CENTENNIAL CARE 2.0 DEMONSTRATION

Section 1115 Demonstration Quarterly Report
Demonstration Year: 7 (1/ 1/ 2020 – 12/ 31/ 2020)
Quarter: 3/2020

December 28, 2020

.

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INTRODUCTION

On December 14, 2018, the Centers for Medicare & Medicaid Services (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 home and community-based services (HCBS).

In Centennial Care 2.0, the state will continue to advance successful initiatives 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:

- Improve 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;
- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue 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;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;
- Build upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

The Centennial Care 2.0 managed care organizations (MCOs) are:

1. Blue Cross Blue Shield of New Mexico (BCBS),
2. Presbyterian Health Plan (PHP), and
3. Western Sky Community Care (WSCC).

Status of Key Dates:

TOPIC	KEY DATE	STATUS
Quality Strategy	Submitted to CMS on March 14, 2019	CMS reported no comments
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 July 31, 2019	Approved by CMS on July 21, 2020

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: QUARTER 2 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	6/30/2020 ENROLLMENT	9/30/2020 ENROLLMENT	PERCENT INCREASE/ DECREASE Q
Blue Cross Blue Shield of New Mexico (BCBS)	252,167	260,361	+3.2%
Presbyterian Health Plan (PHP)	387,757	395,194	+1.9%
Western Sky Community Care (WSCC)	65,255	71,866	+9.2%

Source: Medicaid Eligibility Reports, June 2020 & September 2020

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment data and cost per unit data by programs is provided for July 2018 through June 2020. Please see Attachment A: July 2018 – June 2020 Statewide Dashboards.

MCO Enrollment

- In aggregate, MCO enrollment increased by 2% from the previous to current period. This increase is comprised of the following:
    - 1% increase in physical health enrollment.
    - <1% increase in aggregate Long term services and supports enrollment.
    - 4% increase in other adult group enrollment.

MCO Per Capita Medical Costs

- In aggregate, total MCO per capita medical costs increased by 11% from the previous to current period, this consists of a 12% increase to pharmacy services and 11% increase to non-pharmacy services.

- Primary drivers of increased costs in the current period when compared to previous period costs are the various changes in benefits and fee schedules that went into effect throughout 2019 and January 1, 2020. Service categories most impacted by these changes are Acute Inpatient, Acute Outpatient/Physician, Community Benefit/PCO, and Behavioral Health Services. Details of the benefit and fee schedule changes are included in the cover page of the Statewide dashboards.

CENTENNIAL CARE 1.0 TO CENTENNIAL CARE 2.0 TRANSITION

Molina Healthcare Plan Termination

MHC was required to comply with all duties and obligations incurred prior to the contract termination date, as well as continuing obligations following termination. In DY7 Q2, MHC provided monthly updates on the progress of its termination plan through May. MHC identified the May update as its final termination plan and requested HSD's agreement that MHC had fulfilled all of its obligations. Following internal review and discussion with MHC, HSD decided that it cannot make a determination concerning MHC's completion of its continuing obligations until all outstanding financial transactions have been completed. MHC was informed that HSD did not consider the May termination plan update as the final plan and extended the due date for the final termination plan to 3/31/2021. HSD will continue to work with MHC and monitor the completion of the financial transactions.

UnitedHealthcare Community Plan Termination

In DY7 Q1, UHC submitted its final termination plan report and requested that HSD approve the completion of the termination plan. UHC also requested the opportunity to review and respond to external audit reports, when available, for periods during which UHC was an MCO. In DY7 Q2, HSD provided UHC a draft audit related to Medicaid inpatient hospital claims in CY 2017. UHC responded that it was unable to provide comments as its Subject Matter Experts were no longer available. HSD has made a preliminary determination that UHC has fulfilled its continuing obligations following the termination of its agreement with HSD. The final review is in process within HSD.

CENTENNIAL REWARDS

The Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors as listed below:

- Asthma Management – reward for refills of asthma controller medications for children;
- Bipolar – reward for members who refill their medications;
- Bone Density – reward for women age 65 or older who complete a bone density test within the year;
- Dental – reward for annual dental visits;
- Diabetes – reward for members who complete tests and exams to better manage their diabetes;
- Health Risk Assessment (HRA) – reward for members who complete an HRA;
- Pregnancy – reward for prenatal first trimester and postpartum visit;
- Schizophrenia – reward for medication refill; and
- Adult PCP Visit Well-Child for ages Birth – 15 Month (aka W15)

Participating Members who complete these activities can earn credits, which can then be redeemed for items in the Centennial Rewards catalog.

Table 2: Centennial Rewards

CENTENNIAL REWAR D S			
	Q1	Q2	Q3
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this	120.293	131,348	133,800
Number of Members Registered in the Rewards Program this Quarter	5,345	5,333	6,620
Number of Members Who Redeemed Rewards this Quarter**	11,134	25,939	22,766

*Only includes rewards earned THIS quarter.

**Redeemed rewards could have been earned in any of the previous 24 reporting months.

Source: Centennial Rewards, Q3 2020 Program Results Finity Inc.

Electronic Engagement Reward Alert Campaign

During DY7Q3, Finity conducted a multimedia reward alert campaign to support members during the COVID-19 pandemic. Goals of this campaign included helping members complete childhood immunizations by attending well-child visits to keep their babies ages 0-15 moths vaccinated.

This campaign engagement resulted in the following outreach to members:

- **10,355** texts and emails sent
- **14,544** outbound calls placed to parents/guardians of member children 0-15 months old

Of the members Finity engaged with:

- **4,847** completed a Well-Baby Visit within 60 days of this outreach campaign.
- **36%** of members engaged have completed this important immunization activity during Q3.

In August 2020, Finity added child-sized face masks and face shields to the member rewards catalog. Now members can use their points to purchase disposable face masks and face shields for children and adults.

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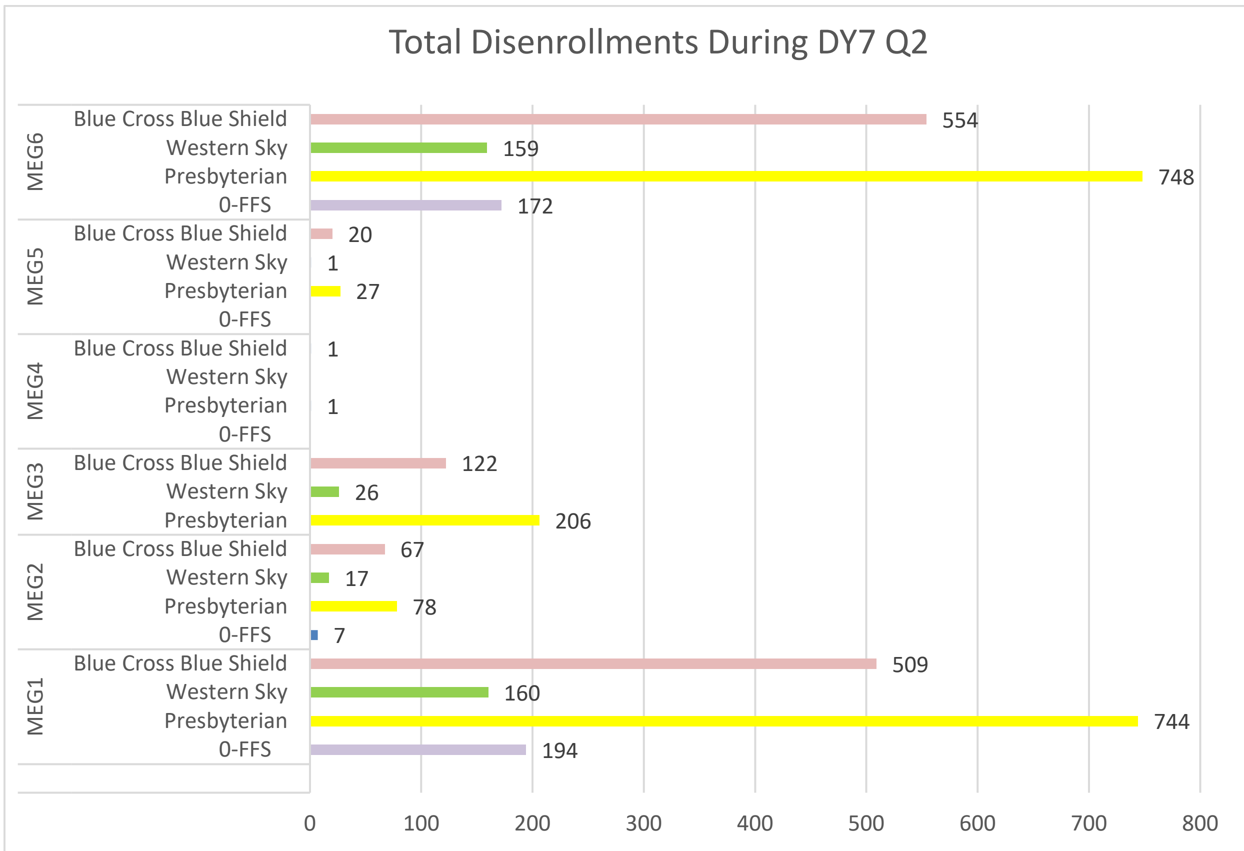
ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

The following table outlines 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. Due to Public Health Emergency (PHE) regarding Coronavirus (COVID-19), HSD meets the Maintenance of Effort (MOE) statutory requirements to receive the 6.2 percent increased 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 disenrollment for this quarter is attributed to incarceration, death, and members moving out of state.

Demonstration Population		Total Number Demonstration Participants DY7 Q3 Ending September 2020	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY7 Q3
Population MEG1 - TANF and Related	0-FFS	33,489	43,524	259
	Presbyterian	194,930	223,944	865
	Western Sky	34,314	39,662	183
	Blue Cross Blue Shield	123,141	138,318	628
	Summary	**385,874**	**445,448**	**1,935**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,059	2,665	5
	Presbyterian	20,232	21,479	80
	Western Sky	3,520	3,791	27
	Blue Cross Blue Shield	11,685	12,116	52
	Summary	**37,496**	**40,051**	**164**
Population MEG3 - SSI and Related - Dual	0-FFS		74	
	Presbyterian	22,775	24,017	159
	Western Sky	2,673	2,735	32
	Blue Cross Blue Shield	10,783	11,347	98
	Summary	**36,231**	**38,173**	**289**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	15	56	4
	Presbyterian	123	161	1
	Western Sky	19	22	1
	Blue Cross Blue Shield	89	115	2
	Summary	**246**	**354**	**8**
Population MEG5 - 217-like Group - Dual	0-FFS		12	
	Presbyterian	2,707	2,806	29
	Western Sky	382	376	2
	Blue Cross Blue Shield	2,072	2,056	19
	Summary	**5,161**	**5,250**	**50**
Population MEG6 - VIII Group (expansion)	0-FFS	24,505	28,775	172
	Presbyterian	131,537	132,507	643
	Western Sky	26,168	26,581	147
	Blue Cross Blue Shield	98,294	98,203	489
	Summary	**280,504**	**286,066**	**1,451**
Summary		745,512	815,342	3,897


Total Disenrollments During DY7 Q2
MEG6
Blue Cross Blue Shield
554
Western Sky
159
Presbyterian
748
0-FFS
172
MEG5
Blue Cross Blue Shield
20
Western Sky
1
Presbyterian
27
0-FFS
MEG4
Blue Cross Blue Shield
1
Western Sky
Presbyterian
1
0-FFS
MEG3
Blue Cross Blue Shield
122
Western Sky
26
Presbyterian
206
MEG2
Blue Cross Blue Shield
67
Western Sky
17
Presbyterian
78
0-FFS
7
MEG1
Blue Cross Blue Shield
509
Western Sky
160
Presbyterian
744
0-FFS
194
0
100
200
300
400
500
600
700
800

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OUTREACH/ INNOVATIVE ACTIVITIES TO ASSURE ACCESS

OUTREACH AND TRAINING	
3rd Quarter Activities	In DY7 Q3, HSD staff conducted monthly trainings for the Presumptive Eligibility (PE) Program and Presumptive Eligibility Determiners (PED) in the JUST Health Program. HSD also conducted YESNM-PE Demonstration trainings for PEDs. The purpose for these on-going trainings is to increase PED enrollment throughout New Mexico. Due to COVID-19, all trainings are conducted remotely and are now via a webinar platform.

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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 MCO's. HSD extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. Based on the most recent quarterly data extracted, the MCO's are compliant with encounter submissions.

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: http:www.hsd.state.nm.us/LookingForInformation/medicad-eligibility.aspx. This report includes enrollment by MCOs and by population.

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OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments through Quarter 3 of demonstration year (DY) 7 reflect the Centennial Care 2.0 rates effective on January 1, 2020. 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, 2020 were submitted to the Centers for Medicare and Medicaid Services (CMS) on January 6, 2020 and approved on October 2, 2020. In addition, the payments during Q3 of DY 7 also reflect the updated rates to remove the Safety Net Care Pool (SNCP) programmatic change and add more System Delivery Provider Payment Initiatives. This rate report was submitted to CMS on April 29, 2020 and approved on October 2, 2020. The rates were updated again for July 1st to December 31st, 2020 to reflect revision to directed payments for nursing facilities, community hospitals serving Native Americans and for-profit and government owned hospitals; the rates were also being updated with the addition of pharmacy clinicians rate adjustment, directed payments for trauma hospitals, hospital access program, COVID-19 directed payments for nursing facilities, directed payments for community benefit retainer, medical residency pilot program, opioid treatment program adjustment, and health care quality surcharge data intermediary. The rate certifications for these rates update were submitted on August 10, 2020.

During DY7 Q3, HIS payments, directed payments and health care quality surcharge payments were made affecting the per member per month (PMPM) of MEGs 1, 2 and 6 of DY 7. The directed payments made to the University of New Mexico Medical Group (UNMMG) and hospital access payment predominantly contribute to the change of the PMPM for MEGs 1 and 6 of DY 7; the payments related to health care quality surcharge contribute to the increase PMPM of MEG 2 for DY 7. The member months for Q2 of DY 7 were refreshed resulting in lower member months and mainly accounted for the change in PMPM for MEG 4 of DY 7, a better reflection of the PMPM for this MEG.

The fiscal impact of the public health emergency due to the Coronavirus (COVID-19) pandemic may be minimal in the financial activities during Quarter 3 of CY 2020. The fiscal impacts from the pandemic period will be better reflected in subsequent quarters.

PUBLIC HEALTH EMERGENCY (PHE) regarding COVID-19

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. In response to the PHE, HSD requested several federal authorities and were approved for the following:

New Mexico Disaster Relief State Plan Amendments (SPAs)

HSD submitted six Disaster Relief SPAs and received CMS approval for the following:

- Expands the list of qualified entities allowed to do Presumptive Eligibility
- Increases DRG rates for ICU inpatient hospital stays by 50% and all other inpatient hospital stays by 12.4%; and
- Established Category of Eligibility (COE) for the COVID Testing Group for the uninsured population
- Targeted Access UPL Supplemental Payments
- Nursing Facility Rate Increases applied when treating fee for service COVID-19 members
- Increased hospital stays services from April 1, 2020 – June 30, 2020

1135 Waiver

HSD submitted a 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
- Extension of time to request fair hearing of up to 120 days
- Enroll providers who are enrolled in another state's Medicaid program or who are enrolled in Medicare
- Waive screening requirements (i.e. Fingerprints, site visits, etc.) to quickly enroll providers
- Cease revalidation of currently enrolled providers
- Payments to facilities for services provided in alternative settings
- Temporarily allow non-emergency ambulance suppliers
- Temporarily suspend payment sanctions
- Temporarily allow legally responsible individuals to provide PCS services to children under the EPSDT benefit.

Appendix Ks

HSD submitted three Appendix Ks and received CMS approval for the following:

- 1915c Waivers (Medically Fragile, Mi Via, and Developmental Disability)
  - Exceed service limitations (i.e. additional funds to purchase electronic devices for members, exceed provider limits in a controlled community residence and suspend prior authorization requirements for waiver services, which are related to or resulting from this emergency)
  - Expand service settings (i.e. telephonic visits in lieu of face-to-face and provider trainings also done through telehealth mechanisms.)
  - Permit payment to family caregivers
  - Modify 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
  - Modifying incident reporting requirements

- 1115 Demonstration Waiver for Home Community Benefit Services (HCBS)
  - Expand service settings (i.e. telephonic visits in lieu of face-face and provider trainings also done through telehealth mechanisms.)
  - Permit 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.
  - Modification to 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
  - Allow for payment for services
  - Retainer payments for personal care services

PATIENT CENTERED MEDICAL HOMES (PCMH)

HSD discontinued the PCMH delivery system improvement project as of DY6. However, MCOs are still required to work with PCP contract providers to implement PCMH programs and report the activities quarterly. Please see DY7Q1 through DY7Q3 listed

below.

PCMH ASSIGNMENT				
Total Members Paneled to a PCMH				
	DY7 Q1	**DY7 Q2**	**DY7 Q3**	**DY7 Q4**
BCBS	108,396	108,409	115,534	
PHP	231,428	230,140	238,861	
WSCC	24,391	25,229	29,028	
Percent of Members Paneled to a PCMH				
BCBS	43.2%	42.5%	43.8%	
PHP	61.9%	59.8%	60.8%	
WSCC	34.6%	34.4%	36.1%	

In DY7 Q3, the MCOs submitted their PCMH quarterly reports. In response to the PHE, HSD directed providers to offer telehealth services to be provided in all physical health, behavioral health, and long-term care settings to ensure safe access to health care. HSD added new telehealth codes to encourage the use of telephonic visits and e-visits in lieu of in-person care to reduce the risk of spreading COVID-19 through face-to-face contact. This initiative has continued through Q3.

CARE COORDINATION MONITORING ACTIVIES

Care Coordination Monitoring Activities	
3rd Quarter Activities	In DY7 Q3, HSD continued to monitor MCO enrollment and Member engagement through the quarterly Care Coordination Report. This report includes required assessments and touchpoints due and completed within contract timeframes. The MCO aggregated results from DY7 Q2 show performance standards of 85% were met or exceeded for timely completion of Health Risk Assessments (HRAs), Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs). See Table 4 MCO Performance Standards: Care Coordination Monitoring listed below.

Table 4 – Care Coordination Monitoring

MCO PERFORMANCE STANDARDS	DY7Q1	DY7Q2
HRAs for new Members	**98%**	**97%**
BCBSNM	98%	97%
PHP	96%	95%
WSCC	100%	100%
HRAs for Members with a change in health condition	**87%**	**92%**
BCBSNM	100%	100%
PHP	81%	87%
WSCC	100%	100%
CNAs for CCL2 Members	**93%**	**93%**
BCBSNM	85%	83%
PHP	98%	99%
WSCC	99%	99%
CNAs for CCL3 Members	**87%**	**90%**
BCBSNM	76%	79%
PHP	91%	98%
WSCC	100%	100%
CCPs for CCL2 Members	**92%**	**91%**
BCBSNM	72%	74%
PHP	100%	99%
WSCC	97%	97%
CCPs for CCL3 Members	**93%**	**91%**
BCBSNM	80%	80%
PHP	99%	99%
WSCC	95%	97%

Source: HSD Report #6 – Quarterly Care Coordination Report

In DY7 Q3, HSD continued to monitor 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. This report monitors compliance of the MCOs’ use of telephonic and video visits for comprehensive needs assessments and required touchpoints. Table 5, listed below, identifies how MCOs are able to continue to provide Care Coordination by completing assessments and touchpoints for Members. The MCOs have reported the comprehensive needs assessments and touchpoints not completed are due to Member-driven COVID-19 concerns, such as the absence of privacy at home or a lack of sufficient minutes on a Member’s phone. These assessments and touchpoints are attempted again, by the MCO, in the following month.

Table 5 - Telephonic In Lieu of Face-To-Face Visits

TELEPHONIC IN LIEU OF FACE TO FACE VISITS	DY7Q1	DY7Q2	DY7Q3
Initial CNAs completed	**N/A**	**2,722**	**3,006**
BCBSNM	N/A	1,177	1,268
PHP	N/A	1,311	1,407
WSCC	N/A	234	331
Initial CNAs not completed due to COVID 19	**N/A**	**3**	**42**
BCBSNM	N/A	1	39
PHP	N/A	1	3
WSCC	N/A	1	0
Annual CNAs completed	**N/A**	**5,896**	**6,052**
BCBSNM	N/A	1,946	2,076
PHP	N/A	3,375	3,326
WSCC	N/A	575	650
Annual CNAs not completed due to COVID 19	**N/A**	**260**	**579**
BCBSNM	N/A	57	291
PHP	N/A	203	288
WSCC	N/A	0	0
Semi-annual CNAs completed	**N/A**	**405**	**581**
BCBSNM	N/A	115	192
PHP	N/A	248	333

TELEPHONIC IN LIEU OF FACE TO FACE VISITS	DY7Q1	DY7Q2	DY7Q3
WSCC	N/A	42	56
Semi-annual CNAs not completed due to COVID 19	**N/A**	**8**	**10**
BCBSNM	N/A	0	0
PHP	N/A	8	10
WSCC	N/A	0	0
Quarterly in-person visits completed	**N/A**	**1,357**	1,492
BCBSNM	N/A	573	650
PHP	N/A	738	801
WSCC	N/A	46	41
Quarterly in-person visits not completed due to COVID 19	**N/A**	**91**	**109**
BCBSNM	N/A	0	1
PHP	N/A	91	108
WSCC	N/A	0	0
Semi-annual in-person visits completed	**N/A**	**5,534**	**8,194**
BCBSNM	N/A	1,601	1,675
PHP	N/A	3,589	5,763
WSCC	N/A	344	756
Semi-annual in-person visits not completed due to COVID 19	**N/A**	**522**	**595**
BCBSNM	N/A	10	19
PHP	N/A	512	576
WSCC	N/A	0	0

Source: MCO Ad Hoc Report: Bi-Weekly Telephonic in Lieu of Face-To-Face Report

Care Coordination Ride-Alongs

HSD conducted two virtual ride-alongs with MCO care coordinators in DY7 Q3 to observe completion of Member assessments. The MCOs began utilizing telephonic or virtual visits in lieu of in-home person touchpoints in DY7 Q1 to reduce the risk of spreading COVID-19 through face-to-face contact. HSD attended two virtual annual CNAs conducted by WSCC. HSD observed how the care coordinator properly administered the Community Benefits Services Questionnaire (CBSQ) and the Community Benefits Member Agreement (CBMA) to ensure the Members had access to Community Benefits.

The observed care coordinators adhered to, and often went beyond, all contractual obligations in their assessments. Care coordinators were thorough, well prepared, showed excellent listening skills and were patient and caring towards their Members. HSD noted that one observed care coordinator had an excellent rapport with the Member and conducted the assessment in a conversational style, which lent a relaxed atmosphere to the meeting. This Member stated he had not been to the dentist in years, which prompted assistance from the care coordinator in obtaining a provider to schedule an appointment**.** HSD observed that another care coordinator, working with a Member in a rural area, was familiar with what resources were available to the Member and referred them to the appropriate resources. This Member requested a new mental health counselor and the care coordinator came prepared with several options and volunteered to print and mail the necessary applications. HSD noted opportunities for improvement by care coordinators such as offering employment resources to one Member and HSD's concern that another Member was leveled incorrectly. HSD provided written feedback to the MCOs on care coordinator strengths and areas that could use improvement. The MCOs followed up to ensure care coordinators provided all required resources and reviewed the Care Coordination Level of the observed Member, per HSD's directive.

Care Coordination All MCO Meeting

In DY7 Q3, HSD conducted a quarterly meeting with all MCOs, to present aggregated data from the quarterly Care Coordination Report on Member engagement, Care Coordination timeliness, performance analysis, and Member outcomes. Representatives from all MCOs attended, including those MCO staff overseeing care coordinators, compiling Care Coordination data, and reviewing HSD required reports. HSD presented aggregated data for DY7 Q2 with report results for completion of contract required assessments and touchpoints. HSD provided the MCOs with data from DY6Q1 through DY7Q2 to show trends in completion rates.

HSD provided aggregated data to the MCOs on the Bi-Weekly Telephonic In Lieu of Face-to-Face Reports for completed assessments conducted during the PHE and the Member-driven issues that contributed to delayed assessments.

HSD reviewed monthly Nursing Facility Level of Care (NF LOC) audits, provided aggregated results and focused on discrepancies that led to files not meeting compliance.

HSD provided the MCOs with targeted training on contract and policy requirements that affect all files audited for improved contract and policy compliance going forward. Additionally, HSD clarified requirements for report submissions, reiterated HSD directives for analysis submissions, updated the MCOs on revisions to the quarterly Care Coordination Report and the expectation that the monthly Transition of Care (TOC), HRA, CNA and Member categorization audits will resume in DY7 Q4.

HSD continues to see improvement in MCO compliance with timely completion of contract required assessments and touchpoints.

BEHAVORIAL HEALTH

In DY7 Q3, the MCOs, in collaboration with the State and the New Mexico Behavioral Health Provider Association (NMBHPA), continued to work together to identify ways to maintain critical behavioral health services during the COVID 19 public health emergency. In mid-March HSD issued a letter of direction (LOD) authorizing the use of telehealth for the majority of behavioral health services, delivered in all settings and using the same codes and rates that are in place for face-to-face services. In addition to standard telehealth delivery methods, behavioral health providers are, for the duration of the emergency, permitted to deliver services telephonically.

The results of expanded access to behavioral health services through telehealth have been dramatic. In the first quarter of DY7, 19,879 individuals received behavioral health through telehealth. In the second quarter, as the public health crisis expanded and BHSD issued the telehealth LOD, that figure jumped by 130 percent, to 45,800 people. Quarter three saw a slight 3 percent decline, to 44,232 people, but was still 123 percent higher than the first quarter.

BHSD did not begin to receive data on behavioral health services delivered over the telephone until this quarter, when the three MCOs reported that 31,554 individuals received needed behavioral health services through this modality. There may be some duplication between the two categories, but together they indicate over 75 thousand individuals were able to access the services they needed this quarter through telehealth and telephone.

In addition to increased utilization, behavioral health providers around the state are reporting 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 has taken on an even more critical role during the COVID 19 crisis. 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. Individuals living in nursing facilities are facing some of the greatest COVID 19 related stress, and during the last quarter BHSD began an initiative that connects Treat First providers with residents of nursing facilities and other long term care settings. BHSD has facilitated partnerships between a local Treat First provider and a nearby LTC facility. The local provider dedicates counselors who build therapeutic relationships with interested residents through telephonic or audio-visual tools such as cell phones, iPad or computers.

New Mexico has 26 Treat First certified provider agencies in the state, most with multiple locations, and the Behavioral Health Services Division of HSD is working with providers to increase that number. A Treat First learning community has been established and will be holding sessions with providers during the coming quarter.

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.

SBIRT utilization increased about 17 percent this quarter, from a total of 1,727 people served in the second quarter to a total of 2,090 in the third quarter. These are not unduplicated client counts, so another way to view the data is to average utilization across the months of each quarter: the second quarter saw an average of 593 people served each month, increasing to an average of 697 people per month in the third quarter. The drop between first and second quarters, described in our last report, was out of synch with previous quarters of robust growth and was driven primarily by lack of access to services during the COVID 19 crisis. In response to the crisis, BHSD opened almost all behavioral health services to delivery via telehealth, and the rebound in SBIRT services is indicative of how much that step expanded access.

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 DY7 Q3, the State continued efforts to implement Crisis Treatment Centers (CTC). Provider-specific cost-based rates were finally established for the first two CTC providers in the state, both of which began delivering services during the third quarter. Two more CTC providers are set to begin rate development in the next month.

Throughout the first three quarters of 2020, BHSD has also focused on expanding other services 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 substance use disorders (SUD) that is not part of a certified general acute care hospital. MAD has expanded coverage of recipients, aged 22 through 64, to inpatient hospitalization in an IMD, for SUD diagnoses only, with criteria for medical necessity and based on ASAM admission criteria. Covered services include withdrawal management (detoxification) and rehabilitation.

Residential or inpatient treatment for SUD in an IMD utilization began dropping in March, shortly after the COVID 19 public health crisis began, and declined a further 2 percent in the second quarter. However, quarter three saw a 14 percent increase in clients served, rising from 2,800 in quarter two to 3,121 in the third quarter. These are not unduplicated client counts, so another way to view the data is to average utilization across the months of each quarter: the third quarter saw an average of 1,040 people served each month, increasing from the 915 persons served during quarter two.

ADULT ACCREDITED RESIDENTIAL TREATMENT CENTERS (AARTC) SERVICES

In late August the Medical Assistance Division (MAD) issued Letter of Direction #45, directing the MCOs to expedite credentialing and contracting with the AARTCs that have been approved by BHSD and have enrolled with Conduent as a MAD provider. MCOs were also directed to expedite any systems configurations necessary to recognize AARTCs as network providers to pay claims using the billing codes in accordance with MAD.

BHSD has received a total of sixteen applications since the beginning of this process, with six AARTCs now enrolled as Medicaid providers. Of the remaining ten applications eight are under various stages of review.

Due to a critical need for services in McKinley County, BHSD is working with a provider to stand up AARTC services with an anticipated opening date of December 2020. BHSD is expediting this application due to the urgency of the need for services in Gallup, New Mexico. The AARTC coordinator is prioritizing requirements of the application process to ensure timely approval and to expedite enrollment with Conduent and credentialing and contracting with the MCOs.

One provider has submitted three applications to expand the current ASAM levels of care for their existing approved AARTC in Santa Fe County. Another provider is awaiting accreditation pending the completion of their survey by CARF.

One applicant is experiencing difficulty in finding and hiring licensed staff which will allow them to provide the ASAM level of care services identified in their application. BHSD has provided names of employment agencies and licensing boards to assist in locating and hiring staff.

Unfortunately, two providers have withdrawn their applications. Although BHSD offered to fund and support these providers to obtain the required accreditation from the Joint Commission, both applicants opted out of this process and will not be moving forward.

BHSD's AARTC Coordinator will continue to review applications, provide technical assistance and evaluate and improve the process to expedite enrollment of Medicaid providers.

Health Homes

The CareLink New Mexico Health Homes (CLNM) program provides integrated care coordination services to Medicaid-eligible adults with Serious Mental Illness and children and adolescents with Severe Emotional Disturbance. Seven providers deliver coordinated care services in 12 counties to support integrated behavioral and physical health services. Two Health Homes (Guidance Center Lea County and Mental Health Resources, Roosevelt County) provide High Fidelity Wraparound services to 150 children and adolescents with SED and complex behavioral health challenges. Wraparound clients are involved with multiple state systems and many have been in out-of-state residential treatment centers. HSD is in the process of adding Substance Use Disorder to the eligibility criteria for Health Homes, which will align this program with the State's 1115 Demonstration Waiver activities and enable CLNM providers to provide services to this vulnerable population. Specific activities in support of this change are listed below.

CLNM Health Home Activities	
3rd Quarter Activities	Since mid-March 2020, CLNM providers have been delivering behavioral health services telephonically and through telehealth technologies. Providers report these delivery methods have been effective in continuing to provide services, particularly to members in rural and frontier areas that have bandwidth. The providers also describe some members experiencing fatigue with technology. During DY7 Q3, Individual meetings were conducted with Health Home providers to render technical assistance for reporting in BHSDStar. Due to staffing turnover, it appeared some Health Home care coordinators were not documenting in Star all services rendered to members. HSD reviewed reports with providers, and responded to questions concerning proper documentation of services. Technical assistance also included relating services and reporting to HEDIS measures, and overall performance monitoring. During this quarter HSD also provided training to CLNM staff for Clinical Reasoning and Case Formulation. The training offers basic clinical and practical reasoning in broad care coordination knowledge, good judgment, and disciplined synthesis of case information. The training enhances providers' ability to effectively use clinical reasoning in decision-making as a complex process, ensuring care

	coordinators are able to use a diverse knowledge base and deal with multiple variables in diagnoses of individuals. Seventy CLNM staff members were trained in three separate trainings. In conjunction with the addition of SUD eligibility criteria for Health Homes, HSD leadership and actuaries have collected and reviewed data from current CLNM providers to determine if a change in PMPM is warranted.

Table 6: Number of Members Enrolled in Health Homes

NUMBER OF MEMBERS ENROLLED IN HEALTH HOMES						
Q1 2019 JAN – MAR	Q2 2019 APR – JUN	Q3 2019 JUL – SEPT	Q4 2019 OCT – DEC	Q1 2020 JAN – MAR	Q2 2020 APR – JUN	Q3 2020 JUL-SEPT
2,540	2,814	3,228	3,637	3,714	3,829	3,858

Supportive Housing
The supportive housing benefit in Centennial Care 2.0 (CC 2.0) provides Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program pre-tenancy and tenancy services. The Linkages program serves individuals 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.

Linkages agencies can bill Medicaid for comprehensive community support services (CCSS), but now that supportive housing services are included in the CC 2.0 waiver, agencies are encouraged to shift to billing directly for supportive housing. The CC 2.0 waiver requires the services be provided by a certified peer support worker (CPSW), in keeping with the state's goals for building the peer support workforce. One Linkages provider is currently using a CPSW to deliver supportive housing services, while other providers utilize case managers, community support workers, and supportive housing coordinators to offer these services.

The lack of CPSWs among Linkages providers is of concern to the state. BHSD continues to collaborate with the Office of Peer Recovery and Engagement (OPRE) to prioritize CPSW training for eligible Linkages staff. Effective July 17, 2020, OPRE had to cease accepting new CPSW applications due to the backlog of current applicants and delays imposed by COVID-19. Prior to COVID-19, CPSW trainings were scheduled, and OPRE agreed to hold approximately five slots for Linkages staff for each CPSW training. Training efforts will resume as state public health orders evolve and the pandemic abates.

BHSD further promoted the use of CPSWs to render Linkages support services by including it as an item of focus for a Linkages training scheduled in October. There will also be language added to the Linkages policy manual explaining the Medicaid H0044 code to encourage utilization in lieu of CCSS. There are at least two Linkages providers currently considering hiring a CPSW.

MEDICAID SUPPORTIVE HOUSING UTILIZATION JANUARY 1, 2020 – SEPTEMBER 30, 2020	
Quarter	Client Count
1	26
2	31
3	28
Unduplicated Total	34

An increase of state general funds (SGF) FY21 allowed BHSD to expand Linkages services that are not covered by Medicaid. SGF supports rental assistance vouchers for eligible Linkages clients. In FY20, there were nine Linkages Support Service Agencies (SSAs) and six Housing Administrators (HAs); there were six Linkages sites statewide. In FY21, Linkages will have eight sites, expanding in Curry and McKinley counties.

The following is SGF data, households served with a Linkages voucher and support services:

NON-MEDICAID LINKAGES UTILIZATION JANUARY 1, 2020 – SEPTEMBER 30, 2020	
Quarter	Households Served
1	148
2	148
3	153

The BHSD Supportive Housing Program Manager provides technical assistance to Linkages providers and Medicaid managed care organizations, as needed, to support the Medicaid Linkages Supportive Housing program.

Centennial Home Visiting (CHV) Pilot Program
At the end of DY7 Q3, the numbers of CC MCO member enrollments for each home visiting (HV) program are as follows:

- **Nurse Family Partnership (NFP):** 54 unique families

  There are still two NFP nurses at the UNM Center for Development and Disability (UNM CDD) dedicated for the CHV Pilot Program in Bernalillo County. Per the NFP model, the UNM CDD NFP program had a capacity of 25 new families for which each one of the new nurses can be responsible. However, during the COVID-19 emergency when home visiting services are provided via telehealth, UNM CDD has increased their enrollment limit to 60 families to account for unexpected events like no-shows.

  UNM CDD received grant funds from the NFP organization to hire a third nurse to be CHV provider. The target hiring date is in October. UNM CDD is looking to utilize the newly hired nurse, who will need to be trained in Q4, to deliver services in Valencia County and Sandoval County, in addition to Bernalillo County.

- **Parents as Teachers (PAT):**

  UNM CDD – 43 unique families

  ENMRSH – 19 unique families

  The capacity of UNM CDD and ENMRSH, the agency that contracts to provide services in Curry and Roosevelt counties, to provide the PAT HV services is 50 and 20 families, respectively.

  The CHV services delivery was still affected by the COVID-19 emergency during DY7 Q3. HSD continued the following guidance to assist CHV providers:

  "HSD is temporarily waiving the requirement that CHV program providers in-home visits. Instead, Nurse Family Partnership and Parents as Teachers home visitors will follow telehealth guidance in accordance with their curriculum standards, including the use of videoconferencing, if possible. Any activities that require an in-person visit with CHV clients will be deferred through the termination of the emergency declaration."

Home visiting agencies reported no interruption of services. Both home visitors and families found this mode of delivery to be a desirable alternative.

In DY7 Q3, Taos Pueblo began to receive some referrals from one of the Centennial Care Managed Care Organizations (MCOs). However, Taos Pueblo has not been able to finalize the home visiting contract with this MCO. Therefore, there was no CHV enrollments with Taos Pueblo in DY7 Q3.

Presumptive Eligibility Program

The NM 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 NM State Agencies including the NM Department of Health (DOH), NM Children Youth and Families Department (CYFD) and the NM Corrections Department (NMCD). Currently, there are approximately 743 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assisting with on-going Medicaid application submissions.

HSD staff conduct monthly PE Certification trainings for employees of qualified entities that chose 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 on-going Medicaid applications. PE program staff conducted three PE certification trainings and three YESNM-PE demo refresher trainings.

In DY7 Q3, HSD maintained a virtual assistant program to help automate the process of adding newborns to existing Medicaid cases. This new "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 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 Presumptive Eligibility Determiners (PEDs). PEDs use YESNM-PE to screen, and grant approvals, for Presumptive Eligibility (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.

HSD program staff implemented Baby Bot through a piloted, phased-in approach. The initial month-long pilot locations included Lovelace and UNM hospitals in Albuquerque – two NM hospitals with high number of Medicaid-covered births. As pilot sites, PEDs at these locations were required to take part in a HSD staff-led training. After a successful pilot, Baby Bot then moved to a full statewide implementation. All PEDs at hospitals, IHS/Tribal 638 and birthing center-based locations were required to participate in a Baby Bot training before being allowed access to the functionality. Currently 222 active PEDs are certified to use the Babybot functionality with more trainings scheduled to increase participation.

Table 7: Program numbers are specific to Medicaid-eligible newborns submitted through BabyBot on YESNM-PE

- **Newborns Submitted**
  Overall number of submissions through BabyBot
- **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

In DY7 Q3 57 PEDs used the Babybot functionality. Although HSD program staff saw a decrease in PED participation, we noticed an increase in the number of newborns added through Babybot. . In this reporting period 69% of all newborns submitted through a Baby Bot chat session resulted in a successful case update. CEB PE program staff are working

with PEDs and system developers to increase the *number* of submissions as well as the number of *successful submissions* through the Baby Bot.

Table 7: PE Approvals

AVA Baby Bot (July – September 2020)					
Month	**Newborns Submitted through AVA**	**Newborns Successfully Enrolled**	**Newborns Unsuccessfully Enrolled- Tasks Created**	**% of Newborns Successfully Enrolled**	**% of Newborns Unsuccessfully Enrolled**
July	745	513	232	69%	31%
August	751	497	254	66%	34%
September	693	510	183	74%	26%
Total	**2,189**	**1,520**	**669**	**69%**	**31%**

Source: Accenture BabyBot dashboard RPA activity detail daily report

Table 8: PE Approvals outlines the numbers of PE approvals granted and the total number of ongoing applications submitted and approved. NM PEDs are aware of the importance of on-going Medicaid coverage for their clients. This is reflected by the high number of PE approvals that also had an ongoing application submitted in DY7Q3. In all three months of DY7 Q3, 99.38% of all PE approvals also had an ongoing application submitted.

PE APPROVALS (July - September 2020)				
MONTH	PES GRANTED	% PE GRANTED W/ ONGOING APPLICATION SUBMITTED	TOTAL INDIVIDUALS APPLIED	INDIVIDUALS APPROVED
July	197	100.00%	1,187	953
August	145	98.62%	1,171	914
September	139	99.28%	933	694
Total	**481**	**99.38%**	**3,291**	**2,561**

Source: Monthly PE001 Report from ASPEN and OmniCaid

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, etc.) upon release. To help facilitate access to care and ensure smooth transitions from correctional facilities, HSD has established the Centennial Care JUST Health workgroup. The workgroup includes representatives from State and County Correctional facilities, Managed Care Organizations, County governments, State agencies, provider organizations and other stakeholders. The goal of the workgroup is to create a transition of care with detailed processes and procedures that can be utilized and adapted to work for all correctional facilities state-wide.

The following table outlines the numbers of PE approvals granted and the total number of ongoing applications submitted and approved. In all three months of DY7 Q3, 100.00% of all PE approvals also had an ongoing application submitted.

Table 9: PE Approvals

PE APPROVALS (July – September 2020)				
MONTH	PES GRANTED	% PE GRANTED W/ ONGOING APPLICATION SUBMITTED	TOTAL INDIVIDUALS APPLIED	INDIVIDUALS APPORVED
July	22	100.00%	121	111
August	8	100.00%	99	95
September	7	100.00%	75	70
Q3 Totals	**37**	**100.00%**	**295**	**276**

Source: Monthly PE001 Report from ASPEN and OmniCaid

7
HCBS REPORTING

Critical Incidents	
3rd Quarter Activities	HSD/MAD conducted a quarterly meeting with MCOs and external stakeholders to discuss critical incident reports (CIRs) reporting expectations, barriers and challenges. An update was provided to include the MCOs annual provider CIR training completed in September 2020. The annual training continues to see an increase in personal care providers attendance since it started online. The training provided the guidelines for reporting critical incidents and how to properly report Neglect CIRs due to COVID-19. HSD/MAD conducted daily reviews of critical incidents submitted by MCOs and providers for the purpose of ensuring reports meet reporting requirements. HSD/MAD provided daily assistance to MCOs and providers to obtain access to the CIR Portal by establishing and/or resetting login credentials as well as deleting duplicate reports. HSD/MAD provided weekly reports of identified critical incident reporting concerns to MCOs for correction and/or follow-up.

CRITICAL INCIDENTS REPORTED (APRIL - JUNE 2020)				
MCO	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	TOTAL FOR QUARTER
BCBS	3,267	152	110	3,529
PHP	9,327	487	419	10,233
WSCC	677	42	37	756
Total	13,271	681	566	14,518

BCBS (April - June 2020)				
CRITICAL INCIDENT TYPES	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	TOTAL FOR QUARTER
Abuse	86	20	4	110
Death	300	5	7	312
Elopement/Missing	9	2	3	14
Emergency Services	1,321	81	67	1,469
Environmental Hazard	14	0	0	14
Exploitation	42	3	4	49
Law Enforcement	27	7	1	35
Neglect	1,468	34	24	1,526
All Incident Types	3,267	152	110	3,529

PHP (April - June 2020)				
CRITICAL INCIDENT TYPES	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	TOTAL FOR QUARTER
Abuse	192	35	18	245
Death	523	16	16	555
Elopement/Missing	10	2	1	13
Emergency Services	4,516	239	298	5,053
Environmental Hazard	93	6	8	107
Exploitation	51	9	5	65
Law Enforcement	42	10	4	56
Neglect	3,900	170	69	4,139
All Incident Types	9,327	487	419	10,233

CRITICAL INCIDENT TYPES	CENTENNIAL CARE	WSCC (April - June 2020) BEHAVIORAL HEALTH	SELF DIRECTED	TOTAL FOR QUARTER
Abuse	31	4	4	39
Death	45	2	2	49
Elopement/Missing	5	3	0	8
Emergency Services	273	17	20	310
Environmental Hazard	7	0	0	7
Exploitation	5	1	1	7
Law Enforcement	7	2	0	9
Neglect	304	13	10	327

Consumer Support Program

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

Reporting for the quarter is provided by the Aging and Long-Term Services Department (ALTSD) - Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the broader public to access a variety of services.

Table 10: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT	
TOPIC	NUMBER OF CALLS
Home/Community Based Care Waiver Programs	2,785
Long Term Care/Case Management	3
Medicaid Appeals/Complaints	1
Personal Care	243
State Medicaid Managed Care Enrollment Programs	17
Medicaid Information/Counseling	1,066

Source: ALTSD GSA Reports Quarter 1 FY 2021

Table 11: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT			
COUNSELING SERVICES	NUMBER OF HOURS	NUMBER OF NURSING HOME RESIDENTS	NUMBER OF CONTACTS
Transition Advocacy Support Services		164	
*Medicaid Education/Outreach	2,865		
Nursing Home Intakes		77	
**LTSS Short-Team Assistance			26

Source: ALTSD GSA Reports Quarter 1 FY2021

*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.

Community Benefit

In DY7 Q3, the Long-Term Care (LTC) workgroup projects have included CC 2.0 program changes such as CC 2.0 reporting revisions, 2021 D-SNP transition, and implementation of the federally required Electronic Visit Verification (EVV) for the Self-Directed Community Benefit (SDCB). Due to the COVID-19 PHE, continued projects included direction to the MCOs to implement Appendix K related CMS approved changes to ensure members continue to receive benefits during the pandemic.

Nursing Facilities

The MCOs presented the first phase of virtual training to NF staff across the state. The training focused on NF LOC packets and the required documentation that must be sent from the NFs to the MCOs. Phases 2 and 3 trainings will be completed by the end of the calendar year. HSD continues to collaborate with DOH and ALTSD to implement best practices for infection control and resident safety.

EVV

In DY7 Q3, HSD, in partnership with the MCOs, continued to operate EVV for Agency-Based Personal Care Services. All parties continue to work towards implementation of EVV for the Self- Directed Community Benefit to meet the Cures Act requirements by January 2021. Please see EVV data for DY7 Q2 outlined in the table below. The MCOs reported that 74% of the total PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder were created through the First Data Authenticare app.

Table 12: EVV DATA

EVV DATA (APR – JUNE 2020)		
MCO	**AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD**	**NUMBER OF TOTAL CLAIMS THIS PERIOD**
BCBS	6,775	431,354
PHP	13,891	910,326
WSCC	1,472	100,097
TOTAL	22,138	1,441,777

Statewide Transition Plan

HSD continues to update the Statewide Transition Plan (STP) milestones as required by CMS. HSD plans to issue the STP for public comment early 2021.

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

HSD requires the MCOs to provide a 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 the HSD NF LOC Criteria and Instructions guidelines. The audit includes file numbers, accuracy, and timeliness. The results and findings are reported quarterly to HSD along with any Quality Performance Improvement Plan.

BCBS conducted 108 audits, PHP conducted 234, and WSCC conducted 60 audits of NF LOC Determinations during DY7 Q3. BCBS, and WSCC met or exceeded expectations for file numbers, accuracy and timeliness for every month of DY7 Q3. PHP's Low NF LOC determinations completed within the required timeframes dipped to 14 for a total of 82% but remained consistent at 100% in Aug and Sept.

HSD's Nurse Manager conducted technical assistance calls with the MCOs during Q3 to review and address accuracy and timeliness findings identified during the review of the MCOs internal audit report submissions.

Table 13 –MCO Internal NF LOC Audits– Facility Based

Facility Based Internal Audits High NF Determinations	Jul	Aug	Sep	DY7 Q3
Total number of High NF LOC files audited	**9**	**10**	**9**	**28**
BCBS	4	4	4	12
PHP	3	4	3	10
WSCC	2	2	2	6
Total number with correct NF LOC determination	**9**	**10**	**9**	**28**
BCBS	4	4	4	12
PHP	3	4	3	10
WSCC	2	2	2	6
Percent of total MCO monthly averages with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Low NF Determinations				
Total number of Low NF LOC files audited	**23**	**22**	**23**	**68**
BCBS	4	4	4	12
PHP	17	16	17	50
WSCC	2	2	2	6
Total number with correct NF LOC determination	**23**	**22**	**23**	**68**
BCBS	4	4	4	12
PHP	17	16	17	50
WSCC	2	2	2	6
Percent of total MCO monthly averages with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**

BCBS	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations				
Total number of High NF LOC determinations completed within required timeframes	**9**	**10**	**9**	**28**
BCBS	4	4	4	12
PHP	3	4	3	10
WSCC	2	2	2	6
Percent of total MCO monthly averages completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Total number of Low NF LOC determinations completed within required timeframes	**20**	**22**	**23**	**65**
BCBS	4	4	4	12
PHP	14	16	17	47
WSCC	2	2	2	6
Percent of total MCO monthly averages completed within required timeframes	**94%**	**100%**	**100%**	**98%**
BCBS	100%	100%	100%	100%
PHP	82%	100%	100%	94%
WSCC	100%	100%	100%	100%

Table 14: Quarterly MCO Internal NF LOC Audit Report – Community Based

Community Based Internal Audits	Jul	Aug	Sep	DY7 Q3
Total number of Community Based NF LOC files audited	**102**	**102**	**102**	**306**
BCBS	28	28	28	84
PHP	58	58	58	174
WSCC	16	16	16	48
Total number with correct NF LOC determination	**102**	**102**	**102**	**306**
BCBS	28	28	28	84
PHP	58	58	58	174
WSCC	16	16	16	48
Percent of total MCO monthly averages with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations				
Total number of Community Based determinations completed within required timeframes	**101**	**102**	**102**	**305**
BCBS	28	28	28	84
PHP	57	58	58	173
WSCC	16	16	16	48
Percent of total MCO monthly averages completed within required timeframes	**99%**	**100%**	**99%**	**100%**
BCBS	100%	100%	100%	100%
PHP	98%	100%	100%	99.44%
WSCC	100%	100%	100%	100%

External Quality Review Organization (EQRO) NF LOC

HSD requires that the MCOs report to the state quarterly, 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 and Instructions. The HSD nurse manager monitors the trends and reviews performance with the MCOs.

During DY7 Q3, HSD monitored EQRO determination/redetermination disagreements identified in the previous quarter. For DY7 Q3 reporting, the total number of determinations/redeterminations completed for High NF LOC Facility-Based requests was 204, with 46 for BCBS, 142 for PHP, and 16 from WSCC. The average percent of Facility-Based determinations/redeterminations that met High NF LOC criteria was aggregated at 60 percent, with 33 percent for BCBS, 65 percent for PHP, and 100 percent for WSCC respectively. The percent of Facility-Based determinations/redeterminations that met Low NF LOC criteria saw a 94 percent aggregate total, with all MCOs scoring above the 91 percentile.

Facility Based Determinations	July	Aug	Sept	DY7 Q3
High NF Determinations				
Total number of determinations/redeterminations completed for High NF LOC requests	**56**	**91**	**57**	**204**
BCBSNM	17	18	11	**46**
PHP	33	69	40	**142**
WSCC	6	4	6	**16**
Total number of determinations/redeterminations that met High NF LOC criteria	**32**	**54**	**37**	**123**
BCBSNM	3	7	5	**15**
PHP	23	43	26	**92**
WSCC	6	4	6	**16**
Percent of determinations/redeterminations that met High NF LOC criteria	**57%**	**59%**	**65%**	**60%**
BCBSNM	**18%**	**39%**	**45%**	**33%**
PHP	**70%**	**62%**	**65%**	**65%**
WSCC	**100%**	**100%**	**100%**	**100%**
Low NF Determinations				
Total number of determinations/redeterminations completed for Low NF LOC requests	**466**	**488**	**410**	**1364**
BCBSNM	152	174	130	**456**
PHP	279	302	243	**824**
WSCC	35	12	37	**84**
Total number of determinations/redeterminations that met Low NF LOC criteria	**429**	**466**	**388**	**1283**
BCBSNM	151	173	124	**448**
PHP	243	281	227	**751**
WSCC	35	12	37	**84**
Percent of determinations/redeterminations that met Low NF LOC criteria	**92%**	**95%**	**95%**	**94%**
BCBSNM	**99%**	**99%**	**95%**	**98%**
PHP	**87%**	**93%**	**93%**	**91%**
WSCC	**100%**	**100%**	**100%**	**100%**
Timeliness of Determinations				
Total number of High NF LOC determinations/redeterminations completed within required timeframes	**38**	**66**	**48**	**152**
BCBSNM	4	9	9	**22**
PHP	28	55	35	**118**
WSCC	6	2	4	**12**
Percent of High NF LOC determinations/redeterminations completed within required timeframes	**68%**	**73%**	**84%**	**75%**
BCBSNM	**24%**	**50%**	**82%**	**48%**
PHP	**85%**	**80%**	**88%**	**83%**
WSCC	**100%**	**50%**	**67%**	**75%**
Total number of Low NF LOC determinations/redeterminations completed within required timeframes	**414**	**430**	**324**	**1168**
BCBSNM	146	164	127	**437**
PHP	233	254	165	**652**
WSCC	35	12	32	**79**

Percent of Low NF LOC determinations/redeterminations completed within required timeframes	**89%**	**88%**	**79%**	**86%**
BCBSNM	**96%**	**94%**	**98%**	**96%**
PHP	**84%**	**84%**	**68%**	**79%**
WSCC	**100%**	**100%**	**86%**	**94%**

Table 15: Quarterly MCO NF LOC Determinations- Facility Based is with regard to the table above. The total number of MCO NF LOC determinations/redeterminations for Community-Based for DY7 Q3 reporting that met High NF LOC criteria was aggregated at 98 percent; with 99 percent for BCBS, 97 percent from PHP, and 96 percent from WSCC. Percent of determinations/redeterminations completed within required timeframes was reported at 99 percent aggregated, with 99 percent for BCBS, 100 percent for PHP, and 98 percent for WSCC respectively.

HSD's Nurse Manager conducted technical assistance calls with each MCO to address the findings of the EQRO NF LOC determination audits.

Table 16: Quarterly MCO NF LOC Determinations- Community Based

Community Based Determinations	July	Aug	Sept	DY7 Q3
Total number of determinations/redeterminations completed	**2288**	**2190**	**2122**	**6600**
BCBSNM PHP WSCC	630	627	571	**1819**
	1496	1408	1407	**4311**
	171	155	144	**470**
Total number of determinations/redeterminations that met NF LOC criteria	**2253**	**2128**	**2071**	**6452**
BCBSNM PHP WSCC	626	619	563	**1808**
	1464	1359	1369	**4192**
	163	150	139	**452**
Percent of determinations/redeterminations that met NF LOC criteria	**98%**	**97%**	**98%**	**98%**
BCBSNM PHP WSCC	**99%**	**99%**	**99%**	**99%**
	98%	**97%**	**97%**	**97%**
	95%	**97%**	**97%**	**96%**
Timeliness of Determinations				
Total number of determinations/redeterminations completed within required timeframes	**2267**	**2186**	**2110**	**6563**
BCBSNM PHP WSCC	610	626	570	**1806**
	1487	1407	1402	**4296**
	170	153	138	**461**
Percent of determinations/redeterminations completed within required timeframes	**99%**	**100%**	**99%**	**99%**
BCBSNM PHP WSCC	**98%**	**100%**	**100%**	**99%**
	99%	**100%**	**100%**	**100%**
	99%	**99%**	**96%**	**98%**

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

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AI/ AN REPORTING

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	Due to the COVID 19 Pandemic there was no Native American Advisory Board meetings this quarter.	Not applicable.
PHP	Due to the COVID 19 Pandemic there was no Native American Advisory Board meetings this quarter.	Not applicable.
WSCC	Due to the COVID 19 Pandemic there was no Native American Advisory Board meetings this quarter.	Not applicable.

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Table 17: Status of Contracting with MCOs

MCO	Status
BCBS	BCBS remains open and willing to contract with any I/T/U provider, however they continue to be unsuccessful in engaging in meaningful negotiations with I/T/U providers. The Navajo Area IHS is the largest, non-contracted I/T/U provider group not contracted with BCBSNM and according to BCBS they are not responsive to outreach efforts or indicate an interest into entering into an agreement. BCBSNM will continue to reach out at least once per month to determine if the status has changed.
PHP	Due to COVID-19 Pandemic many of the Tribes, Nations and Pueblos have closed. Most are limiting access into their communities and programs from the outside. Current efforts to enter into agreements with Tribes, Nations or Pueblos, or ITUs are temporarily suspended. They will resume once respective Tribal leaders deem it safe to open up their communities. Once efforts resume, PHP will continue their respectful, individualized approach for Letters of Agreements (LOA) or Memorandums of Agreement (MOA) tailored for each community's needs. PHP was able to complete one Pilot Program Agreement with the Pueblo of Taos for their Tiwa Babies Home Visiting pilot. This agreement is currently active with PHP.
WSCC	WSCC continues to have Participating Provider Agreements, which contain care coordination agreements with Community Health Representatives (CHRs) from Fort Defiance Health Center, Jemez Health Center, Ramah/Pine Hill Health Center, and Alamo Navajo Health Center. WSCC discussions with several Pueblos and provider partner entities to develop joint ventures on developing health care services at these Pueblos has slowed due to the closures of the Tribes. Until the current COVID-19 Pandemic public health emergency is over, Tribes continue to report that most external meetings, and community gatherings, continue to be cancelled or postponed. At the request of the Tribes, WSCC has been asked to place all outreach, discussions, development and implementation activities relating to new business or agreements on hold until the public health emergency has been contained and restrictions lifted. WSCC was able to continue a dialogue with the Pueblo of Taos Social Services program relating to the development of a Letter of Agreement for the Tribe to provide early child home visiting services to the entire county. WSCC continues to with Taos Pueblo to come to a consensus

	on the language for the Letter of Agreement.

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ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	**Remediate Care Coordination Audit Findings**
IMPLEMENTATION DATE:	**7/19/2016**
COMPLETION DATE:	**Open Item**
ISSUES	Overall care coordination with focus on improved practices following the record review and the onsite review
RESOLUTION	HSD has been monitoring BCBS's leveling of members to ensure that members enrolled in waiver categories are appropriately leveled through a quarterly Internal Action Plan (IAP). HSD placed this quarterly IAP on hold for DY7 Q2 due to the current State COVID-19 health directive. HSD has requested BCBS submit their internal audit results for DY7 Q2 and DY7 Q3 in DY7 Q4. HSD will review BCBS's internal audit results for DY7 Q1 through DY7 Q3 upon submission in DY7 Q4. If BCBS's internal audit results for DY7 Q1 through DY7 Q3 are at or above 85% compliance, HSD will conduct a confirmation audit in DY7 Q4 to determine whether HSD agrees with their results. If HSD agrees with BCBS's internal audit results, this Action Step will be closed in DY8 Q1. If HSD does not agree with BCBS's internal audit results, HSD will conduct a technical assistance call with BCBS to clarify expectations and continue the Action Step.

BLUE CROSS BLUE SHIELD	
ACTION PLAN	**Care Coordination Activities**
IMPLEMENTATION DATE:	**12/21/2018**
COMPLETION DATE:	**Closed 8/13/2020**
ISSUES	This action plan includes the following areas requiring improvement: 1. Compliance of care coordination activities (timeliness and clinical appropriateness) with HRA/CNA/NF LOC –**Closed** (CY19 Q1, BCBS updated processes for conducting HRAs and CNAs timely, improved the auditing of care coordinators work related to timeliness and re-training staff on the updated processes and revised audit tool. BCBS is finalizing workflows for oversight of Delegated Care Coordination entities. BCBS is currently working with PMS to be contracted as a DCCE and an effective date not yet been determined.) 2. Staff Training Evaluation/ Effectiveness Plan **-Closed** 8/13/20 3. Reporting **-Closed** 8/13/20 4. Burndown Plan – **Closed** (HRA backlog completed 12/31/18, CNA and NFLOC backlog completed on 4/22/19.)
RESOLUTION	All line items have been closed on this action plan.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	**There were no open Action Plans for PHP in Q3**

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE:	12/6/2019
COMPLETION DATE:	Open Item
ISSUES	On 12/6/2019, WSCC issued a Notice of Noncompliance and Request for Corrective Action Plan (CAP) to its subcontractor, Secure Transportation, for failure to meet formatting, timeliness, and accuracy requirements for encounter submissions.
RESOLUTION	At Secure Transportation's request, the CAP deadline was extended to 3/31/2020. WSCC determined that Secure had not satisfactorily addressed the encounter deficiencies, and on 6/30/2020 assessed a monetary penalty. On 8/27/2020, WSCC notified Secure Transportation of its intention to terminate the Agreement for failure to cure both the encounter deficiencies and the remaining credentialing deficiencies that were identified in a separate Quality Improvement Plan and subsequent CAP (see below). WSCC has until 10/26/2020 to cure the remaining deficiencies, or the Agreement will term in DY8 Q1.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE:	3/5/2020
COMPLETION DATE:	Open Item
ISSUES	WSCC requested a Quality Improvement Plan (QIP) from its subcontractor, Secure Transportation, on 2/11/2020. The request for a QIP was related to findings from the 2019 annual audit in areas related to credentialing, customer service, and compliance with driver and vehicle requirements.

RESOLUTION	By the 6/3/2020 due date, WSCC had provided documentation for all but four of the action items. The QIP was escalated to a Corrective Action Plan (CAP) on 7/13/2020 for the remaining credentialing deficiencies. On 8/27/2020, WSCC notified Secure Transportation of its intent to terminate the Agreement, in part for the failure to cure the credentialing deficiencies. See the 12/6/2019 Noncompliance Action Plan above.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	**Configuration of WSCC systems to implement required provider rate increases and reprocess claims to adjust payments to Physical Health and Behavioral Health (PH and BH) providers**
IMPLEMENTATION DATE:	**5/28/2020**
COMPLETION DATE:	**Open Item**
ISSUES	Delays in reprocessing of claims for several Physical Health (PH) provider types and completing code configurations identified for Behavioral Health (BH) Providers. Limited progress in reprocessing claims related to the BH configurations for numerous providers.
RESOLUTION	WSCC implemented an Internal Corrective Action Plan (ICAP) to address the identified issues. WSCC's ICAP also proactively addressed pending LTC rate and billing issues. By the end of DY7 Q3, WSCC had completed all PH and BH configurations and claims reprocessing. ICAP completion is anticipated in DY7 Q4.

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FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY7 Q3 reflects the new capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid Services (CMS) on January 6, 2020, updated rates submitted on April 29, 2020. The rates of those submissions were approved on October 2, 2020. Another rate update was submitted on August 10, 2020. The result is higher PMPMs for DY 7 compared to those of DY 6 for all MEGs (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment B – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY 7 is 20.0% below the budget neutrality limit (Table 7.5) through three quarters of payments.

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MEMBER MONTH REPORTING

Member Months		2020
		3
MEG1	0-FFS	101,107
	Presbyterian	589,734
	Western Sky	102,981
	Blue Cross Blue Shield	370,414
	Total	**1,164,236**
MEG2	0-FFS	6,269
	Presbyterian	60,791
	Western Sky	10,489
	Blue Cross Blue Shield	35,004
	Total	**112,553**
MEG3	Presbyterian	67,535
	Western Sky	7,805
	Blue Cross Blue Shield	31,811
	Total	**107,151**
MEG4	0-FFS	58
	Presbyterian	375
	Western Sky	58
	Blue Cross Blue Shield	280
	Total	**771**
MEG5	Presbyterian	7,995
	Western Sky	1,118
	Blue Cross Blue Shield	6,095
	Total	**15,208**
MEG6	0-FFS	73,718
	Presbyterian	387,791
	Western Sky	76,093
	Blue Cross Blue Shield	288,038
	Total	**825,640**
Total		**2,225,559**

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CONSUMER ISSUES

Grievances

HSD/MAD reviewed and analyzed data submitted by the MCOs (Report #37 Grievances and Appeals) for the months of July, August, and September. The report provides information related to the summary of member grievance reason codes. The report presents the MCOs timeliness response standards to ensure that grievances filed by members are addressed timely and appropriately. Presented below is the summary of MCO member grievance reported for DY7 Q3:

GRIEVANCES REPORTED (July - September 2020)			
Grievances	**BCBS**	**PHP**	**WSCC**
Number of Member Grievances	223	301	42
Top Two Primary Member Grievance Codes			
Transportation Ground Non-Emergency	134	55	12
Other Specialties	6	54	0
Variable Grievances	83	192	30

Appeals

HSD/MAD reviewed and analyzed data submitted by the MCOs (Report #37 Grievances and Appeals) for the months of July, August, and September. The report provides information related to the summary of member appeals reason codes. The report presents the MCOs timeliness response standards to ensure that appeals filed by members are addressed timely and appropriately. Presented below is the summary of MCO member appeals reported for DY7 Q3:

APPEALS REPORTED (July - September 2020)			
Appeals	**BCBS**	**PHP**	**WSCC**
Number of Standard Member Appeals	367	469	27
Number of Expedited Member Appeals	37	8	4
Top Two Primary Member Appeal Codes			
Denial or limited authorization of a requested service	361	419	27
Denial in whole of a payment for a service	29	41	0
Variable Appeals	14	17	4

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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: 2020 MCO Advisory Board Meeting Schedules. On 5/4/2020, HSD advised the MCOs that Advisory Board meetings should be suspended or held remotely during the COVID-19 Public Health Emergency.

Table 18: 2020 MCO Advisory Board Meeting Schedules

BCBS 2020			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	2/27/2020	12:00 PM	Los Lunas Transportation Department Auditorium, Los Lunas, NM
BCBS	4/30/2020	12:00 PM	Mesa Verde Community Center, Albuquerque, NM (Cancelled due to COVID-19)
BCBS	8/27/2020	12:00 PM	South Valley Multi-Purpose Senior Center, Albuquerque, NM (Cancelled due to COVID-19)
BCBS	9/24/2020	12:00 PM	Virtual Meeting
BCBS	12/10/2020	12:00 PM	Virtual Meeting
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	6/18/2020	12:00 PM	Frank O'Brien Papen Center, Las Cruces, NM (Cancelled due to COVID-19)
BCBS	10/22/2020	12:00 PM	Virtual Meeting

NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	2/13/2020	12:00 PM	Acoma Community Center, Acoma, NM
BCBS	5/7/2020	12:00 PM	Mescalero Tribal Building Gym, Mescalero, NM (Cancelled due to COVID-19)
BCBS	8/20/2020	12:00 PM	Santo Domingo Elementary/Middle School Gymnasium, Santo Domingo, NM (Cancelled due to COVID-19)
BCBS	9/17/2020	12:00 PM	Virtual Meeting
BCBS	11/12/2020	12:00 PM	Virtual Meeting
**Note cancelled meetings due to COVID-19 will not be rescheduled			

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 (SDCB included in each meeting)

PHP 2020			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	3/6/2020	11:00 AM	PHP Cooper Administrative Center, Albuquerque NM
PHP	6/5/2020	Cancelled COVID-19	PHP Cooper Administrative Center, Albuquerque NM
PHP	9/4/2020	11:00 AM	PHP Cooper Administrative Center, Albuquerque NM Remote Meeting
PHP	12/4/2020	11:00 AM	PHP Cooper Administrative Center, Albuquerque NM
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	6/30/2020	Cancelled COVID-19	TBD, Roswell, NM
PHP	7/1/2020	Cancelled COVID-19	TBD, Ruidoso, NM
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	3/20/2020	Cancelled COVID-19	Tamaya Wellness Center, Santa Ana Pueblo, NM
PHP	5/22/2020	Cancelled COVID-19	Taos Pueblo, NM
PHP	9/25/2020	--	Pine Hill, NM (Navajo) – Remote Meeting
PHP	10/9/2020	--	PHP Cooper Administration Center – Albuquerque, NM Remote Meeting

SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	TBD	TBD	TBD On Hold until DY7 Q4 or DY8 Q1

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	3/31/2020	Cancelled COVID-19	PHP Cooper Administrative Center, Albuquerque NM –
PHP	6/9/2020	Cancelled COVID-19	PHP Cooper Administrative Center, Albuquerque NM
PHP	9/8/2020	1:00 PM	PHP Cooper Administrative Center, Albuquerque NM
PHP	12/8/2020	1:00 PM	PHP Cooper Administrative Center, Albuquerque NM Remote Meeting

WSCC 2020			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	2/13/2020	11:30 AM	Albuquerque, NM - Mesa Verde Community Center
WSCC	6/18/2020	11:30 AM	Albuquerque, NM - Venue location TBD Cancelled due to COVID-19
WSCC	9/24/2020	11:30 AM	Albuquerque, NM – Virtual Meeting
WSCC	12/17/2020	11:30 AM	Albuquerque, NM - Venue location TBD
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	10/14/2020	11:30 AM	Las Cruces, NM – Virtual Meeting
WSCC	11/12/2020	11:30 AM	Roswell, NM – Virtual and/or Telephonic
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	3/5/2020	11:30 AM	WSCC Home Office: 5300 Homestead Rd NE, Albuquerque, NM 87110

WSCC	6/4/2020	5:00 PM	Rio Arriba County - Venue location TBD Cancelled due to COVID-19
WSCC	9/3/2020	11:00 AM	McKinley County – Virtual/Telephonic
WSCC	11/5/2020	5:00 PM	San Juan County – Virtual and/or Telephonic

SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	6/18/2020	1:30 PM	Albuquerque, NM - Venue location TBD Cancelled due to COVID-19

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	10/14/2020	1:30 PM	Las Cruces, NM – Meeting will occur in conjunction with the 10/1/4/2020 meeting above

COMMUNITY ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	12/9/2020	10:30 AM	Albuquerque, NM - Virtual Venue

Quality Assurance	
3rd Quarter Activities	**Quarterly Quality Meeting** HSD holds Quarterly Quality Meetings 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. The Quarterly Quality meeting for Q3 DY7 was held on September 29, 2020. During the meeting HSD provided responses to questions submitted in advance of the meeting by the MCOs regarding data collection and reporting methodologies. HSD provided MCO aggregate HEDIS rates for the DY6 MCO Performance Measurers and DY7 MCO Performance Measurers. HSD provided guidance on the reporting methodology for TM #4, Follow up after Hospitalization for Mental Illness and provided information on the expectations of the reporting elements to be included in the monthly monitoring for two (2) behavioral health HEDIS measures, Follow-Up After Hospitalization for Mental Illness and Follow-Up After Emergency Department Visit for Mental Illness. HSD presented status updates for the CY 2018 and CY 2019 External Quality Review activities. **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** The MCOs submitted the CY 2019 CAHPS HEDIS data to NCQA in June 2020 for certification. The MCO comprehensive CY 2019 CAHPS survey reports will be submitted to HSD on October 15, 2020. **Follow-up after Hospitalization for Mental Illness (FUH) and Follow-up after Emergency Department visit for Mental Illness (FUM) – Monthly Monitoring** HSD initiated a monthly monitoring plan to address the decline in HEDIS rates from CY 2017 to CY 2018, for FUH and FUM with the legacy MCOs (BCBS and PHP). In August of DY7 and after a full year of participating in HEDIS reporting, HSD directed WSCC to provide submissions on both measures.

	HSD provided the MCOs with instructions and a monitoring tool to provide a monthly account of the ongoing interventions, strategies and barriers associated with improving performance outcomes. In Q3 of DY7 HSD reviewed and analyzed the reports submitted in Q2 (April, May, and June). HSD noted the following strategies and interventions developed by the MCOs to improve the rates; BCBS**:** The Performance Measure Workgroup has proposed exploring Value Based Purchasing (VBP) that would enhance transition of care activities. BCBS BH Clinical Operations Transition of Care (TOC) staff are assigned to several larger capacity BH Facilities and Hospitals throughout the state. TOC staff are available to facility staff to assist with discharge planning, arranging transportation and meet with members prior to their discharge to assess post discharge needs. PHP: Conducted meetings with Behavioral Health (BH) hospitals to present detailed overview of their facilities performance. By doing so, there is an increase focus on the needs of members in need of BH services. **<u>Performance Measures (PMs)</u>** HSD performance measures and targets are based on HEDIS technical specifications. The MCO is required to meet the established performance targets. Each CY target is a result of the CY 18 MCO aggregated Audited HEDIS data, calculating an average increase for each CY until reaching the CY 18 Quality Compass Regional Average plus one (1) percentage point. Failure to meet the HSD designated target for individual performance measures during the CY will result in a monetary penalty based on two percent (2%) of the total capitation paid to the MCO for the agreement year. HSD requires the MCOs to submit a quarterly report that is 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 calls and during the Quarterly Quality Meeting. HSD amended the MCO contracts effective January 1, 2020 to include the following PMs and established targets: **PM #1 (1 point) – Well Child Visits in the First fifteen (15) Months of Life (W15)** The percentage of Members who turned fifteen (15) months old during the measurement year and had six (6) or more well-child visits: CY 2020 target is 62.62%. BCBS: Q1 32.12%, Q2 45.41%; Increase of 13.29% Interventions - Member Handbook provided to newly enrolled members and also available for viewing on the BCBSNM member web site includes member benefit information concerning Well-Child Visits, newborn to fifteen months, as well the Community Health Workers (CHWs) tool and Wellness Guideline and Information that encourages parents to schedule a well child visit. PHP: Q1 28.77%, Q2 38.23%; Increase of 9.46% Interventions - Outreach letters and advertisement around well-child visits and immunization program campaigns such as the Got Shots program. WSCC: Q1 20.41%, Q2 34.32%; Increase of 13.91% Interventions - Collaboration with other departments via the Maternal and Child Health Performance Improvement Team to improve the W15 measure. The W15 measure has been added to the list of Pay for Performance measures for the value-based purchasing (VBP) program, the Baby First Program, and the

	Smart Start for your Baby. **PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)** The percentage of Members ages three (3) through seventeen (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: CY 2020 target is 48.52%; BCBS: Q1 4.42%, Q2 4.49%; Increase of +.07% Interventions - Update content for a radio personal service announcement and corresponding postcard promoting the WCC measure to include telehealth promotions. Outreach through mailing and telephone campaigns to include WCC telehealth promotions. PHP: Q1 1.13%, Q2 1.96%; Increase of +.83% Interventions - Increased member outreach through member mailings, telephone campaign from the CHW team and collaboration with the VBP team to increase provider communications with members. WSCC: Q1 4.81%, Q2 6.49%; Increase of +1.68% Interventions - Increased telephone outreach Collaboration and monitoring of WCC by multidisciplinary teams within WSCC to identify gaps, VBP agreements for two provider groups that have remote Electronic Health Record (EHR) access to monitor outcomes. **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 years and October 7 of the measurement year that received a prenatal care visit as a Member of the CONTRACTOR's MCO in the first

	trimester or within forty-two (42) Calendar Days of enrollment in the CONTRACTOR's MCO: CY 2020 target is 78.67%; BCBS: Q1 58.22%, Q2 58.34%; Increase of +.12% Interventions - Mailings or telephonic outreach to members who are pregnant encouraging participation with the BCBS sponsored Special Beginnings maternity program or Centennial Home Visiting program. PHP: Q1 77.47%, Q2 77.58%; Increase of +.11% Interventions - Written and telephonic outreach for members to educate on the importance of continued care during pregnancy and after delivery. Centennial rewards within the Baby Benefit program provides gift cards to members for completing the recommended provider visits during pregnancy. WSCC: Q1 58.91, Q2 58.50%; Decrease of -.41% Interventions - Implemented strategies to identify pregnant women earlier in their pregnancy and provide better guidance around both prenatal and postpartum visits. **PM #4 (1 point) – Prenatal and Postpartum Care (PPC)** The percentage of Member deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) Calendar Days after delivery: CY 2020 target is 63.35%; BCBS: Q1 38.49%, Q2, 43.01%; Increase of +4.52% Interventions - Sending member newsletter educational articles, collaborating with the Certified Nurse Midwives Advisory Board members at their quarterly meetings, and providing care gap reports to providers in hopes of increasing member monitoring. PHP: Q1 46.93%, Q2 49.24%; Increase of +2.31% Interventions - Increased written and telephonic outreach to members and education on the importance of continue care

	after delivery, and continued collaboration between the Clinical teams and CHW team to contact members. WSCC: Q1 35.22%, Q2 38.37%; Increase of +3.15% Interventions - Implemented strategies to identify pregnant women earlier in their pregnancy and provide better guidance around both prenatal and postpartum visits. **PM #5 (1 point) – Childhood Immunization Status (CIS): Combination 3** The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday: CY 2020 target is 68.01%; BCBS: Q1 21.47%, Q2 24.12%; Increase of +2.65% Interventions- Development of Community Health Workers (CHWs) tool that encourages parent/guardian through health education on the importance of immunizations. The Got Shots? Campaign in coordination with the Department of Health. PHP: Q1 54.05%, Q2 60.01%; Increase of +5.96% Interventions - Increased mailings, phone calls to members and CHW outreach calls. Participation with NMIC on the Got Shots event and an upcoming flu shot campaign. WSCC: Q1 45.35%, Q2 51.07%; Increase of +5.72% Interventions- Participating with other MCOs and the NM Immunization Coalition in “Got Shots” campaign development and encourages the participation of their contracted providers. Collaborated with Pfizer for implementation of the VAKs (Vaccine Adherence in Kids) program to send out post card notifications to parents/children.

	PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase The number of Members age eighteen (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 one-hundred eighty (180) Calendar Days (6 months) of continuous treatment with an antidepressant medication: CY 2020 target is 34.33%; BCBS: Q1 27.66%, Q2 33.42%; Increase of +5.76% Interventions - Clinical staff in Care Coordination continuing utilization of reports from Pharmacy to outreach members to ensure that any barriers that members encountered while trying to obtain their antidepressant medication are addressed. PHP: Q1 41.56%, Q2 41.54%; Decrease of -.02% Interventions - Notifying members of the AMM Reward program for medication compliance. In addition, PHP is evaluating a call campaign and distribution of a Depression Flyer. WSCC: Q1 24.90%, Q2 31.37%; Increase of +6.47% Interventions - Quality and Pharmacy teams have continued (and refined) their clinical outreach process for targeted pharmacies. The goal remains to increase the prescription duration of members who are maintaining their current antidepressant prescription whenever clinically appropriate. **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: CY 2020 target is 43.34%;

	BCBS Q1 39.30%, Q2 40.63%; Increase of +1.33% Interventions – Development of a provider HEDIS Tip Sheet for this measure. Also, in Q2 2020, an intern was added to the Care Coordination team to work some evenings and weekends to better assist members with scheduling follow-up appointments. . PHP Q1 40.28%, Q2 53.17; Increase of +12.89% Interventions - Value Based Purchasing (VBP) program was available for provider enrollment in Q2 2020. WSCC: Q1 43.65%, Q2 42.65%; Decrease of -1.00% Interventions - The EDIE/Collective Medical used tool to rapidly identify members with substance use behaviors who are discharged from either inpatient or outpatient facilities. **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: CY 2020 target is 48.42%; BCBS Q1 41.94%, Q2 43.07%; Increase of +1.13% Interventions - The Provider Incentive program and Facility Incentive program. Outreach to members by Care Coordination has been done telephonically, rather than in-person, to assist with scheduling follow-up care. PHP Q1 42.47%, Q2 45.24%; Increase of +2.77% Interventions - Performance improvement activities such as the Care Coordination team being leveraged in Q2 2020 for FUH outreach to members. WSCC Q1 29.23%, Q2 33.16%; Increase of +3.93% Interventions - Utilization management and quality nurse

	intervention teams providing outreach to members hospitalized for behavioral health conditions using Member Connections and/or the Behavioral Health Liaison teams regardless of the ongoing pandemic. **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: CY 2020 target is 43.52%; BCBS Q1 54.75%, Q2 56.04%; Increase of +1.29% Interventions - Transition of Care (TOC) and Recovery Support Assistant (RSA) staff outreach to members identified through the EDIE system as successful interventions that have contributed to the continued improvement of this measure. PHP Q1 64.12%, Q2 67.75%; Increase of +3.63% Interventions - FUM cohort with the PHP Pre-Manage report system developed for telephonic intervention to assist members in attending follow-up appointments following ED visits. WSCC Q1 38.98%, 40.28%; Increase of +1.30% Interventions - Teladoc®, a telemedicine program for which teams have been trained and are encouraging members to utilize, along with local providers using Zoom and telephonic visits, are interventions implemented to improve this measure. WSCC is also working to help members identify and increase utilization of urgent care providers where appropriate in each county. **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: CY 2020 target is 80.63%; - BCBS Q1 45.12%, Q2 57.42%; Increase of +12.30% Interventions - Behavioral Health Care Coordinators outreach to members telephonically for follow-up regarding diabetes monitoring, and Pharmacy mailings to providers informing them of the need for diabetes monitoring as successful interventions. PHP Q1 46.80%, Q2 56.00%; Increase of +9.20% Interventions - SSD measure to the Value Based Purchasing (VBP) Provider Quality Incentive Program in 2020, as well as the exploration of other provider education activities in Q2 2020, including drafting a targeted outreach letter to prescribers within the SSD measure. WSCC Q1 42.15%, Q2 56.89%; Increase of +14.74% Interventions - Remote access and/or supplemental data file transfers initiated with lab facilities to ensure appropriate collection of lab data for members; the completion of monthly Psychotropic Medication Utilization Review (PMUR) for members prescribed this medication type, and providers of members who are listed on monthly-flagged PMUR reports are notified regarding importance of ordering appropriate lab work and utilizing lab work to inform further prescribing practices. **Tracking Measures (TMs)** HSD requires the MCOs to submit quarterly reports for the TMs listed in the MCO contract effective January 1, 2020. HSD reviews and analyzes the reports for completeness and accuracy and to gauge positive or negative outcome trends. MCOs report on interventions, strategies and barriers that impact performance outcomes. HSD's review findings are communicated to the MCOs through scheduled MCO-specific

	technical assistance calls or during the Quarterly Quality Meeting. The following TMs results compare DY7 Q1 to Q2 reporting: **TM #1-Fall Risk Management:** The percentage of Medicaid Members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner. MCO Aggregate: Q1 Total 25.96%; Q2 Total 24.15%: Decrease of 1.81 percentage points BCBS: Q1 28.92%; Q2 26.07%: Decrease of -2.85 percentage points Intervention – Care coordinators and transition coaches assess mobility and identify members who need help with activities of daily living. PHP Q1 25.07%; Q2 23.82%: Decrease of -1.25 percentage points Intervention - Continue to proactively address fall risk when identified and provide rapid follow up to unsafe conditions. WSCC Q1 20.16%; Q2 18.34%: Decrease of -1.82 percentage points Intervention – Refer members to existing falls prevention programs such as A Matter of Balance, Otago, Tai Ji Quan or other evidence-based programs offered throughout the state of NM. **TM #2-Diabetes, Short-Term Complications Admissions Rate:** The number of hospital admissions with ICD-10-CM principal diagnosis codes for diabetes short-term complications for Medicaid enrollees age 18 and older. Reported as a rate per 100,000 member months. MCO Aggregate: Q1 Total 19.49; Q2 Total 16.63: Improvement

	of -2.86 BCBS Q1 26.49; Q2 20.47: Improvement of -6.02 Intervention – Continue to notify contracted providers regarding attributed patients diagnosed with diabetes and their STCA admissions. PHP Q1 15.55; Q2 14.68: Improvement of -.87 Intervention – Member outreach informing them of the measures being taken to ensure their safety when visiting providers and the importance of seeking both urgent and routine care to keep their diabetes under control and prevent serious complications. WSCC Q1 15.19; Q2 12.93: Improvement of -2.26 Intervention – Monitor population for non-compliance with diabetes testing and HbA1c control and initiate nurse follow-up and documented transitions of care plans with members who have experienced admission for diabetic complications. **TM #3-Screening for Clinical Depression and Follow-Up Plan:** The percentage of Medicaid members age 18 and older screened for clinical depression using a standardized depression screening tool, and if positive a follow-up plan is documented on the date of the positive screen. MCO Aggregate: Q1 Total .51%; Q2 Total .60%: Improvement of .09 percentage points BCBS Q1 .30%; Q2 .39%: Improvement of .09 percentage points Intervention – A provider education training focusing on appropriately screening and diagnosing depression and referring members to the appropriate follow-up care has been developed and will be presented to primary care provider groups during the next quarter.

	PHP Q1 .61%; Q2 .73%: Improvement of .12 percentage points Intervention – The Provider Quality Incentive Program was successfully expanded to include depression screening codes. WSCC Q1 .52%; Q2 .49%; Decrease of -.03 percentage points Intervention – Actively monitoring members with newly diagnosed depression for inclusion in the behavioral health disease management program. **TM #4-Follow-up after Hospitalization for Mental Illness (FUH):** 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. MCO Aggregate Q1 Total 63.85%; Q2 Total 65.54 Overall Improvement of 1.69 percentage points BCBS Q1 47.35%; Q2 48.64%: Improvement of 1.29 percentage points Intervention – The Provider Incentive Program and Facility Incentive Program were continued in Q2 2020. PHP Q1 80.74%; Q2 82.14%: Improvement of 1.40 percentage points Intervention – Care coordination team calling members to assist with follow-up care as necessary. WSCC Q1 38.14%; Q2 36.68%: Decrease of -1.46 percentage points Intervention – Launched FUH gift card program to provide members additional incentive to adhere to clinical guidelines to attend follow-up appointments after acute psychiatric inpatient placements. **TM #5-Immunizations for Adolescents:** The percentage of

	adolescents thirteen years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and a cellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. Report rates for each vaccine and one combination rate. MCO Aggregate Q1 Total 67.49%; Q2 Total 68.31%: Improvement of .82 percentage points BCBS Q1 53.96%; Q2 54.72%: Improvement of .76 percentage points Intervention – The "Got shots?" campaign to take place in Q3 in partner with NM Department of Health and participating providers to immunize children 0-18 years. PHP Q1 73.92%; Q2 74.74%: Improvement of .82 percentage points Intervention – Current action plan is to increase communication with members through both writing and telephonic communications. WSCC Q1 69.51%; Q2 70.50%: Improvement of .99 percentage points Intervention – Collaborate with Pfizer for implementation of the VAKs (Vaccine Adherence in Kids) program to send out post card notifications to parents/children. **TM #6-Long Acting Reversible Contraceptive (LARC):** The contractor shall measure the use of LARCs among Members age 15-19. The contractor shall report LARC insertion/utilization data for this measure. Numbers reported are cumulative from quarter to quarter. MCO Aggregate Q1 Total 789; Q2 Total 1,243 BCBS Q1 267; Q2 422 PHP Q1 461; Q2 713 WSCC Q1 61; Q2 108

	TM #7-Smoking Cessation: The Contactor shall monitor the use of smoking cessation products and counseling utilization. Total number of unduplicated members receiving smoking and tobacco cessation products/services. Numbers reported are cumulative from quarter to quarter. MCO Aggregate Q1 Total 3,777; Q2 Total 5,624 BCBS Q1 1,322; Q2 1,976 Intervention – Eliminated barriers to treatment by providing tobacco cessation products without a prior authorization and by removing the limit on the number of days members can access medications. PHP Q1 2,185; Q2 3,198 Intervention – Member outreach to encourage smoking cessation efforts. WSCC Q1 270; Q2 450 Intervention – A special program for pregnant women who smoke, called Puff Free Pregnancy, aims to keep this vulnerable population smoke-free. **TM #8-Ambulatory Care:** Utilization of outpatient visits and emergency department visits reported by all Member months for the measurement year. Reported as a rate per 1,000 member months. Outpatient Visits – (MCO aggregate rates pending PHPs resubmission) BCBS Q1 86.41; Q2 146.72: Improvement of 60.31 Intervention – The Transition of Care team continues to assist members transitioning from a hospital or acute care facility back into their community. PHP Q1 unavailable pending submission; Q2 unavailable

	pending resubmission Intervention – Continuing member education around COVID19 safe practices and member reassurance regarding safety of preventative and wellness visits. WSCC Q1 65.86; Q2 11.83: Decrease of -54.03 Intervention – Increased collaboration with patient-centered medical homes network to focus on increased well visits and improved chronic care management. ED Visits – (MCO aggregate rates pending PHPs resubmission) BCBS Q1 11.99; Q2 19.56: Increase of 7.57 Intervention – Emergency Department Information Exchange allows community health workers to monitor members utilizing the emergency room in real time so peer support workers can identify barriers and encourage care coordination prior to discharge. PHP Q1 unavailable pending resubmission; Q2 unavailable pending resubmission Intervention – Continuing member education around COVID19 safe practices and member reassurance regarding safety. WSCC Q1 12.06; Q2 18.95: Increase of 6.89 Intervention – The Quality Nurse performs direct outreach to members with recent ED visits, particularly those with alcohol or other drug diagnoses. **TM #9-Annual Dental Visits:** The percentage of enrolled Members ages two (2) to twenty (20) years how had at least one (1) dental visit during the measurement year. MCO Aggregate Q1 Total 20.67%; Q2 Total 31.63%: Improvement of 10.96 percentage points.

	BCBS Q1 15.56%; Q2 33.35%: Improvement of 17.79 percentage points Intervention – Member Services provides member education via Member Handbook, new member packets, member website, and member newsletter. PHP Q1 23.55%; Q2 31.27%: Improvement of 7.72 percentage points Intervention – Planning increased letters and phone calls to members to encourage dental visits upon state re-opening for general dentistry, non-emergent needs. WSCC Q1 20.86%; Q2 27.86%: Improvement of 7.00 percentage points Intervention – The OMNI Care Gap alert system alerts Member Services when care gaps need to be closed while on the phone with members. **TM #10-Controlling High Blood Pressure:** 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. Since TM #10 is a hybrid measure, which requires a medical record review, the MCOs will report HEDIS rates on the October 25, 2020 Q3 Report submission. **<u>External Quality Review:</u>** HSD continues to have weekly meeting with the EQRO to review projects and provide consistent feedback and communication; to evaluate issues and provide guidance and support as needed. EQRO reviews and validations in Q3 consisted of the following: CY18 EQR reviews and validations PM validation: Draft report was received by HSD for review and comment and is under finalization review by HSD leadership;

	PIPs validation: Draft report was received by HSD for review and comment; Compliance review: Draft report is under review by HSD leadership. CY19 reviews and validations Compliance Review: EQRO Kick-off with MCO held on July 22, 2020. EQRO submitted Compliance review tools to HSD for review and approval. EQRO scheduled virtual onsite visits with the MCO to be held in November; PM validation: HSD submitted MCO audited HEDIS report to EQRO for review; PIPs validation: MCOs submitted quarterly reports to EQRO for review.

Utilization

Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for July 2018 through June 2020. Please see Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group.

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 three 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. DY7 requirements are as follows:

VBP Level	Level 1	Level 2	Level 3
Required Spend	10%	13%	7%
Required Provider Types	• Traditional PH Providers with at least 2 Small Providers • BH Providers • Long-Term Care Providers including Nursing Facilities	• Traditional PH Providers with at least 2 Small Providers • BH Providers • Actively build readiness for Long-Term Care Providers • Actively build readiness for Nursing Facilities	• Traditional PH Providers • Develop BH full-risk contracting model • Implement a CONTRACTOR led LTC and/or Nursing Facility provider level workgroup to design full-risk

For DY7 Q2, all the MCOs have already met or exceeded the required VBP spend target of 30%. PHP is currently showing a high percentage of VBP spend. This is due to large full risk contracts in Level 3. DY7 Q3 data will be submitted on November 15, 2020.

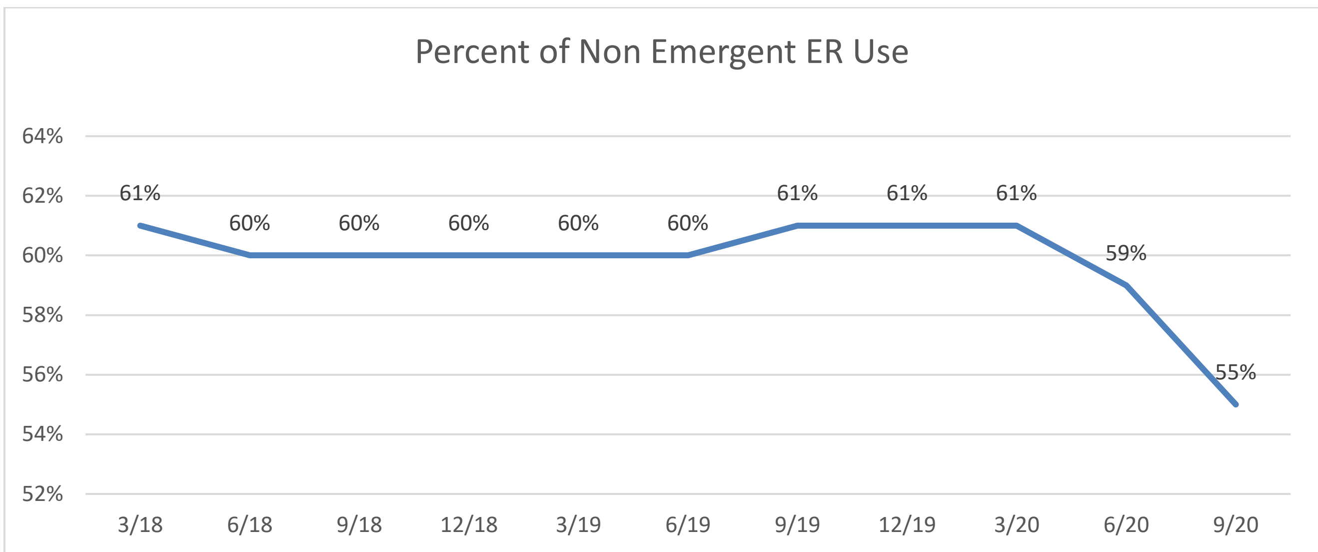
Source: MCO Quarterly Financial VBP Reports CY20 Q2

LOW ACUITY NON-EMERGENT CARE (LANE)

As a result of the MCO strategies and interventions implemented in 2020, which focused on reducing ED visits for non-emergent care, the percentage of emergency utilization that are considered low acuity significantly improved from DY7 Q2 to DY7 Q3. In comparing visits from December of 2019 with 61% visits to September of 2020 with 55% of emergency visits being low acuity, the percentage of visits to the emergency department for non-emergent care decreased by six percentage points. The trend for this measure improved in DY7 Q3.

The table below reflects the percentage of members using the emergency room (ER) for non-emergent care between September of 2019 and September of 2020. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership.

Table 19: Non-Emergent ER Use



14
MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in DY7 with the requirement that at least 90% of members having access to certain provider categories in urban, rural, and frontier geographic areas within a defined distance. Centennial Care 2.0 is effective January 1, 2019 with the two legacy MCOs, PHP and BCBS, and one new to Centennial Care 2.0 MCO, WSCC.

Physical Health and Hospitals

All three MCOs demonstrated steady access with slight fluctuations.

- All three MCOs performance in access to general hospitals, PCP, pharmacies and most specialties in urban, rural and frontier areas have continued to be met.
- Geographic access for dermatology, endocrinology, rheumatology, and urology services as well as access neurosurgeons are anticipated to be limited due to provider shortages in rural and frontier areas.
    - BCBS reports continued increases in member access to dermatology in urban areas (4.9%). Previously reported increases in access to rural dermatology, rural rheumatology, and frontier neurology have been maintained.
    - PHP reports stability in member access to rural endocrinology and frontier ENT services. PHP continues to be the only MCO to meet standard for urban rheumatology (98.8%)
    - WSCC reports increases in urban neurosurgeons (5.1%), rural urology increase (12.3%), rural dermatology (4.0%), and frontier urology (4.6%). Increases in rural dermatology rose above access standards for the 1st time.
        - WSCC reports comparable member access to legacy MCOs in most provider categories.
    - MCOs report utilization of telehealth, recruiting efforts for specific provider categories in areas of low access and systems audits for improved reporting.

Table 20: Physical Health Geographical Access

GeoAccess PH Calendar Year 2020 (April 1st- June 30th, 2020)

Meets Standard | Does Not Meet

	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%	100.0%	100.0%
Pharmacies	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%
FQHC - PCP Only	100.0%	100.0%	100.0%	90.7%	90.3%	99.4%	99.9%	92.3%	98.7%
PH - Standard 2									
Cardiology	99.2%	98.8%	98.9%	99.7%	100.0%	99.9%	99.9%	99.9%	99.0%
Certified Nurse Practitioner	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Certified Midwives	99.1%	98.9%	94.1%	100.0%	94.2%	93.7%	99.8%	98.5%	98.3%
Dermatology	99.1%	98.8%	98.8%	83.8%	72.8%	90.7%	97.9%	89.2%	99.5%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	99.1%	98.8%	98.8%	70.9%	85.5%	75.3%	84.8%	93.1%	82.7%
ENT	99.1%	98.8%	98.8%	91.7%	93.0%	100.0%	92.3%	86.8%	96.0%
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/Oncology	99.1%	98.9%	98.9%	99.5%	97.5%	98.4%	99.3%	97.9%	89.7%
Neurology	99.1%	98.8%	98.8%	99.2%	92.1%	82.8%	95.5%	90.6%	93.4%
Neurosurgeons	99.1%	98.8%	98.8%	36.7%	69.6%	39.6%	67.6%	86.9%	81.4%
OB/Gyn	99.2%	98.9%	98.8%	99.7%	99.7%	99.9%	99.8%	99.9%	99.8%
Orthopedics	99.1%	98.9%	98.8%	99.6%	100.0%	100.0%	99.5%	98.4%	99.6%
Pediatrics	100.0%	98.9%	98.8%	99.9%	100.0%	99.9%	99.8%	99.9%	100.0%
Physician Assistant	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%
Podiatry	99.1%	98.9%	98.9%	99.9%	99.7%	94.3%	99.9%	99.9%	99.8%
Rheumatology	88.2%	98.8%	84.5%	88.7%	83.4%	71.2%	88.3%	85.1%	73.6%
Surgeons	99.2%	98.9%	98.9%	99.9%	100.0%	100.0%	99.9%	99.9%	99.8%
Urology	80.6%	98.7%	98.8%	86.1%	92.3%	74.8%	94.2%	95.9%	88.6%
LTC/OTHER - Standard 2									
Personal Care Service Agencies (PCS)	100.0%	100.0%	100.0%	100.0%	99.8%	99.9%	100.0%	100.0%	100.0%
Nursing Facilities	94.8%	92.5%	94.5%	99.7%	96.8%	99.8%	99.9%	99.9%	99.8%
General Hospitals	99.2%	98.9%	98.9%	99.7%	99.3%	99.9%	99.9%	99.9%	99.8%
Transportation	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: MCO Report #55 GeoAccess for Q2CY20

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. All 3 MCOs identify transportation coverage in all counties across New Mexico.

- **Grievances**: Consistent with previous reporting non-emergency medical transportation (NEMT) grievances is the leading category of grievances in the reporting period. Please see Complaints and Grievances for additional information. PHP identified a lack of wheelchair accessible transportation options as a barrier to member access and reported an increase in transportation provider no shows. See section 9 of this report for improvement plans regarding these barriers and provider issues.

- **Initiatives:** The MCOs are directed to add a new component to the non-emergency medical transportation (NMET) benefit for justice-involved centennial care members who are transitioning out of prison or jail. Justice-Involved members will be allowed one round trip within the first seven days after release, with a current and valid prescription, member may be transported directly to a pharmacy and transported to a domicile or residence within the same city limits as their originating pick-up point.

TELEMEDICINE DELIVERY SYSTEM IMPROVEMENT PERFORMANCE TARGET (DSIPT)

The Telemedicine Delivery System Improvement Performance Target (DSIPT) reporting requirements for the Centennial Care 2.0 MCOs had been suspended due to the public health emergency (PHE) but were resumed as of July 23rd, 2020 to include all data not reported during the suspended reporting period. Full calendar year data will be reported in the DY7 annual report.

During the PHE, telemedicine utilization has increased dramatically in all areas and is playing a vital role in providing health care services statewide while keeping members safe. HSD found that telemedicine utilization grew exponentially and anticipates growth in the future.

Table 21: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine (April – June 2020)			
MCO	Q2CY20 Behavioral Health Visits	Q2Y20 Physical Health Visits	Q2CY20 Total Unduplicated Members
BCBS	10,114	32,199	36,656
PHP	13,764	5,128	17,299
WSCC	2,397	3,075	4,957
Total	26,275	40,402	58,912

TELEHEALTH UTILIZATION DURING THE COVID-19 PUBLIC HEALTH EMERGENCY

Telemedicine utilization reported by the MCOs for the DSIPT is limited to counts for unduplicated members served from April to June, therefore a member with multiple visits would only be counted one time. The numbers shown below are based on paid claims, therefore are not limited to unduplicated members and reflect a higher utilization.

Table 22: TELEHEALTH UTILIZATION DURING THE COVID-19 PUBLIC HEALTH EMERGENCY

Paid Non-Crossover Claims*							
	Fee-for-Service			Managed Care			
Month	Jul-20	Aug-20	Sep-20	Jul-20	Aug-20	Sep-20	Combined Totals
Utilization Counts	803	627	490	19,059	16,706	12,906	50,591
Total Paid Amount	$87,172	$71,917	$55,978	$1,729,380	$1,532,553	$1,110,619	$4,587,619

*Notes:

1. Data is based on paid non-crossover fee-for-service and managed care encounter claims.
2. Data reflects telehealth utilization during the ongoing public health emergency.
3. Both fee-for-service and managed care encounter claims are subject to a 90-day reporting lag since providers are required to submit claims to Medicaid within a 90-day span from the date-of service. Therefore, the data may not reflect complete sets of claims for each month.

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
3rd Quarter Activities	**Procurement of an Independent Evaluator for the 1115 Demonstration Waiver** HSD finalized the draft RFP and submitted to HSD leadership for review and approval on May 7, 2020. Following approval from HSD leadership on June 17, 2020, the RFP was published on June 30th. and a notification to all interested parties was sent June 30, 2020 to begin the procurement process. The final and published RFP can be found at the following website: https://www.hsd.state.nm.us/LookingForInformation/openrfps.aspx. The last day interested parties may submit their proposals was August 4, 2020. HSD received proposals from interested parties August 4, 2020. The Evaluation Committee met August 25th to discuss their reviews of all proposals and collectively agreed on an Evaluator to recommend to leadership through the Evaluation Committee Report. The Evaluation Committee Report was completed by the procurement manager and submitted to leadership for review September 1, 2020.

16
ENCLOSURES/ATTACHMENTS

Attachment A: July 2018 – June 2020 Statewide Dashboards

Attachment B: Budget Neutrality Monitoring Spreadsheet

Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group

17 STATE CONTACTS

HSD State Name and Title	Phone	Email Address	Fax
Nicole Comeaux Director HSD/Medical Assistance	505-827-7703	Nicole.Comeaux@state.nm.us	505-827-3185
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Lorelei Kellogg Deputy Director HSD/Medical Assistance	505-827-1344	Lorelei.Kellogg@state.nm.us	505-827-3185
Linda Gonzales Deputy Director HSD/Medical Assistance	505-827-6222	Linda.Gonzales@state.nm.us	505-827-3185

18
ADDITIONAL COMMENTS

MCO INTIATIVES

BCBS: Respite Beds
BCBS has developed a program to provide guaranteed respite beds for men and women. This is designed mainly for homeless men and women being released from a hospitalization and have physical health needs that are not completely met by their stay in the hospital. BCBS has a guaranteed bed for these members for up to a month stay at the Albuquerque Opportunity Center men's shelter and The Barret House for women.

BCBS: Emergency Department early notification
BCBS developed three distinct teams who are assigned to cover the state in the north, metro, and south. These teams utilize early notification of an Emergency Department (ED) visit to identify members who are experiencing substance use disorder, mental health issues, or suicidal tendencies. BCBS is outreaching to these members immediately upon notification to work with the members to obtain appointments for their specific needs within 14-30 days of the ED visit. BCBS is utilizing care coordination transition of care liaisons and recovery support assistant (peer support) staff to do this outreach.

PHP: Call Center Genesys Upgrade
The Presbyterian Customer Service Center (PCSC) uses a contact center platform developed by the Genesys Telecommunications Lab. After several months of assurance that the remote work-from-home environment was stable, the PCSC was migrated to the new Genesys platform over the weekend of 7/31/2020-8/1/2020. The PCSC was a part of the last wave to receive implementation as smaller, less complex centers were moved first to test viability prior to full migration. There was minimal impact to PCSC service levels. There were some end users with softphone issues, but those were identified quickly and corrected.

PHP: Home Monitoring Program

To support members who tested positive for COVID-19 (COVID+), PHP teamed with Presbyterian Healthcare at Home to develop an innovative program that allows patients to be monitored at home until care is no longer needed. The goal is to recognize and treat symptoms before they worsen and to avoid hospitalizations and Emergency Department visits.

Data about members who have tested positive for COVID-19 is pulled daily from the Clinical Data Integration (CDI) data warehouse developed and maintained by PHP's Analytics Organization (AO). Once identified, the program uses a special smartphone tool and pulse oximeters that report vital signs and oxygen levels to monitor members' health status. If the monitoring data raises a concern, a clinician calls the patient to evaluate their condition and answer questions. The clinician may prescribe oxygen at home, help with medication management, or provide other clinical interventions.

PHP: Food Insecurity Initiative for COVID-19 Positive Members

PHP implemented the new statewide COVID+/Food Insecurity benefit which allows Centennial Care members in the COVID+/Food Insecure category to receive meals from the local Meals on Wheels (MOW) organization as a Value-Added Service. Data about members who have tested positive for COVID-19 and have been identified as food-insecure are pulled daily from the Clinical Data Integration (CDI) data warehouse developed and maintained by PHP's Analytics Organization (AO). This data auto-populates a report that is reviewed each weekday by PHP's Community Health Worker (CHW) team. When a member is identified as eligible for this benefit, the case is assigned to a CHW, who then reaches out to the member to find out if they would like to receive the meal benefit. This outreach process is guided by a formal process and script which facilitates access to a 14-day supply of meals which are delivered to the member's residence to support self-isolation.

WSCC: HEDIS Gap Closure

The WSCC Quality Department launched the Proactive Outreach Manager (POM) tool for initiation of HEDIS measures gap closure. Both before and during this initiative, WSCC worked directly with a provider group for feedback on the best process for rolling out the POM tool. This relationship offered an opportunity for two-way feedback to create best practices for this tool. Examples include developing a test campaign, identifying hours for outreach, selecting members to target, determining the intervals between campaigns, and setting a regular schedule for updates from the WSCC Member Services team. The test campaign and the initial full campaign were both monitored closely, and teams met afterward to develop opportunities to increase efficiency and positive outcomes. Further

campaigns are planned for the first full week in Q4. The current campaign is focused on adult and pediatric well-visits, annual dental visits, and ad-hoc HEDIS campaigns where time-specific or messaging with sensitive content is not required. The WSCC Customer Service Center participated and supported HEDIS Gap Closure initiatives, assisting with the return calls and scheduling appointments.

WSCC: **Assisting Tribal Communities**.
Through materials and communication enhancements, WSCC continues to work towards development of strong communities that actively engage in their healthcare: The WSCC Cultural Competency Team partnered with Tribal Relations to develop and send out COVID-19 care packages to tribal communities around New Mexico, including the Dine, San Ildefonso, and Apache communities. WSCC partnered with First Nations Community Health Source to provide essential items for community members. WSCC also developed and implemented a plan to send out 750 backpacks to community members for back-to-school events during the late summer in Shiprock, Zuni, Albuquerque, Ramah-Pinehill, and Gallup. The WSCC Provider Relations and Quality Departments are partnering to update the WSCC provider website with additional cultural competency information that will increase provider capability to communicate with different member populations more effectively. A provider language assistance poster is being updated. Members who need an interpreter can simply point to the language that they speak. This poster will be used in health care clinics as a quick resource for providers and members.

MEMBER SUCCESS STORIES

A BCBS member is being seen by pediatric specialty clinics at both the Phoenix Children's Hospital in Phoenix, Arizona and the University of New Mexico (UNM) Pediatric Hospital in Albuquerque, New Mexico. Pediatric Neurology at the Phoenix Children's Hospital ordered a renal ultrasound and EKG to be done at the Phoenix Children's Hospital the week of 9/28/2020 and ordered labs to be done locally. The member also had appointments scheduled at UNM Pediatrics specialty clinics for the week of 9/21/2020 and 10/5/2020. The member is medically fragile and does not tolerate travel well and the thought of traveling back and forth between Phoenix and Albuquerque and the coordination of appointments created anxiety for the member's mother, who is a single mother with 4 children. She was also worried about prior authorization for procedures being done out of network. The goal was to consolidate appointments and have them completed at the UNM Pediatric Hospital, limiting travel and decreasing stress and anxiety for the member and his mother and decreasing cost to the MCO by using in network providers and consolidating out of town appointments. The MCO Care Coordinator worked with administration from the Phoenix Children's Neurology department, the UNM Pediatric specialty clinic, and the member's PCP to coordinate the needed procedures. On 9/23/2020 the member had EKG, labs, and a car seat fitting at UNM Pediatric Clinic and on 10/09/2020 the member had a swallow study and renal ultrasound completed at UNM pediatric clinics. This decreased the member's travel from 5 trips to 2 and all procedures were done in-network.

A PHP member who was COVID-19 positive was verified by a community health worker (CHW) late on a Friday afternoon as having food insecurity. The CHW reached out to the member per the newly established process of assisting COVID-19 positive members identified as having potential food insecurity and the family needed food. The CHW placed a late afternoon order; however, this would mean that the family would not begin receiving Meal on Wheels (MOW) until the following Tuesday. The CHW explained to the member's mother how the MOW program works COVID-19 positive members, and the member's mother stated they would benefit from this program. The CHW processed the referral to get food during convalescence. Due to the complexity of the circumstances, the CHW team reached out to the MOW program staff to explain, and the program staff agreed to make an exception to the process. The CHW was able to coordinate the benefit so the family would begin receiving food deliveries that afternoon.

Longer term, the CHW will assist the member with food insecurity and other resources to assist with paying utilities. In addition, the CHW explained other services provided by PHP including:

Pres RN, when to use ED services (Count 123), urgent care locations, provider video visits, transportation and Centennial Rewards Benefits. The CHW provided important telephone numbers. Also, the CHW determined that in addition to the member testing positive for COVID-19, the member appears to have a speech delay. The CHW confirmed that well child visits are established, that the member had a recent well child visit and that the member is established with a PCP. The CHW will assist in making sure the member is referred for the speech delay concern. The CHW stressed the importance of the well child visits and the need for ongoing PCP visits with the member's mother.

A WSCC member who frequently utilizes emergency department services has been working for several months with a WSCC Member Connections Family Peer Support Worker (FPSW). The member has significant anxiety with panic attacks, largely related to COVID-19. The FPSW has been working to build rapport with the member and she has only recently begun to talk openly with the FPSW about her struggles. She had previously been resistant to engage in any behavioral health related services. Recently, the member had a telemedicine visit with a provider to discuss her anxiety and panic attacks and was prescribed medication. Initially, the member did not take medication as prescribed due to the side effects. The FPSW continued to engage with the member to provide support, education, and encouragement. The member currently reports that she has been taking her medication regularly and is feeling much better; her anxiety has lessened, and she feels hopeful. The member reports she will continue to engage with her behavioral health provider. The FPSW will continue to assist and support this member.

Program Changes Effective 7/1/2018	
Physician Office Visit Reimbursement Fee Increase	Increase to the FFS reimbursement for physician office visits for procedure code 99213 from 71.2% of the Medicare fee schedule to 75.0% of the Medicare fee schedule.
Nursing Facility Fee increase	Increase to the FFS reimbursement for nursing facilities by 7.84%.
Assisted Living Reimbursement Fee Increase	Increase to the FFS reimbursement for assisted living (procedure codes T2030 and T2031) by 1.0%.
Adult Day Health Reimbursement Fee Increase	Increasing its FFS reimbursement for adult day health (procedure code S5100) by 38.7%.
Phase 1 Behavioral Health Benefit and Fee Changes	Increase to the FFS reimbursement for TFC, ACT, group therapy, CCSS (performed in the community setting) and therapy services performed after hours by 20%.

Program Changes Effective 1/1/2019	
Long-Acting Reversible Contraceptive Fee Increase	Increase to the FFS reimbursement for procedure codes 11981 and 11983 by 25% and procedure code 58300 by 200%.
Community Benefit Fee Increase	Increase to the FFS reimbursement for community benefit services by 1%. The CC-OAG ABP exempt population is eligible to receive the community benefit.
Child ARTC Payment Change	Changes to the FFS fee schedule for revenue codes 1001 to increase the daily rate for child ARTCs from $270 to $350 per day.
Phase 2 Behavioral Health Benefit and Fee Changes	Expanded billing procedures to allow for increased reimbursement of recovery services provided in a family peer support environment, complex and non-complex interdisciplinary teaming assessments, partial hospitalization services, in addition to expanding OTP to existing clinics, allowing BHA to bill CCSS and adding additional IOPs.
Home visiting pilot programs	New benefit for Home visiting pilot programs NFP and PAT.
SBIRT	Transition from supplemental grant funding to Managed Care coverage for Brief Intervention and Referral to Treatment Services.

Program Changes Effective 7/1/2019	
E&M Fee Schedule Increase	Increase to all FFS rates for procedure codes 99201–99499 below 90% to 90% of the CY2019 Medicare fee schedules. FFS procedure codes already above 90% remain unchanged. Procedure codes without a corresponding Medicare fee schedule have been increased by 14.5%.
Assisted Living Fee Increase	5% increase to procedure codes T2030 and T2031.
Community Pharmacy Dispensing Fee Increase	$2 increase to dispensing fees for select pharmacies.
Chronic Care Management/Transitional Care Management	Implementation of new services for non-dual Medicaid populations.
Hospital Fee Increase	Increase of 5% to inpatient services and 10% increase to outpatient services for State Teaching Hospitals; 14% increase to inpatient services and 25% increase to outpatient services for SNCP providers; 12% increase to inpatient services and 18% increase to outpatient services for all remaining in-state hospitals.
Pre-Tenancy	Implementation of new services for members with SMI.
Personal Care Services Fee Increase	$.50 per hour increase to procedure codes T1019 and 99505.
Dental Fee Schedule Increase	Increase of 2% to dental reimbursement rates.
Dental Fluoride with Varnish	Implementation of new services and procedure codes D1026 and 99188.

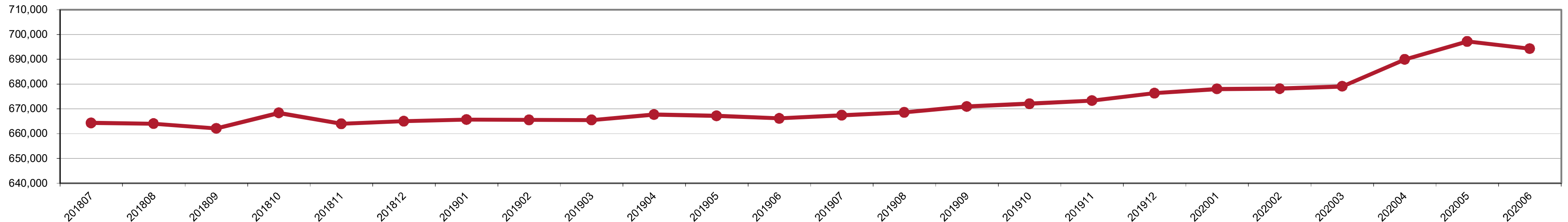
Program Changes Effective 10/1/2019	
BH Outpatient Rate Increase	Increase to all BH OP rates below 90% to 90% of the CY2019 Medicare fee schedules. FFS procedure codes already above 90% remain unchanged. Procedure codes without a Medicare fee schedule have been increased by 30%.
ECHO E&M Reimbursement Adjustments	Increase to program for anticipated additional physician utilization in the Centennial Care program resulting from Project ECHO.
FQHC Base/Dental Rate Increase	Increase to the base PPS rate to a minimum of $169.77 for all FQHC medical services besides dental. For FQHC dental services, this is an increase to the base PPS rate to a minimum $200.
Not-For-Profit Community Hospital Rate Increase	

Program Changes Effective 1/1/2020	
Community Hospital – Native Americans Rate Increase	The Community Hospital – Native Americans Rate Increase reflects a 13.0% increase to reimbursement levels for inpatient services for eligible in-state hospitals.
For-Profit & Government-Owned Hospital Rate Increase	The For-Profit & Government Owned Hospital Rate Increase reflects a 2.0% increase to reimbursement levels to inpatient and outpatient services for in-state for-profit/investor-owned and government-owned hospitals (excluding UNM hospitals).
Adult Residential Treatment Center	The Adult RTC adjustment reflects the added benefit for adults to receive SUD services at three adult RTCs.
Photo-Ocular Screening	The Photo-Ocular Screening adjustment effective January 1, 2020 reflects an expansion of vision screenings available during well-child visits that will include procedure code 99177.
Justice-Involved Transportation to Pharmacies	The Justice-Involved Transportation to Pharmacies adjustment reflects the added benefit for members released from incarceration to be transported to and from a pharmacy within seven days post-discharge to retrieve appropriate medication.
NF VBP	The NF VBP adjustment reflects a $4.5 million increase to Nursing Facilities to improve quality outcomes by comparing the nursing facilities to CMS benchmarks. After the completion of the contract year, a reconciliation will be performed to reflect actual experience.
PCS Minimum Wage Adjustment	The PCS Minimum Wage Adjustment reflects New Mexico's average minimum wage increasing from $7.50 to $9.00 per hour.
Long-Acting Reversible Contraception (1/1/2020)	The Long-Acting Reversible Contraception (LARC) fee schedule increase reflects the following additional rate increases: a 100.9% to procedure code 11981, 100.0% to procedure codes 11982, 11983, 58301 and a 152.0% to procedure code 58300.
Leap Day Adjustment	The Leap Day Adjustment reflects an additional day of utilization for nursing facility and HCBS services.
HCQS and NF MBI Adjustments	The Heath Care Quality Surcharge (HCQS) and Nursing Facility Market Basket Increase (NF MBI) adjustment reflects a new surcharge for nursing facilities with over 60 beds and a 2.8% market basket increase to all nursing facilities.

State of New Mexico - All MCOs
All Centennial Care Populations
Centennial Care Cost Review

Reported Eligibility for Members Enrolled as of: June 30, 2020
Previous Period: July 1, 2018 to June 30, 2019
Current Period: July 1, 2019 to June 30, 2020

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	4,652,359	4,701,625	1%
Long Term Services and Supports	580,682	583,299	0%
Other Adult Group	2,752,653	2,860,459	4%
Total Member Months	**7,985,694**	**8,145,383**	**2%**

	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	$ 1,266,579,096	$ 1,382,566,963	9%	$ 272.24	$ 294.06	8%
Long Term Services and Supports	$ 864,118,111	$ 997,716,224	15%	$ 1,488.11	$ 1,710.47	15%
Other Adult Group Physical Health	$ 1,071,651,338	$ 1,220,428,528	14%	$ 389.32	$ 426.65	10%
Behavioral Health - All Members	$ 386,628,091	$ 474,367,804	23%	$ 48.42	$ 58.24	20%
Total Medical Costs	**$ 3,588,976,636**	**$ 4,075,079,519**	**14%**	**$ 449.43**	**$ 500.29**	**11%**
Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	**% Change**
Admin, care coordination, Centennial Rewards	$ 390,183,776	$ 398,654,358	2%	$ 48.86	$ 48.94	0%
NMMIP Assessment	$ 57,349,445	$ 72,493,619	26%	$ 7.18	$ 8.90	24%
Premium Tax - Net of NIMMP Offset	$ 137,157,944	$ 153,111,612	12%	$ 17.18	$ 18.80	9%
Total Non-Medical Costs	**$ 584,691,164**	**$ 624,259,589**	**7%**	**$ 73.22**	**$ 76.64**	**5%**
Estimated Total Centennial Care Costs	**$ 4,173,667,800**	**$ 4,699,339,108**	**13%**	**$ 522.64**	**$ 576.93**	**10%**

Centennial Care Medical Expenditures

Previous (Q3CY2018 - Q2CY2019): 35%, 24%, 30%, 11%

Current (Q1CY2019 - Q2CY2020): 34%, 24%, 30%, 12%

*See above for legend.

Centennial Care Member Months

Previous (Q3CY2018 - Q2CY2019): 58%, 7%, 35%

Current (Q1CY2019 - Q2CY2020): 58%, 7%, 35%

*See above for legend.

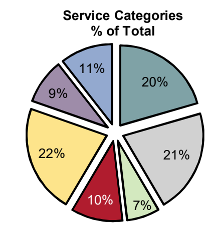
3. Total Program Medical/Pharmacy Dollars

	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	$ 3,210,253,602	$ 3,640,687,858	13%	$ 402.00	$ 446.96	11%
Pharmacy	$ 378,723,034	$ 434,391,661	15%	$ 47.43	$ 53.33	12%
Total	**$ 3,588,976,636**	**$ 4,075,079,519**	**14%**	**$ 449.43**	**$ 500.29**	**11%**

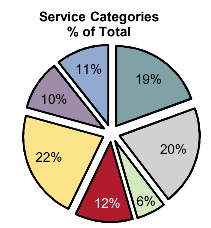
	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
Service Categories	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 736,692,817	$ 791,262,182	7%	$ 92.25	$ 97.14	5%
Acute Outp/Phy	$ 754,485,830	$ 821,682,428	9%	$ 94.48	$ 100.88	7%
Nursing Facility	$ 236,521,541	$ 241,598,447	2%	$ 29.62	$ 29.66	0%
Community Benefit/PCO	$ 372,051,510	$ 475,625,385	28%	$ 46.59	$ 58.39	25%
Other Services	$ 784,838,134	$ 899,451,312	15%	$ 98.28	$ 110.42	12%
Behavioral Health	$ 325,663,770	$ 411,068,104	26%	$ 40.78	$ 50.47	24%
Pharmacy (All)	$ 378,723,034	$ 434,391,661	15%	$ 47.43	$ 53.33	12%
Total Costs	**$ 3,588,976,636**	**$ 4,075,079,519**	**14%**	**$ 449.43**	**$ 500.29**	**11%**

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

Previous (12 mon) service distribution



Current (12 mon) service distribution



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 includes, but is not limited to, the following services: emergent transportation, non-emergent transportation, vision, and dental.
4. Amounts are reported based on dates of service within the previous and current periods.

State of New Mexico - All MCOs

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

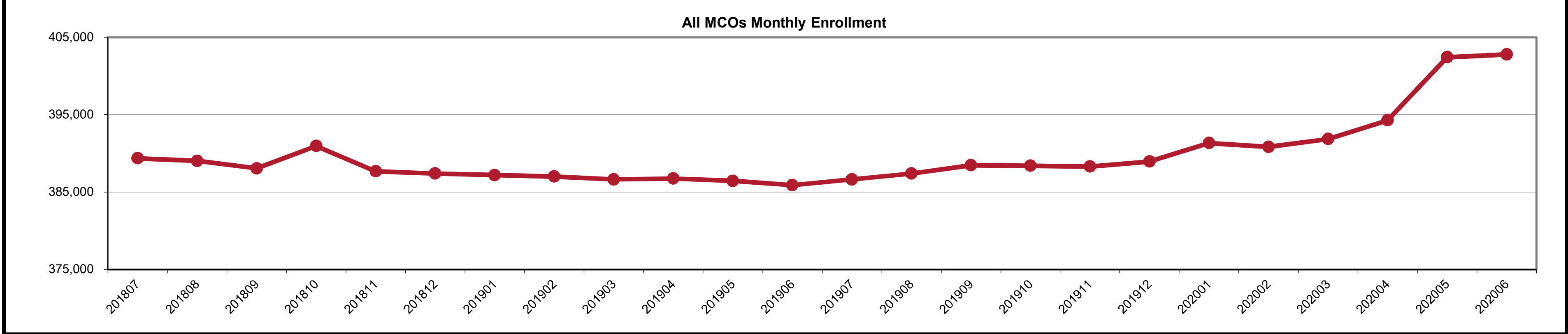
Physical Health Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: June 30, 2020

Previous Period: July 1, 2018 to June 30, 2019

Current Period: July 1, 2019 to June 30, 2020

1. Total Population Monthly Enrollment



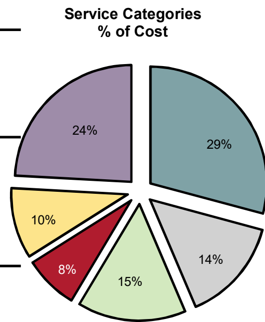
2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,148,744,378	$ 1,247,382,759	9%
Pharmacy	$ 117,834,719	$ 135,184,204	15%
Total	**$ 1,266,579,096**	**$ 1,382,566,963**	**9%**

Aggregate Costs by Service Categories

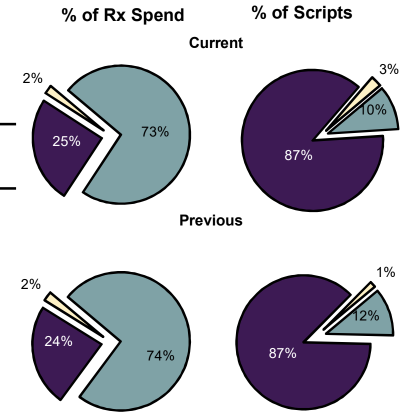
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 377,903,786	$ 403,370,994	7%
Outpatient (OP)	$ 181,974,139	$ 198,757,386	9%
Physician (PH)	$ 199,785,452	$ 207,908,451	4%
Emergency Department (ED)	$ 86,485,552	$ 103,421,554	20%
Pharmacy (RX)	$ 117,834,719	$ 135,184,204	15%
Other (OTH)	$ 302,595,448	$ 333,924,374	10%
Total Population Costs	**$ 1,266,579,096**	**$ 1,382,566,963**	**9%**
Per Capita Cost (PMPM)	**$ 272.24**	**$ 294.06**	**8%**
Total Member Months	**4,652,359**	**4,701,625**	**1%**



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 87,222,206	$ 98,880,941	13%
Generic	$ 27,980,165	$ 33,556,377	20%
Other Rx	$ 2,632,348	$ 2,746,886	4%
Total	**$ 117,834,719**	**$ 135,184,204**	**15%**



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

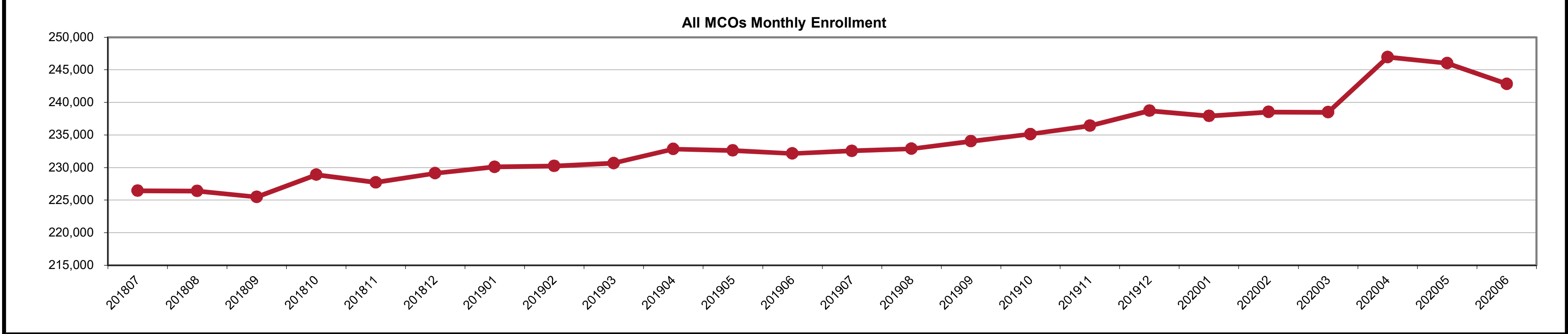
4. Notes

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, and dental.
4. Amounts are reported based on dates of service within the previous and current periods.

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

Reported Eligibility for Members Enrolled as of: June 30, 2020
Previous Period: July 1, 2018 to June 30, 2019
Current Period: July 1, 2019 to June 30, 2020

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 900,418,770	$ 1,016,955,206	13%
Pharmacy	$ 171,232,568	$ 203,473,322	19%
Total	**$ 1,071,651,338**	**$ 1,220,428,528**	**14%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 296,097,764	$ 325,598,733	10%
Outpatient (OP)	$ 166,939,538	$ 192,597,115	15%
Physician (PH)	$ 147,537,651	$ 156,394,928	6%
Emergency Department (ED)	$ 85,988,515	$ 105,067,883	22%
Pharmacy (RX)	$ 171,232,568	$ 203,473,322	19%
Other (OTH)	$ 203,855,301	$ 237,296,547	16%
Total Population Costs	**$ 1,071,651,338**	**$ 1,220,428,528**	**14%**
Per Capita Cost (PMPM)	**$ 389.32**	**$ 426.65**	**10%**
Total Member Months	**2,752,653**	**2,860,459**	**4%**

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	$ 137,594,277	$ 163,190,038	19%
Generic	$ 29,695,317	$ 35,892,979	21%
Other Rx	$ 3,942,973	$ 4,390,305	11%
Total	**$ 171,232,568**	**$ 203,473,322**	**19%**

** "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, and dental.
4. Amounts are reported based on dates of service within the previous and current periods.

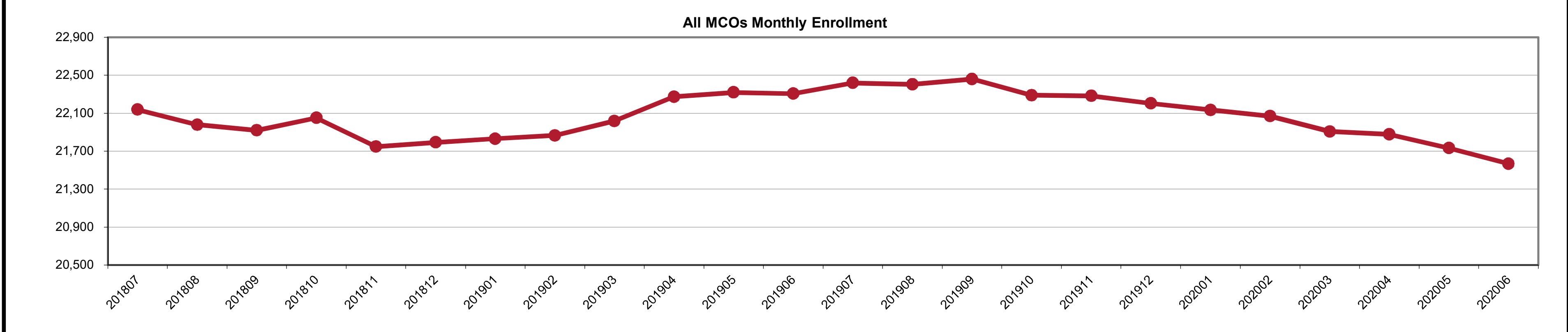
State of New Mexico - All MCOs

LTSS - Healthy Dual Population

Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: June 30, 2020
Previous Period: July 1, 2018 to June 30, 2019
Current Period: July 1, 2019 to June 30, 2020

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 42,233,089	$ 46,013,645	9%
Pharmacy	$ 757,319	$ 489,797	-35%
Total	**$ 42,990,408**	**$ 46,503,442**	**8%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 7,188,373	$ 6,239,521	-13%
Outpatient (OP)	$ 8,484,817	$ 9,022,346	6%
Physician (PH)	$ 4,938,956	$ 5,756,468	17%
Emergency Department (ED)	$ 2,736,432	$ 2,987,065	9%
Pharmacy (RX)	$ 757,319	$ 489,797	-35%
Other (OTH)	$ 18,884,512	$ 22,008,245	17%
Total Population Costs	**$ 42,990,408**	**$ 46,503,442**	**8%**
Per Capita Cost (PMPM)	**$ 162.70**	**$ 175.26**	**8%**
Total Member Months	**264,230**	**265,334**	**0%**

Service Categories
% of Cost

14%, 19%, 12%, 7%, 1%, 47%

3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 505,656	$ 253,914	-50%
Generic	$ 213,202	$ 176,931	-17%
Other Rx	$ 38,461	$ 58,951	53%
Total	**$ 757,319**	**$ 489,797**	**-35%**

% of Rx Spend / **% of Scripts**

Current: % of Rx Spend 52%, 36%, 12%; % of Scripts 64%, 21%, 15%

Previous: % of Rx Spend 67%, 28%, 5%; % of Scripts 78%, 20%, 2%

** "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, and dental.
4. Amounts are reported based on dates of service within the previous and current periods.

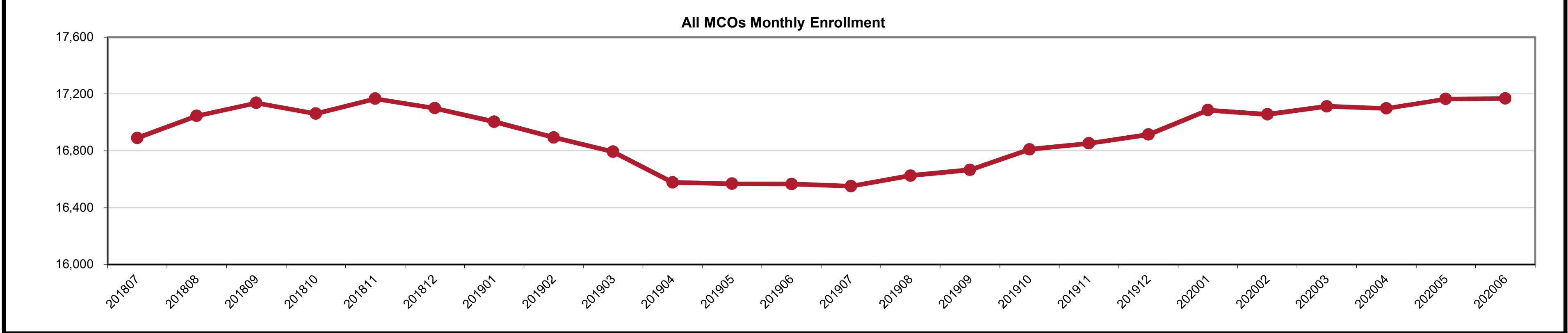
State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Dual Population

Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: June 30, 2020
Previous Period: July 1, 2018 to June 30, 2019
Current Period: July 1, 2019 to June 30, 2020

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 487,850,773	$ 553,991,186	14%
Pharmacy	$ 390,408	$ 182,884	-53%
Total	**$ 488,241,181**	**$ 554,174,069**	**14%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 204,684,542	$ 258,734,515	26%
Nursing Facility (NF)	$ 210,999,589	$ 215,005,729	2%
Inpatient (IP)	$ 10,381,963	$ 9,285,492	-11%
Outpatient (OP)	$ 12,703,048	$ 13,784,772	9%
Pharmacy (RX)	$ 390,408	$ 182,884	-53%
HCBS	$ 14,680,763	$ 20,145,618	37%
Other (OTH)	$ 34,400,868	$ 37,035,060	8%
Total Population Costs	**$ 488,241,181**	**$ 554,174,069**	**14%**
Per Capita Cost (PMPM)	**$ 2,407.45**	**$ 2,728.51**	**13%**
Total Member Months	**202,804**	**203,105**	**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	$ 273,129	$ 85,283	-69%
Generic	$ 92,826	$ 73,114	-21%
Other Rx	$ 24,454	$ 24,486	0%
Total	**$ 390,408**	**$ 182,884**	**-53%**

** "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, and dental.
4. Amounts are reported based on dates of service within the previous and current periods.

State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Medicaid Only Population

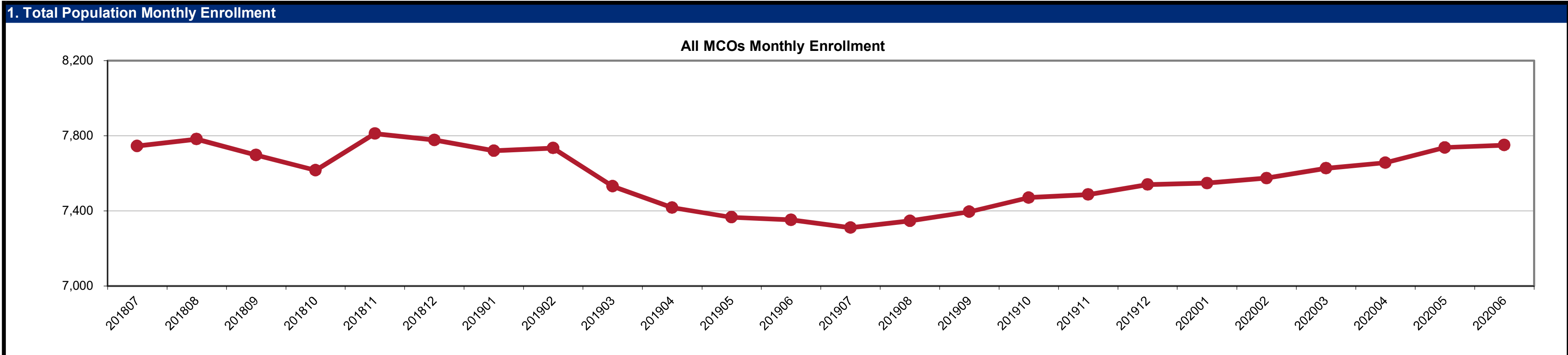
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: June 30, 2020

Previous Period: July 1, 2018 to June 30, 2019

Current Period: July 1, 2019 to June 30, 2020

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 240,972,452	$ 280,558,250	16%
Pharmacy	$ 23,719,209	$ 28,041,754	18%
Total	**$ 264,691,661**	**$ 308,600,004**	**17%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 91,472,465	$ 110,521,085	21%
Nursing Facility (NF)	$ 25,149,518	$ 26,334,666	5%
Inpatient (IP)	$ 41,887,159	$ 44,351,872	6%
Outpatient (OP)	$ 29,084,921	$ 33,589,790	15%
Pharmacy (RX)	$ 23,719,209	$ 28,041,754	18%
HCBS	$ 8,760,416	$ 14,319,456	63%
Other (OTH)	$ 44,617,973	$ 51,441,381	15%
Total Population Costs	**$ 264,691,661**	**$ 308,600,004**	**17%**
Per Capita Cost (PMPM)	**$ 2,891.29**	**$ 3,412.24**	**18%**
Total Member Months	**91,548**	**90,439**	**-1%**

Service Categories % of Cost

36%, 8%, 14%, 11%, 9%, 5%, 17%

3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 18,915,033	$ 22,400,826	18%
Generic	$ 4,180,045	$ 4,942,155	18%
Other Rx	$ 624,132	$ 698,774	12%
Total	**$ 23,719,209**	**$ 28,041,754**	**18%**

	% of Rx Spend	% of Scripts
Current	Brand 80%, Generic 18%, Other Rx 2%	Brand 11%, Generic 86%, Other Rx 3%
Previous	Brand 80%, Generic 17%, Other Rx 3%	Brand 11%, Generic 87%, Other Rx 2%

** "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, and dental.
4. Amounts are reported based on dates of service within the previous and current periods.

State of New Mexico - All MCOs

LTSS - Self Directed Population

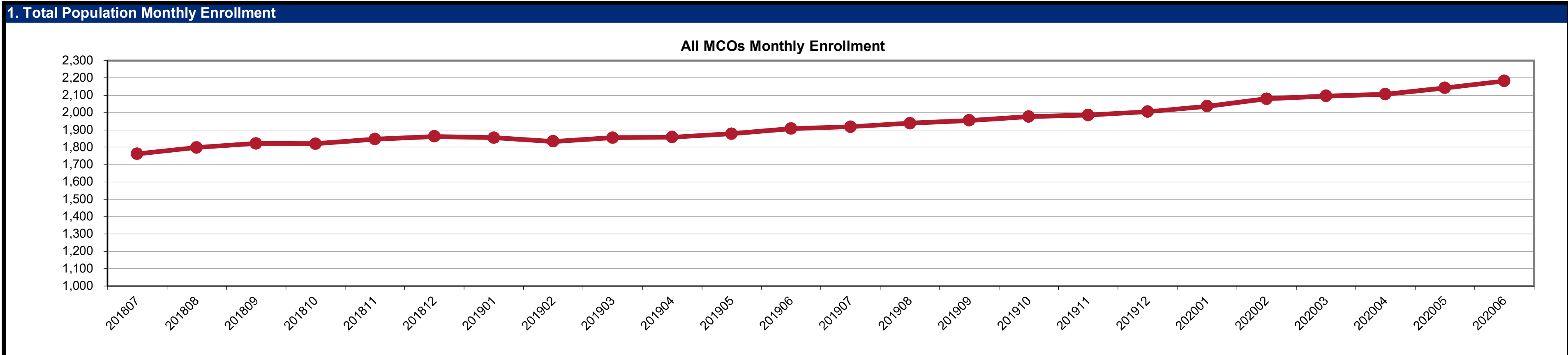
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: June 30, 2020

Previous Period: July 1, 2018 to June 30, 2019

Current Period: July 1, 2019 to June 30, 2020

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 64,370,371	$ 84,718,708	32%
Pharmacy	$ 3,824,490	$ 3,720,001	-3%
Total	**$ 68,194,861**	**$ 88,438,709**	**30%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 372,433	$ 258,053	-31%
Inpatient (IP)	$ 3,233,773	$ 2,415,570	-25%
Outpatient (OP)	$ 3,037,308	$ 3,871,172	27%
Pharmacy (RX)	$ 3,824,490	$ 3,720,001	-3%
HCBS	$ 52,453,324	$ 71,904,710	37%
Other (OTH)	$ 5,273,533	$ 6,269,204	19%
Total Population Costs	**$ 68,194,861**	**$ 88,438,709**	**30%**
Per Capita Cost (PMPM)	**$ 3,085.74**	**$ 3,621.42**	**17%**
Total Member Months	**22,100**	**24,421**	**11%**

Service Categories % of Cost

0% 3% 5% 4% 7% 81%

3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 3,064,225	$ 2,892,241	-6%
Generic	$ 666,611	$ 744,578	12%
Other Rx	$ 93,653	$ 83,182	-11%
Total	**$ 3,824,490**	**$ 3,720,001**	**-3%**

% of Rx Spend **% of Scripts**

Current: Rx Spend 2%, 20%, 78%; Scripts 4%, 13%, 83%

Previous: Rx Spend 3%, 17%, 80%; Scripts 3%, 14%, 83%

** "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, and dental.
4. Amounts are reported based on dates of service within the previous and current periods.

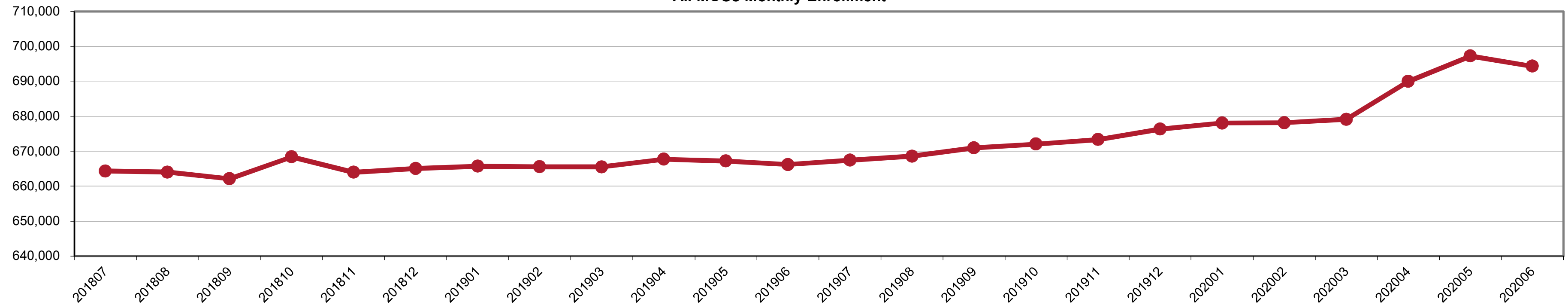
State of New Mexico - All MCOs

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: June 30, 2020
Previous Period: July 1, 2018 to June 30, 2019
Current Period: July 1, 2019 to June 30, 2020

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

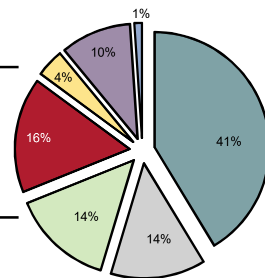
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 325,663,770	$ 411,068,104	26%
Pharmacy	$ 60,964,321	$ 63,299,699	4%
Total	**$ 386,628,091**	**$ 474,367,804**	**23%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 142,629,584	$ 195,959,287	37%
Pharmacy (RX)	$ 60,964,321	$ 63,299,699	4%
Res. Treatment Ctr. (RTC)	$ 69,365,104	$ 67,651,042	-2%
Behavioral Health Prov (BHP)	$ 47,916,292	$ 76,715,143	60%
Core Service Agencies (CSA)	$ 16,438,377	$ 18,595,471	13%
Inpatient (IP)	$ 43,233,126	$ 47,127,267	9%
Other (OTH)	$ 6,081,286	$ 5,019,894	-17%
Total Population Costs	**$ 386,628,091**	**$ 474,367,804**	**23%**
Per Capita Cost (PMPM)	**$ 48.42**	**$ 58.24**	**20%**
Total Member Months	**7,985,694**	**8,145,383**	**2%**

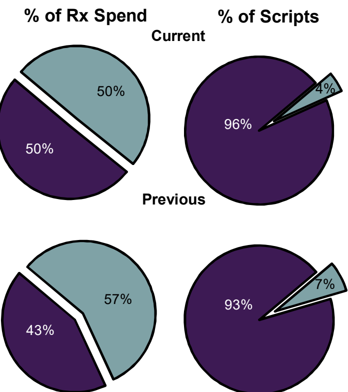
Services Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 34,742,545	$ 31,434,608	-10%
Generic	$ 26,221,776	$ 31,865,092	22%
Total	**$ 60,964,321**	**$ 63,299,699**	**4%**



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.

ATTACHMENT A

New Mexico Budget Neutrality Monitoring Spreadsheet
- PMPM Analysis

DY 7

Start Date: 01/01/2020

End Date: 12/31/2020

Quarter 3

Start Date:7/1/2020

End Date: 9/30/2020

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	4,314,293
PMPM	$ 385.80	$ 329.14	$ 400.77	$ 344.32	$ 416.32	$ 335.32	$ 432.47	$ 344.68	$ 449.25	$ 353.83	$ 460.00	$ 398.73
Dollars	$ 1,823,911,159	$ 1,486,759,546	$ 1,948,487,793	$ 1,533,690,327	$ 2,090,074,424	$ 1,549,715,804	$ 2,202,434,150	$ 1,593,627,368	$ 2,305,734,126	$ 1,564,968,618	$ 2,288,249,485	$ 1,720,240,899

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	448,829
PMPM	$ 1,763.90	$ 1,656.72	$ 1,842.83	$ 1,785.40	$ 1,925.21	$ 1,756.53	$ 2,008.00	$ 1,734.28	$ 2,094.34	$ 1,729.41	$ 2,158.77	$ 1,914.16
Dollars	$ 897,298,062	$ 824,975,534	$ 946,727,393	$ 882,933,884	$ 999,138,707	$ 866,983,765	$ 1,053,669,000	$ 845,979,008	$ 1,111,724,897	$ 795,236,036	$ 1,078,650,304	$ 859,130,719

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	432,860
PMPM	$ 1,780.77	$ 1,333.20	$ 1,857.34	$ 1,342.71	$ 1,937.21	$ 1,361.10	$ 2,020.51	$ 1,273.55	$ 2,107.39	$ 1,290.51	$ 2,057.62	$ 1,285.50
Dollars	$ 665,692,378	$ 570,643,867	$ 706,189,973	$ 584,267,888	$ 749,372,219	$ 609,503,295	$ 795,742,098	$ 564,271,364	$ 845,479,241	$ 558,422,305	$ 962,212,283	$ 556,442,708

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	2,985
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	$ 3,812.57
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	$ 11,380,521

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	50,770
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	$ 2,833.77
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	$ 143,870,505

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	3,072,364
PMPM	$ 577.87	$ 453.48	$ 607.34	$ 476.42	$ 638.31	$ 442.85	$ 670.87	$ 450.31	$ 705.08	$ 484.63	$ 738.22	$ 504.75
Dollars	$ 943,638,928	$ 856,047,942	$ 1,086,464,733	$ 1,309,507,471	$ 1,149,478,718	$ 1,363,120,735	$ 1,183,239,734	$ 1,415,732,252	$ 1,250,319,546	$ 1,463,179,030	$ 2,435,685,299	$ 1,550,784,180

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

Notes:

1.) Actual member months for Demonstration Year 7 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, FFY2020 Quarter 4. Report pulled on 11/03/2020.

ATTACHMENT A

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%	$ 1,233,316,823	$ 1,486,759,546	$ 1,070,401,817
MEG02 - SSI & Related - Medicaid Only	$ 1,763.90	497,958	$ 878,350,269	70.77%	$ 621,603,625	$ 824,975,534	$ 574,937,245
MEG03 - SSI & Related - Dual Eligible	$ 1,780.77	428,025	$ 762,214,336	70.77%	$ 539,414,868	$ 570,643,867	$ 395,585,750
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	70.77%	$ 48,752,593	$ 68,889,323	$ 47,671,412
MEG09 HQII	NA	NA	$ -	70.77%	$ -	$ -	$ -
Grand Total			**$ 3,452,178,905**		**$ 2,443,087,909**	**$ 2,951,268,270**	**$ 2,088,596,224**

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%	$ 1,090,823,562	$ 856,047,942	$ 856,022,312
Grand Total			**$ 1,090,856,222**		**$ 1,090,823,562**	**$ 856,047,942**	**$ 856,022,312**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,443,087,909**
Federal Share (Title XIX) Actual Reported	$ 2,088,596,224
Excess Spending - Test 1	$ 22,069,661
Excess Spending - Test 2	$ -
Total Actuals	$ 2,110,665,885
Difference (Actuals - Limit)	$ (332,422,024)
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, FFY2020 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY2020 Quarter 4. Report pulled on 11/03/2020.

ATTACHMENT A

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%	$ 1,274,541,333	$ 1,533,690,327	$ 1,116,190,097
MEG02 - SSI & Related - Medicaid Only	$ 1,842.83	494,529	$ 911,332,877	71.40%	$ 650,662,973	$ 882,933,884	$ 619,375,970
MEG03 - SSI & Related - Dual Eligible	$ 1,857.34	435,140	$ 808,202,928	71.40%	$ 577,031,437	$ 584,267,888	$ 408,062,785
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	71.40%	$ 49,184,807	$ 67,294,973	$ 46,989,091
MEG09 HQII	NA	NA	$ 2,824,462	71.40%	$ 2,016,577	$ 2,824,462	$ 1,987,574
Grand Total			**$ 3,576,400,227**		**$ 2,553,437,127**	**$ 3,071,011,534**	**$ 2,192,605,517**

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%	$ 1,669,275,994	$ 1,309,507,471	$ 1,309,446,155
Grand Total			**$ 1,669,354,159**		**$ 1,669,275,994**	**$ 1,309,507,471**	**$ 1,309,446,155**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,553,437,127**
Federal Share (Title XIX) Actual Reported	$ 2,192,605,517
Excess Spending - Test 1	$ 19,825,571
Excess Spending - Test 2	$ -
Total Actuals	$ 2,212,431,088
Difference (Actuals - Limit)	$ (341,006,039)
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, FFY2020 Quarter 4 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY2020 Quarter 4. Report pulled on 11/03/2020.

ATTACHMENT A

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	72.14%	$ 1,388,132,714	$ 1,549,715,804	$ 1,139,911,900
MEG02 - SSI & Related - Medicaid Only	$ 1,925.21	493,577	$ 950,239,887	72.14%	$ 685,548,693	$ 866,983,765	$ 614,388,596
MEG03 - SSI & Related - Dual Eligible	$ 1,937.21	447,801	$ 867,484,358	72.14%	$ 625,844,880	$ 609,503,295	$ 430,114,035
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	72.14%	$ 49,700,066	$ 68,889,323	$ 48,608,306
MEG09 HQII	NA	NA	$ 5,764,727	72.14%	$ 4,158,951	$ 7,359,077	$ 5,234,511
Grand Total			**$ 3,816,470,759**		**$ 2,753,385,305**	**$ 3,102,451,264**	**$ 2,238,257,348**

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%	$ 1,963,462,698	$ 1,363,120,735	$ 1,362,211,038
Grand Total			**$ 1,964,773,916**		**$ 1,963,462,698**	**$ 1,363,120,735**	**$ 1,362,211,038**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,753,385,305**
Federal Share (Title XIX) Actual Reported	$ 2,238,257,348
Excess Spending - Test 1	$ 15,674,967
Excess Spending - Test 2	$ -
Total Actuals	$ 2,253,932,315
Difference (Actuals - Limit)	$ (499,452,990)
Percentage Difference	-18.1%

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, FFY2020 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY2020 Quarter 4. Report pulled on 11/03/2020.

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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	73.07%	$ 1,461,055,357	$ 1,593,627,368	$ 1,186,701,910
MEG02 - SSI & Related - Medicaid Only	$ 2,008.00	487,798	$ 979,495,999	73.07%	$ 715,715,728	$ 845,979,008	$ 606,609,382
MEG03 - SSI & Related - Dual Eligible	$ 2,020.51	443,071	$ 895,229,176	73.07%	$ 654,142,132	$ 564,271,364	$ 402,855,014
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	73.07%	$ 50,337,288	$ 68,889,323	$ 49,178,612
MEG09 HQII	NA	NA	$ 8,825,544	73.07%	$ 6,448,807	$ 8,825,541	$ 6,368,511
Grand Total			**$ 3,951,973,963**		**$ 2,887,699,312**	**$ 3,081,592,604**	**$ 2,251,713,429**

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%	$ 2,006,841,842	$ 1,415,732,252	$ 1,347,071,623
Grand Total			**$ 2,109,131,150**		**$ 2,006,841,842**	**$ 1,415,732,252**	**$ 1,347,071,623**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,887,699,312**
Federal Share (Title XIX) Actual Reported	$ 2,251,713,429
Excess Spending - Test 1	$ 16,592,662
Excess Spending - Test 2	$ -
Total Actuals	$ 2,268,306,091
Difference (Actuals - Limit)	$ (619,393,221)
Percentage Difference	-21.4%

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, FFY2020 Quarter 4 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY2020 Quarter 4. Report pulled on 11/03/2020.

ATTACHMENT A

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	74.04%	$ 1,471,163,040	$ 1,564,968,618	$ 1,182,090,942
MEG02 - SSI & Related - Medicaid Only	$ 2,094.34	459,830	$ 963,039,856	74.04%	$ 713,020,492	$ 795,236,036	$ 576,784,792
MEG03 - SSI & Related - Dual Eligible	$ 2,107.39	432,715	$ 911,899,885	74.04%	$ 675,157,213	$ 558,422,305	$ 403,166,440
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.04%	$ 51,004,638	$ 68,889,323	$ 50,084,411
MEG09 HQII	NA	NA	$ 12,011,853	74.04%	$ 8,893,399	$ 12,011,853	$ 8,679,765
Grand Total			**$ 3,942,864,653**		**$ 2,919,238,782**	**$ 2,999,528,135**	**$ 2,220,806,350**

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	94.20%	$ 2,005,349,644	$ 1,463,179,030	$ 1,378,357,614
Grand Total			**$ 2,128,754,916**		**$ 2,005,349,644**	**$ 1,463,179,030**	**$ 1,378,357,614**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,919,238,782**
Federal Share (Title XIX) Actual Reported	$ 2,220,806,350
Excess Spending - Test 1	$ 20,637,930
Excess Spending - Test 2	$ -
Total Actuals	$ 2,241,444,280
Difference (Actuals - Limit)	$ (677,794,502)
Percentage Difference	-23.2%

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, FFY2020 Quarter 4 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY2020 Quarter 4. Report pulled on 11/03/2020.

ATTACHMENT A

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	4,314,293	$ 1,984,562,244	74.53%	$ 1,479,037,576	$ 1,720,240,899	$ 1,306,670,166
MEG02 - SSI & Related - Medicaid Only	$ 2,158.77	448,829	$ 968,920,207	74.53%	$ 722,108,565	$ 859,130,719	$ 628,106,233
MEG03 - SSI & Related - Dual Eligible	$ 2,057.62	432,860	$ 890,659,297	74.53%	$ 663,782,944	$ 556,442,708	$ 402,975,649
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.53%	$ 51,341,245	$ 68,889,316	$ 50,437,970
MEG09 HQII	NA	NA	$ 12,011,853	74.53%	$ 8,952,091	$ 12,000,002	$ 9,127,363
Grand Total			**$ 3,925,042,925**		**$ 2,925,222,422**	**$ 3,216,703,644**	**$ 2,397,317,381**

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	2,985	$ 17,155,680	72.42%	$ 12,424,127	$ 11,380,521	$ 8,246,157
MEG 05 - "217 Like" Dual Eligible	$ 3,661.18	50,770	$ 185,878,356	72.42%	$ 134,612,923	$ 143,870,505	$ 104,186,483
Grand Total			**$ 203,034,037**		**$ 147,037,049**	**$ 155,251,026**	**$ 112,432,640**

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	3,072,364	$ 2,268,079,686	93.24%	$ 2,114,792,001	$ 1,550,784,180	$ 1,445,974,760
Grand Total			**$ 2,268,079,686**		**$ 2,114,792,001**	**$ 1,550,784,180**	**$ 1,445,974,760**

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	$ -		$ -	0.00%	$ -	DY 06	
Grand Total			**$ -**		**$ -**	**$ -**	**$ -**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,925,222,422**
Federal Share (Title XIX) Actual Reported	$ 2,397,317,381
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ -
Total Actuals	$ 2,397,317,381
Difference (Actuals - Limit)	$ (527,905,041)
Percentage Difference	-18.0%

Notes:

1.) Member months as of October 1, 2020.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY2020 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY2020 Quarter 4. Report pulled on 11/03/2020.

ATTACHMENT A

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	3,366,109	$ 1,607,239,573	79.62%	$ 1,279,732,464	$ 1,353,068,754	$ 1,084,360,669
MEG02 - SSI & Related - Medicaid Only	$ 2,247.28	336,471	$ 756,145,674	79.62%	$ 602,065,916	$ 692,340,210	$ 547,533,157
MEG03 - SSI & Related - Dual Eligible	$ 2,141.98	322,771	$ 691,368,181	79.62%	$ 550,488,129	$ 464,209,777	$ 366,340,058
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	79.62%	$ 54,851,750	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	79.62%	$ 9,564,198	$ -	$ -
Grand Total			**$ 3,135,654,604**		**$ 2,496,702,457**	**$ 2,509,618,741**	**$ 1,998,233,884**

Table 7.2: 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 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	2,258	$ 13,380,993	78.91%	$ 10,559,418	$ 9,073,092	$ 7,160,150
MEG 05 - "217 Like" Dual Eligible	$ 3,811.29	43,950	$ 167,506,348	78.91%	$ 132,185,222	$ 139,521,098	$ 110,100,815
Grand Total			**$ 180,887,340**		**$ 142,744,639**	**$ 148,594,190**	**$ 117,260,965**

Table 7.3: 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 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	2,425,164	$ 1,874,448,167	90.27%	$ 1,692,020,245	$ 1,402,894,366	$ 1,266,359,727
Grand Total			**$ 1,874,448,167**		**$ 1,692,020,245**	**$ 1,402,894,366**	**$ 1,266,359,727**

Table 7.4: 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 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	$ -		$ -	0.00%	$ -	DY 06	
Grand Total			**$ -**		**$ -**	**$ -**	**$ -**

Table 7.5: DY 6 Assessment of Budget Neutrality (STC 93, 96, 105)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,496,702,457**
Federal Share (Title XIX) Actual Reported	$ 1,998,233,884
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ -
Total Actuals	$ 1,998,233,884
Difference (Actuals - Limit)	$ (498,468,573)
Percentage Difference	-20.0%

Notes:

1.) Member months as of October 1, 2020.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY2020 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY2020 Quarter 4. Report pulled on 11/03/2020.

MAP Waivers

Waiver Name	A	01	02	03	04
MEG1-TANF & Related	0	1,486,759,546	1,533,690,327	1,549,715,804	1,593,627,368
MEG2- SSI Medicaid Only	0	824,975,534	882,933,884	866,983,765	845,979,008
MEG3- SSI DUAL	0	570,643,867	584,267,888	609,503,295	564,271,364
MEG4-217	0	6,662,064	5,591,208	7,580,640	12,512,314
MEG5- 217 DUAL	0	86,786,741	85,077,407	91,901,521	112,740,550
MEG6-VIII GROUP	0	856,047,942	1,309,507,471	1,363,120,735	1,415,732,252
MEG8-UHC-Uncompensated care	0	68,889,322	36,005,978	0	0
MEG9-HQII-Hospital Quality Improve Incentive	0	0	2,824,462	0	0
UC	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	31,288,995	68,889,323	68,889,323
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	7,359,077	8,825,541
Total	**0**	**3,900,765,017**	**4,471,187,620**	**4,565,054,160**	**4,622,577,720**
Check		*3,900,765,017*	*4,471,187,620*	*4,565,054,160*	*4,622,577,720*
Difference		*0*	*0*	*0*	*0*
Difference from Previous		(557)	(30)	(161,347)	5,386,403

Waiver Name	A	01	02	03	04
MEG1-TANF & Related	0	1,070,401,817	1,116,190,097	1,139,911,900	1,186,701,910
MEG2- SSI Medicaid Only	0	574,937,245	619,375,970	614,388,596	606,609,382
MEG3- SSI DUAL	0	395,585,750	408,062,785	430,114,035	402,855,014
MEG4-217	0	4,617,656	3,906,915	5,353,671	8,934,265
MEG5- 217 DUAL	0	60,154,448	59,416,310	64,866,189	80,515,170
MEG6-VIII GROUP	0	856,022,312	1,309,446,155	1,362,211,038	1,347,071,623
MEG8-UHC-Uncompensated care	0	47,671,411	25,207,785	0	0
MEG9-HQII-Hospital Quality Improve Incentive	0	0	1,987,574	0	0
UC	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	21,781,306	48,608,306	49,178,612
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	5,234,511	6,368,511
Total	**0**	**3,009,390,640**	**3,565,374,897**	**3,670,688,246**	**3,688,234,487**
Check		*3,009,390,640*	*3,565,374,897*	*3,670,688,246*	*3,688,234,487*
Difference		*0*	*0*	*0*	*0*

M-CHIP Waivers

Waiver Name	A	01	02	03	04
MEG7-CHIP GROUP	0	84,356,751	123,819,527	118,474,494	106,620,355
Total	**0**	**84,356,751**	**123,819,527**	**118,474,494**	**106,620,355**

Waiver Name	A	01	02	03	04
MEG7-CHIP GROUP	0	66,272,555	105,308,829	118,474,494	106,620,355
Total	**0**	**66,272,555**	**105,308,829**	**118,474,494**	**106,620,355**

ADM Waivers

Waiver Name	A	01	02	03	04
Admin	0	109,509,693	0	0	0
MEG1-TANF & Related	0	1,954,350	65,528,478	65,128,092	75,672,882
MEG2- SSI Medicaid Only	0	0	7,492,116	7,098,152	8,204,996
MEG3- SSI DUAL	0	0	6,533,901	6,432,635	7,626,009
MEG4-217	0	0	38,287	33,620	78,602
MEG5- 217 DUAL	0	0	408,067	443,667	673,384
MEG6-VIII GROUP	0	36,509,156	42,521,593	46,219,961	60,776,652
MEG7-CHIP GROUP	0	972,016	9,725,447	8,862,780	10,909,982
Total	**0**	**148,945,215**	**132,247,889**	**134,218,907**	**163,942,507**
Check		*148,945,215*	*132,247,889*	*134,218,907*	*163,942,507*
Difference		*0*	*0*	*0*	*0*
Difference from Previous		-	-	-	-

Waiver Name	A	01	02	03	04
Admin	0	72,320,580	0	0	0
MEG1-TANF & Related	0	1,033,347	40,960,378	40,581,487	48,575,411
MEG2- SSI Medicaid Only	0	0	4,682,951	4,421,346	5,263,719
MEG3- SSI DUAL	0	0	4,084,108	4,007,329	4,887,719
MEG4-217	0	0	23,899	21,025	50,385
MEG5- 217 DUAL	0	0	255,098	276,989	432,086
MEG6-VIII GROUP	0	24,041,491	26,579,123	28,804,937	38,875,056
MEG7-CHIP GROUP	0	644,187	6,078,767	5,514,776	6,957,623
Total	**0**	**98,039,605**	**82,664,324**	**83,627,889**	**105,041,999**
Check		*98,039,605*	*82,664,324*	*83,627,889*	*105,041,999*
Difference		*0*	*0*	*0*	*0*

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Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 3/2(

Summary of Expenditures by Waiver Yea
Waiver: 11W00285

Total Computable

05	06	07	08	09	10	11	12
1,564,968,618	1,720,240,899	1,353,068,754	0	0	0	0	0
795,236,036	859,130,719	692,340,210	0	0	0	0	0
558,422,305	556,442,708	464,209,777	0	0	0	0	0
12,068,447	11,380,521	9,073,092	0	0	0	0	0
134,725,706	143,870,505	139,521,098	0	0	0	0	0
1,463,179,030	1,550,784,180	1,402,894,366	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	0
68,889,323	68,889,316	0	0	0	0	0	0
12,011,853	12,000,002	0	0	0	0	0	0
4,609,501,318	**4,922,738,850**	**4,061,107,297**	**0**	**0**	**0**	**0**	**0**
4,609,501,318	*4,922,738,850*	*4,061,107,297*					
0	*0*	*0*					
(4,287,808)	(8,219,747)	1,467,347,237					

05	06	07	08	09	10	11	12
1,182,090,942	1,306,670,166	1,084,360,669	0	0	0	0	0
576,784,792	628,106,233	547,533,157	0	0	0	0	0
403,166,440	402,975,649	366,340,058	0	0	0	0	0
8,714,682	8,246,157	7,160,150	0	0	0	0	0
97,261,654	104,186,483	110,100,815	0	0	0	0	0
1,378,357,614	1,445,974,760	1,266,359,727	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	0
50,084,411	50,437,970	0	0	0	0	0	0
8,679,765	9,127,363	0	0	0	0	0	0
3,705,140,300	**3,955,724,781**	**3,381,854,576**	**0**	**0**	**0**	**0**	**0**
3,705,140,300	*3,955,724,781*	*3,381,854,576*					
0	*0*	*0*					

Total Computable

05	06	07	08	09	10	11	12
97,502,859	103,812,389	87,234,631	0	0	0	0	0
97,502,859	**103,812,389**	**87,234,631**	**0**	**0**	**0**	**0**	**0**

Federal Share

05	06	07	08	09	10	11	12
97,502,626	101,682,379	84,390,784	0	0	0	0	0
97,502,626	**101,682,379**	**84,390,784**	**0**	**0**	**0**	**0**	**0**

Total Computable

05	06	07	08	09	10	11	12
8,558,331	195,550,010	139,756,096	0	0	0	0	0
80,475,712	0	46,869,487	0	0	0	0	0
8,455,296	0	0	0	0	0	0	0
7,887,696	0	0	0	0	0	0	0
73,212	0	0	0	0	0	0	0
847,932	0	0	0	0	0	0	0
59,252,561	0	0	0	0	0	0	0
9,242,308	0	0	0	0	0	0	0
174,793,048	**195,550,010**	**186,625,583**	**0**	**0**	**0**	**0**	**0**
174,793,048	*195,550,010*	*186,625,583*					
0	*0*	*0*					
-	-	75,719,267					

05	06	07	08	09	10	11	12
6,523,508	128,459,080	96,276,386	0	0	0	0	0
50,855,108	0	26,033,764	0	0	0	0	0
5,343,838	0	0	0	0	0	0	0
4,986,257	0	0	0	0	0	0	0
46,287	0	0	0	0	0	0	0
536,858	0	0	0	0	0	0	0
37,448,951	0	0	0	0	0	0	0
5,840,810	0	0	0	0	0	0	0
111,581,617	**128,459,080**	**122,310,150**	**0**	**0**	**0**	**0**	**0**
111,581,617	*128,459,080*	*122,310,150*					
0	*0*	*0*					

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13	14	15	16	17	18	19	20	21
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	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	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	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13	14	15	16	17	18	19	20	21
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	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	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	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13	14	15	16	17	18	19	20	21
0	0	0	0	0	0	0	0	0
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13	14	15	16	17	18	19	20	21
0	0	0	0	0	0	0	0	0
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13	14	15	16	17	18	19	20	21
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	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	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**

13	14	15	16	17	18	19	20	21
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	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	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**

22	23	24	25	Total	Total Less Non-Adds
0	0	0	0	10,802,071,316	10,802,071,316
0	0	0	0	5,767,579,156	5,767,579,156
0	0	0	0	3,907,761,204	3,907,761,204
0	0	0	0	64,868,286	64,868,286
0	0	0	0	794,623,528	794,623,528
0	0	0	0	9,361,265,976	9,361,265,976
0	0	0	0	104,895,300	104,895,300
0	0	0	0	2,824,462	2,824,462
0	0	0	0	0	0
0	0	0	0	306,846,281	306,846,281
0	0	0	0	40,196,473	40,196,473
0	**0**	**0**	**0**	**31,152,931,982**	**31,152,931,982**

22	23	24	25	Total	Total Less Non-Adds
0	0	0	0	8,086,327,501	8,086,327,501
0	0	0	0	4,167,735,375	4,167,735,375
0	0	0	0	2,809,099,731	2,809,099,731
0	0	0	0	46,933,496	46,933,496
0	0	0	0	576,501,069	576,501,069
0	0	0	0	8,965,443,229	8,965,443,229
0	0	0	0	72,879,196	72,879,196
0	0	0	0	1,987,574	1,987,574
0	0	0	0	0	0
0	0	0	0	220,090,606	220,090,606
0	0	0	0	29,410,150	29,410,150
0	**0**	**0**	**0**	**24,976,407,927**	**24,976,407,927**

22	23	24	25	Total	Total Less Non-Adds
0	0	0	0	721,821,006	721,821,006
0	**0**	**0**	**0**	**721,821,006**	**721,821,006**

22	23	24	25	Total	Total Less Non-Adds
0	0	0	0	680,252,022	680,252,022
0	**0**	**0**	**0**	**680,252,022**	**680,252,022**

22	23	24	25	Total	Total Less Non-Adds
0	0	0	0	453,374,130	453,374,130
0	0	0	0	335,629,001	335,629,001
0	0	0	0	31,250,560	31,250,560
0	0	0	0	28,480,241	28,480,241
0	0	0	0	223,721	223,721
0	0	0	0	2,373,050	2,373,050
0	0	0	0	245,279,923	245,279,923
0	0	0	0	39,712,533	39,712,533
0	**0**	**0**	**0**	**1,136,323,159**	**1,136,323,159**

22	23	24	25	Total	Total Less Non-Adds
0	0	0	0	303,579,554	303,579,554
0	0	0	0	208,039,495	208,039,495
0	0	0	0	19,711,854	19,711,854
0	0	0	0	17,965,413	17,965,413
0	0	0	0	141,596	141,596
0	0	0	0	1,501,031	1,501,031
0	0	0	0	155,749,558	155,749,558
0	0	0	0	25,036,163	25,036,163
0	**0**	**0**	**0**	**731,724,664**	**731,724,664**

MEMBER MONTHS

CENTENNIAL CARE MEG REPORTING

Eligibility Group	CY 2016 Quarter 1	2	3	4
Population 1 – TANF and Related	1,130,779	1,150,300	1,169,603	1,170,974
Population 2 – SSI and Related – Medicaid Only	123,597	122,633	123,728	123,619
Population 3 – SSI and Related - Dual	110,017	111,379	113,425	112,980
Population 4 – 217-like Group – Medicaid Only	566	1064	564	793
Population 5 – 217-like Group - Dual	6,938	8,390	7,911	8,627
Population 6 – VIII Group (expansion)	753,995	761,293	778,625	784,161
Population 7 - CHIP Group	151,824	140,006	134,983	132,292
Total	**2,277,716**	**2,295,065**	**2,328,839**	**2,333,446**

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	CY 2017 Quarter					CY 2018 Quarter		
Total	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**
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
493,577	124,408	125,136	122,027	116,227	**487,798**	116,043	115,944	114,284
447,801	111,537	111,883	111,273	108,378	**443,071**	108,032	108,101	108,318
2,987	1,133	1,006	857	801	**3,797**	830	835	853
31,866	9,714	10,023	10,181	10,491	**40,409**	11,050	11,820	12,257
3,078,074	806,114	802,658	773,108	762,010	**3,143,890**	762,410	756,109	747,006
559,105	133,031	130,727	123,340	117,212	**504,310**	117,719	113,236	109,585
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**

		CY 2019 Quarter					CY 2020	
4	Total	1	2	3	4	Total	1	2
1,085,709	**4,422,938**	1,078,873	1,078,079	1,079,775	1,077,566	**4,314,293**	1,080,715	1,121,158
113,559	**459,830**	112,788	112,385	112,000	111,656	**448,829**	112,136	111,782
108,264	**432,715**	108,143	108,169	108,315	108,233	**432,860**	108,050	107,570
789	**3,307**	754	751	746	734	**2,985**	719	768
12,311	**47,438**	12,167	12,421	12,828	13,354	**50,770**	14,040	14,702
753,639	**3,019,164**	759,193	766,481	768,268	778,422	**3,072,364**	784,249	815,275
111,810	**452,350**	113,954	111,658	112,486	115,498	**453,596**	118,775	113,953
2,186,081	**8,837,742**	**2,185,872**	**2,189,944**	**2,194,418**	**2,205,463**	**8,775,697**	**2,218,684**	**2,285,208**
				6,570,234				
				74.9%				
							723	1130

Quarter

3	4	Total
1,164,236		**3,366,109**
112,553		**336,471**
107,151		**322,771**
771		**2,258**
15,208		**43,950**
825,640		**2,425,164**
116,224		**348,952**
2,341,783	**0**	**6,845,675**

9,143,597	4.2%	
1853	2,258	405
#REF!	$9,073,092	#REF!
#REF!	$ 4,018.20	#REF!

Table #9 - Waiver Year 6 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
Admin		**195,550,010**
MEG01 - TANF & Related	$ 1,720,240,899	$ -
MEG02 - SSI & Related - Medicaid Only	$ 859,130,719	$ -
MEG03 - SSI & Related - Dual Eligible	$ 556,442,708	$ -
MEG04 - "217 Like" Medicaid Only	$ 11,380,521	$ -
MEG05 - "217 Like" Dual Eligible	$ 143,870,505	$ -
MEG06 - VIII Group - Medicaid Expansion	$ 1,550,784,180	$ -
MEG07 - CHIP	$ 103,812,389	$ -
Uncompensated Care "UC" Pool	$ 68,889,316	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ 12,000,002	N/A
Grand Total	**$ 5,026,551,239**	**$ 195,550,010**

Source: New Mexico CMS 64 Submission, FFY 2020 Quarer 4, October 3, 2020.

Key Utilization / Cost per Unit Statistics by Major Population Group

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Inpatient (Admissions)	100.4	90.8	$ 9,597	$ 8,715
Inpatient (Days)	449.1	385.3	$ 2,146	$ 2,053
Practitioner / Physician (Services)	8,397.7	7,105.0	$ 73	$ 80
Emergency Department (Visits)	589.8	505.2	$ 366	$ 435
Outpatient (Visits)	1,651.2	1,476.0	$ 276	$ 284
Pharmacy (Scripts)	4,808.7	4,559.4	$ 62	$ 69
Other (Services)1	9,233.7	7,708.2	$ 59	$ 61

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Brand	11.5%	10.1%	$ 398	$ 498
Generic	87.1%	87.3%	$ 17	$ 20
Other Rx2	1.5%	2.6%	$ 92	$ 53

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

Adult Expansion: Other Adult Group

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Inpatient (Admissions)	84.1	74.1	$ 14,317	$ 15,810
Inpatient (Days)	608.7	762.5	$ 1,977	$ 1,537
Practitioner / Physician (Services)	9,008.2	7,675.1	$ 83	$ 91
Emergency Department (Visits)	726.9	628.5	$ 517	$ 606
Outpatient (Visits)	2,359.9	2,063.9	$ 306	$ 340
Pharmacy (Scripts)	9,445.0	9,004.4	$ 78	$ 87
Other (Services)1	10,166.7	8,852.0	$ 67	$ 70

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Brand	10.2%	9.8%	$ 616	$ 715
Generic	88.0%	88.0%	$ 15	$ 17
Other Rx2	1.8%	2.2%	$ 99	$ 84

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

Key Utilization / Cost per Unit Statistics by Major Population Group

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Inpatient (Admissions)	219.6	177.7	$ 2,852	$ 2,952
Inpatient (Days)	1,267.6	986.0	$ 494	$ 532
Nursing Home (Days)	312,429.6	255,744.3	$ 41	$ 44
Personal Care (Services / hr.)	750,145.2	692,835.6	$ 16	$ 17
Outpatient (Visits)	5,110.4	4,266.4	$ 160	$ 174
Pharmacy (Scripts)	947.0	792.6	$ 24	$ 13
HCBS (Services)	4,747.1	4,811.3	$ 178	$ 196
Other (Services)1	41,812.5	35,920.9	$ 47	$ 50

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Brand	13.1%	10.1%	$ 126	$ 60
Generic	84.3%	77.5%	$ 7	$ 6
Other Rx2	2.6%	12.4%	$ 56	$ 14

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Inpatient (Admissions)	350.8	312.1	$ 15,994	$ 16,729
Inpatient (Days)	2,515.9	2,209.9	$ 2,230	$ 2,362
Nursing Home (Days)	18,089.7	14,986.2	$ 186	$ 205
Personal Care (Services / hr.)	732,585.7	650,986.0	$ 16	$ 18
Outpatient (Visits)	7,939.6	7,385.4	$ 517	$ 506
Pharmacy (Scripts)	37,364.1	35,727.9	$ 82	$ 97
HCBS (Services)	10,442.0	12,588.2	$ 108	$ 116
Other (Services)1	62,505.8	57,378.0	$ 91	$ 95

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Brand	11.1%	10.8%	$ 590	$ 718
Generic	86.7%	86.3%	$ 17	$ 20
Other Rx2	2.2%	2.9%	$ 97	$ 83

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

Key Utilization / Cost per Unit Statistics by Major Population Group

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Inpatient (Admissions)	193.8	153.8	$ 9,262	$ 6,904
Inpatient (Days)	1,208.1	748.4	$ 1,486	$ 1,419
Nursing Home (Days)	9,143.3	3,225.4	$ 23	$ 34
Personal Care (Services / hr.)	-	-	$ -	$ -
Outpatient (Visits)	7,105.0	5,853.3	$ 247	$ 286
Pharmacy (Scripts)	13,986.2	12,916.9	$ 143	$ 128
HCBS (Services)	302,996.2	302,041.7	$ 91	$ 90
Other (Services)1	53,674.8	42,964.8	$ 52	$ 58

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Brand	14.2%	13.2%	$ 810	$ 751
Generic	83.0%	83.3%	$ 30	$ 31
Other Rx2	2.8%	3.5%	$ 124	$ 82

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Inpatient (Admissions)	73.4	65.4	$ 4,518	$ 4,093
Inpatient (Days)	472.1	387.8	$ 702	$ 690
Practitioner / Physician (Services)	8,701.5	8,094.6	$ 25	$ 27
Emergency Department (Visits)	730.1	647.0	$ 186	$ 186
Outpatient (Visits)	2,995.8	2,439.5	$ 140	$ 150
Pharmacy (Scripts)	1,361.1	1,230.7	$ 25	$ 17
Other (Services)1	8,982.9	7,515.9	$ 93	$ 108

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Brand	20.1%	15.4%	$ 85	$ 58
Generic	78.0%	64.2%	$ 9	$ 10
Other Rx2	1.9%	20.4%	$ 66	$ 10

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

Key Utilization / Cost per Unit Statistics by Major Population Group

Behavioral Health Services - All Populations (PH, OAG, LTSS)

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Inpatient (Admissions)	43.6	38.2	$ 556	$ 608
Inpatient (Days)	95.2	86.9	$ 255	$ 268
BH Practitioner (services)	246.2	272.7	$ 124	$ 121
Core Service Agency (Services)	239.7	241.0	$ 150	$ 165
BH outpatient / clinic (Services)	3,660.0	3,578.0	$ 58	$ 66
Pharmacy (Scripts)	1,769.4	1,759.6	$ 56	$ 57
Residential Treatment Center (days)	51.6	36.8	$ 2,413	$ 3,055
Other (Services)1	27.7	21.2	$ 105	$ 116

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2018 - June 2019	July 2019 - June 2020	July 2018 - June 2019	July 2019 - June 2020
Brand	6.6%	4.4%	$ 492	$ 640
Generic	93.4%	95.6%	$ 26	$ 30
Other Rx2	0.0%	0.0%	$ -	$ -

Notes:

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

2 - Other Rx includes diabetic supplies.