization Report

14
MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in DY10 with the requirement that at least 90% of members having access to certain provider types in urban, rural, and frontier geographic areas within a defined distance. Geographical Access is collected and validated on a quarterly basis.

Physical Health and Hospitals

All 3 MCOs demonstrated steady access with slight fluctuations during this quarter.

- MCOs performance in access to general hospitals, PCPs, pharmacies, and most specialties in urban, rural, and frontier areas were met.
- Provider shortages have impacted geographic access; however, access has been maintained. MCOs closely monitor the following services and employ ongoing efforts to ensure member access such as targeted recruitments, referral training, provider enrollment training, telehealth options and value-based contract arrangements.
    - Rural areas did not meet standards for certified midwives, with two MCOs.
    - For FQHC – PCP only, one MCO did not meet the standards for Rural areas.
    - For dermatology, one MCO did not meet the standards for Urban areas and two MCOs did not meet the standards for Rural and Frontier areas.
    - For endocrinology, Rural areas did not meet standards and Frontier areas did not meet standards with two MCOs.
    - For Ear, Nose, and Throat (ENT), one MCO did not meet standards for Rural areas and another MCO did not meet standards for Frontier areas.
    - For Urology, one MCO did not meet standards for Frontier areas.
    - For Neurosurgeons, one MCO did not meet standards for Urban areas and none of the MCOs met the standards for Rural and Frontier areas.
    - For Rheumatology, one MCO did not meet standards for Urban areas and none of the MCOs met the standards for Rural and Frontier areas.

Table 29: Physical Health Geographical Access

	Geo Access PH DY10 Q1(January - March 2023 Data)								
	Urban			Rural			Frontier		
PH - Standard 1	BCBS	PHP	WSCC	BCBS	PHP	WSCC	BCBS	PHP	WSCC
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%	99.9%	100.0%
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.9%
FQHC - PCP Only	100.0%	100.0%	100.0%	90.3%	84.2%	99.4%	98.8%	90.0%	98.9%
PH - Standard 2									
Cardiology	99.2%	99.0%	99.0%	99.8%	100.0%	100.0%	99.9%	99.9%	99.8%
Certified Nurse Practitioner	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Certified Midwives	99.1%	98.9%	98.9%	81.4%	88.5%	99.1%	99.5%	98.6%	99.8%
Dermatology	79.4%	98.9%	98.9%	70.6%	71.5%	90.1%	85.2%	88.0%	98.0%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	99.1%	98.9%	98.9%	74.1%	65.6%	87.3%	84.2%	89.0%	92.8%
ENT	99.1%	98.8%	98.9%	82.6%	85.0%	100.0%	89.5%	83.6%	97.1%
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/ Oncology	99.10%	98.9%	98.9%	99.6%	94.7%	99.5%	99.5%	98.0%	93.6%
Neurology	99.10%	99.0%	99.0%	99.0%	96.2%	92.2%	94.0%	93.0%	95.5%
Neurosurgeons	99.10%	83.1%	98.9%	39.5%	67.4%	41.1%	67.9%	86.1%	82.3%
OB/Gyn	99.20%	98.9%	98.9%	99.8%	99.8%	100.0%	99.8%	99.8%	99.7%
Orthopedics	99.20%	98.9%	98.9%	95.4%	94.1%	100.0%	96.5%	98.0%	100.0%
Pediatrics	100.00%	98.9%	99.0%	100.0%	100.0%	99.9%	99.9%	98.7%	100.0%
Physician Assistant	100.00%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.20%	98.9%	99.0%	99.8%	99.7%	99.9%	96.7%	98.7%	100.0%
Rheumatology	99.10%	98.9%	83.3%	77.5%	83.6%	71.6%	82.3%	85.4%	76.3%
Surgeons	99.20%	99.0%	99.0%	100.0%	100.0%	100.0%	99.9%	99.9%	99.8%
Urology	99.10%	98.8%	98.9%	91.2%	93.5%	91.4%	89.3%	93.2%	90.6%
LTC - Standard 2									
Personal Care Service Agencies	100.0%	100.0%	100.0%	100.00%	99.7%	99.7%	100.0%	100.0%	100.0%
Nursing Facilities	99.3%	93.0%	99.4%	99.8%	97.7%	99.7%	99.9%	99.9%	99.8%
General Hospitals	99.2%	98.9%	98.9%	99.8%	99.5%	100.0%	100.0%	99.9%	99.8%
Transportation	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: MCO Report #55 GeoAccess Q1 CY22

Transportation

Non-emergency medical transportation is a means for MCOs to ensure members have timely access to needed services particularly for specialty services and provider shortage areas.

- **Grievances**: Consistent with previous reporting, Non-Emergency Medical Transportation (NEMT) grievances is the leading category of grievances in the reporting period. The MCOs along with HSD are monitoring accessible transportation options as a barrier to member access with transportation vendors and exploring new options. HSD continues to work with MCOs and internal bureaus on the concerns and inquiries surrounding the NEMT program, unreliable transports, and shortage in drivers and vehicles.

- **Initiatives**:
  HSD is continuing to amend directive and the New Mexico Administrative Code (NMAC) to address non-emergency medical transportation Prior Authorizations (PA) from 6-months to 12-month intervals. Additionally, the mileage associated with the aforementioned PA, will also be amended to reflect an increase from 65 miles to 120 miles.

  HSD is enhancing its oversight of the MCOs' provision of NEMT to its members. The initial focus is on trips for Critical Care Appointments: dialysis, radiation, chemotherapy, dialysis, pre/post-surgery, urgent care, and high-risk pregnancy. To date, the MCOs have been directed to: 1) work with their transportation vendors to ensure that all requested rides are provided for these appointments; 2) develop and submit for approval detailed operational plans for providing NEMT for Critical Care service appointments when the transportation vendors are unable to provide the service; 3) submit an NEMT monthly report that provides data on NEMT trips; and 4) in DY9 Q4, HSD provided performance targets to the MCOs for the number of trips that could not be scheduled, and for the number of scheduled trips that did not occur due to transportation provider actions, such as canceled or missed trips. The MCOs were informed that failure to meet the target level of performance would result in significant monetary penalties.

Customer Service Reporting

BCBS met all call center metrics for the reporting period, DY10 Q2.

PHP met all call center metrics for the reporting period, DY10 Q2.

WSCC met all call center metrics for the reporting period, DY 10 Q2.

Telemedicine Delivery System Improvement Performance Target (DSIPT)

The baseline for each upcoming CY will be the total number of unique members with a telemedicine visit at the end of the previous calendar year. If the MCO achieves a minimum

of 5% of total membership with telemedicine visits, as of November 30th of each year, then they must maintain that same 5% at the end of each CY to meet this target. The 5% threshold supersedes the 20% baseline target. The MCOs provide quarterly reports to HSD with the number of unique members served through telemedicine visits and an analysis of trends observed.

The MCOs shall use the end of CY22 as the baseline for CY23 increasing the number of unique members served with a telemedicine visit by 20% for both physical health and behavioral health specialists, focusing on improving telemedicine availability and utilization along with expanding member education and provider support when the 5% threshold is not met.

All three MCOs met the 5% of total membership with telemedicine visits for the Telemedicine Delivery System Improvement Performance Targets for DY10 Q2.

Table 30: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine	DY9 Q3	DY9 Q4	DY10 Q1	DY10 Q2
New Behavioral Health Members	**9,832**	**6,669**	**35,666**	**7,987**
BCBSNM	3,717	2,470	14,928	3,490
PHP	4,896	3,296	16,542	3,122
WSCC	1,219	903	4,196	1,375
New Physical Health Members	**23,879**	**17,694**	**45,696**	**19,953**
BCBSNM	8,941	6,910	17,424	7,187
PHP	12,752	9,235	24,792	10,763
WSCC	2,186	1,549	3,480	2,003
Total New Unduplicated Members	**27,958**	**19,923**	**66,573**	**24,371**
BCBSNM	10,331	7,531	26,217	9,073
PHP	14,749	10,343	33,681	12,342
WSCC	2,878	2,049	6,675	2,956
YTD* Unduplicated Members	**164,920**	**184,843**	**66,573**	**99,478**
BCBSNM	60,474	68,005	26,217	38,394
PHP	90,068	100,411	33,681	50,881
WSCC	14,378	16,427	6,675	10,203

Source: Telemedicine Delivery System Improvement Performance Target (DSIPT) * April – June 2023.

15
DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
DY10 Q2	HSD and Health Services Advisory Group, Inc. (HSAG) continued to work together to refine AIM 4 (Improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder [SUD]) measures for the Summative Evaluation Report and discuss the serious mental illness/serious emotional disturbance (SMI/SED) amendment. HSAG will continue to collaborate with HSD to refine AIM 4 measures and revise the Evaluation Design Plan to include measures that evaluate the SMI/SED amendment. HSD and HSAG continued discussions on the impacts of the COVID-19 PHE on the Waiver Demonstration. The COVID-19 PHE most notably impacted the rate of SUD and the availability of treatment for SUD. Telehealth rates also saw a significant increase during the COVID-19 PHE. Additionally, there was a cost spike in 2021, most likely attributable to the pent-up demand caused by COVID-19.

16
ENCLOSURES/ATTACHMENTS

Attachment A: April 2021 – March 2023 Statewide Dashboards
Attachment B: Budget Neutrality Monitoring Spreadsheet
Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment D: Customer Service

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STATE CONTACTS

HSD State Name and Title	Phone	Email Address
TBD Medicaid Director HSD/Medical Assistance	TBD	TBD
Lorelei Kellogg **Acting Medicaid Director** Deputy Director of Programs HSD/Medical Assistance	505-629-2938	lorelei.kellogg@hsd.nm.gov
Elisa Walker-Moran Deputy Director of Finance HSD/Medical Assistance	505-470-9330	Elisa.Walker-Moran@hsd.nm.gov
TBD Deputy Director of Systems HSD/Medical Assistance	TBD	TBD
Michal Hayes Deputy Director of Contracts HSD/Medical Assistance	505-699-5859	Michal.Hayes@hsd.nm.gov
Annabelle Martinez Acting Deputy Director of Programs HSD/Medical Assistance	505-690-2439	annabellem.martinez@hsd.nm.gov
Alanna Dancis Chief Medical Officer HSD/Medical Assistance	505-470-9334	alanna.dancis@hsd.nm.gov

At the end of January 2023, New Mexico's Medicaid Director, Nicole Comeaux J.D. MPH, departed from the Human Services Department after serving as Director of the Medical Assistance Division since January 2019. Medicaid's Deputy Director of Programs, Lorelei Kellogg was appointed acting Medicaid Director. Lorelei is leading our unwinding activities and has worked for the Department in different roles for 10 years.

In March 2023, New Mexico's Deputy Director of Programs, Erica Archuleta and Deputy

Director of Systems, Linda Gonzales departed from the Human Services Department. Annabelle Martinez, serving as the Bureau Chief of Benefits and Reimbursement was appointed acting Deputy Director of Programs. The Bureau Chief of Systems in collaboration with our Acting Medicaid Director have continued system monitoring and oversight activities.

In November 2023, Michal Hayes filled one of New Mexico's vacant Deputy Director positions. Michal has practiced as an attorney for the State of New Mexico for twenty years working with a variety of State agencies. Annabelle Martinez continues to maintain her active role until activities are fully transitioned. New Mexico will continue to update CMS on new points of contact as positions are permanently filled.

18
ADDITIONAL COMMENTS

MCO INITIATIVES

BCBS:

Behavior Heath Providers

BCBS' Contracting team executed 101 new contracts.

Member Care Fund (MCF)

The Member Care Fund (MCF) has helped BCBS members fill the social determinants of health gaps identified through the care coordination process. In DY10 Q2, the program served 74 members (BH 31) (PH 43) of which 39% are Latino, 38% white, 12% Native American, 5% African American, and 6% unknown. Members served were 55% female, 45% male.

Program results included assisting 36 members with access to address their basic needs with the following reported results: 31 with improved member health and well-being; 5 with improved compliance with treatment; and 2 members with the initiation of Care Coordination. Members received hygiene items, clothing, household furniture, cleaning products, and small appliances. Funds were also used for auto repairs, so members could access medical appointments and employment.

Risk Stratification			
Month	**High**	**Moderate**	**Total Members**
April 2023	15%	85%	27
May 2023	35%	65%	20
June 2023	26%	74%	27

PointClickCare

BCBS uses the PointClickCare system to monitor members with high admission rates to hospitals and emergency rooms. For members with high admission rates or who meet specific SUD criteria, Certified Peer Support workers, also known as Recovery Support Assistants (RSAs) are assigned to meet with the member while they are in the emergency room to assist in addressing member needs. RSAs provide focused peer support by identifying social determinants of health needs. They also identify any needed community

supports and services (e.g., housing, employment, etc.) for the member. RSAs work closely with members to provide recovery support, leveraging their own experiences as peers and their own paths to recovery to develop trust, to engage with the member, and to work toward resolving crises.

PHP:

SDOH-based Referral System Pilot

In DY10 Q1, PHP formed a partnership with Unite Us to explore the development of a closed-loop referral system to screen for social determinants of health (SDOH) needs and provide referrals based on identified needs. The focus was on five priority populations, including PHP Medicaid members who are:

- Pregnant, postpartum, or young children;
- Seniors and those with LTSS needs;
- Experiencing behavioral health needs;
- Belonging to tribal communities; and
- Justice-involved.

In DY10 Q2, PHP launched the development of this closed loop referral system. Implementation will occur in six pilot counties, including:

- Dona Ana
- Lincoln
- Otero
- Rio Arriba
- Taos, and
- San Miguel

PHP launched three primary workstreams to deploy this work, including the following:

- Community Engagement: Organize identification of, outreach to, and engagement with community-based organizations (CBOs) to join the Unite Us platform.
- Provider Network: Organize identification of, outreach to, and engagement with providers and provider groups to join the Unite Us platform.
- Data and IT Integrations: Lead the technological components to launch and implement the Unite Us platform for PHP Members, to include security connections, Member identification, and utilization of data sharing.

Achievements

- Began identification of and engagement with Community Benefit Organizations (CBOs) in all six counties.

- Established communications with Dona Ana County and Santa Fe Connect to align referral network processes and set the stage for state-wide alignment.
- Began identification and outreach to providers in four of the six target counties.
- Completed internal reviews and approvals for data exchange.

Population Health Pilot Programs
In 2023, PHP worked to finalize contracts and launch the following Population Health Pilot Programs:

- *Resilience* – Shared Savings for Members with Serious Mental Illness (SMI) focused on effective management to prevent and reduce emergency department and inpatient services.
- *FamiliesFirst* – Shared Savings, quality perinatal, and pediatric care focused on building a foundational infrastructure for healthy families throughout the perinatal journey and into infancy and childhood development.

Website Tools & Support
In DY10 Q2, PHP researched and explored opportunities to partner with a prospective vendor to deliver population health digital wellbeing tools and support. Additionally, PHP identified focus areas for at-risk populations, specifically perinatal, and special-needs populations. This was also an opportunity to develop Member-centric initiatives, activities, and targeted interventions. The Wellness and Health Education (WHE) Team researched and tested new digital products that are designed to improve member interaction and engagement. As a part of this work, the WHE team was able to gain insight and experience into population health journeys for members.

PHP tested and deployed an updated eligibility file, which included new data sources and transitions between current and prospective claims systems. These updates also induced new file fields to identify at-risk populations and conduct tailored outreach, specifically among native and tribal populations.

WSCC:
Homeless Shelter Outreach: WSCC understands how difficult it can be for members experiencing homelessness to get preventative screenings. Many of these members do not have a mailing address and are unable to participate in the in-home A1c screening program. To assist these members, in March 2023 WSCC implemented a pilot project to make in-home A1c test kits available at local homeless shelters in Albuquerque. The WSCC Member Connections Team takes the kits with them to the shelter, walks members through the instructions to complete the test kit, and then mails the kit to the lab. The Team has gift cards on hand for these members. WSCC continues to work with homeless

shelters to build rapport, provide education about the importance of health screenings, and discuss the benefits and convenience of having onsite screening kits easily accessible.

Provider Outreach and Education

In DY10 Q2, Provider Outreach and Education offered education to our providers, caregivers, and community stakeholders. Below are some highlights:

Highlights:

- By the end of DY10 Q2, WSCC Clinical Provider Trainers will have offered at least 75 trainings on long-term care, foster care, behavioral health, and/or integrated health care related topics. At the time of this report, trainings offered during DY10 Q2 had an average Net Promoter Score (NPS) of 99 and had at least 231 participants.
- At least 61 trainings offered were eligible for continuing education in DY10 Q2.
- All provider training can be accessed on WSCC's Training and Education Page located on its website.
- Caregiver Training for unpaid and partially paid caregivers of vulnerable and/or older adults can be accessed at: Caregiver Resources on WSCC's website.

MEMBER SUCCESS STORIES

BCBS:

A 42-year-old BCBS member and refugee from Ukraine has been in the United States for approximately one year. Member has five-year-old twins, one of whom has a diagnosis of autism. She faces multiple barriers which include language, transportation, culture, location, and trust. She currently has a host family who is assisting her with housing and basic needs. She is also currently enrolled and involved with the Lutheran Family Services Resettlement Agency to assist her with obtaining social services and connecting with community programs. Member needed assistance getting established with medical and dental providers for herself and her children as well as learning how to access transportation to and from appointments.

The Care Coordinator (CC) helped member establish care with medical and dental providers. She is currently taking English classes with Lutheran Family Services, in addition to using an online app. She wants to be employed and own a home. The member receives SNAP. Her two sons recently received their Social Security numbers and cards, and she is awaiting hers.

With the CC's help, the member has established care with providers, and is compliant with

attending appointments for herself and her children. She keeps her translation app by her side when she has difficulty expressing words. She understands how to access transportation services, and routinely communicates to her CC any updates after medical or dental visits. She is well organized and keeps all the paperwork from the Department of Health (DOH), and other agencies, including BCBS, to help her access needed health care and social services assistance. With her CC's assistance, she now understands how to navigate the health care system.

PHP

A PHP member had struggled with medication compliance for years. He often reported he was not getting medications filled timely. In the past, the PHP Care Coordinator (CC) set up medication consultations with his PCP and the local pharmacy, tried using a medication pill box with a reminder and changed him to mail order delivery of prescriptions. However, the member continued to be confused and reported he was not getting medications filled timely. He also reported great difficulty in setting up his pill box due to rheumatoid arthritis (RA) in his hands and fingers. With the member's permission, PHP's CC reached out to the PCP to discuss private duty nursing (PDN). The CC also reached out to home health agencies and was able to find a provider who was willing to travel to Fort Sumner to set up the member's pill box every other week. His PCP wrote an order for PDN services, and this was approved for the remainder of the Level of Care year. The member initially reported that he did not feel PDN was helping him. The CC asked for more details and the member reported the pill box the agency was using was hard to open. CC immediately reached out to Clovis Community Homecare, and they were willing and able to get the member a new pill box that is much easier for him to open. The CC spoke to the member last week and he reported being very pleased with his PDN, and he feels he can manage his medications much better.

WSCC:

A member struggled with alcohol abuse, mental health illness, and homelessness. The member was not taking any medications, placed himself in unsafe situations, and had legal problems. The member's Care Coordinator (CC) referred him to Albuquerque Street Connect – Heading Home and a Case Manager (CM). The CM supported the member in attending needed appointments and helped him get established with a court-appointed treatment guardian and financial payee. The WSCC CC and Street Connect CM collaborated to identify appropriate providers to address all of Member's physical and mental health concerns and get him established with personal caregiving services. The CM worked to get the member into safe and stable housing. The member today has his own apartment, with adequate food and clothing; he also has a caregiver who helps with appointments and medications. The member has not had any hospitalizations or arrests in

over a year and continues to attend all his appointments.

MCO COVID-19 Relief Efforts and Unwinding Activities

BCBS:

Grants

- There were no COVID-19 related grants received or issued in DY10 Q2.

Donations

- There were no donations issued in DY10 Q2.

Events

- McKinley Spring Showcase, April 5
- Luna Community College Health Fair, April 12
- Anthony COVID-19 Vaccine Clinic, April 17
- Sunland Park COVID-19 Vaccine Clinic, April 18
- Premier Medical Group Vaccine Clinic, April 24
- Thomas Branigan Library Vaccine Event, May 5
- Bernalillo County Group Event, May 10
- Premier Medical Group Vaccine Clinic, May 12
- Tijeras Senior Health and Information Fair, May 15
- Anthony COVID-19 Vaccine Clinic, May 15
- Solar Villa Apartments Vaccine Clinic, May 16
- Sunland Park COVID-19 Vaccine Clinic, May 16
- Bernalillo County Group Event, May 18
- Bernalillo County Group Event, May 19
- Premier Medical Group Vaccine Clinic, May 22
- Brentwood Apartments Vaccine Clinic, May 24
- Bernalillo County Group Event, May 24
- National Senior Health & Fitness Day, May 31
- Thomas Branigan Library Vaccine Event, June 2
- Nuevo Atrisco Apartments Vaccine Clinic, June 15
- Anthony COVID-19 Vaccine Clinic, June 19
- Sunland Park COVID-19 Vaccine Clinic, June 20
- Mesilla Ranch Vaccine Clinic, June 21
- San Felipe Pueblo Health Fair, June 22

PHE Unwinding Outreach Actions, June 2023

Member Calls

Direct member (non-prerecorded) outbound calls: June 2023	BCBS
Members scheduled for direct calls	508
Number of calls made	537
Answered	516
No answer	21
Voicemail	N/A
Hung up	N/A
Contact completed (member reached; information conveyed)	497
Average call duration	N/A
Member inbound calls related to recertification	466

Outreach Completed

Outreach Efforts Completed: June 2023	BCBS
Members targeted	28,680
Special COEs/Groups targeted	N/A
Member letters/direct mail	7,499
Email 1	N/A
Email 2	N/A
Postcards	10,760
Text message 1	N/A
Text message 2	N/A
Text message 3	N/A
Text message 4	N/A
Robocalls	N/A

Efforts targeting the closed population
Communications (emails and letters) have been sent to the closed population received via the June 2023 Termination file from the HSD urging members to not go uninsured but explore alternative BCBS plan options at BeWellNM.com.

Notes
BCBS will deliver school supplies to 5 public schools within each quadrant of the state including central New Mexico, from the end of July through the middle of August. At each delivery, backpacks will be provided to students including Medicaid PHE unwinding information for the parents. The backpacks include headphones, notebooks and various grade-appropriate supplies. Teachers and administrators of each school will receive additional supplies including tissue, Clorox wipes, dry erase markers and various requested items.

PHP:

COVID-19 Relief Efforts DY10 Q2

- PHP includes COVID-19 questions in Care Coordinator/Community Health Worker Assessment tools.
- PHP continued to encourage members to get vaccinated.
- PHP held a free COVID-19 vaccination clinic event for New Mexico families on 5/20/23 and 6/10/23. Persons 6 months and older could come get vaccinated with no appointment or insurance required. Families were offered an "Arts & Culture Family Pass" for free admission to the Albuquerque BioPark Zoo, the Albuquerque BioPark Aquarium and Botanic Garden, the Albuquerque Museum, and the Anderson Abruzzo Albuquerque International Balloon Museum. Additionally, a $25.00 gift card was provided to the first 100 people to attend.

PHE Unwinding Outreach Actions, June 2023

Member Calls *

Direct member (non-prerecorded) outbound calls: June 2023	PHP
Members scheduled for direct calls	4,984
Number of calls made	4,984
Answered	1,395
No answer	1,724
Voicemail	1,649
Hung up	216
Contact completed (member reached; information conveyed)	See Notes **
Average call duration	2m 5s
Member inbound calls related to recertification	330

Outreach Completed **

Outreach Efforts Completed: June 2023	PHP
Members targeted	14,535
Special COEs/Groups targeted	
Member letters/direct mail	13,983 (6/8)
Email 1	1,212 (6/14)
Email 2	
Postcards	4,815
Text message 1	14,535 (6/20)
Text message 2	
Text message 3	
Text message 4	

Robocalls	

Efforts targeting the closed population

Notes
* The data above reflects targeted outbound calls to Medicaid members that termed 5/31/2023 in the 5-county area (Bernalillo, Sandoval, Santa Fe, Torrence, and Valencia). The data does not include calls made to members in care coordination as we are calling all impacted members by care coordinator and not tracking to this level of specificity.
** **Contact completed (member reached; information conveyed)** Already Insured-with Another Carrier - 78 Already Insured-with beWellnm - 10 Already Insured-with Employer Group - 305 Already Insured-with PHP - 42 Moved out of NM - 6 Nurturing for HIX enrollment - 72 Spanish Speaking - 52 PHP Premium is too high - 12 Reapplying for Medicaid - 622 Renewed on Medicaid - 132 Wrong Number - 61 Total = 1,395
*** 13,983 letters were sent to members beginning on June 8. 1,212 emails were sent to all members for which we had a valid email address on June 14. The email mirrored the information included in the letter. Text messages were sent in two batches, one on June 20, which went to 6,999 members and a second batch that was sent on June 21 to 7,536 members. Discrepancies between the amount of texts sent and the amount of letters is due to householding the mailing and some invalid mailing addresses.

WSCC:

- WSCC has been collaborating with the other MCOs and community partners to make COVID-19 vaccination a part of immunization events and community outreach.

PHE Unwinding Outreach Actions, June 2023

Member calls

Direct member (non-prerecorded) outbound calls June 2023	Western Sky
Members scheduled for direct calls	314
Number of calls made	314
Answered	0
No answer	12
Voicemail	128
Hung up	9
Contact completed (member reached, information conveyed)	91
Average call duration	2.8 mins

Member inbound calls related to recertification	170

Notes

Answered: references individuals that answered, but could not complete call at the time.
Inbound Calls Activity:
Average Call Duration: 13.6 minutes
Voicemails: 3 inbound voicemails

Outreach Completed

Outreach Efforts Completed June 2023	Western Sky
Members targeted	7260
Special COEs/Groups targeted	31, 300, 301, High Risk Care Coord. (CCL2 & CCL3)
Member letters/direct mail	6171
Email 1	1563
Email 2	1618
Postcards	6171
Text message 1	3467
Text message 2	3435
Text message 3	3394
Text message 4	3621
Robocalls	3638

Efforts targeting the closed population

Western Sky completed a mailer campaign to all May Termed Members in the closure report. We have also initiated text, email and robo to all termed membership. All termed membership is also invited and outreached to for participation at local events - such as the movie night.
- Returned Redetermination Letters : 356
*Members Targeted includes members in Closure report

Notes

Western Sky Community relations attended several community events and addressed redetermination and hosted two movie nights with enrollment assistance in Hobbs and Mora; promoted to members and community. Also, coordinated with local PED's to attend events and support with event outreach efforts, hosted in-services and offered support.

Back-to-school season is right around the corner-Western Sky will host 4 annual back-to-school events in

several areas throughout the state, Albuquerque, Las Cruces, Taos, and Hobbs. At these events we will provide several resources that get children and families ready for the school year, such as sports physicals, haircuts, vaccinations, vision screenings, clothing access, enrollment support and more! Additionally, we're supporting over 5 school districts in Alamogordo, Roswell, Portales, Clovis, Atrisco Heritage (ABQ), and in Las Cruces with DOH-Got Shots campaign. In Alamogordo, we partner with their public school district and offer several health screening resources, mental health access and enrollment assistance.

State of New Mexico
All Centennial Care Populations
Fee & Benefit Change Summary

Reported Eligibility for Members Enrolled as of: March 31, 2023
Previous Period: April 1, 2021 to March 31, 2022
Current Period: April 1, 2022 to March 31, 2023

Program Changes Effective on or after 1/1/2021	
Crisis Triage Center (CTC) Adjustment	Beginning in January 1, 2021, the CTC adjustment reflects the inclusion of CTC providers providing adult outpatient services.
Minimum Wage Increases	The Minimum Wage Adjustment reflects increases in the hourly minimum wage from the base period to the contract period in New Mexico over time.

Program Changes Effective on or after 7/1/2021	
HCQS Per Diem and NF MBI Updates	The HCQS adjustment effective July 1, 2021 reflects an updated surcharge for NFs with over 60 beds. The NF MBI adjustment reflects an update to the MBI increase to all NFs. The MBI adjustment compounds with the total MBI percentage effective July 1, 2020.
Addition of New Home Visiting Providers	The Addition of New Home Visiting Providers adjustment reflects two new providers offering Nurse Family Partnership and Parents as Teachers programs effective October 1, 2021 and three new providers will offer Parents as Teachers programs effective November 1, 2021 under the Centennial Home Visiting program.
Proposal W.2 Temporary Economic Recovery Payment	The Temporary Home & Community Based Services (HCBS) Fee Increase reflects the cost of HSD's Proposal W.2 as outlined in their American Rescue Plan Act (ARPA) spending plan, as part of their efforts to "enhance, expand, or strengthen" the HCBS workforce. The rating adjustment applied as a 15.0% increase effective July 1, 2021.

Program Changes Effective on or after 1/1/2022	
COVID-19 Testing	The COVID-19 Testing Costs adjustment reflects the costs of diagnostic and antibody testing for COVID-19.
COVID-19 Treatment	The COVID-19 Treatment Costs adjustment reflects the cost of treatment for COVID-19.
COVID-19 Net Deferred Costs	The COVID-19 Net Deferred Care adjustment reflects net costs that will be delayed, canceled, and recouped due to reduced elective care and reduced access to some non-elective care. For the contract period, Mercer expects a full-return stage level of care, resulting in a net zero adjustment being applied for all programs.
COVID-19 Enrollment Acuity Adjustment	The COVID-19 Enrollment Acuity adjustment accounts for changes in Medicaid enrollment due to members retaining eligibility through the end of the public health emergency who would otherwise be determined ineligible for Medicaid through the redetermination process.
Community Hospital – Native Americans Rate Increase	The Community Hospital – Native Americans Rate Increase reflects a 33.0% increase to reimbursement levels for inpatient and outpatient services to eligible in-state hospitals with high total Medicaid and high Native American utilization and a 13.0% increase to eligible hospitals with high Native American utilization effective January 1, 2022
Trauma Hospital Rate Increase	The Trauma Hospital Rate Increase reflects the following rate increases to reimbursement levels for inpatient and outpatient trauma services for in-state trauma hospitals and developing trauma hospitals: Level I Hospitals: 0.9%; Level II Hospitals: No Adjustment; Level III Hospitals: 13.3%; Level IV Hospitals: 37.0%. Effective January 2022 Sandoval Regional Medical Center has been classified as a Level III Trauma Center and Cibola General has been removed as a Level IV Trauma Center.
Extension of Postpartum Eligibility	The Extension of Postpartum Eligibility adjustment reflects the rating impact of extending postpartum Medicaid eligibility from 60 days to 1 year, effective April 1, 2022.

Program Changes Effective on or after 7/1/2022	
Health Care Quality Surcharge (HCQS) Per Diem	Beginning in January 1, 2020, the HCQS adjustment reflects a per-diem increase to payment rates of eligible NFs with over 60 beds. The CY2023 rates reflect the HCQS add-in rates effective July 1, 2022 for NFs with over 60 beds.
Nursing Facility Market Basket Index (NF MBI)	Beginning in January 1, 2020, the NF MBI adjustment reflects a percentage increase to payment rates of eligible NFs. The CY2023 rates reflect the NF MBI percentage increase effective July 1, 2022, which is compounded with the MBI percentage increases effective July 1, 2019, July 1, 2020, and July 1, 2021.
Earned Sick Leave	The Earned Sick Leave adjustment reflects the cost of employees working in the state (including part-time, seasonal or temporary workers) previously not provided earned sick leave accruing at least one hour of earned sick leave for every 30 hours worked, up to 64 leave hours per year, pursuant to House Bill 20. 'This adjustment is effective July 1, 2022.
Proposal W.2 Temporary Economic Recovery Payment	The Temporary Home & Community Based Services (HCBS) Fee Increase reflects the cost of HSD's Proposal W.2 as outlined in their American Rescue Plan Act (ARPA) spending plan, as part of their efforts to "enhance, expand, or strengthen" the HCBS workforce. The rating adjustment was revised from 15.0% to 10.0% effective July 1, 2022.
EPSDT Rate Increase	The EPSDT Rate Increase effective July 1, 2022 reflects the following rate increases for selected EPSDT services for members age 0-20 for two provider classes: For Public Duty Nursing (Provider Type 324): 100.3% to procedure code S5125; 92.3% to procedure code S9122; 76.4% to procedure code T1000 with modifier TD; 105.0% to procedure code T1000 with modifier TE; 29.5% to procedure code T1001; 76.4% to procedure code T1002; and 88.9% to procedure code T1003; For Home Health (Provider Type 361): 100.3% to procedure code S5125; 92.3% to procedure code S9122; 76.4% to procedure code T1000 with modifier TD; 105.0% to procedure code T1000 with modifier TE; 29.5% to procedure code T1001; 76.4% to procedure code T1002; and 88.9% to procedure code T1003.
Gross Receipts Tax Reduction	The Gross Receipts Tax Reduction reflects the impact of the New Mexico gross receipts tax rate decreasing from 5.125% to 5.000% effective July 1, 2022, and subsequently decreasing to 4.875% effective July 1, 2023, pursuant to House Bill 163.

Program Changes Effective on or after 1/1/2023	
Expanded Mobile Crisis Initiatives	The Expanded Mobile Crisis Initiatives adjustment effective January 1, 2023 reflects the cost of implementing mobile crisis services in support of state initiatives related to 988.
EBP Rate Enhancements	The EBP Rate Enhancements effective January 1, 2023 reflect the cost of implementing enhanced behavioral health services and evidence-based practices (EBPs) available to all populations, including children in state custody.
RTC Facility Closure	The RTC Facility Closure adjustment reflects the impacts of members transitioning from receiving behavioral health services at Bernalillo Academy residential treatment center to other providers, following the closure of the facility in December 2021.
Orthodontia Authorization Change	The Orthodontia Authorization Change adjustment effective January 1, 2023 reflects the increased orthodontia service utilization estimated due to changes in the clinical evaluation threshold requirements a member must meet in order to obtain approval for orthodontia services.
Silver Diamine Fluoride	The Silver Diamine Fluoride adjustment effective January 1, 2023 reflects the new benefit coverage of silver diamine fluoride billed as D1354 and D1355 provided to the Medicaid population.
Prenatal Genetic Screenings	The Genetic Screenings adjustment effective January 1, 2023 reflects the new benefit coverage of pre-natal genetic screenings for cystic fibrosis (CF), spinal muscular atrophy (SMA), and cell-free DNA for trisomy for pregnant members of the Medicaid population.
NF Ventilator Services	The NF Ventilator Services adjustment effective January 1, 2023 reflects the opening of the in-state ventilator wing at the Rehabilitation Center of Albuquerque, at which reimbursement for Medicaid-eligible ventilator-dependent NF residents will include an additional $305.66 per day on top of the NF daily rate.

State of New Mexico - All MCOs

All Centennial Care Populations

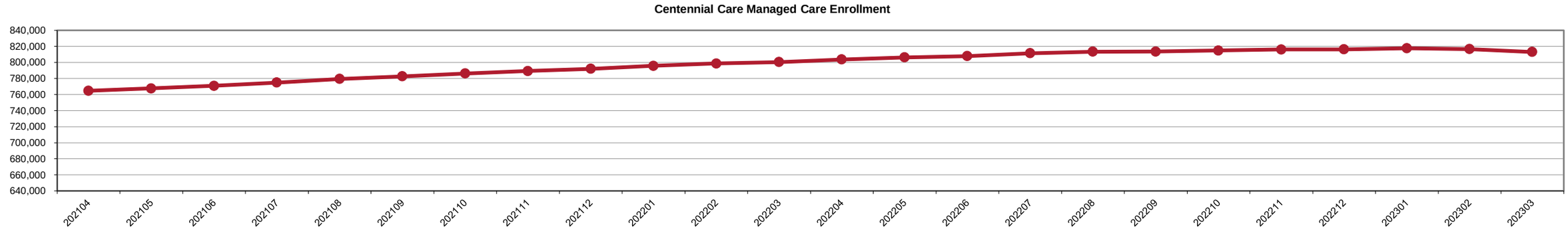
Centennial Care Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023

Previous Period: April 1, 2021 to March 31, 2022

Current Period: April 1, 2022 to March 31, 2023

1. Total Centennial Care Monthly Enrollment



2. Total Centennial Care Dollars and Member Months by Program

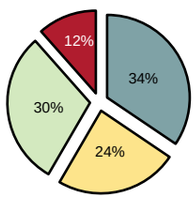
Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	5,610,015	5,909,376	5%
Long Term Services and Supports	614,199	624,622	2%
Other Adult Group	3,178,756	3,217,016	1%
Total Member Months	**9,402,970**	**9,751,014**	**4%**

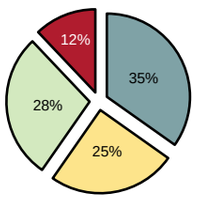
	Aggregate Medical Costs by Program			*Per Capita Medical Costs by Program (PMPM)*		
Programs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,707,233,006	$ 1,771,866,464	4%	$ 304.32	$ 299.84	-1%
Long Term Services and Supports	$ 1,185,808,877	$ 1,267,667,648	7%	$ 1,930.66	$ 2,029.50	5%
Other Adult Group Physical Health	$ 1,490,918,929	$ 1,438,176,858	-4%	$ 469.03	$ 447.05	-5%
Behavioral Health - All Members	$ 571,284,471	$ 614,561,372	8%	$ 60.76	$ 63.03	4%
Total Medical Costs	**$ 4,955,245,282**	**$ 5,092,272,340**	**3%**	**$ 526.99**	**$ 522.23**	**-1%**
Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	**% Change**
Admin, care coordination, Centennial Rewards	$ 404,092,056	$ 435,136,779	8%	$ 42.97	$ 44.62	4%
NMMIP Assessment	$ 89,209,621	$ 109,718,059	23%	$ 9.49	$ 11.25	19%
Premium Tax - Net of NIMMP Offset	$ 222,562,353	$ 361,367,684	62%	$ 23.67	$ 37.06	57%
Total Non-Medical Costs	**$ 715,864,030**	**$ 906,222,522**	**27%**	**$ 76.13**	**$ 92.94**	**22%**
Estimated Total Centennial Care Costs	**$ 5,671,109,312**	**$ 5,998,494,863**	**6%**	**$ 603.12**	**$ 615.17**	**2%**

Centennial Care Medical Expenditures

Previous (Q2CY2021 - Q1CY2022)



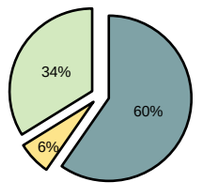
Current (Q2CY2022 - Q1CY2023)



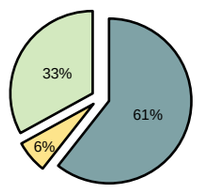
*See above for legend.

Centennial Care Member Months

Previous (Q2CY2021 - Q1CY2022)



Current (Q2CY2022 - Q1CY2023)



*See above for legend.

3. Total Program Medical/Pharmacy Dollars

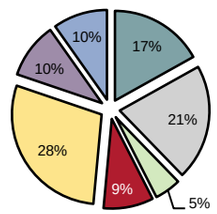
	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 4,470,101,861	$ 4,547,525,295	2%	$ 475.39	$ 466.36	-2%
Pharmacy	$ 485,143,421	$ 544,747,046	12%	$ 51.59	$ 55.87	8%
Total	**$ 4,955,245,282**	**$ 5,092,272,340**	**3%**	**$ 526.99**	**$ 522.23**	**-1%**

	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
Service Categories	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 837,762,362	$ 804,922,861	-4%	$ 89.10	$ 82.55	-7%
Acute Outp/Phy	$ 1,032,619,035	$ 1,031,807,612	0%	$ 109.82	$ 105.82	-4%
Nursing Facility	$ 235,031,798	$ 243,543,077	4%	$ 25.00	$ 24.98	0%
Community Benefit/PCO	$ 445,337,393	$ 558,829,206	25%	$ 47.36	$ 57.31	21%
Other Services	$ 1,423,974,701	$ 1,375,214,019	-3%	$ 151.44	$ 141.03	-7%
Behavioral Health	$ 495,376,572	$ 533,208,519	8%	$ 52.68	$ 54.68	4%
Pharmacy (All)	$ 485,143,421	$ 544,747,046	12%	$ 51.59	$ 55.87	8%
Total Costs	**$ 4,955,245,282**	**$ 5,092,272,340**	**3%**	**$ 526.99**	**$ 522.23**	**-1%**

** Per capita not normalized for case mix changes between periods.*

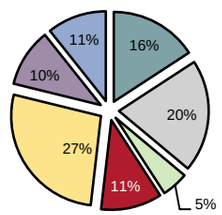
Previous (12 mon) service distribution

Service Categories % of Total



Current (12 mon) service distribution

Service Categories % of Total



4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
3. Other Services category includes, but is not limited to, the following services: emergent and non-emergent transportation, vision, dental, and directed payments.
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

State of New Mexico - All MCOs

Total Population (TANF, Aged, Blind, Disabled, CYFD, Pregnant Women)

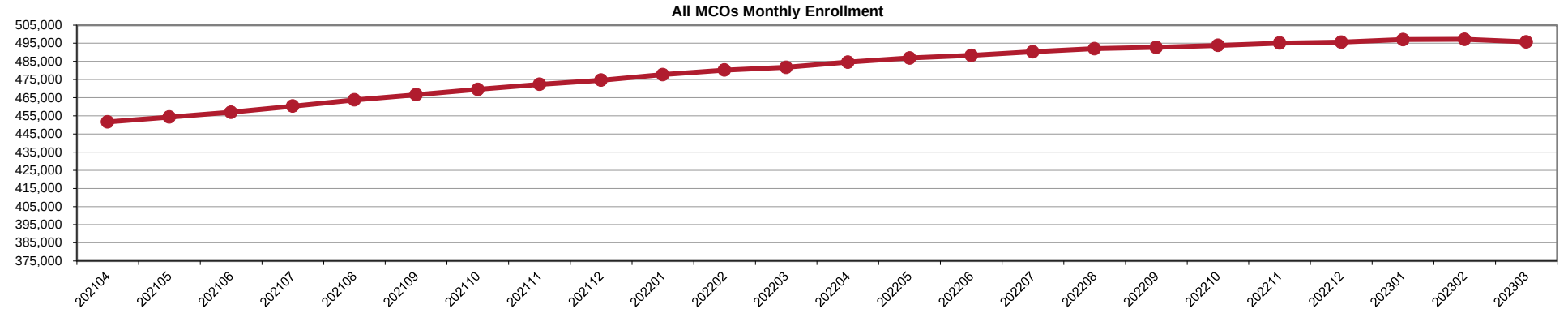
Physical Health Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023

Previous Period: April 1, 2021 to March 31, 2022

Current Period: April 1, 2022 to March 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

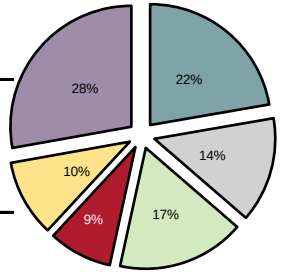
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,549,109,693	$ 1,589,561,375	3%
Pharmacy	$ 158,123,313	$ 182,305,089	15%
Total	**$ 1,707,233,006**	**$ 1,771,866,464**	**4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 405,357,275	$ 394,606,359	-3%
Outpatient (OP)	$ 278,896,468	$ 249,369,639	-11%
Physician (PH)	$ 259,330,502	$ 302,290,130	17%
Emergency Department (ED)	$ 97,873,161	$ 150,481,836	54%
Pharmacy (RX)	$ 158,123,313	$ 182,305,089	15%
Other (OTH)	$ 507,652,287	$ 492,813,411	-3%
Total Population Costs	**$ 1,707,233,006**	**$ 1,771,866,464**	**4%**
Per Capita Cost (PMPM)	**$ 304.32**	**$ 299.84**	**-1%**
Total Member Months	**5,610,015**	**5,909,376**	**5%**

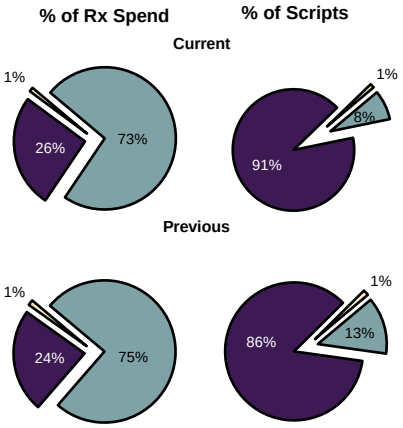
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 118,992,603	$ 133,663,947	12%
Generic	$ 37,166,875	$ 46,869,372	26%
Other Rx	$ 1,963,835	$ 1,771,769	-10%
Total	**$ 158,123,313**	**$ 182,305,089**	**15%**



** "Other Rx" represents supplies such as diabetic test strips.*

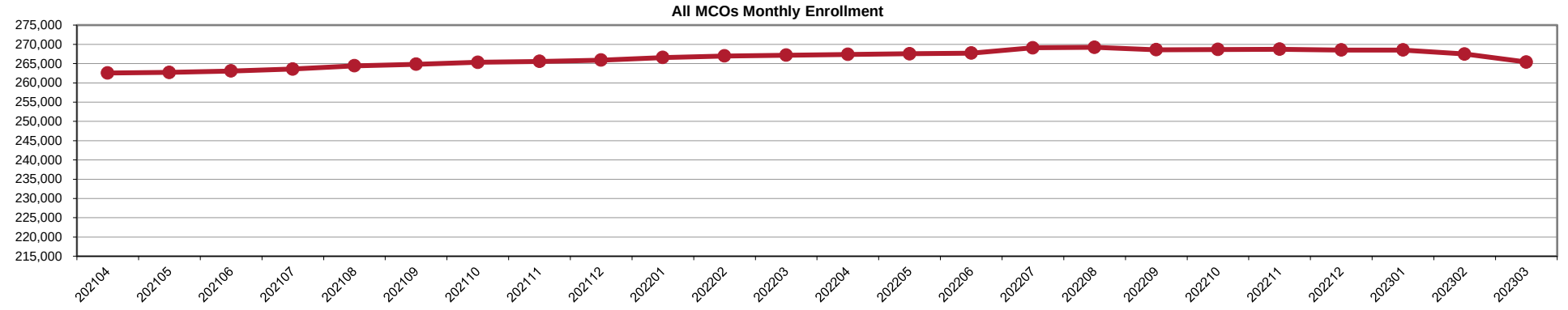
4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
3. Other Services category includes, but is not limited to, the following services: emergent and non-emergent transportation, vision, dental, and directed payments.
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

State of New Mexico - All MCOs
Total Population
Other Adult Group Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023
Previous Period: April 1, 2021 to March 31, 2022
Current Period: April 1, 2022 to March 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

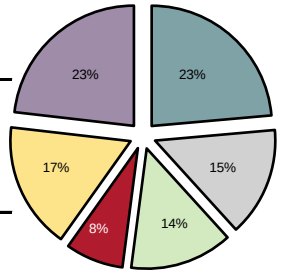
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,272,962,572	$ 1,193,917,742	-6%
Pharmacy	$ 217,956,357	$ 244,259,116	12%
Total	**$ 1,490,918,929**	**$ 1,438,176,858**	**-4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 368,434,965	$ 339,283,143	-8%
Outpatient (OP)	$ 239,869,934	$ 210,956,531	-12%
Physician (PH)	$ 188,149,347	$ 198,429,706	5%
Emergency Department (ED)	$ 90,607,274	$ 112,006,111	24%
Pharmacy (RX)	$ 217,956,357	$ 244,259,116	12%
Other (OTH)	$ 385,901,051	$ 333,242,251	-14%
Total Population Costs	**$ 1,490,918,929**	**$ 1,438,176,858**	**-4%**
Per Capita Cost (PMPM)	**$ 469.03**	**$ 447.05**	**-5%**
Total Member Months	**3,178,756**	**3,217,016**	**1%**

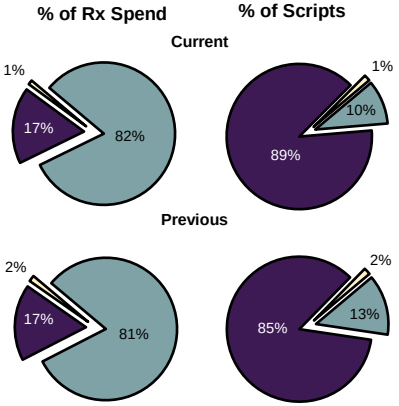
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 177,284,867	$ 199,430,541	12%
Generic	$ 37,614,255	$ 42,318,914	13%
Other Rx	$ 3,057,235	$ 2,509,661	-18%
Total	**$ 217,956,357**	**$ 244,259,116**	**12%**



** "Other Rx" represents supplies such as diabetic strips.*

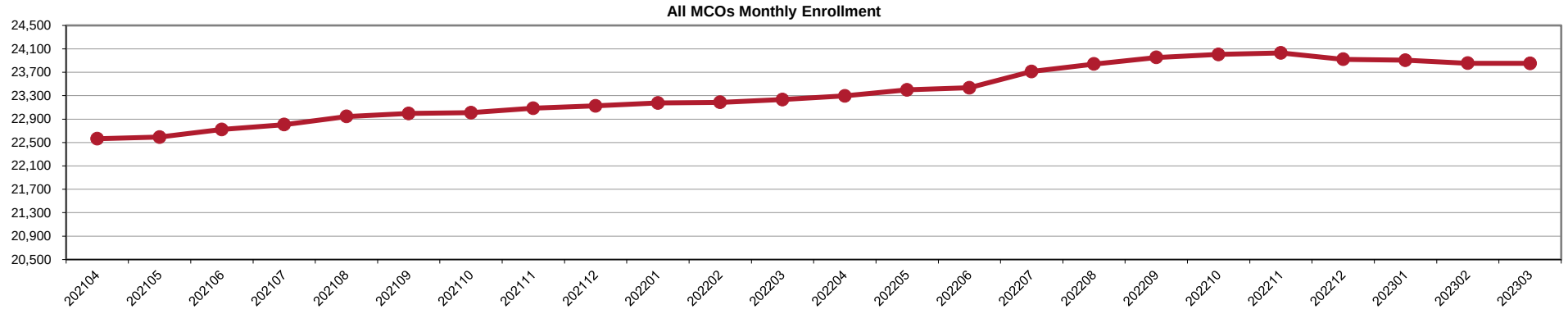
4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
3. Other Services category includes, but is not limited to, the following services: emergent and non-emergent transportation, vision, dental, and directed payments.
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

State of New Mexico - All MCOs
LTSS - Healthy Dual Population
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023
Previous Period: April 1, 2021 to March 31, 2022
Current Period: April 1, 2022 to March 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

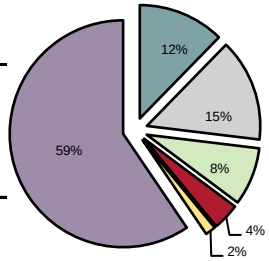
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 56,988,773	$ 61,470,915	8%
Pharmacy	$ 700,267	$ 930,967	33%
Total	**$ 57,689,040**	**$ 62,401,882**	**8%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 7,463,583	$ 7,673,986	3%
Outpatient (OP)	$ 10,730,774	$ 9,122,751	-15%
Physician (PH)	$ 5,586,628	$ 5,168,704	-7%
Emergency Department (ED)	$ 1,826,921	$ 2,388,202	31%
Pharmacy (RX)	$ 700,267	$ 930,967	33%
Other (OTH)	$ 31,380,867	$ 37,117,272	18%
Total Population Costs	**$ 57,689,040**	**$ 62,401,882**	**8%**
Per Capita Cost (PMPM)	**$ 209.45**	**$ 218.80**	**4%**
Total Member Months	**275,434**	**285,202**	**4%**

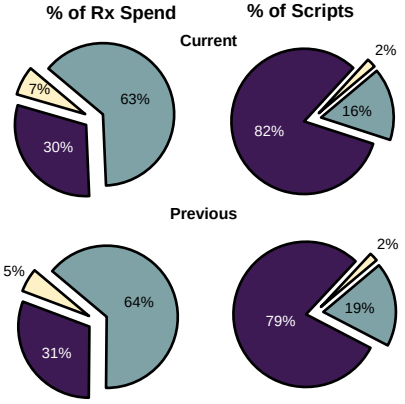
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 448,393	$ 588,413	31%
Generic	$ 214,079	$ 280,738	31%
Other Rx	$ 37,795	$ 61,816	64%
Total	**$ 700,267**	**$ 930,967**	**33%**



** "Other Rx" represents supplies such as diabetic strips.*

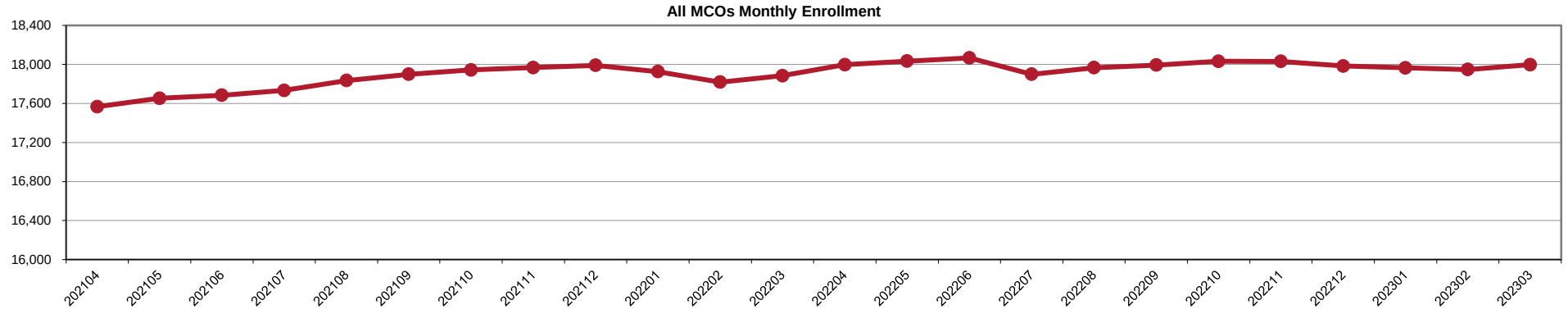
4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
3. Other Services category includes, but is not limited to, the following services: emergent and non-emergent transportation, vision, dental, and directed payments.
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

State of New Mexico - All MCOs
LTSS - Nursing Facility Level of Care Dual Population
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023
Previous Period: April 1, 2021 to March 31, 2022
Current Period: April 1, 2022 to March 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

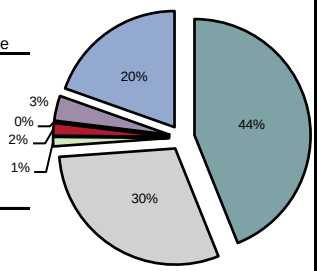
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 663,767,943	$ 710,354,179	7%
Pharmacy	$ 327,129	$ 236,655	-28%
Total	**$ 664,095,072**	**$ 710,590,835**	**7%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 238,259,260	$ 312,125,899	31%
Nursing Facility (NF)	$ 206,948,589	$ 212,620,169	3%
Inpatient (IP)	$ 9,434,603	$ 9,298,168	-1%
Outpatient (OP)	$ 13,876,051	$ 12,460,712	-10%
Pharmacy (RX)	$ 327,129	$ 236,655	-28%
HCBS	$ 20,903,211	$ 24,694,765	18%
Other (OTH)	$ 174,346,229	$ 139,154,465	-20%
Total Population Costs	**$ 664,095,072**	**$ 710,590,835**	**7%**
Per Capita Cost (PMPM)	**$ 3,104.66**	**$ 3,291.07**	**6%**
Total Member Months	**213,903**	**215,915**	**1%**

Service Categories % of Cost

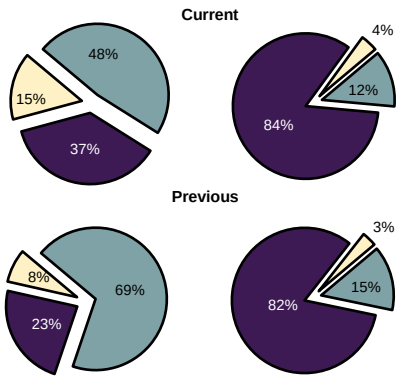


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 225,962	$ 113,147	-50%
Generic	$ 76,329	$ 87,280	14%
Other Rx	$ 24,838	$ 36,228	46%
Total	**$ 327,129**	**$ 236,655**	**-28%**

% of Rx Spend **% of Scripts**



** "Other Rx" represents supplies such as diabetic test strips.*

4. Notes

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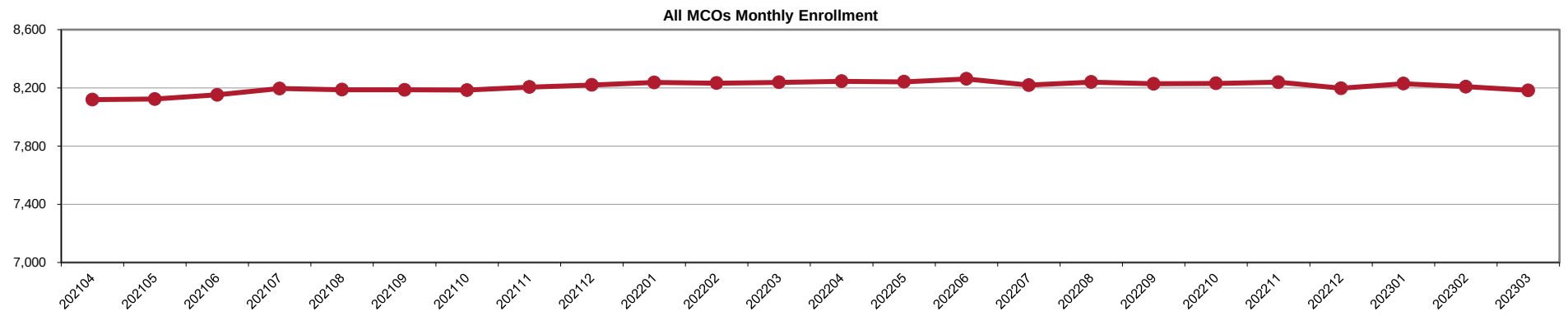
State of New Mexico - All MCOs
LTSS - Nursing Facility Level of Care Medicaid Only Population
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023
Previous Period: April 1, 2021 to March 31, 2022
Current Period: April 1, 2022 to March 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

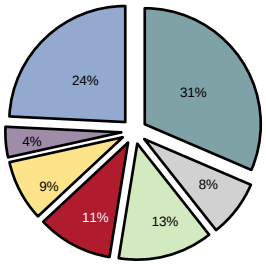
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 319,607,124	$ 352,674,091	10%
Pharmacy	$ 28,979,133	$ 32,725,540	13%
Total	**$ 348,586,257**	**$ 385,399,630**	**11%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 96,058,592	$ 121,183,856	26%
Nursing Facility (NF)	$ 27,743,339	$ 30,544,219	10%
Inpatient (IP)	$ 43,687,382	$ 50,843,153	16%
Outpatient (OP)	$ 32,549,940	$ 40,442,676	24%
Pharmacy (RX)	$ 28,979,133	$ 32,725,540	13%
HCBS	$ 14,091,753	$ 16,282,017	16%
Other (OTH)	$ 105,476,119	$ 93,378,170	-11%
Total Population Costs	**$ 348,586,257**	**$ 385,399,630**	**11%**
Per Capita Cost (PMPM)	**$ 3,546.94**	**$ 3,903.93**	**10%**
Total Member Months	**98,278**	**98,721**	**0%**

Service Categories % of Cost



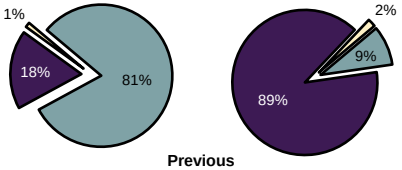
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

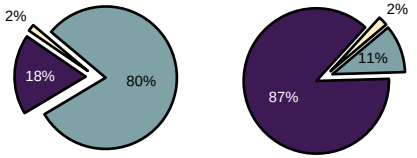
	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 23,276,901	$ 26,496,750	14%
Generic	$ 5,247,651	$ 5,858,777	12%
Other Rx	$ 454,581	$ 370,013	-19%
Total	**$ 28,979,133**	**$ 32,725,540**	**13%**

% of Rx Spend **% of Scripts**

Current



Previous



** "Other Rx" represents supplies such as diabetic test strips.*

4. Notes

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2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
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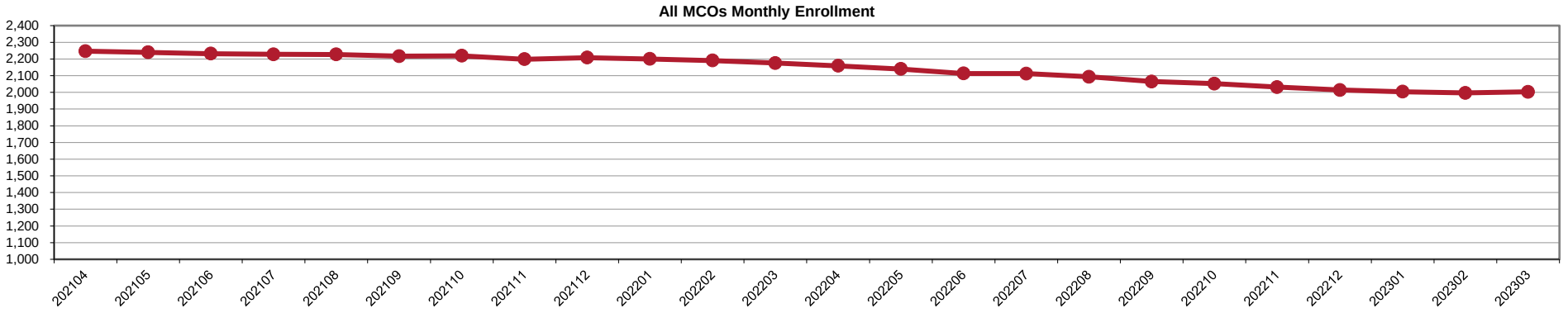
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

State of New Mexico - All MCOs
LTSS - Self Directed Population
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023
Previous Period: April 1, 2021 to March 31, 2022
Current Period: April 1, 2022 to March 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

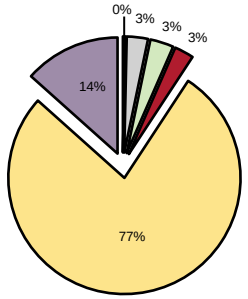
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 112,289,184	$ 106,338,474	-5%
Pharmacy	$ 3,149,324	$ 2,936,826	-7%
Total	**$ 115,438,508**	**$ 109,275,301**	**-5%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 339,869	$ 378,689	11%
Inpatient (IP)	$ 3,384,554	$ 3,218,052	-5%
Outpatient (OP)	$ 3,629,392	$ 3,566,762	-2%
Pharmacy (RX)	$ 3,149,324	$ 2,936,826	-7%
HCBS	$ 76,024,577	$ 84,542,669	11%
Other (OTH)	$ 28,910,793	$ 14,632,302	-49%
Total Population Costs	**$ 115,438,508**	**$ 109,275,301**	**-5%**
Per Capita Cost (PMPM)	**$ 4,342.41**	**$ 4,409.11**	**2%**
Total Member Months	**26,584**	**24,784**	**-7%**

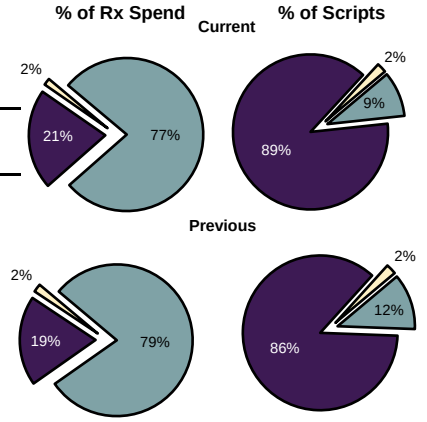
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 2,492,474	$ 2,273,038	-9%
Generic	$ 601,304	$ 620,835	3%
Other Rx	$ 55,546	$ 42,953	-23%
Total	**$ 3,149,324**	**$ 2,936,826**	**-7%**



** "Other Rx" represents supplies such as diabetic test strips.*

4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
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3. Other Services category includes, but is not limited to, the following services: emergent and non-emergent transportation, vision, dental, and directed payments.
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State of New Mexico - All MCOs

Total Population (Physical Health, Long Term Services and Support, and Other Adult Group)

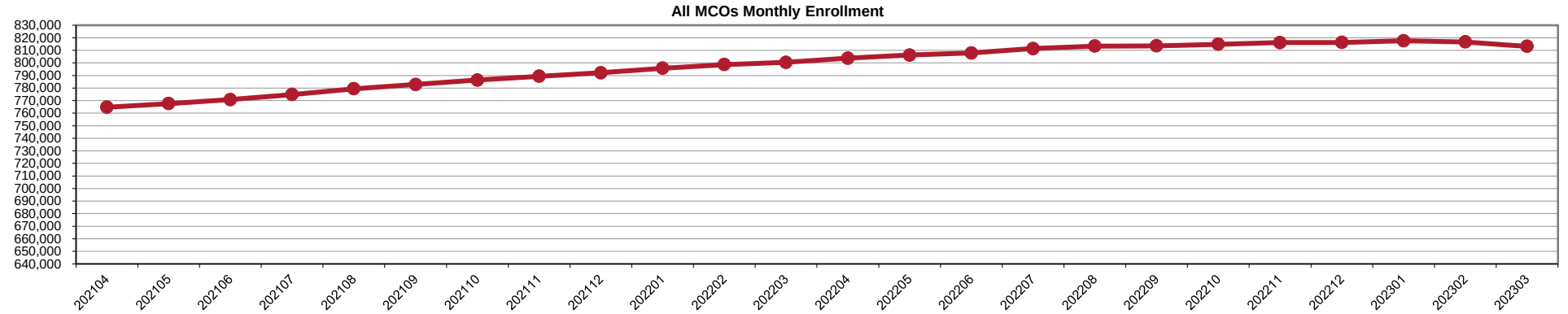
Behavioral Health Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: March 31, 2023

Previous Period: April 1, 2021 to March 31, 2022

Current Period: April 1, 2022 to March 31, 2023

1. Total Population Monthly Enrollment



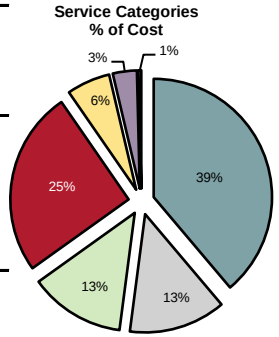
2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 495,376,572	$ 533,208,519	8%
Pharmacy	$ 75,907,899	$ 81,352,853	7%
Total	**$ 571,284,471**	**$ 614,561,372**	**8%**

Aggregate Costs by Service Categories

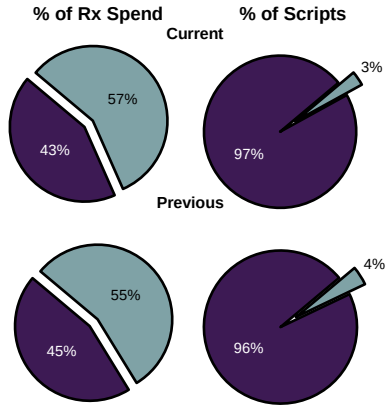
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 217,388,268	$ 238,629,730	10%
Pharmacy (RX)	$ 75,907,899	$ 81,352,853	7%
Res. Treatment Ctr. (RTC)	$ 111,842,622	$ 80,172,344	-28%
Behavioral Health Prov (BHP)	$ 112,949,227	$ 155,306,664	38%
Core Service Agencies (CSA)	$ 31,065,415	$ 36,518,485	18%
Inpatient (IP)	$ 20,268,281	$ 20,167,244	0%
Other (OTH)	$ 1,862,760	$ 2,414,051	30%
Total Population Costs	**$ 571,284,471**	**$ 614,561,372**	**8%**
Per Capita Cost (PMPM)	**$ 60.76**	**$ 63.03**	**4%**
Total Member Months	**9,402,970**	**9,751,014**	**4%**



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 41,846,286	$ 46,582,979	11%
Generic	$ 34,061,614	$ 34,769,874	2%
Total	**$ 75,907,899**	**$ 81,352,853**	**7%**



4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
3. Other Services category includes, but is not limited to, the following services: Psychosocial Rehab and Skills Training & Development (Behavioral Management Services).
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

ATTACHMENT B
New Mexico Budget Neutrality Monitoring Spreadsheet
- PMPM Analysis
DY 10
Start Date: 01/01/2023
End Date: 12/31/2023

Quarter 2
Start Date:4/1/2023
End Date: 6/30/2023

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01 TANF & Related	DY 01 Cost Estimates	DY 01 YTD - Actuals [2]	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	4,621,656	5,092,636	4,623,475	5,132,359	4,422,938	4,974,487	4,313,641
PMPM	$ 385.80	$ 329.14	$ 400.77	$ 344.32	$ 416.32	$ 334.75	$ 432.47	$ 341.04	$ 449.25	$ 353.31	$ 460.00	$ 397.15
Dollars	$ 1,823,911,159	$ 1,486,786,187	$ 1,948,487,793	$ 1,533,690,296	$ 2,090,074,424	$ 1,547,091,441	$ 2,202,434,150	$ 1,576,787,609	$ 2,305,734,126	$ 1,562,670,889	$ 2,288,249,485	$ 1,713,148,209

MEG02 SSI & Related - Medicaid Only	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	508,700	497,958	513,736	494,529	518,976	493,577	524,737	487,798	530,824	459,830	499,659	448,460
PMPM	$ 1,763.90	$ 1,656.75	$ 1,842.83	$ 1,785.41	$ 1,925.21	$ 1,756.52	$ 2,008.00	$ 1,734.28	$ 2,094.34	$ 1,729.96	$ 2,158.77	$ 1,930.36
Dollars	$ 897,298,062	$ 824,991,985	$ 946,727,393	$ 882,936,445	$ 999,138,707	$ 866,977,418	$ 1,053,669,000	$ 845,978,765	$ 1,111,724,897	$ 795,489,421	$ 1,078,650,304	$ 865,689,020

MEG03 SSI & Related - Dual Eligible	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	373,823	428,025	380,215	435,140	386,831	447,801	393,832	443,071	401,197	432,715	467,635	433,415
PMPM	$ 1,780.77	$ 1,333.20	$ 1,857.34	$ 1,342.71	$ 1,937.21	$ 1,361.10	$ 2,020.51	$ 1,273.53	$ 2,107.39	$ 1,290.50	$ 2,057.62	$ 1,285.27
Dollars	$ 665,692,378	$ 570,643,867	$ 706,189,973	$ 584,265,571	$ 749,372,219	$ 609,500,283	$ 795,742,098	$ 564,265,856	$ 845,479,241	$ 558,419,629	$ 962,212,283	$ 557,054,910

MEG04 "217 Like" Medicaid Only	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	5,841	2,799	5,898	2,382	5,959	2,987	6,025	3,797	6,095	3,307	4,087	2,990
PMPM	$ 4,936.92	$ 2,380.16	$ 5,090.46	$ 2,347.27	$ 5,248.77	$ 2,537.88	$ 5,412.01	$ 3,295.32	$ 5,580.32	$ 3,649.36	$ 5,747.30	$ 3,807.10
Dollars	$ 28,834,295	$ 6,662,064	$ 30,025,379	$ 5,591,208	$ 31,274,952	$ 7,580,640	$ 32,605,551	$ 12,512,314	$ 34,009,571	$ 12,068,447	$ 23,490,632	$ 11,383,232

MEG05 "217 Like" Dual Eligible	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	27,935	26,895	28,413	27,063	28,907	31,866	29,430	40,409	29,981	47,438	43,493	50,767
PMPM	$ 1,776.90	$ 3,226.87	$ 1,853.31	$ 3,143.68	$ 1,933.00	$ 2,884.00	$ 2,016.12	$ 2,789.99	$ 2,102.81	$ 2,840.04	$ 3,661.18	$ 2,834.27
Dollars	$ 49,637,569	$ 86,786,741	$ 52,657,285	$ 85,077,407	$ 55,877,183	$ 91,901,521	$ 59,334,769	$ 112,740,550	$ 63,043,435	$ 134,725,706	$ 159,236,444	$ 143,887,343

MEG06 VIII Group - Medicaid Expansion	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	1,632,968	1,887,728	1,788,895	2,748,632	1,800,808	3,078,074	1,763,748	3,143,890	1,773,299	3,019,164	3,299,404	3,070,895
PMPM	$ 577.87	$ 453.48	$ 607.34	$ 476.42	$ 638.31	$ 442.85	$ 670.87	$ 450.19	$ 705.08	$ 484.90	$ 738.22	$ 524.67
Dollars	$ 943,638,928	$ 856,045,974	$ 1,086,464,733	$ 1,309,500,952	$ 1,149,478,718	$ 1,363,113,600	$ 1,183,239,734	$ 1,415,362,892	$ 1,250,319,546	$ 1,463,984,401	$ 2,435,685,299	$ 1,611,192,640

MEG08 Uncompensated Care Pool	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
Total Allotment	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 67,294,973	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,316

MEG09 Hospital Quality Improvement Incentive Pool	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
Total Allotment	$ -	$ -	$ 2,824,462	$ 2,824,462	$ 5,764,727	$ 7,359,077	$ 8,825,544	$ 8,825,541	$ 12,011,853	$ 12,011,853	$ 12,000,000	$ 12,000,002

Centennial Care 2.0 Medicaid SUD/IMD	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MM											595	595
PMPM											$ 808.21	$ 5,795.10
Dollars											$ 480,885	$ 3,448,086

Notes:
1.) Actual member months for Demonstration Year 9 include the reported member months for this Centennial Care Quarterly Report, Section XIV and Section IX.

2.) Expenditures as reported on the CMS-64 Schedule C, FFY2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 1

Start Date: 01/01/2014

End Date: 12/31/2014

Table 1.1: Budget Neutrality Limit DY 1 (Special Terms and Conditions (STC) 106)

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 385.80	4,517,149	$ 1,742,724,978	70.77%	$ 1,233,319,149	$ 1,486,786,187	$ 1,070,423,106
MEG02 - SSI & Related - Medicaid Only	$ 1,763.90	497,958	$ 878,350,269	70.77%	$ 621,604,797	$ 824,991,985	$ 574,950,391
MEG03 - SSI & Related - Dual Eligible	$ 1,780.77	428,025	$ 762,214,336	70.77%	$ 539,415,885	$ 570,643,867	$ 395,585,750
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	70.77%	$ 48,752,685	$ 68,889,323	$ 47,671,412
MEG09 HQII	NA	NA	$ -	70.77%	$ -	$ -	$ -
Grand Total			**$ 3,452,178,905**		**$ 2,443,092,516**	**$ 2,951,311,362**	**$ 2,088,630,659**

Table 1.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 4,936.92	2,799	$ 13,818,444	69.31%	$ 9,577,968	$ 6,662,064	$ 4,617,656
MEG 05 - "217 Like" Dual Eligible	$ 1,776.90	26,895	$ 47,789,749	69.31%	$ 33,124,475	$ 86,786,741	$ 60,154,448
Grand Total			**$ 61,608,193**		**$ 42,702,443**	**$ 93,448,805**	**$ 64,772,104**

Table 1.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 1 - PMPM	DY 1 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 1 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 577.87	1,887,728	$ 1,090,856,222	100.00%	$ 1,090,823,365	$ 856,045,974	$ 856,020,190
Grand Total			**$ 1,090,856,222**		**$ 1,090,823,365**	**$ 856,045,974**	**$ 856,020,190**

Table 1.4: DY 1 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,443,092,516**
Federal Share (Title XIX) Actual Reported	$ 2,088,630,659
Excess Spending - Test 1	$ 22,069,661
Excess Spending - Test 2	$ -
Total Actuals	$ 2,110,700,320
Difference (Actuals - Limit)	$ (332,392,197)
Percentage Difference	-13.6%

Notes:

1.) Member months as of November 3, 2015.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 2

Start Date: 01/01/2015

End Date: 12/31/2015

Table 2.1: Budget Neutrality Limit DY 2 (Special Terms and Conditions (STC) 106)

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 400.77	4,454,290	$ 1,785,150,637	71.40%	$ 1,274,542,294	$ 1,533,690,296	$ 1,116,190,075
MEG02 - SSI & Related - Medicaid Only	$ 1,842.83	494,529	$ 911,332,877	71.40%	$ 650,663,463	$ 882,936,445	$ 619,379,415
MEG03 - SSI & Related - Dual Eligible	$ 1,857.34	435,140	$ 808,202,928	71.40%	$ 577,031,872	$ 584,265,571	$ 408,061,166
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	71.40%	$ 49,184,844	$ 67,294,973	$ 46,989,091
MEG09 HQII	NA	NA	$ 2,824,462	71.40%	$ 2,016,578	$ 2,824,462	$ 1,987,574
Grand Total			**$ 3,576,400,227**		**$ 2,553,439,051**	**$ 3,071,011,747**	**$ 2,192,607,321**

Table 2.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,090.46	2,382	$ 12,125,476	69.84%	$ 8,468,468	$ 5,591,208	$ 3,906,915
MEG 05 - "217 Like" Dual Eligible	$ 1,853.31	27,063	$ 50,156,129	69.84%	$ 35,029,186	$ 85,077,407	$ 59,416,310
Grand Total			**$ 62,281,604**		**$ 43,497,654**	**$ 90,668,615**	**$ 63,323,225**

Table 2.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 2 - PMPM	DY 2 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 2 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 607.34	2,748,632	$ 1,669,354,159	100.00%	$ 1,669,275,988	$ 1,309,500,952	$ 1,309,439,632
Grand Total			**$ 1,669,354,159**		**$ 1,669,275,988**	**$ 1,309,500,952**	**$ 1,309,439,632**

Table 2.4: DY 2 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,553,439,051**
Federal Share (Title XIX) Actual Reported	$ 2,192,607,321
Excess Spending - Test 1	$ 19,825,571
Excess Spending - Test 2	$ -
Total Actuals	$ 2,212,432,892
Difference (Actuals - Limit)	$ (341,006,159)
Percentage Difference	-13.4%

Notes:

1.) Member months as of November 10, 2016.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 3

Start Date: 01/01/2016

End Date: 12/31/2016

Table 3.1: Budget Neutrality Limit DY 3 (Special Terms and Conditions (STC) 106)

MEG	DY 3 - PMPM	DY 3 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 3 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 416.32	4,621,656	$ 1,924,092,463	72.12%	$ 1,387,680,219	$ 1,547,091,441	$ 1,137,287,817
MEG02 - SSI & Related - Medicaid Only	$ 1,925.21	493,577	$ 950,239,887	72.12%	$ 685,325,222	$ 866,977,418	$ 614,385,717
MEG03 - SSI & Related - Dual Eligible	$ 1,937.21	447,801	$ 867,484,358	72.12%	$ 625,640,871	$ 609,500,283	$ 430,111,909
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	72.12%	$ 49,683,865	$ 68,889,323	$ 48,608,306
MEG09 HQII	NA	NA	$ 5,764,727	72.12%	$ 4,157,595	$ 7,359,077	$ 5,234,511
Grand Total			**$ 3,816,470,759**		**$ 2,752,487,772**	**$ 3,099,817,542**	**$ 2,235,628,260**

Table 3.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 3 - PMPM	DY 3 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 3 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,248.77	2,987	$ 15,678,086	70.59%	$ 11,066,436	$ 7,580,640	$ 5,353,671
MEG 05 - "217 Like" Dual Eligible	$ 1,933.00	31,866	$ 61,596,973	70.59%	$ 43,478,457	$ 91,901,521	$ 64,866,189
Grand Total			**$ 77,275,059**		**$ 54,544,893**	**$ 99,482,161**	**$ 70,219,860**

Table 3.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 3 - PMPM	DY 3 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 3 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 638.31	3,078,074	$ 1,964,773,916	99.93%	$ 1,963,462,690	$ 1,363,113,600	$ 1,362,203,902
Grand Total			**$ 1,964,773,916**		**$ 1,963,462,690**	**$ 1,363,113,600**	**$ 1,362,203,902**

Table 3.4: DY 3 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,752,487,772**
Federal Share (Title XIX) Actual Reported	$ 2,235,628,260
Excess Spending - Test 1	$ 15,674,967
Excess Spending - Test 2	$ -
Total Actuals	$ 2,251,303,227
Difference (Actuals - Limit)	$ (501,184,546)
Percentage Difference	-18.2%

Notes:

1.) Member months as of October 3, 2017.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 4

Start Date: 01/01/2017

End Date: 12/31/2017

Table 4.1: Budget Neutrality Limit DY 4 (Special Terms and Conditions (STC) 106)

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 432.47	4,623,475	$ 1,999,533,921	73.08%	$ 1,461,177,683	$ 1,576,787,609	$ 1,174,583,364
MEG02 - SSI & Related - Medicaid Only	$ 2,008.00	487,798	$ 979,495,999	73.08%	$ 715,775,651	$ 845,978,765	$ 606,610,371
MEG03 - SSI & Related - Dual Eligible	$ 2,020.51	443,071	$ 895,229,176	73.08%	$ 654,196,900	$ 564,265,856	$ 402,851,084
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	73.08%	$ 50,341,502	$ 68,889,323	$ 49,178,612
MEG09 HQII	NA	NA	$ 8,825,544	73.08%	$ 6,449,347	$ 8,825,541	$ 6,368,511
Grand Total			**$ 3,951,973,963**		**$ 2,887,941,083**	**$ 3,064,747,094**	**$ 2,239,591,942**

Table 4.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,412.01	3,797	$ 20,549,402	71.42%	$ 14,675,372	$ 12,512,314	$ 8,934,265
MEG 05 - "217 Like" Dual Eligible	$ 2,016.12	40,409	$ 81,469,347	71.42%	$ 58,181,400	$ 112,740,550	$ 80,515,170
Grand Total			**$ 102,018,749**		**$ 72,856,773**	**$ 125,252,864**	**$ 89,449,435**

Table 4.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 670.87	3,143,890	$ 2,109,131,150	95.15%	$ 2,006,846,946	$ 1,415,362,892	$ 1,346,723,601
Grand Total			**$ 2,109,131,150**		**$ 2,006,846,946**	**$ 1,415,362,892**	**$ 1,346,723,601**

Table 4.4: DY 4 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,887,941,083**
Federal Share (Title XIX) Actual Reported	$ 2,239,591,942
Excess Spending - Test 1	$ 16,592,662
Excess Spending - Test 2	$ -
Total Actuals	$ 2,256,184,604
Difference (Actuals - Limit)	$ (631,756,479)
Percentage Difference	-21.9%

Notes:

1.) Member months as of October 4, 2018.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 5

Start Date: 01/01/2018

End Date: 12/31/2018

Table 5.1: Budget Neutrality Limit DY 5 (Special Terms and Conditions (STC) 106)

MEG	DY 5 - PMPM	DY 5 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 5 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 449.25	4,422,938	$ 1,987,023,736	74.05%	$ 1,471,328,125	$ 1,562,670,889	$ 1,180,620,861
MEG02 - SSI & Related - Medicaid Only	$ 2,094.34	459,830	$ 963,039,856	74.05%	$ 713,100,503	$ 795,489,421	$ 576,990,150
MEG03 - SSI & Related - Dual Eligible	$ 2,107.39	432,715	$ 911,899,885	74.05%	$ 675,232,974	$ 558,419,629	$ 403,164,614
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.05%	$ 51,010,361	$ 68,889,323	$ 50,084,411
MEG09 HQII	NA	NA	$ 12,011,853	74.05%	$ 8,894,397	$ 12,011,853	$ 8,679,765
Grand Total			**$ 3,942,864,653**		**$ 2,919,566,360**	**$ 2,997,481,115**	**$ 2,219,539,801**

Table 5.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 107)

MEG	DY 5 - PMPM	DY 5 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 5 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,580.32	3,307	$ 18,454,130	72.19%	$ 13,322,745	$ 12,068,447	$ 8,714,682
MEG 05 - "217 Like" Dual Eligible	$ 2,102.81	47,438	$ 99,753,194	72.19%	$ 72,015,661	$ 134,725,706	$ 97,261,654
Grand Total			**$ 118,207,324**		**$ 85,338,406**	**$ 146,794,153**	**$ 105,976,336**

Table 5.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 108)

MEG	DY 5 - PMPM	DY 5 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 5 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 705.08	3,019,164	$ 2,128,754,916	94.19%	$ 2,005,116,985	$ 1,463,984,401	$ 1,378,956,293
Grand Total			**$ 2,128,754,916**		**$ 2,005,116,985**	**$ 1,463,984,401**	**$ 1,378,956,293**

Table 5.4: DY 5 Assessment of Budget Neutrality (STC 102, 104, 111)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,919,566,360**
Federal Share (Title XIX) Actual Reported	$ 2,219,539,801
Excess Spending - Test 1	$ 20,637,930
Excess Spending - Test 2	$ -
Total Actuals	$ 2,240,177,731
Difference (Actuals - Limit)	$ (679,388,629)
Percentage Difference	-23.3%

Notes:

1.) Member months as of October 3, 2019.

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 6

Start Date: 01/01/2019

End Date: 12/31/2019

Table 6.1: Budget Neutrality Limit DY 6 (Special Terms and Conditions (STC) 96)

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 460.00	4,313,641	$ 1,984,262,326	74.74%	$ 1,483,081,701	$ 1,713,148,209	$ 1,307,629,456
MEG02 - SSI & Related - Medicaid Only	$ 2,158.77	448,460	$ 968,123,620	74.74%	$ 723,597,080	$ 865,689,020	$ 633,237,982
MEG03 - SSI & Related - Dual Eligible	$ 2,057.62	433,415	$ 891,801,274	74.74%	$ 666,552,065	$ 557,054,910	$ 403,429,612
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.74%	$ 51,489,409	$ 68,889,316	$ 50,869,441
MEG09 HQII	NA	NA	$ 12,000,000	74.74%	$ 8,969,066	$ 12,000,002	$ 9,127,363
Grand Total			**$ 3,925,076,543**		**$ 2,933,689,321**	**$ 3,216,781,457**	**$ 2,404,293,854**

Table 6.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 98)

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,747.30	2,990	$ 17,184,417	72.42%	$ 12,444,939	$ 11,383,232	$ 8,248,128
MEG 05 - "217 Like" Dual Eligible	$ 3,661.18	50,767	$ 185,867,373	72.42%	$ 134,604,989	$ 143,887,343	$ 104,198,687
Grand Total			**$ 203,051,789**		**$ 147,049,929**	**$ 155,270,575**	**$ 112,446,815**

Table 6.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 99)

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 738.22	3,070,895	$ 2,266,995,241	93.12%	$ 2,110,918,164	$ 1,611,192,640	$ 1,500,265,968
Grand Total			**$ 2,266,995,241**		**$ 2,110,918,164**	**$ 1,611,192,640**	**$ 1,500,265,968**

Table 6.4: Supplemental Budget Neutrality Test 3: SUD/IMD (STC 100)

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 808.21	595	$ 480,885	92.33%	$ 444,008	$ 3,448,086	$ 3,183,671
Grand Total			**$ 480,885**		**$ 444,008**	**$ 3,448,086**	**$ 3,183,671**

Table 6.5: DY 6 Assessment of Budget Neutrality (STC 93, 96, 105)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,933,689,321**
Federal Share (Title XIX) Actual Reported	$ 2,404,293,854
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,739,663
Total Actuals	$ 2,404,293,854
Difference (Actuals - Limit)	$ (529,395,467)
Percentage Difference	-18.0%

Notes:

1.) Member months as of October 4, 2021.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 7

Start Date: 01/01/2020

End Date: 12/31/2020

Table 7.1: Budget Neutrality Limit DY 7 (Special Terms and Conditions (STC) 96)

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 477.48	4,593,472	$ 2,193,277,156	80.26%	$ 1,760,378,045	$ 1,952,950,338	$ 1,584,348,581
MEG02 - SSI & Related - Medicaid Only	$ 2,247.28	450,397	$ 1,012,169,676	80.26%	$ 812,392,210	$ 1,007,337,497	$ 798,971,042
MEG03 - SSI & Related - Dual Eligible	$ 2,141.98	433,319	$ 928,159,496	80.26%	$ 744,963,579	$ 625,585,792	$ 494,862,803
MEG08 Uncompensated Care Pool	NA	NA	$ -	80.26%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	80.26%	$ 9,631,494	$ 11,999,993	$ 9,559,194
Grand Total			**$ 4,145,606,329**		**$ 3,327,365,327**	**$ 3,597,873,620**	**$ 2,887,741,620**

Table 7.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 98)

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 5,926.04	3,007	$ 17,819,595	79.12%	$ 14,098,167	$ 12,139,659	$ 9,603,953
MEG 05 - "217 Like" Dual Eligible	$ 3,811.29	60,564	$ 230,827,177	79.12%	$ 182,621,446	$ 191,823,587	$ 151,763,800
Grand Total			**$ 248,646,772**		**$ 196,719,613**	**$ 203,963,246**	**$ 161,367,753**

Table 7.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 99)

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 772.92	3,276,975	$ 2,532,826,556	90.29%	$ 2,286,975,817	$ 1,976,405,997	$ 1,784,564,643
Grand Total			**$ 2,532,826,556**		**$ 2,286,975,817**	**$ 1,976,405,997**	**$ 1,784,564,643**

Table 7.4: Supplemental Budget Neutrality Test 3: SUD/IMD (STC 100)

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 841.35	2,729	$ 2,296,044	89.79%	$ 2,061,629	$ 4,652,746	$ 4,177,723
Grand Total			**$ 2,296,044**		**$ 2,061,629**	**$ 4,652,746**	**$ 4,177,723**

Table 7.5: DY 7 Assessment of Budget Neutrality (STC 93, 96, 105)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,327,365,327**
Federal Share (Title XIX) Actual Reported	$ 2,887,741,620
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,116,094
Total Actuals	$ 2,887,741,620
Difference (Actuals - Limit)	$ (439,623,707)
Percentage Difference	-13.2%

Notes:

1.) Member months as of July 12, 2022.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 8

Start Date: 01/01/2021

End Date: 12/31/2021

Table 8.1: Budget Neutrality Limit DY 8 (Special Terms and Conditions (STC) 96)

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 495.62	5,134,949	$ 2,544,989,120	82.59%	$ 2,101,887,289	$ 2,356,887,642	$ 1,948,602,026
MEG02 - SSI & Related - Medicaid Only	$ 2,339.42	461,295	$ 1,079,163,653	82.59%	$ 891,273,109	$ 1,070,547,524	$ 874,969,433
MEG03 - SSI & Related - Dual Eligible	$ 2,229.80	436,507	$ 973,322,633	82.59%	$ 803,859,810	$ 670,697,311	$ 561,396,712
MEG08 Uncompensated Care Pool	NA	NA	$ -	82.59%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	82.59%	$ 9,910,709	$ 12,000,000	$ 9,559,194
Grand Total			**$ 4,609,475,406**		**$ 3,806,930,918**	**$ 4,110,132,477**	**$ 3,394,527,365**

Table 8.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 98)

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,110.34	3,086	$ 18,856,501	84.30%	$ 15,896,123	$ 11,711,889	$ 9,766,272
MEG 05 - "217 Like" Dual Eligible	$ 3,967.56	68,559	$ 272,011,706	84.30%	$ 229,307,211	$ 245,828,315	$ 207,341,392
Grand Total			**$ 290,868,206**		**$ 245,203,335**	**$ 257,540,204**	**$ 217,107,664**

Table 8.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 99)

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 809.24	3,504,702	$ 2,836,155,907	90.68%	$ 2,571,762,264	$ 2,174,850,856	$ 1,972,105,746
Grand Total			**$ 2,836,155,907**		**$ 2,571,762,264**	**$ 2,174,850,856**	**$ 1,972,105,746**

Table 8.4: Supplemental Budget Neutrality Test 3: SUD/IMD (STC 100)

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 875.85	3,809	$ 3,336,113	88.99%	$ 2,968,911	$ 6,518,997	$ 5,801,460
Grand Total			**$ 3,336,113**		**$ 2,968,911**	**$ 6,518,997**	**$ 5,801,460**

Table 8.5: DY 8 Assessment of Budget Neutrality (STC 93, 96, 105)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,806,930,918**
Federal Share (Title XIX) Actual Reported	$ 3,394,527,365
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,832,549
Total Actuals	$ 3,394,527,365
Difference (Actuals - Limit)	$ (412,403,553)
Percentage Difference	-10.8%

Notes:

1.) Member months as of July 7, 2023.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 9

Start Date: 01/01/2022

End Date: 12/31/2022

Table 9.1: Budget Neutrality Limit DY 9 (Special Terms and Conditions (STC) 96)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 514.45	5,451,035	$ 2,804,284,956	72.02%	$ 2,019,635,412	$ 2,808,449,869	$ 1,948,602,026
MEG02 - SSI & Related - Medicaid Only	$ 2,435.34	472,178	$ 1,149,913,971	72.02%	$ 828,163,690	$ 1,182,946,423	$ 874,969,433
MEG03 - SSI & Related - Dual Eligible	$ 2,321.22	448,041	$ 1,040,001,730	72.02%	$ 749,005,310	$ 721,940,563	$ 561,396,712
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	72.02%	$ 49,613,830	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	72.02%	$ 8,650,891	$ -	$ 9,559,194
Grand Total			**$ 5,075,101,832**		**$ 3,655,069,133**	**$ 4,713,336,855**	**$ 3,394,527,365**

Table 9.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 98)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,300.37	3,457	$ 21,780,379	77.39%	$ 16,856,594	$ 11,166,009	$ 9,766,272
MEG 05 - "217 Like" Dual Eligible	$ 4,130.23	70,608	$ 291,627,280	77.39%	$ 225,700,503	$ 269,358,476	$ 207,341,392
Grand Total			**$ 313,407,659**		**$ 242,557,097**	**$ 280,524,485**	**$ 217,107,664**

Table 9.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 99)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 847.28	3,531,240	$ 2,991,949,027	83.17%	$ 2,488,405,714	$ 2,371,172,769	$ 1,972,105,746
Grand Total			**$ 2,991,949,027**		**$ 2,488,405,714**	**$ 2,371,172,769**	**$ 1,972,105,746**

Table 9.4: Supplemental Budget Neutrality Test 3: SUD/IMD (STC 100)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 911.76	3,462	$ 3,156,513	80.49%	$ 2,540,682	$ 7,207,664	$ 5,801,460
Grand Total			**$ 3,156,513**		**$ 2,540,682**	**$ 7,207,664**	**$ 5,801,460**

Table 9.5: DY 9 Assessment of Budget Neutrality (STC 93, 96, 105)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,655,069,133**
Federal Share (Title XIX) Actual Reported	$ 3,394,527,365
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 3,260,778
Total Actuals	$ 3,394,527,365
Difference (Actuals - Limit)	$ (260,541,768)
Percentage Difference	-7.1%

Notes:

1.) Member months as of July 7, 2023.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 10

Start Date: 01/01/2023

End Date: 12/31/2023

Table 9.1: Budget Neutrality Limit DY 9 (Special Terms and Conditions (STC) 96)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 534.00	2,711,567	$ 1,447,976,778	79.78%	$ 1,155,180,900	$ 1,129,901,905	$ 908,480,857
MEG02 - SSI & Related - Medicaid Only	$ 2,535.19	240,124	$ 608,759,964	79.78%	$ 485,662,404	$ 550,788,786	$ 435,682,583
MEG03 - SSI & Related - Dual Eligible	$ 2,416.39	225,776	$ 545,562,869	79.78%	$ 435,244,415	$ 360,959,060	$ 284,643,618
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	79.78%	$ 54,959,189	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	79.78%	$ 9,582,932	$ -	$ -
Grand Total			**$ 2,683,200,786**		**$ 2,140,629,839**	**$ 2,041,649,751**	**$ 1,628,807,058**

Table 9.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 98)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,496.31	2,195	$ 14,259,400	78.85%	$ 11,244,192	$ 5,734,354	$ 4,521,643
MEG 05 - "217 Like" Dual Eligible	$ 4,299.57	36,197	$ 155,631,535	78.85%	$ 122,722,614	$ 137,248,338	$ 108,226,777
Grand Total			**$ 169,890,936**		**$ 133,966,806**	**$ 142,982,692**	**$ 112,748,420**

Table 9.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 99)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 887.10	1,776,336	$ 1,575,787,666	90.50%	$ 1,426,134,556	$ 1,090,136,273	$ 986,605,647
Grand Total			**$ 1,575,787,666**		**$ 1,426,134,556**	**$ 1,090,136,273**	**$ 986,605,647**

Table 9.4: Supplemental Budget Neutrality Test 3: SUD/IMD (STC 100)

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 949.14	1,458	$ 1,383,846	87.67%	$ 1,213,158	$ 3,002,943	$ 2,632,550
Grand Total			**$ 1,383,846**		**$ 1,213,158**	**$ 3,002,943**	**$ 2,632,550**

Table 10.5: DY 10 Assessment of Budget Neutrality (STC 93, 96, 105)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,140,629,839**
Federal Share (Title XIX) Actual Reported	$ 1,628,807,058
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 1,419,392
Total Actuals	$ 1,628,807,058
Difference (Actuals - Limit)	$ (511,822,781)
Percentage Difference	-23.9%

Notes:

1.) Member months as of July 7, 2023.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2023 Quarter 3 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 3. Report pulled on 08/07/2023.

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 1/2023

Summary of Expenditures by Waiver Year
Waiver: 11W00285

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,486,786,187	1,533,690,296	1,547,091,441	1,576,787,609	1,562,670,889	1,713,148,209	1,952,950,338	2,356,887,642	2,808,449,869	1,129,901,905	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,668,364,385	17,668,364,385
MEG2- SSI Medicaid Only	0	824,991,985	882,936,445	866,977,418	845,978,765	795,489,421	865,689,020	1,007,337,497	1,070,547,524	1,182,946,423	550,788,786	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8,893,683,284	8,893,683,284
MEG3- SSI DUAL	0	570,643,867	584,265,571	609,500,283	564,265,856	558,419,629	557,054,910	625,585,792	670,697,311	721,940,563	360,959,060	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,823,332,842	5,823,332,842
MEG4-217	0	6,662,064	5,591,208	7,580,640	12,512,314	12,068,447	11,383,232	12,139,659	11,711,889	11,166,009	5,734,354	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	96,549,816	96,549,816
MEG5- 217 DUAL	0	86,786,741	85,077,407	91,901,521	112,740,550	134,725,706	143,887,343	191,823,587	245,828,315	269,358,476	137,248,338	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,499,377,984	1,499,377,984
MEG6-VIII GROUP	0	856,045,974	1,309,500,952	1,363,113,600	1,415,362,892	1,463,984,401	1,611,192,640	1,976,405,997	2,174,850,856	2,371,172,769	1,090,136,273	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,631,766,354	15,631,766,354
MEG8-UHC-Uncompensated care	0	68,889,322	36,005,978	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	104,895,300	104,895,300
MEG9-HQII-Hospital Quality Improve Incentive	0	0	2,824,462	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,824,462	2,824,462
UC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	31,288,995	68,889,323	68,889,323	68,889,323	68,889,316	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	306,846,281	306,846,281
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	7,359,077	8,825,541	12,011,853	12,000,002	11,999,993	12,000,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	64,196,466	64,196,466
Centennial Care 2.0 Medicaid SUD/IMD	0	0	0	0	0	0	3,448,086	4,652,746	6,518,997	7,207,664	3,002,943																24,830,436	24,830,436
Total	**0**	**3,900,806,141**	**4,471,181,314**	**4,562,413,303**	**4,605,362,850**	**4,608,259,669**	**4,986,692,758**	**5,782,895,609**	**6,549,042,534**	**7,372,241,773**	**3,277,771,659**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**50,116,667,610**	**50,116,667,610**
Check		*3,900,806,141*	*4,471,181,314*	*4,562,413,303*	*4,605,362,850*	*4,608,259,669*	*4,986,692,758*	*5,782,895,609*	*6,549,042,534*	*7,372,241,773*	*3,277,771,659*																	
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																	

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,070,423,106	1,116,190,075	1,137,287,817	1,174,583,364	1,180,620,861	1,307,629,456	1,584,348,581	1,948,602,026	2,317,495,686	908,480,857		0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,745,661,829	13,745,661,829
MEG2- SSI Medicaid Only	0	574,950,391	619,379,415	614,385,717	606,610,371	576,990,150	633,237,982	798,971,042	874,969,433	953,194,556	435,682,583		0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,688,371,640	6,688,371,640
MEG3- SSI DUAL	0	395,585,750	408,061,166	430,111,909	402,851,084	403,164,614	403,429,612	494,862,803	561,396,712	585,597,293	284,643,618		0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,369,704,561	4,369,704,561
MEG4-217	0	4,617,656	3,906,915	5,353,671	8,934,265	8,714,682	8,248,128	9,603,953	9,766,272	9,056,375	4,521,643		0	0	0	0	0	0	0	0	0	0	0	0	0	0	72,723,560	72,723,560
MEG5- 217 DUAL	0	60,154,448	59,416,310	64,866,189	80,515,170	97,261,654	104,198,687	151,763,800	207,341,392	218,974,710	108,226,777		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,152,719,137	1,152,719,137
MEG6-VIII GROUP	0	856,020,190	1,309,439,632	1,362,203,902	1,346,723,601	1,378,956,293	1,500,265,968	1,784,564,643	1,972,105,746	2,147,148,117	986,605,647		0	0	0	0	0	0	0	0	0	0	0	0	0	0	14,644,033,739	14,644,033,739
MEG8-UHC-Uncompensated care	0	47,671,411	25,207,785	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	72,879,196	72,879,196
MEG9-HQII-Hospital Quality Improve Incentive	0	0	1,987,574	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,987,574	1,987,574
UC	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	21,781,306	48,608,306	49,178,612	50,084,411	50,869,441	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	220,522,077	220,522,077
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	5,234,511	6,368,511	8,679,765	9,127,363	9,559,194	9,589,200	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	48,558,544	48,558,544
Centennial Care 2.0 Medicaid SUD/IMD	0	0	0	0	0	0	3,183,671	4,177,723	5,801,460	6,344,080	2,632,550																22,139,484	22,139,484
Total	**0**	**3,009,422,953**	**3,565,370,178**	**3,668,052,022**	**3,675,764,978**	**3,704,472,430**	**4,020,190,308**	**4,837,851,739**	**5,589,572,241**	**6,237,810,817**	**2,730,793,675**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41,017,161,857**	**41,017,161,857**
Check		*3,009,422,953*	*3,565,370,178*	*3,668,052,022*	*3,675,764,978*	*3,704,472,430*	*4,020,190,308*	*4,837,851,739*	*5,589,572,241*	*6,237,810,817*	*2,730,793,675*																	
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																	

M-CHIP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	84,356,751	123,819,527	118,473,862	106,619,834	97,506,744	105,963,616	118,376,144	127,135,265	140,107,193	69,159,693	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,091,518,629	1,091,518,629
Total	**0**	**84,356,751**	**123,819,527**	**118,473,862**	**106,619,834**	**97,506,744**	**105,963,616**	**118,376,144**	**127,135,265**	**140,107,193**	**69,159,693**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,091,518,629**	**1,091,518,629**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	66,272,555	105,308,829	118,473,862	106,619,822	97,505,399	103,493,469	110,807,002	108,144,802	119,094,685	58,712,765	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	994,433,190	994,433,190
Total	**0**	**66,272,555**	**105,308,829**	**118,473,862**	**106,619,822**	**97,505,399**	**103,493,469**	**110,807,002**	**108,144,802**	**119,094,685**	**58,712,765**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**994,433,190**	**994,433,190**

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	109,509,693	0	0	0	8,558,331	196,959,429	236,056,796	215,438,573	233,933,937	61,125,403	113,018,659	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,174,600,821	1,174,600,821
MEG1-TANF & Related	0	1,954,350	65,528,478	65,128,092	75,672,882	80,475,712	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	288,759,514	288,759,514
MEG2- SSI Medicaid Only	0	0	7,492,116	7,098,152	8,204,996	8,455,296	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	31,250,560	31,250,560
MEG3- SSI DUAL	0	0	6,533,901	6,432,635	7,626,009	7,887,696	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28,480,241	28,480,241
MEG4-217	0	0	38,287	33,620	78,602	73,212	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	223,721	223,721
MEG5- 217 DUAL	0	0	408,067	443,667	673,384	847,932	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,373,050	2,373,050
MEG6-VIII GROUP	0	36,509,156	42,521,593	46,219,961	60,776,652	59,252,561	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	245,279,923	245,279,923
MEG7-CHIP GROUP	0	972,016	9,725,447	8,862,780	10,909,982	9,242,308	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	39,712,533	39,712,533
Total	**0**	**148,945,215**	**132,247,889**	**134,218,907**	**163,942,507**	**174,793,048**	**196,959,429**	**236,056,796**	**215,438,573**	**233,933,937**	**61,125,403**	**113,018,659**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,810,680,363**	**1,810,680,363**
Check		*148,945,215*	*132,247,889*	*134,218,907*	*163,942,507*	*174,793,048*	*196,959,429*	*236,056,796*	*215,438,573*	*233,933,937*	*61,125,403*	*113,018,659*																
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	72,320,580	0	0	0	6,523,508	129,519,032	155,939,388	141,935,766	157,143,677	40,824,318	76,642,697	0	0	0	0	0	0	0	0	0	0	0	0	0	0	780,848,966	780,848,966
MEG1-TANF & Related	0	1,033,347	40,960,378	40,581,487	48,575,411	50,855,108	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	182,005,731	182,005,731
MEG2- SSI Medicaid Only	0	0	4,682,951	4,421,346	5,263,719	5,343,838	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19,711,854	19,711,854
MEG3- SSI DUAL	0	0	4,084,108	4,007,329	4,887,719	4,986,257	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,965,413	17,965,413
MEG4-217	0	0	23,899	21,025	50,385	46,287	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	141,596	141,596
MEG5- 217 DUAL	0	0	255,098	276,989	432,086	536,858	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,501,031	1,501,031
MEG6-VIII GROUP	0	24,041,491	26,579,123	28,804,937	38,875,056	37,448,951	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	155,749,558	155,749,558
MEG7-CHIP GROUP	0	644,187	6,078,767	5,514,776	6,957,623	5,840,810	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,036,163	25,036,163
Total	**0**	**98,039,605**	**82,664,324**	**83,627,889**	**105,041,999**	**111,581,617**	**129,519,032**	**155,939,388**	**141,935,766**	**157,143,677**	*40,824,318*	**76,642,697**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,182,960,312**	**1,182,960,312**
Check		*98,039,605*	*82,664,324*	*83,627,889*	*105,041,999*	*111,581,617*	*129,519,032*	*155,939,388*	*141,935,766*	*157,143,677*	*40,824,318*	*76,642,697*																
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																

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MEMBER MONTHS
CENTENNIAL CARE MEG REPORTING

Eligibility Group	CY 2016 Quarter					CY 2017 Quarter					CY 2018 Quarter					CY 2019 Quarter					CY 2020 Quarter					CY 2021 Quarter					CY 2022 Quarter					CY 2023 Quarter				
	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total
Population 1 – TANF and Related	1,130,779	1,150,300	1,169,603	1,170,974	**4,621,656**	1,180,160	1,170,146	1,145,575	1,127,594	**4,623,475**	1,129,981	1,116,304	1,090,944	1,085,709	**4,422,938**	1,078,850	1,077,954	1,079,500	1,077,337	**4,313,641**	1,080,904	1,121,423	1,179,371	1,211,774	**4,593,472**	1,242,048	1,264,108	1,303,124	1,325,669	**5,134,949**	1,344,424	1,359,991	1,370,788	1,375,832	**5,451,035**	1,382,978	1,328,589			**2,711,567**
Population 2 – SSI and Related – Medicaid Only	123,597	122,633	123,728	123,619	**493,577**	124,408	125,136	122,027	116,227	**487,798**	116,043	115,944	114,384	113,559	**459,830**	112,782	112,246	111,860	111,572	**448,460**	112,231	111,666	112,949	113,551	**450,397**	114,465	115,066	115,626	116,138	**461,295**	116,733	118,231	118,192	119,022	**472,178**	119,792	120,332			**240,124**
Population 3 – SSI and Related - Dual	110,017	111,379	113,425	112,980	**447,801**	111,537	111,883	111,273	108,378	**443,071**	108,032	108,101	108,318	108,264	**432,715**	108,143	108,378	108,509	108,385	**433,415**	108,324	108,074	108,273	108,648	**433,319**	107,956	108,420	109,664	110,467	**436,507**	110,715	111,766	112,371	113,189	**448,041**	113,413	112,363			**225,776**
Population 4 – 217-like Group – Medicaid Only	566	1064	564	793	**2,987**	1,133	1,006	857	801	**3,797**	830	835	853	789	**3,307**	754	751	746	739	**2,990**	724	762	775	746	**3,007**	779	729	727	801	**3,086**	857	851	873	876	**3,457**	982	1,213			**2,195**
Population 5 – 217-like Group - Dual	6,938	8,390	7,911	8,627	**31,866**	9,714	10,023	10,181	10,491	**40,409**	11,050	11,820	12,257	12,311	**47,438**	12,167	12,422	12,828	13,350	**50,767**	14,040	14,723	15,545	16,256	**60,564**	16,706	17,025	17,347	17,481	**68,559**	17,394	17,654	17,616	17,944	**70,608**	18,172	18,025			**36,197**
Population 6 – VIII Group (expansion)	753,995	761,293	778,625	784,161	**3,078,074**	806,114	802,658	773,108	762,010	**3,143,890**	762,410	756,109	747,006	753,639	**3,019,164**	759,129	765,866	767,811	778,088	**3,070,895**	784,171	814,819	827,548	850,436	**3,276,975**	866,005	871,996	879,825	886,876	**3,504,702**	887,618	880,537	881,352	881,733	**3,531,240**	884,501	891,835			**1,776,336**
Population 7 - CHIP Group	151,824	140,006	134,983	132,292	**559,105**	133,031	130,727	123,340	117,212	**504,310**	117,719	113,236	109,585	111,810	**452,350**	113,954	111,660	112,480	115,511	**453,605**	118,810	114,070	118,310	119,859	**471,049**	124,273	128,782	118,258	121,187	**492,500**	124,273	129,112	131,429	135,116	**519,930**	140,616	123,450			**264,066**
Population 10 - SUD IMD																93	324	92	86	**595**	609	621	651	848	**2,729**	1,192	1,305	650	662	**3,809**	775	853	958	876	**3,462**	974	484			**1,458**
Total	**2,277,716**	**2,295,065**	**2,328,839**	**2,333,446**	**9,235,066**	**2,366,097**	**2,351,579**	**2,286,361**	**2,242,713**	**9,246,750**	**2,246,065**	**2,222,349**	**2,183,247**	**2,186,081**	**8,837,742**	**2,185,872**	**2,189,601**	**2,193,826**	**2,205,069**	**8,774,368**	**2,219,813**	**2,286,158**	**2,363,423**	**2,422,118**	**9,291,512**	**2,473,424**	**2,507,481**	**2,545,221**	**2,579,281**	**10,105,407**	**2,602,789**	**2,618,995**	**2,633,579**	**2,644,588**	**10,499,951**	**2,661,428**	**2,596,291**	**0**	**0**	**5,257,719**

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Table #9 - Waiver Year 9 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
Admin		**233,933,937**
MEG01 - TANF & Related	$ 2,808,449,869	$ -
MEG02 - SSI & Related - Medicaid Only	$ 1,182,946,423	$ -
MEG03 - SSI & Related - Dual Eligible	$ 721,940,563	$ -
MEG04 - "217 Like" Medicaid Only	$ 11,166,009	$ -
MEG05 - "217 Like" Dual Eligible	$ 269,358,476	$ -
MEG06 - VIII Group - Medicaid Expansion	$ 2,371,172,769	$ -
MEG07 - CHIP	$ 140,107,193	$ -
Uncompensated Care "UC" Pool	$ -	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Centennial Care 2.0 Medicaid SUD/IMD	$ 7,207,664	N/A
Grand Total	**$ 7,512,348,966**	**$ 233,933,937**

Source: New Mexico CMS 64 Submission, FFY 2023 Quarer 2, 2023.

Cost per Unit Statistics by Major Population Group

Physical Health Population: TANF, Aged, Blind, Disabled, CYFD, Pregnant Women

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Inpatient (Admissions)	82.8	72.6	$ 10,960	$ 9,493
Inpatient (Days)	388.0	321.9	$ 2,340	$ 2,141
Practitioner / Physician (Services)	7,282.7	6,815.9	$ 82	$ 83
Emergency Department (Visits)	489.4	531.2	$ 503	$ 513
Outpatient (Visits)	1,818.5	1,512.3	$ 269	$ 282
Pharmacy (Scripts)	4,360.8	4,350.0	$ 79	$ 82
Other (Services)1	8,854.5	8,145.8	$ 62	$ 64

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Brand	13.3%	7.9%	$ 445	$ 762
Generic	85.4%	91.0%	$ 22	$ 23
Other Rx2	1.3%	1.1%	$ 74	$ 70

Notes:

1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through March 31, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Adult Expansion: Other Adult Group

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Inpatient (Admissions)	77.2	65.0	$ 17,152	$ 17,571
Inpatient (Days)	633.7	831.2	$ 2,090	$ 1,375
Practitioner / Physician (Services)	8,138.4	7,070.0	$ 94	$ 96
Emergency Department (Visits)	590.6	541.3	$ 656	$ 685
Outpatient (Visits)	2,397.0	1,933.1	$ 318	$ 345
Pharmacy (Scripts)	8,009.1	7,358.4	$ 105	$ 121
Other (Services)1	9,670.1	8,218.8	$ 74	$ 79

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Brand	13.5%	9.8%	$ 632	$ 1,006
Generic	85.0%	88.8%	$ 21	$ 24
Other Rx2	1.5%	1.4%	$ 96	$ 89

Notes:

1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through March 31, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Cost per Unit Statistics by Major Population Group

Long Term Services and Supports: Dual Eligible - Nursing Facility Level of Care

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Inpatient (Admissions)	219.6	193.0	$ 2,754	$ 1,987
Inpatient (Days)	1,439.8	1,274.2	$ 420	$ 301
Nursing Home (Days)	247,581.2	182,786.7	$ 49	$ 60
Personal Care (Services / hr.)	781,204.0	724,305.0	$ 19	$ 20
Outpatient (Visits)	5,756.4	5,058.5	$ 147	$ 132
Pharmacy (Scripts)	791.2	758.6	$ 24	$ 16
HCBS (Services)	6,756.4	8,933.2	$ 180	$ 133
Other (Services)1	43,984.3	36,815.7	$ 42	$ 44

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Brand	14.4%	12.5%	$ 116	$ 61
Generic	82.4%	83.6%	$ 7	$ 7
Other Rx2	3.3%	3.9%	$ 56	$ 64

Notes:

1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through March 31, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Long Term Services and Supports: Medicaid Only - Nursing Facility Level of Care

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Inpatient (Admissions)	326.6	305.7	$ 17,748	$ 17,801
Inpatient (Days)	2,669.5	2,316.5	$ 2,171	$ 2,349
Nursing Home (Days)	16,493.4	17,343.1	$ 203	$ 196
Personal Care (Services / hr.)	672,248.5	620,556.1	$ 20	$ 21
Outpatient (Visits)	8,397.4	7,459.7	$ 485	$ 532
Pharmacy (Scripts)	30,948.7	29,072.7	$ 121	$ 139
HCBS (Services)	25,359.1	25,614.2	$ 90	$ 91
Other (Services)1	61,209.5	56,305.3	$ 101	$ 102

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Brand	10.6%	8.8%	$ 914	$ 1,272
Generic	87.2%	89.4%	$ 25	$ 28
Other Rx2	2.1%	1.8%	$ 90	$ 86

Notes:

1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through March 31, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Inpatient (Admissions)	189.1	183.5	$ 9,145	$ 7,466
Inpatient (Days)	1,400.7	1,219.7	$ 1,235	$ 1,123
Nursing Home (Days)	6,687.5	4,463.7	$ 21	$ 38
Personal Care (Services / hr.)	-	-	$ -	$ -
Outpatient (Visits)	7,217.4	6,146.2	$ 238	$ 240
Pharmacy (Scripts)	11,487.2	10,463.2	$ 130	$ 137
HCBS (Services)	283,736.1	254,730.8	$ 95	$ 93
Other (Services)1	51,056.4	43,633.6	$ 54	$ 59

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Brand	11.7%	9.4%	$ 878	$ 1,125
Generic	86.1%	88.6%	$ 29	$ 33
Other Rx2	2.2%	2.0%	$ 105	$ 99

Notes:

1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through March 31, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Long Term Services and Supports: Dual Eligible - Healthy Dual Population

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Inpatient (Admissions)	79.3	49.7	$ 4,207	$ 5,914
Inpatient (Days)	539.1	367.7	$ 619	$ 800
Practitioner / Physician (Services)	8,213.5	6,875.1	$ 29	$ 28
Emergency Department (Visits)	589.1	512.5	$ 170	$ 164
Outpatient (Visits)	2,980.4	2,527.9	$ 163	$ 143
Pharmacy (Scripts)	1,352.3	1,168.1	$ 26	$ 24
Other (Services)1	7,226.9	6,254.5	$ 92	$ 117

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Brand	18.7%	16.1%	$ 90	$ 94
Generic	79.3%	81.8%	$ 10	$ 9
Other Rx2	1.9%	2.1%	$ 74	$ 78

Notes:

1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through March 31, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Cost per Unit Statistics by Major Population Group

Behavioral Health Services - All Populations (PH, OAG, LTSS)				
	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Inpatient (Admissions)	38.4	34.6	$ 614	$ 552
Inpatient (Days)	90.6	77.9	$ 260	$ 246
BH Practitioner (services)	678.6	619.9	$ 155	$ 163
Core Service Agency (Services)	298.6	305.6	$ 179	$ 189
BH outpatient / clinic (Services)	3,439.3	3,084.8	$ 76	$ 81
Pharmacy (Scripts)	1,586.8	1,502.0	$ 63	$ 67
Residential Treatment Center (days)	37.2	35.2	$ 3,449	$ 2,828
Other (Services)1	12.6	11.0	$ 117	$ 127
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	April 2021 - March 2022	April 2022 - March 2023	April 2021 - March 2022	April 2022 - March 2023
Brand	4.0%	3.1%	$ 860	$ 1,233
Generic	96.0%	96.9%	$ 29	$ 29
Other Rx2	0.0%	0.0%	$ -	$ -

Notes:

1. Other services includes BMS, PSR and PES services.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through March 31, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

BCBS CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			BCBS											
		CONTRACT STANDARD	January	February	March	April	May	June	July	August	September	October	November	December
Member Services	Number of Calls Received - All Queues		13,537	11,573	12,390	10,238	10,943	9,883						
	Number of Calls Answered - All Queues		13,474	11,476	12,276	10,180	10,900	9,804						
	Percent of Calls Abandoned	< 5%	0.5%	0.8%	0.9%	0.6%	0.4%	0.8%						
	Percent of Calls Answered within 30 Seconds	85%	94.5%	89.9%	89.9%	92.9%	95.7%	94.1%						
	Average Wait Time	< 2 minutes	0.1	0.2	0.3	0.2	0.1	0.2						
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						
Nurse Advice Line	Number of Calls Received - All Queues		624	601	637	560	591	491						
	Number of Calls Answered - All Queues		612	593	627	555	589	488						
	Percent of Calls Abandoned	< 5%	1.9%	1.3%	1.6%	0.9%	0.3%	0.6%						
	Percent of Calls Answered within 30 Seconds	85%	89.9%	89.4%	89.0%	91.4%	91.7%	91.2%						
	Average Wait Time	< 2 minutes	0.2	0.3	0.2	0.2	0.2	0.2						
Provider Services	Number of Calls Received - All Queues		6,355	5,814	6,391	5,747	6,240	6,361						
	Number of Calls Answered - All Queues		6,322	5,762	6,345	5,725	6,213	6,329						
	Percent of Calls Abandoned	< 5%	0.5%	0.9%	0.7%	0.4%	0.4%	0.5%						
	Percent of Calls Answered within 30 Seconds	85%	93.7%	89.0%	89.2%	92.3%	95.5%	92.5%						
	Average Wait Time	< 2 minutes	0.2	0.3	0.3	0.2	0.1	0.2						
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						
UM Line	Number of Calls Received - All Queues		4,955	4,810	5,073	4,411	5,170	4,851						
	Number of Calls Answered - All Queues		4,937	4,791	5,037	4,395	5,159	4,831						
	Percent of Calls Abandoned	< 5%	0.4%	0.4%	0.7%	0.4%	0.2%	0.4%						
	Percent of Calls Answered within 30 Seconds	85%	97.9%	98.3%	97.5%	98.6%	99.2%	98.9%						
	Average Wait Time	< 2 minutes	0.1	0.1	0.1	0.1	0.0	0.0						

Source: BCBS Report 2, M1-M6 CY23

PHP CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			PHP											
		CONTRACT STANDARD	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		23,433	18,763	19,051	16,428	17,437	17,911						
	Number of Calls Answered - All Queues		23,036	18,605	18,786	16,266	17,185	17,597						
	Percent of Calls Abandoned	< 5%	1.7%	0.8%	1.4%	1.0%	1.4%	1.8%						
	Percent of Calls Answered within 30 Seconds	85%	90%	95%	90%	93.0%	91.0%	88.2%						
	Average Wait Time	< 2 minutes	0.3	0.2	0.3	0.2	0.3	0.4						
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100.0%	100.0%	100.0%						
Nurse Advice Line	Number of Calls Received - All Queues		2,319	2,111	2,611	2,101	2,168	1,974						
	Number of Calls Answered - All Queues		2,284	2,052	2,553	2,054	2,139	1,957						
	Percent of Calls Abandoned	< 5%	1.5%	2.8%	2.2%	2.2%	1.3%	0.9%						
	Percent of Calls Answered within 30 Seconds	85%	97%	93%	94%	92%	97%	98%						
	Average Wait Time	< 2 minutes	0.1	0.2	0.2	0.3	0.1	0.1						
Provider Services	Number of Calls Received - All Queues		3,929	3,700	6,227	5,462	5,204	4,976						
	Number of Calls Answered - All Queues		3,897	3,686	6,196	5,417	5,187	4,955						
	Percent of Calls Abandoned	< 5%	0.8%	0.4%	0.5%	0.8%	0.3%	0.4%						
	Percent of Calls Answered within 30 Seconds	85%	93%	96%	90%	89.3%	90.7%	90.4%						
	Average Wait Time	< 2 minutes	0.2	0.1	0.2	0.2	0.2	0.2						
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100.0%	100.0%	100.0%						
UM Line	Number of Calls Received - All Queues		971	844	1,283	1,061	851	937						
	Number of Calls Answered - All Queues		966	836	1,277	1,056	847	933						
	Percent of Calls Abandoned	< 5%	0.5%	0.9%	0.5%	0.5%	0.5%	0.4%						
	Percent of Calls Answered within 30 Seconds	85%	90%	92%	96%	94%	91%	91%						
	Average Wait Time	< 2 minutes	0.2	0.2	0.1	0.1	0.2	0.2						

Source: PHP Report 2, M1-M6 CY23

WSCC CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			WSCC											
		CONTRACT STANDARD	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		5,740	4,868	5,509	4,585	5,154	5,305						
	Number of Calls Answered - All Queues		5,604	4,735	5,405	4,547	5,111	5,277						
	Percent of Calls Abandoned	< 5%	2.4%	2.7%	1.9%	0.8%	0.8%	0.8%						
	Percent of Calls Answered within 30 Seconds	85%	86.7%	86.9%	91.6%	97.2%	97.7%	97.9%						
	Average Wait Time	< 2 minutes	0.5	0.4	0.3	0.1	0.1	0.1						
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	100.0%	100.0%	100%	100%	100%						
Nurse Advice Line	Number of Calls Received - All Queues		162	134	159	138	153	158						
	Number of Calls Answered - All Queues		158	132	158	135	151	156						
	Percent of Calls Abandoned	< 5%	2.5%	1.5%	0.6%	2.2%	1.3%	1.3%						
	Percent of Calls Answered within 30 Seconds	85%	96.2%	93.9%	93.7%	93.3%	97.4%	97.4%						
	Average Wait Time	< 2 minutes	0.7	0.1	0.2	0.2	0.1	0.2						
Provider Services	Number of Calls Received - All Queues		4,122	4,163	4,283	3,960	4,605	4,377						
	Number of Calls Answered - All Queues		4,044	4,052	4,204	3,887	4,505	4,294						
	Percent of Calls Abandoned	< 5%	1.9%	2.7%	1.8%	1.8%	2.2%	1.9%						
	Percent of Calls Answered within 30 Seconds	85%	90.9%	84.3%	88.5%	89.9%	91.1%	86.90%						
	Average Wait Time	< 2 minutes	0.3	0.6	0.4	0.4	0.3	0.5						
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	100.0%	100.0%	100%	100%	100%						
UM Line	Number of Calls Received - All Queues		1,552	1,435	1,691	1,516	1,650	1,551						
	Number of Calls Answered - All Queues		1,524	1,408	1,657	1,465	1,601	1,492						
	Percent of Calls Abandoned	< 5%	1.8%	1.9%	2.0%	3.4%	3.0%	3.8%						
	Percent of Calls Answered within 30 Seconds	85%	94.4%	92.2%	91.7%	87.3%	88.1%	85.7%						
	Average Wait Time	< 2 minutes	0.3	0.4	0.4	0.3	0.3	0.3						

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