TURQUOISE CARE DEMONSTRATION

1115 Demonstration Quarterly & Annual Report
Demonstration Year: 12 (7/1/2024 – 12/31/2024)
Quarter 2 of the Demonstration Year & Annual Report

April 30, 2025

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INTRODUCTION

On July 1, 2024, the State of New Mexico launched the New Mexico Health Care Authority, a new agency. The agency merged the New Mexico Human Services Department, the State Employee Benefits team from the General Services Department, and the Developmental Disabilities Supports Division and Division of Health Improvement from the New Mexico Department of Health, and the Health Care Affordability Fund from the Office of the Superintendent of Insurance. The New Mexico Health Care Authority will leverage purchasing power, partnerships and data analytics to create innovative policies and models of comprehensive coverage for New Mexicans.

The State of New Mexico primarily operates its Medicaid and Children's Health Insurance Program (CHIP) under a federal 1115 Demonstration Waiver authorized by the US Centers for Medicare & Medicaid Services (CMS). The demonstration authorizes the comprehensive managed care delivery system, the Home and Community-Based Services (HCBS) Community Benefit (CB) program and several transformative initiatives that serve most of the State's Medicaid beneficiaries. Following is the evolution of New Mexico's 1115 Demonstration Waiver:

- On July 12, 2013, CMS approved New Mexico's 1115 Demonstration Waiver under the name Centennial Care, January 1, 2014, through December 31, 2018, which created a comprehensive managed care delivery system offering the full array of Medicaid services, including acute care, pharmacy, behavioral health services, institutional services, and community-based long term services and supports. Other features included expanded care coordination for all beneficiaries and a member rewards program to provide incentives for members to pursue healthy behaviors.
- On December 14, 2018, CMS approved New Mexico's 1115 Demonstration Waiver extension under the name Centennial Care 2.0, effective January 1, 2019, through December 31, 2023, which featured an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care, pharmacy, behavioral health services, institutional services, and HCBS.
- On February 7, 2020, CMS approved New Mexico's 1115 Demonstration Waiver Amendment, effective February 7, 2020, through December 31, 2023. The amendment removed three authorities: co-payments for non-emergency use of the emergency room and non-preferred prescription drugs, monthly premiums for the

Adult Expansion Group, and limitations on retroactive eligibility beginning on February 8, 2020. Additionally, the amendment authorized the state to increase the number of CB slots and expand the Centennial Home Visiting pilot program by removing restrictions.

- On March 28, 2023, CMS approved New Mexico's 1115 Demonstration Waiver amendment, effective March 28, 2023, through December 31, 2023. The amendment provided expenditure authority for two initiatives: short-term stays in applicable Institutions for Mental Diseases (IMDs) for diagnoses of serious mental illness (SMI) and/or serious emotional disturbance (SED); and implementation of a High-Fidelity Wraparound (HFW) intensive care coordination benefit. The amendment also approved HCBS improvements, including increases to CB slots and specific benefit limits.
- On September 5, 2023, CMS approved a temporary extension of New Mexico's Centennial Care 2.0 demonstration extending the expiration date from December 31, 2023, to December 31, 2024, to allow New Mexico and CMS to continue negotiations over New Mexico's demonstration application submitted on December 15, 2022.
- On September 7, 2023, CMS approved a time-limited amendment to New Mexico's 1115 Demonstration Waiver, Centennial Care 2.0, effective May 11, 2023, to November 11, 2023, to provide expenditure authority for payments to Legally Responsible Individuals (LRIs) rendering personal care services (PCS).
- On December 15, 2023, CMS approved an amendment to New Mexico's Centennial Care 2.0 demonstration effective January 1, 2024, through December 31, 2024, for a number of initiatives included in the state's demonstration extension application submitted on December 15, 2022. The amendment included approval for the following: LRIs providing PCS to members receiving benefits under the CB and Early and Periodic Screening, Diagnostic and Treatment programs; increased enrollment limit for CB program from 6,789 to 7,789 slots; increased enrollment limit for supportive housing program from 180 to 450 members with SMI; continuous eligibility for children up to age six; and expansion of the Home Visiting program to incorporate additional evidence based models.
- On July 25, 2024, CMS approved New Mexico's 1115 Demonstration Waiver extension under the name Turquoise Care, July 25, 2024, through December 31, 2029. The extension approval time period incorporated a 6-month temporary extension period and New Mexico's request to align the demonstration years with the calendar year to reflect New Mexico's managed care contract schedule. The demonstration extension includes approval of longstanding authorities as well as new initiatives including the Reentry Demonstration initiative and the Health-Related Social Needs (HRSN) Services program, which includes Medical Respite and meals

for pregnant members. The extension also approved expansions to Supportive Housing and CB Home-Delivered Meals and phased out the Family Planning waiver authority and a Self-Directed CB healer benefit.
- On October 16, 2024, CMS approved an amendment to New Mexico's 1115 Demonstration Waiver providing expenditure authority for coverage of traditional health care practices effective October 16, 2024, through December 31, 2029.

Turquoise Care's goals and initiatives center on improving core health outcomes and attending to the social and economic determinants of health, and in particular addressing the needs of the State's historically underserved populations. New Mexico's vision is that every Medicaid member has high-quality, well-coordinated, person-centered care to achieve their personally defined health and wellness goals. To advance on these opportunities and move closer to this vision, the New Mexico Health Care Authority (HCA) will operate a data-driven Medicaid program that measures quality based on population health outcomes.

With the launch of Turquoise Care, New Mexico contracted with different MCOs. HCA's quarterly and annual monitoring reports for Calendar Year (CY) 2024 will reflect data and information for the MCOs as specified below.

Demonstration Year (DY) 11 Quarter 1 (January – March) and 2 (April – June) reports include data and information for the following Centennial Care 2.0 MCOs:
- BlueCross BlueShield of New Mexico (BCBS),
- Presbyterian Health Plan (PHP), and
- Western Sky Community Plan (WSCC).

DY12 Quarter 1 (July – September) and 2 (October – December) reports, and DY13 (CY2025) future reports will include data and information for the following Turquoise Care MCOs:
- BlueCross BlueShield of New Mexico (BCBS),
- Presbyterian Health Plan (PHP),
- Molina Health Care (MHC), and
- United Health Care (UHC).

HCA is refining its monitoring report structure to comply with the current Special Terms and Conditions (STCs) executed between New Mexico and CMS. Report refinements will continue to be made with a target completion date of DY13 (CY2025) reporting.

TURQUOISE CARE POST AWARD FORUMS

On August 20, 2024, HCA provided an update on the implementation of Turquoise Care to the Medicaid Advisory Committee (MAC), which serves as the post award forum meeting. HCA presented progress reports on the Turquoise Care waiver at all subsequent MAC meetings. All MAC meetings have a public comment opportunity. The following includes a summary of all MAC meetings held in 2024.

During the May 6, 2024, MAC meeting the following topics were addressed in support of the Turquoise Care waiver and Medicaid 1115 demonstration waiver renewal:

- Leadership update – Provided budget update,
- Updates on approved State Plan Amendments,
- 1115 Demonstration Updates – Included information on approved services, ongoing waivers, and updates to the 1902 Eligibility Waiver to include approval from CMS to extend eligibility for seniors received long-erm care and individuals with disabilities,
- Maternal Health Strategy and the impact of Maternal Mortality Review Committee on policy including key findings, proposed interventions, and recommendations,
- Update on Health Care Authority (HCA) including a transition timeline and operational changes being completed by June 2024,
- Turquoise Care overview – Including transitions and goals to include enhancing healthcare delivery, implementing payment reforms, addressing health disparities, and supporting Children in State Custody through Presbyterian Healthcare, and
- Medicaid Management Information System Replacement (MMISR) - Included updates on MMISR project overview, go live dates, and module updates.

A Special Session of the Medicaid Advisory Committee meeting was held during DY11 Q2 on June 20, 2024 (date correction for the DY11 Q2 report). The following topics were discussed:

- Medicaid Forward Plan per HB400 (2023) – Discussion included partnering with Mercer Government Human Services Consulting to conduct a study mandated by the bill, and assess impacts on enrollment, premiums, provider reimbursement, costs, waivers, and budgets, including effects on other insurance markets.
- Update provided on CMS Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) changes and new requirements. Provided an overview of the timeline and highlighted bills impacting Medicaid.

During the August 5, 2024, MAC meeting the following topics were addressed in support of the Medicaid 1115 demonstration waiver renewal and implementation of Turquoise Care:

- Budget and 1115 Demonstration updates,

- Review of new benefit implementation progress including Community Health Worker (CHW) services, step therapy pharmacy, delivery of necessary diabetic resources, and mobile crisis intervention and mobile response and stabilization services.
- Progress on the development of the Behavioral Health continuum of care and the increases of Medicaid BH provider enrollment,
- Presentation of the justice-related program: Reach, Intervene, Support and Engage (RISE), which in collaboration with managed care organizations (MCOs), assists justice-involved Medicaid members with warm hand-offs to care coordination in the community,
- Medicaid Management Information System Replacement (MMISR) – Announcement that the Benefit Management Services (Provider Enrollment) module will be going live on October 30, 2024, and the Unified Portal will be going live for Medicaid applicants on August 22, 2024.

During October 2024, there was a series of MAC Membership and Bylaws Subcommittee Meetings. MAC Membership Subcommittee Meetings were held with the goal of developing effective strategies for recruiting future MAC members and to create a plan to gradually build a Beneficiary Advisory Committee (BAC) membership. The Bylaws Subcommittee Meetings were held to discuss and update the MAC bylaws and establish the Beneficiary Advisory Committee (BAC) bylaws.

- October 1, 2024 – MAC Membership Subcommittee Meeting
- October 1, 2024 – MAC Bylaws Subcommittee Meeting
- October 15, 2024 – MAC Membership Subcommittee Meeting II
- October 18, 2024 – MAC Bylaws Subcommittee Meeting II
- October 25, 2024 – MAC Bylaws Subcommittee Meeting III
- October 28, 2024 – MAC Member Subcommittee Meeting III

Following the series of Subcommittee Meetings in October, a regular Medicaid Advisory Committee meeting was held during DY12 Q2 on November 4, 2024. The following topics were discussed:

- Presentation of Subcommittee Reports: Bylaws and Membership Subcommittees,
- Discussion of MAC 2025 Calendar and 2025 Strategic Plan and that all updates will be on the HCA website,
- Financial Update including a projection model overview,
- Review of Value Based Programs and Primary Care Payment Reform implementation progress,
- Discussion of New Benefits detail and timelines,
- Overview of Justice Re-Entry Program progress,

- Discussion about Presumptive Eligibility training, testing, and methodologies,
- Update on the Medicaid Management Information System Replacement (MMISR) – Benefit Management Services module and presumptive eligibility determiners going live in November, and
- Notification that the Medicaid Forward Letter is live on the HCA website and available to review.

An opportunity to provide public comment on the progress of the demonstration was provided. At the November 4, 2024 meeting, a MAC Member asked about audits as a means to assure greater accountability for MCOs. Discussion included MCO data and reporting as well as audits and oversight. The MAC Member is particularly interested in spot checks on networks showing gaps. A MAC Member seconded the need for MCO accountability and suggested a standing Eligibility and Enrollment Subcommittee. All stakeholder feedback gathered at the Medicaid Advisory Committee (MAC) as well as other public forums have been and will continue to be used to monitor and inform the development of the Turquoise Care waiver. The following is a listing of MAC meeting dates that occurred in CY2024:

- March 4, 2024
- May 6, 2024
- June 20, 2024
- August 5, 2024
- November 4, 2024

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

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: DY12 QUARTER 2 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	9/30/2024 ENROLLMENT	12/31/2024 ENROLLMENT	PERCENT INCREASE / DECREASE Q4
BlueCross BlueShield of New Mexico (BCBS)	267,073	255,726	-4.2%
Presbyterian Health Plan (PHP)	364,496	347,395	-4.7%
UnitedHealthcare (UHC)	39,759	37,202	-6.9%
Molina Health Care (MHC)	41,222	39,167	-5.2%

Source: Medicaid Eligibility Reports, October 2024 and December 2024

TURQUOISE CARE ENROLLMENT

Turquoise Care MCO enrollment and expenditure data by programs for October 2022 – September 2024 is available in Attachment A to this report.

MCO Enrollment

In aggregate, MCO enrollment decreased by 10% from the previous-to-current period. This decrease is comprised of the following:

- 14% decrease in Physical Health enrollment,
- 5% decrease in Long-Term Services and Supports enrollment,
- 3% decrease in Other Adult Group enrollment.

Enrollment levels have continued to decline in recent months as a result of member disenrollments that began May 1, 2023. Enrollment graphs in Attachment A illustrate a decrease for the most recent month which is mostly due to retroactivity not yet accounted for at the cutoff date of the enrollment data (i.e., September 30, 2024). Historically, this decrease in the last month changes to an increase in the subsequent quarter due to additional runout.

MCO Per Capita Medical Costs:
In aggregate, total MCO per capita medical costs increased by 17% from the previous-to-current period. This consists of an 11% increase to pharmacy services and 18% for non-pharmacy services.

On a dollar basis, the lower enrollment levels (17%) have been offset by the increase in per capita medical costs (-10%), driving the 6% increase in total medical expenses.

TURQUOISE REWARDS
The Centennial Rewards program was renamed to Turquoise Rewards beginning DY12 Q1 and provides incentives to members for engaging in and completing healthy activities and behaviors. New Mexico modified its 2024 Turquoise Rewards Program as illustrated below.

Reward Activity	Age Requirement	2024 Modification
Address Update (supports PHE unwinding efforts)	Any	Added new reward activity
Adult Primary Care Provider (PCB) Checkup – Complete annual PCP wellness checkup	Ages 20+	Age requirement changed from Ages 22+ to 20+
Antidepressant Medication Management - Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	No Change
Breast Cancer Screening (BCS) – Complete mammogram	Ages 50-74	Added new reward activity
Cervical Cancer Screening (CCS) – Ages 21-64: Cervical cytology (pap test) Ages 30-64 high-risk women: HPV test and/or pap test	Ages 21-64	Added new reward activity
Childhood immunizations (CIS) – Complete immunization series	Age 2	Added new reward activity
Child & Adolescent Well-Care Visit - Complete annual wellness checkup with a PCP or an OB/GYN • Bonus: Adolescent Immunization Series – Complete adolescent immunization series by 13th birthday	Ages 3-21	No Change
Schedule and Complete First Medicaid Home Visit (MHV)	All ages	Added new reward activity
MHV Video Completion	All ages	Added new reward activity

First MHV after baby is born	All ages	Added new reward activity
Ongoing MHV Visits	All ages	Added new reward activity
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	No change
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75	No change
Flu Shot - Receive flu vaccine	Ages 6 months+	No change
1st Prenatal Care Visit – Complete prenatal care visit in the first trimester or within 42 days of enrollment	All ages	No change
Postpartum Visit – Complete postpartum care visit between 7 and 84 days after delivery	All ages	No change
Postpartum Depression Screening – Complete postpartum depression screening	All ages	Added new reward activity
Smoking/Vaping Prevention – Complete vaping/smoking prevention learning module	Age under 18	No change
Step-Up Challenge (FCHAL-SU-3)– Successfully complete 3-week Step-Up Challenge	Ages 10+	No change
Well-Baby Checkups – Complete up to six well-child visits with a PCP during the first 15 months of life and up to two well-child visits with a PCP between 16-30 months of life • Bonus: Complete all eight well-child visits with a PCP between 0-30 months of life	0-30 months	No change

Turquoise Rewards Participation

In DY12 Q2, 723,764 Turquoise Care members are participating in the Member Rewards program. Registering for the Turquoise Rewards program is not required to participate in the program but is required for reward redemption. Quality improvement and participation trends are demonstrated in the table below.

Table 2: Turquoise Rewards

TURQUOISE REWARDS				
	Jan – Mar 2024	Apr – Jun 2024	Jul – Sep 2024	Oct-Dec 2024
Number of Medicaid Enrollees Receiving a Turquoise Care Reward Service per Quarter*	200,373	182,437	150,441	128,009
Number of Members Newly Registered in the Rewards Program per Quarter**	3,332	5,003	6,911	8,103
Number of Members Who Redeemed Rewards per Quarter***	17,180	29,960	26,902	50,341

Source: Finity DY12 Quarter 2 Report

*Only includes rewards earned in relevant quarter. This measure is typically highest early in the year as the majority of members have gaps-in-care at that time.

**Members only need to register to redeem rewards. Registration is typically lowest early in the year as members save their reward points to spend when they have more buying power or during the holidays.

Turquoise Rewards Multimedia Campaigns

In DY12 Q2, Finity conducted the following multimedia campaigns to encourage members to complete their preventive care appointments, receive vaccinations, and complete targeted condition management activities that align with state performance, LFC, and HEDIS measures. All multimedia communications align with HSD's strategic goals and promote the healthy activities that members are eligible to complete to earn rewards by closing gaps-in-care.

Flu Shot Campaign: Designed to encourage members over 6 months old to go in for their flu shot. This reward is earned through self-attestation on the member portal. Members earn $5 or 50 reward points for completing their visit. Texts and emails were sent in October and November 2024.

- 307K texts sent in DY12 Q2
- 244K emails sent in DY12 Q2

Monthly Redemptions Campaign: Designed to notify members who have earned rewards that they have points to spend in the Turquoise Rewards Catalog on healthy items like oximeters, thermometers, cleaning supplies, diapers, nursing supplies, kitchen items, and more. Texts and emails were sent October through December 2024. This is an ongoing campaign; results are provided below:

- 367K texts sent in DY12 Q2
- 425K emails sent in DY12 Q2

Points Expiration Campaign: Designed to notify members who have earned rewards to spend their points before they expire. Texts and emails were sent in November and December. This is a DY12 Q2 campaign and results are provided below:

- 294K texts sent in DY12 Q2
- 247K emails sent in DY12 Q2

Well-Baby Immunization Campaign: Designed to encourage parents/guardians to complete immunizations for their babies ages 0-30 months. Campaign texts and emails were sent in October. This is an ongoing campaign and Q4 results are provided below:

- 25K texts sent in DY12 Q2
- 9K emails sent in DY12 Q2

Additional Key Stats through DY12 Q2 2024:

- In DY12 Q2 2024, the number of newly registered members increased by 17% over DY12 Q1, with 35% of the total new registrations occurring in DY12 Q2 for the year.
- With 50K members redeeming more than $2M in rewards, DY12 Q2 redemptions were higher than any quarter in the last 5 years.
- 128K members earned rewards for closing gaps-in-care, the most of any DY12 Q2 in program history.

Table 3: Turquoise Rewards Customer Satisfaction Survey

Turquoise Rewards Customer Satisfaction Survey									
	DY11 Q2			DY12 Q1			DY12 Q2		
	# OF RESPONDENTS 1,492			# OF RESPONDENTS 1,339			# OF RESPONDENTS 1,792		
	YES	NO	OTHER	YES	NO	OTHER	YE%S	NO	OTHER
Are you satisfied with the Turquoise Rewards Program?	96%	4%	n/a	98%	2%	n/a	98%	2%	n/a
Are you satisfied with your doctor?	87%	5%	8% I don't have a doctor	87%	3%	10% I don't have a doctor	87%	5%	8% I don't have a doctor
Are you satisfied with your health plan?	96%	4%	n/a	96%	4%	n/a	96%	4%	n/a
Are you satisfied with the help provided by your care coordinator?	92%	7%	<1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator

Source: Finity DY12 Quarter 2 Report

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ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

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

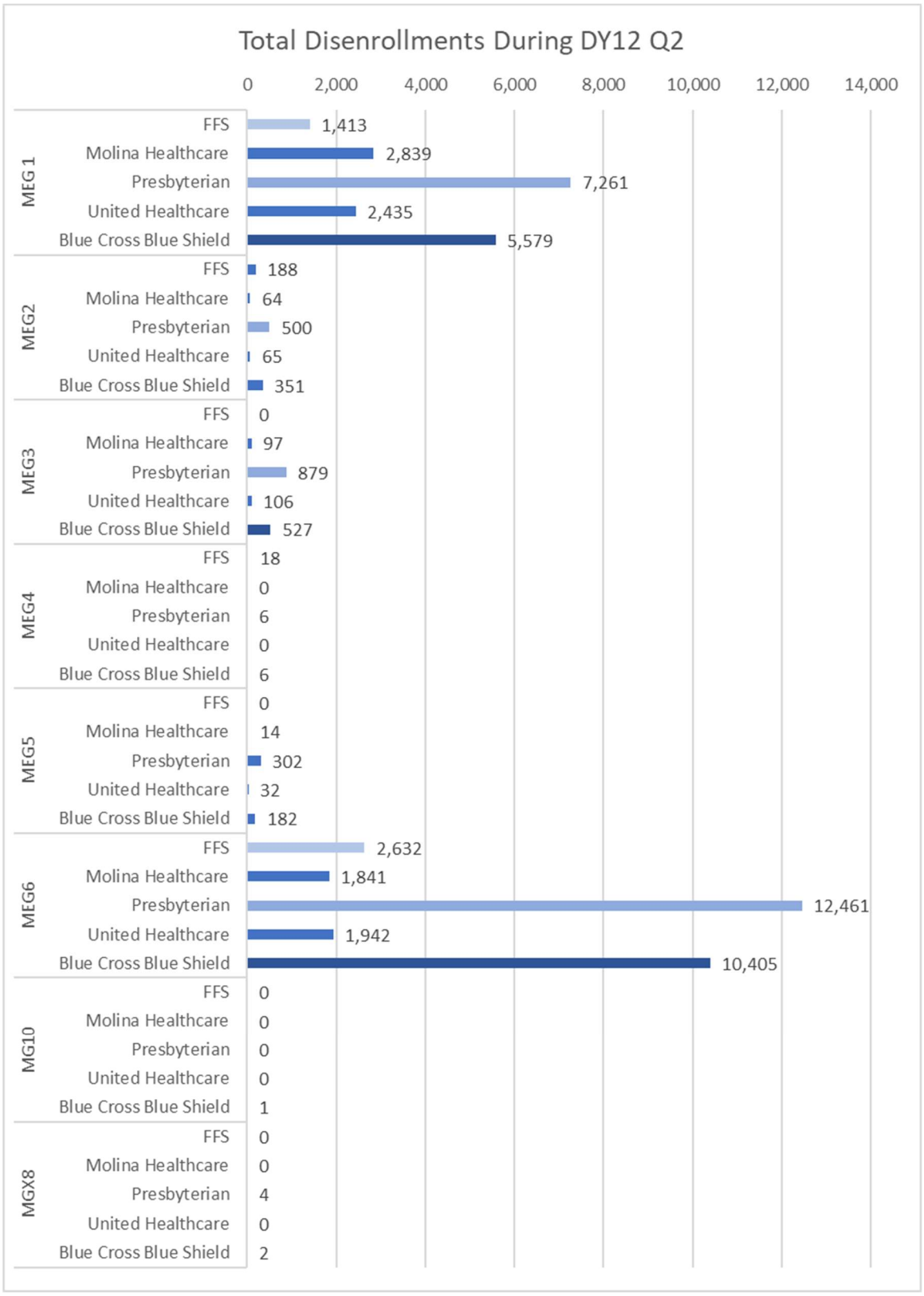
The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment and disenrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of the reporting quarter.

As the public health emergency (PHE) ended on May 11, 2023, and the MOE continuous eligibility ended March 31, 2023. New Mexico began its unwinding activities in March 2023 and terminations began May 1, 2023. As a result of unwinding activities, New Mexico had observed increases in disenrollments across all MEGs. Most disenrollments for this quarter are attributed to loss of eligibility, administrative closures, and incarcerated individuals.

DY12 Q2 Data

Demonstration Population		Total Number Demonstration Participants DY12 Q2 Ending Dec. 2024	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY12 Q2 (Oct.-Dec. 2024)
Population MEG1 - TANF and Related	0-FFS	25,264	296,558	1,413
	Molina Healthcare	17,965	4,685	2,839
	Presbyterian	167,318	23,758	7,261
	United Healthcare	15,818	4,804	2,435
	Western Sky	0	1253	0
	Blue Cross Blue Shield	120,050	19,270	5,579
	Summary	**346,415**	**350,328**	**19,527**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,208	32,641	188
	Molina Healthcare	1,624	261	64
	Presbyterian	18,745	2,781	500
	United Healthcare	1,409	248	65
	Western Sky	0	126	0
	Blue Cross Blue Shield	12,303	1,779	351
	Summary	**36,289**	**37,836**	**1,168**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Molina Healthcare	1,669	1,915	97
	Presbyterian	19,191	22,378	879
	United Healthcare	1,991	2,201	106
	Western Sky	0	180	0
	Blue Cross Blue Shield	10,240	12,166	527
	Summary	**33,091**	**38,840**	**1,609**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	193	344	18
	Molina Healthcare	8	1	0
	Presbyterian	113	30	6
	United Healthcare	5	1	0
	Western Sky	0	0	0
	Blue Cross Blue Shield	72	23	6
	Summary	**391**	**399**	**30**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Molina Healthcare	162	179	14
	Presbyterian	3,559	3,984	302
	United Healthcare	291	311	32
	Western Sky	0	18	0
	Blue Cross Blue Shield	2,491	2,774	182
	Summary	**6,503**	**7,266**	**530**
Population MEG6 - VIII Group (expansion)	0-FFS	24,032	251,192	2,632
	Molina Healthcare	15,592	5,961	1,841
	Presbyterian	120,306	55,743	12,461
	United Healthcare	15,108	6,007	1,942
	Western Sky	0	3223	0
	Blue Cross Blue Shield	98,174	44,956	10,405
	Summary	**273,212**	**367,082**	**29,281**
Population MEG10 - IMDSUD Group	0-FFS	10	31	0
	Molina Healthcare	1	12	0
	Presbyterian	48	389	0
	United Healthcare	5	20	0
	Western Sky	0	24	0
	Blue Cross Blue Shield	64	302	1
	Summary	**128**	**778**	**1**
Population MEGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Molina Healthcare	8	56	0
	Presbyterian	138	1,311	4
	United Healthcare	22	83	0
	Western Sky	0	94	0
	Blue Cross Blue Shield	274	1,374	2
	Summary	**442**	**2,918**	**6**
Summary		**696,471**	**805,447**	**52,152**

Source: Enrollee Counts Report


Total Disenrollments During DY12 Q2
0
2,000
4,000
6,000
8,000
10,000
12,000
14,000
MEG 1
FFS 1,413
Molina Healthcare 2,839
Presbyterian 7,261
United Healthcare 2,435
Blue Cross Blue Shield 5,579
MEG2
FFS 188
Molina Healthcare 64
Presbyterian 500
United Healthcare 65
Blue Cross Blue Shield 351
MEG3
FFS 0
Molina Healthcare 97
Presbyterian 879
United Healthcare 106
Blue Cross Blue Shield 527
MEG4
FFS 18
Molina Healthcare 0
Presbyterian 6
United Healthcare 0
Blue Cross Blue Shield 6
MEG5
FFS 0
Molina Healthcare 14
Presbyterian 302
United Healthcare 32
Blue Cross Blue Shield 182
MEG6
FFS 2,632
Molina Healthcare 1,841
Presbyterian 12,461
United Healthcare 1,942
Blue Cross Blue Shield 10,405
MG10
FFS 0
Molina Healthcare 0
Presbyterian 0
United Healthcare 0
Blue Cross Blue Shield 1
MGX8
FFS 0
Molina Healthcare 0
Presbyterian 4
United Healthcare 0
Blue Cross Blue Shield 2

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OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY12 Q2	In DY12 Q2, the New Mexico Health Care Authority (HCA), Medical Assistance Division (MAD) continued to provide coaching, outreach, and educational activities through webinars to Presumptive Eligibility Determiners (PEDs) in the Presumptive Eligibility (PE) and Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) programs to help PEDs better assist their clients in the completion of Medicaid eligibility applications, both online and telephonically. A monthly “PED Medicaid Monthly” newsletter is sent by HCA to active PEDs. The newsletter provides updates on HCA programs, policy changes, YESNM-PE system updates, tips and audit reminders for PEDs. The newsletter features a PED Hero section to allow active PEDs to nominate and feature one of their own. HCA also continues to provide online PED certification and refresher demo training sessions for prospective and current PEDs. HCA continues to provide Turquoise Care members with information about Turquoise Care benefits, open enrollment and value-added benefits through each of the 4 new MCOs. During the quarter Medical Assistance Division (MAD) staff attended the Aging and Long-term Services Department’s (ALTSD) Conference on Aging as well as Family Resource Night held at a local high school.

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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 are not accepted by HCA. HCA meets regularly with the MCOs to address specific issues and to provide guidance. HCA regularly monitors encounters by comparing encounter submissions to financial reports to ensure completeness. HCA monitors encounters by extracting data monthly to identify the accuracy of encounter submissions and shares this information with MCOs. HCA extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. Based on the most recent quarterly data extracted, the MCOs are compliant with encounter submissions and there are no issues or findings to report for the encounter and enrollment data. Molina and UHC required testing prior to submitting production encounters. Molina Health Care (MHC) and UnitedHealthcare (UHC) have completed encounter uploads beginning July 1, 2024. MHC and UHC had improved encounter accuracy this quarter compared to last quarter. HCA expects MHC and UHC to meet compliance standards next quarter.

Data is extracted monthly to identify Turquoise 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, HCA continues to monitor enrollment and any anomalies that may arise, so they are identified and addressed timely. HCA posts the monthly Medicaid Eligibility Reports (MERs) to the HCA website at: https://www.hca.nm.gov/medicaid-eligibility-reports/. 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 DY 12 Q2 reflect the Turquoise Care rates effective for the period from January 1, 2024, through December 31, 2024. The rates were 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, 2024, were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 28, 2023; the updated rates for the July 1 through December 31, 2024 were submitted to CMS on June 28, 2024.

During DY12 Q2, financial payments were made for University of New Mexico Medical Group (UNMMG) directed payment, University of New Mexico Hospital (UNMH) directed payment, hospital value-based payments, retroactive reconciliation, health care quality surcharge reconciliation, non-risk COVID-19 vaccine payment, and performance measures penalty recoupment were made related to demonstration years 9, 10, 11 and 12.

SYSTEM ISSUES

There were no system issues or concerns this quarter.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities	
DY12 Q1 and Q2	The Health Care Authority (HCA) continued to monitor Managed Care Organization (MCO) compliance with Care Coordination requirements and their progress on improving Care Coordination for our members through the quarterly Care Coordination Report. This quarterly report had significant revisions from Centennial Care 2.0 (CC 2.0) to Turquoise Care (TC). HCA sent the revised report to all TC MCOs for review and comment and followed up with a meeting to further review the report and clarify any questions. This report includes: • Enrollment and engagement data for all members, • Enrollment and engagement for specific populations such as Perinatal/Postpartum, Justice Involved, and Long-Term Services and Supports members, • Data tracking members with auto-qualifying diagnosis, • Data on the completion of required assessments and touchpoints within contract timeframes, • Tracking MCO progress on increasing Full and Shared Delegated Provider sites and the members assigned to these sites, specifically Perinatal/Postpartum, Medicaid Home Visiting, and Comprehensive Addiction and Recovery (CARA) members, • MCO staffing ratios for high-needs populations and trainings conducted for care coordinators during the reporting quarter, • Data on Emergency Department, Inpatient Admission, and Behavioral Health Crisis Intervention Utilization for members in different categories of Care Coordination, and • Data on referrals provided in specific service categories and the number of those referrals' members fulfilled. The MCO aggregate results for DY12 Q1 show MCOs did not meet performance benchmarks of 85% for timely completion of Health Risk Assessments (HRAs) for 'New to Medicaid' members, initial Comprehensive Needs Assessments (CNAs), semi-annual CNAs or initial Comprehensive Care Plans (CCPs). Improvement was seen in DY12 Q2 for HRAs, initial CNAs, and initial CCPs. The table below details aggregate and individual MCO performance from DY12 Q1 and Q2.

Table 4: Care Coordination Monitoring

MCO Performance Standards	DY12 Q1	DY12 Q2
HRAs for new members	**80%**	**85%**
BCBSNM	77%	81%
MHC	100%	100%
PHP	89%	91%
UHC	81%	87%
Initial CNAs	**49%**	**75%**
BCBSNM	40%	38%
MHC	94%	71%
PHP	86%	89%
UHC	44%	86%
Annual CNAs for CCL1/CCL2 members	**87%**	**86%**
BCBSNM	85%	83%
MHC	7%	48%
PHP	87%	88%
UHC	100%	100%
Semi-annual CNAs for CCL2 members	**77%**	**74%**
BCBSNM	68%	60%
MHC	0%	33%
PHP	87%	85%
UHC	x	100%
Initial CCPs for CCL1 and CCL2 members	**82%**	**89%**
BCBSNM	77%	61%
MHC	100%	94%
PHP	100%	100%
UHC	57%	92%

Source: HCA DY12 Q1 and DY12 Q2 Report #6 –Care Coordination Report

Percentages in bold are MCO aggregate of the total assessments due and completed.
* UHC reported no Semi-annual CNAs due in DY12 Q1.

HCA met with each MCO in DY12 Q1 and DY12 Q2 to discuss their Care Coordination Report submissions. All MCOs experienced issues related to the transitioning of members from Centennial Care 2.0 to Turquoise Care, Western Sky Community Care (WSCC) leaving the New Mexico Medicaid program, and Molina Health Care (MHC) and United Health Care (UHC) onboarding new members. MHC and UHC reported significant systems issues throughout DY12 Q1 and Q2 causing delays in receiving data for their newly attributed membership. These systems issues were resolved by the end of DY12 Q2. Additionally, Turquoise Care requirements increased the categories of members required to be engaged in Care Coordination as well as increasing the number and frequency of required touchpoints. While the total MCO membership decreased by 5% from DY12 Q1 to DY12 Q2, members engaged in Care Coordination increased by 26%.

Blue Cross Blue Shield (BCBS) reported a 15% increase in members engaged in CCL1 or CCL2 from DY12 Q1 to DY12 Q2 as well as a high rate of staff turnover during the transition which contributed to their lower rates of timely completion of required assessments. BCBS also stated that there were inconsistencies in receiving member files timely from outgoing WSCC. BCBS reported that their staffing issues have been resolved, and they are on track to meet performance benchmarks for DY13 Q1.

MHC reported high rates of compliance for HRAs, initial CNAs and initial CCPs; however, MHC reported 48% of their membership as Unable to be Reached (UTR). MHC reported having issues receiving encounter data as well as timely member files for those transitioning from WSCC which affected their ability to complete annual CNAs timely. MHC has stated that these issues have now been resolved, and they expect to meet performance benchmarks for all assessments in DY13 Q1.

In DY12 Q2, MHC's UTR membership decreased slightly to 44%, an unacceptable percentage for HCA. Data provided by Centennial Care MCOs in DY11 Q2 showed an aggregate of UTR members significantly lower than MHC's UTR members. HCA met with MHC who stated that they considered all of their transitioning members as "New to Medicaid" and in need of HRAs whether these members had been reached, assessed, and leveled previously. MHC acknowledged that they were unable to connect with all 42,271 members and those not reached were listed as UTR. MHC acknowledged their process was poorly initiated and are working to recategorize members, increase claims mining, and continue to outreach to those members not yet reached.

Presbyterian (PHP) reported a 2.5% decrease in members engaged in CCL1 and a 67% increase in members engaged in CCL2 from DY12 Q1 to DY12 Q2. HCA met with PHP to discuss their significant increase in CCL2 members. PHP stated that Turquoise Care requirements for specific populations to be leveled at a CCL2 led to this significant increase. It was also noted that PHP's Difficult to Engage (DTE), Unable to Reach (UTR) and Refused Care Coordination (RCC) members increased by 22% during this same reporting period. All MCOs reported increases for DTE, UTR, and RCC members was directly related to TC requirements that certain memberships be leveled at CCL1 or CCL2 as well as an increase in required touchpoints for members engaged in Care Coordination. PHP met all performance benchmarks for DY12 Q1 and DY12 Q2. It should be noted that PHP began assigning a significant percentage of their members (12%) to Full Delegation Care Coordination. Currently, HCA does not have specific benchmarks for members receiving Care Coordination through a Full Delegation Model.

UHC improved their timely completion of required assessments significantly between DY12 Q1 and DY12 Q2 meeting all standards in DY12 Q2. Like MHC, UHC reported an unacceptable number and percentage of members as UTR; 89% in DY12 Q1 and 87% in DY12 Q2. HCA met with UHC to discuss their UTR membership and receive their plan for outreaching to and engaging with their members. UHC acknowledged that most of their UTR members had been reached and leveled in DY11 Q2; however, UHC chose to treat all of their transitioning members as arriving with no CCL. UHC also acknowledged this was a

poor decision as they were unable to complete outreach to all 41,782 members within DY12 Q1 and Q2. HCA directed UHC to increase their outreach, claims mining, and research on their Member's history. UHC agreed to ensure their UTR members would significantly decrease by DY13 Q2.

Care Coordination Audits

HCA did not conduct Care Coordination audits in DY12 Q1. HCA met with all TC MCOs to advise them that recurring CNA and CCP audits would begin in DY12 Q2. All MCOs were utilizing the newly Standardized CNA and CCP. HCA advised the MCOs that audits would begin in DY12 Q2.

In DY12 Q2, recurring quarterly CNA audits began. The results of the CNA audits were positive. All MCOs had excellent documentation, included member requested referrals, and members were leveled correctly per the new TC requirements. HCA noted some issues related to members' eligibility not being in alignment with HCA data. All MCOs reviewed and updated any mismatched eligibility categories in audited files.

In DY12 Q2, HCA implemented a quarterly Comprehensive Care Plan (CCP) Audit, reviewing CCPs for each of the audited CNAs. MCOs are completing CCPs utilizing the new, Standardized CCP which all MCOs developed together in DY11 Q1. HCA considers the DY12 Q2 CCP Audit a baseline and an opportunity to determine if the CCP meets all the needs of our members.

Both BCBS and PHP's CCPs captured the specific goals documented in the accompanying CNAs. Goals were member-centric, written with clear action steps for both the member and Care Coordinator to follow, and included physical, behavioral, and Health Related Social Needs (HRSN) goals as appropriate.

In reviewing MHC and UHC CCPs, HCA reviewers noted targeted training is needed to ensure goals outlined in the CCP match those documented in the CNA. HCA determined that MHC and UHC CCPs were not consistently member-centric and often referred to the Member as "Member" rather than by their name. HCA also noted goals listed that did not align with the Member's needs such as a goal for increased childcare for a member without children. HCA met with both MHC and UHC outlining multiple areas needing to be addressed. Both MHC and UHC agreed that targeted training would occur weekly with care coordinators and increased review of, and oversight on CCPs by supervisors. Additionally, HCA offered to conduct a Care Coordination training on CNAs and CCPs in DY13 Q1 to which MHC and UHC agreed their staff would attend. HCA will continue to audit CCPs quarterly and if progress by MHC and UHC is not evident, a Performance Improvement Plan will be implemented.

Care Coordination CNA Ride-Alongs
HCA conducted 2 CNA ride-alongs with MCO care coordinators in DY12 Q1 and 7 in DY12 Q2 to observe completion of member assessments.

HCA attended initial and annual CNAs conducted by BCBS, MHC, PHP and UHC.

HCA determined whether care coordinators properly administered the Community Benefits Services Questionnaire (CBSQ) and the Community Benefits Member Agreement (CBMA) to ensure that members had appropriate access to Community Benefits. HCA observed the relationship between the care coordinator and Member, whether the care coordinator had reviewed Member information prior to the assessment, whether appropriate referrals were made or followed up on, and whether all required areas of the assessment were completed.

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

- Care coordinators adhered to all contractual responsibilities in their assessments.
- Care coordinators were kind, thorough, and professional with the members.
- HCA noted care coordinators employing motivational interviewing with members.
- Care coordinators often went beyond contract requirements to assist members with locating and applying for additional resources and services.
- Care coordinators were fluent in the language preferred by their member.
- HCA noted that care coordinators were well-versed in Medicare dual eligible members.
- HCA reiterated the need for care coordinators to review their member's file, recent PH and BH appointments, and diagnosis prior to conducting the CNA to avoid unnecessary questions. While most care coordinators were well-versed with their member's needs, HCA noted a few instances where reviewing member files prior to the assessment would have alleviated unnecessary questions.
- Care coordinators made referrals and followed up on past referrals.

Care Coordination HRA Ride-Alongs
HCA conducted 13 virtual HRA ride-alongs with BCBS and PHP MCO care coordinators in DY12 Q1, to observe completion of member assessments. All HRAs observed were conducted telephonically. HCA determined that it was more appropriate to begin reviewing HRA ride-alongs with MHC and UHC in DY12 Q2 and conducted 20 HRA ride-alongs in DY12 Q2.

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

- The majority of assessors were friendly, thorough, non-judgmental, and professional with the members.

- Assessors explained to members who refused Care Coordination that they could request Care Coordination in the future if they would like additional assistance.
- Assessors provided additional information such as offering Transition of Care services if the member had recently been released from incarceration.
- Assessors referred members to resources to address specific concerns.
- Assessors provided warm handoffs to customer service staff for needs such as additional insurance cards or to Care Coordination staff to schedule their Comprehensive Needs Assessment.
- HCA revised the HRA to ensure all prenatal members are referred to and encouraged to engage with Home Visiting programs. Assessors were consistent in following this new directive.
- HCA requested MCOs continue ongoing training and internal review of HRA Assessors to ensure any issues are resolved quickly.
- HCA noted that MHC and UHC use assessors based out of state. These assessors may be conducting assessments on members in various states with different assessments. HCA met with MHC and UHC to discuss the need for staff conducting HRAs to be well versed on programs in New Mexico, follow the questions in New Mexico's Standardized HRA, and ensure correct information is being provided. Both MHC and UHC stated additional oversight, including internal review of recorded HRAs, would be conducted to determine which assessors need additional, targeted training on TC HRAs.

Care Coordination MCO Meetings
HCA held two All TC MCO meetings in DY12 Q1.

The first meeting, on July 25, 2024, focused on Care Coordination Delegation. HCA discussed MCO successes and barriers in contracting with providers, especially in rural areas of the state, and steps being taken to increase engagement in delegated Care Coordination. HCA reiterated contract requirements that all Perinatal/Postpartum members be offered Care Coordination through a Full Delegation model. HCA provided clarification on reporting requirements.

HCA held an All TC MCO meeting on August 24, 2024, to specifically address MCO confusion on Care Coordination levels. HCA made significant changes in Care Coordination levels from Centennial Care 2.0 to Turquoise Care including changing the naming of levels, specifying populations that are required to be leveled, and specifying specific populations that may or may not be recategorized. MCOs expressed concerns that there may be an increase in members refusing Care Coordination if they are unable to be leveled down due to their inclusion in a specific population. MCOs also requested clarification on the change in

naming of levels and which populations would be included in each level. HCA provided MCOs with charts outlining the revisions and provided clarification for all questions. HCA also revised the Standardized CNA to add additional information on which members may not be leveled down. All MCOs expressed a clearer understanding of the new leveling requirements.

HCA held a meeting with MHC and UHC in DY12 Q1 to provide instructions on recurring deliverables and processes. These included the process for submitting a CNA exception request, a requirement to submit quarterly Care Coordination Contact lists for members receiving waiver services, a quarterly contact list for MCO contacts overseeing specific populations, the process for submitting audit universes, submitting recorded HRAs and available CNAs for quarterly ride-alongs. HCA also discussed the purpose for, and oversight of, quarterly Care Coordination Performance Measure submissions. MHC and UHC expressed appreciation for the targeted training on required recurring submissions and assured HCA that all required reports and processes would be submitted timely. Additionally, HCA conducted separate meetings, on September 11, 2024, with MHC and UHC to answer additional questions they had concerning CARA member enrollment, Justice Involved member engagement, demographic information on CNAs, and touchpoint requirements.

In DY12 Q2, HCA held an All TC MCO quarterly meeting on November 20, 2024. This meeting addressed all MCO aggregate data on the HRA Ride-Along findings, CNA Audit findings, results from the CCP reviews, and an open discussion with all MCOs on the transition to Turquoise Care. MCOs provided HCA with updates on progress in outreach and engaging with UTR members, targeted training to staff on the new CNA and CCP, and shared ways to complete the additional member touchpoints timely. HCA recognized the barriers MCOs face in connecting members to timely appointments with providers in rural and frontier areas of the state. Additionally, MCOs and HCA discussed the continued shortage of caregivers for members across the state and how MCOs are working with their members, member’s families, community providers, and non-profits to cover needed services. HCA provided dates for upcoming Care Coordination trainings on CNAs, CCPs, and touchpoints. All MCOs appreciated the additional opportunities available for staff training.

BEHAVORIAL HEALTH

The Behavioral Health Services Division (BHSD) continues to maintain and expand critical behavioral health services established during the COVID-19 public health emergency. Telehealth service offering continues to expand and is a great resource for expanding capacity by reaching those in the most rural and frontier areas of the state.

In DY12 Q1, a total of 36,270 Medicaid members accessed behavioral health services via telehealth, marking a 2.1% increase from the previous quarter (DY11 Q2), which recorded 35,508 individuals. Of those receiving services in DY12 Q1, 16,421 individuals reside in rural or frontier counties, representing 44.3% of the total population receiving telehealth services. This trend reflects both client and provider preferences, as well as the essential role telehealth plays in meeting the unique needs of New Mexico's rural and frontier communities.

Telephonic service delivery remained largely consistent in DY12 Q1, with a 4.7% difference in members served (17,836), compared to the same quarter in the previous year (DY10 Q3), which recorded 17,035 individuals served. The Behavioral Health Services Division (BHSD) continues to evaluate which behavioral health services remain suitable for telephonic delivery post-public health emergency. This service, critical during the COVID-19 pandemic, continues to be vital for improving access in rural and frontier areas.

While the end of the Public Health Emergency reduced telehealth and telephonic service utilization among Medicaid beneficiaries, demand remains steady in rural and frontier regions, helping to reduce barriers to care. Although in-person treatment remains preferred, telehealth and telephonic services continue to enhance capacity and access with ongoing widespread use.

TREAT FIRST

As depression, anxiety and other behavioral health needs surge, Treat First engages clients quickly in services that address their immediate needs. The 40 certified Treat First agencies have seen over 3,766 new clients during the 12 months of 2024. With support from the Treat First agencies, 40% of these individuals were able to resolve their issues with solution focused interventions within four visits. The balance of those clients continued in services. The "No Show" rate for clients in this period was low, representing only 10.6% of scheduled appointments. This is significantly lower than before agencies started the Treat First approach.

Youth or adults were asked how they felt their Treat First visits were going, and on average, both groups felt that the sessions were working very well to address their immediate needs. Youth rated sessions at 92.9% and adults at 87.0%.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an important evidence-based tool that can be used by virtually all primary care providers to identify problematic

alcohol or drug use, depression, or trauma, and then refer a patient for additional treatment if appropriate. SBIRT was added to the state's Medicaid program for the first time in 2019, and since then, BHSD has conducted expanded outreach to providers as well as state-sponsored provider trainings around the state.

In DY12 Q1, SBIRT utilization remained comparable to the previous quarter, with 1,312 individuals served compared to 1,331 in DY11 Q2. However, compared to the same quarter in the previous year (DY10 Q3), the total number of individuals served in DY12 Q1 decreased by 41.4%, from 2,239 to 1,312.

On a monthly average, 469 individuals received SBIRT services in DY12 Q1, with the highest utilization reported in August, when 525 individuals were screened. The monthly average for SBIRT services in DY12 Q1 was 46.2% lower than the previous quarter (DY11 Q2, 500 screened) and 41.7% lower than the same quarter of the previous year (DY10 Q3, 804 screened).

The ongoing decline in utilization, both quarter-over-quarter and year-over-year, likely points to issues with provider training and billing practices. Despite ongoing outreach and training efforts, these challenges appear to be impacting the number of individuals served and the consistency of SBIRT implementation. To address this decline, the program continues to focus on enhancing provider training, improving billing processes, and conducting targeted outreach to ensure that more providers are properly equipped to deliver and document SBIRT services effectively.

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

The Turquoise Care program includes new and expanded services for Medicaid recipients with Substance Use Disorder (SUD). In State Fiscal Year (SFY) 24, the state finalized the contract to deliver SBIRT training for primary care and hospitals statewide and will continue training through SFY 2025. Expansion of 988 Crisis Now initiatives continue with support for crisis triage centers, mobile crisis teams and alternative crisis triage center sites whereas space set up to be utilized when needed such as a hotel room, firehouse, or outpatient clinic.

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

As part of the SUD 1115 Waiver, services have been approved for specific substance abuse populations in an Institution for Mental Disease (IMD). An IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating

SUD that is not part of a certified general acute care hospital. HCA has expanded coverage of recipients ages 22 through 64 to inpatient hospitalization in an IMD, for SUD diagnoses only, with criteria for medical necessity, and based on American Society of Addiction Medicine (ASAM) admission criteria. Covered services include withdrawal management (detoxification) and rehabilitation.

In DY12 Q1, the total number of people served with a SUD in an IMD was 3,794, which is a slight decrease (0.63%) compared to the 3,818 reported in DY11 Q2. When comparing DY12 Q1 results to DY11 Q2, the utilization remained stable at 1,687 people served on a monthly average. The total number served in an IMD with SUD through the nine months of 2024 was 8,996. The latest quarter's results show a stable rate of utilization through the start of DY12.

SUD HEALTH IT

In DY12, HCA developed and maintained the necessary SUD Health IT capabilities and infrastructure to support member health outcomes and address the SUD goals of the demonstration. This is demonstrated through progress reports.

Utilization of the New Mexico Prescription Monitoring Program (NM PMP) continues to be utilized by prescribers with the number of providers utilizing the NM PMP providers checking the PMP at 88%. This is a 1% increase over the previous year at 87%. HCA continues to monitor with data as updated from the New Mexico Board of Pharmacy.

The New Mexico Fee for Service (FFS) Drug Utilization Review (DUR) Board conducted the Fee for Service Drug Utilization Review meeting on August 28, 2024. Attendees included board members (a quorum was met electronically for voting purposes) and invited guests, including managed care organization representatives. Client counts for both FFS and Managed Care were reported, and a continued trend of small decreases in total members enrolled was noted. Utilization of Prospective DUR edits targeted for prevention of fraud, waste and abuse and to meet Support Act requirements were presented and reviewed for the period of April 1, 2024, to June 30, 2024. The data demonstrate the effectiveness of the Prospective DUR edits for preventing overutilization and deterring abuse and waste. No new changes were recommended for the reported edits. The Prospective DUR reporting will continue as a quarterly report at the DUR meetings. For DY12 Q1, the intervention that was decided on was the underutilization of sodium-glucose co-transporter 2 (SGLT-2). The purpose of this intervention is to identify patients who have heart failure, but who are not being treated with the sodium glucose co-transporter inhibitor. There were 397 providers, concerning 276 patients, identified. The intervention was mailed on 9/19/2024.

Support Act reports for Metabolic Monitoring of Second-Generation Antipsychotics (SGAs) in youth and adults, opioid usage with benzodiazepines, antipsychotics, smooth muscle relaxants, Gabapentinoids, stimulants, and non-benzodiazepine sedative hypnotics were presented with no trends or concerns noted. While the reporting for metabolic monitoring of SGAs is currently mandatory in youth, the DUR board agreed to continue to report on both youth and adults. New reports for each month of DY11 Q2 were presented with an analysis of the top 25 drugs utilized. The reports were broken out by the top 25 drugs by the number of claims, the top 10 brand name drugs by claims, the top 10 generic drugs by claims, and the top 10 therapeutic classes by claims. The board agreed that for DY12 Q2, the retrospective intervention will be an educational letter sent to providers regarding SMART (Single Maintenance and Reliever Therapy) and will include new treatment recommendations from the Global Initiative for Asthma (GINA) guidelines and the National Asthma Education and Prevention Program.

In 2024, Project ECHO introduced 39 new clinics, bringing the total to 65. Unique clinical, mental, and public health topic areas were addressed, including but not limited to: Diabetes Management in Primary Care, Improving Perinatal Health Opioid Use Disorders for Prescribers, Adverse Childhood Events, and Alcohol Use and Mental Health. HCA released a supplement to providers outlining opportunities to participate in ECHO case reviews. Additionally, recruitment for participation continues to expand, with particular emphasis on engaging rural, underserved, and tribal communities. Project Echo will continue these programs in 2025.

The New Mexico Bridge Program continues to expand its training on prescribing for Opioid Use Disorder (OUD) for hospital emergency departments, inpatient, and related clinics throughout the state. The New Mexico Bridge team conducts live trainings at hospitals and provides a virtual training series for hospitals and community members. The project engaged with 12 hospitals since its inception in 2021. These hospitals have completed various stages of engagement and implementation. These include Holy Cross Medical Center, Gallup Indian Medical Center, Socorro General Hospital, Memorial Medical Center, University of New Mexico Hospital, Lovelace Women’s Hospital, and Sierra Vista Hospital. These seven hospitals have started prescribing buprenorphine and the program has tracked 744 patients that have received this treatment to date from Taos, Memorial, Gallup, Socorro, and UNM Hospital (data collection from Lovelace and Sierra Vista Hospital is currently being gathered). Five hospitals participated in aspects of engagement and/or training, including Christus St. Vincent Regional Medical Center, San Juan Regional Medical Center, Plains Region Medical Center, Northern Navajo Medical Center, and Gerald Champion Medical Center. NM Bridge is in discussion with other hospitals to plan engagement in the future, including Mesilla Valley Hospital and Lincoln County Medical Center. All hospitals serve

patients in/from both rural and urban settings. During this time period, NM Bridge helped Lovelace Women's Hospital L&D and UNM Hospital ED complete their programs. The NM Bridge team started working on extending the programs to Lovelace Women's Hospital ED and UNM Hospital Pediatric ED. Sierra Vista Hospital completed the program during this time period but continues to stay in contact with team for support during the final stages. NM Bridge remains in beginning stages with Christus St. Vincent Regional Medical Center and San Juan Regional Medical Center. NM Bridge continues to work with Socorro General Hospital and Taos Holy Cross Medical Center's Women's Health Institute. NM Bridge conducted additional on-site provider and nursing trainings to Holy Cross Medical Center in September 2024, conducted on-site nursing trainings to Sierra Vista Hospital in September 2024, and conducted remote provider trainings to University of New Mexico in September 2024. NM Bridge continues providing monthly trainings remotely to hospitals. The NM Bridge trainings include buprenorphine initiation, responsible opioid prescribing, treatment in clinic settings, SUD and pregnancy, neurobiological basis of SUD, case reviews, toxicology updates, fentanyl updates, and more. NM Bridge continues to reach out statewide to encourage engagement. In addition to the new Bridge team member that was added to provide peer support worker and supervisor education, another new Bridge team member was added to support and enhance engagement efforts for new hospital partners. More information on the program can be found at www.nmbridge.com.

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

ADULT ACCREDITED RESIDENTIAL TREATMENT CENTERS (AARTC) SERVICES

During DY12 Q1, two AARTC applications were in the review process and two applications were approved. A total of 27 AARTCs provider applications have been approved since the onset of the application process in December of 2019 (multiple providers have multiple locations).

Table 5: AARTC Client Counts

MEDICAID CLIENT COUNTS				
PROVIDER #	PROVIDER NAME	DY11 Q1	DY11 Q2	DY12 Q1
15453081	SHADOW MOUNTAIN RECOVERY RIO RANCHO	27	0	0
20887825	TURNING POINT DETOX LLC	12	18	17
23501090	HOY RECOVERY PROGRAM INC	66	52	52
32279302	CARLSBAD LIFEHOUSE INC	105	122	69
32736258	NEW MEXICO WELLNESS LLC	18	37	52
35605081	ZIA RECOVERY CENTER	1	0	0
42155037	SANTA FE RECOVERY CENTER	399	349	275
51679060	ICARUS BEHAVIORAL HEALTH	19	52	45
55074049	TURQUOISE LODGE HOSPITAL	25	21	27
58186760	MAKING AN IMPACT LLC	69	70	74
72030569	VANGUARD BEHAVIORAL HEALTH		1	5
82536716	FOUR CORNERS DETOX RECOVERY CENTER	5	12	21
95158332	CENIKOR FOUNDATION	86	94	68
250589	SHADOW MOUNTAIN RECOVERY TAOS	22	1	0
4327896	TURNING POINT DETOX LLC	7	9	12
Unduplicated Count		**819**	**808**	**691**

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

There are 22 AARTCs approved to bill Medicaid. The table above identifies the total number of clients who received AARTC services during DY12 Q1. The provider number is a unique identifier and is used to correlate the number of members seen by each provider for each quarter. Providers who were not approved to bill Medicaid for previous quarters have NA in the data field to represent this. Although 15 provider sites are represented in the chart above, Santa Fe Recovery Center has four sites represented. All AARTC provider sites are actively in the process of receiving distinct identification numbers to ensure accuracy in client counts for each site.

Medicaid utilization declined from 808 individuals in DY11 Q2 to 691 individuals in DY12 Q1. The decline is likely due to claims lag which can take up to 120 days for submission and processing. It is expected that numbers will fluctuate as the actual counts are adjusted to account for claims lag. Further analysis is warranted to ensure counts are accurately reported and represented for those providers. The table reflects refreshed numbers in all quarters.

Rates have been assessed by acquiring one full year of utilization by each provider with a review of expenditure data collected to determine the actual costs of operation. As of February 2025, a per diem rate has been established for Tier 1, 2 and 3, and will go into effect on January 1, 2026.

HEALTH HOMES (HHs)

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

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

CareLink Health Homes (CLNM) Activities	
DY12 Q2 Activities	In Q2 the CLNM Health Homes attended a re-education on CMS and State requirements for health homes, as there has been increased turnover of staff. Together, they developed a growth strategy for the next year. The goals were 1) new methods to attract new staff; 2) a re-education on the merits of service tracking in the IT system designed for health homes in NM; 3) re-education on the documentation of client goals and their progress; and 4) upgraded documentation on the activities for health promotion within the health home and outside classes. State plans to re-integrate high fidelity wraparound into health home. Membership was welcomed as this short-term service modality; seen as critical for many children and adolescents with special needs.

Table 6: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY11 Q1 JAN - MAR	DY11 Q2 APR - JUNE	DY12 Q1 JUL - SEPT	DY12 Q2 OCT - DEC
3,488	3,348	3,248	3,069
% CHANGE	% CHANGE	% CHANGE	% CHANGE
5.15%	4.01%	2.99%	5.51%
Decrease	Decrease	Decrease	Decrease

Source: NMStar, CLNM Opt-in Report.

HIGH FIDELITY WRAPAROUND

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

The goal of the program is to provide intervention to individuals with the most complex behavioral health needs to reduce the occurrence of placement in higher levels of care, detention, hospitalization, or institutionalization. HFW was approved as a part of the New Mexico Section 1115 Medicaid Waiver effective March 28, 2023. Since that time the NM HFW Steering Committee, including representatives from HCA Behavioral Health Services Division (BHSD) and Medical Assistance Division (MAD) as well as the Children Youth and Families Department (CYFD) has met weekly to review HFW provider certification applications as these providers transition from other funding sources to Medicaid enrolled providers. As part of this process, the HFW Steering Committee assessed the providers' readiness and adherence to the HFW model. The HFW Steering Committee also provides support and oversight on long-term strategies of the HFW model within the state including implementation and long-term objectives.

The HFW Steering Committee transitioned the role of reviewing provider applications to CYFD Licensing and Certification Authority. The HFW Steering Committee will transition to focus primarily on program support, monitoring, and development of long-term strategies. Additionally, as part of the implementation process, HCA and CYFD are in process of developing claims data, provider level, and MCO reports to monitor program requirements including eligibility criteria as well as provider employee requirements. Additionally, HFW treatment plans will receive clinical review through CYFD.

HCA and CYFD continue to collaborate on the development of HFW performance measures as well as data report development. The measures will be reported as soon as they are available.

SUPPORTIVE HOUSING

The supportive housing benefit in Turquoise Care provides Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program pre-tenancy and tenancy services. The Linkages program serves individuals diagnosed with serious mental illness

with functional impairment who are homeless or precariously housed and are extremely low-income, per the Department of Housing and Urban Development (HUD) guidelines. Extremely low income is defined as a household income that falls at or below 30% Area Median Income (AMI); AMI varies by county. HUD posts AMI Income Limits for each county of every state annually.

Linkages agencies can bill Medicaid for comprehensive community support services (CCSS), but since the H0044 supportive housing services inclusion in the Section 1115 Waiver, BHSD continues to strongly encourage Linkages providers to shift to billing the supportive housing benefit directly. The H0044 benefit reimburses at a higher rate than CCSS. The Turquoise Care waiver requires that the services be rendered by a certified peer support worker (CPSW) aligning with the state's goals for building the peer support workforce; however, the Section 1115 renewal application included an expansion item to allow for other roles to be eligible to bill H0044. The request is pending CMS approval; and if approved, the expansion will benefit providers and improve H0044 utilization. One Linkages provider has 8 CPSWs assigned to deliver Linkages supportive housing services. The 8 CPSWs of this provider carry a Linkages program specific caseload. Utilizing CPSWs with a specialized case load has optimized Linkages service provision and outcomes. This provider previously had 5 CPSWs assigned to clients participating in Linkages and various other programs. CPSWs assigned to deliver Linkages supportive housing services currently include a CPSW Supervisor, a CPSW Lead, and 6 field CPSWs.

This provider has consistently utilized the H0044 code for reimbursement since October 2019 and is contracted with all 3 MCOs for reimbursement. A second Linkages provider has 3 CPSW positions, 2 full-time CPSW field staff and 1 part-time CPSW supervisor/manager. A CPSW is the primary provider for Linkages, and a second CPSW serves as Linkages back up and assisting clients in need of SSI/SSDI Outreach, Access to Recovery (SOAR). This second provider has been utilizing the H0044 code for reimbursement since January 2022 and is contracted with all 3 MCOs for reimbursement. A third Linkages provider has three CPSWs assigned to render Linkages supportive housing services. This provider has two CPSWs who render Linkages services and billing of H0044, and one CPSW who assists with billing H0044 due to having other administrative duties. The third provider has been utilizing the H0044 code for reimbursement since December 2021 and is contracted with all three MCOs for reimbursement. A fourth Linkages provider hired one1 CPSW in December 2021 and has been utilizing the H0044 code for reimbursement since July 2022. The delay with billing by the fourth provider was due to an MCO system issue with the modifier codes and required provider type; issues have since been resolved. A fifth Linkages provider attempted to fill their Linkages position with a CPSW but has not been successful; therefore, this provider is not currently able to bill H0044 due to the current provider eligibility

guidelines. This provider, however, built a housing bill code in their current electronic health records (EHR) system in preparation to bill upon hire of a CPSW and/or updates to the H0044 eligibility criteria to allow for Community Support Workers or Supportive Housing Coordinator roles. The Linkages providers that have secured a CPSW to render supportive housing services relative to H0044 have also updated their agency's EHR systems to allow for appropriate documentation and revised workflows to clarify the process for H0044 delivery and billing.

There are 11 Linkages support service providers, and the remaining six Linkages providers continue to consider hiring CPSW staff for Linkages programming and/or are actively seeking CPSWs to hire. In the meantime, these providers are utilizing case managers, community support workers, and/or supportive housing coordinators to render the supportive housing services. These roles were included in the Section 1115 renewal application expansion item. The interest of all providers not yet utilizing H0044 remains high and increases with the progress made by the providers who have established H0044 reimbursement. The BHSD Supportive Housing Coordinator and Supportive Housing Coordinator-Supervisor continue to support providers and work with the BHSD MCO Contract Managers and MCOs to ensure successful processing establishment and billing of H0044. MCOs submit quarterly Ad Hoc reports with H0044 encounters data.

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

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

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

Table 7: Medicaid Supportive Housing Utilization

MEDICAID SUPPORTIVE HOUSING UTILIZATION (January 1, 2024 – December 31, 2024)			
DY11 Q1	**DY11 Q2**	**DY12 Q1**	**DY12 Q2**
128	145	102	97
Unduplicated Total - 176			

Source: MCO Ad Hoc Quarterly Reports

As a result of legislative sessions, an increase of State General Funds (SGF) for State Fiscal Years (SFY) 2021, SFY2023, SFY2024 and FY2026 have been and/or shall be applied to Linkages programming. The funding increases allow HCA to expand Linkages services that are not covered by Medicaid. HCA also utilizes these funds to support rental assistance vouchers for eligible Linkages clients. Since SFY2020, there has been an increase of 236 vouchers with increased SGF. Since SFY 202 and currently in SFY 2025, the voucher capacity is 396; the voucher capacity was 338 in SFY2023. An individual does not need to be a Medicaid member to obtain a voucher or services; however, many Linkages clients are Medicaid members. Through this quarter in SFY2025, an average of 353 vouchers were issued or filled; the previous quarter had an average of 356. A filled voucher means housing has been secured. Therefore, 353 individuals and their households benefited from a voucher with housing stability. The decrease may be attributed to transition within a provider agency.

Since SFY2021 and currently, there are eight Linkages sites. Effective in FY2024, Linkages policy includes an update that allows providers to serve surrounding counties beyond their service areas, which supports program coverage expansion. Increased funding for FY2026 will support an increased voucher capacity, increased motel/hotel vouchers for the period between issued and filled voucher status and for households that are literally homeless, and a possible site expansion.

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

On March 28, 2023, CMS approved New Mexico's SMI/SED waiver amendment request to enhance access to mental health services and continue delivery system improvements for these services. New Mexico's plan provides more coordinated and comprehensive treatment of Medicaid beneficiaries with SMI and SED. This demonstration will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI and SED while they are short-term residents in residential and inpatient treatment settings that qualify as an Institutions for Mental Diseases (IMD). It will also support state efforts to enhance provider capacity and improve access to a continuum of SMI/SED evidence-based services at varied levels of intensity.

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

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

New Mexico's SMI/SED Implementation plan was submitted on June 25, 2023. CMS provided feedback to New Mexico on July 17, 2023, and New Mexico resubmitted its implementation plan on October 18, 2023. CMS provided feedback to New Mexico on October 31, 2023. New Mexico resubmitted its implementation plan on February 20, 2024. CMS provided feedback to New Mexico on March 14, 2024. New Mexico resubmitted its implementation plan on April 11, 2024, and, following receipt of CMS feedback on August 21, 2024 and resubmission of the implementation plan on October 18, 2024, the implementation plan approval is pending further CMS feedback. New Mexico also provides assurance that Federal Financial Participation (FFP) will not be claimed until CMS approves the State's SMI/SED Implementation Plan.

Per STC requirements, the SMI/SED Monitoring Protocol was due on August 25, 2023; however, on August 18, 2023, CMS extended the deadline to September 29, 2023. On September 1, 2023, CMS extended the deadline to January 31, 2024, and indicated that deadlines would continue to be extended until CMS develops and issues new monitoring templates and guidance to states. On December 22, 2023, CMS extended the deadline to May 31, 2024. On May 4, 2024, CMS extended the deadline to March 2025. New Mexico prepared, completed, and submitted its SMI/SED Monitoring Protocol on March 31, 2025, following receipt of new templates and guidance from CMS. New Mexico awaits CMS feedback and/or approval of the monitoring protocol at this time.

MEDICAID HOME VISITING (MHV) PROGRAM

In DY12 Q2, the Medicaid Home Visiting (MHV) program served 840 families. The following is DY12 Q2 data for each model:

Nurse Family Partnership (NFP) Model:

- University of New Mexico Center for Development and Disability (UNM CDD) NFP served a total of 63 unique families in DY12 Q2 in Bernalillo County and Valencia Counties.
- Youth Development Inc. (YDI) served 114 families in DY12 Q2 in Bernalillo, Rio Arriba, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 13 unique families in DY12 Q2 in Bernalillo County.
- ENMRSH served 38 unique families in DY12 Q2 in Curry and Roosevelt Counties.
- Taos Pueblo served 15 unique families in DY12 Q2 in Taos County.
- MECA Therapies served 227 unique families in DY12 Q2 in Chaves, Curry, Doña Ana, Roosevelt, and Lea Counties.
- Aprendamos served 272 unique families in DY12 Q2 in Doña Ana, Sierra, and Otero Counties.
- Community Action Agency of Southern New Mexico served 23 unique families in DY12 Q2 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 20 unique families in DY12 Q2 in San Juan County.
- Tresco served 30 unique families in DY12 Q2 in Bernalillo and Santa Fe Counties.
- Guidance Center of Lea County served 25 unique families in DY12 Q2 in Lea County.

The Medicaid Home Visiting Program (MHV) program is expanding with more Medicaid members having access to services. This is due to increased enrollment of new providers and expansion of additional services available through the program. HCA has been

approved to add 4 MHV models to include Child First, Family Connect, Healthy Families America, and SafeCare Augmented.

Several strategies are currently being employed to streamline the process of enrollment, credentialing, billing, and referral management. The Provider Billing Manual has been revised to provide updated MCO information and is currently out for Public Comment. HCA and the Early Childhood Education and Care Department (ECECD) meet monthly with providers to ensure support for providers with any questions and concerns that may hinder member access to MHV services. ECECD has established a provider concerns email for providers to submit issues and concerns which will allow a timely resolution.

PRESUMPTIVE ELIGIBILITY PROGRAM

The New Mexico HCA Presumptive Eligibility (PE) program continues to be an important part of the State's efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some New Mexico State Agencies including the New Mexico Department of Health (DOH), New Mexico Children Youth and Families Department (CYFD), and the New Mexico Corrections Department (NMCD). During this reporting period, the PE program implemented new system enhancements in the Health Care Authority's Unified Portal system. The system enhancements include new features in Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE), a Presumptive Eligibility Determiner provider enrollment platform and a new Learning Management platform.

PE program staff provided one instructor led training and a self-paced, computer-based training that was available for one month. It trained PEDs on how to use the new system platforms. Each PED had to provide a certificate of completion and sign a new Code of Conduct form to confirm their recertification as a New Mexico Presumptive Eligibility Determiner and proficiently using the platforms. Due to the system transition, the number of active PEDs dropped to approximately 559 state-wide. PE program staff continue to build computer-based trainings in the LMS platform for individuals from certified entities who want to become certified Presumptive Eligibility Determiners. These training courses will be released during the next reporting period.

The new features allow PEDs to provide PE screening, grant PE approvals, assist with ongoing Medicaid application submissions as well as assist individuals with applications for CASH assistance, Supplement Nutrition Assistance Program (SNAP) and Low Income Energy Assistance program (LIHEAP). The PEDs can also assist with renewal applications for all the programs mentioned above. These new capabilities allow for New Mexico PEDs

to provide a more person-centered approach for New Mexico most vulnerable population making it easier to access benefits.

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

YESNM-PE is only available to certified PEDs. PEDs use YESNM-PE to screen and grant approvals for PE coverage. They also use YESNM-PE to submit ongoing Medicaid applications. With Baby Bot, PEDs at hospitals, IHS/Tribal 638s and birthing centers also have the enhanced capabilities of electronically adding newborns to an existing case. Access to the Baby Bot is available through a link located on the PED’s home page in YESNM-PE. The Baby Bot platform operates as a webservice and sends the information electronically to ASPEN, HCA’s eligibility system. Once the mother’s eligibility has been electronically verified in ASPEN, the system automatically adds the newborn to the case. This allows immediate access to benefits for the newborn. Currently, 198 active PEDs are certified to use the Baby Bot functionality with more trainings scheduled to increase participation.

Following are descriptions for each column header in the table below:

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

Table 8: Medicaid-eligible newborns submitted through Baby Bot on YESNM-PE

AVA Baby Bot (Oct - Dec 2024)					
Month	Newborns Submitted through AVA	Newborns Successfully Enrolled	Newborns Unsuccessfully Enrolled - Tasks Created	% of Newborns Successfully Enrolled	% of Newborns Unsuccessfully Enrolled
October	837	616	221	74%	27%
November	958	716	242	75%	25%
December	931	718	213	77%	23%
Total	**2,726**	**2,050**	**676**	**75%**	**25%**

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY12 Q2, 64 PEDs used the Baby Bot functionality. Program staff had a decrease in the amount of PED participation during this reporting period however an increase in the number of newborns added through the Baby Bot functionality. In this reporting period, staff observed a slight increase in the percentage of Newborns "Successfully Enrolled." HCA program staff continue to work with system developers and PEDs to continue the increase of the number of newborn submissions as well as the number of successful submissions through the Baby Bot functionality.

Table 9: PE Approvals

PE APPROVALS (Oct to Dec 2024)				
Month	PEs Granted	% PE Granted with Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
October	282	100%	816	581
November	82	96%	637	468
December	158	99%	803	625
Total	**522**	**99%**	**2,256**	**1,674**

Source: Monthly PE001 Report from ASPEN and OmniCaid

Table 9 above outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. NM PEDs are aware of the importance of ongoing Medicaid coverage for their clients. In this reporting period, HCA saw a decrease in the number of PEs granted and PEs that also had an ongoing application submitted. In DY12 Q2, 99% of all PE approvals had an ongoing application submitted.

JUST HEALTH PROGRAM

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

The JUST Health program was established to ensure justice-involved individuals have timely access to healthcare services upon release from correctional facilities. To ensure this access can occur, individuals who have active Medicaid coverage at the time of incarceration do not lose their Medicaid eligibility, but rather, have their Medicaid benefits suspended after 30 days. Benefits are reinstated upon the individual's release from incarceration, which allows immediate access to care. Individuals who are not Medicaid participants, but who appear to meet eligibility requirements, are given the opportunity to apply while incarcerated. Application assistance is provided by PEDs at the correctional facilities.

It is HCA's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, behavioral health appointments, outpatient/inpatient residential treatment for SUD) upon release. To help facilitate access to care and ensure a smooth transition from correctional facilities back out into the communities, HCA has established the Turquoise Care JUST Health workgroup. The monthly workgroup includes representatives from State and County Correctional facilities, Managed Care Organizations, County governments, State agencies, provider organizations, and other stakeholders. The goal of the workgroup is to create a transition of care with detailed processes and procedures that can be utilized and adapted to work for all correctional facilities statewide.

The following table outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. HCA observed a decrease in the amount of PE applications granted, and a decrease in the number of Medicaid applications submitted from jail or prison settings in DY12 Q2. Now that the PHE has ended and COVID-19 protocols in jails and prisons are lifted, HCA expects to see the numbers of applications submitted increase over the next two years. The department continues to work on the relationships between the jails and prisons, and with the justice-involved population. Following the State's approval of the 1115 Re-entry demonstration waiver the department has started meeting with justice involved stakeholders to develop the framework and implementation plan for the enhanced JUST Health Plus program. In DY12 Q2, 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 10: PE Approvals

PE APPROVALS – JUST HEATH Oct - Dec 2024				
Quarter	**PEs Granted**	**% PE Granted w/ Ongoing Applications Submitted**	**Total Individuals Applied**	**Individuals Approved**
October	5	100%	120	99
November	3	100%	96	83
December	4	100%	124	109
Total	**12**	**100%**	**340**	**291**

Source: Monthly PE001 Report from ASPEN and OmniCaid

7
HCBS REPORTING

Community Benefit

In DY12 Q2, Community Benefit (CB) related projects have included:

- continued monitoring of MCO implementation of the CB program,
- completion of the CB rate study,
- increasing CB allocations to fill approved slots,
- planning for implementation of new CB meals benefit, and
- response to CMS related to the on-site visit for the Final HCBS Settings Rule.

HCA also continued to collaborate with providers, stakeholders, and state agencies to implement initiatives approved under its American Rescue Plan Act (ARPA) HCBS Spending Plan and Narrative.

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

- Implementing rate increases for PCS and other CB services to coincide with state and local minimum wage increases.
    - HCA will establish a fee schedule for CB services in July 2025.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers. A quarterly 5% payment was issued in 2024. HCA requires that providers attest that they are using the funding in accordance with the CMS approved ARPA spending plan before any payments are made.
- Approving higher rates for certain caregivers in rural areas on a case-by-case basis.
- One MCO issued grants to PCS agencies through the NM Association for Home Health and Hospice Care. These grants continued in 2024.
- Another MCO convened an LTSS provider stakeholder group to obtain feedback and develop solutions to address workforce shortages.
- HCA, in collaboration with the NM Aging and Long-Term Services Department has been awarded a direct care workforce (DCW) TA opportunity through the ACL DCW Strategies Center. HCA has regular meetings with this workgroup to strategize for statewide improvements.

- HCA conducted a rate study for CB services. Rates may be increased in CY 2025 if sufficient funding is awarded by the legislature.

Under the TC waiver, CMS approved 6,789 CB slots for those who are not otherwise Medicaid eligible. The state may expand the number of slots by an additional 800 slots, bringing the total number of slots to 7,589, if the state finds it has sufficient funding. At the end of DY12 Q2, 5,801 of the 6,789 available slots were filled, leaving 988 available slots. HCA will report the total number of expanded slots that should be counted for ARPA to CMS as required.

Electronic Visit Verification

HCA, in partnership with the MCOs, continued to operate EVV for Agency-Based Community Benefit (ABCB), Self-Directed Community Benefit (SDCB), and EPSDT Personal Care Services. EVV for Home Healthcare Services and respite services was implemented in January 2024 and HCA continues to collaborate with the MCOs, providers, and CMS to ensure requirements are met.

Electronic Visit Verification - HCBS

For DY12 Q2, the average number of SDCB caregivers using EVV is 65%. HCA is continuing to offer training and technical assistance for SDCB agencies and individual employees to encourage more SDCB providers to use EVV. In DY11 Q2, HCA began working with the SDCB Fiscal Management Agency (FMA) and the EVV vendor to explore ways to streamline file feeds and improve EVV user experience. This work is continued in DY12 Q2.

ABCB EVV data for DY12 Q2 is outlined in the table below. The MCOs reported that 77% of the total ABCB PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder of claims were created through the Fiserv Authenticare mobile application.

Electronic Visit Verification - Physical Health

EPSDT PCS: From October 1 to December 31, 2024, MCOs reported that 99% of EPSDT PCS captured with EVV used either Fiserv Authenticare application (31%) or Interactive Voice Response (IVR) phone system (68%).

Home Healthcare Services: From October 1 to December 31, 2024, MCOs reported 57% of Home Health services captured with EVV used either Fiserv Authenticare application (55%) or Interactive Voice Response (IVR) phone system (2%). HCA has

been able to capture issues in reporting the recently implemented EVV. HCA accessing ways to improve data collection and monitoring MCOs actions to assist home health agencies in their transition to EVV utilization. It is noted that this is the first quarter for 2 MCOs. HCA anticipates continued improvement as new MCOs align systems and process.

Table 11: ABCB EVV DATA

EVV DATA (Oct-Dec 2024)		
MCO	**AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD**	**NUMBER OF TOTAL CLAIMS THIS PERIOD**
BCBS	7,508	469,126
PHP	13,029	854,165
MHC	720	43,233
UHC	2,039	41,316
TOTAL	**23,296**	**1,407,840**

Source: MCO Report #35 DY12 Q2, October- December 2024

Statewide Transition Plan

HCA received approval of its Statewide Transition Plan (STP) on March 10, 2023. The 508 compliant version of the statewide transition plan has been posted online. The MCOs formed a workgroup and continue to collaborate on ongoing monitoring activities including provider training, attestations and care coordination tools. The MCOs audited all Community Benefit settings in DY10 Q4 and no concerns were identified. HCA completed an on-site review from CMS and New Editions in September 2024. HCA staff were in attendance during the site visits. For the 1115 CB program, two assisted living facilities and one adult day health facility were visited. On December 18, 2024, HCA received the report of findings from CMS. HCA responded to all concerns by the January 21, 2025 deadline.

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

HCA requires the MCOs to provide a quarterly summary of their internal audits of NF LOC Determinations. Each MCO conducts internal random sample audits of both community-based and facility-based determinations completed by their staff based on HCA's NF LOC criteria and guidelines. The audit includes accuracy, timeliness, consistency, and training of reviewers. The results and findings are reported quarterly to HCA along with any Quality Performance Improvement Plan. HCA is reporting DY12 Q1 audit results this quarter and audit findings for DY12 Q2 will be reported in DY13 Q1.

Total audits for DY12 Q1:

- BCBS conducted 108 total audits of NF LOC determinations, 18 facility-based and 90 community-based.
- MHC conducted 24 total audits of NF LOC determinations, six facility-based and 18 community-based.
- PHP conducted 202 total audits of NF LOC determinations, 55 facility-based and 147 community-based.
- UHC conducted 37 total audits of NF LOC determinations, three facility-based determinations and 34 community-based.

Audit results for NF LOC determinations for DY12 Q1:

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

Audit results for timeliness of determinations for DY12 Q1:

- BCBS reported 100% timeliness of determinations for High and Low Facility Based and 93% for Community Based NF LOCs.
- MHC reported 33% timeliness of determinations for High Facility Based NF LOCs and 100% timeliness of determinations for Low Facility Based NF LOCs and 100% timeliness for Community Based NF LOCs.

- PHP reported 67% timeliness of determinations for High Facility Based NF LOCs and 100% timeliness of determinations for Low Facility Based NF LOCs and 100% for Community Based NF LOCs.
- UHC reported 100% timeliness of determinations for Low Facility Based as there were no determination for Hight Facility based and 100% for Community Based NF LOCs.

Aggregate results:

- NF LOC determinations aggregate results are 100% for High and Low Facility Based and 100% for Community Based NF LOCs.
- Timeliness of determinations aggregate results are 100% for High and Low - Facility Based and 97.9% for Community Based.

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

Table 12: MCO Internal NF LOC Audits – Facility-Based

Facility-Based Internal Audits				
High NF Determinations	**Jul**	**Aug**	**Sep**	**DY12 Q1**
Total number of High NF LOC files audited	**4**	**6**	**3**	**13**
BCBSNM	3	4	3	**10**
MHC	0	1	0	**1**
PHP	1	1	0	**2**
UHC	0	0	0	**0**
Total number of files with correct NF LOC determination	**4**	**6**	**3**	**13**
BCBSNM	3	4	3	**10**
MHC	0	1	0	**1**
PHP	1	1	0	**2**
UHC	0	0	0	**0**
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
MHC	0%	100%	0%	**100%**
PHP	100%	100%	0%	**100%**
UHC	0%	0%	0%	**0%**
Low NF Determinations	**Jul**	**Aug**	**Sep**	**DY12 Q1**
Total number of Low NF LOC files audited	**24**	**25**	**20**	**69**
BCBSNM	3	2	3	**8**
MHC	2	2	1	**5**
PHP	19	19	15	**53**
UHC	0	2	1	**3**
Total number of files with correct NF LOC determination	**24**	**25**	**20**	**69**
BCBSNM	3	2	3	**8**
MHC	2	2	1	**5**
PHP	19	19	15	**53**
UHC	0	2	1	**3**
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
MHC	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
UHC	0%	100%	100%	**100%**

Source: DY12 Q1 MCO Internal Audit Results

Table 13: MCO Internal NF LOC Audit Report – Community-Based

Community-Based Internal Audits	July	Aug	Sep	DY12 Q1
Total number of Community-Based NF LOC files audited	**104**	**92**	**93**	**289**
BCBSNM	30	30	30	**90**
MHC	6	6	6	**18**
PHP	56	45	46	**147**
UHC	12	11	11	**34**
Total number with correct NF LOC determination	**104**	**92**	**93**	**289**
BCBSNM	30	30	30	**90**
MHC	6	6	6	**18**
PHP	56	45	46	**147**
UHC	12	11	11	**34**
% with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
MHC	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
UHC	100%	100%	100%	**100%**
Timeliness of Determinations	**July**	**Aug**	**Sep**	**DY12 Q1**
Total number of Community-Based determinations completed within required timeframes	**103**	**92**	**88**	**283**
BCBSNM	29	30	25	**84**
MHC	6	6	6	**18**
PHP	56	45	46	**147**
UHC	12	11	11	**34**
				0
% of Community-Based determinations completed within required timeframes	**99%**	**100%**	**95%**	**97.9%**
BCBSNM	97%	100%	83%	**93%**
MHC	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
UHC	100%	100%	100%	**100%**

Source: DY12 Q1 MCO Internal Audit Results

MCO NF LOC Determinations

HCA requires that the MCOs report to the state a monthly breakdown of all the NF LOC determinations/redeterminations that were conducted. This report includes the total number of NF LOC determinations completed and the number of determinations that were completed timely.

- The aggregated Facility Based High NF LOC determination/redetermination percentage for DY12 Q1 was 81%, an increase from DY11 Q2 of 79%.

- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY12 Q1 was 95%, remaining the same from DY11 Q2 of 95%.
- The aggregated Community Based determination/redetermination percentage for DY12 Q1 was 98%, remained the same as the 98% reported for DY11 Q2.

HCA will continue to monitor the MCO NF LOC determinations to identify and address any trends and provide technical assistance as needed. MCO NF LOC determinations for DY12 Q2 will be reported in the DY13 Q1 report.

Table 14: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	**July**	**Aug**	**Sept**	**DY12 Q1**
Total number of determinations/redeterminations completed for High NF LOC requests	**57**	**59**	**96**	**212**
BCBSNM	37	38	65	**140**
MHC	0	3	9	**12**
PHP	20	13	17	**50**
UHC	0	5	5	**10**
Total number of determinations/redeterminations that met High NF LOC criteria	**45**	**41**	**85**	**171**
BCBSNM	32	25	55	**112**
MHC	0	3	9	**12**
PHP	13	9	17	**39**
UHC	0	4	4	**8**
% of determinations/redeterminations that met High NF LOC criteria	**79%**	**69%**	**89%**	**81%**
BCBSNM	86%	66%	85%	**80%**
MHC	0%	100%	100%	**100%**
PHP	65%	69%	100%	**78%**
UHC	0%	80%	80%	**80%**
Low NF Determinations	**July**	**Aug**	**Sept**	**DY12 Q1**
Total number of determinations/redeterminations completed for Low NF LOC requests	**382**	**373**	**561**	**1316**
BCBSNM	148	119	189	**456**
MHC	2	8	33	**43**
PHP	229	226	317	**772**
UHC	3	20	22	**45**
Total number of determinations/redeterminations that met Low NF LOC criteria	**370**	**348**	**532**	**1250**
BCBSNM	146	115	183	**444**
MHC	2	8	33	**43**
PHP	219	206	294	**719**
UHC	3	19	22	**44**
% of determinations/redeterminations that met Low NF LOC criteria	**97%**	**93%**	**95%**	**95%**
BCBSNM	99%	97%	97%	**97%**
MHC	100%	100%	100%	**100%**
PHP	96%	91%	93%	**93%**
UHC	100%	95%	100%	**98%**

Source: DY12 Q1 MCO NF LOC Determinations Report

Table 15: MCO NF LOC Determinations – Community-Based

Community Based Determinations	July	Aug	Sept	DY12 Q1
Total number of determinations/redeterminations completed	**1950**	**1511**	**2067**	**5528**
BCBSNM	548	598	604	**1750**
MHC	36	87	92	**215**
PHP	1304	709	1277	**3290**
UHC	62	117	94	**273**
Total number of determinations/redeterminations that meet NF LOC criteria	**1929**	**1482**	**2014**	**5425**
BCBSNM	542	587	589	**1718**
MHC	36	87	92	**215**
PHP	1289	692	1251	**3232**
UHC	62	116	82	**260**
% of determinations/redeterminations that meet NF LOC criteria	**99%**	**98%**	**97%**	**98%**
BCBSNM	99%	98%	98%	**98%**
MHC	100%	100%	100%	**100%**
PHP	99%	98%	98%	**98%**
UHC	100%	99%	87%	**95%**

Source: DY12 Q1 MCO NF LOC Determinations Report.

External Quality Review Organization (EQRO) NF LOC

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

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

In DY12 Q1:
Based on the EQRO's evaluation of NF LOC determinations, aggregated results reflect 80% compliance for High NF LOC determinations, and 89% compliance for Low NF LOC determinations. Areas of noncompliance were addressed with the applicable MCOs. HCA collaborated with the applicable MCOs to improve processes for providing complete audit materials. Separately, the EQRO determined 100% compliance for Community Based NF LOC determinations.

HCA will continue to monitor the EQRO audit of MCO NF LOC determinations to identify and address any trends and provide technical assistance as needed. NF LOC determinations for DY12 Q2 will be reported in the DY13 Q1 report.

Table 16: EQRO NF LOC Review

Facility-Based		
High NF Determination	**DY12 Q1**	**DY12 Q2**
Number of Member files audited	**20**	
BCBSNM	6	
MHC	3	
PHP	6	
UHC	5	
Number of Member files the EQRO agreed with the determination	**16**	
BCBSNM	6	
MHC	2	
PHP	6	
UHC	2	
% of Member files the EQRO agreed with the determination	**80%**	
BCBSNM	100%	
MHC	67%	
PHP	100%	
UHC	40%	
Low NF Determination	**DY12 Q1**	**DY12 Q2**
Number of Member files audited	**45**	
BCBSNM	12	
MHC	11	
PHP	12	
UHC	10	
Number of Member files the EQRO agreed with the determination	**40**	
BCBSNM	12	
MHC	11	
PHP	12	
UHC	5	
% of Member files the EQRO agreed with the determination	**89%**	
BCBSNM	100%	
MHC	100%	
PHP	100%	
UHC	50%	
Community-Based	**DY12 Q1**	**DY12 Q2**
Number of Member files audited	**115**	
BCBSNM	30	
MHC	25	
PHP	30	
UHC	30	
Number of Member files the EQRO agreed with the determination	**115**	
BCBSNM	30	
MHC	25	
PHP	30	
UHC	30	
% of Member files the EQRO agreed with the determination	**100%**	
BCBSNM	100%	
MHC	100%	
PHP	100%	
UHC	100%	

Source: DY12 Q1 EQRO NF LOC Report.

Waiver Assurance Performance Measures

In accordance with New Mexico's 1115 Demonstration Waiver STCs and clarification received from CMS, HCA has removed the 1915(c)-like waiver assurance performance measures from this quarterly monitoring report. With guidance from CMS, HCA has addressed the waiver assurances by including performance measures in its Quality Improvement Strategy (QIS) that was submitted to CMS on February 25, 2025, and HCBS Performance Measure Reports that were submitted to CMS on February 28, 2025. These deliverables remain under CMS review.

8
AI/AN REPORTING

Contracting between Managed Care Organizations and I/T/U Providers
The following are DY12 Q2 updates on contracting between MCOs and I/T/U providers.

MCO	
BCBSNM	BCBS reports they reached out to San Ildefonso Pueblo (contract pending provider response), Navajo Regional Behavioral Health, Pine Hill (contract pending provider response) and the Southern Ute Tribe, Albuquerque Area IHS, Ysleta Del Sur Pueblo who has expressed an interest in contracting with BCBS. According to BCBSNM they are waiting for signature from San Ildefonso Behavioral Health. BCBS has been unsuccessful at scheduling a meeting with Navajo Regional BH but will continue to try and reach this provider. BCBS sent a contract to Pine Hill Health Center. They are waiting for the provider to respond. BCBS requested additional information from Southern Ute Indian Tribe dba: Southern Ute Health Center to write up contracts. BCBS has been unsuccessful in connecting with Albuquerque IHS. Ysleta Del Sur's contract became effective 01/20/2025.
MHC	The Office of Native American Affairs and Provider Contracts with Molina has been engaging with Indian Health Service (IHS), Tribal 638s, and Urban Indian providers (I/T/Us) for contracting efforts. Key presentations held during the reporting period included: Ysleta de Sur Health Clinic: Provided technical assistance to complete their tribal agreement and answered reimbursement questions for Tribal-specific services. Navajo Department of Behavioral and Mental Health Services: Provided technical assistance related to tribal agreements for behavioral health services.

	Crownpoint IHS Hospital: Discussed opportunities for IHS agreements to support care coordination/case management. Navajo Area IHS Purchased Referred Care: Discussed opportunities for IHS agreements to support patient referrals to non-IHS and Tribal providers. Picuris Pueblo: Discussed opportunities for Tribal agreement to support tribal-specific services for their health center and CHR program. Mescalero Apache: Discussed opportunities for Tribal agreements to support tribal-specific services for their CHR program and nursing facility.
PHP	PHP Native American Affairs continues to work with contracting departments to update Mutual Partnership Agreement templates. Discussions with potential Tribal partners include an introduction to VBP agreements and support for other programs that address Native American health disparities. There has been no response yet. PHP has configured their provider process to allow interested Tribal Community Health Representatives (CHR) and/or Community Health Workers (CHW) to start the process to be added to the PHP network. San Ildefonso Pueblo Behavioral Health – This Agreement has been signed and is now live in the network. Kewa Pueblo Health Corporation, Inc., Kewa Health Center and Kewa Family Wellness Center - PHP recently updated this agreement to add the FQHC rates. The Behavioral Health Division at the Kewa Family Wellness Center has been loaded as participating in the PHP Network. PHP provides technical assistance to the Wellness Center as requested. Pueblo of Picuris Health Center and Behavioral Health Program - PHP Native American Affairs and Provider Network Operations (PNO) have had discussions regarding agreements with the Pueblo as they execute their new health center and behavioral health services. Jicarilla Apache Behavioral Health - PHP Native American Affairs reached out to this organization or offer support. No response from the Tribe. Pueblo of Laguna Community Health and Wellness - PHP Native American Affairs is waiting for a response from this organization.

	San Felipe Health Center/San Felipe Pueblo - PHP continues to await further direction from their clinical director and Pueblo Administration. First Nations Community Healthsource (FNCH) - PHP recently updated this agreement to a large volume VBP agreement. The Hep C team will continue to meet with them to develop this program. First Nations also has a Traditional Wellness Program. PHP provides support to the wellness program. Technical assistance regarding billing processes for this program is ongoing. Navajo Nation Division of Behavioral and Mental Health Services (NNBMHS) - NNBHS provides behavioral and mental health service to PHP Turquoise Care members via locations at Shiprock, Gallup and Crownpoint. PHP Provider Network Operations and Native American Affairs have provided an onboarding training and NNBMHS are now live in the PHP network. Native American Affairs also engages NNBMHS as a resource when addressing complex member cases and issue on Jurisdiction. Pueblo of Nambe/Tewa Roots Society - This Tribal 638 program has been successfully loaded into the PHP Provider Network as participating. Provider Network Operations continues providing technical assistance regarding billing capacity as requested Taos Pueblo Community Health and Wellness Division/Tiwa Babies Home Visiting – NA Affairs and Population Health have met with this organization to provide tech support. Mescalero Apache CHR Program - Four Directions Treatment and Recovery Center has been loaded to the network as a Tribal 638. An official contract is not required for IHS/638 providers. PHP has provided technical support calls with Mescalero Care Center.
UHC	UHC entered Turquoise Care on 7/01/2024. They report they are working on building relationships with Tribes/Pueblos/Nations and IHS, Tribal 638 and Urban Indian Health Centers by listening to their needs and assisting with their priorities. UHC has not entered into any agreements with I/T/Us, IHS and Tribal 638s at this time.

Timely Payment for all I/T/U Providers, including Complaints.
According to MCO Report 47, *Claims Activity Report* for DY12 Q2:

- BCBSNM processed 99.6% clean claims within 15 days and 99.8% clean claims within 30 days.
- MHC processed 90.5% clean claims within 15 days and 99.1% within 30 days.
- PHP processed 98.5% clean claims within 15 days and 100.0% clean claims within 30 days.
- UHC processed 100.0% clean claims within 15 days and 100.0% clean claims within 30 days.

There were complaints that PHP was not paying the correct rate for pharmacy claims. This issue was resolved to IHS' satisfaction.

Native American Technical Advisory Committee (NATAC) Issues and Recommendations:

At the DY12 Q2 NATAC meeting held on December 16, 2024 –

- Request to go over Governor's budget for 2025. Since 60-day session just began, update will be done at the March 2025 NATAC.
- The Department of Health and the HCA have developed a CHR 101 training course that includes billing guideline for Community Health Representative (CHR) billing.
- Traditional Health Care Practices (THCP) Demonstration approved by CMS in October 2024 held a kick-off meeting to develop a workgroup to address CMS' Special Terms and Conditions as part of the demonstration waiver.
- Justice Involved Pre-Release Services – NM is one of seven states that was approved by CMS to start a Justice Re-Entry Waiver Program. Incarcerated individuals will receive care coordination, Medication Assisted Treatment (MAT) and 30-day supply of prescriptions prior to their release from jail/incarceration beginning July 2025.

The DY12 Native American Technical Advisory Committee (NATAC) Schedule

Date		Time	Location
December 16, 2024	1:00 p.m. - 4:00 p.m.	virtual	
March 17, 2025	1:00 p.m. – 4:00 p.m.	virtual	
June 16, 2025	1:00 p.m. – 4:00 p.m.	virtual	
September 15, 2025	1:00 p.m. – 4:00 p.m.	virtual	

Native American Advisory Board (NAAB) Issues and Recommendations

The following issues were raised at the DY12 Q1 NAAB meetings.

MCO	DATE	Issues/Recommendations
BCBS	N/A	There is no meeting scheduled until October.
PHP	September 26, 2024 Dulce, NM	Members had questions about whether they could use IHS and Presbyterian simultaneously (which is allowed), how to tell if your Traditional Healing Benefit is approved, and if you can receive the benefit if you are listed as Caucasian. PHP responded that you have to be listed as Native American in the Medicaid web portal to receive this benefit. The stipend is to be used for traditional or ceremonial services only. Some questions from the Albuquerque meeting were: **Question: "**If a member is further along in their pregnancy, can they get the Pregnancy Passport program?" **Answer:** "Yes". **Question**: "With the switch from Centennial Care to Turquoise Care, will the same providers and VAS be available?" **Answer:** "The way it is structured, there should be very little member disruptions with member benefits and VAS. The member can call the customer service number on the back of their membership card if they have any questions." **Question**: "If I haven't communicated with my care coordinator for a while, will I still have the same one?" **Answer:** "Have the member call the Care Coordination hotline to see if their case is closed. If it is, they can start over again."
MHC	N/A 10/16/2024 12/18/2024	There is no meeting scheduled until October. 10 am – 1 p.m.: Albuquerque, NM - Hybrid 10 am – 1130 a.m. - Virtual
UHC	September 25, 2024 (virtual meeting)	There were no questions from the four attendees at the meeting. However, they had the following comments: • "Make sure there are language interpreters for crisis calls and interpreters for doctor appointments for patients who need that." "Explore additional services in rural areas such as work therapy, massage/acupuncture therapy, children's services, justice involved services, and long-term care services."

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ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE	3/26/21
COMPLETION DATE	Open
ISSUES	ModivCare has been placed on a corrective action plan for not meeting the contractual timeliness measures for certain Customer Service Call Center metrics and other additional contractual requirements.
RESOLUTION	Due to continued service level failures, the action plan remains open. **DY12 Q2 update:** The Plan of Action (POA) related to the non-emergency medical transportation (NEMT) call center remains open. For DY12 Q2, ModivCare did not meet all call metrics 90% of calls were not answered by a live voice within (30) seconds. BCBS continues to meet with ModivCare daily to discuss issues and/or concerns. BCBSNM meets with ModivCare weekly to monitor the on-time performance measures. ModivCare reports there were several challenges that impacted ModivCare's Service Level results. • ModivCare had a higher-than-expected call volume • ModivCare staffing ModivCare reported higher than expected call volume, and they were understaffed for the quarter. ModivCare reports they hired individuals to fill the staffing gaps that affected the service levels. HCA meets with BCBS regularly to review the progress of this POA.

PRESBYTERIAN	
ACTION PLAN	None in effect in DY12 Q2
IMPLEMENTATION DATE	
COMPLETION DATE	
ISSUES	

Molina Health Care	
ACTION PLAN	New Member Enrollment Requirements
IMPLEMENTATION DATE	10/30/2024
COMPLETION DATE	Open
ISSUES	Molina Health Care (MHC) identified issues of timeliness for PCP Auto Assignment, Member PCP Selection, and Member ID Card Replacement
RESOLUTION	Processes and controls that incorporate the correct logic have been re-designed for inbound file processing and outbound extracts to the appropriate vendor. Monitoring is in place to ensure timeliness.

Molina Health Care	
ACTION PLAN	Institution of Mental Disease (IMD) Claims Standard Operating Procedure not reflecting 15-day or less reimbursement
IMPLEMENTATION DATE	12/19/2004
COMPLETION DATE	Open
ISSUES	Molina Health Care (MHC) identified the need to re-program systems for timely payment of IMD. The system will identify claims billed for IMD with date spans greater than 15 days. MHC processed an upfront edit and is considering a custom solution for the tracking of these claims.
RESOLUTION	MHC to monitor to ensure consistent processing which meets contract requirements.

Molina Health Care	
ACTION PLAN	Standard and Expedited Prior Authorization timeliness challenges
IMPLEMENTATION DATE	12/31/2024
COMPLETION DATE	Open
ISSUES	Molina Health Care (MHC) identified issues of incorrect inputs for the calculation of timeliness in their Utilization Management (UM) automated system that resulted in reporting of some Standard and Expedited Authorizations as non-compliant, outside of the 7-business day and 24-hour respective requirement.
RESOLUTION	The MHC system has been updated, and MHC is monitoring compliance.

Molina Health Care	
ACTION PLAN	Delegation Oversight – DentaQuest Credentialing
IMPLEMENTATION DATE	12/31/2024
COMPLETION DATE	Open
ISSUES	Molina Health Care (MHC) reports that during an annual credentialing audit, it was determined that DentaQuest's Policies and Procedures did not reflect the required NM standards that require a 30-day timeline from application to committee review.
RESOLUTION	DentaQuest has updated Policies and Procedure and has educated their staff regarding the correct processing timeline. MHC continues oversight.

United Health Care	
ACTION PLAN	Critical Incidents
IMPLEMENTATION DATE	10/1/2024
COMPLETION DATE	Open
ISSUES	UnitedHealthcare (UHC) reports working to obtain Admissions, Discharges and Transfers (ADT) data feeds as it has not been receiving adequate data on Emergency Department (ED) visits for Critical Incident reporting.

	UHC reports that monthly Critical Incident audit results have been below 90%.
RESOLUTION	UHC reports that it has gained access to Point Click Care which provides almost real-time ADT data feeds on Admissions, Discharges, and Transfers. Additional UHC Critical Incidents staff have been hired, and UHC has developed a process for tracking all incidents within 24 hours to ensure they are up to date. UHC has implemented a process that requires a Clinical Administrative Coordinator to send weekly files of all incidents that have been reviewed to verify accuracy. UHC is engaged in Re-training of Care Coordination staff on Critical Incidents and ongoing monthly Personal Care Service (PCS) Agency training on Critical Incidents.

United Health Care	
ACTION PLAN	HEDIS Measure Improvement and Provider Outreach
IMPLEMENTATION DATE	10/1/2024
COMPLETION DATE	Open
ISSUES	UHC reports that as a new MCO entering the market on July 1, 2024, it has used the July through December timeframe to develop a baseline for their member population to understand HEDIS measure performance. UHC reports that they have limited data and that their denominators continued to grow through DY12 Q2. UHC has developed a level 1 provider incentive program to engage providers on improved HEDIS measure performance.
RESOLUTION	UHC reports that they have successfully contracted 12 provider groups through DY12 Q2 for inclusion in their CP-PCPi provider incentive program (VBP). UHC has targeted 40 additional groups in 2025.

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FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY12 Q2 reflects the capitation rates for Turquoise Care that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 28, 2023, and the updated rates were submitted on June 28, 2024. On weighted average, the CY 2024 rate is 4.69% higher than that of CY 2023; the fee-for-service claim payments for CY 2024 are still lagging. In addition, data run for CYs 2023 and 2024 will continue and the PMPMs will continue to change as expenditures come in (see Attachment B – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). Attachment B – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis indicates that DY10, Table 10.5, is 9.6% below the budget neutrality limit with data through eight (8) quarters. Table 11.5 shows a 13.6% below the budget neutrality limit for DY11 with data of four (4) quarters, and Table 12.5 shows preliminary data for DY12 of 4.1% below the budget neutrality limit with two (2) quarters of data.

11

MEMBERMONTH REPORTING

Member Months		2024
		4
MEG1	0-FFS	69,973
	Molina Healthcare	58,837
	Presbyterian	527,026
	United Healthcare	53,347
	Blue Cross Blue Shield	376,986
	Total	**1,086,169**
MEG2	0-FFS	5,797
	Molina Healthcare	4,893
	Presbyterian	56,780
	United Healthcare	4,225
	Blue Cross Blue Shield	36,821
	Total	**108,516**
MEG3	0-FFS	0
	Molina Healthcare	4,834
	Presbyterian	57,673
	United Healthcare	5,477
	Blue Cross Blue Shield	30,475
	Total	**98,459**
MEG4	0-FFS	177
	Molina Healthcare	21
	Presbyterian	359
	United Healthcare	14
	Blue Cross Blue Shield	224
	Total	**795**
MEG5	0-FFS	0
	Molina Healthcare	461
	Presbyterian	10,430
	United Healthcare	727
	Blue Cross Blue Shield	7,432
	Total	**19,050**
MEG6	0-FFS	60,185
	Molina Healthcare	44,920
	Presbyterian	359,052
	United Healthcare	43,824
	Blue Cross Blue Shield	292,052
	Total	**800,033**
MG10	0-FFS	12
	Molina Healthcare	6
	Presbyterian	187
	United Healthcare	11
	Blue Cross Blue Shield	156
	Total	**372**
MGX8	0-FFS	0
	Molina Healthcare	22
	Presbyterian	636
	United Healthcare	52
	Blue Cross Blue Shield	724
	Total	**1,434**
	Total	**2,114,828**

Source: Enrollee Counts Report

The new Financial Service module will go live December 11, 2025. The change for the new SMI/SUD MEG will need to be developed in the new Omnicaid system (CMdS). The current Omnicaid system will go into a hard freeze in a few months.

12
CONSUMER ISSUES

GRIEVANCES

HCA receives MCO Report 37 Grievances and Appeals quarterly. The report analyzes the MCOs' responses to ensure that grievances filed by members are addressed timely and appropriately. The report also provides information related to the summary of member grievance reason codes.

In DY12 Q2, Report 37 was suspended pending template and instructions updates. These updates are necessary due to data inconsistencies discovered by HCA in the MCOs' DY12 Q1 submissions. HCA conducted a technical assistance call with all MCOs in December 2024 and concluded the data inconsistencies were due to methodology errors in the report instructions. HCA anticipates that the updated reporting package will be implemented by DY13 Q1 and will have MCOs submit data retrospectively to July 1, 2024.

APPEALS

Report 37 appeals section provides monitoring to guarantee that member appeals are handled promptly and suitably. The report also provides data related to the summary of member appeals reason codes.

In DY12 Q2, Report 37 was suspended pending template and instructions updates. These updates were necessary due to data inconsistencies discovered by HCA in the MCOs' DY12 Q1 submissions. HCA conducted a technical assistance call with all MCOs in December 2024 and concluded the data inconsistencies were due to methodology errors in Report 37 instructions. HCA anticipates that the updated reporting package will be implemented by DY13 Q1 and will have MCOs submit data retrospectively to July 1, 2024.

13
QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HCA's Turquoise Care 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. HCA specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference the table below for 2024 MCO Advisory Board Meeting Schedules.

Table 17 2024 MCO Advisory Board Meeting Schedule

BCBS 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	03/21/2024	12:00-2:00 PM	Hybrid - Albuquerque - Metro
BCBS	04/13/2024	12:00-2:00 PM	Hybrid - Sandoval County - Central
BCBS	09/12/2024	12:00-2:00 PM	Hybrid - Albuquerque - Metro
BCBS	11/07/2024	12:00-2:00 PM	Hybrid - Albuquerque - Metro
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	04/11/2024	12:00-2:00 PM	Hybrid – Farmington (San Juan County) - Regional
BCBS	10/26/2024	12:00-2:00 PM	Hybrid - Las Cruces (Dona Ana County) - Regional
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	02/29/2024	12:00-2:00 PM	Virtual – Otero County (Mescalero) TBD
BCBS	05/09/2024	12:00-2:00 PM	Hybrid – McKinley County (Crownpoint) TBD
BCBS	08/15/2024	12:00-2:00 PM	Hybrid – Rio Arriba County (Dulce) TBD
BCBS	10/10/2024	12:00-2:00 PM	Hybrid – Albuquerque Blue Door Neighborhood Center
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	See above	See above	All above locations (SDCB included in each meeting)
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	See above	See above	All above locations (BH included in each meeting)

PHP 2024			
SDCB Subcommittee Member Advisory Board Meetings are currently on hold.			
MEMBER ADVISORY BOARD MEETING SCHEDULE (CENTRAL AREA)			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/08/2024	11:30 AM-1:00 PM	Presbyterian Rev. Cooper Center
PHP	06/07/2024	11:30 AM-1:00 PM	Presbyterian Rev. Cooper Center
PHP	09/05/2024	3:30 PM-5:00 PM	Presbyterian Rev. Cooper Center
PHP	12/05/2024	3:30 PM-5:00 PM	Presbyterian Rev. Cooper Center
STATEWIDE MEETINGS			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	05/09/2024	5:00 PM – 6:30 PM	Presbyterian Store Front, Las Cruces
PHP	11/07/2024	11:30 AM – 1:00 PM	Virtual Meeting via Teams
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/07/2024	Noon-1:00 PM	Virtual Meeting
PHP	08/29/2024	Noon-1:00 PM	Jicarilla Apache Health Care Facility
PHP	11/21/2024	Noon-1:00 PM	Presbyterian Cooper Administrative Center
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/11/2024	1:00 PM-2:30 PM	Virtual Meeting (Zoom)
PHP	06/06/2024	1:00 PM–2:30 PM	Virtual Meeting (Zoom)
PHP	09/10/2024	1:00 PM–2:30 PM	Virtual Meeting (Zoom)
PHP	12/10/2024	1:00 PM–2:30 PM	Virtual Meeting (Zoom)

MHC 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
MHC	9/26/24	12:00 PM – 1:30 PM	Virtual
MHC	12/4/24	5:30 PM – 6:35 PM	Las Cruces - Hybrid
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
N/A	N/A	N/A	N/A
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
MHC	10/16/24	10:00 AM – 1:00 PM	Las Cruces - Hybrid
MHC	12/18/24	10:00 AM – 11:30 AM	Virtual

UHC 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
UHC	9/25/24	5:30 PM – 6:30 PM	Virtual
UHC	12/4/24	5:30 PM – 6:30 PM	Virtual
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
N/A	N/A	N/A	N/A
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
UHC	9/25/24	12:00 PM – 1:00 PM	Virtual
UHC	12/4/24	12:00 PM – 1:00 PM	Virtual

Quality Assurance
DY12 Q2

Quarterly Quality Meeting

HCA holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HCA updates and guidance on required quality monitoring activities as well as relay HCA findings from the monthly, quarterly, and annual reports submitted by the MCOs.

The DY12 Q2 meeting was held on December 18, 2024. HCA agenda items included a summary overview of SFY25 Legislative Finance Committee (LFC)-assigned Performance Measures and targets (26 in total; five reported quarterly). The five quarterly measures are collected from MCOs on an ad hoc reporting template to include data and analysis for the following measures: Percent of hospital readmissions for children in Medicaid managed care ages two through 17 years within 30 days of discharge; Percent of adults in Medicaid managed care age 18 and over readmitted to a hospital within 30 days of discharge; Percent of non-emergent utilization of all emergency department utilization that is categorized as non-emergent care; Number of Medicaid managed care members that have received treatment for hepatitis C in the reporting year; and Number of Medicaid managed care members being served by Patient-Centered Medical Homes (PCMH).

HCA presented Turquoise Care Performance Measures (PMs) (13 in total) and included: Well Child Visits in the First 30 Months of Life; Child and Adolescent Well-Care Visits; Prenatal and Postpartum Care; Oral Evaluation Dental Services; 7 Day Follow-Up After Hospitalization for Mental Illness; Breast Cancer Screening; Follow-up Care for Children Prescribed ADHD Medication – Initiation; Immunizations for Adolescents – Combination 2; Pharmacotherapy for Opioid Use Disorder; Glycemic Status Assessment for Patients With Diabetes; Eye Exam for Patients With Diabetes; Kidney Health Evaluation for Patients With Diabetes; and Lead Screening in Children. The presentation included CY24 Q3 MCO aggregate administrative rates for each PM compared to the upcoming CY25 targets, MY23 Quality Compass National Average, and MY23 MCO aggregate HEDIS rates.

HCA also presented Turquoise Care Tracking Measures (TMs) (total of 11): Smoking Cessation; Childhood Immunization Status - Combination 3; 7 Day Follow-Up After Emergency Department Visit for Mental Illness; Depression Screening and Follow-Up for Adolescents and Adults; Cervical Cancer Screening; Statin Therapy for Patients with Diabetes; Statin Therapy for Patients with Cardiovascular Disease; Statin Therapy for Patients with Cardiovascular Disease; Contraceptive Care - Postpartum Women; Initiation and Engagement of Substance Use Disorder Treatment; Prenatal Depression

Screening and Follow-Up; Postpartum Depression Screening and Follow-Up; and Diabetes Short-Term Complications Admission Rate. The presentation included CY24 Q3 MCO aggregate administrative rates for each TM, with trend comparison to CY23 Q3. Although TMs do not have assigned targets, HCA expects MCOs to closely monitor TMs by setting internal quarterly targets to achieve.

MCOs were advised of HCA's reporting expectations, emphasizing that analyses must be clear, thorough and meaningful in a narrative paragraph format to explain the story behind their reported data and observations.

Performance Measures (PMs)

The introduction of Turquoise Care includes the quarterly monitoring of 13 Performance Measures. HCA Performance Measures (PMs) are based on HEDIS technical specifications for the current reporting year. Each MCO is required to meet the DY13 through DY15 established performance targets. The PMs and targets for CY 2025, 2026, and 2027 include HCA established performance targets for three (3) years by applying the result of the CY 2022 NCQA National Average, calculating an average increase for each CY until reaching the CY22 Quality Compass National Average plus one (1) percentage point. Failure to meet targets for the PMs will result in a monetary penalty based on 3% of the total capitation paid to the MCO for the agreement year. Targets are not associated to DY12 rates; however, MCOs are expected to maintain or improve final DY10 rates.

HCA requires the MCOs to submit quarterly reports that are used to monitor the performance of each PM to determine if MCOs are on track for meeting the established target. MCOs report any significant changes as well as interventions, strategies, and barriers that impact improved performance. HCA staff will review and analyze the data to determine if the MCOs are trending towards meeting the established targets. HCA findings are communicated to the MCOs through MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meeting (QQM). HCA expects to see rates improve quarter over quarter.

Below are the MCO quarterly rates and interventions for each Turquoise Care PM for DY12 Q1 (CY24 Q3). As these measures are reported in the Managed Care Program Annual Report (MCPAR), the HCA will discontinue reporting these measures in the 1115 demonstration progress report beginning DY13 Q1.

PM #1 – Well-Child Visits in the First 30 Months of Life (W30) (two indicators)
The percentage of members who turned 15 months old during the measurement year and had 6 or more well-child visits, and the percentage of members who turned thirty (30) months old during the measurement year and had two (2) or more well-child visits during the last 15 months.

First 15 months:
DY13 target is 54.50%.

- BCBS Q3 59.22%
- MHC Q3 No Data
- PHP Q3 59.99%
- UHC Q3 22.56%
- MCO Aggregate: Q3 58.54%

15-30 months:
DY13 target is 64.48%.

- BCBS Q3 68.15%
- MHC Q3 No Data
- PHP Q3 67.15%
- UHC Q3 25.55%
- MCO Aggregate: Q3 66.09%

MCO Strategies and Interventions:

- BCBS Quality Management specialist continued to conduct outreach calls to encourage parents/guardians to schedule and complete well-child visits in the first 15 months of life. BCBS continued to send “Happy Birthday” postcards to members who have turned 1- 3 years old. BCBSNM Wellness Education Specialist also assisted with member outreach to inform parents/guardians of needed Well Child Visits. BCBS continued to engage providers with its reserved wellness appointment initiative. This initiative incentivizes providers that offer after-hour and weekend appointments for Well Child visits and use the appropriate W30 CPT code.

- MHC mailed birthday cards, postcards, or letters to all children aged birth to 21 with milestones according to the Bright Futures Periodicity table. The mailings offer education about the best practice recommended services, developmental assessments, referrals, immunizations, and reminders to schedule and attend appointments. Molina’s 2024 Pay for Quality Gap Closure program incentivizes Value Based providers to establish provider/member engagement, encourage

EPSDT assessment, age-appropriate immunization, and set children on a schedule for ongoing preventive services.

- PHP Performance Improvement Interventionist team continued to perform monthly member outreach calls to parents/guardians of members. During these calls, the parents/guardians are educated on the importance of well-child visits and offered assistance with scheduling appointments. PHP continued to mail Early and Periodic Screening Diagnostic and Treatment letters to remind parents/guardians to complete well-child visits. PHP continues to promote the Baby Bonuses rewards program. PHP used social media posts to promote compliance with this measure.

- UHC Care Coordinators conducted targeted outreach to members to assist with scheduling appointments. UHC's Quality Clinical Practice Consultant team (CPC) engaged providers on the W30 HEDIS measure, showed individual practice performance, and provided member-level detail. UHC's School Based Health Centers liaison and Tribal Health liaison worked with School-Based Health Centers and our Tribal community to improve communication on care options for members and promote the Turquoise Rewards program. UHC partnered with Finity to promote the Turquoise Care Rewards program which offers an incentive for members to complete well-child visits.

PM #2 – Children/Adolescents Well-Care Visits (WCV) (three indicators)

The percentage of members ages 3 through 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

3-11 years of age

DY13 target is 54.24%.

- BCBS Q3 42.17%
- MHC Q3 No Data
- PHP Q3 38.43%
- UHC Q3 11.40%
- MCO Aggregate: Q3 37.79%

12-17 years of age:

DY13 target is 47.68%.

- BCBS Q3 37.76%
- MHC Q3 No Data

- PHP Q3 35.54%
- UHC Q3 10.12%
- MCO Aggregate: Q3 34.36%

18-21 years of age:
DY13 target is 23.73%.

- BCBS Q3 16.58%
- MHC Q3 No Data
- PHP Q3 15.01%
- UHC Q3 4.42%
- MCO Aggregate: Q3 14.56%

MCO Strategies and Interventions:

- BCBS deployed SMS text messages to complete their child's annual check-up. The BCBSNM Fall member newsletter included an article about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The article provided education regarding EPSDT assessments. There was also an article regarding School-Based Health Centers (SBHC). SBHCs are a resource for students to seek physical, mental and dental care. BCBSNM Wellness Education Specialists (WES) attended events in Espanola and Las Vegas, NM to provide resources to members. Resources include BCBSNM Provider Finder site, Value Added Services, Dentists in Network, Child Care Guidelines, Immunizations, and Tot to Teen Collateral.

- MHC sent emails and SMS reminders to parents/guardians of members to remind them to schedule well-child visits. MHC also mailed birthday cards to all children ages birth to 21 years, which offer education about best practice, recommended services, developmental assessments, referrals, immunizations, and reminders to schedule and attend those appointments. MHC developed a dashboard to assist health plan staff in targeting outreach to members with care gaps. During outreach, health plan staff educate parents/guardians about EPSDT and the importance of well-child visits and assist them in connecting with the appropriate providers and resources to overcome barriers to scheduling and attending appointments.

- PHP focused on collaborative outreach with Presbyterian Medical Group (PMG) pediatric clinics to implement changes in the clinic to decrease the rate of no-show patients. PHP's Performance Improvement (PI) department began a call campaign focused on households with multiple children who have not completed their well-child visits. PHP held a provider presentation regarding the importance of well-child visits, immunizations, and dental visits, among other important children's health topics.

- UHC Care Coordinators addressed preventive care visits with members. UHC's Quality Clinical Practice Consultant team (CPC) met with providers monthly to show individual practice performance and provide member-level detail. The CPC team discussed the WCV measure and the provider's scorecard during the meetings. Providers are also encouraged to promote the Turquoise Rewards program and inform patients of the benefits of the program. The Turquoise Care Rewards program is also promoted during scheduled meetings with Chapter Houses during tribal outreach events.

PM #3 – Prenatal and Postpartum Care (PPC) (two indicators)

The percentage of member deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit as a member of the MCO in the first trimester or within 42 Calendar Days of enrollment and the percent of deliveries in which members had a Postpartum visit on or between 7 and 84 days after delivery.

For this measure, the National Committee for Quality Assurance (NCQA) offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data.

Timeliness of Prenatal Care:

DY13 target is 80.69%.

- BCBS Q3 59.07%
- MHC Q3 69.05%
- PHP Q3 64.88%
- UHC Q3 50.00%
- MCO Aggregate: Q3 62.57%

Postpartum:

DY13 target is 74.70%.

- BCBS Q3 51.57%
- MHC Q3 11.90%
- PHP Q3 63.46%
- UHC Q3 No Data
- MCO Aggregate: Q3 58.43%

MCO Strategies and Interventions:

- BCBS deploys targeted member outreach efforts to engage members in their healthcare. BCBS collaborated with a local Gallup food pantry to offer maternal food boxes to 800 expectant mothers with diabetes and high blood pressure in New Mexico's McKinley and Cibola counties. BCBS and Walmart Baby Days held collaboration events in September at five different New Mexico sites. Health screenings and educational fliers were provided by the community outreach team. The M.O.M.S (Maternal Outcomes Matter Shower) tour event was held on

September 28 in Albuquerque. The BCBS community outreach team provided health-related member educational materials including pregnancy-related fliers. BCBS Value-Added Services program offers pregnant members infant car seats and portable cribs. BCBS offers care coordination services to all BCBS pregnant members through collaboration with the Special Beginnings maternity program. BabySmart Health provides pregnancy-related education and virtual doula health coaching.

- MHC confirms members' pregnancy status during outreach and determines if the member has an upcoming appointment or needs assistance with establishing care or scheduling an appointment. MHC utilizes Lucina, a platform that identifies additional member information and creates pregnancy risk scores to identify and assist high-risk members earlier in their pregnancy. MHC also contracted with Ouma Telehealth to provide Prenatal and postpartum telehealth visits, family planning education, high-risk pregnancy screening (including depression screening), remote fetal monitoring, access to lactation consultants, and behavioral health support. Molina's Pay for Quality Gap Closure program incentivized providers to establish member engagement and set pregnant members on a schedule for timely prenatal and postpartum care.

- PHP continued to use the Early Identification of Pregnancy report to provide outreach to members. PHP PI staff sends letters to members of childbearing age and confirmed pregnancy with information and resources on perinatal care. PHP deployed social media posts to provide information for members about the importance of prenatal and postpartum visits. PHP launched Neuroflow, a mobile/web application that provides educational journeys regarding healthy pregnancy, postpartum health, and other women's health topics. PHP continued the Pregnancy Passport program that provides member rewards for early prenatal and postpartum care visits. The Prenatal reward is $150 for attending a prenatal visit within the first trimester or 42 days of enrollment in the health plan. The postpartum reward is $100 for attending postpartum visit within 7-84 days after delivery.

- UHC offers incentives to members for joining the Healthy First Steps program and completed prenatal care visits. UHC worked with Finity to identify members with open gaps in care and promote the Turquoise Care Rewards program which offers an incentive to members for completing the 1st prenatal visit. Finity also sends letters to members who are due. UHC Care Coordinators reached out to members during regular touch points either by phone or in person to discuss their care plan and care gaps. The Clinical Practice Consultant team and Population Health

promote the Turquoise Rewards program during regularly scheduled meetings to encourage providers to inform patients on the benefits of the program.

PM #4 – Oral Evaluation Dental Services (OED)

The percentage of members under 21 years of age, who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

DY13 target is 45.01%.

- BCBS Q3 35.48%
- MHC Q3 No Data
- PHP Q3 46.67%
- UHC Q3 16.88%
- MCO Aggregate: Q3 38.37%

MCO Strategies and Interventions:

- BCBS held a Care Van event, which provided dental screenings with fluoride varnish. BCBS mailed an educational Dental flyer to members in Dona Ana County. The letter reminded members to schedule their dental exams. BCBS deployed an SMS text message to remind parents/guardians to schedule a dental exam. BCBS also emailed their Fall member newsletter with an article educating members about School-Based Health Centers (SBHC). SBHCs are a resource for students to seek physical, mental and dental care.

- MHC Care Coordinators receive Clinical Care Advance Care Gap Alerts. Care coordinators follow up with members with gaps to complete their Dental screenings and educate parents/guardians on the importance of oral health. MHC sends targeted e-mail and SMS reminders to schedule Dental screenings. MHC created a dashboard to identify all members under age 21 for outreach to assist them in connecting with appropriate provider(s) and resources to overcome barriers to scheduling and attending dental appointments.

- PHP mailed Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters that included education on the importance of annual dental visits. PHP's Performance Improvement interventionists performed outreach calls to assist members with scheduling appointments. PHP held a provider presentation to educate providers on the importance of well-child visits, immunizations, and dental visits, among other important children's health topics.

- UHC displayed OED care gaps for each member in the Community Care portal to prompt Care Coordination to assist with scheduling appointments. Care Coordinators follow the touch points and reassessment based on Turquoise Care requirements. UHC's Clinical Practice Consultant and Population Health teams promoted the Turquoise Rewards program during provider regularly scheduled meetings to encourage providers to inform patients of the benefits of the program. UHC's Clinical Practice Consultant team also worked with providers to review HEDIS technical specifications for the OED measure and provide lists of members due for needed care.

PM #5 – 7 Day Follow-up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health practitioner within 7 days after discharge.

DY13 target is 29.92%.

- BCBS Q3 32.14%
- MHC Q3 25.35%
- PHP Q3 26.95%
- UHC Q3 15.09%
- MCO Aggregate: Q3 28.87%

MCO Strategies and Interventions:

- BCBS conducted member outreach calls to assist members in finding appointments after their hospitalization. BCBS deployed SMS text messages to remind members of the importance of continuous treatment and encourage follow-up. BCBS continued to incentivize five facilities to ensure appropriate follow-up. BCBS also continued to incentivize outpatient providers with a higher payment for appointments held within 30 days of an inpatient stay. BCBS continued to reserve medication management and therapy appointments at outpatient facilities for members who are discharging from an inpatient stay.

- MHC partnered with Brave Health, a virtual outpatient mental health provider to offer therapy and medication management services to members. MHC partnered with Care Connections, a contracted group of licensed mental health professionals and psychiatric nurse practitioners, to conduct outreach to members to complete

telehealth assessments upon discharge. MHC's Community Connector team attempted to complete face-to-face outreach with members who are Difficult to Engage or Unable to Reach at their home addresses.

- PHP's Inpatient Care Coordinators (IPCC) contacted members who were hospitalized and offered Care Coordination services, including discharge planning assistance. PHP continued its pilot program to provide discharge planners at inpatient facilities with a list of providers who can take new members within 30 days. PHP's Quality Improvement department analyzed claims monthly to determine which members completed follow-up appointments within 7 days of discharge. PHP continued to educate provider networks and Care Coordinators regarding the importance of follow-up appointments, how to address barriers and increase outcomes.

- UHC identified members who were being discharged from behavioral health stays and assisted with scheduling follow-up appointments within 7 days. UHC's Care Coordinators also conducted specific outreach/follow-up for their members who have been discharged to ensure follow-up visits are scheduled. UHC displayed gaps in care on the Customer Service representative dashboards to encourage and assist members with scheduling appointments for needed care.

PM #6 – Breast Cancer Screening (BCS-E)

The percentage of members 50-74 years of age who had at least one mammogram to screen for breast cancer at any time on or between October 1 two years prior to the measurement period and the end of the measurement period.

DY13 target is 50.17%.

- BCBS Q3 43.52%
- MHC Q3 66.67%
- PHP Q3 38.98%
- UHC Q3 17.43%
- MCO Aggregate: Q3 39.09%

MCO Strategies and Interventions:

- BCBS collaborated with a mammogram screening center and planned mammogram screening events. BCBS mailed flyers to members in Otero, and San Juan Counties to invite them to schedule a mammogram at the BCBS mammogram events held in

September. BCBS also assisted providers with gap lists to contact members by phone to invite them to mammogram events or offer assistance with scheduling an appointment. The Blue for Your Health member newsletter also included an article about preventive cancer screening.

- While very few members currently qualify for this measure due to continuous enrollment requirements, MHC's Care Coordinators identify members in the BCS age group to assist with scheduling appointments and provide education on the importance of preventative screenings. Members are also advised of Turquoise Care rewards incentives for preventative screenings. MHC's Care Coordinators also receive Clinical Care Advance Care Gap Alerts regarding mammogram care gaps to conduct follow-ups with members and incorporate care gaps into the member's care plan.

- PHP completed telephonic outreach to members overdue for screening mammograms. PHP provided mobile mammography in the Santa Fe, Taos, and Raton Counties. PHP collaborated with an imaging partner to perform outreach to members turning 40 within the previous year.

- UHC's Care Coordinators conducted targeted outreach to their members to assist with scheduling appointments for breast cancer screening. Care Coordination reached out to members during regular touch points either by phone or in person to discuss their care plan and address preventive assessment needs. UHC's customer service representatives are prompted by a gap in care notification on their customer service dashboard to schedule appointments for members with a BCS-E gap in care. UHC's Clinical Practice Consultant team worked with providers to review HEDIS technical specifications for the BCS measure and provide lists of members due for needed care.

PM #7 – Follow-Up Care for Children Prescribed ADHD Medication (ADD-E): Initiation Phase

The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.

DY13 target is 41.36%.

- BCBS Q3 48.64%
- MHC Q3 No Data
- PHP Q3 38.47%
- UHC Q3 No Data
- MCO Aggregate: Q3 42.84%

MCO Strategies and Interventions:

- BCBS conducted member outreach calls regarding ADD medication refills. BCBS developed a provider video regarding ADD medication treatment and follow-up. BCBS offered providers continuing education units for attending an ADD measure medication training. BCBS also published an ADD measure tip sheet for providers.

- MHC received first-fill data from CVS Pharmacy regarding members who have filled their first prescription of a new ADHD medication within the previous week. MHC is developing a workflow for care coordination and other outreach teams to use to connect with members and/or their parents or guardians and provide education and assistance in scheduling an appointment with their prescribing clinician within 30 days of starting the new medication. MHC is developing a School-Based Health Center Tool Kit containing the ADD-E measure. MHC's providers access HEDIS tip sheets via the Availity Provider Portal to guide best practices and appropriate billing codes. MHC partnered with PsychHub, an online platform for digital mental health education to provide educational courses regarding ADHD to providers.

- PHP made outreach calls to the parents/guardians of members to remind them of the need for 30-day follow-up appointments. PHP developed a process for earlier identification of members who fall into the ADD measure, which allows earlier intervention. PHP identified high-volume attention deficit hyperactivity disorder (ADHD) medication prescribers for outreach from the Behavioral Health (BH) Medical Director to discuss the ADD-E measure and its requirements. PHP's Care Coordinators attended a presentation with topics on how to support members in the ADD-E measure.

- UHC's Health Equity team, School-Based Health Centers liaison, and Tribal Health liaison worked with School-Based Health Centers and our Tribal community to improve communication on care options for members. UHC's Quality Clinical Practice Consultant team engaged providers on the ADD HEDIS measure showed

individual practice performance and provided member-level details of non-compliant members. The Quality Clinical Practice Consultant team worked to uncover barriers to care and assist providers with developing strategies for improvement, find coding opportunities, and offer assistance with scheduling appointments.

PM #8 – Immunizations for Adolescents (IMA) – Combination 2

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus vaccine series by their 13th birthday.

For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data.

DY13 target is 33.29%.

- BCBS Q3 32.85%
- MHC Q3 No Data
- PHP Q3 35.03%
- UHC Q3 2.90%
- MCO Aggregate: Q3 33.07%

MCO Strategies and Interventions:

- BCBS Quality Management Specialist Staff and Wellness specialists have conducted member outreach calls. BCBS Care Van held an Immunization event at the West Mesa Vaccine Clinic and the Mesa Verde Center Vaccine Clinic. BCBS Wellness Education Specialists (WES) attended events in Espanola and Las Vegas, NM. The WES interacted with members and provided resources like the BCBSNM Provider Finder site, Immunizations, and Tot to Teen Collateral. BCBS deployed a social media post educating members on the importance of speaking to their child's provider about recommended vaccinations. This post also provides education about myths vs. facts about immunizations.

- MHC performed outreach calls to educate parents/guardians about adolescent immunizations and well visits and assist them with resources to overcome barriers to scheduling and attending appointments. MHC mailed cards, postcards, or letters to all children aged birth to 21 years with milestones according to the Bright Futures Periodicity table. MHC uses claims and NMSIIS to identify children BEFORE they

meet NCQA continuous enrollment requirements to target children falling behind on their adolescent immunization series – especially the 2nd/3rd HPV doses for children who have one (or fewer) HPV doses.

- PHP initiated a social media campaign to educate people on the importance of adolescents receiving their recommended vaccination. PHP launched a summer vaccine campaign, “Hero Days”. PHP’s Performance Improvement (PI) Interventionist team made outreach calls to parents and guardians of members on the Gap in Care list for participating clinics. PHP’s (PI) Interventionist team also invited members to participate in Hero Day appointments. PHP mailed Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters to members 12 years old that included information on recommended adolescent vaccinations. PHP hosted a provider presentation to educate providers on the importance of well child-visits, immunizations, and dental visits, among other important children’s health topics.

- UHC partnered with Finity to promote the Turquoise Care Rewards program which offers an incentive to members for completing immunizations. UHC worked with FINITY to identify members with open gaps in care, FINITY then sent letters to the members who were due for immunizations. UHC’s Health Equity team worked with School-Based Health Centers and our Tribal community to improve communication on care options for members and promote the Turquoise Rewards program. UHC’s Clinical Practice Consultant team met with providers monthly to review provider scorecards, uncover coding opportunities to report compliance data because the IMA measure is hybrid, assist with scheduling appointments, and conduct clinic days to promote preventive care.

PM #9 – Pharmacotherapy for Opioid Use Disorder (POD)

The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.

DY13 target is 25.22%.

- BCBS Q3 13.47%
- MHC Q3 No Data
- PHP Q3 21.05%
- UHC Q3 No Data
- MCO Aggregate: Q3 17.88%

MCO Strategies and Interventions:

- BCBS conducted outreach calls to remind members to refill prescriptions and connect them with case management assistance when needed. BCBS posted a YouTube video on social media educating members on the importance of remaining on medication for Opioid Use Disorder. BCBS conducted a listening session with a top-volume provider of the POD population to better understand the challenges facing Opioid Use Disorders and barriers to interventions. BCBS also produced a provider education video regarding medication for Opioid Use Disorder.

- MHC's Utilization Management team referred adult members who are admitted to a Substance Abuse Residential Treatment Center to MHC's specialized team of certified Community Health Workers and Peer Support Specialists to provide support with transitioning to a lower level of care. Providers submit referral forms for patients struggling with alcohol or drug abuse or dependency to MHC's care management program. MHC received first-fill data from CVS Pharmacy identifying members who have filled their first prescription of a new opioid pharmacotherapy medication within the previous week.

- PHP increased collaboration among providers and pharmacies to provide outreach education to newly prescribed members. PHP's Care Coordinators with a large percentage of members with a primary Behavioral Health (BH) diagnosis, attended presentations regarding Quality Improvement initiatives, including POD and how to support members who fall into this metric. PHP included topic on the POD measure and encouraged providers to schedule follow-up appointments in the provider newsletter.

- UHC Care Coordinators will conduct targeted outreach to members to ensure that they have the resources they need and will assist with scheduling appointments. Care Coordination will reach out to members during regular touch points either by phone or in-person to discuss their care plan and address chronic condition management needs.

PM #10 – Glycemic Status Assessment for Patients with Diabetes (GSD)

The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% (poor control) during the measurement year. A lower rate indicates improvement for this measure.

For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data.

DY13 target is 42.60%.

- BCBS Q3 69.27%
- MHC Q3 No Data
- PHP Q3 65.07%
- UHC Q3 4.07%
- MCO Aggregate: Q3 65.75%

MCO Strategies and Interventions:

- BCBS partnered with Everlywell Health Systems to launch an in-home A1c testing kit program. A1c in-home testing kits were sent to 2340 members. Two reminder letters and three IVR calls were made to help BCBS members who received kits to return their samples via the pre-paid packing envelope. BCBS Health Education and Health Literacy (HEHL) attended several community events to promote diabetes education. BCBS Care Coordinators continued to receive monthly reports regarding condition management care gaps. Care Coordinators discuss diabetes adherence with members during routine visits.

- MHC Care Coordinators identify members with diabetes who have open gaps in care to encourage them to work with their medical provider to schedule needed lab testing. MHC's Quality Improvement team performed outreach to identified Members with uncontrolled A1c and/or hypertension to encourage them to participate in the Champions program, which provides education and resources around healthy lifestyle changes.

- PHP's Performance Improvement (PI) outreach team performed telephonic outreach to members with an A1c >9 or still in need of an A1c screening to promote routine testing. PHP referred members to Healthy Solutions for chronic condition management, and the Diabetes Recharge program offered through Presbyterian's Community Health Resource Center. PHP offered additional services like the Good Measures Healthy Weight program.

- UHC's Clinical Practice Consultant team meets with providers at least monthly to discuss scorecards on provider adherence to all diabetic measures, uncover coding opportunities to report compliance data as the GSD is a hybrid measure, assists with scheduling appointments, and conducts clinic days promoting preventive care. UHC's Care Coordinators will reach out to members during regular touch points either by phone or in person to discuss their care plan and address preventive and chronic condition management needs.

PM #11 – Eye Exam for Patients with Diabetes (EED)

The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data.

DY13 target is 49.21%.

- BCBS Q3 33.80%
- MHC Q3 100.00%
- PHP Q3 43.05%
- UHC Q3 14.99%
- MCO Aggregate: Q3 39.12%

MCO Strategies and Interventions:

- BCBS Health Education and Health Literacy (HEHL) attended several community events to promote diabetes education and distribute educational flyers. BCBS Quality Improvement team deployed SMS text messages to members that have an EED gap in the current measuring year educating members on the need for an annual Diabetic Retinopathy Examination (DRE). BCBS Care Coordinators are given gap lists to address with their members during routine visits. BCBS continues to partner with Davis Vision to bridge diabetic retinopathy HEDIS gaps. Letters are mailed to members encouraging them to schedule an examination.

- MHC encourages members to participate in Turquoise Rewards to receive rewards based on healthy behaviors. MHC's Quality Improvement team identified members needing diabetes assessments. MHC's Care Coordinators performed targeted outreach to diabetic members who have not had a recent retinal eye screen. The

identified members were educated about the importance of this exam and provided scheduling assistance when needed.

- PHP's Performance improvement (PI) outreach team completed telephonic outreach to members overdue for a retinal eye exam. PHP purchased a Retina Vue 700 camera and service plan. PHP is looking to operationalize the use of cameras for members with diabetes who are due for a retinal eye exam in areas of the state with disparities in access to comprehensive eye care.

- UHC instituted processes system-wide to address diabetes gaps in care which include Quality, Health Equity, Population Health, Health Services, and Customer Service. UHC's Care Coordinators conducts targeted outreach/follow-up to assist with scheduling appointments for diabetes care. Care Coordinators also discuss the members' care plan and address preventive and chronic condition management needs. UHC's Customer Service representative dashboards display members' gaps in care to prompt the representative to assist members with scheduling appointments.

PM #12 – Kidney Health Evaluation for Patients with Diabetes (KED)

The percentage of members 18-85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation, including a blood test for kidney function (estimated glomerular filtration rate [eGFR]) and a urine test for kidney damage (urine albumin-creatinine ratio [uACR]) during the measurement year.

DY13 target is 32.28%.

- BCBS Q3 27.16%
- MHC Q3 No Data
- PHP Q3 28.82%
- UHC Q3 21.52%
- MCO Aggregate: Q3 28.11%

MCO Strategies and Interventions:

- BCBS Quality Improvement team mailed kidney health examination educational flyers to members with diabetes. BCBS Care Coordinators attended a training regarding diabetes and the KED and EED HEDIS measures. The Care Coordinators use the training to appropriately address KED and EED gaps in care with their members. BCBSNM Quality Improvement's Wellness Specialists attended several

community events to interact and educate members and the general public on diabetes education and distribute flyers.

- MHC's Care Coordination team used Clinical Care Advance Care gap alerts to get KED assessments scheduled for the identified members. MHC's Outreach teams contacted identified members who need assessments.

- PHP performed targeted outreach to members with diabetes. The Performance Improvement (PI) outreach team completed telephonic outreach to members overdue for kidney health lab tests. PHP is exploring the inclusion of Turquoise Care Members with diabetes in a vendor-supported at-home testing campaign for A1C and Kidney Health.

- UHC displayed the KED HEDIS measures for each member in Community Care, prompting Care Coordination to assist with scheduling appointments. Care Coordinators will reach out to members during regular touch points by phone or in-person to discuss their care plan and address preventive or chronic condition management needs. UHC's Clinical Practice Consultants (CPC) reviewed prospective scorecards with providers and discussed adherence to all diabetic measures. The Clinical Practice Consultants also discuss coding opportunities, offer assistance with scheduling appointments, and help coordinate clinic days to promote preventive care.

PM #13 (1 point) – Lead Screening in Children (LSC)

The percentage of children two years of age who had one or more capillary or venous blood test for lead poisoning by their second birthday.

For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data.

DY13 target is 57.10%.

- BCBS Q3 45.05%
- MHC Q3 No Data
- PHP Q3 39.28%
- UHC Q3 24.64%
- MCO Aggregate: Q3 41.01%

MCO Strategies and Interventions:

- BCBS mailed a postcard to the parents/guardians of members statewide regarding EPSDT education on Lead Screenings. The Quality Management staff conducted telephonic outreach to members to encourage parents/guardians to schedule and complete well-child visits. During this call, the QM staff informs the member of the importance of lead screenings and what to expect during testing. The BCBS Wellness Education Specialists support provider groups in scheduling appointments for their members.

- MHC's Pay for Quality Gap Closure program incentivized providers for preventive services appointments including Lead Screening. MHC partnered with Ouma Telehealth, which provided outreach and educated families on newborn upcoming screenings. MHC's Care Coordinators identified members with an LSC care gap and contacted the members' parents/guardians to incorporate care gaps into the member's care plan. MHC created a dashboard to identify all members under age 21 for outreach to assist them in connecting with appropriate provider(s) and resources to overcome barriers to scheduling and attending appointments.

- PHP Performance Improvement (PI) Interventionist team performs monthly outreach to educate on the importance of these visits and assist with scheduling when possible. PHP continued the Baby Bonus rewards program to encourage participation in well-baby visits and lead screenings. PHP continued to utilize social media posts to help members understand why these visits matter. PHP mailed Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters to parents and caregivers to complete well-baby visits.

- UHC's Health Equity team works with School-Based Health Centers and our Tribal community to improve communication on care options for members and promote the Turquoise Rewards program. UHC's Care Coordinators conduct targeted outreach to members. Care Coordinators also discuss their care plan and address preventive assessment needs. UHC's Quality Clinical Practice Consultant team (CPC) engage providers on the LSC HEDIS measure by showing individual practice performance and providing member-level details of members who are due for lead screening.

Tracking Measures (TMs)

HCA requires the MCOs to submit quarterly reports for Tracking Measures (TMs) listed in the Turquoise Care MCO contract. HCA Quality Bureau reviews and analyzes the reports for completeness and accuracy and to gauge positive or negative outcomes and trends.

The MCOs report interventions, strategies, and barriers that impact performance outcomes. HCA's review findings are communicated to the MCOs through scheduled MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meetings (QQMs). Numbers and rates reported are cumulative from quarter to quarter for all TMs.

The introduction of Turquoise Care includes quarterly monitoring of 11 Tracking Measures effective DY12 Q1. The following TMs show results for DY12 Q1 reporting:

TM #1 – Smoking Cessation

The MCO shall monitor the use of smoking cessation products, counseling utilization and successful quit attempts. The total number of unduplicated members receiving smoking and tobacco cessation products/services are reported below.

- BCBS Q3 2,526
- MHC Q3 102
- PHP Q3 3,806
- UHC Q3 77
- MCO Aggregate: Q3 6,511

MCO Strategies and Interventions:

- BCBS: Providers, care coordinators, and members make referrals to BCBS's Quitline and distributes information and materials to promote their Tobacco Cessation Program. BCBS will continue ongoing collaborative relationships with New Mexico Department of Health (NMDOH) and all NM Medicaid MCOs to commit resources to a single DOH Quitline.

- MHC: Member's tobacco use is identified via the Health Risk Assessment. Members interested in quitting are referred to the MHC Care Management nurse-certified tobacco quit specialists for education. Members are encouraged to call the quit line and engage with their primary care provider for evidence-based tobacco cessation medications.

- PHP: The nurse-led Tobacco Cessation Disease Management program presented annually during the Care Coordination team webinar to promote the program to staff and to members ages 14 and older. The PHP tobacco cessation flyer is distributed to providers and members during community events to expand program enrollment.

- UHC: Members have access to comprehensive digital platforms to include a dedicated resource website, Text2Enroll, Mobile App, and virtual chat with coach to help quit smoking. UHC support services include: one on one coaching calls and group sessions.

TM #2 – 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. An increase in percentage indicates improvement for this measure.

- BCBS Q3 60.07%
- MHC Q3 No Data
- PHP Q3 39.04%
- UHC Q3 0.00%
- MCO Aggregate: Q3 45.93%

MCO Strategies and Interventions:

- BCBS: Mailed monthly “Happy Birthday” postcards to remind the parent or guardian of members who turned 1, 2, and 3-years old to get immunizations and well-child visit. BCBS Care Van held an Immunization event at the West Mesa Vaccine Clinic and the Mesa Verde Center Vaccine Clinic. There were 38 immunizations administered during these events.

- MHC: Mailed cards, postcards, or letters to all children from birth to 21 years with milestones according to the Bright Futures Periodicity table. with education about the best practice recommended services, developmental assessments, well-child visit and immunizations at corresponding age and reminders to schedule and attend those appointments.

- PHP: PHP Performance Improvement (PI) Interventionist team performs outreach to educate on the importance of well-child visits and assist with scheduling. The PI interventionist team completed 3,025 outreach attempts in DY12 Q1, with 1,210 successful engagements for well child visits.

- UHC: Care Coordination performs outreach to members to ensure that they have completed immunizations and will assist with scheduling appointments. Care

Coordination contacts members either by phone or in person to discuss their care plan and address preventive care management needs. Turquoise Care Rewards program offers an incentive to members for completing immunizations.

TM #3 – 7 Day Follow-Up After Emergency Department Visit for Mental Illness (FUM)

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days). An increase in percentage indicates improvement for this measure.

- BCBS Q3 42.02%
- MHC Q3 10.00%
- PHP Q3 28.29%
- UHC Q3 15.38%
- MCO Aggregate: Q3 33.36%

MCO Strategies and Interventions:

- BCBS: To improve the follow-up measure, members were contacted via telephone to provide assistance and support with finding follow-up appointments after discharge. Provider education webinars are offered to train on barriers that members could be facing that could prevent them from attending follow-up treatment.

- MHC: Partnered with Brave Health, a virtual outpatient mental health provider, to offer therapy and medication management services to members. Services are 100% virtual and are designed to serve individuals with complex needs such as serious mental illness.

- PHP: Provider education on the HEDIS measure for FUM and best practices for follow-up care through training were provided by the quality team at the behavioral health Provider Education Conference (PEC) meeting. Inpatient Care Coordination (IPCC) includes contacting members who were hospitalized and offering Care Coordination services, including discharge planning assistance.

- UHC: Care Coordination works with Behavioral Health Advocates to contact members after emergency department visits to ensure members have a 7-day follow-up appointment.

TM #4 – Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days of a positive depression screen finding. An increase in percentage indicates improvement for this measure.

Screening:

- BCBS Q3 0.00%
- MHC Q3 28.57%
- PHP Q3 15.94%
- UHC Q3 No Data
- MCO Aggregate: Q3 10.17%

Follow-Up:

- BCBS Q3 No Data
- MHC Q3 No Data
- PHP Q3 51.94%
- UHC Q3 No Data
- MCO Aggregate: Q3 51.94%

MCO Strategies and Interventions:

- BCBS: Members were called monthly with reminders on the importance of follow up after positive screening for depression. A provider education webinar recording that included depression screening for adolescents and adults was available to view and receive continuing education credit.

- MHC: Interventions include the Behavioral Health (BH) Tool Kit which gives all providers access to educational information via the MHC website and the PsychHub Mental Health online platform for digital mental health education.

- PHP: Educating providers on the importance of member health by screening for depression during the Provider Education Conference (PEC) in DY12 Q1 PHP encourages providers to screen members for depression and offers tips and resources on how to code appropriately.

- UHC: Early Periodic Diagnostic Screening and Testing (EPSDT) services are in place to ensure members receive necessary screening and follow-up. Care

Coordination works with Behavioral Health Advocates to contact members to ensure follow up after a positive depression screen.

TM #5 – Cervical Cancer Screening (CCS)

The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer and had cervical cytology performed within the last 3 years. An increase in percentage indicates improvement for this measure.

- BCBS Q3 43.52%
- MHC Q3 40.00%
- PHP Q3 41.30%
- UHC Q3 9.92%
- MCO Aggregate: Q3 40.27%

MCO Strategies and Interventions:

- BCBS: BCBS provided a newsletter with an article titled, “When to get screened for cervical cancer”, which provided information about the age to begin cervical cancer screening, what age to discuss whether to continue screening and explained the difference in a Pap test and HPV test.

- MHC: Care coordinators contacted members within 30 days of enrollment to complete a Health Risk Assessment (HRA). MHC launched HEDIS Clinical Care Advance Care Gap Alerts, Care gap alerts are automatically generated and sent to care coordinators when members need to complete their cervical cancer screenings.

- PHP: Performance Improvement Outreach team made 8 successful telephonic outreach efforts to members still in need of a cervical cancer screening to remind and assist with appointment scheduling. PHP launched Neuroflow an online/mobile app for women’s health which includes three lessons related to cervical cancer screening.

- UHC: Annual preventive care letters are sent to members encouraging them to complete their cervical cancer screening. Care Coordination provides member outreach for those identified in the CCS HEDIS measure. By contacting members either by phone or in person to discuss their care plan and preventive management needs.

TM #6 – Statin Therapy for Patients With Diabetes (SPD)

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who received and adhered to statin therapy. An increase in percentage indicates improvement for this measure.

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Received Therapy:

- BCBS Q3 49.08%
- MHC Q3 100.00%
- PHP Q3 47.08%
- UHC Q3 No Data
- MCO Aggregate: Q3 47.83%

Adherence:

- BCBS Q3 29.59%
- MHC Q3 0.00%
- PHP Q3 49.17%
- UHC Q3 No Data
- MCO Aggregate: Q3 41.70%

MCO Strategies and Interventions:

- BCBS: Health Education and Health Literacy (HEHL) attended the following local community events to promote diabetes education, providing diabetes education and materials the events include Roswell Health Expo, Laguna Pueblo, Albuquerque and Las Cruces Member Advisory Board meeting and Dulce Native American Advisory Board meeting.

- MHC: The food for medicine strategy emphasizes the importance of nutrition in managing diabetes and preventing complications. Value-based contract for providers encourage member adherence with diabetes screening and treatment.

- PHP: Encourage members to sign up for mail order and a 90-day supply of prescriptions medications when possible.

- UHC: Care Coordination provides outreach to non-compliant members to discuss their care plan and address preventative and chronic condition management needs. They will contact members either by phone or in person and assist with scheduling appointments.

TM #6 – Statin Therapy for Patients With Cardiovascular Disease (SPC)

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who received and adhered to high-intensity or moderate-intensity statin therapy. An increase in percentage indicates improvement for this measure.

Received Therapy:

- BCBS Q3 64.49%
- MHC Q3 No Data
- PHP Q3 61.51%
- UHC Q3 No Data
- MCO Aggregate: Q3 62.75%

Adherence:

- BCBS Q3 30.98%
- MHC Q3 No Data
- PHP Q3 56.80%
- UHC Q3 No Data
- MCO Aggregate: Q3 45.74%

MCO Strategies and Interventions:

- BCBS: BCBS distributed an educational flyer targeting those who are overweight or obese and have hypertension also included members who met the prior criteria and who are identified for the SPC measure. It prompted members to schedule an appointment with their health care provider to have a blood pressure check, Body Mass Index (BMI), height and weight assessment. Members were encouraged to talk with their provider about diet, nutrition, exercise, and weight management.

- MHC: MHC launched HEDIS Clinical Care Advance Care Gap Alerts. HEDIS care gap alerts appear in the case management monitoring system. The Care Coordination team conducts proactive review of members' records to identify HEDIS gaps and coordinates with member to get services scheduled.

- PHP: Encourage members to sign up for mail order and a 90-day supply of prescriptions medications when possible.

- UHC: Care Coordination provides outreach to non-compliant members to discuss

their care plan and address preventative and chronic condition management needs. They contact members either by phone or in person and assist with scheduling appointments.

TM #7 – Contraceptive Care – All Women Ages 15 to 44 (CCW)

Rate 1: The percentage of women ages 15 to 44 at risk of unintended pregnancy that were provided a most effective or moderately effective method of contraception. Rate 2: The percentage women ages 15 to 44 at risk of unintended pregnancy that were provided a long-acting reversible method of contraception (LARC).

Rate 1: Most or moderately effective:

- BCBS Q3 18.15%
- MHC Q3 0.00%
- PHP Q3 17.91%
- UHC Q3 No Data
- MCO Aggregate: Q3 18.00%

Rate 2: LARC

- BCBS Q3 3.33%
- MHC Q3 0.00%
- PHP Q3 4.87%
- UHC Q3 6.82%
- MCO Aggregate: Q3 4.29%

MCO Strategies and Interventions:

- BCBS: BCBS recognizes that disparities in health outcomes are often rooted in inequitable access to care, particularly for vulnerable populations, including those in rural and underserved areas. BCBS aims to reduce these disparities by ensuring equitable access to healthcare services for all members.

- MHC: MHC works with StellarRx to increase access to essential family planning services by providing medications and medical devices at point of care for vulnerable populations. StellarRx has placed cabinets containing LARCs in the following 13 NM sites: 4 School Based Health Centers, 6 Federally Qualified Health Center (FQHC), and 3 private practices.

- PHP: Presbyterian Population Health has launched an online/mobile application called Neuroflow. This application is tailored towards emotional well-being, and

family planning. It specifically outlines birth control methods for family planning and the importance of contraception.

- UHC: UHC's Population Health and Health Equity teams reach out to providers including the School Based Health Center liaisons to improve care delivery.

TM #7 – Contraceptive Care – Postpartum Women Ages 15 to 44 (CCP)

Rate 1: The percentage of women ages 15 to 44 who had a live birth that were provided a most effective or moderately effective method of contraception within three and 90 days of delivery. Rate 2: The percentage women ages 15 to 44 who had a live birth that were provided a long-acting reversible method of contraception (LARC) within three and 90 days of delivery.

Rate 1: Most or moderately effective:

- BCBS Q3 24.17%
- MHC Q3 22.34%
- PHP Q3 38.33%
- UHC Q3 25.00%
- MCO Aggregate: Q3 33.05%

Rate 2: LARC

- BCBS Q3 13.45%
- MHC Q3 10.64%
- PHP Q3 14.80%
- UHC Q3 6.25%
- MCO Aggregate: Q3 14.21%

MCO Strategies and Interventions:

- BCBS: BCBS is working directly with providers to ensure that care coordination is seamless and that members receive the appropriate care at the right time.

- MHC: In September 2024, Molina has contracted with Ouma Telehealth to help improve timeliness of maternity care for its members.

- PHP: Presbyterian Population Health has launched an online/mobile application called Neuroflow. This application is tailored towards women's health and family planning. It highlights birth control methods for family planning and postpartum contraception and the importance of contraception.

- UHC: Clinical Practice Consultant team meets with providers at least monthly to review provider scorecards which include performance of measures in contraceptive care postpartum women.

TM #8 – Initiation and Engagement of Substance Use Disorder Treatment (IET)

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days and engagement within 34 days of initiation. An increase in percentage indicates improvement for this measure.

Initiation:

- BCBS Q3 47.68%
- MHC Q3 No Data
- PHP Q3 49.02%
- UHC Q3 No Data
- MCO Aggregate: Q3 48.53%

Engagement:

- BCBS Q3 18.44%
- MHC Q3 No Data
- PHP Q3 17.97%
- UHC Q3 No Data
- MCO Aggregate: Q3 18.14%

MCO Strategies and Interventions:

- BCBS: Interventions for members include distributed member education videos on the importance of substance use treatment and follow up after an initial substance use diagnosis. A member-focused video on opioid use disorder launched through a social media campaign. The providers are given educational training, and the Payment Initiative offers providers financial incentive for providing timely follow-up appointments.

- MHC: Adult members who are not assigned to a Care Coordinator and are admitted to a Substance Abuse Residential Treatment Center (SA RTC) are referred to MHC's specialized team of certified Community Health Workers and Peer Support Specialists. The Community Connector completes all applicable assessments, works with the member to develop a Transition of Care Plan, assists the member with scheduling appointments and connecting with community resources.

- PHP: Members who receive services from peer support or community health worker teams receive education on the importance of engaging in Alcohol and Substance Use Disorder (AOD/SUD) treatment and recovery services.

- UHC: Care Coordination outreach to members identified in this measure to review and discuss their care plan and assist with scheduling appointments.

TM #9 – Prenatal Depression Screening and Follow-Up (PND-E)

The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care within 30 days of a positive depression screen finding. An increase in percentage indicates improvement for this measure.

Screening:

- BCBS Q3 0.00%
- MHC Q3 0.00%
- PHP Q3 24.60%
- UHC Q3 0.00%
- MCO Aggregate: Q3 16.38%

Follow-Up:

- BCBS Q3 No Data
- MHC Q3 No Data
- PHP Q3 45.83%
- UHC Q3 No Data
- MCO Aggregate: Q3 45.83%

MCO Strategies and Interventions:

- BCBS: A provider HEDIS tip sheet focusing on the PND measures was created and distributed to provide education on ways to impact the measures, improve care to members, and best practices.

- MHC: MHC is partnering with Ouma Telemed, a total maternity telehealth organization, to conduct outreach to pregnant members who are not engaged in prenatal care. Ouma's maternal fetal medicine specialists, perinatal nurse navigators, and maternal behavioral health experts' complete prenatal depression screenings and provide prenatal care to participating members.

- PHP: The Presbyterian Performance Improvement team has a focus on identifies members who are pregnant within the first trimester or within 42 calendar days of enrollment to complete their first prenatal appointment.

- UHC: Care Coordination outreach to members due for depression screening includes contacting members during regular touch points either by phone or in person to discuss their care plan and address preventive or chronic condition management needs.

TM #10 – Postpartum Depression Screening and Follow-Up (PDS-E)

The percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care within 30 days of a positive depression screen finding. An increase in percentage indicates improvement for this measure.

Screening:

- BCBS Q3 0.00%
- MHC Q3 0.00%
- PHP Q3 12.92%
- UHC Q3 0.00%
- MCO Aggregate: Q3 9.52%

Follow-Up:

- BCBS Q3 No Data
- MHC Q3 No Data
- PHP Q3 66.67%
- UHC Q3 No Data
- MCO Aggregate: Q3 66.67%

MCO Strategies and Interventions:

- BCBS: A provider HEDIS tip sheet focusing on the PDS measures was created and distributed to provide education on ways to impact the measures, improve care to members, and best practices.

- MHC: MHC is partnering with Ouma Telemed, a total maternity telehealth organization. Ouma's perinatal nurse navigators and maternal behavioral health experts' complete postpartum depression screenings and provide postpartum care to participating members. MHC staff receive training to educate members about

Turquoise Care Member Rewards which includes member rewards for completing the postpartum depression screening.

- PHP: The Pregnancy Passport program is incentivized to attend postpartum visits and providers can complete the depression screening. Neuroflow is an online/mobile app for women's health. The Neuroflow is tailored towards women's health, healthy pregnancy, emotional well-being, and mental health. It specifically outlines emotional changes and warning signs for depression after delivery.

- UHC: Care Coordination outreach to members due depression screening includes contacting members during regular touch points either by phone or in person to discuss their care plan and address preventive or chronic condition management needs.

TM #11 – Diabetes Short-Term Complications Admission Rate

Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees ages 18 and older. Reported as a rate per 100,000 member months. A lower rate indicates improvement for this measure.

- BCBS Q3 26.36
- MHC Q3 4.55
- PHP Q3 21.59
- UHC Q3 3.80
- MCO Aggregate: Q3 22.37

MCO Strategies and Interventions:

- BCBS: BCBS' Health Education and Health Literacy (HEHL) team traveled to Albuquerque, Dulce, Las Cruces, Laguna Pueblo and Roswell, New Mexico during DY12 Q1 to discuss health education with BCBS and community members. Working closely with BCBS Community Outreach, BCBS HEHL educates adult members on how to lower the risk of type 2 diabetes through dietary changes, exercise, and following up with diabetes health care providers.

- MHC: Member engagement interventions include care coordinators contacting members when discharged from the hospital to help coordinate care to avoid readmission for diabetes.

- PHP: Members who are admitted to an inpatient setting are assessed for a change in condition and have a transition of care plan implemented to facilitate a successful transition to a lower level of care. PHP also partners with Albuquerque Ambulance to reduce low acuity ED utilization. A monthly report reviews showing members with a pattern of low acuity ED utilization is provided by PHP to Albuquerque Ambulance. The paramedics visit these members in their homes to identify healthcare needs and educate members on alternatives to the emergency room.

- UHC: All readmissions within 30 days are reviewed at rounds with the Chief Medical Officer to identify opportunities to reduce readmissions. Members are followed by Care Coordination who assist with strategies to improve member's care and well-being.

External Quality Review

HCA holds bi-weekly meetings with the External Quality Review Organization (EQRO) to review monthly projects, provide feedback, offer support, and assess issues. This process ensures that deliverables are met and that desired outcomes are achieved within the established timeframe. The meetings facilitate identifying potential areas for improvement, reviewing, and revising existing processes, and developing new strategies for optimal project performance. HCA's collaboration with the EQRO fosters a culture of continuous improvement.

EQR Reviews and Validations in DY12 Q2 consisted of the below:

DY10 CY23 EQR statuses of reviews and validations:

- Validation of Performance Improvement Projects, received by HCA from the EQRO,
- Validation of Performance Measures, in review with HCA,
- Validation of Network Adequacy, received by HCA from the EQRO,
- Compliance Review, in review with HCA, and
- Annual Technical Report, in development with the EQRO, due to HCA on February 17, 2025, for review and approval for submission by April 30, 2025.

UTILIZATION

As noted in Section 5 of this report, MHC and UHC have completed encounter uploads back to July 1, 2024. HCA will provide aggregated utilization data in the next progress report.

VALUE BASED PURCHASING

To support Turquoise Care value-based purchasing goals, HCA requires the MCOs to implement a Value Based Purchasing program that is based upon improved quality and/or member healthcare outcomes. To accomplish this, the MCO must meet minimum targets for 3 levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY11 requirements are as follows:

VBP Level Minimum Requirements for **Legacy Contractors** (BCBS and PHP)

VBP Level	Level 1	Level 2	Level 3
Required Spend	10%	13%	7%
Required Provider Types	• Traditional Physical Health (PH) providers with at least 2 small Providers. • Behavioral Health (BH) Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty BH services. • Long-Term Care (LTC) providers including nursing facilities.	• Traditional Physical Health (PH) providers with at least 2 small Providers. • Behavioral Health (BH) Providers (whose primary services are BH and/or integrated providers who offer a continuum of specialty BH services. • Actively build readiness for Long Term (LTC) providers including nursing facilities.	• Traditional Physical Health (PH) providers. • Develop Level 3 Behavioral Health (BH) provider agreement model that includes providers who are primarily BH and/or integrated provider systems who offer a continuum of specialty BH services. • Implement a contractor led Long-Term Care (LTC) provider (including nursing facilities) level workgroup to design full-risk model.

VBP Level Minimum Requirements for **New Contractors** (MHC and UHC)

VBP Level	Level 1	Level 2	Level 3
Required Spend	8%	11%	5%
Required Provider Types	• Traditional Physical Health (PH) providers with at least 2 small Providers. • Behavioral Health (BH) providers whose primary	• Traditional PH Providers with at least 2 small Providers. • Behavioral Health (BH) providers whose primary services are BH and/or integrated providers who offer a	• Traditional Physical Health (PH) providers. • Implement a contractor led Behavioral Health (BH) provider level workgroup that works with BH Providers to

	services are BH and/or integrated Providers • Long-Term Care (LTC) providers including nursing facilities.	continuum of specialty BH services. • Actively build readiness for Long-Term Care (LTC) Providers including nursing facilities.	design full risk model.

In DY12 Q2, the Value-Based Purchasing financial report was suspended pending template and instructions revisions. The updates are necessary due to data inconsistencies discovered by HCA in MCO submissions. HCA will provide a revised VBP report template affording MCOs an opportunity to review the template prior to implementing the report and respond to any technical assistance requests. HCA will report cumulative results in upcoming progress reporting.

LOW ACUITY NON-EMERGENT CARE (LANE)

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

The Community Paramedicine Program is an additional outreach project supporting this effort. The program helps direct members to the right care, at the right time, and in the right setting for better health outcomes. The program is intended to reduce non-emergency medical calls, improve patient care and relieve rescue units for more life-threatening calls. The program targets members with chronic medical conditions such as diabetes and congestive heart failure who also may face social barriers to better health, including unstable housing or unreliable transportation. In rural communities where transportation may be difficult to obtain or distance is a barrier, especially for people who are elderly or homebound, community paramedics play an important role on a patient's care team because they can also deliver basic primary care services in the patient's home without requiring them to travel to a clinic. Community paramedicine services can ensure prompt care and identify health issues that need to be escalated to another provider. Community

paramedics can also facilitate communication between the patient and their primary care provider.

Because access to primary care is a key factor in reducing nonemergent emergency department visits, HCA is also working with graduate medical education (GME) programs to establish and/or expand existing programming, specifically in the primary care specialties of family medicine, general internal medicine, general psychiatry, and general pediatrics. A GME expansion 5-year strategic plan released by HCA in January 2020 estimates that 46 new primary care residents will graduate in New Mexico each year, beginning in 2025; and the number of primary care GME programs will grow by more than 60% within the next 5 years.

Blue Cross Blue Shield's strategies and interventions for managing non-emergent care include promoting preventative care through regular checkups, utilizing telehealth for consultations, encouraging members to contact their PCP first for non-urgent issues, leveraging urgent care clinics for after-hours needs, all aimed at reducing unnecessary emergency room visits and ensuring members receive timely, appropriate care. Member education and engagement through a digital texting campaign that targets members visiting the ED has been ongoing since DY9 Q4 with plans to continue throughout DY12. Members who have visited the ED at a minimum of two times in the past 60 days are sent a text, with links to offer assistance with finding a PCP, location of the nearest Urgent Care Centers and the telephone number for the Nurse Advice Line. This target membership goal is to provide early intervention prior to an established pattern of seeking care in an ED setting. BCBS monitors when Critical Incident reports show a pattern of frequent ED visits, who are not listed as having a care coordinator assigned, are then be referred to Care Coordination for follow-up and assessment. ED Reduction Program targets members who have visited the Emergency Department (ED) more than six times in the last six months. Targeted members are contacted by a Community Health Worker. The goal is to ensure members are established with a Primary Care Provider (PCP). Education is provided on the importance of being connected to out-patient care. Members are educated on utilizing alternative care settings such as telehealth for remote consultations and follow-ups. BCBS's team of medical directors and utilization management continue to partner with Care Coordination to best identify appropriate discharge disposition and reduce re-admissions.

Presbyterian Health Plan (PHP) has many interventions in place to reduce LANE utilization. Members in care coordination receive immediate follow-up from following an emergency room (ER) visit to assess a possible change in condition. Additionally, care coordination receive education concerning alternatives to ER utilization for low acuity needs. Members

who are not engaged in care coordination are monitored for ER use through data mining. PHP's community health worker (CHW) program provides education concerning alternatives to ER utilization, evaluates for unmet social determinants of health (SDOH) needs and works to engage members in care coordination, as appropriate. PHP's peer support workers provide support to members who utilize the ER due to substance use disorder (SUD) by providing education and supports to reduce LANE utilization. An established partnership with Albuquerque Ambulance provides member education for members who utilize the ER for low acuity needs. Albuquerque Ambulance assesses current needs and provides alternative care sites and appropriate care settings. Care coordination referrals are submitted if appropriate. PHP promotes the use of the PresNow urgent care facilities and telehealth options to reduce inappropriate ER utilization and provide alternatives to low acuity ER utilization. PHP supported member participation in a web-based computerized cognitive behavioral therapy program, On to Better Health, for conditions including addiction, depression, insomnia and chronic pain. PHP's disease management program offers integrated coaching to members with various chronic conditions. PHP monitors individual member data to determine if interventions are effective and PHP continues to seek innovative strategies to improve prevention.

Molina Health Care's strategic plan for DY12 Q1 includes both immediate and future interventions. Continuous strategies involve enhanced access to primary care, such as a 24/7 nurse hotline for medical advice and triage of non-emergent cases. Member education and outreach are also key components, with Care Coordination staff educating members on when to use the ER versus primary care or urgent care. Care coordination efforts include assigning Care Coordinators to high-risk members and providing post-ER follow-up to ensure members understand their discharge instructions and have scheduled follow-up appointments. Telehealth services are also promoted within Molina's member-facing teams to provide quick access to care without the need for an ER visit for members. Integrated health information systems allow for data sharing to identify members who could be treated at lower acuity facilities and help them locate nearby urgent care facilities. This data is used to outreach members that had an avoidable ER visit and used for an educational opportunity to encourage members to see their PCP, utilize nearby urgent care (if appropriate), help obtain a PCP if they do not have one and reinforcing telehealth options. A few future interventions include using data analytics to identify high-risk members, partnering with community organizations to address social determinants of health, deploying mobile health units to underserved areas, transitioning to value-based care models, offering member incentives for utilizing primary care, and establishing ongoing quality improvement programs to monitor ER utilization and implement changes as needed.

UnitedHealthcare (UHC) monitors ER visits to identify members who went to ERs. UHC identifies members who do not have a Primary Care Provider (PCP) assigned and outreaching to members to assign a PCP. UHC is educating members about the importance of having a PCP; making appointments with the PCP at least annually; and seeing the PCP, as needed, for non-emergent medical issues. UHC educates members on the importance of preventative care and as needed access to urgent care when appropriate vs ER visits. UHC is using Community Health Workers to meet difficult to engage members while they are in the hospital to provide contact information and work with members to engage in care coordination, if not already engaged.

The percentage of emergency utilization considered low acuity remained consistent from DY11 Q2 (57%) to DY12 Q1 (57%). In comparing low acuity ED visits from DY10 Q3 (57%) to DY12 Q1 (57%), the percentage of visits to the emergency department for non-emergent care indicates a steady trend. HCA expects to see this rate decrease quarter-over-quarter as a lower rate indicates improvement for this measure. The graph below reflects the percentage of members using the ER for non-emergencies between DY10 Q2 and DY11 Q2. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership.

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MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in the Turquoise Care Contract with the requirement that at least 90% of members having access to certain provider types in urban, rural, and frontier geographic areas within a defined distance. Geographic Access is collected, analyzed, and validated on a quarterly basis. Distance requirements have become stricter with the Turquoise Care change in contract for the different geographic regions. Distance requirements for all providers for this contract are that a member should not have to travel more than 30 miles for Urban, 45 miles for Rural, or 60 miles for Frontier areas to a provider as opposed to the 30, 60, 90 miles in the Centennial Care 2.0 contract. In addition, the Turquoise Care Contract has identified additional provider types in the transition for more robust monitoring. Due to these differences, HCA has changed its reporting and analysis to visually cross compare the MCOs and share a quarterly reporting dashboard with these indicators.

GeoAccess has been analyzed each quarter for 2023 into 2024. The graphs and analysis may be found in Attachment C – Physical Health Geographical Access.

Physical Health and Hospitals

This is the first GeoAccess report for Turquoise Care. Provider shortages have impacted geographic access across New Mexico. MCOs closely monitor providers and services delivered and employ ongoing efforts to ensure member access such as targeted recruitments, referral training, provider enrollment training, telehealth options, and value-based contract arrangements.

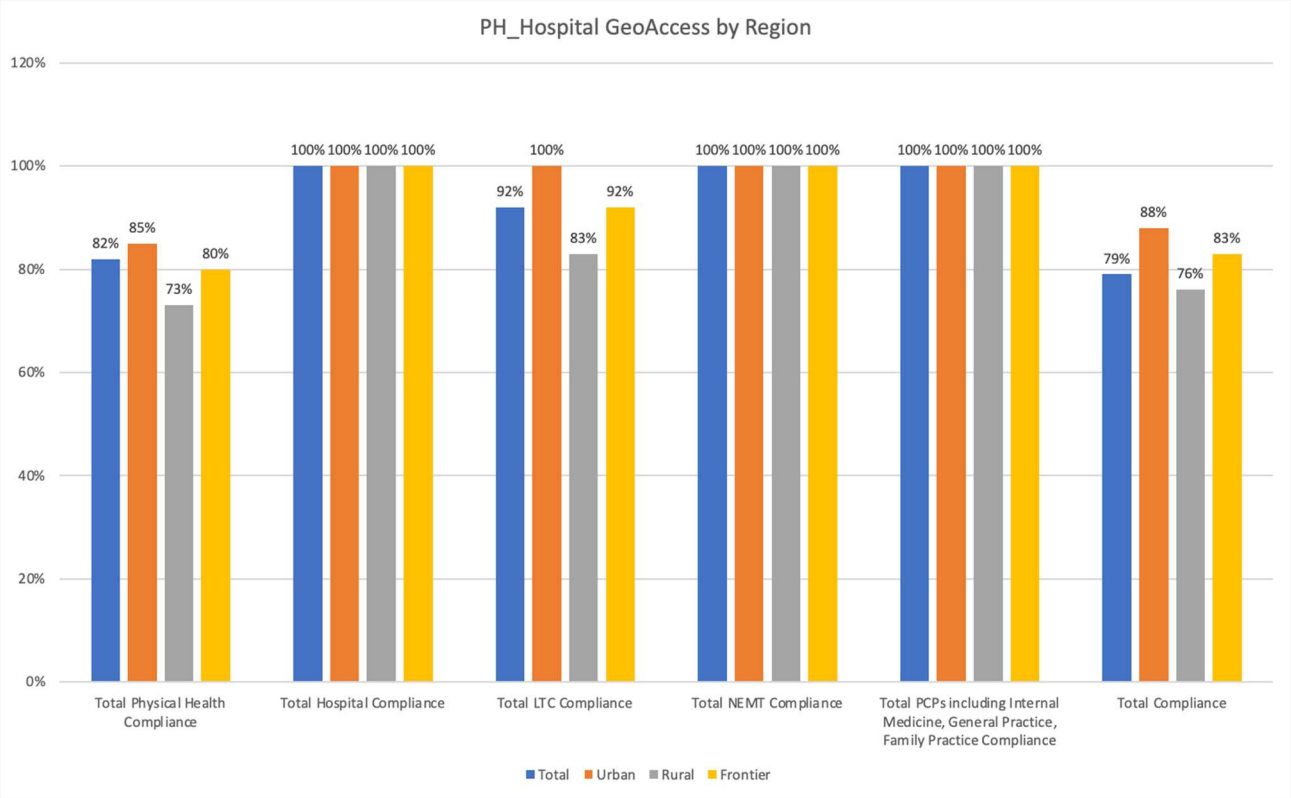
Overall MCOs are meeting Physical Health distance standards in all three regions in the following Provider Types:

- Hospitals – 100% Compliance
- Pharmacies – 100% Compliance
- Pediatrics - 100% Compliance
- Total PCPs including Internal Medicine, General Practice, and Family Practice – 100% Compliance
- LTC is meeting distance standards in the Urban and Frontier regions, meeting overall distance standards at 92%
- NEMT – 100% Compliance

- Several Specialty areas meet distance standards in all three regions including:
    - Cardiology
    - Certified Nurse Practitioners
    - Certified Midwives
    - Dental
    - FQHC
    - Hematology/Oncology
    - Neurology
    - OB/GYN
    - Orthopedics
    - Physician Assistant
    - Podiatry
    - Surgeons

- Provider shortages are found in the Rural and Frontier areas including:
- Dermatology
- Endocrinology
- ENT
- Gastroenterology
- Nephrology (Rural)
- Neurosurgeon
- Optometry (Rural)
- Rheumatology
- Urology (Rural)

Table 18: Physical Health Geographical Access



Source: MCO Report 55 GeoAccess Q3CY24

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.

- **Initiatives**

  HCA is enhancing its oversight of the MCOs' provision of NEMT to its members. The initial focus is on trips for Critical Care Appointments: dialysis, radiation, chemotherapy, dialysis, pre/post-surgery, urgent care, and high-risk pregnancy.

  To date, the MCOs have been directed to: 1) work with their transportation vendors to ensure that all requested rides are provided for these appointments; 2) develop and submit for approval detailed operational plans for providing NEMT for Critical Care service appointments when the transportation vendors are unable to provide the service. In DY11 Q2, appointment arrival and pick up time standards were implemented for the MCOs and vendors. Arrival time must be no sooner than 1 hour before the appointment. Pick-up shall occur within 15 minutes of the scheduled time.

Customer Service Reporting

With the inception of Turquoise Care, a call center metric, Percent of Calls Resolved in the First Call was added for both the Member and Provider Services lines. Additionally, the performance standard for Percent of Calls Answered by a Live Voice within 30 Seconds increased from 85% to 90%. HCA revised its Attachment D – Customer Service Summary for DY12 Q1 and summary below to reflect the new performance standards.

With one instance of rounding required, BCBS met all call center metrics for DY12 Q1. In DY12 Q2, BCBS exceeded all required performance standards.

PHP met all call center metrics for the reporting periods, DY12 Q1 and Q2.

MHC did not meet call center standards the first month of Turquoise Care for Percent of Calls Answered by a Live Voice within 30 seconds and the Average Wait Time for the Member Services line. Since the first month of Turquoise Care, July 2024, MHC has exceeded all call center performance standards.

In DY12 Q1 UHC missed meeting one performance standard for the Nurse Advice Line and one for the Provider Services line. In DY12 Q2, UHC did not meet the Percent of Calls Abandoned standard in October and December for the Nurse Advice Line. Additionally, UHC did not meet the Average Wait Time performance standard in December for the Member Services line. While there is no specific pattern or trend, HCA is monitoring for consistency in meeting performance standards and in particular an improvement for the Percent of Calls Abandoned on the Nurse Advice Line.

Telemedicine Delivery System Improvement Performance Target (DSIPT)

The baseline for each upcoming CY will be the total number of unique members with a telemedicine visit at the end of the previous calendar year. If the MCO achieves a minimum of 5% of total membership with telemedicine visits, as of November 30th of each year, then they must maintain that same 7% at the end of each CY to meet this target. The 7% threshold supersedes the 20% baseline target. The MCOs provide quarterly reports to HCA with the number of unique members served through telemedicine visits and an analysis of trends observed.

The MCOs shall use the end of CY23 as the baseline for CY24 increasing the number of unique members served with a telemedicine visit by 20% for both physical health and behavioral health specialists, focusing on improving telemedicine availability and utilization along with expanding member education and provider support when the 7% threshold is

not met. This is Molina Health Care (MHC) and United Health Care (UHC) baseline report

Each MCO met the 7% of total membership with telemedicine visits for the Telemedicine Delivery System Improvement Performance Targets for DY12 Q1 with the exception of the MHC and UHC as this served as their baseline report.

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
DY12 Q2	The New Mexico Health Care Authority (HCA) and Health Services Advisory Group, Inc. (HSAG) worked together in DY12 Q2 (October 1, 2024, to December 31, 2024) to evaluate New Mexico's Section 1115 Demonstration Waivers, Centennial Care 2.0 and Turquoise Care. This report provides an overview of the evaluation activities accomplished in accordance with Special Terms and Conditions (STCs). In DY12 Q2, HSAG and HCA performed the following accomplishments: **Centennial Care 2.0** HCA and HSAG began preparing for the summative evaluation quantitative analyses, including reviewing the interim evaluation data sources to prepare for data extraction and measure calculation. HSAG submitted the summative evaluation data request to HCA, which encompassed all necessary non-MMIS data that are not included in the regular quarterly MMIS extracts provided by HCA. The requested data included program rosters, MCO reports, and Department of Health (DOH) reports. HCA and HSAG established a secure process for file exchange through HSAG's Secure Access File Exchange (SAFE) site. HSAG submitted the Summative Evaluation Report template for HCA review and approval. The template provided an outline of each section of the Summative Evaluation Report with a brief description of the content of each section. HCA identified High Fidelity Wraparound (HFW) program Subject Matter Experts (SMEs) to participate in key informant interviews with HSAG. HSAG employed an actuarial approach to the interim cost-effectiveness evaluation and requested HCA approval to revise this methodology for the summative evaluation to employ a statistical method that aligns with CMS guidance on serious mental illness/serious emotional disturbance (SMI/SED) and substance use disorder (SUD) evaluations.

	Turquoise Care HCA and HSAG finalized a contract to conduct the independent evaluation of Turquoise Care, including developing the Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report. HSAG and HCA established a project work plan detailing the major evaluation deliverables, which include the Evaluation Design, due to the Centers for Medicare & Medicaid Services (CMS) on January 21, 2025, the Interim Evaluation Report, due to CMS on December 31, 2028, and the Summative Evaluation Report, due to CMS on June 30, 2031. The project work plan outlined all tasks associated with the development and submission of deliverables, responsible parties, and deadlines. HSAG developed the Turquoise Care Evaluation Design for submission to CMS on January 21, 2025, which included reviewing the STCs to determine the goals and focus of Turquoise Care. Turquoise Care will continue to build upon the success of Centennial Care 2.0 by providing critical healthcare coverage and access, improving health outcomes, and addressing the social and economic determinants of health. New programs approved with Turquoise Care include the reentry program, traditional healthcare practices, and health-related social needs (HRSN) support services for individuals meeting eligibility criteria, such as medically tailored home-delivered meals and short-term post-hospitalization respite. Activities associated with the development of the Turquoise Care Evaluation Design included, revising the evaluation aims in accordance with Turquoise Care programs and goals. Four evaluation aims were developed: o *Aim One*: Continue the use of appropriate services by members to enhance member access to services and quality of care while maintaining cost-effective care. o *Aim Two*: Improve quality of care and outcomes for Medicaid members with substance use disorder (SUD). o *Aim Three*: Improve quality of care and outcomes for Medicaid members with serious mental illness/serious emotional disturbance (SMI/SED). o *Aim Four*: Improve health outcomes and reduce health inequities among members with HRSN and members in the reentry program. Continued activities included, developing approximately 23 hypotheses, 45 research questions, and 110 measures that will comprehensively evaluate

	Turquoise Care and determine if the evaluation aims are met, collaborating with HCA subject matter experts to determine the data sources that will be available to conduct the evaluation determining the analytic methodologies that will be employed to assess Turquoise Care performance.

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ENCLOSURES ATTACHMENTS

Attachment A: October 2022 – September 2024 Statewide Dashboards
Attachment B: Budget Neutrality Monitoring Spreadsheet
Attachment C: Physical Health Geographic Access
Attachment D: Customer Service

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ADDITIONAL COMMENTS

MCO INITIATIVES

BCBS

BCBS provided support to members who are homeless or at risk of homelessness. BCBS Staff identified that their value-added service of funding behavioral health peer run Wellness Centers may best support their members who are not accessing regular care and have limited access to technology to utilize telehealth. BCBSNM met with all their Wellness Centers to see which had the capability to partner with BCBS to add technology hubs at their center and train staff about the BCBS telehealth provider, MDLive, to connect members to the technology at their center. BCBS also connected with New Mexico Reentry Center in Albuquerque said that they had the space and the staff to help monitor and support their project. BCBSNM purchased the equipment and helped install it at the center for the members to begin using this resource. Plans are underway to expand the project to wellness centers in Rio Arriba County.

PHP

PHP invested in a new software that will allow for an enhanced opportunity to model and monitor value-based care contracts, which they will begin to implement in early 2025. With this technology in place, both PHP and their provider partners will have much clearer line-of-sight into how their providers are performing. PHP will be able to easily identify where there are gaps in care for members and the ability to perform outreach to meet identified needs in a timely manner. This technology will empower and strengthen PHP providers' opportunities to take care of their patients in a holistic way

MHC

MHC launched an initiative to conduct Key Information Interviews to increase Pediatric Care. The MHC Population Health team conducted key informant interviews to gather insights on the needs and challenges faced by prenatal, postpartum and pediatric populations. MHC interviewed providers and organizations serving New Mexico counties with a high percentage of Molina members. Interviews focused on understanding barriers, access issues, and opportunities to improve care for prenatal individuals, postpartum members, and children aged 0-3 years. MHC reports that they intend to use the information gathered from interviews to inform Molina's quality strategies to enhance member health outcomes, access to care and support services for pediatric members.

UHC

UHC engaged with Syncronys (NMHIE) Access and Training, to create access for and trained approximately 90 care coordinator, quality, population health, and health equity staff to use the NMHIE for activities like justice-population work, case management rounds, etc. Syncronys improves ability to understand longer term patterns in how our members access health services and to gain a more comprehensive look at their health issues.

MEMBER SUCCESS STORIES

BCBS

BCBS engaged a 28-year-old male who was previously engaged with Behavioral Health Care Coordinator and was hospitalization in acute setting for major depressive disorder with psychotic features. Member had not been participating in any Behavioral Health medication management nor established with a primary care provider and had only recently started participating in one-on-one counseling sessions prior to hospitalization. Through 90-day Behavioral Health Transition of Care (BH TOC) program, member engaged with BH TOC. Member was referred to and has been consistently participating in an intensive outpatient program for group counseling and psychiatric medication management and was assisted via three-way call with scheduling an intake appointment for primary care in which he has participated.

PHP

Multiple PHP team members collaborated very closely with UNMH and Princeton Place Nursing Facility to ensure a positive discharge outcome for a PHP member. Member had been at UNMH since February 2024. Although Member was both psychiatrically and medically stable for over 150 days, it was difficult to find long term care placement due to her previous history. UNMH sent out multiple referrals to long term care facilities in the state but continued to get denials due to Member's past behaviors and facilities past experiences with Member. PHP Care Coordination, Medical Directors, and PHP Leaders continued to meet with UNMH weekly, to provide updates and to brainstorm on various potential placement options. Despite multiple denials from Princeton Place, PHP and UNMH scheduled a meeting with Princeton Place Corporate Leadership. Princeton Place Leadership shared their concerns in taking this member. The UNMH Provider eased concerns by agreeing to continue as Member's Psychiatrist, and if there were any concerns going forward, UNMH Provider agreed to re-admit Member to UNMH. Princeton Place agreed to place Member at their facility for long term care and work with Member's UNMH care team in order to ensure psychiatric support. Due to the collaboration between PHP, UNMH, and Princeton Place, Member's placement needs are now being met.

MHC

Molina Health Care successfully engaged a member who has been diagnosed with pancreatic cancer. The MHC member was interested in Care Coordination to understand their gaps in care and completed a Care Needs Assessment which identified therapy and nutritional needs.

The member was referred to Mountain Hospice who will provide assistance with emotional counseling for guided reflection and peaceful conversation about their life's meaning. The member has identified their Care Coordinator and support broker as two of their strongest supports.

UHC

A UHC member missed a dose of her prescribed blood pressure medication, resulting in elevated blood pressure, dizziness, and headache while at work. Concerned about her symptoms, she called the UHC Nurseline powered by Galileo to determine whether an emergency room visit was necessary.

An RN at the UHC Nurse Advice Line triaged the call and transferred the patient to a clinician for further assessment. After evaluating her condition, the provider determined that an ER visit was not required and advised the patient to take her medication immediately. The provider remained on the line for 20 minutes to monitor symptom improvement, which was successfully achieved.

To ensure the patient's safety, travel arrangements were coordinated for her return home from work. Additionally, the provider educated the patient on medication adherence and provided strategies to prevent missed doses in the future. The patient was referred back to her primary care provider for ongoing management and follow-up.