CENTENNIAL CARE 2.0 DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 11 (1/1/2024 – 12/31/2024)
Quarter 1 of 2024

June 14, 2024

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INTRODUCTION

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

On December 14, 2018, CMS approved New Mexico's 1115 Demonstration Waiver, 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 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 in order to allow New Mexico and CMS to continue negotiations over New Mexico's demonstration application submitted on December 15, 2022. 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 and negotiations continue over the remaining initiatives.

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

- Improving continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, increasing utilization of preventive services, and promoting administrative simplification and fiscal sustainability of the Medicaid program;
- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;

- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continuing the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;
- Building upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplifying administrative complexities and implementing refinements in program and benefit design.

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

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

Status of Key Dates:

TOPIC	KEYDATE	STATUS
Quality Strategy	Final Quality Strategy posted to HSD website on September 1, 2022.	Final copy submitted to CMS on October 26, 2022.
Substance Use Disorder (SUD) Implementation Plan	Approved by CMS on May 21, 2019.	Approved by CMS on May 21, 2019.
Evaluation Design Plan	Submitted to CMS on June 27, 2019.	Approved by CMS on April 3, 2020.
SUD Monitoring Protocol	Submitted to CMS on July 31, 2019.	Approved by CMS on July 21, 2020.
1115 Demonstration Amendment #2	Submitted to CMS on March 1, 2021.	Approved by CMS on March 28, 2023.
1115 Demonstration Amendment #2 Letter Amendment	Submitted to CMS on December 30, 2021.	Approved by CMS on March 28, 2023.

New Mexico Turquoise Care 1115 Waiver Renewal Application	Submitted to CMS on December 15, 2022.	CMS Completeness Letter received on December 29, 2022. Federal Comment Period occurred December 29, 2022 through January 28, 2023. CMS' Temporary Extension Approval received on September 5, 2023. CMS Amendment Approval received on December 15, 2023 for some waiver renewal initiatives. CMS and New Mexico continue negotiations.
SMI/SED Implementation Plan	Due to CMS June 26, 2023. Resubmission due January 31, 2024 (extensions approved by CMS). Resubmission due date April 12, 2024.	Submitted to CMS 6/26/2023. CMS feedback received July 17, 2023 and New Mexico resubmitted September 29, 2023. New Mexico resubmitted plan on 10/18/2023 and CMS provided additional feedback on 10/31/2023. New Mexico resubmitted plan on February 20, 2024 and CMS provided feedback on March 14, 2024. Pending New Mexico resubmission.
SMI/SED Monitoring Protocol	Due to CMS August 25, 2023.	On August 18, 2023, CMS extended the deadline to September 29, 2023. On September 1, 2023, CMS extended the deadline to January 31, 2024. On December 22, 2023, CMS extended the deadline to May 31, 2024. Deadlines will continue to be extended until CMS develops and issues new monitoring templates and guidance.
Centennial Care 2.0 - COVID-19 Vaccine Final Report	Due to CMS September 4, 2023.	On September 18, 2023, CMS granted New Mexico an extension to submit by October 31, 2023.

		On November 16, 2023, CMS granted New Mexico an extension to submit by February 29, 2024. New Mexico submitted the COVID-19 Report to CMS on February 28, 2024. Under CMS review.
Centennial Care 2.0 Amended Evaluation Design	Due to CMS September 25, 2023. Resubmission due March 1, 2024.	New Mexico submitted September 25, 2023 to include Serious Mental Illness (SMI)/serious emotional disturbance (SED), High Fidelity Wraparound (HFW), Home and Community Based Services (HCBS) Enhancements, and Legally Responsible Individual (LRI) components. On December 13, 2023, CMS provided feedback. On March 1, 2024, New Mexico resubmitted its Evaluation Design to CMS. Under CMS review.
Centennial Care 2.0 Public Health Emergency Amendment for Legally Responsible Individuals under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit Final Report	Due to CMS November 11, 2024. Reporting Period: May 11, 2023 – November 11, 2023	In progress.
NM COVID Authorities Temporary Extension for Legally Responsible Individuals under EPSDT and Community Benefit Final Report	Due to CMS February 28, 2025. Reporting Period: November 12, 2023 – February 29, 2024	In progress.

NEW MEXICO AND CMS WAIVER ACTIVITIES

New Mexico Centennial Care 2.0 Waiver Amendment #2

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

- Federal Financial Participation (FFP) for inpatient, residential and other services

provided to otherwise-eligible Medicaid beneficiaries while they are short-term residents in Institutions for Mental Diseases (IMD) for diagnoses of Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). FFP will become available once CMS approves New Mexico's SMI/SED Implementation plan, which is currently due June 26, 2023.

- FFP for improvements to New Mexico's Home and Community Based Services (HCBS), including the increase of enrollment limits for the Community Benefit program and increase in service limits for Community Transition and Environmental Modification services.
- FFP and expenditure authority for the implementation of a High-Fidelity Wrap Around (HFW) Intensive Care Coordination Benefit.

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

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

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

Updates for Q3 CY2023
New Mexico resubmitted its SMI/SED Implementation Plan to CMS on July 17, 2023 and received additional feedback from CMS on September 29, 2023, which the state is addressing.

Updates for Q4 CY2023
New Mexico resubmitted its SMI/SED Implementation plan to CMS on 10/18/2023 and CMS provided additional feedback on 10/31/2023. New Mexico is required to submit its implementation plan by January 31, 2024.

Updates for Q1 CY2024
New Mexico resubmitted its SMI/SED Implementation Plan to CMS on 2/20/2024 and CMS provided feedback on 3/14/2024. New Mexico is preparing the resubmission. Separately, New Mexico submitted its Centennial Care 2.0 COVID-19 Vaccine Final Report to CMS on

2/28/2024, which remains under CMS review. Lastly, New Mexico resubmitted its revised Evaluation Design to CMS on 3/1/2024, which remains under CMS review.

New Mexico Turquoise Care 1115 Waiver Renewal

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

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

Date	Meeting
April 26, 2022	Tribal Listening Session
May 4, 2022	Sister Agency and Partner Session
May 5, 2022	Large Stakeholder Session
May 11, 2022	Legislator Session
May 11, 2022	Legislative Finance Committee (LFC), Department of Finance Administration (DFA), and Governor's Office Listening Session
May 12, 2022	Tribal Meeting with Navajo Nation
May 13, 2022	Tribal Meeting with Zuni and Laguna Pueblo
July 18, 2022	Virtual Tribal Listening Session
July 19, 2022	Virtual Tribal Listening Session
July 21, 2022	Virtual Tribal Listening Session

September 30, 2022	Public Hearing
October 7, 2022	Public Hearing
October 14, 2022	Tribal Consultation

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

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

In alignment with HSD's mission, Turquoise Care's goals and initiatives center on improving core health outcomes and attending to the social and economic determinants of health, particularly centered on addressing the needs of the State's historically underserved

populations. HSD's vision is that every New Mexico Medicaid member has high-quality, well-coordinated, person-centered care to achieve their personally defined health and wellness goals. To advance on these opportunities and move closer to our vision, HSD will operate a data-driven Medicaid program that measures quality based on population health outcomes. To support this vision, the Turquoise Care waiver is constructed around three goals:

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

Turquoise Care has targeted initiatives focused on the following populations:

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

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

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

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

- Expanded access to Supportive Housing.

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

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

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

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

Updates for Q2 CY2023

CMS informed New Mexico of its intent to extend the existing Centennial Care 2.0 waiver to allow the state and CMS additional time to review and negotiate the state's demonstration

application submitted December 15, 2022. New Mexico was advised that CMS is prioritizing the following proposals for an effective approval date of January 1, 2024:

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

Updates for Q3 CY2023

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 in order to allow New Mexico and CMS to continue negotiations over New Mexico's demonstration application submitted on December 15, 2022.

During the COVID-19 public health emergency (PHE), the traditional provider workforce was diminishing leading to inadequate capacity to provide medically necessary services such as supporting activities of daily living. To alleviate this provider workforce shortage, New Mexico applied for and received approval on July 1, 2020 from CMS for section 1135 authority to provide payment to Legally Responsible Individuals (LRIs) providing Personal Care Services (PCS) for children receiving the Early and Periodic Screening Diagnostic, and Treatment (EPSDT) benefit. At the conclusion of the PHE on May 11, 2023, the section 1135 authority expired. On May 11, 2023, New Mexico submitted a request to seek authority for these payments under COVID-19 PHE authority. CMS approved the state's request on September 7, 2023, which provided section 1115 authority retroactive to May 11, 2023 for payment for 1905(a) PCS through 6 months following the end of the PHE. To ensure this authority would continue beyond 6 months post the PHE, the state submitted an addendum to its demonstration extension application on September 18, 2023, to seek authority for payments under the demonstration long-term. The Community Benefit population had also received authority to provide payment for LRIs with the approval of a demonstration amendment to respond to the PHE with an Emergency Preparedness and Response Appendix K on October 9, 2020. New Mexico requested to incorporate this program on a longer-term basis into its demonstration with its demonstration extension request of December 15, 2022.

Updates for Q4 CY2023

On November 8, 2023, CMS approved a temporary extension of the COVID authorities that allow LRIs as paid caregivers under the Community Benefit and EPSDT benefit, extending

the expiration date from November 12, 2023 to February 29, 2024. On December 15, 2023, CMS approved the following 1115 waiver renewal initiatives effective January 1, 2024 through December 31, 2024 as an amendment to New Mexico's existing 1115 demonstration waiver:

- Continuous eligibility for children up to age 6;
- Payment to LRIs for providing PCS to individuals receiving benefits under the Community Benefit and EPSDT programs;
- Increase to the enrollment limit of the Community Benefit Program by 1,000, thereby expanding the enrollment limit from 6,789 to 7,789;
- Increase to the current annual enrollment limit for the existing Supportive Housing Program from 180 to 450 demonstration members; and
- Addition of four evidence-based program models into the Centennial Home visiting program.

CMS and New Mexico continue negotiations on the state's pending requests under the waiver renewal application submitted December 15, 2022.

Updates for Q1 CY2024
CMS and New Mexico continue negotiations on the state's 1115 Waiver Renewal request and are targeting an approval by June 30, 2024.

CENTENNIAL CARE 2.0 POST AWARD FORUMS

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

During the March 4, 2024 MAC meeting the following topics were addressed in support of the Centennial Care 2.0 waiver and Medicaid 1115 demonstration waiver renewal:

- Leadership update, which included an announcement of a new Deputy Cabinet Secretary and Medicaid Director.
- Legislative Update – Provided an overview of the timeline and highlighted bills impacting Medicaid.
- Medicaid Dashboard Overview - Included updates on growth in the Medicaid program, increases and decreases of expenditures, nursing facility level of care, and changes in behavioral health services.

- Updates on approved State Plan Amendments.
- 1115 Demonstration Updates – Included information on approvals effective January 1, 2024, Turquoise Care goals, and pending approvals to expand services to address member health and health-related social needs and options for members to stay in their comes and communities.
- Update on moving from the Human Services Department to the Health Care Authority (HCA) to include organizational changes, and upcoming Medicaid Managed Care name change from Centennial Care 2.0 to Turquoise Care.
- Turquoise Care Readiness – Include updates on scheduled MCO on-site visits, MCO options, open enrollment, FAQ's link, and Turquoise Care Roadshows.
- Medicaid Management Information System Replacement (MMISR) - Included updates on Turquoise Care Medicaid Roadshow, MMISR project overview and module update.
- Update on moving Primary Care Payment Reform (PCPR) to Value-Based Payment which included information on implementation date, framework, model, quality metric structure, and training schedule.

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

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

- February 13, 2023
- May 8, 2023
- August 21, 2023
- November 13, 2023
- March 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: QUARTER 1 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	12/31/2023 ENROLLMENT	3/31/2024 ENROLLMENT	PERCENT INCREASE / DECREASE Q1
BlueCross BlueShield of New Mexico (BCBS)	260,299	259,620	-0.3%
Presbyterian Health Plan (PHP)	371,569	368,761	-0.8%
Western Sky Community Care (WSCC)	87,517	90,234	3.1%

Source: Medicaid Eligibility Reports, December 2023 and March 2024

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment and expenditure data by programs for January 2022 – December 2023 is available in Attachment A to this report.

MCO Enrollment

In aggregate, MCO enrollment decreased by 3% from the previous to current period. This decrease is comprised of the following:

- 0.5% decrease in Physical Health enrollment.
- 0% increase in Long-Term Services and Supports enrollment.
- 1% decrease in Other Adult Group enrollment.

Enrollment levels have started 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., December 31, 2023). Historically, this decrease in the last month changes to an increase in subsequent quarter due to additional runout.

MCO Per Capita Medical Costs:

In aggregate, total MCO per capita medical costs increased by 3% from the previous to

current period. This consists of a 8% increase to pharmacy services, while non-pharmacy services increased 3% between periods.

On a dollar basis, the lower enrollment levels (-3%) have been offset by the increase in per capita medical costs (3%), driving the negligible decrease in total medical expenses.

CENTENNIAL CARE 2.0 AND TURQUOISE CARE

CENTENNIAL REWARDS

The Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors. Beginning in DY11, New Mexico modified its 2024 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 Centennial Home Visit (CHV)	All ages	Added new reward activity
CHV Video Completion	All ages	Added new reward activity

First CHV after baby is born	All ages	Added new reward activity
Ongoing CHV Visits	All ages	Added new reward activity
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	No change
Diabetes HbA1C Test – Completion of HbA1C Test • Bonus: Diabetes HbA1C Control – Attain HbA1c control (<8%)	Ages 10-75	Reward activity eliminated
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75	No change
Flu Shot - Receive flu vaccine	Ages 6 months+	No change
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

Centennial Rewards Participation

In DY11 Q1, there were 220,800 Centennial Care members participating in the Centennial Rewards Program. Registering for the Centennial Rewards program is not required to participate in the program but is required for reward redemption. Quality improvement and participation trends are demonstrated in the table below.

Table 2: Centennial Rewards

CENTENNIAL REWARDS				
	April - June 2023	July - September 2023	October - December 2023	January - March 2024
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	234,766	209,316	125,575	200,288
Number of Members Newly Registered in the Rewards Program this Quarter**	4,497	4,612	6,497	3,332
Number of Members Who Redeemed Rewards this Quarter***	30,608	30,542	50,159	17,180

Source: Finity Quarter 1 Report
*Only includes rewards earned in relevant quarter. This measure is typically highest in the first half of 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 in the first half of the year as members save their reward points to spend when they have more buying power or during the holidays.
***In line with registration trends, reward redemptions are typically lowest in the first half of the year as members save their reward points to spend when they have more buying power or during the holidays. Earned rewards expire December 31st of the following year (e.g., rewards earned in 2023 expire on December 31st, 2024). Rewards can be redeemed anytime during that period.

Following is a summary of DY11 Q1 observations:

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

Centennial Care Rewards Multimedia Campaigns

In DY11 Q1, Finity conducted the following multimedia campaigns to encourage members

to keep their preventive appointments, receive vaccinations, and complete targeted condition management activities that align with state performance. All multimedia communications align with HSD's strategic goals, and promote the healthy activities that members are eligible to complete to earn rewards and close gaps-in-care.

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 points for completing their visit. Texts and emails were sent January through March 2024:

- 503K texts sent in Q1 2024
- 313K emails sent in Q1 2024

Monthly Redemptions Campaign: Designed to notify members who have earned rewards that they have points to spend in the Centennial Rewards Catalog on essential items like oximeters, thermometers, cleaning supplies, diapers, nursing supplies, kitchen items, and more. Texts and emails were sent January through March 2024. This is an ongoing campaign and Q1 2024 results are provided below:

- 77K texts sent in Q1 2024
- 65K emails sent in Q1 2024

Women's Cancer Screening Campaign: Designed to encourage eligible members to complete breast and cervical cancer screenings. Campaign texts and emails were sent in January through March 2024. This is an ongoing campaign and DY11 Q1 results are provided below:

- 329K texts sent in Q1 2024
- 238K emails sent in Q1 2024

Additional Key Statistics through DY11 Q1 2024:

- Member participation in DY11 Q1 2024 reached an all-time high of over 77.15%.
    - In DY11 Q1 2024, more than 200K members earned rewards, the highest total seen in any Q1 in program history.
- There were $4.5M in rewards earned in Q1 2024 which exceeded Q1 2023 by $250K.

Enhanced Customer Satisfaction Survey: The results of the DY11 Q1 2024 survey are listed in table 3.

Table 3: Centennial Rewards Customer Satisfaction Survey

Centennial Rewards Customer Satisfaction Survey												
	DY10 Q2			DY10 Q3			DY10 Q4			DY11 Q1		
	# OF RESPONDENTS 2,981			# OF RESPONDENTS 2,686			# OF RESPONDENTS 3,954			# OF RESPONDENTS 867		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Centennial Care?	96%	4%	n/a	97%	3%	n/a	96%	4%	n/a	98%	2%	n/a
Are you satisfied with your doctor?	88%	4%	8% I don't have a doctor	88%	5%	7% I don't have a doctor	88%	5%	8% I don't have a doctor	86%	4%	10% I don't have a doctor%
Are you satisfied with your health plan?	95%	5%	n/a	95%	5%	n/a	96%	4%	n/a	97%	3%	n/a
Are you satisfied with the help provided by your care coordinator?	92%	8%	<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	93%	7%	<1% I don't have a care coordinator

Source: Finity Quarter 1 Report

TURQUOISE CARE

The New Mexico Turquoise Care Program begins 7/1/2024. In DY11 Q1, Turquoise Care Readiness Review activities continued and included Desk Audit and On-Site Reviews of the four Turquoise Care MCOs: Blue Cross Blue Shield of New Mexico, Presbyterian Health Plan, Molina Healthcare of New Mexico, and United Healthcare Insurance Company.

Reviews were conducted on:

- Finance and VBP
- Administration and Organization
- Care Coordination
- Grievances and Appeals
- Information Systems and Claims Management
- Long Term Services and Supports
- Member Services
- Population Health and Quality Management
- Program Integrity
- Utilization Management

- Provider Network and Provider Services

Following the Desk Audits, two-day onsite reviews were conducted at each MCO.

3

ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

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

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

Most disenrollments for this quarter are attributed to loss of eligibility, members moving out of state, death and unwinding activities.

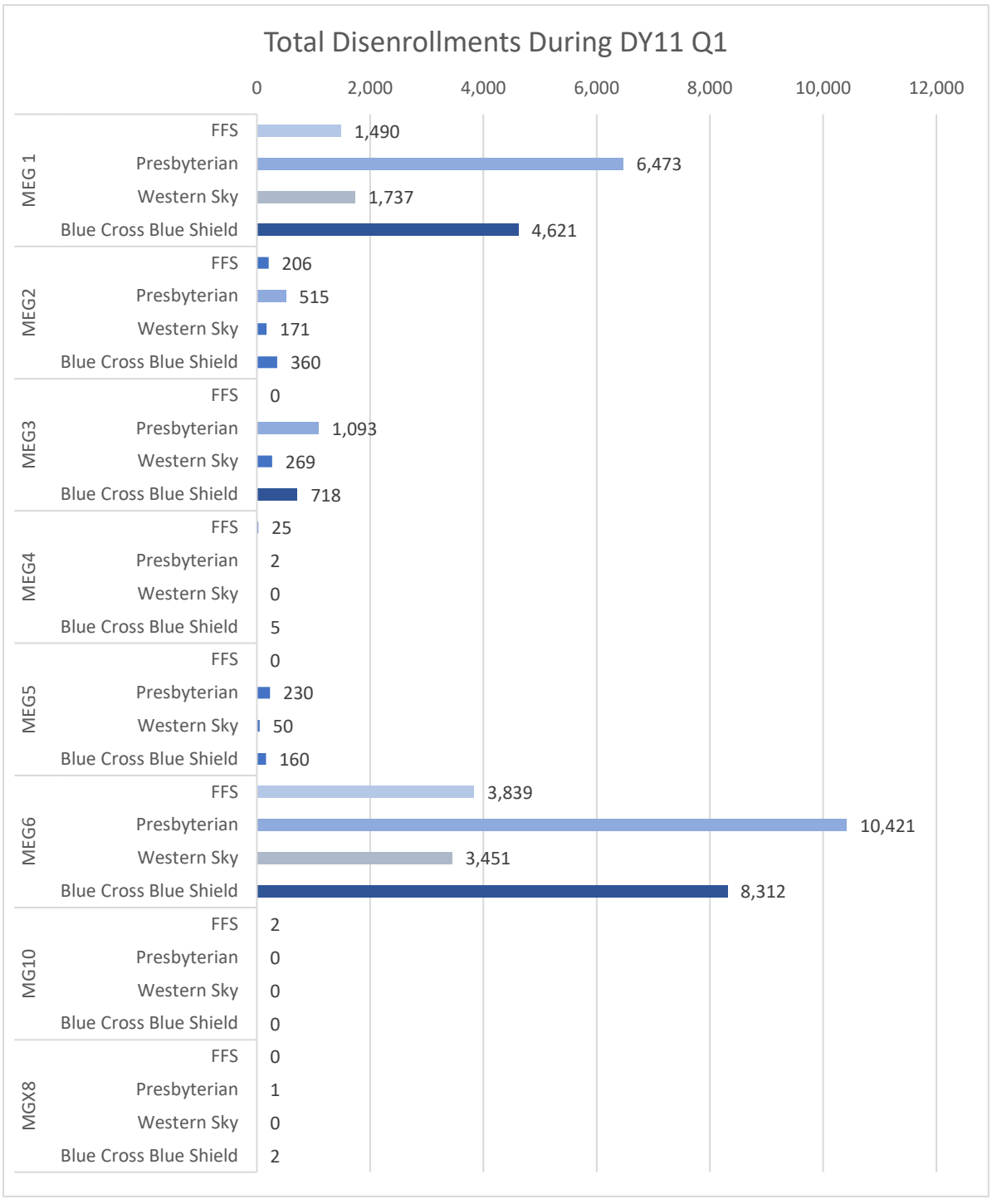
Due to Public Health Emergency (PHE) regarding Coronavirus (COVID-19), HSD meets the Maintenance of Effort (MOE) statutory requirements to receive the 6.2% increased Federal Medical Assistance Percentage (FMAP) by ensuring individuals are not terminated from Medicaid if they were enrolled in the program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

DY11 Q1 Data

Demonstration Population		Total Number Demonstration Participants DY11 Q1 Ending March 2024	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY11 Q1 (January-March 2024)
Population MEG1 - TANF and Related	0-FFS	32,353	328,201	1,490
	Presbyterian	179,405	29,688	6,473
	Western Sky	39,437	7,315	1,737
	Blue Cross Blue Shield	122,164	21,003	4,621
	Summary	**373,359**	**386,207**	**14,321**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,543	35,265	206
	Presbyterian	20,064	2,295	515
	Western Sky	4,120	576	171
	Blue Cross Blue Shield	12,519	1,394	360
	Summary	**39,246**	**39,530**	**1,252**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Presbyterian	21,388	23,817	1,093
	Western Sky	4,138	4,709	269
	Blue Cross Blue Shield	11,009	12,496	718
	Summary	**36,535**	**41,022**	**2,080**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	156	306	25
	Presbyterian	107	10	2
	Western Sky	13	2	0
	Blue Cross Blue Shield	72	21	5
	Summary	**348**	**339**	**32**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Presbyterian	3,129	3,561	230
	Western Sky	546	617	50
	Blue Cross Blue Shield	2,316	2,680	160
	Summary	**5,991**	**6,858**	**440**
Population MEG6 - VIII Group (expansion)	0-FFS	31,597	288,510	3,839
	Presbyterian	128,408	55,229	10,421
	Western Sky	38,057	16,190	3,451
	Blue Cross Blue Shield	100,242	43,784	8,312
	Summary	**298,304**	**403,713**	**26,023**
Population MEG10 - IMDSUD Group	0-FFS	14	44	2
	Presbyterian	42	435	0
	Western Sky	10	85	0
	Blue Cross Blue Shield	51	313	0
	Summary	**117**	**877**	**2**
Population MEGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Presbyterian	147	1,031	1
	Western Sky	76	368	0
	Blue Cross Blue Shield	211	1,028	2
	Summary	**434**	**2,427**	**3**
Summary		**754,334**	**880,973**	**44,153**

Source: Enrollee Counts Report

DY11 Q1 Complete Data



Source: Enrollee Counts Report

4

OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY11 Q1	In DY11 Q1, the Human Service Department (HSD), Medical Assistance Division (MAD) continued to provide coaching, outreach, and educational activities through webinars to Presumptive Eligibility Determiners (PEDs) in the Presumptive Eligibility (PE) and Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) programs to help PEDs better assist their clients in the completion of Medicaid eligibility applications, both online and telephonically. A monthly “PED Medicaid Monthly” newsletter is sent by HSD to active PEDs. The newsletter provides updates on HSD programs, policy changes, YESNM-PE system updates, tips and audit reminders for PEDs. The newsletter features a PED Hero section to allow active PEDs to nominate and feature one of their own. HSD also provided online PE certification and refresher demo training sessions for prospective and current PEDs.

5

COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

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

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

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OPERATIONAL/ POLICY/ SYSTEMS/ FISCAL DEVELOPMENT/ ISSUES

FISCAL ISSUES

The capitation payments through DY11 Q1 with the extension reflect the Centennial Care 2.0 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.

During DY11 Q1, 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, medical care credit reconciliation, and recoupments for medical loss ratio adjustments.

The payments related to the public health emergency due to the Coronavirus (COVID-19) pandemic was $22.4 million, including $17.9 million of non-risk payments, paid through March 31, 2024. In addition, expenditures and member months for substance use disorder in an institution for mental diseases (SUD IMD) were reported for DY6 to DY11 for both fee-for-service and managed care.

SYSTEM ISSUES

There are no system issues to report for this quarter.

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

On January 31, 2020 the Health and Human Services Secretary, Alex M. Azar II, declared a public health emergency for the United States to aid the nation’s healthcare community in responding to the 2019 novel coronavirus also known as COVID-19. This declaration is retroactive to January 27, 2020. To help meet the needs of the nation during the ongoing COVID-19 pandemic, U.S. Health and Human Services (HHS) Secretary Xavier Becerra renewed the COVID-19 PHE declaration for COVID-19 on February 9, 2023 and the Biden

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

Following is a chronology of the renewals to date:

Historically the Maintenance of Effort (MOE) for Medicaid enrollment has been tied to the PHE declaration; however, with the passing of the Consolidation Appropriations Act of 2023 in December 2022, the MOE and the PHE were decoupled, and both had different end dates. The PHE ended on May 11, 2023 and the MOE continuous eligibility ended March 31, 2023. New Mexico began its unwinding activities in March 2023 and terminations began May 1, 2023. CMS provided states with three different options to begin unwinding activities, and New Mexico elected to begin activities in March 2023. New Mexico will use all 12 months of the unwinding period and will prioritize members that are expected to be financially ineligible based on existing system data and analyses. On February 15, 2023, New Mexico submitted its State Renewal Distribution Report (baseline report) and PHE Unwinding Configuration and Testing Plan to CMS. During New Mexico's 12-month unwinding period, it will submit a monthly report to CMS by the 8th of each month. To date, New Mexico has submitted unwinding reports to CMS through March 2024.

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

On August 25, 2023, New Mexico requested that CMS provide authority under section 1902(e)(14)(A) of the Social Security Act to implement the following strategies to protect beneficiaries from inappropriate terminations and reduce state administrative burden:

- Renew Medicaid eligibility for individuals with income at or below 100% Federal Poverty Level (FPL) and no data returned on an ex parte basis
    - Approved by CMS September 5, 2023 effective September 1, 2023 and will remain effective for renewals initiated through the end of the state's 12-month unwinding period, as defined in the March 3, 2022 CMS State Health Official (SHO) letter #22-001.
        - On September 14, 2023, New Mexico requested to modify its request to renew eligibility when there is no data returned and the income is at or below 100% FPL, by changing the effective date to April 1, 2023 and also apply this strategy to individuals who have procedurally closed since April 1, 2023.
            - Approved by CMS September 29, 2023 effective April 1, 2023 and will remain effective for renewals initiated through the end of the state's 12-month unwinding period, as defined in the March 3, 2022 CMS SHO letter #22-001.
- Permit Managed Care Plans to provide assistance to enrollees to complete and submit Medicaid renewal forms
    - Approved by CMS September 5, 2023 effective September 1, 2023 and will remain effective for renewals initiated through the end of the state's 12-month unwinding period, as defined in the March 3, 2022 CMS SHO letter #22-001.
- Permit the designation of an authorized representative for the purposes of signing and application of renewal form by the telephone without a signed designation from the applicant or beneficiary
    - Approved by CMS September 7, 2023 effective September 1, 2023 and will remain effective until 14 months after the end of the continuous enrollment condition (i.e. May 31, 2024).
- Waive the recording of the telephone signature from the applicant or beneficiary
    - Approved by CMS September 7, 2023 effective September 1, 2023 and will remain effective until 14 months after the end of the continuous enrollment condition (i.e. May 31, 2024).
- Reinstate eligibility effective on the individuals' s prior termination date for individuals disenrolled based on a procedural reason who are subsequently redetermined eligible for Medicaid during a 90-day reconsideration period
    - Approved by CMS September 7, 2023 effective September 1, 2023 and will remain effective until 17 months after the end of the continuous enrollment condition (i.e., August 31, 2024).

- Extend automatic reenrollment into a Medicaid Managed Care Plan up to 120 days after a loss of Medicaid coverage
    - Approved by CMS September 29, 2023 effective September 1, 2023 and will remain effective until 17 months after the end of the continuous enrollment conditions (i.e., August 31, 2024)
- Delay procedural terminations for beneficiaries for 1 month while the state conducts targeted renewal outreach
    - On August 30, 2023, CMS permitted the state to begin implementing this strategy, but a formal concurrence would follow.
        - On November 3, 2023, CMS concurred with New Mexico's request to use the exception in the regulations (42 CFR 435.912(e)) in meeting timeliness requirements to support states processing of Medicaid eligibility and enrollment actions conditioned that the state documents the reason for delay in each beneficiary's case record. The exception is effective for renewals due in the month of September 2023 and will remain effective for renewals due in each subsequent month of the state's unwinding period.

On December 28, 2023, New Mexico requested that CMS provide authority under section 1902(e)(14)(A) of the Social Security Act to waive renewals for individuals whose eligibility is determined under non-Modified Adjusted Gross Income (MAGI) rules and who are not enrolled in limited benefit plans to protect beneficiaries from inappropriate terminations and reduce state administrative burden. Request remains under CMS review.

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

New Mexico Disaster Relief State Plan Amendments (SPAs)

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

- Expanding the list of qualified entities allowed to do Presumptive Eligibility.
- Increasing Diagnosis-related Group (DRG) rates for ICU inpatient hospital stays by 50% and all other inpatient hospital stays by 12.4% from April 1, 2020 – September 30, 2020.
- Establishing Category of Eligibility (COE) for the COVID-19 Testing Group for the uninsured population.
- Providing Targeted Access UPL Supplemental Payments.
- Applying a Nursing Facility Rate Increase when treating fee for service COVID-19 members from April 1, 2020 – June 30, 2020.

- Increasing reimbursement for hospital stay services from April 1, 2020 – June 30, 2020.
- Increasing reimbursement to non-hospital providers for E&M codes and non-E&M codes, as well as an increase to Medicaid only procedure codes from April 1, 2020 – June 30, 2020.
- Increasing rates for services provided under the Family Infant Toddler (FIT) Program for July 1, 2020 through July 31, 2020.
- Providing Targeted Access supplemental payments for Safety-Net Care Pool (SNCP) hospitals from April 1, 2020 through December 31, 2020.
- Implementing coverage and reimbursement for COVID-19 vaccine and vaccine administration in accordance with Medicare's billing and reimbursement guidance.
- Providing reimbursement for administration of COVID-19 vaccines to homebound eligible Medicaid beneficiaries from March 15, 2021 through the end of the PHE.
- Applying a rate increase to non-emergency transportation providers from January 1, 2022 through June 30, 2022 or the end of the PHE, whichever comes first.
- Applying a nursing facility rate increase for COVID-19 members from January 1, 2022 through June 30,2022 or the end of the PHE, whichever comes first.
- Applying rate increases for ICU inpatient hospital services and for all other inpatient hospital services from January 1, 2022 through June 30, 2022 or the end of the PHE, whichever comes first.
- Implementing targeted access supplemental payments for Safety-Net Care Pool (SNCP) hospitals from January 1, 2021 through the end of the PHE.
- Implementing a temporary 15% reimbursement increase in accordance with Section 9817 of the American Rescue Plan (ARP) Act of 2021 and New Mexico's approved Spend Plan for providers of Personal Care Services (PCS) and Private Duty Nursing (PDN) under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit from May 1, 2021 to June 30, 2022, or the end of the PHE, whichever comes first.
- Allowing hospital providers to bill and be paid for pasteurized donor human milk (PDHM) services separate from the Diagnosis-related group (DRG) and in addition to the inpatient hospital stay for infants through New Mexico Medicaid enrolled medical supply companies effective July 1, 2022.
- Implementing a rate increase for providers of Personal Care Services (PCS) and Private Duty Nursing (PDN) services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Effective July 1, 2022 through the end of the PHE, reimbursement for providers of PCS and PDN services under EPSDT will be set at the same rates as 1915(c) provider rates.

In May 2023, New Mexico submitted NM SPA 23-0007 requesting CMS' approval effective

April 30, 2023 to end coverage for the COVID-19 testing group at 1902(a)(10)(A)(ii)(XXIII) of the Act as previously authorized in New Mexico Disaster SPA 20-0007. On August 11, 2023, CMS approved New Mexico's request effective April 30, 2023.

1135 Waiver

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

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

On May 11, 2023, New Mexico submitted a COVID-19 PHE 1115 Demonstration Waiver Application to CMS to continue the coverage of Legally Responsible Individuals (LRIs) as paid caregivers under the State's EPSDT benefit following the expiration of 1135 waiver authority and end of PHE. On September 7, 2023, CMS approved New Mexico's Centennial Care 2.0 PHE demonstration amendment for LRIs to provide PCS for individuals receiving EPSDT benefits from May 11, 2023 to November 11, 2023, for the duration of a period of 6 months after the end of the PHE to align with the current timeframe of the state's Appendix K below for Home and Community Benefit Services. To ensure this authority would continue beyond 6 months post the PHE, the state submitted an addendum to its demonstration extension application on September 18, 2023, to seek authority for payments under the demonstration long-term. On November 18, 2023, CMS issued a temporary extension of this COVID authority, extending the end date to February 29, 2024. On December 15, 2023, CMS provided permanent authorization for LRIs as paid caregivers under the EPSDT benefit effective January 1, 2024 through December 31, 2024.

Appendix Ks

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

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

- Exceeding service limitations (i.e., allowing additional funds to purchase electronic devices for members, exceeding provider limits in a controlled community residence

and suspending prior authorization requirements for waiver services, which are related to or resulting from this emergency).
- Expanding service settings (i.e., telephonic visits in lieu of face-to-face and provider trainings also done through telehealth mechanisms).
- Permitting payment to family caregivers.
- Modifying provider enrollment requirements (i.e., suspending fingerprinting and modifying training requirements).
- Reducing provider qualification requirements by allowing out-of-state providers to provide services, allowing for an extension of home health aide supervision with the ability to do the supervision remotely.
- Utilizing currently approved Level of Care Assessments to fulfil the annual requirement or completing new assessments telephonically.

Modifying the person-centered care plan development process to allow for telephonic participation and electronic approval.

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

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

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

1115 Demonstration Waiver for Home and Community Benefit Services (HCBS)

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

On May 11, 2023, New Mexico submitted a COVID-19 PHE 1115 Demonstration Waiver Application to CMS to continue the coverage of Legally Responsible Individuals (LRIs) as paid caregivers under the State's Community Benefit program following the expiration of Appendix K authority (6 months following end of PHE) and until CMS approved the permanent request under New Mexico's demonstration extension submitted December 15, 2022; however, upon further consultation with CMS in August 2023, additional flexibilities exist to temporarily extend COVID-19 authorities, which CMS is exploring. On November 18, 2023, CMS issued a temporary extension of this COVID authority, extending the end date to February 29, 2024. On December 15, 2023, CMS provided permanent authorization for LRIs as paid caregivers under the Community Benefit effective January 1, 2024 through December 31, 2024.

1915c (Supports Waiver and Developmental Disabilities Waiver)

- Modifying provider qualifications to suspend fingerprint checks or modify training requirements.
- Modifying processes for level of care evaluations or re-evaluations.
- Temporarily modifying incident report requirements for deviations in staffing.
- Temporarily allowing for payment of services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary

supports are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
- Allowing flexibility of timeframes for the CMS 372, evidentiary package(s), and performance measure data collection.
- Adding an electronic method of service delivery allowing services to continue to be provided remotely in the home setting.
- Allowing an option to conduct evaluations, assessments, and person- centered service planning meetings virtually in lieu of face-to-face meetings and adjusting assessment requirements.
- Modifying incident reporting requirements.
- Clarifying the effective dates in section (f.) to temporarily increase payment rates with effective dates 3/16/20 – 9/30/20 for supportive living, intensive medical living, and family living as approved in NM.0173.R06.03.

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

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

PATIENT CENTERED MEDICAL HOMES (PCMH)

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

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

Table 4 below reports the total number of members paneled to a PCMH per MCO. DY10 Q4 reflects an overall aggregate decrease in members receiving care through a PCMH compared

to DY10 Q3. The DY11 Q1 data will be reported in the DY11 Q2 CMS Quarterly Monitoring Report. This reduction in membership and subsequent paneling to PCMH can be attributed to the ending of the Public Health Emergency (PHE). As a result, members were required to renew their Medicaid financial eligibility. During the PHE, members eligibility was continuously renewed as approved by federal waiver. Members have been issued correspondence related to the ending of the PHE and several different options on how to renew their Medicaid.

Table 4: PCMH Assignment

PCMH ASSIGNMENT				
Total Members Paneled to a PCMH				
	DY10 Q1	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
BCBS	167,746	161,328	151,385	140,280
PHP	269,447	267,851	225,734	226,527
WSCC	38,316	52,767	47,826	44,770
Percent of Members Paneled to a PCMH				
	DY10 Q1	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
BCBS	55.30%	52.70%	53.60%	51.00%
PHP	62.80%	66.10%	61.00%	60.90%
WSCC	40.10%	59.80%	51.40%	48.00%

Source: MCO Report #48 DY10 Q4

MCO PCMH initiatives:

BCBS: BCBS utilizes an array of programs, including care coordination, community health workers, and the paramedicine program to positively impact hospital readmission and high emergency room (ER) utilization. Care Coordinators and Community Health Care Workers (CHWs) are also proactively engaged to follow up with members post-ER visit and post-hospitalization. BCBS tracks members with a chronic medical history who are likely to have increased ER visits from chronic diseases. BCBS care managers perform outreach to members and clinicians to involve them in disease management. BCBS continues to develop predictive modeling programs to identify PCMH members at risk of developing these chronic diseases who are likely to be high utilizers for hospital admission and ER visits.

PHP: PHP continues to educate and support groups on various Quality Improvement topics such as Medical Record Review (MRR) and Clinical Data Integration (CDI). Monthly scorecards, including Emergency Department (ED) utilization and inpatient admission rates, are reviewed routinely with clinic leadership. PHP attempts to identify members who would

benefit from telehealth visits. PHP provides programs such as the pre-diabetes education program for members. Education on enrolling members is provided during monthly touchpoints with PCMH groups. PHP continues to review patient resources with providers, such as care coordination, transportation, member incentives, and provider education on quality measure details. PHP also continues to monitor disease management, potential risk outcomes based on chronic conditions, and the impact of disease management on utilization and medication adherence.

WSCC: WSCC works to improve health outcomes, reduce healthcare costs, and provide efficient patient-centered care by actively leveraging telehealth capabilities, identifying and addressing Social Determinants of Health, providing analytic tools and offering value-based contracts to PCMH providers. Telehealth services is promoted via outreach campaigns. Education and options for telemedicine provider visits are offered. WSCC's ongoing efforts to expand telehealth access to PCMH members via night and weekend provider visits, to reduce emergency room utilization for non-emergent needs continued in DY10 Q4 with Teledoc. The WSCC Member Connections team consistently sends text messaging, via campaigns, to members with high ED or inpatient admissions, educating members on the availability of Telemedicine through their PCMH. During Q4, they completed a community newsletter to include a highlight of Teladoc information distributed to all members.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities	
DY11 Q1	HSD continued to monitor MCO enrollment and member engagement through the quarterly Care Coordination Report. This report includes data related to the completion of required assessments and touchpoints within contract timeframes. The DY11 Q1 report contains data from DY10 Q4. DY11 Q1 data will be reported in DY11 Q2. The MCO aggregate results show performance benchmarks of 85% were met, or exceeded, for timely completion of Health Risk Assessments (HRAs) for 'new to Medicaid' members, members with a change in health condition, Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs). The aggregate completion rate for HRAs for 'new to Medicaid' members decreased from 96% in DY10 Q3 to 95% in DY10 Q4. The aggregate completion rate for HRAs for members with a 'change in health condition' decreased from 99% in DY10 Q3 to 98% in DY10 Q4. Aggregate completion percentages for CNAs for CCL2 members decreased from 90% in DY10 Q3 to 89% in DY10 Q4. Aggregate completion percentages for CNAs for CCL3 members decreased from 86% in DY10 Q3 to 85% in DY10 Q4. MCOs noted that multiple rescheduled assessments and members not keeping scheduled appointments, specifically during the holiday season, resulted in a decrease in timely completion of CNAs. MCOs will continue to monitor by utilizing daily operational oversight reports and tracking mechanisms to increase timely completion. Aggregate completion percentages of CCPs for CCL2 members increased from 94% in DY10 Q3 to 95% in DY10 Q4. CCPs for CCL3 members was at 96% in DY10 Q3 and DY10 Q4. In DY10 Q1, BCBS initiated a process improvement project to streamline CCP completion, decrease the completion time, allow for more detail, and be more member centric. HSD notes that BCBS increased their CCP timely completion percentage for CCL2 Members from 85% in DY10 Q1 to 87% in DY10 Q4. For CCL3 Members, their CCP timely completion percentage increased from 86% in DY10 Q1 to 91% in DY10 Q4. BCBS will continue to measure outcomes and the benefits of the project with the intent of increasing all timeliness levels.

	The Care Coordination Report includes MCO strategies for engaging and retaining members. In DY10 Q4, MCOs reported on multiple strategies to retain engagement with members. BCBS is providing increased awareness of the various services available through care coordination at health fairs and community events across the state. Managers and care coordinators attend events to meet with members, provide information on their programs for targeted populations, and receive feedback to their program. BCBS has increased incentives through their Centennial Rewards program and is utilizing Community Health Workers (CHWs) to connect with members where they are. PHP utilizes Community Health Workers (CHWs) and Peer Support Specialists (PSSs) who collaborate with community-based organizations to facilitate increased engagement. PHP's PSS staff engage members with high emergency room utilization and history of substance use with a goal of facilitating engagement in care coordination leading to accessing resources and services. WSCC participates in numerous community events across the state, from school-based activities to cultural celebrations with the goals of increasing engagement in care coordination and increasing their members' quality of life. WSCC provides food boxes, that include turkeys, to all community members that attend local events. WSCC staff offer Medicaid determination, onsite assessments, resources for dental, vaccinations, and health services at no cost to participants. WSCC has also partnered with New Mexico Community Care (NMCC), a statewide paramedicine program, to expand efforts to complete HRAs for members unable to be reached, outreach to members with a Notification of Pregnancy, provide education, and to complete A1C test administration for members who are non-compliant with their annual screening. NMCC is able to outreach to 5,000 member referrals each month statewide. HSD continues to monitor strategies and interventions for all MCOs to increase member engagement and compliance with performance benchmarks. The table below details aggregate and individual MCO performance from DY10 Q1 through DY10 Q4. DY11 Q1 data will be reported in DY11 Q2.

Table 5: Care Coordination Monitoring

MCO Performance Standards	DY10 Q1	DY10 Q2	DY10 Q3	DY10 Q4
HRAs for new Members	**97%**	**96%**	**96%**	**95%**
BCBSNM	97%	95%	96%	97%
PHP	96%	95%	94%	90%
WSCC	100%	100%	100%	100%
HRAs for Members with a change in health condition	**99%**	**99%**	**99%**	**98%**
BCBSNM	99%	100%	100%	100%
PHP	98%	98%	96%	95%
WSCC	100%	100%	100%	100%
CNAs for CCL2 Members	**90%**	**91%**	**90%**	**89%**
BCBSNM	88%	88%	87%	86%
PHP	90%	92%	90%	90%
WSCC	99.70%	100%	100%	100%
CNAs for CCL3 Members	**86%**	**90%**	**86%**	**85%**
BCBSNM	86%	86%	83%	82%
PHP	85%	91%	85%	85%
WSCC	100%	100%	100%	97%
CCPs for CCL2 Members	**94%**	**94%**	**94%**	**95%**
BCBSNM	85%	85%	84%	87%
PHP	99%	99%	99%	99%
WSCC	96%	93%	97%	95%
CCPs for CCL3 Members	**95%**	**95%**	**96%**	**96%**
BCBSNM	86%	87%	90%	91%
PHP	99%	98%	99%	99%
WSCC	96%	94%	96%	94%

Source: HSD DY10 Q1 to DY10 Q4 Report #6 –Care Coordination Report
Percentages in bold are MCO aggregate of the total assessments due and completed.

Care Coordination Audits

In DY10 Q4, HSD monitored MCO compliance with contract and policy by continuing to conduct care coordination audits. These audits monitor:

- Verification that Transition of Care (TOC) plans for members transitioning from an In-Patient (IP) hospital stay or Nursing Facility (NF) to the community adequately address the members' needs, including the need for Community Benefits: Transition of Care Audit.
- Confirmation that members are being correctly referred for a Comprehensive Needs

Assessment (CNA) if triggered by a completed Health Risk Assessment (HRA): Health Risk Assessment and Care Coordination Level Audit.

- Placement of members in the correct Care Coordination Level (CCL), based on information in the CNA and criteria outlined in contract: Health Risk Assessment and Care Coordination Level Audit.

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

HSD audits 15 member files per category, per MCO, for a total of 45 HRA, 45 CCL, 45 TOC from In-Patient (IP) to community, and 45 from Nursing Facility (NF) to community. In some quarters, an MCO may not have had 15 IP or 15 NF members transitioning back to the community, in which case HSD will audit fewer member files.

The table below details the Transition of Care (TOC) Audit results from DY10 Q1 through DY10 Q4. DY11 Q1 data will be reported in DY11 Q2.

Table 6: Transition of Care Audit

Transition of Care	DY10 Q1	DY10 Q2	DY10 Q3	DY10 Q4
In-Patient	**99%**	**91%**	**88%**	**97%**
BCBS	97%	97%	85%	94%
PHP	99%	99%	85%	99%
WSCC	100%	77%	93%	x*
Nursing Facility	**96%**	**90%**	**99%**	**97%**
BCBS	98%	93%	100%	97%
PHP	100%	100%	100%	100%
WSCC	90%	77%	96%	95%

Source: HSD DY10 Q1 to DY10 Q4 Quarterly TOC Audits
Percentages in bold are MCO averages.
*WSCC had no IP to Community Transitions in DY10 Q4.

The aggregate compliance rate for IP to Community TOC files increased from 88% in DY10 Q3 to 97% in DY10 Q4. The aggregate compliance for NF to Community TOC audited files decreased from 99% in DY10 Q3 to 97% in DY10 Q4.

HSD provided detailed findings, reiterated contract requirements, and stressed the

importance of comprehensive documentation. Additionally, HSD met with each MCO at monthly meetings and discussed the findings.

Areas noted for discussions with MCOs:

- BCBS's compliance percentage for IP to community increased from 85% in DY10 Q3 to 94% in DY10 Q4, due primarily to significant improvement in documentation and care coordinators ensuring 3-day post discharge assessments were being conducted in the member's home.
- PHP's compliance percentage for IP to community increased from 85% in DY10 Q3 to 99% in DY10 Q4, primarily due to an increase in coordination with hospital discharge planners and excellent file documentation.
- WSCC had no members transitioning from IP to the Community in need of Community Benefits in DY10 Q4.
- BCBS's compliance percentage for NF to community decreased from 100% in DY10 Q3 to 97% in DY10 Q4. WSCC also reported a decrease for their NF to community member compliance from 96% in DY10 Q3 to 95% in DY10 Q4.

  HSD noted that points deducted for BCBS audits were primarily due to BCBS's system not aligning with HSD's leveling verbiage as well as inadequate documentation of discharge planning meetings. HSD deducted points for WSCC TOC audits related to documentation that was not clear. BCBS and WSCC assured HSD that increased/targeted training to staff on the importance of consistent documentation would continue.
- PHP's compliance percentage for NF to community was at 100% for DY10 Q3 and DY10 Q4.

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

The table below details the Health Risk Assessment and Care Coordination Level Audit results from DY10 Q1 through DY10 Q4. DY11 Q1 data will be reported in DY11 Q2.

Table 7: Health Risk Assessment and Care Coordination Level Audit

HRA/CCL Audit	DY10 Q1	DY10 Q2	DY10 Q3	DY10 Q4
Health Risk Assessment (HRA)	**95%**	**98%**	**98%**	**98%**
BCBS	99%	99%	99%	99%
PHP	100%	99%	96%	96%
WSCC	86%	96%	99%	99%
Care Coordination Level (CCL)	**97%**	**95%**	**98%**	**99.70%**
BCBS	99.70%	90%	99%	99%
PHP	99.70%	100%	99%	100%
WSCC	92%	96%	97%	100%

Source: HSD DY10 Q1 to DY10 Q4 HRA and CCL Audits
Percentages in bold are MCO averages

Results of the HRA Audit showed that the MCOs consistently met all contract requirements when completing HRAs. HSD noted that aggregate rates of compliance remained at 98% in DY10 Q3 and DY10 Q4. BCBS was at 99% compliance from throughout DY10. PHP was at 96% in DY10 Q3 and DY10 Q4. WSCC was at 99% in DY10 Q3 and DY10 Q4.

Aggregate rates of compliance for the CCL Audit increased from 98% in DY10 Q3 to 99.7% in DY10 Q4. BCBS was at 99% in DY10 Q3 and DY10 Q4. PHP increased from 99% in DY10 Q3 to 100% in DY10 Q4. WSCC increased from 97% in DY10 Q3 to 100% in DY10 Q4. All MCOs provided excellent file documentation, covered all required elements for their transitioning members, and ensured that members were receiving their needed services once back in the community.

Care Coordination CNA Ride-Alongs

HSD conducted 3 CNA ride-alongs with MCO care coordinators in DY10 Q4, to observe completion of member assessments.

HSD attended annual CNAs conducted by BCBS and WSCC. HSD scheduled 3 ride-alongs with PHP which were cancelled due to member issues.

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

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

- Care coordinators adhered to all contractual responsibilities in their assessments.
- Care coordinators were kind, thorough, and professional with the members.
- HSD noted care coordinators employing motivational interviewing with members.
- Care coordinators often went beyond contract requirements to assist members with locating and applying for additional resources and services.
- Care coordinators were cognizant of the language preferred by their member.
- HSD recommended that MCOs conduct additional training on Medicare for increased knowledge with dual eligible members.
- HSD recommended that MCOs remind care coordinators of the importance of assisting with scheduling appointments in addition to providing referrals.

Care Coordination HRA Ride-Alongs

HSD conducted 15 virtual HRA ride-alongs with MCO care coordinators in DY10 Q4, to observe completion of member assessments. All HRAs observed were conducted telephonically.

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

- The majority of Assessors were friendly, thorough, non-judgmental, and professional with the members.
- Assessors often explained to members that they could request care coordination in the future if they would like assistance.
- Assessors 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.
- HSD noted opportunities for improvement that included:
    - Ensuring that Assessors explain the purpose of the HRA;
    - Ensuring that Assessors thoroughly explain the services available through care coordination;
    - Ensuring all Assessors employ an unhurried demeanor with heightened listening skills; and
    - Ensuring all contract required topics are addressed in the HRA.
- HSD requested MCOs conduct more frequent oversight of Assessor training and increase internal review of HRAs conducted to ensure any issues are resolved quickly.

Care Coordination MCO Meetings

HSD conducts regular quarterly meetings with all MCOs to review data on member engagement, care coordination timeliness, performance analysis, and member outcomes.

HSD held the DY10 Q4 Quarterly Meeting on December 21, 2023, and reviewed:

- Aggregate data from the following reports related to enrollment and compliance with assessment and touchpoint timeliness:
    - care coordination Report
    - Children in State Custody (CISC) Report
    - Comprehensive Addiction and Recovery Act (CARA) Report
- Aggregate data from the care coordination and Children in State Custody Performance Measures (CC and CISC PMs)
- Results of the DY10 Q3 audits of member categorization, Health Risk Assessments (HRAs), Care Coordination Levels (CCLs) and compliance with Transition of Care (TOC) requirements
- Results of the DY10 Q3 audits of CISC Health Risk Assessments (HRAs) and Care Coordination Levels (CCLs)

HSD updated the MCOs on revisions to quarterly reports in CY24, including transitioning a Children in State Custody (CISC) report focused on traditional healing benefits for Native American youth. HSD discussed additional requirements that will be in place for Q1 CY24 reporting of members accessing Maternal Home Visiting services. HSD and MCOs discussed the benefits of continuing Performance Measures specific to tracking utilization of services for members engaged in care coordination in comparison to members eligible for care coordination that have refused to engage. HSD and MCOs also discussed barriers experienced connecting timely with CYFD Permanency Planning Workers and what interventions HSD could assist with to increase collaboration.

All MCOs expressed that connecting with members who have been unable to reach or difficult to engage is a challenge; however, they continue to utilize community health workers (CHWs) and peer-support specialists (PSS) staff to connect with increased success.

The MCOs also noted the difficulty in finding providers in rural and frontier areas of New Mexico. With in-home equipment for virtual visits, the use of paramedical professionals, and incentives for providers, the MCOs are continuously working to provide access to all members regardless of location.

HSD also meets individually with each MCO quarterly to address care coordination issues related specifically to their MCO. In DY10 Q4, meeting topics included:

- Reviewing Care Coordination Performance Measures and the impact of Care Coordination in encouraging members to access preventative services;
- CISC Performance Measures and ways to engage CISC members who are in their late teens and early twenties or have transitioned out of foster care and are more difficult to connect with;
- Discussion of HRA and CNA ride-along findings; and
- Discussion of increased requirements for care coordinators related to Comprehensive Addiction Recovery Act (CARA) members.

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 DY10 Q4, a total of 33,992 Medicaid members received behavioral health services through telehealth. This quarter's total did see a decrease of 13.4% compared to the DY9 Q4 total of 39,271 persons served through this medium. Of those served in DY10 Q4 through telehealth,14,162 persons reside in rural or frontier counties. This accounts for 41.6% of those served and is reflective of client and provider preferences and the high value of telehealth in New Mexico's rural and frontier landscapes.

Service delivery over telephonic means continues to see a decrease. In DY10 Q4, 27,878 members received services through this modality compared to 38,913 in DY9 Q4 which is a decrease of 11,035 people or 28.4%. BHSD continues to evaluate which behavioral health services are appropriate to continue delivery through telephone now that the public health emergency is over. This option was undoubtably a critical link to services during the COVID-19 crisis and remains vital to increasing access in rural and frontier areas of the state.

Overall, due to the end of the public health emergency, which was tied to COVID-19 mitigation efforts, the number of Medicaid beneficiaries utilizing telehealth and telephonic services has overall decreased. However, these services remain steady or have increased in rural and frontier areas, mitigating barriers to access of services. As telehealth and telephonic services remain available, the trend indicates person-to-person treatment is widely preferred, but for increased capacity and access, telehealth continues to be a great tool and is still widely utilized.

TREAT FIRST

As depression, anxiety and other behavioral health needs surge from the stresses related to COVID-19, Treat First engages clients quickly in services that address their immediate needs. The 39 certified Treat First agencies have seen over 1,049 new clients during the first three months of 2024. With support from the Treat First agencies, 27.2% of these individuals were able to resolve their issues with solution focused interventions within 4 visits. The balance of those clients continued in services. The “No Show” for clients in this period was very low, only 8.7%.

When youth or adults were asked how they felt their Treat First visits were going, on average, both groups felt that the sessions were working very well to address their immediate needs. Youth rated sessions at 92.6% 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 DY10 Q4, SBIRT utilization increased 26.25% to 6,728 persons served during the quarter compared to 5,329 in DY10 Q3. The increased utilization of SBIRT is also noted in DY10 Q4 when compared to the same quarter of the prior year, where 1,501 persons were served. The increase in persons receiving SBIRT can be linked to additional funding and efforts to offer more SBIRT training to hospital, emergency department and primary care staff.

On a monthly average, 742 persons received SBIRT in DY10 Q4 with the greatest utilization occurring in August with 949 persons screened. The current utilization trend in SBIRT for DY10 is greater than any of the DY9 quarterly results thus far.

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

The Centennial Care 2.0 program includes new and expanded services for Medicaid recipients with Substance Use Disorder (SUD). The state finalized the contract to deliver SBIRT training to primary care and hospitals statewide and will continue the training throughout State Fiscal Year 2025. Expansion of 988 Crisis Now initiatives continues with support for crisis triage centers, mobile crisis teams and alternative crisis triage center sites; space set up to be utilized when needed such as a hotel room, firehouse, or outpatient clinic.

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

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

In DY10 Q4, the total number of persons served with a SUD in an IMD was 3,249, which is a decrease of 631 persons (or 16.26%) compared to DY10 Q3. When comparing DY10 Q4 results to DY10 Q3, the utilization declined from 1,610 persons served on a monthly average to 1,447. The downward trend in utilization of persons served in an IMD with a substance use disorder started in November 2023 and continued into December. As the latest trend does reverse the upward trend over prior quarters, likely impacts to this measure may be the Public Health Emergency unwinding which is ongoing through 2023 and will result in less fully eligible Medicaid beneficiaries. As the latest trend for DY10 shows a decline compared to the prior three quarters of the report period, the results will continue to be reviewed and analyzed into next demonstration year.

SUD HEALTH IT

In DY11, HSD developed and maintain the necessary SUD Health IT capabilities and infrastructure to support member health outcomes and address the SUD goals of the demonstration. New Mexico SUD workgroup continues to review our Health IT plan to ensure the progress and support of each milestone.

Utilization of the New Mexico Prescription Monitoring Program (NM PMP) continues to 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%. HSD continues to monitor with data as updated from the New Mexico Board of Pharmacy.

The New Mexico Fee for Service (FFS) Drug Utilization Review (DUR) Board conducted the Fee for Service Drug Utilization Review meeting on February 7, 2024. Attendees included board members (a quorum was met for voting purposes) and invited guests, including managed care organization representatives. Client counts for both FFS and Managed Care

were reported with small decreases in total members enrolled. This was reported as an expected decrease correlating with the public health emergency unwinding. Prospective DUR edits targeted for fraud waste and abuse prevention and the SUPPORT Act were presented and quantitative reporting will begin for the second quarter 2024 at the DUR meeting. The edits presented are existing edits, and no new edits or changes are needed for the quarterly reporting. The State's Fiscal Agent presented an overview of the new data collection program "Hercules" which is anticipated to begin in winter 2024. The system will have more integrated analytics with respect to DUR reports and data, eliminating a portion of the manual reviews performed on data now. The fourth quarter 2023 intervention for patients diagnosed with hepatitis C and no record of medication treatment was mailed on December 4, 2023. A summary report for Antipsychotic Metabolic Monitoring Intervention was reported with a 7.1% response rate. This intervention was to ensure members are receiving appropriate metabolic monitoring needed to avoid poor metabolic outcomes which can be associated with first and second generation antipsychotic treatment. The most common response was "patient is no longer under provider's care". Standing reports for SUPPORT Act were reported with no new trends or concerns. The Board approved the first quarter 2024 mailing of use of a glucagon-like peptide (GLP-1) inhibitor approved for therapy for treatment of type 2 diabetes without the clinical diagnosis of diabetes. The mailing also included education of GLP-1 inhibitors and FDA approved indications and education around the use of these products. A presentation of a proposed intervention for compliance with the SUPPORT Act targeted an intervention of Opioids concurrently prescribed with central nervous system depressants and a diagnosis of respiratory impairment. A second arm of this intervention would be to identify patients without a naloxone claim in the last 2 years. This intervention will be presented at the second quarter 2024 DUR meeting with populated data for a vote to approve the intervention for mailing. Work continues for removal of the prior authorization for treating naive or pan sensitive hepatitis C treatment medications.

In 2023, Project ECHO trained over 3,100 New Mexico healthcare providers. Thirty-six 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. HSD 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 2024.

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 has engaged with 11 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, and Lovelace Women's Health Center. These six 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 is currently being gathered). Four hospitals participated in aspects of engagement and/or training, including Sierra Vista Hospital, Plains Region Medical Center, Northern Navajo Medical Center, and Gerald Champion Medical Center. NM Bridge started engagement and planning trainings with Christus St. Vincent Regional Medical Center, Sierra Vista Hospital, and San Juan Regional Medical Center. including both their emergency department and labor and delivery department. NM Bridge is in discussion with other hospitals to plan engagement in the future, including San Juan Regional Medical Center, UNM Sandoval Regional Medical Center, and Lincoln County Medical Center. All hospitals serve patients in/from both rural and urban settings. Most of the work during this time period has been helping UNM Hospital and Lovelace complete their programs, as well as starting new programs with Sierra Vista and Christus St. Vincent. NM Bridge continues to work with Socorro General Hospital to provide additional trainings. NM Bridge also continues to work with Taos Holy Cross to support their Women's Health Institute. NM Bridge is planning on-site trainings with Lovelace Women's Hospital in 2024, and 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. As part of this outreach, the NM Bridge team presented on the NM Bridge program to the New Mexico Hospital Association on November 11, 2023. The NM Bridge team also is working on adding a new team member who is a Certified Peer Support Specialist and a Peer Supervisor at Presbyterian Health Systems to support NM Bridge hospitals with the hiring and supervision of a peer. More information on the program can be found at www.nmbridge.com.

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

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

HSD and vendors for the new MMISR continue to design and implement enhanced data analytics in 2024. Smart phone apps are part of the MMISR unified public interface (UPI). HSD 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. HSD 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 DY11 Q1, 3 AARTC applications are in the review process. An AARTC provider has decided to stop providing services at all 3 of their locations as of March 26, 2024. A total of 24 AARTCs provider applications have been approved since the onset of the application process in December of 2019 (multiple providers have multiple locations).

Table 8: AARTC Client Counts

MEDICAID CLIENT COUNTS				
PROVIDER #	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**	**DY11 Q1**
716	0	0	0	0
090	58	67	44	60
037	343	331	90	275
081	5	14	22	26
589	5	8	4	10
332	0	26	18	29
049	21	54	12	21
825	24	30	8	11
896	0	0	2	6
302	88	105	33	50
60	33	27	5	16
258	0	0	0	9
760	14	17	41	65
Unduplicated Total	**591**	**679**	**279**	**578**

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

There are 17 AARTCs in operation, approved to bill Medicaid. The data above identifies the

total number of clients who received AARTC services during DY11 Q1. Client counts are impacted by a claim lag of up to 120 days following the end of the recent quarter. The provider number is a unique identifier and is used to correlate the number of members seen by each provider for each quarter. Providers who were not approved to bill Medicaid for previous quarters have NA in the data field to represent this. Although 12 provider sites are represented in the chart above, provider 037 has 4 sites represented in their data. 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 increased from 279 individuals in DY10 Q4, to 578 individuals in DY11 Q1. The increase may be attributable to the 90-day claim lag for services provided during the period. It is expected that numbers will fluctuate as actual counts are adjusted to account for claims lag. Further analysis is warranted to ensure counts are accurately reported and represented for those providers. The table reflects refreshed numbers in all quarters. Rates are assessed by acquiring 1 full year of utilization by each provider with a review of expenditure data collected to determine the actual costs of operation. The next phase of rebasing began in DY11 Q1. The rate development process continues to be refined as the progression of the data collection expands.

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	
DY11 Q1 Activities	In Q1, Presbyterian Medical Services Rio Rancho Family Health Center announced they will stop rendering services on 8/22/2024. The PRISM system usage from which the health homes (HH) can retrieve diagnostic information, has increased since recent trainings held on 2/08/2024, 2/13/2024, and 2/22/2024. The CareLink Health Homes (CLNM) Policy Manual has been updated by the HHs program manager and is in the review process by leadership. BHSD collaborated with the HH directors and Falling Colors to update the Comprehensive Needs Assessment (CNA) in NM Star to document current/accurate edits. The CNA is now being reviewed by Falling Colors for a timeline on making the changes. The HH program manager also identified the vendor, Spectrum, for mandatory reporting on the HH metrics for FY 25. BHSD is coordinating training for HH directors that will specify any assistance necessary, which was found in the site visits from Q4. The first training that is being planned is on the SMART method for care planning. Training will also include NM Star.

Table 9: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY10 Q2 APR - JUNE	DY10 Q3 JUL - SEPT	DY10 Q4 OCT - DEC	DY11 Q1 JAN - MAR
4,102	3,868	3,692	3,488
% CHANGE	% CHANGE	% CHANGE	% CHANGE
2.59%	5.70%	4.55%	5.15%

Source: NMStar, CLNM Opt-in Report.

HIGH FIDELITY WRAPAROUND

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

The goal of the program is to provide intervention to individuals with the most complex

behavioral health needs to reduce the occurrence of placement in higher levels of care, detention, hospitalization, or institutionalization. HFW was approved as part of the Centennial Care 2.0 demonstration effective March 28, 2023. Since that time the NM HFW Steering Committee, including representatives from the Human Services Department (HSD) Behavioral Health Services Division (BHSD) and Medical Assistance Division (MAD) as well as the Children Youth and Families Department (CYFD) has met weekly to review HFW provider certification applications as these providers transition from other funding sources to Medicaid enrolled providers. As part of this process, the HFW Steering Committee 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 has 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, HSD and CYFD are in process of developing claims data, provider level, and MCO reports to monitor program requirements including eligibility criteria outlined in STC 69 as well as provider employee requirements. Additionally, HFW treatment plans will receive clinical review through CYFD.

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

HSD and CYFD are collaborating on the development of HFW performance measures as well as data report development. HSD anticipates draft measures to be available in June 2024.

SUPPORTIVE HOUSING

The supportive housing benefit in Centennial Care 2.0 provides Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program pre-tenancy and tenancy services. The Linkages program serves individuals diagnosed with serious mental illness with functional impairment who are homeless or precariously housed and are extremely low-income, per the Department of Housing and Urban Development (HUD)

guidelines. Extremely low income is defined as a household income that falls at or below 30% Area Median Income (AMI); AMI varies by county. HUD posts AMI Income Limits for each county of every state annually.

Linkages agencies have been able to bill Medicaid for comprehensive community support services (CCSS), but since the H0044 supportive housing services inclusion in the Centennial Care 2.0 waiver, BHSD continues to strongly encourage Linkages providers to shift to billing the supportive housing benefit directly. The H0044 benefit reimburses at a higher rate than CCSS. The Centennial Care 2.0 waiver requires that the services be provided by a certified peer support worker (CPSW) to align with the state's goals for building the peer support workforce. One Linkages provider has 4 CPSWs assigned to deliver Linkages supportive housing services. The 4 CPSWs of this provider carry a Linkages program specific caseload. This provider previously had 9 CPSWs assigned to clients participating in Linkages and various other programs; however, utilizing less CPSWs with a specialized case load has optimized Linkages service provision and outcomes. CPSWs assigned to deliver Linkages supportive housing services currently include a CPSW Supervisor, a CPSW Lead, and 2 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 full time positions, 2 CPSW field staff and 1 CPSW supervisor/manager. Since last quarter, this provider filled 2 vacant field staff CPSW positions. A CPSW will be the primary provider for Linkages, and a second CPSW as Linkages back up and to assist 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 had 5 CPSWs assigned to render Linkages supportive housing services with 1 CPSW fully dedicated to Linkages and billing H0044 last quarter. This quarter, this provider has 4 CPSWs rendering Linkages supportive housing services with 2 CPSWs who are billing H0044. The 5th CPSW from last quarter is no longer employed with the provider. The third provider has been utilizing the H0044 code for reimbursement since December 2021 and is contracted with all 3 MCOs for reimbursement. A fourth Linkages provider hired 1 CPSW in December 2021 and has been utilizing the H0044 code for reimbursement since July 2022. The delay with billing by the fourth provider was due to an MCO system issue with the modifier codes and required provider type; issues have since been resolved. A fifth Linkages provider has 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 6 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. The interest of all providers not yet utilizing H0044 remains high and increases with the progress made by the providers who have established H0044 reimbursement. The BHSD Supportive Housing Coordinator and Supportive Housing Coordinator-Supervisor continue to support providers and work with the BHSD MCO Contract Managers and MCOs to ensure successful processing establishment and billing of H0044. MCOs submit quarterly Ad Hoc reports with H0044 encounters data.

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

HSD continues to promote the use of CPSWs to render Linkages support services; however, Linkages providers and providers of other behavioral health services have experienced continued challenges with vacancies, transition, 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 10: Medicaid Supportive Housing Utilization

MEDICAID SUPPORTIVE HOUSING UTILIZATION (January 1, 2024 – December 31, 2024)			
DY11 Q1	DY11 Q2	DY11 Q3	DY11 Q4
118			
Unduplicated Total - 118			

Source: MCO Ad Hoc Quarterly Reports

As a result of legislative sessions, an increase of State General Funds (SGF) for State Fiscal Years (SFY) 2021, SFY2023, and SFY2024 have been and/or shall be applied to Linkages programming. The funding increases allow HSD to expand Linkages services that are not covered by Medicaid. HSD also utilizes these funds to support rental assistance vouchers for eligible Linkages clients. Since SFY2020, there has been an increase of 236 vouchers with increased SGF. In SGF 2024, the voucher capacity is 396; the voucher capacity was 338 in SFY2023. An individual does not need to be a Medicaid member to obtain a voucher or services; however, many Linkages clients are Medicaid members. Through this quarter in SFY2024, an average of 356 vouchers were issued or filled; the previous quarter had an average of 345. A filled voucher means housing has been secured. Therefore, 356 individuals and their households benefited from a voucher and housing stability.

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

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

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

efforts to enhance provider capacity and improve access to a continuum of SMI/SED evidence-based services at varied levels of intensity.
The goals of the SMI/SED demonstration amendment are to:

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

New Mexico's SMI/SED Implementation plan was submitted on June 25, 2023. 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 is pending 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. New Mexico will prepare its SMI/SED Monitoring Protocol following issuance of new templates and guidance from CMS.

CENTENNIAL HOME VISITING (CHV) PROGRAM

In DY11 Q1, the Centennial Home Visiting (CHV) program served 418 families. Following is DY11 Q1 data for each model:

Nurse Family Partnership (NFP) Model:

- University of New Mexico Center for Development and Disability (UNM CDD) NFP served a total of 82 unique families in DY11 Q1 in Bernalillo County and Valencia Counties.
- Youth Development Inc. (YDI) served 0 families in DY11 Q1 in Bernalillo, Rio Arriba, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 0 unique families in DY11 Q1 in Bernalillo County.
- ENMRSH served 35 unique families in DY11 Q1 in Curry and Roosevelt Counties.
- Taos Pueblo served 17 unique families in DY11 Q1 in Taos County.
- MECA Therapies served 132 unique families in DY11 Q1 in Chaves, Curry, Doña Ana, Roosevelt, and Lea Counties.
- Aprendamos served 84 unique families in DY11 Q1 in Doña Ana, Sierra, and Otero Counties.
- Community Action Agency of Southern New Mexico served 23 unique families in DY11 Q1 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 25 unique families in DY11 Q1 in San Juan County.
- Tresco served 9 unique families in DY11 Q1 in Bernalillo and Santa Fe Counties.
- Guidance Center of Lea County served 11 unique families in DY11 Q1 in Lea County.

The Centennial Home Visiting Program (CHV) 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.

Several strategies are currently being employed to streamline the process of enrollment, credentialing, billing, and referral management. HSD is meeting regularly with the Early Childhood Education and Care Department (ECECD) to create a provider manual and process map that will live on the HSD website. The MCOs are also contributing their procedures to the process map. There are also changes to new MCO contracts that will start next year to streamline the referral process for members and there will be a rate increase for nurse-family partnership agencies starting in July 2024.

PRESUMPTIVE ELIGIBILITY PROGRAM

The New Mexico HSD Presumptive Eligibility (PE) program continues to be an important part of the State's efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community

organizations, County Jails and Detention Centers, and some New Mexico State Agencies including the New Mexico Department of Health (DOH), New Mexico Children Youth and Families Department (CYFD), and the New Mexico Corrections Department (NMCD). Currently, there are approximately 904 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assist with on-going Medicaid application submissions.

HSD staff conduct monthly PE certification trainings for employees of qualified entities that choose to participate in the PE program. PE certification requirements include active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct "Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE)" demo trainings. During demo trainings, the PEDs have the opportunity to take a refresher training on "How To" utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit ongoing Medicaid applications. PE program staff conducted 3 PE certification trainings and 3 YESNM-PE demo refresher trainings in DY11 Q1.

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

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

Access to the Baby Bot is available through a link located on the PED's home page in YESNM-PE. The Baby Bot platform operates as a webservice and sends the information electronically to ASPEN, HSD's eligibility system. Once the mother's eligibility has been electronically verified in ASPEN, the system automatically adds the newborn to the case. This allows immediate access to benefits for the newborn. Currently 288 active PEDs are certified to use the Baby Bot functionality with more trainings scheduled to increase participation.

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

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

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

AVA Baby Bot (January - March 2024)					
Month	**Newborns Submitted through AVA**	**Newborns Successfully Enrolled**	**Newborns Unsuccessfully Enrolled - Tasks Created**	**% of Newborns Successfully Enrolled**	**% of Newborns Unsuccessfully Enrolled**
January	866	545	321	63%	37%
February	766	463	303	60%	40%
March	821	543	278	66%	34%
Total	**2,453**	**1,551**	**902**	**63%**	**37%**

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY11 Q1, 71 PEDs used the Baby Bot functionality. Program staff noticed a decrease in the amount of PED participation during this reporting period and in the number of newborns added through the Baby Bot functionality. In this reporting period, staff observed a slight decrease in the percentage of Newborns “Successfully Enrolled”. HSD 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 12: PE Approvals

PE APPROVALS (January - March 2024)				
Month	**PEs Granted**	**% PE Granted with Ongoing Applications Submitted**	**Total Individuals Applied**	**Individuals Approved**
January	409	99.00%	839	472
February	344	98.00%	738	462
March	350	99.00%	834	509
Total	**1103**	**98.67%**	**2,411**	**1,443**

Source: Monthly PE001 Report from ASPEN and OmniCaid

Table 12 above outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. NM PEDs are aware of the importance of ongoing Medicaid coverage for their clients. In this reporting period we saw an slight decrease in the number of PEs granted and PEs that also had an ongoing application submitted. In DY11 Q1, 98% of all PE approvals had an ongoing application submitted.

JUST HEALTH PROGRAM

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

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

It is HSD's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, behavioral health appointments, outpatient/inpatient residential treatment for SUD) upon release. To help facilitate access to care and ensure a smooth transition from correctional facilities back out into the communities, HSD has established the Centennial Care JUST Health workgroup. The monthly workgroup includes representatives from State and County Correctional facilities,

Managed Care Organizations, County governments, State agencies, provider organizations, and other stakeholders. The goal of the workgroup is to create a transition of care with detailed processes and procedures that can be utilized and adapted to work for all correctional facilities statewide.

The following table outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. HSD observed 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 DY11 Q1. Now that the PHE has ended and COVID-19 protocols in jails and prisons are lifted, we do expect to see the numbers of applications submitted increase over the next 2 years. The department continues to work on the relationships between the jails and prisons, and with the justice involved population. In DY11 Q1, 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 13: PE Approvals

PE APPROVALS – JUST HEATH (January - March 2024)				
Quarter	**PEs Granted**	**% PE Granted w/ Ongoing Applications Submitted**	**Total Individuals Applied**	**Individuals Approved**
January	6	100%	48	41
February	16	100%	72	55
March	16	100%	88	79
Total	**38**	**100%**	**208**	**175**

Source: Monthly PE001 Report from ASPEN and OmniCaid

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HCBS REPORTING

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

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

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

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

Consumer Support Program

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

Year to Date (YTD) and quarterly reporting are provided by the Aging and Long-Term

Services Department (ALTSD), Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the broader public to access a variety of services. The type and number of issues identified and resolved through the Consumer Support Program for DY11 Q1 are listed in the tables below.

Table 14: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT (January - March 2024)	
TOPIC	**NUMBER OF CALLS**
Home/Community Based Care Waiver Programs	3,139
Long Term Care/Case Management	2
Medicaid Appeals/Complaints	10
Personal Care	14
State Medicaid Managed Care Enrollment Programs	3
Medicaid Information/Counseling	659

Source: SAMS Call Profiler Report; GSA I 7-630-8000-0001 CDA 93-778 State Fiscal Year 2024, Quarter 3 report

Table 15: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT (January - March 2024)			
COUNSELING SERVICES	**NUMBER OF HOURS**	**NUMBER OF NURSING HOME RESIDENTS**	**NUMBER OF CONTACTS**
Transition Advocacy Support Services		149	
*Medicaid Education/Outreach	2,095		
Nursing Home Intakes		87	
**LTSS Short-Team Assistance			124

*Care Transition Specialist team educates residents, surrogate decision makers, and facility staff about Medicaid options available to the resident and assist with enrollment.
**Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed decisions about appropriate long-term services and supports choices in the context of their personal needs, preferences, values, and individual circumstances.
Source: Care Transition Bureau (CTB) GSA I 7-630-8000-0001 CFDA 93-778 State Fiscal Year 2024, Quarter 3 report

Critical Incidents

Critical Incidents	
DY11 Q1	HSD conducts a quarterly meeting with all MCOs to provide guidance and discuss findings related to the MCOs' critical incident reporting. The quarterly meeting was held on November 15, 2023. The primary discussion was regarding an increase in Critical Incident Reports (CIRs) filed for neglect. Two of the 3 MCOs reported that the increase was attributed to agencies filing reports retroactively. MCOs reported the top neglect CIRs filed continue to be refusing services, insufficient staffing, and issues with hiring/firing caregivers. MCOs reported conducting outreach to the top agencies identified as having challenges with staffing member services and that monthly and weekly meetings between the MCOs and provider agencies would continue. HSD conducts individual monthly meetings with each MCO. The goal of these meetings is to provide guidance and address any questions or concerns related to performance measures, monthly and quarterly reports, CIRs, and contract and policy requirements. A list of CIRs to be discussed on the call is sent to each MCO prior to the monthly call. During the Q4 MCO monthly meetings, the MCOs reported there were no concerns regarding the newly implemented CIR review process and that receiving the agenda, CIR Review, and audit findings in advance was helpful for research purposes. Each issue found in the weekly report review was discussed and addressed by the MCOs. There were no issues to address related to performance measures, monthly and quarterly reports, or contract and policy requirements. HSD conducted daily reviews of critical incidents submitted by the MCOs and providers for the purpose of ensuring compliance with reporting requirements, identifying areas of concern, and monitoring members' health and safety. HSD provided daily assistance to MCOs and providers to obtain access to the CIR portal by establishing and/or resetting login credentials and deleting duplicate reports. During DY10 Q4, 42,364 CIRs were filed in the Centennial Care category, which includes Physical Health (41,027), Behavioral Health (709), and Self-Directed members (628). In DY10 Q4, the total number of Centennial Care CIRs filed decreased 3% from DY10 Q3, behavioral health reports decreased 10% from DY10 Q3, and SDCB reports decreased 7% from DY10 Q3. The tables below represent a summary of the critical incident reporting for DY10. DY11 Q1 data will be reported in the DY11 Q2 report.

Table 16: Critical Incidents Reported

CRITICAL INCIDENTS REPORTED (DY10 Q1 - DY10 Q4)															
MCO	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
BCBS	10,031	11,040	12,929	12,598	161	134	141	117	204	267	221	211	46,598	553	903
PHP	21,208	35,687	26,305	25,278	667	623	535	554	513	508	418	394	108,478	2,379	1,833
WSCC	1,859	2,282	3,443	3,151	56	52	56	38	132	25	37	23	10,735	202	217
Total	33,098	49,009	42,677	41,027	884	809	732	709	849	800	676	628	165,811	3,134	2,953

Source MCO quarterly report #36

BCBS (DY10 Q1 - DY10 Q4)															
Critical Incident Types	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	110	108	83	83	25	17	13	17	13	8	6	5	384	72	32
Death	213	202	204	194	2	11	8	7	7	8	8	10	813	28	33
Elopement / Missing	7	5	3	9	0	1	0	1	0	1	0	1	24	2	2
Emergency Services	1,739	2,210	1,988	1,838	88	81	84	70	111	162	137	127	7,775	323	537
Environmental Hazard	35	37	25	32	2	2	2	1	2	4	2	1	129	7	9
Exploitation	30	83	22	24	1	1	0	0	0	0	1	2	159	2	3
Law Enforcement	29	36	29	19	7	6	8	2	1	5	8	1	113	23	15
Neglect	7,868	8,359	10,575	10,399	36	15	26	19	70	79	59	64	37,201	96	272
All Incident Types	10,031	11,040	12,929	12,598	161	134	141	117	204	267	221	211	46,598	553	903

Source MCO quarterly report #36

PHP (DY10 Q1 - DY10 Q4)															
CRITICAL INCIDENT TYPES	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	167	168	188	185	61	55	62	54	12	10	8	4	708	232	34
Death	428	398	316	336	8	16	11	8	16	13	13	11	1,478	43	53
Elopement/ Missing	18	20	15	13	1	2	0	1	0	1	1	0	66	4	2
Emergency Services	6,519	6,787	6,063	5,755	459	435	333	332	360	377	324	306	25,124	1,559	1,367
Environmental Hazard	68	109	100	82	5	6	5	4	6	6	6	6	359	20	24
Exploitation	51	65	46	73	0	3	2	3	10	12	3	17	235	8	42
Law Enforcement	56	63	63	44	10	10	18	11	3	11	5	3	226	49	22
Neglect	13,901	28,077	19,514	18,790	123	96	104	141	106	78	58	47	80,282	464	289
All Incident Types	21,208	35,687	26,305	25,278	667	623	535	554	513	508	418	394	108,478	2,379	1,833

Source MCO quarterly report #36

WSCC (DY10 Q1 - DY10 Q4)															
CRITICAL INCIDENT TYPES	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	21	29	29	31	3	9	9	5	3	1	3	1	110	26	8
Death	42	27	29	37	1	2	2	2	5	1	1	1	135	7	8
Elopement/ Missing	4	4	3	2	0	2	0	0	1	0	0	0	13	2	1
Emergency Services	295	285	265	239	42	32	28	25	41	21	28	19	1,084	127	109
Environmental Hazard	5	12	56	3	0	0	0	2	1	0	0	2	76	2	3
Exploitation	16	8	5	12	2	1	1	1	2	0	1	0	41	5	3
Law Enforcement	13	8	11	7	2	1	6	1	4	2	2	0	39	10	8
Neglect	1,463	1,909	3,045	2,820	6	5	10	2	75	0	2	0	9,237	23	77
All Incident Types	1,859	2,282	3,443	3,151	56	52	56	38	132	25	37	23	10,735	202	217

Source MCO quarterly report #36

Community Benefit

In DY11 Q1, Community Benefit (CB) related projects have included:

- implementing rate increases for the direct care workforce in accordance with state minimum wage updates;
- reporting for the new tracking database for HSD approved Agency-Based Community Benefit (ABCB) providers;
- implementing EVV for ABCB respite services;
- Turquoise Care readiness activities; and
- increasing CB allocations to fill approved slots.

HSD 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.

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

- Implementing rate increases for PCS and other CB services to coincide with state and local minimum wage increases, and the paid sick leave requirement for NM employees per the Healthy Workforce Act.
    - HSD continues to monitor MCO accountability to ensure minimum wage increases and paid sick leave requirements are met with weekly MCO report updates. There were several local minimum wage increases effective in early 2024.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers. A quarterly 5% payment is being issued in 2024. HSD 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 are continuing in 2024.
- Another MCO is convening an LTSS provider stakeholder group to obtain feedback and develop solutions to address workforce shortages.
- HSD, in collaboration with the NM Aging and Long-Term Services Department has applied for a direct care workforce (DCW) TA opportunity through the ACL DCW Strategies Center and we will report on any progress in DY11 Q2.

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

Electronic Visit Verification

HSD, 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 HSD continues to collaborate with the MCOs, providers, and CMS to ensure requirements are met. HSD completed certification review with CMS on March 14, 2024 and is awaiting results.

Electronic Visit Verification (EVV) - HCBS

For DY11 Q1, the average number of SDCB caregivers using EVV is 67%. HSD is continuing to offer training and technical assistance for SDCB agencies and individual employees to encourage more SDCB providers to use EVV. In DY11 Q1, HSD 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.

ABCB EVV data for DY11 Q1 is outlined in the table below. The MCOs reported that 76.5% of the total ABCB PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder of claims were created through the Fiserv Authenticare application.

Electronic Visit Verification - Physical Health

EPSDT PCS: Over calendar year 2023, MCOs reported that 99% of EPSDT PCS captured with EVV used either Fiserv Authenticare application (28%) or Interactive Voice Response (IVR) phone system (71%).

Home Healthcare Services: MCOs, providers, and CMS continue to collaborate to ensure requirements are met for January 2024 implementation. HSD will begin reporting January to March 2024 data in DY11 Q2 report as data is in process of validation.

Table 17: ABCB EVV DATA

EVV DATA (January - March 2024)		
MCO	AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD	NUMBER OF TOTAL CLAIMS THIS PERIOD
BCBS	8,366	463,363
PHP	19,356	881,094
WSCC	2,762	124,021
TOTAL	**30,484**	**1,468,478**

Source: MCO Report #35 DY11 Q1, January – March 2024

Statewide Transition Plan

HSD 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. HSD will receive an on-site review from CMS and New Editions in the second half of 2024. HSD has received limited preliminary information about the visit and will continue to meet with CMS to finalize plans as the time approaches.

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

HSD requires the MCOs to provide a quarterly summary of their internal audits of NF LOC Determinations. Each MCO conducts internal random sample audits of both community-based and facility-based determinations completed by their staff based on HSD's NF LOC criteria and guidelines. The audit includes accuracy, timeliness, consistency, and training of reviewers. The results and findings are reported quarterly to HSD along with any Quality Performance Improvement Plan. HSD is reporting DY10 Q4 audit results this quarter and audit findings for DY11 Q1 will be reported in DY11 Q2.

Total audits for DY10 Q4:

- BCBS conducted 106 total audits of NF LOC determinations, 18 facility-based and 88 community-based.
- PHP conducted 254 total audits of NF LOC determinations, 75 facility-based and 179 community-based.

- WSCC conducted 30 total audits of NF LOC determinations, 6 facility-based determinations and 24 community-based.

Audit results for NF LOC determinations for DY10 Q4:

- BCBS reported 100% agreement with reviewer determination for High and Low Facility Based NF LOC, and 100% agreement for Community Based NF LOC.
- PHP reported 100% agreement with reviewer determination for High and Low Facility Based NF LOCs, and 100% agreement for Community Based NF LOCs.
- WSCC reported 100% agreement with reviewer determination for Low Facility Based There were not any High NF LOCs audited for the quarter, and 100% agreement for Community Based NF LOCs.

Audit results for timeliness of determinations for DY10 Q4:

- BCBS reported 100% timeliness of determinations for High and Low Facility Based and 96% for Community Based NF LOCs.
- PHP reported 100% timeliness of determinations for High and Low Facility Based and 100% for Community Based NF LOCs.
- WSCC reported 100% timeliness of determinations for High and Low 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 99% for Community Based.

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

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

Facility-Based Internal Audits				
High NF Determinations	**Oct**	**Nov**	**Dec**	**DY10 Q4**
Total number of High NF LOC files audited	**18**	**14**	**9**	**41**
BCBSNM	3	3	3	**9**
PHP	14	10	5	**29**
WSCC	1	1	1	**3**
Total number of files with correct NF LOC determination	**18**	**14**	**9**	**41**
BCBSNM	3	3	3	**9**
PHP	14	10	5	**29**
WSCC	1	1	1	**3**
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Low NF Determinations	**Oct**	**Nov**	**Dec**	**DY10 Q4**
Total number of Low NF LOC files audited	**15**	**19**	**24**	**58**
BCBSNM	3	3	3	**9**
PHP	11	15	20	**46**
WSCC	1	1	1	**3**
Total number of files with correct NF LOC determination	**15**	**19**	**24**	**58**
BCBSNM	3	3	3	**9**
PHP	11	15	20	**46**
WSCC	1	1	1	**3**
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Timeliness of Determinations	**Oct**	**Nov**	**Dec**	**DY10 Q4**
Total number of High NF LOC determinations completed within required timeframes	**18**	**14**	**9**	**41**
BCBSNM	3	3	3	**9**
PHP	14	10	5	**29**
WSCC	1	1	1	**3**
% of High NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Total number of Low NF LOC determinations completed within required timeframes	**15**	**19**	**24**	**58**
BCBSNM	3	3	3	**9**
PHP	11	15	20	**46**
WSCC	1	1	1	**3**
% of Low NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**

Source: DY10 Q4 MCO Internal Audit Results

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

Community-Based Internal Audits	Oct	Nov	Dec	DY10 Q4
Total number of Community-Based NF LOC files audited	**94**	**98**	**99**	**291**
BCBSNM	28	30	30	**88**
PHP	58	60	61	**179**
WSCC	8	8	8	**24**
Total number with correct NF LOC determination	**94**	**98**	**99**	**291**
BCBSNM	28	30	30	**88**
PHP	58	60	61	**179**
WSCC	8	8	8	**24**
% with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Timeliness of Determinations	**Oct**	**Nov**	**Dec**	**DY10 Q4**
Total number of Community-Based determinations completed within required timeframes	**93**	**98**	**99**	**290**
BCBSNM	27	30	30	**87**
PHP	58	60	61	**179**
WSCC	8	8	8	**24**
% of Community-Based determinations completed within required timeframes	**99%**	**100%**	**100%**	**100%**
BCBSNM	96%	100%	100%	**99%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**

Source: DY10 Q4 MCO Internal Audit Results

MCO NF LOC Determinations

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

- The aggregated Facility Based High NF LOC determination/redetermination percentage for DY10 Q4 was 73%, an increase from DY10 Q3 of 71%.
- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY10 Q4 was 80%, a decrease from DY10 Q3 of 93%.
- The aggregated Community Based determination/redetermination percentage for DY10 Q4 was 97%, a slight decrease from the 98% reported for DY10 Q3.

HSD will continue to monitor the MCO NF LOC determinations to identify and address

any trends and provide technical assistance as needed. MCO NF LOC determinations for DY1 Q1 will be reported in the DY11 Q2 report.

Table 20: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	**Oct**	**Nov**	**Dec**	**DY10 Q4**
Total number of determinations/redeterminations completed for High NF LOC requests	**99**	**74**	**56**	**229**
BCBSNM	60	46	30	**136**
PHP	31	20	22	**73**
WSCC	8	8	4	**20**
Total number of determinations/redeterminations that met High NF LOC criteria	**68**	**58**	**42**	**168**
BCBSNM	44	37	22	**103**
PHP	16	13	16	**45**
WSCC	8	8	4	**20**
% of determinations/redeterminations that met High NF LOC criteria	**69%**	**78%**	**75%**	**73%**
BCBSNM	73%	80%	73%	**76%**
PHP	52%	65%	73%	**62%**
WSCC	100%	100%	100%	**100%**
Low NF Determinations	**Oct**	**Nov**	**Dec**	**DY10 Q4**
Total number of determinations/redeterminations completed for Low NF LOC requests	**431**	**351**	**365**	**1147**
BCBSNM	126	85	117	**328**
PHP	265	231	229	**725**
WSCC	40	35	19	**94**
Total number of determinations/redeterminations that met Low NF LOC criteria	**354**	**276**	**289**	**919**
BCBSNM	116	73	108	**297**
PHP	198	168	162	**528**
WSCC	40	35	19	**94**
% of determinations/redeterminations that met Low NF LOC criteria	**82%**	**79%**	**79%**	**80%**
BCBSNM	92%	86%	92%	**91%**
PHP	75%	73%	71%	**73%**
WSCC	100%	100%	100%	**100%**

Source: DY10 Q4 MCO NF LOC Determinations Report

Table 21: MCO NF LOC Determinations – Community-Based

Community Based Determinations	Oct	Nov	Dec	DY10 Q4
Total number of determinations/redeterminations completed	**2043**	**2035**	**1984**	**6062**
BCBSNM	531	563	574	**1668**
PHP	1314	1315	1282	**3911**
WSCC	198	157	128	**483**
Total number of determinations/redeterminations that meet NF LOC criteria	**1970**	**1983**	**1929**	**5882**
BCBSNM	515	545	558	**1618**
PHP	1260	1284	1243	**3787**
WSCC	195	154	128	**477**
% of determinations/redeterminations that meet NF LOC criteria	**96%**	**97%**	**97%**	**97%**
BCBSNM	97%	97%	97%	**97%**
PHP	96%	98%	97%	**97%**
WSCC	98%	98%	100%	**99%**

Source: DY10 Q4 MCO NF LOC Determinations Report.

External Quality Review Organization (EQRO) NF LOC

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

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

In DY10 Q4:
Aggregated results for NF LOC determinations from EQRO were 100% in agreement with High NF, 94% in agreement with Low NF. Two disagreements with WSCC during the quarter and as a result a deliverable to conduct a technical assistance call with MCO and the HSD Nurse Auditor to review findings from the disagreement. The EQRO is 100% in agreement for Community Based NF LOC determinations.

HSD will continue to monitor the EQRO audit of MCO NF LOC determinations to identify and address any trends and provide technical assistance as needed. NF LOC determinations for DY11 Q1 will be reported in the DY11 Q2 report.

Table 22: EQRO NF LOC Review

Facility-Based				
High NF Determination	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**18**	**18**	**18**	**18**
BCBSNM	6	6	6	6
PHP	6	6	6	6
WSCC	6	6	6	6
Number of Member files the EQRO agreed with the determination	**18**	**16**	**18**	**18**
BCBSNM	6	6	6	6
PHP	6	6	6	6
WSCC	6	4	6	6
% of Member files the EQRO agreed with the determination	**100%**	**89%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	67%	100%	100%
Low NF Determination	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**36**	**36**	**36**	**36**
BCBSNM	12	12	12	12
PHP	12	12	12	12
WSCC	12	12	12	12
Number of Member files the EQRO agreed with the determination	**36**	**33**	**35**	**34**
BCBSNM	12	11	12	12
PHP	12	12	12	12
WSCC	12	10	11	10
% of Member files the EQRO agreed with the determination	**100%**	**92%**	**97%**	**94%**
BCBSNM	100%	92%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	83%	92%	83%
Community-Based	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**90**	**90**	**90**	**90**
BCBSNM	30	30	30	30
PHP	30	30	30	30
WSCC	30	30	30	30
Number of Member files the EQRO agreed with the determination	**90**	**90**	**90**	**90**
BCBSNM	30	30	30	30
PHP	30	30	30	30
WSCC	30	30	30	30
% of Member files the EQRO agreed with the determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%

Source: DY10 Q4 EQRO NF LOC Report.

Waiver Assurance Performance Measures

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

- Administrative Authority: HSD developed 3 performance measures to monitor the HCBS Administrative Authority.
    - PM #1: Percentage of required HCBS reports submitted timely by the MCOs. DY11 Q1 results are reported below.
        - Report #4, *Community Benefit* – 100% compliance
        - Report #8, *Nursing Facility Level of Care* – 100% compliance
        - Report #35, *Electronic Visit Verification* – 100% compliance
    - PM #2: Percentage of required HCBS reports submitted accurately without an MCO Self-Identified Error. DY11 Q1 results are reported below.
        - Report #4, *Community Benefit* –67% compliance (one MCO had a self-identified error in their report)
        - Report #8, *Nursing Facility Level of Care* –100% compliance
        - Report #35, *Electronic Visit Verification*- 100% compliance
    - PM #3: Percentage of required HCBS reports submitted accurately without an HSD rejection. DY11 Q1 results are reported below.
        - Report #4, *Community Benefit* – 100% compliance
        - Report #8, *Nursing Facility Level of Care* –100% compliance
        - Report #35, *Electronic Visit Verification* –100% compliance

  There was a decrease in report 4 compliance in DY11 Q1 because 1 MCO had a self-identified error in their reporting. HSD will continue to work with the MCOs to clarify reporting requirements and hold technical assistance calls with the MCOs as needed.

- Nursing Facility Level of Care (NF LOC): In addition to regular EQRO audits of NF LOC, the MCOs submit quarterly NF LOC reports (report 8 above) to HSD that identify the number of initial NF LOCs conducted in the quarter. Reports are reviewed by HSD LTSS staff, and any identified trends are addressed with the MCOs. The information to support that the initial NF LOC is conducted timely is reported above under the NF LOC reporting.

- Qualified Providers: In DY11 Q1, HSD continued to receive and review applications for incoming CB providers. HSD reviews and approves all Agency-Based Community Benefit (ABCB) providers to ensure that they meet all program

requirements as outlined in Section 8 of the Managed Care Policy Manual. Providers must obtain this program approval from HSD prior to enrolling with the state as a Medicaid provider, contracting with the MCOs and providing services to ABCB members. In the Self-Directed Community Benefit (SDCB), the MCOs contract with a single Fiscal Management Agency (FMA) to oversee provider enrollment. The FMA ensures that all providers meet program requirements as outlined in Section 9 of the managed Care Policy Manual. SDCB providers must meet all program requirements and be approved by the FMA prior to rendering services to SDCB members. 100% of providers meet the program requirements prior to providing services to members. HSD has directed the MCOs to audit all ABCB providers and the SDCB FMA on an annual basis, starting in DY10. The MCOs completed their annual 2023 audit of all CB providers and the SDCB FMA. No audits resulted in provider terminations; however, several providers were placed on corrective action plans until audit concerns are resolved. The MCOs will complete another ABCB provider and SDCB FMA audit in DY11.

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

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

in the sample, the MCO staff display pertinent information in the MCO's care coordination systems to demonstrate compliance. Pertinent information includes, but is not limited to: the comprehensive needs assessment; HCBS service plan; back-up plan; disaster plan; progress notes; claims; and eligibility data. A total of 8 performance measures are reviewed for each record. MCO agreement/acceptance of the review determination (met or not met) for each performance measure is captured prior to the conclusion of the review. Following is a summary of DY10 Q4 monitoring results:

- Statewide, 94 records are reviewed each quarter, which began January 1, 2023.
- DY10 Q4 indicates 100% compliance across all performance measures for WSCC and PHP. BCBS indicates 94% compliance on PM #4 and PM #6, and 100% compliance for all other PMs.

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

The tables below include a summary of the quarterly HCBS Service Plan data for DY10 Q4. The DY11 Q1 data will be reported on the DY11 Q2 CMS Quarterly Monitoring Report

Table 23: HCBS Service Plan Review Summary

Eligible Population and Sample Size, DY10 Q4			
MCO	**Eligible Population for DY10 Q4**	**MCO % of Entire HCBS Population in DY10 Q4**	**Number of HCBS Files Reviewed for DY10 Q4**
BCBS	4,931	26%	34
PHP	12,718	66%	54
WSCC	1,604	8%	6
Centennial Care	**19,253**	**100%**	**94**

Service Plan Review Results DY10 Q4						
Performance Measure	MCO	Total Files Reviewe	# of Files Met	# of Files Not Met	# of Files Not Applicable	% of Files Met
Member's choice to receive HCBS services versus institutional care is documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's choice of HCBS services and providers are documented in a written comprehensive care plan	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's HCBS service plan adequately addressed his/her assessed needs	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Services authorized by the MCO were delivered in accordance with the HCBS service plan, including the type, scope, amount, duration, and frequency are specified in the HCBS service plan	BCBS	34	32	2	0	94%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**92**	**2**	**0**	**98%**
The HCBS service plan was revised, as needed, to address changing needs	BCBS	34	5	0	29	100%
	PHP	54	4	0	50	100%
	WSCC	6	0	0	6	100%
	Statewide	**94**	**9**	**0**	**85**	**100%**
A disaster preparedness plan specific to the member was in the HCBS service plan and documented	BCBS	34	32	2	0	94%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**92**	**2**	**0**	**98%**
Member's eligibility start and end dates are documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Linkages to protective services are documented	BCBS	34	0	0	34	100%
	PHP	54	0	0	54	100%
	WSCC	6	0	0	6	100%
	Statewide	**94**	**0**	**0**	**94**	**100%**

Source: DY10 Q4 External Quality Review Organization (EQRO) Quarterly HCBS Service Plan Report

Health and welfare of enrollees: HSD has implemented a monitoring process for assuring the health and welfare of members enrolled in HCBS through quarterly MCO reporting on established performance measures. The critical incident performance measures listed below identify, address, and seek to prevent instances of abuse, neglect, exploitation, and unexpected death. HSD staff reviews and analyzes the data to determine whether the MCOs report any significant changes from previous reporting

periods. HSD findings are communicated to each MCO through monthly critical incident calls between HSD and each individual MCO and during the quarterly critical incident meeting with HSD and all MCOs.

In the DY10 Q4 Performance Measures (PMs), HSD observed the following notable fluctuation: PM #2:The percentage of substantiated critical incidents reported within 24 hours increased by 4 percentage points between DY10 Q3 and DY10 Q4.

All other performance measures demonstrated consistency or slight differences in percentages reported.

The table below details the quarterly data reported by the MCOs from DY10 Q1 through DY10 Q4. DY11 Q1 data will be reported in DY11 Q2.

Table 24: Critical Incidents Performance Measures

Critical Incident Performance Measures (CI PM)				
CI PM	BCBS	PHP	WSCC	Total by Quarter
	Q4	Q4	Q4	Q4
The number of all substantiated critical incidents.	12,598	25,278	3,151	41,027
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #1: The percentage of substantiated critical incidents reported by category of abuse, neglect, exploitation and unexpected death:				
	Q4	Q4	Q4	Q4
1.a. Percentage of substantiated individual abuse incidents identified and reported.	0.66	0.73	0.98	0.79%
1.b. Percentage of substantiated individual neglect incidents identified and reported.	82.54	78.7	89.5	82.12%
1.c. Percentage of substantiated individual exploitation incidents identified and reported.	0.19	0.86	0.38	0.29%
1.d. Percentage of substantiated individual unexpected death incidents identified and reported.	0.36	0.7	0.57	0.37%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #2: The percentage of substantiated critical incidents being reported within the required timeframe.				
	Q4	Q4	Q4	Q4
Percentage of substantiated critical incidents being reported within 24 hours.	96.63	93.38	96.35	95.45%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #3: The percentage of substantiated individual critical incidents where follow up (safety plans, corrective action plans, etc.) was completed:				
	Q4	Q4	Q4	Q4
Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed.	85.29	98.43	21.99	53.64%

CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #4: The percentage of follow-up actions taken on the substantiated critical incidents on a systemic basis to prevent future incidents, such as investigation as well as educating individuals and families:				
	Q4	Q4	Q4	Q4
4.a. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents.	28.99	31.13	21.99	27.37%
4.b. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) included investigation and educating individuals and families was completed.	24.37	1.97	13.23	13.19%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #5: The percentage of the substantiated critical incidents with a referral to Adult Protective Services (APS) or Child Protective Services (CPS):				
	Q4	Q4	Q4	Q4
5.a. Percentage of substantiated individual critical incidents where referrals to APS were completed.	0.44	0.59	1.21	0.75%
5.b. Percentage of substantiated individual critical incidents where referrals to CPS were completed.	0.03	0.11	0.16	0.07%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #6: The percentage of providers and MCO staff trained on reporting critical incidents into the HSD Portal:				
	Q4	Q4	Q4	Q4
6.a The percentage of contracted providers, agencies and MCO educated about reporting critical incidents to the HSD Portal initially at the start or at hire during the reporting period.	85	0.95	0.72	28.89%
6.b. The percentage of contracted providers, agencies and MCO that attended the annual training and were educated about reporting critical incidents to the HSD Portal. NOTE: THIS WILL ONLY BE REPORTED ONCE A YEAR IN THE QUARTER THE ANNUAL TRAINING IS HELD.	60.4	64.89	62.89	62.73%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #7: The percentage of substantiated critical incidents for Members with Multiple critical incidents identified and reported:				
	Q4	Q4	Q4	Q4
The percentage of substantiated Members with Multiple critical incidents identified and reported.	62.15	79.35	91.08	77.53%

Source: MCO CI PM quarterly report.

- **Financial Accountability:** In DY10 Q1, the EQRO began reviewing MCO claims for financial accountability to ensure that Community Benefit claims were not overpaid. New Mexico has received data from all MCOs for DY10 Q1 through DY10 Q4. Reporting for this measure has been delayed and will occur once data has been validated, in DY11 Q2.

8
AI/AN REPORTING

Access to Care

According to MCO Report #55, *Geographical Access Report* for Q1 2024:

- BCBSNM reported 96.4% access to behavioral health services in rural areas and 95.4% access in frontier areas. For physical health, BCBSNM reported 96.4% in rural areas and 97.4% in frontier areas.
- PHP reported 98.3% access to behavioral health services in rural areas and 98.7% access in frontier areas. For physical health, PHP reported 98.3% in rural areas and 98.6% in frontier areas.
- WSCC reported 96.7% access to behavioral health services in rural areas and 100.0% access in frontier areas. For physical health, WSCC reported 96.7% in rural areas and 100.0% in frontier areas.

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

The following are DY11 Q1 updates on contracting between MCOs and I/T/U providers.

MCO	Status of Contracting with MCOs
BCBSNM	BCBSNM has not executed any new I/T/U contracts at this time. Below are the latest updates with Indian Health Service and Tribal 638 providers: • **Canoncito Band of Navajos Health Center** - BCBSNM is discussing a partnership agreement with Canoncito on all lines of business since some Tribal members have Medicare, Medicaid or commercial insurance with BCBS. • **Navajo Regional Behavioral Health** - BCBSNM is in current conversation about partnership agreements with this group. BCBSNM is including in the discussion additional clinics across the Navajo reservation with three being in New Mexico. Discussions include Medicare, Medicaid, and commercial lines of business. • **Pine Hill** - BCBSNM is in discussions with Pine Hill Health Center about partnership agreements with all lines of business with the clinic (Medicare, Medicaid and commercial). • **Southern Ute Indian Tribe dba: Southern Ute Health Center** - BCBSNM is meeting with the Ute Tribe to discuss partnering with them on Commercial, Medicare and Medicaid lines of business. This is ongoing.

PHP	PHP utilizes Mutual Partnership Agreements (MPA) or Letters of Direction (LOD) to support contracting efforts. Each agreement is tailored to meet the specific goals, needs and services of Tribal communities, with a goal of improving access to health care for Native American members. Below is an update of current contracting efforts: • **San Ildefonso Pueblo Behavioral Health** - Agreement discussion was completed, and an agreement has been signed with the Tribal Behavioral Health Program. • **Kewa Pueblo Health Corporation, Inc., Kewa Health Center and Kewa Family Wellness Center** - PHP recently updated their agreement to add FQHC rates as well as Value Based Purchasing (VBP) agreements. Other discussions pending due to 2024 leadership changes at the Pueblo. • **Pueblo of Picuris Health Center and Behavioral Health Program** - Native American Affairs is in discussion with the Pueblo regarding Non-Emergency Medical Transportation (NEMT). Discussions included clarification of non-emergent transportation for non-Tribal members. Picuris has been selected as a pilot for the Rural Health Care Delivery Fund. • **Jicarilla Apache Behavioral Health** – PHP Native American Affairs reached out to offer support for their detox and behavioral health program. The Tribal program is undergoing staff changes. PHP will work with the program once the legislative council appoints/identifies contacts. • **Pueblo of Laguna Community Health and Wellness** - Native American Affairs from PHP provided two benefit education sessions at the Pueblo. There were further discussions regarding partnership, including a VBP agreement with their Health and Wellness Department. PHP Native American Affairs is awaiting response from the organization.
WSCC	• **Ohkay Owingeh Senior Center's** new director requested a meeting with WSCC to discuss contracting for all health plans, assistance with Presumptive Eligibility determiner/enrollment, developing tele-medicine capacity and obtaining necessary requirements for NEMT. WSCC provided additional information regarding Community Health Representative (CHR) reimbursement. WSCC will be discussing an agreement with WellCare and Ambetter Health and continue to provide assistance until 06/30/24, when WSCC contract with NM Medicaid expires. • **Pueblo of San Ildefonso** - WSCC is currently developing a Provider Participation Agreement (PPA) with San Ildefonso which will be

	transmitted for signature in early Q2 2024. • **San Felipe Health Center** reached out to WSCC to solve claims denials for DSNP and other crossover claims. WSCC is currently researching the issue. WSCC current guidance is for the facility to enter into a PPA with WellCare to resolve the claims denials. WSCC will continue to meet with the facility to resolve the issue and/or enter into a PPA for all health plans offered by WSCC. • **Santa Clara Adult Day Care Center** met with WSCC Tribal Relations to provide technical assistance on getting their NEMT Public Regulation Commission (PRC) Certification and National Provider Identifier (NPI) so they can start billing for NEMT. WSCC assisted with the PRC application and provided contact information for a Conduent representative to assist with the Medicaid PPA submission. WSCC informed Santa Clara that they will only be able to provide assistance until 06/30/24, when their Centennial Care 2.0 contract expires. • **Canoncito Health Center (To'hajiilee)** met with WSCC staff regarding WellCare crossover claim denials. WSCC Tribal Relations staff are aware of internal configuration issues around the requirement to contract. WSCC staff continues to research the issue and provide explanations. Tribal Relations recommended that the facility enter into a PPA to include all WSCC health plan products to avoid any claims denials. WSCC will continue to meet with the provider in Q2 2024 until the WSCC contract expires on 6/30/24. • **Navajo Nation Division of Social Services** and other Navajo Nation departments met with WSCC to discuss how to improve surveillance of Navajo Medicaid members who have been targeted in a Medicaid fraud originating in Arizona with their Medicaid members. WSCC and the Arizona Health Plan partnered with the Navajo Nation to coordinate and implement Operation Rainbow Bridge to find and assist Native American members who were victims of the fraud cases. WSCC provided insight and guidance on care coordination and Managed Care and will continue to meet in Q2 2024 with Navajo Nation officials to enter into a consultative agreement.

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

According to MCO Report #47, *Claims Activity Report* for Q1 2024:

- BCBSNM processed 99.1% clean claims within 15 days and 100.0% clean claims within 30 days.
- PHP processed 99.0% clean claims within 15 days and 100.0% clean claims within 30 days.

- WSCC processed 99.4% clean claims within 15 days and 99.7% clean claims within 30 days.

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

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

At the DY11 Q1 NATAC meeting held on March 11, 2024 –

- There was discussion about the forthcoming Turquoise Care Roadshow. The schedule will be available on the HSD website.
- The acting Medicaid Director shared recently approved State Plan Amendments (SPAs) and billable services for Tribes which includes limited billing for CHR services and reimbursement for Tribally run nursing home facilities at the enhanced Medicaid rate.
- A committee member discussed Senate Bill 47, Health Care Personnel Recruitment. New Mexico has a shortage of health care professionals. Any recruitment efforts to hire and retain health care professionals will increase services to Medicaid clients in underserved areas, and the importance for Tribes to have their own health councils.
- Lastly, the need for Medication Assisted Treatment services and inpatient treatment resources on reservations was raised. Currently New Mexico doesn't have enough residential treatment programs to meet the needs for Native American youth.

Following is the DY11 schedule for the Native American Technical Advisory Committee (NATAC) meetings.

The DY11 Native American Technical Advisory Committee (NATAC) Schedule

Date	Time	Location
March 11, 2024	1:00 p.m. – 4:00 p.m.	Virtual
June 17, 2024	1:00 p.m. – 4:00 p.m.	Hybrid
September 16, 2024	1:00 p.m. – 4:00 p.m.	Hybrid
December 16, 2024	1:00 p.m. – 4:00 p.m.	Hybrid

Native American Advisory Board (NAAB) Issues and Recommendations

The following issues were raised at the DY11 Q1 NAAB meetings:

MCO	DATE	Issues/Recommendations
BCBSNM	February 29, 2024 Hybrid meeting Mescalero, NM	The first quarter Native American Advisory Board (NAAB) meeting for BCBSNM was held on February 29, 2024. It was a hybrid meeting targeting Native American Members in the Otero County and the Mescalero Apache Tribal community. Meeting invitations were shared statewide. A total of 54 attendees attended the meeting including 13 members, 13 guests, four providers/community partners, one Tribal representative and 23 BCBSNM staff members. **Question – "**Is Turquoise Transport still available? I am satisfied with them because they would pick me up on time." **Response –** The transportation provider responded that they lost a couple of drivers in the area, so their service area is smaller, but they still service the area. **Question -** "How do we sign up to attend these meetings? I want to attend the MAB and NAAB meetings." **Response** – "Please provide your phone numbers and we will be sure to let the Outreach staff know you are interested in attending all future meetings." **Question -** "My husband and I have not received the turquoise envelope; do you know why?" **Response – "**You might want to update your information with the state and check your renewal date. If the date has passed, you may need to reapply." Recommendations from feedback forms included: • You could give more information, brochures, and links to members with breast and cervical cancer. • You need more meetings in Mescalero.
PHP	March 7, 2024 In person meeting Zuni Pueblo, NM	PHP Native American Affairs hosted the 2024 Q1 Native American Consumer Advisory Board (NACAB) meeting on March 7th, 2024. Recruitment efforts included two mailings of 151 invitation letters mailed to randomly selected members of the Zuni Pueblo. Invitations were also sent to the surrounding ITUs via PHP Provider Network Operations. PHP care coordination from the designated areas was also invited. A total of 5 members were in attendance for this in-person event. A full team of PHP departments was available to present on their respective services and directly respond to any member inquiries. Time was allowed to gather meaningful feedback and comments. These specific questions and concerns were posed

		by members: **Question** – "Will transportation be covered for orthodontic appointments in Gallup?" **Response** - PHP indicated it is reviewed on a case-by-case basis. PHP asked the member to follow up with him after the meeting. **Question – "**How does a member find a provider or doctor? How do I select an MCO when they have a blue card?" **Response** - PHP went over the process of selecting an MCO then provided guidance to either enter care coordination or use the online "find a doctor" tool to find a provider. **Question** – "Where do we go for wellness classes?" **Response** - PHP referred to the website www.phs.org for a listing of classes.
WSCC	March 20, 2024 Hybrid meeting in Gallup, NM	WSCC first quarter Native American Advisory Board (NAAB) meeting for 2024 was hybrid style with virtual call-in and in-person capability. The meeting was held on Wednesday March 20, 2024, from 11:00AM - 1:00PM. The in-person meeting was at the Octavia Fellin Public Library located at 115 W. Hill Ave Gallup, NM 87301. The Western Sky's Tribal Liaisons contacted 100 randomly selected WSCC Native American members residing in McKinley County and parts of Cibola County. Members were contacted by phone call to personally invite them to the NAAB meeting. To promote the NAAB meeting, a virtual postcard was also created and was sent to Western Sky members and providers with email addresses. There were no Western Sky Community Care members in attendance. Western Sky team continued to stay online and at the meeting location for 1.5 hours before logging off the online meeting and closing location site. Some barriers to members attending the NAAB meeting included member connectivity and transportation. There was also police activity near the library location resulting in lock down of the area and some road blocks. Tribal Relations staff were on standby to interact with members that may have been in attendance at post-meeting, but they did not have any members attend at the meeting close.

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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. **DY11 Q1 update:** Plan of Action (POA) related to call center remains open. For Q1 2024, ModivCare did not met all metrics. BCBS continues to meet with ModivCare daily to discuss issues and/or concerns. HCSC/BCBSNM meets with ModivCare weekly to monitor the on-time performance measures. Below are the most current statistics: **January 2024 – March 2024(average):** ASA = 00:21 seconds (Met) Abandonment Rate = 0.22% (Met) Service Level = 81.2% **(NOT** Met) Member Satisfaction = 92% (Met) A-Leg Pick-up = 91.6% (Met) Provider No-Shows = 14.66 For Q1 2024, ModivCare experienced some challenges to their metrics. ModivCare encountered IT issues that prevented the agents from being able to access the ModivCare system to set up trips and review trip information. ModivCare reports call center enhancements that went into production 02/01/2024 had an error which impacted call center containment. ModivCare reports all issues have been resolved. BCBS continues to meet with ModivCare daily to discuss issues and/or concerns. HCSC/BCBSNM meets with ModivCare weekly to monitor the on time performance measures.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	PHP
IMPLEMENTATION DATE	03/31/24
COMPLETION DATE	Closed
ISSUES	2020 Provider Directory Audit
RESOLUTION	04/01/21: Seven findings related to a provider directory audit were identified. The first finding was not contested, which found that the general and online provider directories did not include all information components required by Contract, Sections 4.14.5.1 and 4.14.5.4. The additional findings are being carefully reviewed. PHP is creating a detailed project plan to add required information to the website and to improve the quality of the information. HSD will receive updates for PHP's Provider Database Management project, which is in production and will improve the provider information required to feed the provider directory and downstream claims and encounters databases and other requirements dependent on provider information. The project plan was received by HSD on April 23, 2021. HSD accepted PHP's remediation plan and is monitoring the progress of activities. 07/06/21: PHP's corrective action plan (CAP) is in progress. An update of the project plan was provided to the HSD Contract Manager. 10/01/21: PHP CAP is being reviewed monthly to assess progress and resource needs. A system build is required to ensure accuracy and provider adoption to help ensure required information is updated. PHP is working on both strategies. 12/31/21: PCP CAP is continuing to be reviewed monthly and is working on the system build and provider adoption. 02/21/22: Final scope document completed and being presented to leadership for sign off next week. 04/04/22: Project team had a meeting on 4/1/22 to discuss leadership feedback and questions. 05/18/22: Project scope was approved and is moving forward. 05/20/22: HSD Project Scope Statement was approved, including Lexis Nexis Verified roster automation. PHP finalizing costs and implementation timeline. Lexis Nexis can provide the required data for the HSD deficiencies. 06/22/22: Information Technology (IT) and internal stakeholders very

nearly have the final budget and scope statement ready for signature so work can begin.

09/15/22: VP of Finance reviewing final budget, approval pending. 12/31/22: Status remains unchanged.

03/31/23: PHP is working to add fields to the Provider Directory Manager (PDM) b. PHP is working through the issue of getting data from the old claims system Facets to the new system. PHP is attempting a work around until the required fields are put into place in the new system, then that can be linked to the PDM which produces the Provider Directory.

06/30/23: PHP continues to make progress. The required fields have been added to the Provider Directory Manager (PDM) system. The fields have been completed and approved, and they have been moved to Production in PDM. Training for all team leads is scheduled for 7/11 and 7/13 at the Cooper Center. Additionally, review of the requirements and finalization of placement and any additional filter options for these fields were completed. For the paper directory, Telehealth indicators have been added by PHP's vendor Clarity.

09/30/23: A data gathering survey is currently being developed to assist in gathering data for the required fields. It is under final review and is expected to be completed by 10/6/2023. All required elements have been included in the initial release. Provider Information Technology (IT) has indicated that they will begin working on the Provider Directory tables to include additional fields for the directory data. The online directory will pull data once the fields are complete, and data is available. PHP continues to utilize Lexis Nexis to scrub and cleanse provider directory data. Lexis Nexis provides monthly reports of identified corrections and additional augmented data for review. The implementation team has increased its monthly audits from 100 to 200 each month. Additionally, a Research & Polling vendor is conducting an audit to comply with an Office of the Secretary of Insurance (OSI) directory audit. This should provide valuable feedback. The OSI Directory Audit is expected to be completed by 11/30/23.

12/15/2023: In order to advance efforts more quickly and effectively, PHP proactively established a Provider Directory Steering Committee that will ensure all needed action items are completed and implemented for compliance in 2024. The committee is comprised of senior leaders who are committed to ensuring that the provider directory is brought into full compliance (many items have been remediated). The committee will ensure that the ADA information, cultural competency,

	website URLs, individual provider languages, and provider specialties match that of HSD's Master Provider File. The recently developed provider directory files now have the fields that were initially not available: ADA Compliance, Cultural Competency Training, Languages Spoken by Clinical and Non-Clinical Staff, Website URLs. Target date for all information to be populated is Q2 2024. 03/25/2024: PHP is closing this internal corrective action plan. The ADA (accessibility) and cultural competency provider directory fields are available in the Provider Directory Manual (PDM), and information is being entered as it is received. PHP's Provider Network Operations team will continue to utilize Lexis Nexis to scrub and cleanse provider directory data. Lexis Nexis provides monthly reports of identified corrections and additional augmented data for review. The PDMI team has increased its monthly audits from 100 to 200 each month. The Provider Directory Steering Committee continues to meet monthly to ensure that all provider directory items are implemented and completed.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	Secure Transportation
IMPLEMENTATION DATE	03/31/24
COMPLETION DATE	Closed
ISSUES	Improvement Plan – Network Adequacy
RESOLUTION	Secure Transportation (ST) was placed on an improvement plan for network issues. Monthly meetings will be held between ST and PHP leadership to review issues/concerns. 09/13/21: Network concerns remained an issue for ST. PHP placed ST on a corrective action plan (CAP) as the issues are not resolved timely. ST will provide monthly updates on efforts to improve the network, the next update was due in October 2021. 02/15/22: ST added new providers to its network of drivers. PHP is working on increasing mileage reimbursement. Mileage reimbursement is offered at the front end of the scheduling process through care coordination to free up drivers for members who do not have supports for this option. ST is offering hiring bonuses and retention bonuses to help maintain the current network. 04/01/22: Areas that are remaining a focus of the CAP for ST. This CAP is to remain open until network adequacy is improved.

Action Plan Items:

- Risk Stratification – policy to identify and prioritize high risk members (dialysis, chemotherapy, radiation, pre or post operative care, surgery, high risk pregnancy related appointments and urgent care); and members at risk of being dropped by their provider for missed appointments
- Network Adequacy Plan - include specifics to ensure statewide coverage including 100 miles from the NM state borders (excluding Mexico)
- Recruiting Plan – include number of vehicles, candidates, and area serviced
- Network Monitoring processes
- Retention Plan
- Incentive Plans - including incentive plans for resolving issue regarding short distance trips
- Provider Issues – action plan to address providers regarding no-shows and those with excessive late pick-ups.

12/15/22: ST remains on a CAP. PHP and ST developed a policy and process to improve access for critical care appointment scheduling and transportation completion that was approved by HSD. PHP is monitoring and seeing improved results.

03/28/23: Q1CY23: This CAP has remained open for continuous monitoring of the critical care appointments and efforts to reduce all provider missed transportation. Critical care appointments have been reduced significantly. There were 11 missed appointments in January and 9 missed appointments in February.

Additional policy and procedures were implemented in CY22 which are directing the improvements. PHP will continue to monitor critical care appointments daily.
Initiatives that are currently in progress include: per member per month (PMPM) rate review with guarantees, PHP contracting directly with Community Outreach Centers for partnering with transportation needs, and PHP contracting directly with tribal communities that offer transportation. Secure is adding additional vehicles to the fleet and looking to update correct scheduling platform/software for better performance.

06/30/23: May’s report remains consistent with zero critical care trips that were unable to be scheduled and approximately 20 driver no shows/cancellations. May also had zero unable to schedule non-critical care appointments, down from 90 in April. Member no-shows have increased. PHP is working with care coordination to contact members

who are missing and not cancelling appointments, specifically around critical care appointments and continued missed methadone appointments. Lyft ride share has been approved by the Public Regulation Commission (PRC). There will be a meeting with Secure and Clinical Operations to determine criteria and rollout plan.

09/30/23: Critical care appointments continue to be prioritized over other transportation types, and PHP remains consistent with zero trips unable to be scheduled. Implemented Lyft Transportation services as a backup, if available and only if the member is fully ambulatory and agrees to Lyft services. Provider-missed non-critical care appointments are also trending down. Member no-show and mileage reimbursement requests are trending higher than normal. PHP is implementing initiatives to target members that are missing scheduled appointments, including post card reminders about transportation and use of the transportation app, Itineris. PHP is working with care coordination and community health workers (CHWs) to outreach to members who missed a critical care appointment, confirming member had alternative transportation, inpatient status or other areas of concern. PHP Oversight Manager continues to monitor transportation daily, weekly, and monthly. The corrective action plan (CAP) with Secure will remain open for continued oversight.

12/31/23: PHP and Secure Transportation continue to monitor critical care appointment times working with internal teams as needed on initiatives for improvement. PHP has seen a significant decrease in missed trips for all transportation types and member grievances have reduced by 80% over the last 12-months. PHP engages the clinical ops team for additional member support as needed. PHP is contemplating moving its Corrective Action Plan (CAP) with Secure to an Improvement Plan (IP), PHP will continue monitoring only. Transportation will continue to be a focus for improvement initiatives and requirements.

03/25/2024: No new updates to report, PHP and Secure Transportation continue to monitor all appointment types. Critical care appointments are a focus, and PHP has continued to trend down on missed appointments due to driver call outs, January and February missed trips was 20 out of the 13k trips scheduled and completed. In January of 2024, Uber was added to the rideshare contracts and helps as a backup resource for critical care appointments and those trips in areas of the state with few drivers. The rideshare option is for members that are full ambulatory and need no assistance to the car. PHP has reduced the CAP to an improvement plan for monitoring only.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	None in effect in DY11 Q1.
IMPLEMENTATION DATE	
COMPLETION DATE	
ISSUES	
RESOLUTION	

10

FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY11 Q1 reflects the capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 28, 2023. On weighted average, the CY2024 rate is 4.07% higher than that of CY2023; the fee-for-service claim payments for CY2024 are still lagging. In addition, data runs out 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 DY8 is 10.7% below the budget neutrality limit (Table 8.5) through 13 quarters of payments. For DY9, Table 9.5 shows a 9.1% below the budget neutrality limit with data through 9 quarters. Table 10.5 shows a 10.7% below the budget neutrality limit for DY10 with data of 5 quarters. And Table 11.5 shows preliminary data for DY11 of 16.7% below the budget neutrality limit with a single quarter of data.

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MEMBER MONTH REPORTING

Member Months		2024
		1
MEG1	0-FFS	93,564
	Presbyterian	546,933
	Western Sky	119,288
	Blue Cross Blue Shield	370,763
	Total	**1,130,548**
MEG2	0-FFS	7,614
	Presbyterian	60,358
	Western Sky	12,328
	Blue Cross Blue Shield	37,498
	Total	**117,798**
MEG3	0-FFS	0
	Presbyterian	62,954
	Western Sky	12,024
	Blue Cross Blue Shield	32,159
	Total	**107,137**
MEG4	0-FFS	546
	Presbyterian	313
	Western Sky	40
	Blue Cross Blue Shield	217
	Total	**1,116**
MEG5	0-FFS	0
	Presbyterian	9,088
	Western Sky	1,574
	Blue Cross Blue Shield	6,704
	Total	**17,366**
MEG6	0-FFS	84,835
	Presbyterian	365,830
	Western Sky	108,527
	Blue Cross Blue Shield	286,342
	Total	**845,534**
MG10	0-FFS	14
	Presbyterian	46
	Western Sky	12
	Blue Cross Blue Shield	60
	Total	**132**
MGX8	0-FFS	0
	Presbyterian	159
	Western Sky	102
	Blue Cross Blue Shield	244
	Total	**505**
	Total	**2,220,136**

Source: Enrollee Counts Report.

The new MEG for SMI/SUD has not been developed. HSD will work with their fiscal agent to add the new MEG to the Enrollee Counts Report within 60 days of this report.

12
CONSUMER ISSUES

GRIEVANCES

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

In DY10 Q4, the reports submitted by MCOs for October through December were reviewed and analyzed. It was determined reports were in compliance with contractual requirements. HSD observed in DY10 Q4 that the top member grievance reporting code continues to be "Transportation Ground Non-Emergency". The number of these grievances filed in DY10 Q4 demonstrated a 12% decrease from DY10 Q3 and a 17% decrease from DY10 Q1.

"Provider Specialist" was the second most frequently reported member grievance code, as it was in DY10 Q3 and Q2. In DY10 Q3, "Other Specialties" was the second most frequently reported code. The table below is a summary of the quarterly data reported by the MCOs for DY10 Q4.

Table 25: Grievances Reported

Grievances Reported (January - March 2024)																
Grievances	BCBS				PHP				WSCC				TOTAL BY QUARTER			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Member Grievances	405	483	462	409	326	243	295	230	50	52	59	46	781	778	816	685
Top Two Primary Member Grievance Codes																
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER			
													Q1	Q2	Q3	Q4
Transportation Ground Non-Emergency	288	361	326	273	116	48	68	63	19	8	7	15	423	417	401	351
Provider Specialist	17	27	33	14	0	0	0	0	2	2	5	2	28	33	53	17
Variable Grievances	100	95	103	122	210	195	227	167	29	42	47	29	339	332	377	318

Source: MCO Report #37

APPEALS

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

In DY10 Q4, the reports submitted by MCOs for October through December were reviewed and analyzed. It was determined that all reports were in compliance with contractual requirements. HSD observed in DY10 Q4, the top primary member appeals code continues to be "Denial or limited authorization of a requested service". The number of these appeals filed in DY10 Q4 demonstrated a 13% decrease from DY10 Q3 and a 20% decrease from DY10 Q1.

"Denial in whole of a payment for a service" was the second most frequently reported member appeal code. The number of these appeals filed in DY10 Q4 showed a 44% decrease from DY10 Q3 and an 80% decrease from DY10 Q2.

These two primary member appeals codes have remained consistent since DY9. The table

below is a summary of the quarterly data reported by the MCOs for DY10 Q4.

Table 26: Appeals Reported

Appeals Reported (January - March 2024)																
APPEALS	BCBS				PHP				WSCC				TOTAL BY QUARTER			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Standard Member Appeals	534	588	409	333	627	582	581	489	56	56	71	38	1,217	1,226	1,061	860
Number of Expedited Member Appeals	35	29	32	31	23	28	17	30	12	11	9	10	70	68	58	71
Top Two Primary Member Appeal Codes																
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER			
													Q1	Q2	Q3	Q4
Denial or limited authorization of a requested service	397	410	366	327	624	583	568	502	65	60	71	45	1,086	1,053	1,005	874
Denial in whole of a payment for a service	165	199	63	32	15	12	12	10	0	0	0	0	180	211	75	42
Variable Appeals	7	8	12	5	11	15	18	7	3	7	9	3	21	30	39	15

Source: MCO Report #37

13
QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HSD's Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference the table below for 2024 MCO Advisory Board Meeting Schedules.

Table 27: 2024 MCO Advisory Board Meeting Schedules

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			
Meetings will be held virtually until state restrictions are lifted for in-person meetings. SDCB Subcommittee Member Advisory Board Meetings are currently on hold.			
MEMBER ADVISORY BOARD MEETING SCHEDULE (CENTRAL AREA)			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/08/2024	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	06/04/2024	Noon-1:00 PM	TBD
PHP	08/29/2024	Noon-1:00 PM	TBD
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)

WSCC 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	02/11/2023	10:00 AM-12:00 PM	Virtual Meeting
WSCC	05/18/2023	2:00 PM-4:00 PM	Virtual Meeting
WSCC	08/16/2023	11:00 AM-1:00 PM	Virtual Meeting
WSCC	12/02/2023	2:00 PM-4:00 PM	Virtual Meeting
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	04/19/2023	4:00 PM-6:00 PM	Virtual Meeting
WSCC	10/12/2023	3:00 PM-5:00 PM	Virtual Meeting
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	03/03/2023	11:00 AM-1:00 PM	Virtual Meeting
WSCC	06/01/2023	4:00 PM-6:00 PM	Virtual Meeting
WSCC	08/25/2023	11:00 AM-1:00 PM	Virtual Meeting
WSCC	12/09/2023	11:00 AM-1:00 PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	08/16/2023	11:00 AM-1:00 PM	Virtual Meeting (Included in the MAB Presentation)
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	10/12/2023	3:00 PM-5:00 PM	Virtual Meeting (Included in Statewide)
COMMUNITY ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	06/16/2023	3:00 PM-4:30 PM	Virtual Meeting

Quality Assurance	
DY11 Q1	**Quarterly Quality Meeting** HSD holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HSD updates and guidance on required quality monitoring activities as well as relay HSD findings from the monthly, quarterly, and annual reports submitted by the MCOs. The DY11 Q1 meeting was held on March 27, 2024. Performance Measure (PM) rates, annual CAHPS survey results, and tobacco cessation outcomes were presented. HSD presented the MCOs with their individual performance rate, and the aggregate state rate as of DY10 Q4 for each PM, compared to the respective DY10 annual HSD established targets based on their reported administrative data. As of DY10 Q4, the MCOs aggregate performance exceeded the DY10 HSD established targets for 3 of 10 performance measures: Antidepressant Medication Management−Continuous Phase, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment-Initiation Phase, and 30-Day Follow-Up After Emergency Department Visit for Mental Illness. As of DY10 Q4, the MCOs aggregate performance is at risk in meeting the DY10 HSD established targets for 7 of 10 performance measures: Well-Child Visits in the First 15 Months of Life, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Timeliness of Prenatal Care, Postpartum Care, Childhood Immunization Status-Combination 3, 30 Day Follow-Up After Hospitalization for Mental Illness, and Diabetes Screening for People with Schizophrenia for Bipolar Disorder Who Are Using Antipsychotic Medications. HSD presented the 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for the Adult, Child General and Children with Chronic Conditions populations. HSD presented individual MCO results for DY8, DY9 and DY10, compared to the National Average for the following measures identified by AHRQ as the highest scoring measures; How Well Doctors Communicate and Rating of Personal Doctor, and the lowest scoring measures, Rating of Health Care and Getting Needed Care.

	Two of the MCOs met the 2022 National Average of 92% for How Well Doctors Communicate for the Adult population. For Getting Needed Care, the individual MCO outcomes were significantly below the 81% national average in DY10 for the Adult population. For the Rating of Personal Doctor measure, 1 MCO exceeded the National Average of 82% in MY2022 for the Adult population. All 3 MCO individual results for Health Care Rating for the Children with Chronic Conditions population fell significantly below the National Average of 83% in MY2022. For Getting Needed Care, the individual MCO survey results were significantly below the National Average of 81% in MY2022 for the Adult population. MCOs were encouraged to develop initiatives to improve satisfaction in these focus areas. HSD and the MCOs discussed smoking cessation data that is periodically presented to a higher-level committee, the Tobacco Settlement Revenue Oversight Committee. The discussion focused on HSD Tracking Measure data to address the MCO's gradual increase in utilization and dollars spent on cessation products and services as compared to the previous quarter. HSD also announced a smoking cessation workgroup will resume to address and strategize efforts and initiatives related to smoking prevention and cessation for Medicaid members. **Monthly Performance Measure Monitoring Plan** In DY9 Q3, HSD introduced 3 measures to the Monthly Monitoring Plan for MCOs due to the observed decline in performance measure outcome rates. Well Child Visits within the first 15 months of life, Timeliness of Prenatal Care, and Childhood Immunization Status are now monitored monthly by HSD. HSD provides the MCOs with reporting instructions and a monitoring template which is submitted monthly to HSD. The report requires the MCO to give an account of the ongoing interventions, strategies, and barriers associated with improving performance outcomes for the selected measures. This allows HSD to monitor the progress towards improving outcomes and meeting the established PM targets. HSD established an annual target rate for DY10 for PM #1 – Well Child Visits in the First 15 Months of Life (W30) of 65.91%. Through DY10 Month 12 (M12), the MCOs reported the following average rates: BCBS 63.97%, PHP 64.18%, and WSCC 58.40%.

	The DY10 HSD annual target rate for PM #3 – Prenatal Care (PPC) is 84.75%. Through DY10 M12, the MCOs reported the following average rates for Timeliness of Prenatal Care: BCBS 61.24%, PHP 70.43%, and WSCC 57.59%. The DY10 HSD annual target rate for PM #5 – Childhood Immunization Status (CIS) is 71.78%. Through DY10 M12, the MCOs reported the following average rates for Combination 3 Immunizations: BCBS 57.53%, PHP 62.36%, and WSCC 57.03%. HSD expects to see these rates increase quarter over quarter. The final determination of whether the MCOs have met the established targets is reliant on the CY 2023 annual audited HEDIS report, which will be received in June 2024. **BCBS:** **W30:** M10 63.55%; M11 64.11%; M12 64.26%. Increase of .71 percentage points from M10 to M12. **Strategies and Interventions:** In DY10 Q4, BCBS continued to promote the 6X15 media campaign to encourage the adherence of well-child visits. BCBS has begun a reserved wellness appointment program with two provider groups. This program incentivizes providers that offer after-hour and weekend appointments for well-child visits and childhood (Combo 3) immunizations. BCBS mailed a total of 4,039 “Happy Birthday” immunization reminder postcards to members who turned 1 – 3 years old in Q4. The success of the reminder postcards is evaluated based on how many of the recipients complete their visit. The Quality Management staff continues to conduct member outreach calls to remind parents/ guardians that their child is due for a well-child visit and immunizations. BCBS also engages providers with joint operating committee meetings and offers assistance with member outreach to close W30 gaps. **PPC:** M10 61.12%; M11 61.28%; M12 61.33%. Increase of .21 percentage points from M10 to M12. **Strategies and Interventions:** BCBS continued member outreach efforts to encourage prenatal visits. The Special Beginnings program continues to identify pregnant members to offer care coordination, education, and virtual doula health coaching. During calendar year 2023, this program has

	identified 2,113 pregnancies. Member outreach efforts also include Centennial Rewards, SMS text messages, and member newsletters. BCBS provider initiatives include monthly value-based provider groups, where providers are provided with member gap lists. BCBS Wellness Education Specialists offer providers member outreach assistance to offer members help with scheduling appointments. **CIS:** M10 57.44%; M11 57.60%; M12 57.56%. Increase of .12 percentage points from M10 to M12. **Strategies and Interventions:** BCBS continues performing member outreach calls to inform parents of upcoming or overdue immunizations. The Quality Management Specialists offer parents/ guardians assistance with scheduling appointments and transportation during the outreach calls. BCBS engages providers during monthly joint operating committee meetings. Provider groups are sent member gap/opportunity lists. BCBS has also resumed sending SMS messages to promote well-child visits and immunizations to parents/guardians. On 12/6/2023, 4,109 SMS messages were sent to member's parents/guardians. **PHP:** **W30:** M10 64.22%; M11 64.93%; M12 63.39%. Decrease of .83 percentage points from M10 to M12. **Strategies and Interventions:** PHP continues to perform member outreach via Early and Periodic Screening, Diagnostic and Treatment (EPSDT) letters and phone calls to parents/guardians of members within the W30 age range. During DY10 Q4, there were 11,338 EPSDT letters specific to the W30 measure mailed to members. PHP abstraction teams have begun to identify members in the Neonatal Intensive Care Unit (NICU) who are compliant with the W30 measure. The records of the compliant members in the NICU are submitted to be included in the numerator for this measure. PHP will also continue to work with PMG clinics to create and implement interventions to increase member compliance. **PPC:** M10 68.88%; M11 71.98%; M12 70.42%. Increase of 1.54 percentage points from M10 to M12.

	Strategies and Interventions: PHP continues to make member outreach calls to encourage pregnant members to attend prenatal and postpartum appointments. Community Health Workers also encourage members to participate in the Baby Benefits prenatal reward program. This program rewards members with gift cards for compliance with prenatal and postpartum care. There were 484 new enrollments into the Baby Benefits program during Q4. PHP continues to receive referrals for member outreach from Families First. PHP conducted an analysis of PPC visit coding and identified visits that count towards this measure for manual abstraction. PHP engages providers with education training regarding prenatal and postpartum care. **CIS:** M10 58.86%; M11 64.95%; M12 63.26%. Increase of 4.40 percentage points from M10 to M12. **Strategies and Interventions:** PHP continued to mail Early and Periodic Screening and Diagnostic Treatment (EPSDT) letters to the parents/guardians of members in this age group. These letters encourage the completion of well-child visits and age-appropriate immunizations. There were 10,964 EPSDT letters mailed during DY10 Q4. PHP also performs member outreach calls to inform parents/guardians of the importance of well-child visits. During DY10 Q4, PHP conducted 1,152 member outreach calls related to this measure. **WSCC:** **W30:** M10 55.34%; M11 55.99%; M12 63.86%. Increase of 8.52 percentage points from M10 to M12. **Strategies and Interventions:** WSCC conducts targeted member outreach to parents/guardians via mPulse text messages and phone calls. During member outreach, the WSCC Quality Improvement (QI) team reminds parents/guardians of overdue well-child visits and educates them on the importance of well-child visits. WSCC engages members with My Health Pays rewards when members complete the series of well-child visits. WSCC also engages providers with bimonthly/monthly Value-Based Provider meetings to assist providers with scorecards and barriers.

	PPC: M10 56.60%; M11 57.86%; M12 58.32%. Increase of 1.72 percentage points from M10 to M12. **Strategies and Interventions:** WSCC continues to receive Notifications of Pregnancy (NOP) forms from New Mexico Community Care. The NOPs also allow WSCC the opportunity to assess the risk of the member's pregnancy and educate the members on benefits and incentives. The members are also enrolled in the Start Smart for your Baby (SSFB) program. WSCC also sponsored a virtual baby shower during M10. This program provides members in need with a car seat or crib. WSCC performs member outreach via mPulse text messages which provide prenatal care tips and reminders. WSCC also offers lactation consulting and access to virtual doulas via the Pacify app. Pregnant members are also referred to the Centennial Home Visiting program. This program supports expecting moms and new parents to promote maternal and infant health. **CIS:** M10 56.92%; M11 57.07%; M12 57.11%. Increase of .19 percentage points from M10 to M12. **Strategies and Interventions:** WSCC continues member outreach via the Vaccine Adherence in Kids (VAKS) program to remind parents/guardians of members who are due or overdue for immunizations. The WSCC Quality team also performs outreach calls to parents/guardians to educate them on the importance of immunizations and vaccines and address any barriers that may exist. WSCC also engages members with its My Health Pays incentive program. This program rewards the parents/guardians of members who complete the various immunizations listed within the CIS measure. WSCC also engages providers with Value-Based Provider meetings. These meetings are an opportunity to discuss how to close care gaps. **<u>Performance Measures (PMs)</u>** HSD Performance Measures (PMs) and targets are based on HEDIS technical specifications. Each MCO is required to meet the established performance targets. Each DY target is a result of the DY6 MCO aggregated Audited HEDIS data, calculating an average increase for each DY until reaching the DY6 Quality Compass Regional Average plus 1 percentage point. Failure to meet the HSD-designated target for individual performance measures during the DY will result in a monetary penalty based on 2% of the total capitation paid to the MCO for the agreement year.

	HSD requires the MCOs to submit quarterly reports that are used to monitor the performance of each PM to determine if MCOs are on track for meeting the established target. MCOs report any significant changes as well as interventions, strategies, and barriers that impact improved performance. HSD staff will review and analyze the data to determine if the MCOs are trending towards meeting the established targets. HSD findings are communicated to the MCOs through MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meeting (QQM). HSD expects to see rates increase quarter over quarter and the final determination of whether the MCOs have met the targets is reliant on the DY10 annual audited HEDIS report, which will be received in DY11 Q2. Below are the MCO quarterly rates and interventions for each PM and the established target for DY10. The following PMs show results for DY10 Q4 reporting. ***PM #1 (1 point) – Well-Child Visits in the First 15 Months of Life (W30)*** The percentage of members who turned 15 months old during the measurement year and had 6 or more well-child visits. **DY10 target is 65.91%.** • BCBS Q1 35.34%; Q2 51.93%; Q3 61.51%; Q4 64.26%: Increase of 2.75 percentage points from Q3 to Q4 and 1.65 percentage points below the DY10 target. • PHP Q1 32.32%; Q2 49.88%; Q3 62.03%; Q4 63.39%: Increase of 1.36 percentage points from Q3 to Q4 and is 2.52 percentage points below the DY10 target. • WSCC Q1 28.88*%; Q2 42.97%; Q3 53.08%; Q4 56.39%: Increase of 3.31 percentage points from Q3 to Q4 and is 9.52 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 33.02%; Q2 Total 49.78%; Q3 Total 60.69%; Q4 Total 62.81%: Increase of 2.12 percentage points from Q3 to Q4 and is 3.10 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS conducted various forms of member outreach to encourage the parents/guardians of members to complete well-child visits during the first 15 months of life. Their efforts consisted of phone calls, SMS text messages, emails, and

	postcards. Members were also offered assistance with scheduling well-child appointments. BCBS hosted a hybrid Member Advisory Board Meeting (MAB) in October and a Native American Advisory Board (NAAB) meeting in November to provide education on the importance of well-child visits. BCBS also continues to promote the 6x15 initiative with Esparza Advertising. This initiative encourages the importance of 6 well visits in the first 15 months of life by overlaying a child's first 6 visits. BCBS' Wellness Education Specialists provide their value-based contracted providers assistance with member outreach to help improve their W30 performance rate. • PHP conducted member outreach calls to guardians of members to assist with scheduling well-child visits. Efforts to conduct medical record abstraction for compliant members located in the Neonatal Intensive Care Unit (NICU) also assist with this measure. PHP also shared enrollment information with providers to promote the PHP Centennial Care Baby Bonuses incentive program for eligible PHP Centennial Care members. • WSCC's Quality team conducts targeted member outreach to members who are due or overdue for their well-child visits. The team also assists with scheduling appointments and helping members overcome barriers, such as lack of transportation. WSCC partners with Arkos to conduct member outreach and in-home interventions with members via telemedicine. WSCC also continues to offer My Health Pays, a member incentive program where a member receives rewards when completing well-child visits. WSCC created a Well Child Visit flyer for members' parents/guardians about the importance of well-child visits. WSCC's Value-Based teams conduct bimonthly/monthly engagement meetings with providers to review scorecards, discuss barriers, and share member gaps in care lists. ***PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*** The percentage of members ages 3 through 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement

	year. For this measure the National Committee for Quality Assurance (NCQA) offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 62.93%.** • BCBS Q1 12.76%; Q2 20.04%; Q3 28.10%; Q4 32.33%: Increase of 4.23 percentage points from Q3 to Q4 and is 30.60 percentage points below the DY10 target. • PHP Q1 12.42%; Q2 15.31%; Q3 23.91%; Q4 30.57%: Increase of 6.66 percentage points from Q3 to Q4 and is 32.36 percentage points below the DY10 target. • WSCC Q1 12.12%; Q2 16.40%; Q3 18.52%; Q4 31.49%: Increase of 12.97 percentage points from Q3 to Q4 and is 31.44 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 12.53%; Q2 Total 17.13%; Q3 Total 24.79%; Q4 Total 31.28%: Increase of 6.49 percentage points from Q3 to Q4 and is 31.65 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS continues member engagement with an SMS text messaging campaign to provide education to parents and guardians about the importance of maintaining a healthy weight for their children. BCBS Wellness Education Specialists also call parents of members/guardians to remind parents to schedule an annual physical for their children and ensure their immunizations are up to date. The BCBS Member Newsletter winter edition featured articles with ideas for indoor exercise activities for the family. BCBS continues the Centennial Rewards program which includes 200 reward points ($20 value) per year for completing at least one child or adolescent well-care visit. BCBS continues to implement provider initiatives to educate providers and promote WCC measure performance during joint operating committee meetings. The increased payout rate for CPT code G0447 has been extended through 6/30/2024.

	• PHP implemented strategies and interventions to increase and improve this measure. These interventions include increased provider education on the importance of well-child checks and proper coding for nutrition and physical activity. PHP member outreach efforts include calls to the parents or guardians of members to educate them on recommended well-care visits and immunizations and offer assistance with appointment scheduling. • WSCC's Quality Reporting Specialists and Value-Based Payment (VBP) team partner for monthly provider engagement meetings to review scorecards, and gap-in-care lists. During these meetings, providers are encouraged to discuss well-care visits, including counseling for nutrition and physical activity with members' parents/guardians. WSCC hosts community events throughout the state of New Mexico to provide sports physicals and back-to-school events. WSCC also provides an incentive program for members who complete the requirements for the WCC measure. WSCC conducts medical record reviews for non-compliant members to close the care gap. ***PM #3 (1 point) – Prenatal and Postpartum Care (PPC)*** The percentage of member deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit as a member of the MCO in the first trimester or within 42 calendar days of enrollment in the contractor's MCO. **DY10 target is 84.75%.** • BCBS Q1 58.09%; Q2 58.80%; Q3 60.66%; Q4 61.30%: Increase of .64 percentage points from Q3 to Q4 and is 23.45 percentage points below the DY10 target. • PHP Q1 66.68%; Q2 67.34%; Q3 68.69%; Q4 70.42%: Increase of 1.73 percentage points from Q3 to Q4 and is 14.33 percentage points below the DY10 target. • WSCC Q1 55.82%; Q2 54.10%; Q3 55.05%; Q4 58.38%: Increase of 3.33 percentage points from Q3 to Q4 and is 26.37 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 62.08%; Q2 Total 62.48%; Q3 Total 64.07%; Q4 Total 65.75%: Increase of 1.68 percentage points from Q3 to Q4 and is 19 percentage

	points below the DY10 target. **MCO Strategies and Interventions:** • BCBS Special Beginnings maternity program collaborated with Finity Baby Smart and Families First to perform member outreach to high-risk and low-risk pregnant members early in their pregnancy. BCBS also held another community baby shower in November. BCBS promotes the Centennial Rewards Program and provides members with reward points for attending their initial prenatal appointment during their 1st trimester. BCBS hosts a monthly joint operating committee with value-based contracted providers to incentivize the PPC rate. The Special Beginnings program also continues to collaborate with the Rhodes Group to identify pregnant members early in their pregnancy which provides an early opportunity to perform member outreach calls. • PHP's Performance Improvement (PI) team continues to focus on identifying coding discrepancies for prenatal visits. These discrepancies exclude compliant members due to providers using a different code than the standard code. The PI team has also included these codes in the Early Identification of Pregnancy report which is used for outreach by the Community Health Worker (CHW) team. Ongoing interventions also include the Baby Benefits reward program, and outreach calls to high-risk pregnant members performed by the care coordination team and PI Staff. PHP Analytics Organization (AO) developed a new process for validating completed prenatal and postpartum visits. The new process allows PHP to provide compliant members with member rewards promptly. • WSCC uses the Notification of Pregnancy (NOP) process which notifies WSCC of a member's pregnancy. WSCC provides both provider and member incentives for the completion of the NOP. WSCC's OB Care Coordinators conduct member outreach to identify if the members pregnancy is high, medium, or low risk to ensure the member is provided with the appropriate care. The Start Smart for your Baby (SSFB) Care Coordinators also assist members with scheduling their prenatal visits and address any barriers that the member may have. WSCC hosts virtual

baby showers where members are educated on incentives, benefits, and the importance of prenatal care. WSCC also offers an in-person Doula program through Health Connect One and a virtual doula program through Pacify with 24/7 on-demand access. WSCC conducts Medical Record Reviews to review medical charts to determine members' compliance in efforts to address gaps in care.

PM #4 (1 point) – Prenatal and Postpartum Care (PPC)

The percentage of member deliveries that had a postpartum visit on or between 7 and 84 calendar days after delivery.

For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6.

DY10 target is 67.26%.

- BCBS Q1 46.45%; Q2 51.69%; Q3 54.18%; Q4 58.60%: Increase of 4.42 percentage points from Q3 to Q4 and is 8.66% percentage points below the DY10 target.
- PHP Q1 52.79%; Q2 58.49%; Q3 60.09%; Q4 65.87%: Increase of 5.78 percentage points from Q3 to Q4 and is 1.39 percentage points below the DY10 target.
- WSCC Q1 41.95%; Q2 46.98%; Q3 51.94%; Q4 57.59%: Increase of 5.65 percentage points from Q3 to Q4 and is 9.67 percentage points below the DY10 target.
- MCO Aggregate: Q1 Total 49.06%; Q2 Total 54.49%; Q3 Total 56.95%; Q4 Total 62.33%: Increase of 5.38 percentage points from Q2 to Q3 and is 4.93 percentage points below the DY10 target.

MCO Strategies and Interventions:

- BCBS member engagement efforts include the Special Beginnings Maternity Care Coordination Program to perform member outreach to high-risk and low-risk members. BCBS Quality Management staff also performs member outreach calls to offer assistance with scheduling postpartum visits and transportation if necessary. BCBS also sent postpartum care SMS messages in November to 2,213 members. The Centennial Rewards Program offers reward points to

	members for attending a postpartum appointment, well-baby checkups, and updating their address. BCBS also engages providers by offering gap-in-care lists and offering assistance with member outreach during monthly joint operating committee meetings. On a system level, BCBS has an ongoing collaboration with the Rhodes Group to identify pregnant members earlier in their pregnancy. • PHP's Performance Improvement (PI) team is still focusing on identifying coding discrepancies for prenatal visits and submitting them for abstraction. The coding inconsistencies cause compliant members to be incorrectly excluded from the numerator. PHP Community Health Workers (CHW) use the Early identification of pregnancy reports to contact pregnant members to inform them about the Baby Benefits Program. The Community Health Workers and Care Coordination teams also perform member outreach calls to high-risk pregnant members. PHP analytics staff developed a new process for validating completed prenatal and postpartum visits for the Baby Benefits program. • WSCC conducts member outreach via its OB care coordination program, Start Smart for your Baby (SSFB) in which care coordinators assist with scheduling postpartum visits. WSCC also hosts virtual baby showers where they educate expecting parents on the importance of prenatal care. WSCC is also utilizing Pacify, a mobile application that gives members 24/7 access to the WSCC Nurse advice line, virtual lactation consultation, and Doula support. The Centennial Home Visiting Program (CHV) promotes maternal and infant health via home visits. This program provides a Parent as Teachers (PAT) curriculum and Nurse Family Partnership (NFP) which provides 1st time mothers with a personal nurse. Both programs focus on education around prenatal care, postpartum care, and early childhood development. ***PM #5 (1 point) – Childhood Immunization Status (CIS): Combination 3*** The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps and rubella (MMR); 3 haemophilus influenza type B (HiB); 3

	hepatitis B (HepB); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their 2nd birthday. For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 71.78%.** • BCBS Q1 48.03%; Q2 54.37%; Q3 56.82%; Q4 57.56%: Increase of .74 percentage points from Q3 to Q4 and is 14.22 percentage points below the DY10 target. • PHP Q1 43.76%; Q2 56.98%; Q3 58.76%; Q4 63.26%: Increase of 4.5 percentage points from Q3 to Q4 and is 8.52 percentage points below the DY10 target. • WSCC Q1 43.01%; Q2 50.59%; Q3 51.17%; Q4 57.12%: Increase of 5.95 percentage points from Q3 to Q4 and is 14.66 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 45.20%; Q2 Total 55.25%; Q3 Total 57.13%; Q4 Total 60.48%: Increase of 3.35 percentage points from Q3 to Q4 and is 11.30 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS supports community outreach with Member Advisory Board (MAB) and Native American Advisory Board (NAAB) meetings to provide education on the importance of well-child visits and immunizations. BCBS member outreach efforts include calls, targeted emails, and SMS text messages to assist the parents/guardians of members with scheduling well-child visits and childhood immunizations. They also mailed well-child visit reminder postcards to parents/guardians of members who turned 1,2, and 3 years old. BCBS continues to promote the 6x15 initiative to encourage the importance of well-child visits during the first 15 months of life. BCBS provider outreach efforts consist of joint operating committee meetings with Value-Based Contracted (VBC) providers. BCBS and providers review dashboards measuring performance goals against the target goal for W30, address barriers and BCBS offers member outreach assistance to providers during the joint operating

meetings.

- PHP Performance Improvement (PI) staff presented education on the importance of immunizations to both internal and external stakeholders. This includes providers, clinical operations, and community health workers. The Community Health Workers and Care Coordination teams continue to encourage members to complete this measure through member outreach efforts. PHP Performance Improvement staff also provides immunization information during outreach calls to parents and guardians of members.

- WSCC continues to offer the Vaccine Adherence in Kids (VAK's) program. This program sends parents immunization reminders when immunizations are due or overdue. The Quality reporting specialists and Value-Based team conduct monthly provider engagement meetings to review provider scorecards, identify members with open care gaps, and discuss barriers. WSCC also provides an incentive for members who complete immunizations related to the CIS measure via My Health Pays. WSCC quality reporting specialists collaborate with providers to discuss opportunities to increase childhood immunizations. WSCC partners with Arkos to conduct targeted outreach to address gaps in care.

PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase

The number of members age 18 years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least 180 calendar days (6 months) of continuous treatment with an antidepressant medication.

DY10 target is 35.61%.

- BCBS Q1 33.59%; Q2 38.36%; Q3 41.98%; Q4 42.17%: Increase of .19 percentage points from Q3 to Q4 and is 6.56 percentage points above the DY10 target.
- PHP Q1 40.87%; Q2 45.66%; Q3 50.16%; Q4 51.03%: Increase of .87 percentage points from Q3 to Q4 and is 15.42 percentage points above the DY10 target.
- WSCC Q1 35.87%; Q2 42.07%; Q3 45.86%; Q4 45.70%: Decrease of .16 percentage points from Q3 to Q4 and is

	10.09 percentage points above the DY10 target. • MCO Aggregate: Q1 Total 37.46%; Q2 Total 42.47%; Q3 Total 46.66%; Q4 Total 47.14%: Increase of .48 percentage points from Q3 to Q4 and is 11.53 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS sent an SMS text message in December 2023, informing members of the importance of consistency with antidepressant medication. The SMS message was sent in both English and Spanish. BCBS continues to call members to remind them to fill and maintain consistency with their antidepressant prescriptions. To encourage medication adherence, members receive an incentive to refill their medications. • PHP continues member outreach efforts to provide members with education on medication adherence. Members who have comorbid conditions linked with high rates of depression, such as diabetes and cardiovascular disease were sent educational flyers about depression symptoms, treatment, and medication adherence. PHP also engaged providers with provider education opportunities such as an education conference, newsletters, Behavioral Health Townhall, and incentive programs. PHP initiated a call campaign to educate members on the value of antidepressant adherence in counties with low AMM rates. PHP has also included the AMM measure in the Provider Quality Incentive Program (PQIP) and Patient-Centered Medical Home (PCMH) incentive programs. • WSCC continues to partner with Outcomes™ to educate members on the importance of taking their prescribed medications, and effectively managing their medical and behavioral health needs. WSCC BH disease management registered nurses encourage members to adhere to their medication regimens and provide education during member outreach. WSCC offers telemedicine to reduce barriers to care via Teladoc Health. Transportation services through Secure Transportation are available and encouraged for members who are having difficulty getting to their appointments. WSCC provider interventions include Provider

	Quality Liaisons (PQLs) educating providers about behavioral health measures, such as providing member care gap lists and examining tools available to help practitioners overcome barriers. WSCC also leverages local, state, and federal expertise to offer no-cost training opportunities to behavioral health and integrated care practitioners. ***PM #7 (1 point) – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation*** The total percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment. **DY10 target is 47.54%**. • BCBS Q1 43.82%; Q2 45.25%; Q3 45.13%; Q4 45.72%: Increase of .59 percentage points from Q3 to Q4 and is 1.82 percentage points below the DY10 target. • PHP Q1 51.40%; Q2 51.81%; Q3 53.11%; Q4 54.49%: Increase of 1.38 percentage points from Q3 to Q4 and is 6.95 percentage points above the DY10 target. • WSCC Q1 44.62%: Q2 45.91%; Q3 46.98%; Q4 46.63%: Decrease of .35 percentage points from Q3 to Q4 and is .91 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 47.61%; Q2 Total 48.56%; Q3 Total 49.46%; Q4 Total 50.47%: Increase of 1.01 percentage points from Q3 to Q4 and is 2.93 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS continues to distribute an informational video on substance use to members through flyers with a QR code. Value-based contracting with providers and enhanced payment initiatives is ongoing. BCBS also offers providers continuing medical education units to attend training on synthetic opioids. The live training was recorded and is available virtually at providers convenience. BCBS staff utilizes the Emergency Department Information Exchange (EDIE) system to provide immediate support and connect members with proper follow-up treatment. • PHP continues to work to increase provider enrollment in value-based programming for completion of IET by 5% each

year through Behavioral Quality Incentive Program (BQIP) and Provider Quality Incentive Program (PQIP) programs. PHP continues to support state efforts to implement Screening, and Brief Interventions and Referral to Treatment programs (SBIRT) in rural hospitals and emergency departments. PHP continues to present providers with education on the IET HEDIS measure, the IET incentive, and the identified gaps of services through the Provider Education Conference and eblasts. PHP has identified geographic areas with the highest rates for lack of services to incentivize increased provider capacity.

- WSCC continues to conduct targeted outreach to members to increase access to and initiation of treatment after a new episode of substance abuse. WSCC is continuing its collaboration with NM Family Services (NMFS), to conduct an initial telehealth assessment with members who are experiencing substance use challenges. WSCC's 2023 Value Added Services include a sober living benefit and room and board at Heading Home's Respite Care Program facility with 24-hour care. WSCC also engages providers with Monthly and Quarterly Provider Engagement Meetings and provider training opportunities. WSCC continues to engage providers with monthly and quarterly meetings to close care gaps and enhance performance.

PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness (FUH): 30 Day

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

DY10 target is 53.80%.

- BCBS Q1 46.90%; Q2 53.33%; Q3 53.84%; Q4 53.66%: Decrease of .18 percentage points from Q3 to Q4 and is .14 percentage points below the DY10 target.
- PHP Q1 43.08%; Q2 48.10%; Q3 51.27%; Q4 52.29%: Increase of 1.02 percentage points from Q3 to Q4 and is 1.51 percentage points below the DY10 target.
- WSCC Q1 39.91%; Q2 52.65%; Q3 53.84%; Q4 55.97%: Increase of 2.13 percentage points from Q3 to Q4 and is

	2.17 percentage points above the DY10 target. • MCO Aggregate: Q1 Total 44.01%; Q2 Total 50.79%; Q3 Total 52.62%; Q4 Total 53.32%: Increase of .70 percentage points from Q3 to Q4 and is .48 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS distributed flyers to members with a QR code to provide access to a video on mental health. BCBS contracted 3 new facilities to participate in the BCBS facility incentive program to impact the FUH measure. The Outpatient Facility Incentive Program was advertised on the New Mexico Psychological Association website in December. BCBS continues the reserved appointment initiative providing members with one appointment for mental health therapy and one appointment for medication management needs. • PHP incentivizes the FUH metric as a part of its Behavioral Quality Incentive Program. PHP continues to prioritize an inpatient pilot program to conduct clinical behavioral health (BH) follow-up appointments post-discharge. The inpatient pilot targeted Behavioral Health members who were discharged to nursing facilities to provide clinical follow-up appointments at the nursing facility. PHP continues to offer incentives to BH providers that provide BH telehealth services in geographic areas with low access. PHP's BH network continues to recruit telepsychiatry groups into the network. PHP also assists inpatient facilities in conducting a clinical call post-discharge within seven days. PHP also pilots a discharge planning program to improve the coordination of care after members are discharged from an acute care facility. • WSCC's Behavioral Health Utilization Management (BH UM) and Behavioral Health Facility Liaison (BH Liaison) teams continue to provide transitional care coordination services for members admitted for an inpatient behavioral health hospital stay. The WSCC member connections team conducts outreach campaigns to contact high-risk members. Their efforts resulted in 387 member engagements during Q4. WSCC continues to collaborate with TeamBuilders

	Behavioral Health (TBBH) to conduct an initial telehealth assessment with members who have recently completed an inpatient behavioral health stay. WSCC also utilizes the Choose Tomorrow® Program to engage members who have been recognized as being at high risk of suicide. WSCC incentivizes discharge planning through its Telemedicine Discharge Program. WSCC also engages providers by offering no-cost training opportunities and behavioral health-related toolkits. ***PM #9 (1 point) – Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Day*** The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days of the ED visit. **DY10 target is 48.00%.** • BCBS Q1 43.26%; Q2 50.79%; Q3 55.46%; Q4 56.34%: Increase of .88 percentage points from Q3 to Q4 and is 8.34 percentage points above the DY10 target. • PHP Q1 36.95%; Q2 41.85%; Q3 49.56%; Q4 49.82%: Increase of .26 percentage points from Q3 to Q4 and is 1.82 percentage points above the DY10 target. • WSCC Q1 35.43%; Q2 45.13%; Q3 46.83%; Q4 46.11%: Decrease of .72 percentage points from Q3 to Q4 and is 1.89 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 39.35%; Q2 Total 45.45%; Q3 Total 51.24%; Q4 Total 51.54%: Increase of .30 percentage points from Q3 to Q4 and is 3.54 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS continues its efforts to increase follow-up visits by reserving appointments for members at provider offices. BCBS staff also conducts member outreach to assist with scheduling appointments. The BCBS Quality team continues to encourage providers to view an educational webinar on maternal mental health and the FUM measure. Providers are given continuing education credits for their participation. • During Q4, PHP continued provider training through a

	Provider Education Conference (PEC). PHP also continues to partner with the Value-Based Purchasing team to include the FUM metric for behavioral health outpatient providers in the Behavioral Quality Incentive Program (BQIP). The BH network team works to increase telehealth psychiatric providers to improve access to care. In another effort to increase access to behavioral health services, PHP is offering training in behavioral telehealth certification. PHP continues to educate providers on the FUM metric and encourages BH providers to partner with Emergency Departments (ED) to offer behavioral health follow-up appointments. Presbyterian Health Services provides onsite peer consult liaison services at the ED to support members in attending aftercare appointments. • WSCC continues to conduct targeted outreach to increase access to follow-up care with a primary care or behavioral health provider after a mental health-related ED visit. WSCC also partners with UNM Hospital's Community Health Worker (CHW) program to connect with WSCC members while they are in the ED. WSCC also offers members access to NeuroFlow, Pyx Health, and MyStrength apps to support members in managing and improving their overall health and mental well-being. To reduce barriers to care, WSCC's member-facing personnel continue to encourage telemedicine and educate members and encourage the use of Teladoc Health. WSCC also offers value-added services including electroconvulsive therapy, reimbursement for ceremonial or spiritual healing for Native American members and a holistic care grant up $250 per household. WSCC also offers no-cost training opportunities to providers. ***PM #10 (1 point) – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*** The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. **DY10 target is 82.78%**. • BCBS Q1 43.49%; Q2 61.44%; Q3 73.92%; Q4 79.87%:

	Increase of 5.95 percentage points from Q3 to Q4 and is 2.91 percentage points below the DY10 target. • PHP Q1 44.06%; Q2 64.32%; Q3 75.77%; Q4 82.74%: Increase of 6.97 percentage points from Q3 to Q4 and is .04 percentage points below the DY10 target. • WSCC Q1 35.31%; Q2 60.11%; Q3 72.67%; Q4 79.87%: Increase of 7.20 percentage points from Q3 to Q4 and is 2.91 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 42.56%; Q2 Total 62.61%; Q3 Total 74.67%; Q4 Total 81.37%: Increase of 6.70 percentage points from Q3 to Q4 and is 1.41 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS identified six provider partners and sent bulk testing kits for members in December. The BCBS Care Coordinators offer A1C test kits to members via telephone outreach. They also encourage members to have testing done at a lab. The pharmacy staff continues to send reminder letters to members. Members who qualify for this measure are also sent text messages to remind them of their need for a diabetes screening. • PHP continues member outreach efforts and provides point-of-service A1c test kits to prescribers. The abstraction of SSD records also assists with this measure. PHP continues to mail providers letters with members that were identified in geographic areas with a high volume of members on the gap in care list. The value-based purchasing team continues to recruit providers in the high-volume areas into the Behavioral Quality Incentive Program (BQIP) program. Providers are continuously educated on the SSD HEDIS measure and best practices in prescribing antipsychotics through training provided by the Medical Director. • WSCC member outreach efforts include its partnership with Harmony Cares to provide members with in-home A1c test kits. In 2023, 746 members completed their screening through the testing kits or via their provider. WSCC's Quality Improvement Nurses continue to conduct monthly member outreach by providing education about the importance of A1c screenings when taking antipsychotic medications to

members. Through collaboration with NM Community Cares (NMCC), paramedicine professionals have completed outreach to members in the Albuquerque Metro area, Roswell, and Las Cruces. Through this program, NMCC's staff conduct A1c screenings with members in their homes. Member engagement also includes an incentive of $30 -$50 gift cards for the completion of A1c screenings. WSCC provider engagement efforts include weekly and quarterly faxes, monthly and quarterly engagement meetings, and no cost training opportunities.

Tracking Measures (TMs)

HSD requires the MCOs to submit quarterly reports for the Tracking Measures listed in the MCO contract. HSD Quality Bureau reviews and analyzes the reports for completeness and accuracy and to gauge positive or negative outcomes and trends. The MCOs report interventions, strategies, and barriers that impact performance outcomes. HSD's review findings are communicated to the MCOs through scheduled MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meetings (QQMs). Numbers and rates reported are cumulative from quarter to quarter for all TMs except for TM #1, which is reported on a 12-month rolling period.

The following TMs show results for DY10 Q4 reporting:

TM #1 – Fall Risk Management

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

- BCBS Q1 0.01%; Q2 0.03%; Q3 0.01%; Q4 0.01%: No change in percentage point from Q3 to Q4.
- PHP Q1 1.51%; Q2 1.08%; Q3 1.17%; Q4 1.05%: Decrease of 0.12 percentage points from Q3 to Q4.
- WSCC Q1 0.11%; Q2 0.10%; Q3 0.10%; Q4 0.17%: Increase of 0.07 in percentage points from Q3 to Q4.
- MCO Aggregate: Q1 Total 0.37%; Q2 Total 0.28%; Q3 Total 0.30%; Q4 Total 0.29%: Decrease of 0.01 percentage point from Q3 to Q4.

	MCO Strategies and Interventions: • BCBS: Care coordinators conducted the comprehensive needs assessment (CNA) to assess members' home environment including fall risk. Care coordinators developed a comprehensive plan of care to address the risks identified, including caregiver support, environmental modifications, therapy needs, home health, and appropriate medical follow-up. • PHP: Monitored members for fall risk via the CNA. Implemented interventions on the plan of care to reduce identified fall risks, including medical follow-up or treatment such as physical therapy, home health care, long-term services and supports (LTSS), durable medical equipment, environmental modifications, and natural support systems. • WSCC: Provided members with recent hospitalization the opportunity to participate in the Transition of Care (TOC) program. The TOC coaches educate members on preventing falls, discuss falls with their providers, work with members to address health concerns, and identify risk factors that may increase the chance of rehospitalization. *TM #2 – Diabetes Short-Term Complications Admission Rate* Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees ages 18 and older. Reported as a rate per 100,000 member months. A lower rate indicates improvement for this measure. • BCBS Q1 20.78; Q2 22.02; Q3 23.95; Q4 23.83: Improvement in performance of 0.12 per 100,000 member months from Q3 to Q4. • PHP Q1 15.25; Q2 18.49; Q3 18.46; Q4 19.39: Decline in performance of 0.93 per 100,000 member months from Q3 to Q4. • WSCC Q1 13.21; Q2 12.62; Q3 10.81; Q4 15.09: Decline in performance of 4.28 per 100,000 member months from Q3 to Q4. • MCO Aggregate: Q1 Total 16.95; Q2 Total 19.05; Q3 Total 19.50; Q4 Total 20.44 Decline in performance of 0.94 per 100,00 member months from Q3 to Q4.

	MCO Strategies and Interventions: • BCBS: BCBS' Quality Improvement continued to in-reach to various departments with the goal of increasing awareness and opportunities to assist members to improve their diabetic wellness. Data concerning A1c testing completion, A1c testing results >8 and STCA event data were shared with both care coordination and pharmacy to help support their initiatives and goals toward improving member health along with positively increasing measurement year 2023 diabetes HEDIS rates. • PHP: Started monthly new hire training for Care Coordinators in DY10 Q4. This training focused on meeting HEDIS measures, improving A1c rates, and providing resources for diabetes care related to the Centennial Care 2.0 measures. • WSCC: The TOC staff assisted members post discharge with coordinating care with their providers to ensure health care needs are met to reduce rehospitalization; guided and educated members on managing health conditions including diabetes for diabetic members; and helped members identify opportunities to reduce risk of future diabetic complications and promote overall health improvement. *TM #3 – Screening for Clinical Depression* Percentage of Medicaid enrollees ages 18 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. An increase in percentage indicates improvement for this measure. • BCBS Q1 0.88%; Q2 1.19%; Q3 1.52%; Q4 1.76%: Increase of 0.24 percentage points from Q3 to Q4. • PHP Q1 1.08%; Q2 1.29%; Q3 1.74%; Q4 2.12%: Increase of 0.38 percentage points from Q3 to Q4. • WSCC Q1 0.93%; Q2 1.50%; Q3 1.61%; Q4 2.27%: Increase of 0.66 percentage points from Q3 to Q4. • MCO Aggregate: Q1 Total 1.00%; Q2 Total 1.28%; Q3 Total 1.66%; Q4 Total 2.03%: Increase of 0.37 percentage points from Q3 to Q4.

	MCO Strategies and Interventions: • BCBS: Added a quick response (QR) code to provider news articles, allowing providers easy access to an educational video about appropriate billing of depression screening to improve this measure. • PHP: Continued with the Performance Improvement Project (PIP) targeting primary care providers for education and incentivization for this measure. The PIP interventions focused on reducing stigma for members participating in screening for depression and educating providers on the value of screening for depression for members' health. • WSCC: Provider website allows healthcare providers to access a wide range of behavioral health-related provider toolkits that include the topics of anxiety, bipolar disorder, depression, health equality, integrated care, substance use disorders, and socioeconomic determinants of health. *TM #4 – Follow-up after Hospitalization for Mental Illness* The percent of 7-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days. An increase in rate indicates improvement for this measure. • BCBS Q1 35.78%; Q2 38.48%; Q3 38.53%; Q4 38.04%: Decrease of 0.49 percentage points from Q3 to Q4. • PHP Q1 32.31%; Q2 33.37%; Q3 35.09%; Q4 36.00%: Increase of 0.91 percentage points from Q3 to Q4. • WSCC Q1 30.08%; Q2 32.65%; Q3 36.27%; Q4 33.88%: Decrease of 2.39 percentage points from Q3 to Q4. • MCO Aggregate: Q1 Total 33.16%; Q2 Total 35.22%; Q3 Total 36.55%; Q4 Total 36.35%: Decrease of 0.20 percentage points from Q3 to Q4. **MCO Strategies and Interventions:** • In DY10 Q4, the Outpatient Facility Incentive program was advertised on the New Mexico Psychological Association website, incentivizing facilities to positively impact the Follow-up after Hospitalization (FUH) measure. • PHP: Held meetings in DY10 Q4 with facilities with low FUH

	rates to identify their unique barriers to improving their FUH rates. • WSCC: Following members' release from inpatient treatment for substance use disorders, WSCC's Certified Peer Support Workers (CPSW) assisted members in transitioning to outpatient care. The assistance included collaborating with facility discharge planners to assure prompt follow-up appointments are scheduled and offering peer support to help members transition between treatment settings. *TM #5 – Immunizations for Adolescents (IMA)* The percentage of adolescents 13 years of age who had 1 dose of meningococcal vaccine, 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. An increase in percentage indicates improvement for this measure. • BCBS Q1 74.58%; Q2 77.50%; Q3 82.43%; Q4 83.27%: Increase of 0.84 percentage points from Q3 to Q4. • PHP Q1 74.64%; Q2 76.87%; Q3 80.60%; Q4 82.94: Increase of 2.34 percentage points from Q3 to Q4. • WSCC Q1 71.39%; Q2 73.19%; Q3 59.14%; Q4 60.25%: Increase of 1.11 percentage points from Q3 to Q4. • MCO Aggregate: Q1 Total 74.28%; Q2 Total 76.69%; Q3 Total 78.88%; Q4 Total 80.60%: Increase of 1.72 percentage points from Q3 to Q4. **MCO Strategies and Interventions:** • BCBS: Sent text messages to 4,109 members' parents/guardians in December 2023 to encourage parents/guardians to schedule an appointment with their child's healthcare provider for well-care visits, including immunization for adolescents. • PHP: Mailed monthly Early Periodic Screening Diagnostic and Treatment (EPSDT) letters in DY10 Q4 to 2,113 members in this age group. • WSCC: The WSCC Quality team conducted outreach to parents/guardians of members who are due or overdue for immunizations and addressed concerns parent/guardians had about immunizations, explained the importance of immunizations and vaccines, and addressed existing barriers.

	TM #6 – Long-Acting Reversible Contraceptive (LARC) Utilization of Long-Acting Reversible Contraceptives. The contractor shall report LARC insertion/utilization data for this measure. • BCBS Q1 182; Q2 330; Q3 482; Q4 628. • PHP Q1 293; Q2 596; Q3 917; Q4 1,217. • WSCC Q1 37; Q2 90; Q3 163; Q4 215. • MCO Aggregate: Q1 Total 512; Q2 Total 1,016; Q3 Total 1,562; Q4 Total 2,060. *TM #7 – Smoking Cessation* The MCO shall report the number of successful quit attempts. The MCO shall monitor the use of smoking cessation products and counseling utilization. Total number of unduplicated members receiving smoking and tobacco cessation products/services. • BCBS Q1 1,080; Q2 1,963; Q3 2,681; Q4 3,390: Increase of 709 members from Q3 to Q4. • PHP Q1 1,364; Q2 3,043; Q3 4,136; Q4 5,273: Increase of 1,137 members from Q3 to Q4. • WSCC Q1 281; Q2 587; Q3 880; Q4 922: Increase of 42 members from Q3 to Q4. • MCO Aggregate: Q1 Total 2,725; Q2 Total 5,593; Q3 7,697 Total; Q4 Total 9,585: Increase of 1,888 members from Q3 to Q4. **MCO Strategies and Interventions:** • BCBS: Annual care coordination tobacco cessation education and training conducted by the Condition Management Coordinator included tobacco use screening and assessment, program referral process, covered treatments/services (counseling and pharmacotherapy), tobacco use, cessation resources, and member co-management. • PHP: PHP's Healthy Solutions coaches administered the Tobacco Cessation program in conjunction with other disease management programs, such as diabetes and chronic obstructive pulmonary disease (COPD), to members who use tobacco and have other risk factors. • WSCC: Members had the option to participate in the Tobacco Cessation Health Coaching program. This program provides

members with telephone coaching from certified tobacco cessation specialists that includes an individualized cessation plan, coping strategies, information on risk factors; and member education that adheres to evidence-based guidelines.

TM #8 – Ambulatory Care Outpatient Visits
Utilization of outpatient visits reported as a rate per 1,000 member months. An increase in rate indicates improvement for this measure.

- BCBS Q1 73.63; Q2 166.63; Q3 256.14; Q4 329.44: Increase of 73.30 per 1,000 member months from Q3 to Q4.
- PHP Q1 52.55; Q2 140.10; Q3 197.77; Q4 299.70: Increase of 101.93 per 1,000 member months from Q3 to Q4.
- WSCC Q1 68.51; Q2 137.41; Q3 164.28; Q4 272.94: Increase of 108.66 per 1,000 member months from Q3 to Q4.
- MCO Aggregate: Q1 Total 61.89; Q2 Total 149.16; Q3 Total 213.45; Q4 Total 306.20: Increase of 92.75 per 1,000 member months from Q3 to Q4.

MCO Strategies and Interventions:

- BCBS: BCBS partners with MDLIVE, which offers reliable 24/7 health care by phone or video to help provide additional access to services and increase utilization of telehealth services.

- PHP: The expansion of the Tyto Care at-home primary care provider (PCP) and urgent care through Presbyterian Medical Group (PMG) offers members and patients the option for at-home and remote visits to meet the expanding need for virtual care.

- WSCC: The TOC coaches outreach to members post-hospitalization to offer WSCC's TOC program. The TOC coaches assist members with addressing healthcare needs, barriers, management of conditions, and access to care to ensure members have needs addressed to prevent risk for rehospitalization.

TM #8 – Ambulatory Care Emergency Department Visits
Utilization of emergency department (ED) visits reported as a rate per 1,000 member months. A lower rate indicates improvement for

	this measure. • BCBS Q1 9.75; Q2 21.62; Q3 33.66; Q4 43.79: Decline in performance of 10.13 per 1,000 member months from Q3 to Q4. • PHP Q1 7.01; Q2 18.37; Q3 25.57; Q4 38.26: Decline in performance of 12.69 per 1,000 member months from Q3 to Q4. • WSCC Q1 10.96; Q2 21.21; Q3 24.65; Q4 42.90: Decline in performance of 18.25 per 1,000 member months from Q3 to Q4. • MCO Aggregate: Q1 Total 8.44; Q2 19.85 Total; Q3 Total 28.18; Q4 Total 40.69: Decline in performance of 12.51 per 1,000 member months from Q3 to Q4. **MCO Strategies and Interventions:** • BCBS: The ED Reduction program targets members who have visited the ED more than 6 times in the last 6 months by having community health workers contact these members to reduce ED visits. • PHP: The options for improved urgent care at home through PMG may decrease the need for escalated ED visits due to delayed care. • WSCC: Members have the option of utilizing telehealth services through Teledoc. Teledoc allows members access to phone or video telemedicine appointments, which can help with avoiding unnecessary ER visits. *TM #9 – Annual Dental Visit (ADV)* The percentage of enrolled members ages 2 to 20 years who had at least 1 dental visit during the measurement year. An increase in percentage indicates improvement for this measure. • BCBS Q1 19.77%; Q2 35.56%; Q3 46.83%; Q4 64.78%: Increase of 17.95 percentage points from Q3 to Q4. • PHP Q1 21.34%; Q2 44.59%; Q3 56.29%; Q4 62.54%: Increase of 6.25 percentage points from Q3 to Q4. • WSCC Q1 17.30%; Q2 35.65%; Q3 51.03%; Q4 57.66%: Increase of 6.63 percentage points from Q3 to Q4. • MCO Aggregate: Q1 Total 20.37%; Q2 Total 40.59%; Q3

Total 52.64%; Q4 Total 62.74%: Increase of 10.10 percentage points from Q3 to Q4.

MCO Strategies and Interventions:

- BCBS: Mailed a dental postcard in October 2023 to 7,573 Albuquerque members' parents/caregivers and adult members ages 18-20 to schedule a dental exam. This postcard also provided education to the members and parents/caregivers on the importance of fluoride treatments twice a year and completing x-ray exams to ensure comprehensive treatment.

- PHP: In DY10 Q4 there were 40,067 EPSDT letters mailed to members in this age group.

- WSCC: WSCC's Quality team conducts outreach to invite members to attend or schedule an appointment at various events where dental visits are being offered.

TM #10 – Controlling High Blood Pressure (CBP)

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

- BCBS Q1 15.92%; Q2 27.46%; Q3 32.71%; Q4 36.62%: Increase of 3.91 percentage points from Q3 to Q4.
- PHP Q1 25.39%; Q2 35.88%; Q3 41.28%; Q4 41.55%: Increase of 0.27 percentage points from Q3 to Q4.
- WSCC Q1 9.38%; Q2 18.85%; Q3 27.58%; Q4 31.78%: Increase of 4.20 percentage points from Q3 to Q4.
- MCO Aggregate: Q1 Total 19.82%; Q2 Total 30.66%; Q3 Total 36.55%; Q4 Total 38.60%: Increase of 2.05 percentage points from Q3 to Q4.

MCO Strategies and Interventions:

- BCBS: Mailed an offer from 4 provider groups in urban and rural areas of New Mexico to adult members ages 18 and older who are overweight or diagnosed with obesity and hypertension to opt in to receive a blood pressure monitor for in-home monitoring.

	• PHP: In DY10 Q4, 45 members with a gap in blood pressure screening were called as part of a continued call campaign focusing on controlling blood pressure. Of the 45 members who were called, 17 were successfully contacted to get screened. • WSCC: Members with hypertension had the opportunity to participate in WSCC's Cardiac Health Coaching program where members work with a registered nurse health coach to guide and instruct them in the management of cardiac conditions, including hypertension. The health coaches promote adherence to cardiac guidelines, provide members with medication education, encourage medication compliance, educate members about their hypertension diagnosis, and promote heart-healthy nutrition habits and weight management. *TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)* Initiation Phase: The percentage of members ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had 1 follow-up visit with a practitioner with prescribing authority within 30 days of when the first ADHD medication was dispensed. An increase in rate indicates improvement for this measure. • BCBS Q1 45.44%; Q2 46.15%; Q3 46.22%; Q4 46.41%: Increase of 0.19 percentage points from Q3 to Q4. • PHP Q1 28.70%; Q2 30.08%; Q3 30.32%; Q4 30.06%: Decrease of 0.26 percentage points from Q3 to Q4. • WSCC Q1 46.09%; Q2 50.22%; Q3 51.34%; Q4 52.02%: Increase of 0.68 percentage points from Q3 to Q4. • MCO Aggregate: Q1 Total 37.29%; Q2 Total 38.66%; Q3 Total 38.75%; Q4 Total 38.72%: Decrease of 0.03 percentage points from Q3 to Q4. **MCO Strategies and Interventions:** • BCBS: Provided access to a video on medication adherence to members via a QR code on the member newsletter in December 2023. • PHP: Member and provider education continued in DY10 Q4

	on this measure. • WSCC: Provided training opportunities and continuing education for behavioral health and integrated care practitioners, including a behavioral health webinar series, behavior management, BH screening tools overview, and the referral process for non-BH providers. *TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)* Continuation and Maintenance Phase: The percentage of members ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at least 2 follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure. • BCBS Q1 57.14%; Q2 60.67%; Q3 57.14%; Q4 58.66%: Increase of 1.52 percentage points from Q3 to Q4. • PHP Q1 36.04%; Q2 38.07%; Q3 39.65%; Q4 36.91%: Decrease of 2.74 percentage points from Q3 to Q4. • WSCC Q1 72.22%; Q2 66.67%; Q3 67.50%; Q4 66.67%: Decrease of 0.83 percentage points from Q3 to Q4. • MCO Aggregate: Q1 Total 45.54%; Q2 Total 48.47%; Q3 Total 47.26%; Q4 Total 45.07%: Decrease of 2.19 percentage points from Q3 to Q4. **MCO Strategies and Interventions:** • BCBS: Conducted an annual training for BCBS employees on HEDIS measures, including ADD. • PHP: Conducted an outreach campaign to members in DY10 to remind them to schedule follow-up visits related to ADHD medications. • WSCC: Encouraged the use of available transportation services through Secure Transportation for members who are having difficulty getting to their appointments. Members can also use Secure Transportation to travel to the pharmacy to pick up their prescription medications after being discharged from a behavioral health inpatient stay. There were 9,288

trips completed by WSCC members through Secure Transportation in DY10.

TM #12 – Child and Adolescent Well-Care Visits (WCV)

The percentage of members 3 to 21 years of age who had at least 1 comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. An increase in percentage indicates improvement for this measure.

- BCBS Q1 9.68%; Q2 21.11%; Q3 36.77%; Q4 45.77%: Increase of 9.00 percentage points from Q3 to Q4.
- PHP Q1 7.67%; Q2 19.21%; Q3 34.97%; Q4 43.38%: Increase of 8.41 percentage points from Q3 to Q4.
- WSCC Q1 8.18%; Q2 16.36%; Q3 32.68%; Q4 43.33%: Increase of 10.65 percentage points from Q3 to Q4.
- MCO Aggregate: Q1 Total 8.41%; Q2 Total 19.54%; Q3 Total 35.30%; Q4 Total 44.14%: Increase of 8.84 percentage points from Q3 to Q4.

MCO Strategies and Interventions:

- BCBS: E-mailed 4,852 parents of targeted members in October 2023 to encourage child and adolescent well-care visits and immunizations.

- PHP: In DY10 Q4 there were 38,192 automated EPSDT letters mailed to members in this age group.

- WSCC: When members complete well-child visits listed within the WCV measure, they are eligible for incentives from My Health Pays Rewards. In DY10, data shows members used My Health Pays Rewards towards rent/utilities and groceries at Walmart.

External Quality Review

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

	of continuous improvement. EQR Reviews and Validations in DY11 Q1 consisted of the below. DY9 EQR Reviews and Validations • Validation of Performance Improvement Projects, received by HSD from the EQRO. • Validation of Performance Measures, posted to the HSD website. • Validation of Network Adequacy, in review with HSD. • Compliance Review, received by HSD from the EQRO. • Annual Technical Report, received by HSD from the EQRO.

UTILIZATION

- Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for January 2023 – December 2023. Please see Attachment C: Key Utilization/cost per Unit Statistics by Major Population Group.
- The underlying utilization and unit cost data is based on paid claims with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent months of the January 2023 – December 2023 time period.

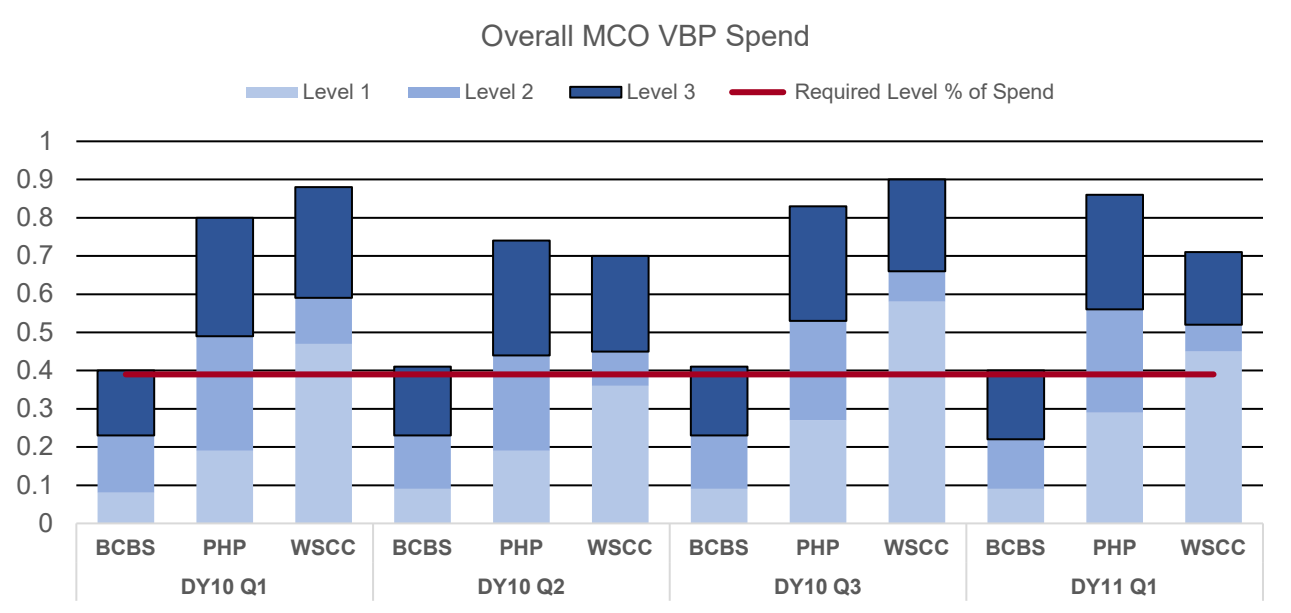
VALUE BASED PURCHASING

To support Centennial Care 2.0's value-based purchasing goals, HSD requires the MCOs to implement a Value Based Purchasing program that is based upon improved quality and/or member healthcare outcomes. To accomplish this, the MCO must meet minimum targets for 3 levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY11 requirements are as follows:

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

For DY11 Q1, BCBS, PHP, and WSCC exceeded the required VBP spend target of 39%.

Table 28: MCO VBP Spend



Source: MCO Calendar Year (CY) 2023 DY10Q2, DY10Q3, DY10Q4 Quarterly Financial Reports_ DY11Q1Annual Supplement (AS) VBP Financial Reports.

LOW ACUITY NON-EMERGENT CARE (LANE)

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

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

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

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

BCBS's ED Reduction Program targeted members who have visited the Emergency Department (ED) more than 6 times in the last 6 months. Community Health Workers contact members to ensure members are established with a Primary Care Provider (PCP) and provide education on the importance of being connected to an outpatient care provider or facility. Members who have visited the ED a minimum of 2 times in the past 60 days are sent links within a text to help with finding a PCP, location of the nearest Urgent Care Centers and the telephone number for the Nurse Advice Line.

Presbyterian members engaged in care coordination receive outreach after an ER visit to assess for needs, ensure appropriate follow up care, and to discuss alternative sites of care. Care Coordinators conduct ongoing education on ER use, alternatives to ER. PHP has a 24/7 nurse advice line that provides nurse triage and guidance concerning clinical questions or concerns. PHP encourages the use of the PRESNow facilities, which provide 24/7 access to urgent care, but also provide emergent care if necessary.

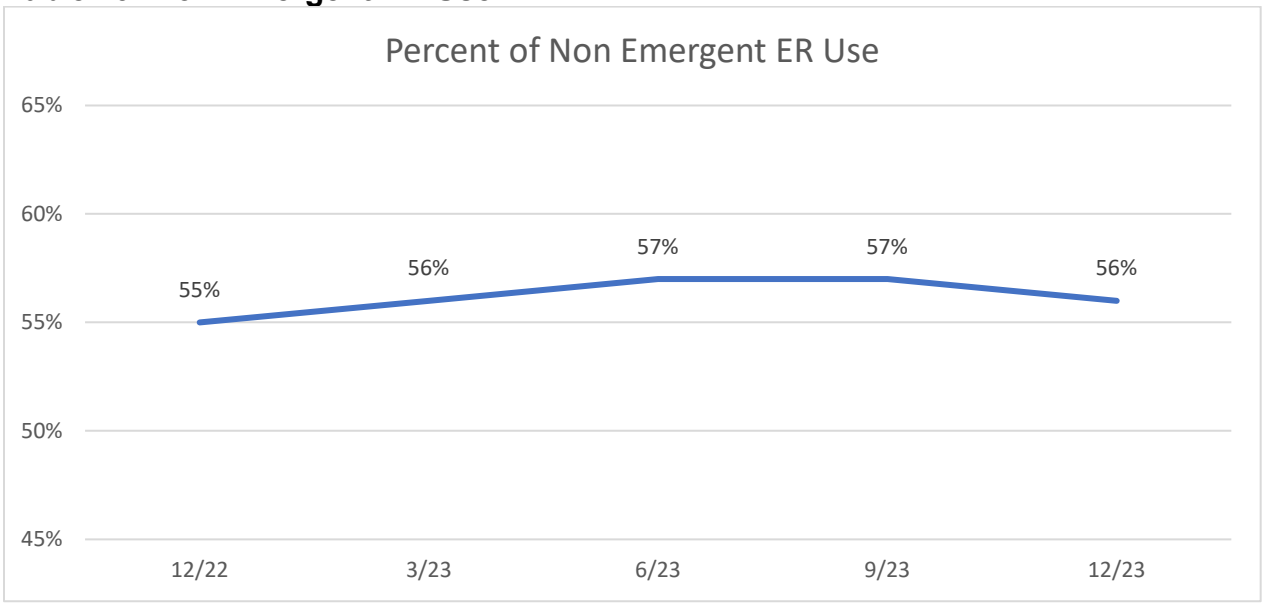
WSCC's continued strategies to reduce ER visits include utilizing mPulse Mobile to text members who discharged from the ED. It provides member information on how to find an urgent care, number for the Nurse Advice Line and information on Teladoc. WSCC offered a $30 dollar gift card for having a follow up visit within 14 days of an ED visit for Substance Abuse as well as Centennial Rewards for members that have a follow-up after being in the ED for Mental Health. WSCC utilizes Pyx Health to support members. As of Q4, 2023, 1,780 WSCC members have enrolled in the program and actively benefited from the variety

of offered support and services. WSCC's health outcomes with Pyx Health has shown a 49% reduction in loneliness based on UCLA-3 scores as well as a 43% reduction in Depression and Anxiety based on the PHQ-4 scores.

The percentage of emergency utilization that are considered low acuity increased from DY9 Q4 to DY10 Q4. In comparing low acuity ED visits from DY9 Q4 (55%) to DY10 Q4 (56%), the percentage of visits to the emergency department for non-emergent care increased by 1 percentage point. A lower rate indicates improvement for this measure. The trend for this measure indicates an increase in the number of low acuity ED visits.

The graph below reflects the percentage of members using the ER for non-emergent care between DY9 Q4 and DY10 Q4. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership. The data for DY11 Q1 will be reported in the DY11 Q2 CMS Quarterly Monitoring Report.

Table 29: Non-Emergent ER Use



Source: Mercer- Non-Emergent Emergency Room Utilization Report

14
MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in DY11 with the requirement that at least 90% of members having access to certain provider types in urban, rural, and frontier geographic areas within a defined distance. Geographical Access is collected and validated on a quarterly basis.

Physical Health and Hospitals

Due to technical reporting errors DY10 Q4 complete and validated data is not available at this time. New Mexico intends to report both DY10 Q4 - DY11 Q2 in the DY11 Q2 report.

Transportation

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

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

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

  HSD is enhancing its oversight of the MCOs' provision of NEMT to its members. The initial focus is on trips for Critical Care Appointments: dialysis, radiation, chemotherapy, dialysis, pre/post-surgery, urgent care, and high-risk pregnancy. To date, the MCOs have been directed to: 1) work with their transportation vendors to

ensure that all requested rides are provided for these appointments; 2) develop and submit for approval detailed operational plans for providing NEMT for Critical Care service appointments when the transportation vendors are unable to provide the service; and 3) submit a NEMT monthly report that provides data on NEMT trips. In DY11 Q1, 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 with 15 minutes of the scheduled time.

Customer Service Reporting

BCBS met all call center metrics for the reporting period, DY11 Q1.

PHP met all call center metrics for the reporting period, DY11 Q1.

WSCC did not meet call center metrics for Percent of Calls Answered within 30 Seconds. The volume of calls was down from January and approximately the same for February. WSCC missed the target of 85% by 0.6% and may see an increase in calls as its enrolled members are transitioned to the Turquoise Care MCOs. HSD is discussing with WSCC to ensure call center metrics are met throughout the transition period.

Telemedicine Delivery System Improvement Performance Target (DSIPT)

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

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

All three MCOs met the 5% of total membership with telemedicine visits for the Telemedicine Delivery System Improvement Performance Targets for DY10 Q4.

Table 30: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine	DY10 Q2	DY10 Q3	DY10 Q4	DY11 Q1
New Behavioral Health Members	**13,736**	**10,757**	**7,846**	**32,522**
BCBSNM	6,565	4,989	3,395	14,293
PHP	5,636	4,572	3,531	14,515
WSCC	1,535	1,196	920	3,714
New Physical Health Members	**21,660**	**14,883**	**12,377**	**22,738**
BCBSNM	5,894	4,419	3,793	6,309
PHP	13,605	9,202	7,346	14,368
WSCC	2,161	1,262	1,238	2,061
Total New Unduplicated Members	**30,725**	**21,562**	**16,800**	**52,405**
BCBSNM	10,891	7,930	5,940	19,633
PHP	16,615	11,522	9,027	27,244
WSCC	3,219	2,110	1,833	5,528
YTD* Unduplicated Members	**109,186**	**130,748**	**147,548**	**52,405**
BCBSNM	40,379	48,309	54,249	19,633
PHP	58,312	69,834	78,861	27,244
WSCC	10,495	12,605	14,438	5,528

Source: Telemedicine Delivery System Improvement Performance Target (DSIPT) data is refreshed quarterly* January – December 2024.

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	

DY11 Q1	The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) worked together in DY11 Q1 to perform evaluation work on New Mexico's Section 1115 Waiver Demonstration, Centennial Care 2.0.
	
	In DY11 Q1, HSAG and HSD performed the following accomplishments:
	• Submitted the revised Evaluation Design with the Centers for Medicare & Medicaid (CMS) feedback incorporated. Revisions to the Evaluation Design included adding components to evaluate the serious mental illness (SMI), high-fidelity wraparound (HFW), and home- and community-based services (HCBS) Amendment; refining the existing AIM 4 (Improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder [SUD]) and Centennial Rewards measures; and adding components to evaluate personal care services. CMS feedback included:
	  ○ Updating the demonstration approval and evaluation periods to accommodate Centennial Care 2.0's extension from December 31, 2023, to December 31, 2024.
	  ○ Addressing all goals mentioned in the 2018 SMI/SED State Medicaid Director Letter (SMDL).
	  ○ Including hypotheses and measures to evaluate all demonstration components.
	  ○ Reviewing the extent to which some of the proposed measures and hypotheses align with the broader goals of the Waiver and modifying the hypotheses/measure definitions to improve alignment.
	  ○ Providing more details about how the State will measure care coordination to evaluate AIM 5, Hypothesis 2, Research Question 1 and include any limitations of using the data source, Medicaid Management Information Statistics (MMIS), if relevant.
	  ○ Adding a cost analysis to AIM 5, similar to the cost analysis used to evaluate SUD in AIM 4.
	  ○ Adding the qualitative methods that will be used to collect and analyze qualitative data.
	  ○ Evaluating all primary drivers presented in the driver diagram related to AIM 5.
	  ○ Clarifying whether the estimated budget and timeline will cover evaluation activities planned beyond 2023.

	○ Addressing additional challenges in the Methodological Limitations about how the evaluation will address the limited post-implementation period to evaluate hypotheses related to the SMI/SED amendment. In DY11 Q1, HSAG performed an analysis for the COVID-19 PHE Vaccine Report and calculated expenditures related to COVID-19 vaccine administration related to the COVID-19 PHE Vaccine Amendment. This included developing an interview protocol for use in the qualitative interviews, conducting a qualitative interview with an HSD subject matter expert (SME) to gather information about the implementation of the COVID-19 Vaccine Amendment, and gathering expenditure data, HSD's methodology on calculating expenditures related to the COVID-19 PHE Vaccine Amendment, and relevant COVID-19 procedure codes. The report was submitted to CMS on February 29, 2024; HSAG and HSD are awaiting feedback from CMS as of the end of DY11 Q1. Currently, HSAG and HSD are continuing to collaboratively plan to develop a Summative Evaluation Report for Centennial Care 2.0 1115 Waiver Evaluation.

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ENCLOSURES/ATTACHMENTS

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

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STATE CONTACTS

HSD State Name and Title	Phone	Email Address
Dana Flannery Medicaid Director HSD/Medical Assistance	480-375-0567	Dana.Flannery@hsd.nm.gov
Heidi Capriotti Deputy Director of Communication and Innovation HSD/Medical Assistance	(505) 629-2938	Heidi.Capriotti@hsd.nm.gov
Elisa Walker-Moran Deputy Director of Finance HSD/Medical Assistance	505-470-9330	Elisa.Walker-Moran@hsd.nm.gov
TBD Deputy Director of Systems HSD/Medical Assistance	TBD	TBD
Michal Hayes Deputy Director of Contracts HSD/Medical Assistance	505-699-5859	Michal.Hayes@hsd.nm.gov
Alanna Dancis Chief Medical Officer HSD/Medical Assistance	505-470-9334	alanna.dancis@hsd.nm.gov

New Deputy Director Heidi Capriotti, who began on April 29, 2024, brings 20 years of experience in higher education, non-profit, and Medicaid communications leadership. She has successfully executed communications campaigns to increase stakeholder engagement, public visibility, and programmatic success. Heidi's expertise in visual storytelling allows her to create engaging media, branding, and messaging based on data. She is skilled in managing multiple projects, motivating teams, and promoting collaboration. During her tenure with Arizona's Medicaid agency, Heidi led media relations, developed strategic communications campaigns, managed public relations situations, and served in crisis management. Prior to that, she led marketing and communications teams in the Maricopa Community College system. Heidi is a graduate of Boston University and Southern New Hampshire University.

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ADDITIONAL COMMENTS

MCO INITIATIVES

BCBS:

Achievements

BCBSNM executed value-based contracts with two large OB/GYN groups. The value-based contracts are Maternity Episode of Care programs that include quality measures specific to maternity and total cost of care targets. If providers come under the total cost of care targets, BCBSNM shares a percentage of savings with providers, depending on their quality scores. The higher the quality scores, the higher the percentage of savings that is shared with the provider. The program incentivizes provider to manage the care of their maternity members to avoid unnecessary emergency room utilization and unnecessary inpatient utilization, which increases the total costs of the maternity episode of care.

As of the first quarter of DY11, BCBSNM Customer Service went live with a Provider Secured Message for Claims questions in Availity. This is a new real time tool for providers to contact customer service without having to dial into the customer service line and/or contact the provider representative for Network services. It will also enhance the provider experience and leverage coordination and engagement related to provider issues and questions.

PHP:

Achievements

Diabetes Prevention and Healthy Weight Programs

In Q1 2024, the Diabetes Prevention Program (DPP) and Healthy Weight (HW) Program enrolled 33 new participants; 4 for DPP and 29 for HW; committing to a 12-month structured curriculum and coaching schedule. Since implementation, PHP had 435 Centennial Care Members enrolled and a total of 193 participants with logged individual sessions related to physical activity, healthy food choices, eating patterns, and daily weight management. The 12-month programs are offered to eligible Members and are evidence-based programs with oversight by the Centers for Disease Control and Prevention.

NCQA Health Equity Accreditation

In Q1 2024, PHP continued its work in this area with the following enhancements:

- Creation of a formal implementation structure, including the development of 6 workstreams focused on each of the main areas of accreditation
    - Diversity, equity, and inclusion in the workforce
    - Health equity data systems and collection
    - Language services
    - Provider network adequacy
    - Health Disparities (including HEDIS, quality improvement, and Culturally and Linguistically Appropriate Services program development
    - Delegation
- Health Equity Steering Committee: PHP's Health Equity Steering Committee will include representatives from each of the workstreams and will focus in 2024 on alignment of NCQA health equity initiatives and gap mitigation.

NCQA Health Equity Accreditation

As part of the NCQA Health Equity Accreditation, PHP has received approval from PHS' Governance Committee to include diversity, equity, and inclusion as a priority in the PHS Board Charter. This includes the development of a Board Member Profile form which will be implemented in 2024 to track Board member demographics and identify areas where increased representation is needed. This is a significant achievement for PHP in its efforts to increase diversity at its highest level of leadership.

Value-Based Care Digital Tools

Presbyterian Health Plan Value-Based Programs (VBP) have developed a provider readiness assessment. Its provider readiness assessment tool is a digital tool in which provider groups can answer questions on a multitude of areas that are applicable to VBP. For example, digital integration, experience in value-based care, delegation care teams, etc. The Provider Readiness Assessment tool will allow PHP to not only see which level of VBP is appropriate for a provider but also identify areas for educational support. This allows PHP to implement provider input to expand its learning collaboratives. PHP's Provider readiness assessment tool is set to deploy in early Q2 2024.

WSCC:

Pyx Health Program

Pyx Health is a free program for WSCC members to address loneliness, social isolation and Social Determinants of Health (SDoH) needs. Through the combination of an engaging mobile app, as well as staff at the Compassionate Support Center, Pyx Health supports WSCC Members 24/7. The program went live for WSCC members in July 2022. As of Q4, 2023, 1,780 WSCC members have enrolled in the program and actively

benefited from the Phone App or the live support to access health plan resources, community services, address general health care questions, urgent support, caregiver support, mental health, and substance abuse support, LGBTQIA services, and pregnancy support. Out of the 1,780 WSCC Members benefiting from the program: 40% are Hispanic, 33% are White, 6% are American Indian or Alaska Native, 4% are Black, 1% are Native Hawaiian or Other Pacific Islander, 3% are Other Race, and 26% are Unknown. WSCC's health outcomes for members that utilize Pyx Health has shown a 49% reduction in loneliness based on UCLA-3 scores as well as a 43% reduction in Depression and Anxiety based on the PHQ-4 scores.

Doula Services

Starting in January 2023, WSCC offered in person doula services for members in Dona Ana, Bernalillo, San Juan, and Santa Fe counties. A doula is a trained non-medical companion that supports pregnant women. A doula provides comfort and emotional support, and answers questions about pregnancy, labor and after birth. Through the partnership with Health Connect One and the Doula Network, doulas are contracted to provider prenatal and postpartum services for WSCC members. The benefits include three visits while pregnant; in person labor support at the birth location; 2 visits after birth; text, email and phone support between visits; and 24/7 on-call support after 37 weeks until birth. Doula visits can be at the member's home, doctor's office, or public place. Services are covered by WSCC. For all eligible members. Doula services are also offered virtually through the 24/7 lactation consulting app, Pacify. Eleven members utilized doula services through Health Connect One/the Doula Network in DY10 Q4 2023 and 103 have used services in DY10. Ten members utilized doula services through Pacify in DY10 Q4 and 331 have used services in DY10.

NeuroFlow®

The NeuroFlow® platform is available to members through mobile app and internet. This HIPAA-compliant interactive platform provides individualized, preventative resources to support members in managing and improving their overall health and mental wellbeing. A Members can engage with customized journeys intended to reduce depression and anxiety, which helps to decrease suicidal thoughts. As of November 2023, 273 members have registered with the platform, with 88% continued engagement. Member screenings show a 31% reduction in depression and a 31% reduction in anxiety symptoms for members utilizing the platform.

MEMBER SUCCESS STORIES

BCBS:

Member is a 41-year-old female with a diagnosis of Cerebral Palsy and is dependent on a wheelchair. Member's mother died during childbirth. Member was shunted due to hydrocephaly. Recently, the member called her Care Coordinator (CC), feeling despondent because of her recurring severe headaches. Member was unsure of what to do and asked her CC for help. Member repeatedly stated she needed her "shunt doctor".

CC actively listened to the member's concerns, and recommended she call her Primary Care Provider (PCP) to schedule an appointment as soon as possible. CC gave the provider's telephone number to the member and encouraged her to call.

CC followed up with the member to ensure the appointment had been made. Member scheduled and attended a virtual appointment with her PCP. The PCP appointment resulted in a neurology referral and a CT scan. It was determined that the member had a large tumor, for which surgery was performed, and radiation may be required.

At last contact, member reported to CC she is doing well with the support of her CC and family. CC will continue to meet with member for continued care coordination.

PHP

A 40-year-old PHP member, who lives in Dona Ana County, received a direct referral from care coordination for CHW Services. The member has a learning disability and limited natural supports, needs behavioral health supports, and has significant trauma. She experienced a significant loss (her boyfriend) because of gun violence in July 2022. Member had some knowledge of available resources, but it was limited. Member displayed an extremely low trust of providers. CHW determined that member needed clothing assistance, food pantry resources and a microwave donation. Member was skeptical about receiving help; however, CHW was able to provide her with a positive and trusting experience. CHW was able to get member a food box, along with a list of food pantries, clothes from the La Vida Project Closet in Las Cruces, and a microwave donation within a business day of her identifying that need. Member expressed her gratitude and said she was not used to someone caring enough about her situation to help her so quickly. CHW was able to assist her in resuming her caregiver services by collaborating with her assigned PHP Care Coordinator and the PCS agency. CHW shared that "having connections in the community helps us to meet Member needs a lot faster than our members expect, so it felt really great to see my member smile and have a happy experience with our work."

WSCC:

A member with Western Sky Community Care (WSCC), called to express gratitude for the assistance she received from a Member Services Rep (MSR). The member and her family were homeless when they moved to New Mexico. The member enrolled with WSCC and needed services. MSR referred the member to WSCC's care coordination team. She was contacted by WSCC's Housing Management Specialist (HMS) and was able to find a place to live and receive clothing and food. The MSR also assisted the member and her family in finding a provider. The member is grateful for WSCC and the personal service she received.

BCBS:

PHE Unwinding Outreach Actions, March 2024

Member Calls

Direct member (non-prerecorded) outbound calls: March 2024	BCBS
Members scheduled for direct calls	3195
Number of calls made	5565
Answered	3463
No answer	934
Voicemail	1168
Hung up	20
Contact completed (member reached; information conveyed)	937
Average call duration	0:00:54
Member inbound calls related to recertification	564

Outreach Completed

Outreach Efforts Completed: March 2024	BCBS
Members targeted	3857
Special COEs/Groups targeted	N/A
Member letters/direct mail	3067
Email 1	N/A
Email 2	N/A
Postcards	790
Text message 1	N/A
Text message 2	N/A
Text message 3	N/A
Text message 4	N/A
Robocalls	N/A
Efforts targeting the closed population	
Communications (emails and letters) have been sent to the Closed population received via the February 2024 Termination file from HSD, urging members to not go uninsured but explore alternative Blue Cross and Blue Shield of New Mexico plan options at BeWellNM.com.	
Notes	
N/A	

-**PHP**:

PHE Unwinding Outreach Actions, March 2024

Member Calls

Direct member (non-prerecorded) outbound calls: March 2024	PHP
Members scheduled for direct calls	1481
Number of calls made	1481
Answered	250
No answer	788
Voicemail	423
Hung up	20
Contact completed (member reached; information conveyed)	234
Average call duration	3m 4s
Member inbound calls related to recertification	1270

Outreach Completed

Outreach Efforts Completed: March 2024	PHP
Members targeted	4840
Special COEs/Groups targeted	N/A
Member letters/direct mail	4768
Email 1	457
Email 2	N/A
Postcards	755
Text message 1	5
Text message 2	N/A
Text message 3	N/A
Text message 4	N/A
Robocalls	N/A
Efforts targeting the closed population	

Notes

- Postcards to members in the 5-county area.
- 4768 letters were sent to members on 3/7. Emails were sent to all members for which we had a valid email address on 3/19 (457 total) that mirrored the information relayed in the letter. Texts were sent out to 4840 members on 3/26. Discrepancies between the number of texts sent and the amount of letters is due to householding the mailing and some invalid mailing addresses.
- PHP care coordination completed outreach out to 421 members
- PHP Medicaid Outreach and Retention conducted and attended fifteen outreach events with 1 Recertifications/Renewals for the month of March 2024.

WSCC
PHE Unwinding Outreach Actions, March 2024
Member calls

Direct member (non-prerecorded) outbound calls March 2024	Western Sky
Members scheduled for direct calls	1061
Number of calls made	953
Answered	287
No answer	43
Voicemail	437
Hung up	105
Contact completed (member reached, information conveyed)	167
Average call duration	1.91
Member inbound calls related to recertification	69

Notes

Wrong Number: 56
Inbound Calls Activity:
Average Call Duration: 13.3 minutes
Voicemails: 0 inbound voicemails

In this month's telephonic outreach, Western Sky representatives assisting individuals with Medicaid renewal questions noticed an increase in expressed concerns about long hold times and calls dropped when reaching out to Member Services. Some PE Determiners are also still experiencing issues in being able to assist members when calling HSD or utilizing the chat. PEDs are being advised that if they're not on the case they may not be provided case status information.

Outreach Completed

Outreach Efforts Completed March 2024	Western Sky
Members targeted	1128
Special COEs/Groups targeted	31, 300, 301, High Risk Care Coord. (CCL2, CCL 3, CCL4 & CCL5), 400, 401, 403
Member letters/direct mail	1128
Email 1	238
Email 2	226
Postcards	0
Text message 1	717
Text message 2	715
Text message 3	712
Text message 4	712
Robocalls	1585

Efforts targeting the closed population

For the Closed population, Western Sky targeted individuals that have not completed their renewal application or did not return requested info. In addition, we targeted individuals whose income exceeds the guidelines and referred to Marketplace. We continue our text, email and robo campaign to all termed membership. All termed membership is also invited to participate at local events and renewal events - such as the Western Sky Resource Night. Specific telephonic outreach campaign has been completed to members that did not submit required documentation or are not eligible for Medicaid, based on income, and are being referred to BeWellNM for enrollment or our Ambetter Broker Line.

Notes

N/A

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

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

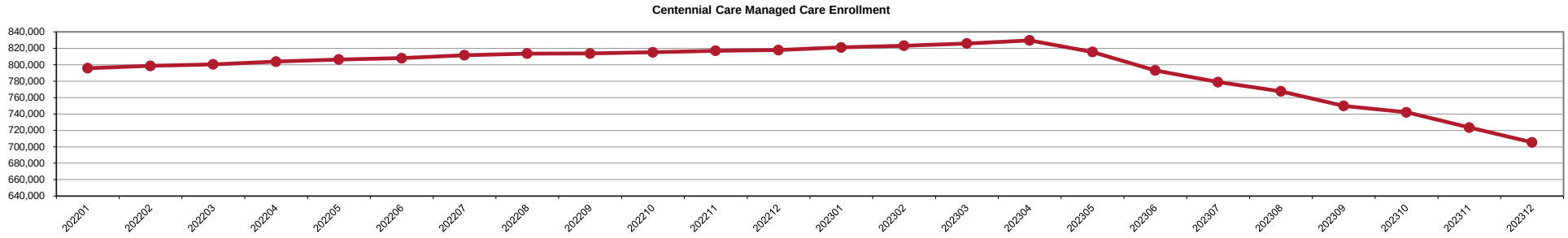
Program Changes Effective on or after 1/1/2023	
Expanded Mobile Crisis Initiatives	The Expanded Mobile Crisis Initiatives adjustment effective January 1, 2023 reflects the cost of implementing mobile crisis services in support of state initiatives related to 988.
EBP Rate Enhancements	The EBP Rate Enhancements effective January 1, 2023 reflect the cost of implementing enhanced behavioral health services and evidence-based practices (EBPs) available to all populations, including children in state custody.
Orthodontia Authorization Change	The Orthodontia Authorization Change adjustment effective January 1, 2023 reflects the increased orthodontia service utilization estimated due to changes in the clinical evaluation threshold requirements a member must meet in order to obtain approval for orthodontia services.
Silver Diamine Fluoride	The Silver Diamine Fluoride adjustment effective January 1, 2023 reflects the new benefit coverage of silver diamine fluoride billed as D1354 and D1355 provided to the Medicaid population.
Prenatal Genetic Screenings	The Genetic Screenings adjustment effective January 1, 2023 reflects the new benefit coverage of pre-natal genetic screenings for cystic fibrosis (CF), spinal muscular atrophy (SMA), and cell-free DNA for trisomy for pregnant members of the Medicaid population.
RTC Facility Closure	The RTC Facility Closure adjustment reflects the impacts of members transitioning from receiving behavioral health services at Bernalillo Academy residential treatment center to other providers, following the closure of the facility in December 2021.
NF Ventilator Services	The NF Ventilator Services adjustment was added effective January 1, 2023 reflects the opening of the in-state ventilator wing at the Rehabilitation Center of Albuquerque, at which reimbursement for Medicaid-eligible ventilator-dependent NF residents will include an additional $305.66 per day on top of the NF daily rate. The state plan amendment was approved by CMS in June 2022.

Program Changes Effective on or after 7/1/2023	
Long-Acting Reversible Contraception (1/1/2020)	The Long-Acting Reversible Contraception (LARC) fee schedule increase effective January 1, 2020 reflects the following additional rate increases: 100.9% to procedure code 11981, 100.0% to procedure codes 11982, 11983 and 58301 and 152.0% to procedure code 58300.
Photo Screening	The Photo Screening adjustment effective January 1, 2020 reflects a rate increase of 250% to procedure code 99177 and a rate decrease of 12% to procedure code 99173.
Justice-Involved Transportation to Pharmacies	The Justice-Involved Transportation to Pharmacies adjustment reflects the added benefit for members released from incarceration to be transported to and from a pharmacy within seven days post-discharge to retrieve appropriate medication.
Adult Accredited Residential Treatment Center (ARTC)	Beginning in January 1, 2020, the Adult ARTC adjustment reflects the added benefit for adults to receive SUD services at adult ARTCs. This adjustment was revised effective January 1, 2023 to reflect updated provider information and emerging utilization experience.
Trauma Hospital Rate Increase	Beginning in January 1, 2021, the Trauma Hospital Rate Increase reflects the following rate increases to reimbursement levels for inpatient and outpatient trauma services for in-state trauma hospitals and developing trauma hospitals: Level I Hospitals: 0.9%; Level II Hospitals: No Adjustment; Level III Hospitals: 13.3%; Level IV Hospitals: 37.0%. This adjustment was revised effective January 1, 2022 to reflect Sandoval Regional Medical Center classified as a Level III Trauma Center and Cibola General removed as a Level IV Trauma Center.
Pharmacists With Prescriptive Authority	Effective July 1, 2020, Pharmacists With Prescriptive Authority are allowed to bill naloxone and other additional services to procedure code 99213 at a rate of $65.66. The adjustment accounts for the increased rates from the incentive fees paid prior to July 1, 2020 to procedure code 99213.
Opioid Treatment Program (OTP) Adjustment	The OTP Adjustment reflects the removal of projected OTP expenses for Dual-eligible members effective October 1, 2020, as Medicare will become the primary payer for these services.
Rural Health Clinic (RHC) Prospective Payment System (PPS) Rate Rebase	The RHC PPS Rate Rebase reflects increasing the PPS rate for RHC to $169.77 for all RHC medical services effective October 1, 2020.
Addition of New Home Visiting Providers	The Addition of New Home Visiting Providers adjustment reflects two new providers offering Nurse Family Partnership and Parents as Teachers programs effective October 1, 2021 and five new providers will offer Parents as Teachers programs with effective dates between August 2022 and January 2023 under the Centennial Home Visiting program.
Air Ambulance Rate Increase	The air ambulance fee-for-service (FFS) fee schedule increase effective November 15, 2020 reflects the following additional rate increases: 28.56% to procedure code A0430, 35.51% to procedure codes A0431, and 68.13% to procedure code A0436.
Crisis Triage Center (CTC) Adjustment	Beginning in January 1, 2021, the CTC adjustment reflects the inclusion of CTC providers providing adult outpatient services. This adjustment was revised effective January 1, 2023 to reflect updated provider information and emerging utilization experience that illustrates slower ramp up than initial expectations.
Pasteurized Human Donor Milk	The PHDM adjustment effective January 1, 2023 reflects implementation of reimbursement changes to increase access and reimbursement for PHDM in inpatient and outpatient settings for high-risk Medicaid eligible infants up to 12 months old, effective for dates of service from July 1, 2022.
Community Health Worker Benefit	The Community Health Worker (CHW) Benefit adjustment effective July 1, 2023 reflects the new benefit and reimbursement structure for community health workers.
House Bill 2 Provider Reimbursement Increases	The House Bill 2 Provider Reimbursement Increases effective July 1, 2023 reflects the cost of implementing provider reimbursement rate increases for professional and institutional services pursuant to the passage of House Bill 2 in the 2023 New Mexico Legislative Session.
Revised BH Adjustments Effective Prior to July 1, 2023	The following rating adjustments were revised to reflect updated projected enrollment for July 2023-December 2023, but the total CY2023 projected cost assumption was unchanged: Adult Accredited Residential Treatment Center, Crisis Triage Center Adjustment, EBP Rate Enhancements, and Expanded Mobile Crisis Initiatives.

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

Reported Eligibility for Members Enrolled as of: December 31, 2023
Previous Period: January 1, 2022 to December 31, 2022
Current Period: January 1, 2023 to December 31, 2023

1. Total Centennial Care Monthly Enrollment



2. Total Centennial Care Dollars and Member Months by Program

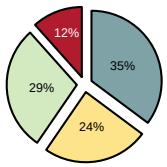
Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	5,860,116	5,572,071	-5%
Long Term Services and Supports	625,804	624,547	0%
Other Adult Group	3,216,368	3,179,137	-1%
Total Member Months	**9,702,288**	**9,375,755**	**-3%**

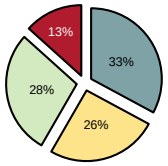
	Aggregate Medical Costs by Program			*Per Capita Medical Costs by Program (PMPM)*		
Programs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,820,385,173	$ 1,696,307,129	-7%	$ 310.64	$ 304.43	-2%
Long Term Services and Supports	$ 1,261,909,817	$ 1,314,481,122	4%	$ 2,016.46	$ 2,104.70	4%
Other Adult Group Physical Health	$ 1,491,757,349	$ 1,462,380,119	-2%	$ 463.80	$ 459.99	-1%
Behavioral Health - All Members	$ 600,574,124	$ 688,313,698	15%	$ 61.90	$ 73.41	19%
Total Medical Costs	**$ 5,174,626,463**	**$ 5,161,482,068**	**0%**	**$ 533.34**	**$ 550.51**	**3%**
Aggregate Non-Medical Costs						
Admin, care coordination, Centennial Rewards	$ 439,377,373	$ 430,366,282	-2%	$ 45.29	$ 45.90	1%
NMMIP Assessment	$ 100,325,349	$ 131,156,566	31%	$ 10.34	$ 13.99	35%
Premium Tax - Net of NIMMP Offset	$ 374,711,584	$ 359,766,868	-4%	$ 38.62	$ 38.37	-1%
Total Non-Medical Costs	**$ 914,414,306**	**$ 921,289,716**	**1%**	**$ 94.25**	**$ 98.26**	**4%**
Estimated Total Centennial Care Costs	**$ 6,089,040,769**	**$ 6,082,771,783**	**0%**	**$ 627.59**	**$ 648.78**	**3%**

Centennial Care Medical Expenditures

Previous (Q1CY2022 - Q4CY2022)



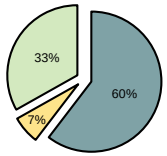
Current (Q1CY2023 - Q4CY2023)



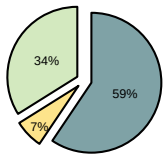
*See above for legend.

Centennial Care Member Months

Previous (Q1CY2022 - Q4CY2022)



Current (Q1CY2023 - Q4CY2023)



*See above for legend.

3. Total Program Medical/Pharmacy Dollars

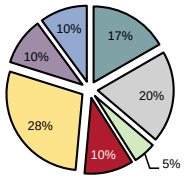
	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 4,653,102,674	$ 4,616,174,106	-1%	$ 479.59	$ 492.35	3%
Pharmacy	$ 521,523,789	$ 545,307,962	5%	$ 53.75	$ 58.16	8%
Total	**$ 5,174,626,463**	**$ 5,161,482,068**	**0%**	**$ 533.34**	**$ 550.51**	**3%**

	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
Service Categories	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 863,149,309	$ 766,001,135	-11%	$ 88.96	$ 81.70	-8%
Acute Outp/Phy	$ 1,010,360,673	$ 1,078,941,568	7%	$ 104.14	$ 115.08	11%
Nursing Facility	$ 249,042,316	$ 266,045,966	7%	$ 25.67	$ 28.38	11%
Community Benefit/PCO	$ 539,326,701	$ 573,792,421	6%	$ 55.59	$ 61.20	10%
Other Services	$ 1,469,090,982	$ 1,317,608,835	-10%	$ 151.42	$ 140.53	-7%
Behavioral Health	$ 522,132,692	$ 613,784,180	18%	$ 53.82	$ 65.47	22%
Pharmacy (All)	$ 521,523,789	$ 545,307,962	5%	$ 53.75	$ 58.16	8%
Total Costs	**$ 5,174,626,463**	**$ 5,161,482,068**	**0%**	**$ 533.34**	**$ 550.51**	**3%**

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

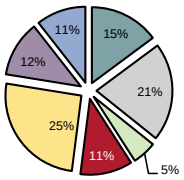
Previous (12 mon) service distribution

Service Categories % of Total



Current (12 mon) service distribution

Service Categories % of Total



4. Notes

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State of New Mexico - All MCOs

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

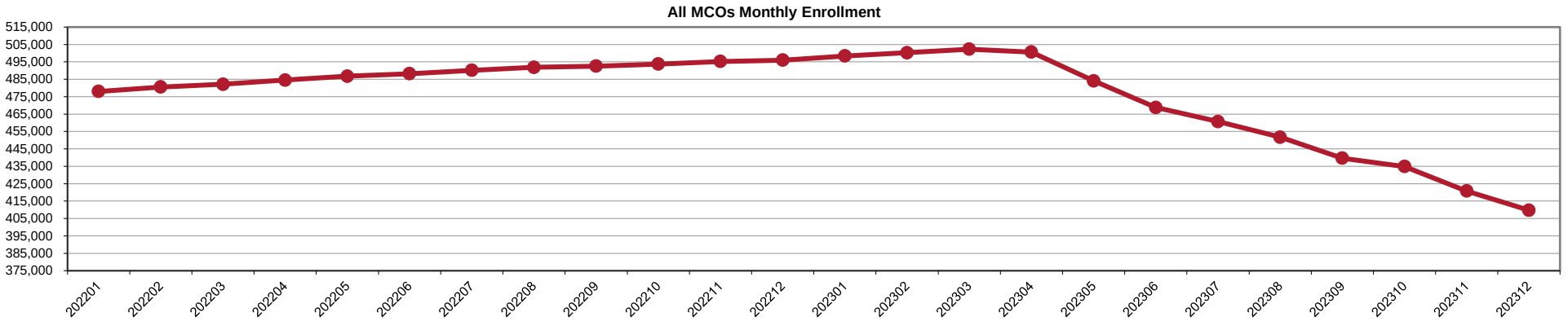
Physical Health Utilization and Cost Review

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

Previous Period: January 1, 2022 to December 31, 2022

Current Period: January 1, 2023 to December 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

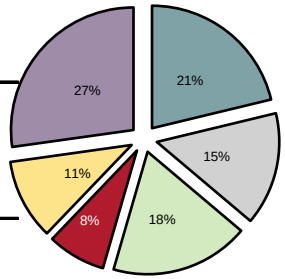
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,646,364,340	$ 1,516,207,692	-8%
Pharmacy	$ 174,020,833	$ 180,099,436	3%
Total	**$ 1,820,385,173**	**$ 1,696,307,129**	**-7%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 427,180,071	$ 360,175,555	-16%
Outpatient (OP)	$ 244,567,565	$ 253,194,010	4%
Physician (PH)	$ 288,126,874	$ 310,763,330	8%
Emergency Department (ED)	$ 140,008,949	$ 130,408,501	-7%
Pharmacy (RX)	$ 174,020,833	$ 180,099,436	3%
Other (OTH)	$ 546,480,880	$ 461,666,296	-16%
Total Population Costs	**$ 1,820,385,173**	**$ 1,696,307,129**	**-7%**
Per Capita Cost (PMPM)	**$ 310.64**	**$ 304.43**	**-2%**
Total Member Months	**5,860,116**	**5,572,071**	**-5%**

Service Categories % of Cost



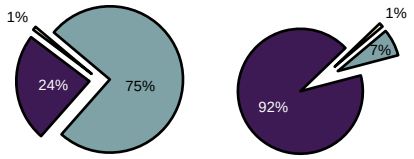
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

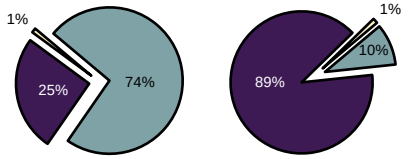
	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 127,951,481	$ 135,776,913	6%
Generic	$ 44,298,683	$ 42,857,937	-3%
Other Rx	$ 1,770,668	$ 1,464,586	-17%
Total	**$ 174,020,833**	**$ 180,099,436**	**3%**

% of Rx Spend **% of Scripts**

Current



Previous



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

4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
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State of New Mexico - All MCOs

Total Population

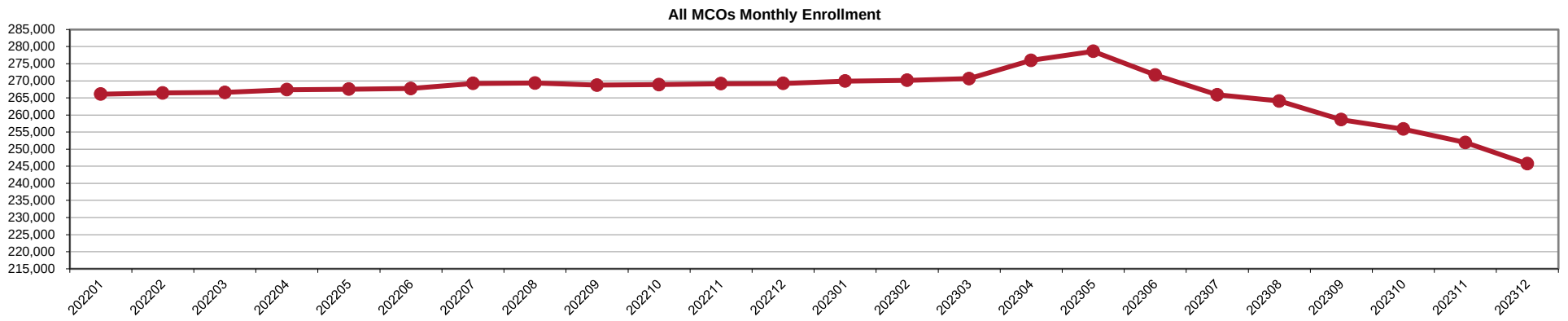
Other Adult Group Utilization and Cost Review

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

Previous Period: January 1, 2022 to December 31, 2022

Current Period: January 1, 2023 to December 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

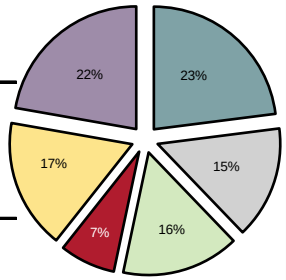
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,257,479,226	$ 1,212,166,798	-4%
Pharmacy	$ 234,278,123	$ 250,213,321	7%
Total	**$ 1,491,757,349**	**$ 1,462,380,119**	**-2%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 358,212,615	$ 336,133,418	-6%
Outpatient (OP)	$ 211,981,481	$ 216,938,839	2%
Physician (PH)	$ 194,611,199	$ 226,763,955	17%
Emergency Department (ED)	$ 108,311,903	$ 107,199,443	-1%
Pharmacy (RX)	$ 234,278,123	$ 250,213,321	7%
Other (OTH)	$ 384,362,027	$ 325,131,143	-15%
Total Population Costs	**$ 1,491,757,349**	**$ 1,462,380,119**	**-2%**
Per Capita Cost (PMPM)	**$ 463.80**	**$ 459.99**	**-1%**
Total Member Months	**3,216,368**	**3,179,137**	**-1%**

Service Categories % of Cost



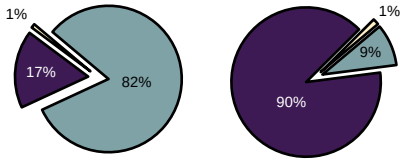
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

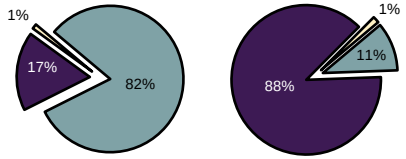
	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 190,901,745	$ 205,143,893	7%
Generic	$ 40,788,029	$ 42,805,424	5%
Other Rx	$ 2,588,349	$ 2,264,003	-13%
Total	**$ 234,278,123**	**$ 250,213,321**	**7%**

% of Rx Spend **% of Scripts**

Current



Previous



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

4. Notes

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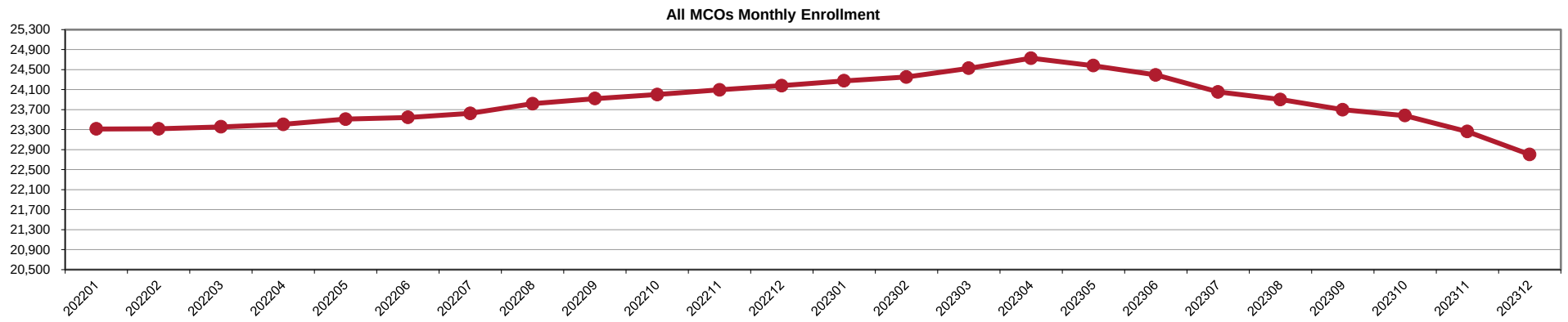
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

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

Reported Eligibility for Members Enrolled as of: December 31, 2023
Previous Period: January 1, 2022 to December 31, 2022
Current Period: January 1, 2023 to December 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

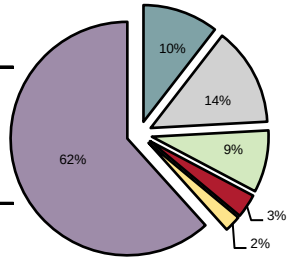
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 65,662,357	$ 67,825,690	3%
Pharmacy	$ 913,257	$ 1,585,780	74%
Total	**$ 66,575,614**	**$ 69,411,470**	**4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 9,965,733	$ 7,274,725	-27%
Outpatient (OP)	$ 10,802,764	$ 9,478,816	-12%
Physician (PH)	$ 5,930,682	$ 5,971,612	1%
Emergency Department (ED)	$ 2,577,261	$ 2,292,812	-11%
Pharmacy (RX)	$ 913,257	$ 1,585,780	74%
Other (OTH)	$ 36,385,917	$ 42,807,725	18%
Total Population Costs	**$ 66,575,614**	**$ 69,411,470**	**4%**
Per Capita Cost (PMPM)	**$ 234.35**	**$ 240.88**	**3%**
Total Member Months	**284,083**	**288,156**	**1%**

Service Categories % of Cost

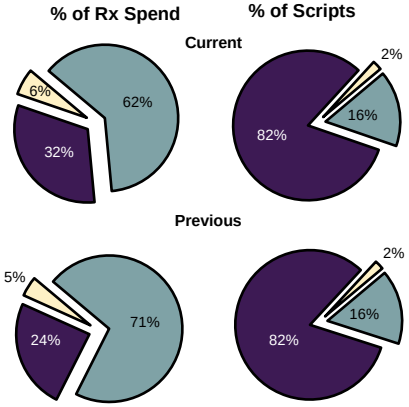


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 651,360	$ 989,484	52%
Generic	$ 221,827	$ 503,498	127%
Other Rx	$ 40,070	$ 92,798	132%
Total	**$ 913,257**	**$ 1,585,780**	**74%**

% of Rx Spend **% of Scripts**



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

4. Notes

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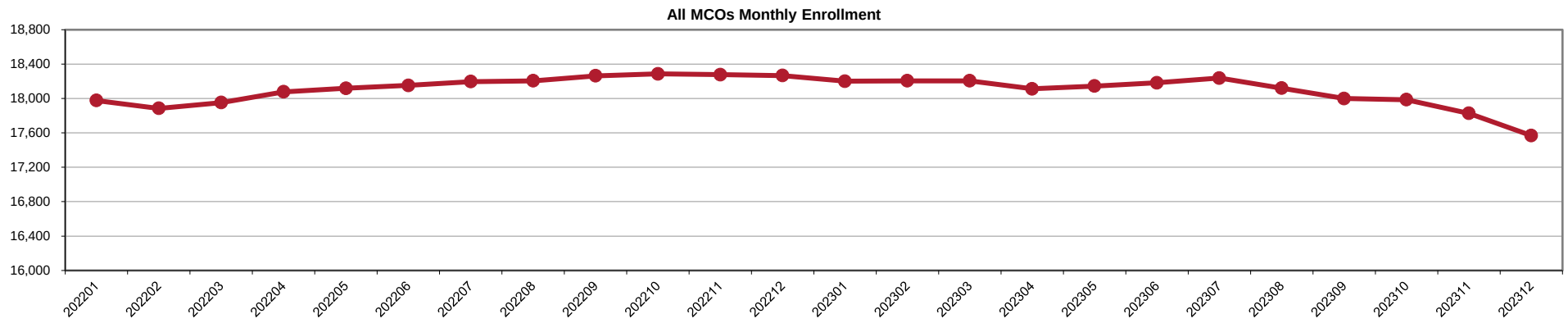
State of New Mexico - All MCOs
LTSS - Nursing Facility Level of Care Dual Population
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: December 31, 2023
Previous Period: January 1, 2022 to December 31, 2022
Current Period: January 1, 2023 to December 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

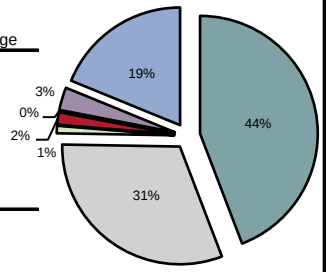
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 710,877,728	$ 743,229,873	5%
Pharmacy	$ 235,004	$ 337,940	44%
Total	**$ 711,112,732**	**$ 743,567,813**	**5%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 299,804,828	$ 328,553,338	10%
Nursing Facility (NF)	$ 218,571,041	$ 231,148,601	6%
Inpatient (IP)	$ 12,453,952	$ 7,595,279	-39%
Outpatient (OP)	$ 14,120,727	$ 12,659,543	-10%
Pharmacy (RX)	$ 235,004	$ 337,940	44%
HCBS	$ 24,919,572	$ 23,271,846	-7%
Other (OTH)	$ 141,007,608	$ 140,001,265	-1%
Total Population Costs	**$ 711,112,732**	**$ 743,567,813**	**5%**
Per Capita Cost (PMPM)	**$ 3,267.08**	**$ 3,429.87**	**5%**
Total Member Months	**217,660**	**216,792**	**0%**

Service Categories % of Cost

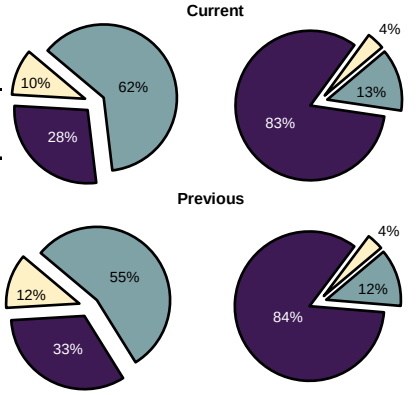


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 129,321	$ 209,536	62%
Generic	$ 77,386	$ 93,915	21%
Other Rx	$ 28,297	$ 34,489	22%
Total	**$ 235,004**	**$ 337,940**	**44%**

% of Rx Spend **% of Scripts**



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State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Medicaid Only Population

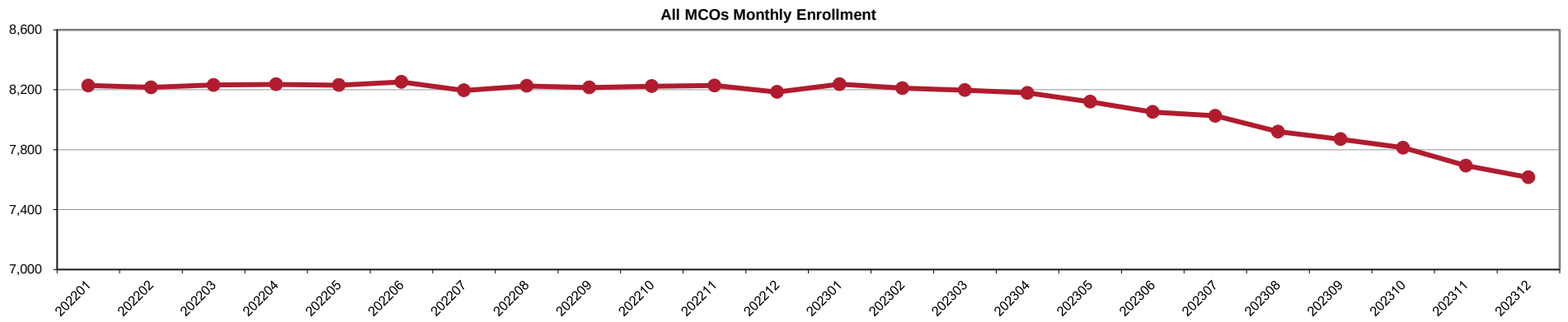
Utilization and Cost Review

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

Previous Period: January 1, 2022 to December 31, 2022

Current Period: January 1, 2023 to December 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

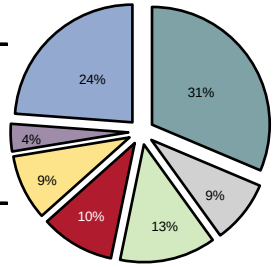
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 344,597,657	$ 358,367,377	4%
Pharmacy	$ 30,733,120	$ 35,471,561	15%
Total	**$ 375,330,777**	**$ 393,838,937**	**5%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 116,305,082	$ 123,467,908	6%
Nursing Facility (NF)	$ 30,061,939	$ 34,316,360	14%
Inpatient (IP)	$ 51,610,514	$ 51,919,385	1%
Outpatient (OP)	$ 36,481,912	$ 39,982,255	10%
Pharmacy (RX)	$ 30,733,120	$ 35,471,561	15%
HCBS	$ 15,268,500	$ 14,834,962	-3%
Other (OTH)	$ 94,869,710	$ 93,846,507	-1%
Total Population Costs	**$ 375,330,777**	**$ 393,838,937**	**5%**
Per Capita Cost (PMPM)	**$ 3,803.94**	**$ 4,105.40**	**8%**
Total Member Months	**98,669**	**95,932**	**-3%**

Service Categories % of Cost



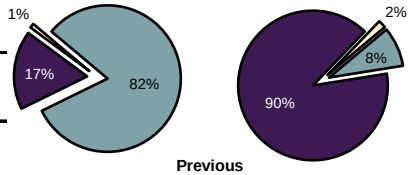
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

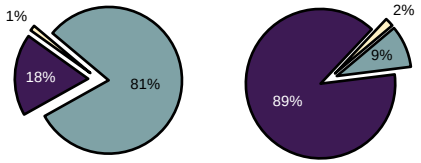
	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 24,825,676	$ 28,958,888	17%
Generic	$ 5,530,867	$ 6,164,069	11%
Other Rx	$ 376,577	$ 348,603	-7%
Total	**$ 30,733,120**	**$ 35,471,561**	**15%**

% of Rx Spend **% of Scripts**

Current



Previous



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

4. Notes

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

State of New Mexico - All MCOs

LTSS - Self Directed Population

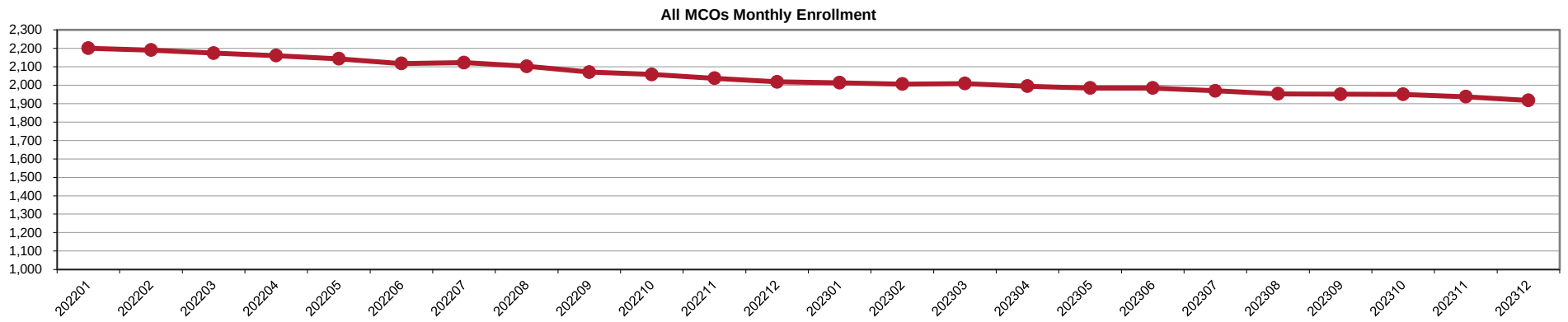
Utilization and Cost Review

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

Previous Period: January 1, 2022 to December 31, 2022

Current Period: January 1, 2023 to December 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

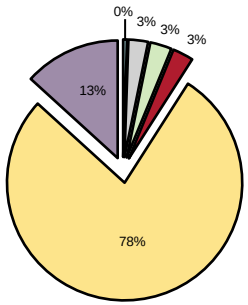
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 105,988,675	$ 104,592,496	-1%
Pharmacy	$ 2,902,019	$ 3,070,406	6%
Total	**$ 108,890,694**	**$ 107,662,902**	**-1%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 409,337	$ 581,006	42%
Inpatient (IP)	$ 3,726,424	$ 2,902,772	-22%
Outpatient (OP)	$ 3,737,468	$ 3,189,208	-15%
Pharmacy (RX)	$ 2,902,019	$ 3,070,406	6%
HCBS	$ 83,028,719	$ 83,664,367	1%
Other (OTH)	$ 15,086,727	$ 14,255,142	-6%
Total Population Costs	**$ 108,890,694**	**$ 107,662,902**	**-1%**
Per Capita Cost (PMPM)	**$ 4,288.39**	**$ 4,549.07**	**6%**
Total Member Months	**25,392**	**23,667**	**-7%**

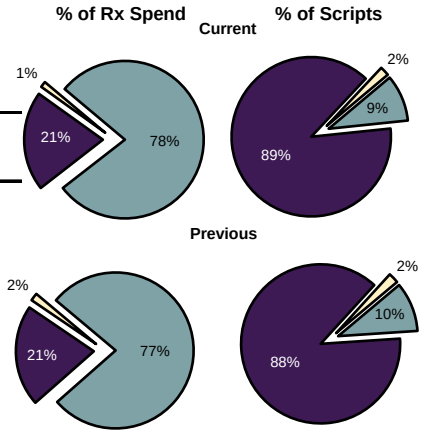
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 2,246,131	$ 2,406,292	7%
Generic	$ 609,095	$ 627,001	3%
Other Rx	$ 46,793	$ 37,113	-21%
Total	**$ 2,902,019**	**$ 3,070,406**	**6%**



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

4. Notes

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

State of New Mexico - All MCOs

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

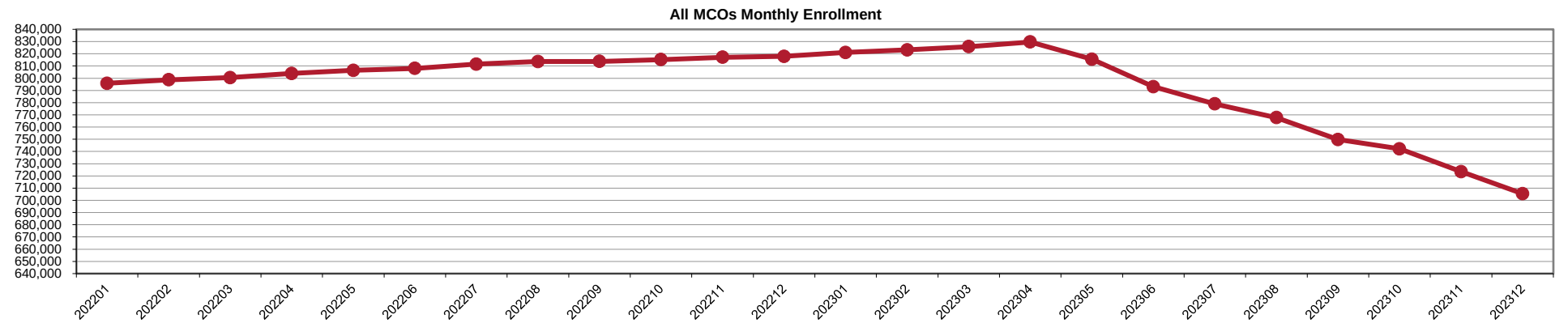
Behavioral Health Utilization and Cost Review

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

Previous Period: January 1, 2022 to December 31, 2022

Current Period: January 1, 2023 to December 31, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

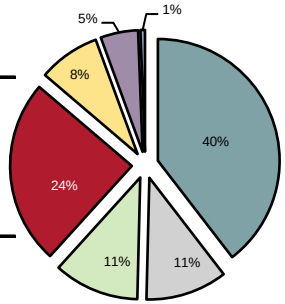
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 522,132,692	$ 613,784,180	18%
Pharmacy	$ 78,441,432	$ 74,529,518	-5%
Total	**$ 600,574,124**	**$ 688,313,698**	**15%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 227,577,695	$ 272,258,631	20%
Pharmacy (RX)	$ 78,441,432	$ 74,529,518	-5%
Res. Treatment Ctr. (RTC)	$ 87,986,389	$ 78,034,683	-11%
Behavioral Health Prov (BHP)	$ 150,440,036	$ 168,755,381	12%
Core Service Agencies (CSA)	$ 35,064,062	$ 56,290,351	61%
Inpatient (IP)	$ 18,879,028	$ 34,328,842	82%
Other (OTH)	$ 2,185,482	$ 4,116,292	88%
Total Population Costs	**$ 600,574,124**	**$ 688,313,698**	**15%**
Per Capita Cost (PMPM)	**$ 61.90**	**$ 73.41**	**19%**
Total Member Months	**9,702,288**	**9,375,755**	**-3%**

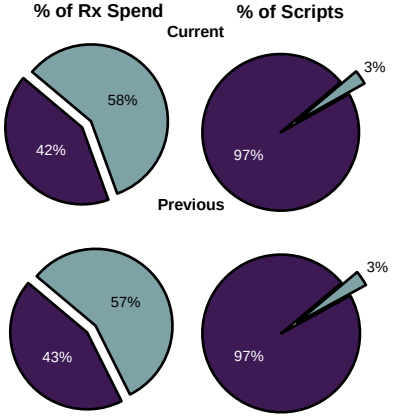
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 44,325,281	$ 43,492,194	-2%
Generic	$ 34,116,151	$ 31,037,324	-9%
Total	**$ 78,441,432**	**$ 74,529,518**	**-5%**



4. Notes

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

ATTACHMENT B
New Mexico Budget Neutrality Monitoring Spreadsheet
- PMPM Analysis
DY 11
Start Date: 01/01/2024
End Date: 12/31/2024

Quarter 1
Start Date:1/1/2024
End Date: 3/31/2024

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01 TANF & Related	DY 01 Cost Estimates	DY 01 YTD - Actuals [2]	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	4,621,656	5,092,636	4,623,475	5,132,359	4,422,938	4,974,487	4,313,641
PMPM	$ 385.80	$ 329.14	$ 400.77	$ 344.32	$ 416.32	$ 334.75	$ 432.47	$ 341.04	$ 449.25	$ 353.31	$ 460.00	$ 397.14
Dollars	$ 1,823,911,159	$ 1,486,786,187	$ 1,948,487,793	$ 1,533,690,296	$ 2,090,074,424	$ 1,547,091,436	$ 2,202,434,150	$ 1,576,787,544	$ 2,305,734,126	$ 1,562,668,928	$ 2,288,249,485	$ 1,713,138,470

MEG02 SSI & Related - Medicaid Only	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	508,700	497,958	513,736	494,529	518,976	493,577	524,737	487,798	530,824	459,830	499,659	448,460
PMPM	$ 1,763.90	$ 1,656.75	$ 1,842.83	$ 1,785.41	$ 1,925.21	$ 1,756.52	$ 2,008.00	$ 1,734.28	$ 2,094.34	$ 1,729.94	$ 2,158.77	$ 1,930.33
Dollars	$ 897,298,062	$ 824,991,985	$ 946,727,393	$ 882,936,445	$ 999,138,707	$ 866,977,418	$ 1,053,669,000	$ 845,978,765	$ 1,111,724,897	$ 795,478,519	$ 1,078,650,304	$ 865,674,976

MEG03 SSI & Related - Dual Eligible	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	373,823	428,025	380,215	435,140	386,831	447,801	393,832	443,071	401,197	432,715	467,635	433,415
PMPM	$ 1,780.77	$ 1,333.20	$ 1,857.34	$ 1,342.71	$ 1,937.21	$ 1,361.10	$ 2,020.51	$ 1,273.53	$ 2,107.39	$ 1,290.50	$ 2,057.62	$ 1,285.26
Dollars	$ 665,692,378	$ 570,643,867	$ 706,189,973	$ 584,265,571	$ 749,372,219	$ 609,500,283	$ 795,742,098	$ 564,265,856	$ 845,479,241	$ 558,418,717	$ 962,212,283	$ 557,052,123

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

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

MEG06 VIII Group - Medicaid Expansion	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	1,632,968	1,887,728	1,788,895	2,748,632	1,800,808	3,078,074	1,763,748	3,143,890	1,773,299	3,019,164	3,299,404	3,070,895
PMPM	$ 577.87	$ 453.48	$ 607.34	$ 476.42	$ 638.31	$ 442.85	$ 670.87	$ 450.19	$ 705.08	$ 484.90	$ 738.22	$ 524.64
Dollars	$ 943,638,928	$ 856,045,974	$ 1,086,464,733	$ 1,309,500,952	$ 1,149,478,718	$ 1,363,113,600	$ 1,183,239,734	$ 1,415,361,896	$ 1,250,319,546	$ 1,463,979,757	$ 2,435,685,299	$ 1,611,114,312

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

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

Centennial Care 2.0 Medicaid SUD/IMD	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MM											595	595
PMPM											$ 808.21	$ 5,794.53
Dollars											$ 480,885	$ 3,447,745

Notes:
1.) Actual member months for Demonstration Year 11 include the reported member months for this Centennial Care Quarterly Report, Section XIV and Section IX.

2.) Expenditures as reported on the CMS-64 Schedule C, FFY2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 1

Start Date: 01/01/2014

End Date: 12/31/2014

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

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

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

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

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

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

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

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

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 2

Start Date: 01/01/2015

End Date: 12/31/2015

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

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

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

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

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

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

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

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

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 3

Start Date: 01/01/2016

End Date: 12/31/2016

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

MEG	DY 3 - PMPM	DY 3 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 3 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 416.32	4,621,656	$ 1,924,092,463	72.12%	$ 1,387,680,218	$ 1,547,091,436	$ 1,137,287,812
MEG02 - SSI & Related - Medicaid Only	$ 1,925.21	493,577	$ 950,239,887	72.12%	$ 685,325,222	$ 866,977,418	$ 614,385,717
MEG03 - SSI & Related - Dual Eligible	$ 1,937.21	447,801	$ 867,484,358	72.12%	$ 625,640,871	$ 609,500,283	$ 430,111,909
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	72.12%	$ 49,683,865	$ 68,889,323	$ 48,608,306
MEG09 HQII	NA	NA	$ 5,764,727	72.12%	$ 4,157,595	$ 7,359,077	$ 5,234,511
Grand Total			**$ 3,816,470,759**		**$ 2,752,487,771**	**$ 3,099,817,537**	**$ 2,235,628,255**

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

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

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

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

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,752,487,771**
Federal Share (Title XIX) Actual Reported	$ 2,235,628,255
Excess Spending - Test 1	$ 15,674,967
Excess Spending - Test 2	$ -
Total Actuals	$ 2,251,303,222
Difference (Actuals - Limit)	$ (501,184,549)
Percentage Difference	-18.2%

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 4

Start Date: 01/01/2017

End Date: 12/31/2017

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

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 432.47	4,623,475	$ 1,999,533,921	73.08%	$ 1,461,177,683	$ 1,576,787,544	$ 1,174,583,317
MEG02 - SSI & Related - Medicaid Only	$ 2,008.00	487,798	$ 979,495,999	73.08%	$ 715,775,651	$ 845,978,765	$ 606,610,371
MEG03 - SSI & Related - Dual Eligible	$ 2,020.51	443,071	$ 895,229,176	73.08%	$ 654,196,900	$ 564,265,856	$ 402,851,084
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	73.08%	$ 50,341,502	$ 68,889,323	$ 49,178,612
MEG09 HQII	NA	NA	$ 8,825,544	73.08%	$ 6,449,347	$ 8,825,541	$ 6,368,511
Grand Total			**$ 3,951,973,963**		**$ 2,887,941,084**	**$ 3,064,747,029**	**$ 2,239,591,895**

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

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

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

MEG	DY 4 - PMPM	DY 4 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 4 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 670.87	3,143,890	$ 2,109,131,150	95.15%	$ 2,006,846,948	$ 1,415,361,896	$ 1,346,722,655
Grand Total			**$ 2,109,131,150**		**$ 2,006,846,948**	**$ 1,415,361,896**	**$ 1,346,722,655**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,887,941,084**
Federal Share (Title XIX) Actual Reported	$ 2,239,591,895
Excess Spending - Test 1	$ 16,592,662
Excess Spending - Test 2	$ -
Total Actuals	$ 2,256,184,557
Difference (Actuals - Limit)	$ (631,756,526)
Percentage Difference	-21.9%

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 5

Start Date: 01/01/2018

End Date: 12/31/2018

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

MEG	DY 5 - PMPM	DY 5 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 5 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 449.25	4,422,938	$ 1,987,023,736	74.05%	$ 1,471,328,212	$ 1,562,668,928	$ 1,180,619,329
MEG02 - SSI & Related - Medicaid Only	$ 2,094.34	459,830	$ 963,039,856	74.05%	$ 713,100,545	$ 795,478,519	$ 576,982,272
MEG03 - SSI & Related - Dual Eligible	$ 2,107.39	432,715	$ 911,899,885	74.05%	$ 675,233,014	$ 558,418,717	$ 403,163,956
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.05%	$ 51,010,364	$ 68,889,323	$ 50,084,411
MEG09 HQII	NA	NA	$ 12,011,853	74.05%	$ 8,894,397	$ 12,011,853	$ 8,679,765
Grand Total			**$ 3,942,864,653**		**$ 2,919,566,533**	**$ 2,997,467,340**	**$ 2,219,529,733**

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

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

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

MEG	DY 5 - PMPM	DY 5 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 5 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 705.08	3,019,164	$ 2,128,754,916	94.19%	$ 2,005,116,998	$ 1,463,979,757	$ 1,378,951,928
Grand Total			**$ 2,128,754,916**		**$ 2,005,116,998**	**$ 1,463,979,757**	**$ 1,378,951,928**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,919,566,533**
Federal Share (Title XIX) Actual Reported	$ 2,219,529,733
Excess Spending - Test 1	$ 20,637,930
Excess Spending - Test 2	$ -
Total Actuals	$ 2,240,167,663
Difference (Actuals - Limit)	$ (679,398,870)
Percentage Difference	-23.3%

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 6

Start Date: 01/01/2019

End Date: 12/31/2019

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

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 460.00	4,313,641	$ 1,984,262,326	74.74%	$ 1,483,082,345	$ 1,713,138,470	$ 1,307,622,792
MEG02 - SSI & Related - Medicaid Only	$ 2,158.77	448,460	$ 968,123,620	74.74%	$ 723,597,394	$ 865,674,976	$ 633,227,846
MEG03 - SSI & Related - Dual Eligible	$ 2,057.62	433,415	$ 891,801,274	74.74%	$ 666,552,354	$ 557,052,123	$ 403,427,596
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.74%	$ 51,489,431	$ 68,889,316	$ 50,869,441
MEG09 HQII	NA	NA	$ 12,000,000	74.74%	$ 8,969,070	$ 12,000,002	$ 9,127,363
Grand Total			**$ 3,925,076,543**		**$ 2,933,690,594**	**$ 3,216,754,887**	**$ 2,404,275,038**

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

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

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

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 738.22	3,070,895	$ 2,266,995,241	93.12%	$ 2,110,918,404	$ 1,611,114,312	$ 1,500,193,203
Grand Total			**$ 2,266,995,241**		**$ 2,110,918,404**	**$ 1,611,114,312**	**$ 1,500,193,203**

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

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 808.21	595	$ 480,885	92.33%	$ 444,008	$ 3,447,745	$ 3,183,354
Grand Total			**$ 480,885**		**$ 444,008**	**$ 3,447,745**	**$ 3,183,354**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,933,690,594**
Federal Share (Title XIX) Actual Reported	$ 2,404,275,038
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,739,346
Total Actuals	$ 2,404,275,038
Difference (Actuals - Limit)	$ (529,415,556)
Percentage Difference	-18.0%

Notes:

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

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 7

Start Date: 01/01/2020

End Date: 12/31/2020

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

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 477.48	4,593,472	$ 2,193,277,156	80.26%	$ 1,760,368,286	$ 1,952,251,033	$ 1,583,770,238
MEG02 - SSI & Related - Medicaid Only	$ 2,247.28	450,397	$ 1,012,169,676	80.26%	$ 812,387,706	$ 1,007,266,377	$ 798,914,770
MEG03 - SSI & Related - Dual Eligible	$ 2,141.98	433,319	$ 928,159,496	80.26%	$ 744,959,449	$ 625,561,374	$ 494,843,452
MEG08 Uncompensated Care Pool	NA	NA	$ -	80.26%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	80.26%	$ 9,631,441	$ 11,999,993	$ 9,559,194
Grand Total			**$ 4,145,606,329**		**$ 3,327,346,881**	**$ 3,597,078,777**	**$ 2,887,087,654**

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

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

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

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 772.92	3,276,975	$ 2,532,826,556	90.29%	$ 2,286,976,398	$ 1,976,250,709	$ 1,784,424,882
Grand Total			**$ 2,532,826,556**		**$ 2,286,976,398**	**$ 1,976,250,709**	**$ 1,784,424,882**

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

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 841.35	2,729	$ 2,296,044	89.79%	$ 2,061,629	$ 4,652,395	$ 4,177,407
Grand Total			**$ 2,296,044**		**$ 2,061,629**	**$ 4,652,395**	**$ 4,177,407**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,327,346,881**
Federal Share (Title XIX) Actual Reported	$ 2,887,087,654
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,115,778
Total Actuals	$ 2,887,087,654
Difference (Actuals - Limit)	$ (440,259,227)
Percentage Difference	-13.2%

Notes:

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

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 8

Start Date: 01/01/2021

End Date: 12/31/2021

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

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 495.62	5,134,916	$ 2,544,972,764	82.57%	$ 2,101,454,896	$ 2,364,678,131	$ 1,954,432,778
MEG02 - SSI & Related - Medicaid Only	$ 2,339.42	462,038	$ 1,080,901,844	82.57%	$ 892,530,759	$ 1,071,071,960	$ 875,334,404
MEG03 - SSI & Related - Dual Eligible	$ 2,229.80	436,655	$ 973,652,643	82.57%	$ 803,972,106	$ 670,751,953	$ 561,435,474
MEG08 Uncompensated Care Pool	NA	NA	$ -	82.57%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	82.57%	$ 9,908,734	$ 12,000,000	$ 9,559,194
Grand Total			**$ 4,611,527,251**		**$ 3,807,866,496**	**$ 4,118,502,044**	**$ 3,400,761,850**

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

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,110.34	2,998	$ 18,318,791	84.29%	$ 15,440,049	$ 11,711,889	$ 9,766,272
MEG 05 - "217 Like" Dual Eligible	$ 3,967.56	68,653	$ 272,384,656	84.29%	$ 229,580,243	$ 246,269,325	$ 207,673,986
Grand Total			**$ 290,703,447**		**$ 245,020,292**	**$ 257,981,214**	**$ 217,440,258**

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

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 809.24	3,504,683	$ 2,836,140,532	90.67%	$ 2,571,625,042	$ 2,189,168,431	$ 1,984,993,443
Grand Total			**$ 2,836,140,532**		**$ 2,571,625,042**	**$ 2,189,168,431**	**$ 1,984,993,443**

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

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 875.85	4,781	$ 4,187,439	88.99%	$ 3,726,434	$ 6,524,166	$ 5,805,905
Grand Total			**$ 4,187,439**		**$ 3,726,434**	**$ 6,524,166**	**$ 5,805,905**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,807,866,496**
Federal Share (Title XIX) Actual Reported	$ 3,400,761,850
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,079,471
Total Actuals	$ 3,400,761,850
Difference (Actuals - Limit)	$ (407,104,646)
Percentage Difference	-10.7%

Notes:

1.) Member months as of October 9, 2023.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 9

Start Date: 01/01/2022

End Date: 12/31/2022

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 514.45	5,451,168	$ 2,804,353,378	73.57%	$ 2,063,217,773	$ 2,711,112,268	$ 1,954,432,778
MEG02 - SSI & Related - Medicaid Only	$ 2,435.34	474,323	$ 1,155,137,775	73.57%	$ 849,857,513	$ 1,182,816,202	$ 875,334,404
MEG03 - SSI & Related - Dual Eligible	$ 2,321.22	449,777	$ 1,044,031,368	73.57%	$ 768,114,351	$ 728,432,827	$ 561,435,474
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	73.57%	$ 50,683,226	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	73.57%	$ 8,837,356	$ -	$ 9,559,194
Grand Total			**$ 5,084,423,696**		**$ 3,740,710,218**	**$ 4,622,361,297**	**$ 3,400,761,850**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,300.37	2,877	$ 18,126,164	76.72%	$ 13,905,546	$ 11,072,102	$ 9,766,272
MEG 05 - "217 Like" Dual Eligible	$ 4,130.23	71,207	$ 294,101,288	76.72%	$ 225,620,764	$ 272,365,729	$ 207,673,986
Grand Total			**$ 312,227,452**		**$ 239,526,310**	**$ 283,437,831**	**$ 217,440,258**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 847.28	3,531,619	$ 2,992,270,146	84.81%	$ 2,537,712,984	$ 2,340,547,043	$ 1,984,993,443
Grand Total			**$ 2,992,270,146**		**$ 2,537,712,984**	**$ 2,340,547,043**	**$ 1,984,993,443**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 911.76	6,016	$ 5,485,148	79.27%	$ 4,348,308	$ 7,323,826	$ 5,805,905
Grand Total			**$ 5,485,148**		**$ 4,348,308**	**$ 7,323,826**	**$ 5,805,905**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,740,710,218**
Federal Share (Title XIX) Actual Reported	$ 3,400,761,850
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 1,457,597
Total Actuals	$ 3,400,761,850
Difference (Actuals - Limit)	$ (339,948,368)
Percentage Difference	-9.1%

Notes:

1.) Member months as of April 2, 2024.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 10

Start Date: 01/01/2023

End Date: 12/31/2023

Table 10.1: Budget Neutrality Limit DY 10 (Special Terms and Conditions (STC) 96)

MEG	DY 10 - PMPM	DY 10 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 10 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 534.00	5,175,984	$ 2,763,975,456	78.36%	$ 2,165,841,151	$ 2,657,750,861	$ 2,111,003,447
MEG02 - SSI & Related - Medicaid Only	$ 2,535.19	479,908	$ 1,216,657,963	78.36%	$ 953,368,771	$ 1,210,241,568	$ 930,881,467
MEG03 - SSI & Related - Dual Eligible	$ 2,416.39	451,560	$ 1,091,145,068	78.36%	$ 855,017,322	$ 733,584,613	$ 563,894,181
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	78.36%	$ 53,981,424	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	78.36%	$ 9,412,444	$ -	$ -
Grand Total			**$ 5,152,679,663**		**$ 4,037,621,112**	**$ 4,601,577,042**	**$ 3,605,779,095**

Table 10.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 98)

MEG	DY 10 - PMPM	DY 10 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 10 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,496.31	3,550	$ 23,061,901	76.83%	$ 17,717,744	$ 12,100,433	$ 9,288,415
MEG 05 - "217 Like" Dual Eligible	$ 4,299.57	73,654	$ 316,680,529	76.83%	$ 243,295,838	$ 280,779,800	$ 215,722,393
Grand Total			**$ 339,742,429**		**$ 261,013,581**	**$ 292,880,233**	**$ 225,010,808**

Table 10.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 99)

MEG	DY 10 - PMPM	DY 10 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 10 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 887.10	3,507,784	$ 3,111,755,186	90.49%	$ 2,815,771,912	$ 2,363,810,468	$ 2,138,970,042
Grand Total			**$ 3,111,755,186**		**$ 2,815,771,912**	**$ 2,363,810,468**	**$ 2,138,970,042**

Table 10.4: Supplemental Budget Neutrality Test 3: SUD/IMD (STC 100)

MEG	DY 10 - PMPM	DY 10 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 10 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 949.14	6,453	$ 6,124,800	86.66%	$ 5,307,942	$ 7,662,017	$ 6,640,142
Grand Total			**$ 6,124,800**		**$ 5,307,942**	**$ 7,662,017**	**$ 6,640,142**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 4,037,621,112**
Federal Share (Title XIX) Actual Reported	$ 3,605,779,095
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 1,332,200
Total Actuals	$ 3,605,779,095
Difference (Actuals - Limit)	$ (431,842,017)
Percentage Difference	-10.7%

Notes:

1.) Member months as of April 2, 2024.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 11

Start Date: 01/01/2024

End Date: 12/31/2024

Table 11.1: Budget Neutrality Limit DY 11 (Special Terms and Conditions (STC) 96)

MEG	DY 11 - PMPM	DY 11 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 11 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 469.61	1,130,548	$ 530,920,778	73.02%	$ 387,663,622	$ 450,019,006	$ 329,990,591
MEG02 - SSI & Related - Medicaid Only	$ 2,428.87	117,798	$ 286,116,402	73.02%	$ 208,914,259	$ 268,399,917	$ 195,353,642
MEG03 - SSI & Related - Dual Eligible	$ 1,706.81	107,137	$ 182,862,860	73.02%	$ 133,521,387	$ 181,479,253	$ 131,736,449
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	73.02%	$ 50,301,072	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	73.02%	$ 8,770,722	$ -	$ -
Grand Total			**$ 1,080,801,215**		**$ 789,171,062**	**$ 899,898,176**	**$ 657,080,682**

Table 11.2: Supplemental Budget Neutrality Test 1: Hypothetical Groups (STC 98)

MEG	DY 11 - PMPM	DY 11 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 11 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 3,011.83	1,116	$ 3,361,204	72.59%	$ 2,439,898	$ 3,013,432	$ 2,187,451
MEG 05 - "217 Like" Dual Eligible	$ 4,101.86	17,366	$ 71,232,941	72.59%	$ 51,707,993	$ 69,939,465	$ 50,769,058
Grand Total			**$ 74,594,144**		**$ 54,147,890**	**$ 72,952,897**	**$ 52,956,509**

Table 11.3: Supplemental Budget Neutrality Test 2: VIII Group (STC 99)

MEG	DY 11 - PMPM	DY 11 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 11 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 717.20	845,534	$ 606,420,969	90.28%	$ 547,500,109	$ 547,913,500	$ 494,677,322
Grand Total			**$ 606,420,969**		**$ 547,500,109**	**$ 547,913,500**	**$ 494,677,322**

Table 11.4: Supplemental Budget Neutrality Test 3: SUD/IMD (STC 100)

MEG	DY 11 - PMPM	DY 11 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 11 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 1,548.75	637	$ 986,554	85.44%	$ 842,931	$ 894,546	$ 764,318
Grand Total			**$ 986,554**		**$ 842,931**	**$ 894,546**	**$ 764,318**

Table 11.5: DY 11 Assessment of Budget Neutrality (STC 93, 96, 105)

Federal Share (Title XIX) Budget Neutrality Limit	**$ 789,171,062**
Federal Share (Title XIX) Actual Reported	$ 657,080,682
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ -
Total Actuals	$ 657,080,682
Difference (Actuals - Limit)	$ (132,090,380)
Percentage Difference	-16.7%

Notes:

1.) Member months as of April 2, 2024.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 2 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 2. Report pulled on 5/8/2024.

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 2/2024

Summary of Expenditures by Waiver Year
Waiver: 11W00285

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,486,786,187	1,533,690,296	1,547,091,436	1,576,787,544	1,562,668,928	1,713,138,470	1,952,251,033	2,364,678,131	2,711,112,268	2,657,750,861	450,019,006	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19,555,974,160	19,555,974,160
MEG2- SSI Medicaid Only	0	824,991,985	882,936,445	866,977,418	845,978,765	795,478,519	865,674,976	1,007,266,377	1,071,071,960	1,182,816,202	1,210,241,568	268,399,917	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9,821,834,132	9,821,834,132
MEG3- SSI DUAL	0	570,643,867	584,265,571	609,500,283	564,265,856	558,418,717	557,052,123	625,561,374	670,751,953	728,432,827	733,584,613	181,479,253	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,383,956,437	6,383,956,437
MEG4-217	0	6,662,064	5,591,208	7,580,640	12,512,314	12,068,447	11,383,232	12,139,659	11,711,889	11,072,102	12,100,433	3,013,432	0	0	0	0	0	0	0	0	0	0	0	0	0	0	105,835,420	105,835,420
MEG5- 217 DUAL	0	86,786,741	85,077,407	91,901,521	112,740,550	134,725,706	143,887,343	191,823,587	246,269,325	272,365,729	280,779,800	69,939,465	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,716,297,174	1,716,297,174
MEG6-VIII GROUP	0	856,045,974	1,309,500,952	1,363,113,600	1,415,361,896	1,463,979,757	1,611,114,312	1,976,250,709	2,189,168,431	2,340,547,043	2,363,810,468	547,913,500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,436,806,642	17,436,806,642
MEG8-UHC-Uncompensated care	0	68,889,322	36,005,978	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	104,895,300	104,895,300
MEG9-HQII-Hospital Quality Improve Incentive	0	0	2,824,462	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,824,462	2,824,462
UC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	31,288,995	68,889,323	68,889,323	68,889,323	68,889,316	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	306,846,281	306,846,281
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	7,359,077	8,825,541	12,011,853	12,000,002	11,990,993	12,000,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	64,196,466	64,196,466
Centennial Care 2.0 Medicaid SUD/IMD	0	0	0	0	0	0	3,447,745	4,652,395	6,524,166	7,323,826	7,662,017	894,546															30,504,695	30,504,695
Total	**0**	**3,900,806,141**	**4,471,181,314**	**4,562,413,298**	**4,605,361,789**	**4,608,241,250**	**4,986,587,519**	**5,781,945,127**	**6,572,175,855**	**7,253,669,997**	**7,265,929,760**	**1,521,659,119**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**55,529,971,169**	**55,529,971,169**
Check		*3,900,806,141*	*4,471,181,314*	*4,562,413,298*	*4,605,361,789*	*4,608,241,250*	*4,986,587,519*	*5,781,945,127*	*6,572,175,855*	*7,253,669,997*	*7,265,929,760*	*1,521,659,119*																
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,070,423,106	1,116,190,075	1,137,287,812	1,174,583,317	1,180,619,329	1,307,622,792	1,583,770,238	1,954,432,778	2,243,577,360	2,111,003,447	329,990,591	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,209,500,845	15,209,500,845
MEG2- SSI Medicaid Only	0	574,950,391	619,379,415	614,385,717	606,610,371	576,982,272	633,227,846	798,914,770	875,334,404	952,936,149	930,881,467	195,353,642	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,378,956,444	7,378,956,444
MEG3- SSI DUAL	0	395,585,750	408,061,166	430,111,909	402,851,084	403,163,956	403,427,596	494,843,452	561,435,474	590,735,509	563,894,181	131,736,449	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,785,846,526	4,785,846,526
MEG4-217	0	4,617,656	3,906,915	5,353,671	8,934,265	8,714,682	8,248,128	9,603,953	9,766,272	8,981,356	9,288,415	2,187,451	0	0	0	0	0	0	0	0	0	0	0	0	0	0	79,602,764	79,602,764
MEG5- 217 DUAL	0	60,154,448	59,416,310	64,866,189	80,515,170	97,261,654	104,198,687	151,763,800	207,673,986	221,241,548	215,722,393	50,769,058	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,313,583,243	1,313,583,243
MEG6-VIII GROUP	0	856,020,190	1,309,439,632	1,362,203,902	1,346,722,655	1,378,951,928	1,500,193,203	1,784,424,882	1,984,993,443	2,119,661,876	2,138,970,042	494,677,322	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,276,259,075	16,276,259,075
MEG8-UHC-Uncompensated care	0	47,671,411	25,207,785	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	72,879,196	72,879,196
MEG9-HQII-Hospital Quality Improve Incentive	0	0	1,987,574	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,987,574	1,987,574
UC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	21,781,306	48,608,306	49,178,612	50,084,411	50,869,441	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	220,522,077	220,522,077
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	5,234,511	6,368,511	8,679,765	9,127,363	9,550,194	9,589,200	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	48,558,544	48,558,544
Centennial Care 2.0 Medicaid SUD/IMD	0	0	0	0	0	0	3,183,354	4,177,407	5,805,905	6,445,325	6,640,142	764,318															27,016,451	27,016,451
Total	**0**	**3,009,422,953**	**3,565,370,178**	**3,668,052,017**	**3,675,763,985**	**3,704,457,997**	**4,020,098,410**	**4,837,057,696**	**5,609,031,462**	**6,143,579,123**	**5,976,400,087**	**1,205,478,831**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45,387,696,288**	**45,387,696,288**
Check		*3,009,422,953*	*3,565,370,178*	*3,668,052,017*	*3,675,763,985*	*3,704,457,997*	*4,020,098,410*	*4,837,057,696*	*5,609,031,462*	*6,143,579,123*	*5,976,400,087*	*1,205,478,831*																
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																

M-CHIP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	84,356,751	123,819,527	118,473,862	106,619,834	97,506,744	105,961,052	118,364,817	127,139,403	140,204,132	138,962,942	33,401,769	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,194,810,833	1,194,810,833
Total	**0**	**84,356,751**	**123,819,527**	**118,473,862**	**106,619,834**	**97,506,744**	**105,961,052**	**118,364,817**	**127,139,403**	**140,204,132**	**138,962,942**	**33,401,769**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,194,810,833**	**1,194,810,833**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	66,272,555	105,308,829	118,473,862	106,619,822	97,505,399	103,491,095	110,796,508	108,148,159	119,174,788	116,205,830	26,991,968	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,078,988,815	1,078,988,815
Total	**0**	**66,272,555**	**105,308,829**	**118,473,862**	**106,619,822**	**97,505,399**	**103,491,095**	**110,796,508**	**108,148,159**	**119,174,788**	**116,205,830**	**26,991,968**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,078,988,815**	**1,078,988,815**

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	109,509,693	0	0	0	8,558,331	196,959,429	236,056,796	215,438,573	233,952,557	367,965,093	103,682,148	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,472,122,620	1,472,122,620
MEG1-TANF & Related	0	1,954,350	65,528,478	65,128,092	75,672,882	80,475,712	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	288,759,514	288,759,514
MEG2- SSI Medicaid Only	0	0	7,492,116	7,098,152	8,204,996	8,455,296	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	31,250,560	31,250,560
MEG3- SSI DUAL	0	0	6,533,901	6,432,635	7,626,009	7,887,696	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28,480,241	28,480,241
MEG4-217	0	0	38,287	33,620	78,602	73,212	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	223,721	223,721
MEG5- 217 DUAL	0	0	408,067	443,667	673,384	847,932	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,373,050	2,373,050
MEG6-VIII GROUP	0	36,509,156	42,521,593	46,218,961	60,776,652	59,250,561	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	245,279,923	245,279,923
MEG7-CHIP GROUP	0	972,016	9,725,447	8,862,780	10,909,982	9,242,308	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	39,712,533	39,712,533
Total	**0**	**148,945,215**	**132,247,889**	**134,218,907**	**163,942,507**	**174,793,048**	**196,959,429**	**236,056,796**	**215,438,573**	**233,952,557**	**367,965,093**	**103,682,148**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,108,202,162**	**2,108,202,162**
Check		*148,945,215*	*132,247,889*	*134,218,907*	*163,942,507*	*174,793,048*	*196,959,429*	*236,056,796*	*215,438,573*	*233,952,557*	*367,965,093*	*103,682,148*																
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	72,320,580	0	0	0	6,523,508	129,519,032	155,939,388	141,935,766	157,144,300	245,177,152	74,616,356	0	0	0	0	0	0	0	0	0	0	0	0	0	0	983,176,082	983,176,082
MEG1-TANF & Related	0	1,033,347	40,960,378	40,581,487	48,575,411	50,855,108	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	182,005,731	182,005,731
MEG2- SSI Medicaid Only	0	0	4,682,951	4,421,346	5,263,719	5,343,838	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19,711,854	19,711,854
MEG3- SSI DUAL	0	0	4,084,108	4,007,329	4,887,719	4,986,257	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,965,413	17,965,413
MEG4-217	0	0	23,899	21,025	50,385	46,287	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	141,596	141,596
MEG5- 217 DUAL	0	0	255,098	276,989	432,086	536,858	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,501,031	1,501,031
MEG6-VIII GROUP	0	24,041,491	26,579,123	28,804,937	38,875,056	37,448,951	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	155,749,558	155,749,558
MEG7-CHIP GROUP	0	644,187	6,078,767	5,514,776	6,957,623	5,840,810	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,036,163	25,036,163
Total	**0**	**98,039,605**	**82,664,324**	**83,627,889**	**105,041,999**	**111,581,617**	**129,519,032**	**155,939,388**	**141,935,766**	**157,144,300**	*245,177,152*	**74,616,356**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,385,287,428**	**1,385,287,428**
Check		*98,039,605*	*82,664,324*	*83,627,889*	*105,041,999*	*111,581,617*	*129,519,032*	*155,939,388*	*141,935,766*	*157,144,300*	*245,177,152*	*74,616,356*																
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																

Created On: Wednesday, May 8, 2024 7:24 AM

MEMBER MONTHS
CENTENNIAL CARE MEG REPORTING

	CY 2016 Quarter					CY 2017 Quarter					CY 2018 Quarter					CY 2019 Quarter					CY 2020 Quarter					CY 2021 Quarter					CY 2022 Quarter					CY 2023 Quarter					CY 2024 Quarter				
Eligibility Group	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**	**1**	**2**	**3**	**4**	**Total**
Population 1 – TANF and Related	1,130,779	1,150,300	1,169,603	1,170,974	**4,621,656**	1,180,160	1,170,146	1,145,575	1,127,594	**4,623,475**	1,129,981	1,116,304	1,090,944	1,085,709	**4,422,938**	1,078,850	1,077,954	1,079,500	1,077,337	**4,313,641**	1,080,904	1,121,423	1,179,371	1,211,774	**4,593,472**	1,242,048	1,264,108	1,303,124	1,325,636	**5,134,916**	1,344,362	1,360,171	1,370,665	1,375,970	**5,451,168**	1,383,838	1,345,762	1,258,040	1,188,344	**5,175,984**	1,130,548				**1,130,548**
Population 2 – SSI and Related – Medicaid Only	123,597	122,633	123,728	123,619	**493,577**	124,408	125,136	122,027	116,227	**487,798**	116,043	115,944	114,284	113,559	**459,830**	112,782	112,246	111,860	111,572	**448,460**	112,231	111,666	112,949	113,551	**450,397**	114,465	115,066	115,626	116,881	**462,038**	117,425	118,845	118,596	119,457	**474,323**	120,142	120,564	120,239	118,963	**479,908**	117,798				**117,798**
Population 3 – SSI and Related - Dual	110,017	111,379	113,425	112,980	**447,801**	111,537	111,883	111,273	108,378	**443,071**	108,032	108,101	108,318	108,264	**432,715**	108,143	108,378	108,509	108,385	**433,415**	108,324	108,074	108,273	108,648	**433,319**	107,956	108,420	109,664	110,615	**436,655**	110,905	112,214	112,889	113,769	**449,777**	114,332	114,330	112,747	110,151	**451,560**	107,137				**107,137**
Population 4 – 217-like Group – Medicaid Only	566	1064	564	793	**2,987**	1,133	1,006	857	801	**3,797**	830	835	853	789	**3,307**	754	751	746	739	**2,990**	724	762	775	746	**3,007**	779	779	727	713	**2,998**	764	686	703	724	**2,877**	814	884	912	940	**3,550**	1,116				**1,116**
Population 5 – 217-like Group - Dual	6,938	8,390	7,911	8,627	**31,866**	9,714	10,023	10,181	10,491	**40,409**	11,050	11,820	12,257	12,311	**47,438**	12,167	12,422	12,828	13,350	**50,767**	14,040	14,723	15,545	16,256	**60,564**	16,706	17,025	17,347	17,575	**68,653**	17,493	17,830	17,789	18,095	**71,207**	18,357	18,543	18,520	18,234	**73,654**	17,366				**17,366**
Population 6 – VIII Group (expansion)	753,995	761,293	778,625	784,161	**3,078,074**	806,114	802,658	773,108	762,010	**3,143,890**	762,410	756,109	747,006	753,639	**3,019,164**	759,129	765,866	767,811	778,089	**3,070,895**	784,171	814,819	827,549	850,436	**3,276,975**	866,005	871,996	879,825	886,857	**3,504,683**	887,606	880,676	881,394	881,943	**3,531,619**	885,341	903,210	869,233	850,000	**3,507,784**	845,534				**845,534**
Population 7 - CHIP Group	151,824	140,006	134,983	132,292	**559,105**	133,031	130,727	123,340	117,212	**504,310**	117,719	113,236	109,585	111,810	**452,350**	113,954	111,660	112,480	115,511	**453,605**	118,810	114,070	118,310	119,859	**471,049**	124,273	128,782	118,258	121,190	**492,503**	124,276	129,115	131,436	135,056	**519,883**	140,479	125,104	116,491	115,407	**497,481**	114,301				**114,301**
Population 10 - SUD IMD																93	324	92	86	**595**	609	621	651	848	**2,729**	1,192	1,305	1,101	1,183	**4,781**	1,330	1,462	1,677	1,547	**6,016**	1,733	1,697	1,583	1,440	**6,453**	637				**637**
Total	**2,277,716**	**2,295,065**	**2,328,839**	**2,333,446**	**9,235,066**	**2,366,097**	**2,351,579**	**2,286,361**	**2,242,713**	**9,246,750**	**2,246,065**	**2,222,349**	**2,183,247**	**2,186,081**	**8,837,742**	**2,185,872**	**2,189,601**	**2,193,826**	**2,205,069**	**8,774,368**	**2,219,813**	**2,286,158**	**2,363,423**	**2,422,118**	**9,291,512**	**2,473,424**	**2,507,481**	**2,545,672**	**2,580,650**	**10,107,227**	**2,604,161**	**2,620,999**	**2,635,149**	**2,646,561**	**10,506,870**	**2,665,036**	**2,630,094**	**2,497,765**	**2,403,479**	**10,196,374**	**2,334,437**	**0**	**0**	**0**	**2,334,437**

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Table #9 - Waiver Year 10 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
Admin		**367,965,093**
MEG01 - TANF & Related	$ 2,657,750,861	$ -
MEG02 - SSI & Related - Medicaid Only	$ 1,210,241,568	$ -
MEG03 - SSI & Related - Dual Eligible	$ 733,584,613	$ -
MEG04 - "217 Like" Medicaid Only	$ 12,100,433	$ -
MEG05 - "217 Like" Dual Eligible	$ 280,779,800	$ -
MEG06 - VIII Group - Medicaid Expansion	$ 2,363,810,468	$ -
MEG07 - CHIP	$ 138,962,942	$ -
Uncompensated Care "UC" Pool	$ -	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Centennial Care 2.0 Medicaid SUD/IMD	$ 7,662,017	N/A
Grand Total	**$ 7,404,892,702**	**$ 367,965,093**

Source: New Mexico CMS 64 Submission, FFY 2024, Quarer 2.

Key Utilization
Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Inpatient (Admissions)	82.8	68.4	$ 10,591	$ 10,029
Inpatient (Days)	378.0	308.5	$ 2,321	$ 2,225
Practitioner / Physician (Services)	7,361.9	6,648.5	$ 83	$ 94
Emergency Department (Visits)	552.4	485.2	$ 513	$ 537
Outpatient (Visits)	1,658.4	1,456.8	$ 283	$ 312
Pharmacy (Scripts)	4,413.8	4,116.7	$ 80	$ 92
Other (Services)1	8,807.8	8,648.2	$ 64	$ 70

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Brand	9.4%	7.0%	$ 626	$ 992
Generic	89.4%	91.9%	$ 23	$ 24
Other Rx2	1.2%	1.1%	$ 70	$ 71

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

Adult Expansion: Other Adult Group

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Inpatient (Admissions)	71.8	70.1	$ 16,666	$ 17,044
Inpatient (Days)	592.5	899.9	$ 2,019	$ 1,328
Practitioner / Physician (Services)	7,747.5	7,207.0	$ 95	$ 110
Emergency Department (Visits)	576.7	532.4	$ 686	$ 719
Outpatient (Visits)	2,119.0	1,906.1	$ 350	$ 367
Pharmacy (Scripts)	7,572.5	7,172.9	$ 115	$ 131
Other (Services)1	9,036.5	8,670.5	$ 78	$ 87

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Brand	10.5%	9.1%	$ 892	$ 1,186
Generic	88.0%	89.6%	$ 23	$ 25
Other Rx2	1.4%	1.3%	$ 90	$ 89

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

Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Inpatient (Admissions)	241.8	237.7	$ 2,772	$ 1,584
Inpatient (Days)	1,696.4	1,611.8	$ 395	$ 234
Nursing Home (Days)	249,768.2	213,009.0	$ 50	$ 55
Personal Care (Services / hr.)	796,708.9	767,406.8	$ 20	$ 22
Outpatient (Visits)	6,038.9	4,901.6	$ 139	$ 127
Pharmacy (Scripts)	832.4	765.1	$ 19	$ 20
HCBS (Services)	8,966.1	10,032.1	$ 146	$ 124
Other (Services)1	44,939.0	38,415.2	$ 42	$ 48

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Brand	12.4%	13.5%	$ 86	$ 94
Generic	83.9%	82.7%	$ 8	$ 7
Other Rx2	3.6%	3.9%	$ 64	$ 54

Notes:

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

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Inpatient (Admissions)	338.7	310.2	$ 18,713	$ 18,504
Inpatient (Days)	2,718.3	2,353.0	$ 2,332	$ 2,440
Nursing Home (Days)	18,893.7	20,120.8	$ 199	$ 198
Personal Care (Services / hr.)	681,051.9	649,314.3	$ 21	$ 22
Outpatient (Visits)	8,010.5	7,396.2	$ 532	$ 559
Pharmacy (Scripts)	29,873.7	28,839.4	$ 132	$ 153
HCBS (Services)	27,982.8	26,065.7	$ 92	$ 96
Other (Services)1	61,054.7	58,787.4	$ 102	$ 115

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Brand	9.1%	8.6%	$ 1,165	$ 1,458
Generic	89.0%	89.7%	$ 27	$ 30
Other Rx2	1.9%	1.7%	$ 87	$ 88

Notes:

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

Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Inpatient (Admissions)	213.1	201.8	$ 7,395	$ 7,205
Inpatient (Days)	1,428.2	1,435.4	$ 1,104	$ 1,013
Nursing Home (Days)	5,838.8	6,605.1	$ 35	$ 34
Personal Care (Services / hr.)	-	-	$ -	$ -
Outpatient (Visits)	7,168.7	5,779.2	$ 238	$ 240
Pharmacy (Scripts)	10,830.3	10,468.2	$ 132	$ 145
HCBS (Services)	282,018.0	257,934.8	$ 91	$ 93
Other (Services)1	51,306.7	45,392.3	$ 57	$ 63

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Brand	10.1%	9.5%	$ 1,014	$ 1,205
Generic	87.8%	88.6%	$ 31	$ 34
Other Rx2	2.1%	1.9%	$ 101	$ 93

Notes:

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

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Inpatient (Admissions)	71.4	49.8	$ 5,057	$ 6,385
Inpatient (Days)	527.9	356.1	$ 684	$ 894
Practitioner / Physician (Services)	8,365.3	7,209.6	$ 29	$ 32
Emergency Department (Visits)	604.0	495.9	$ 167	$ 177
Outpatient (Visits)	3,073.6	2,430.0	$ 151	$ 132
Pharmacy (Scripts)	1,314.7	1,263.9	$ 36	$ 25
Other (Services)1	7,445.4	7,174.4	$ 79	$ 109

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Brand	16.1%	16.4%	$ 161	$ 95
Generic	82.0%	81.5%	$ 11	$ 10
Other Rx2	2.0%	2.1%	$ 80	$ 71

Notes:

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

Key Utilization

Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Inpatient (Admissions)	38.6	36.3	$ 597	$ 589
Inpatient (Days)	90.0	79.7	$ 256	$ 268
BH Practitioner (services)	683.2	729.5	$ 161	$ 177
Core Service Agency (Services)	334.6	367.8	$ 187	$ 184
BH outpatient / clinic (Services)	3,368.9	3,178.1	$ 81	$ 87
Pharmacy (Scripts)	1,535.8	1,512.5	$ 65	$ 67
Residential Treatment Center (days)	39.1	46.9	$ 3,008	$ 2,080
Other (Services)1	12.2	10.8	$ 122	$ 158

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	January 2022 - December 2022	January 2023 - December 2023	January 2022 - December 2022	January 2023 - December 2023
Brand	3.2%	3.0%	$ 1,162	$ 1,318
Generic	96.8%	97.0%	$ 29	$ 29
Other Rx2	0.0%	0.0%	$ -	$ -

Notes:

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

DY11 Q1 Attachment D: Customer Service Summary (Jan 1 - Mar 31, 2024)

BCBS CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			WSCC											
		CONTRACT STANDARD	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		12,278	10,435	10,710									
	Number of Calls Answered - All Queues		12,148	10,376	10,620									
	Percent of Calls Abandoned	**< 5%**	1.1%	0.6%	0.8%									
	Percent of Calls Answered within 30 Seconds	**85%**	89.9%	92.3%	93.2%									
	Average Wait Time	**< 2 minutes**	0.2	0.3	0.2									
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%									
Nurse Advice Line	Number of Calls Received - All Queues		597	539	587									
	Number of Calls Answered - All Queues		590	533	586									
	Percent of Calls Abandoned	**< 5%**	1.2%	1.1%	0.2%									
	Percent of Calls Answered within 30 Seconds	**85%**	87.6%	90.2%	92.5%									
	Average Wait Time	**< 2 minutes**	0.2	0.2	0.2									
Provider Services	Number of Calls Received - All Queues		8,091	7,078	7,242									
	Number of Calls Answered - All Queues		8,059	7,056	7,205									
	Percent of Calls Abandoned	**< 5%**	0.4%	0.3%	0.5%									
	Percent of Calls Answered within 30 Seconds	**85%**	89.3%	91.0%	90.0%									
	Average Wait Time	**< 2 minutes**	0.3	0.2	0.3									
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%									
UM Line	Number of Calls Received - All Queues		4,874	4,000	3,723									
	Number of Calls Answered - All Queues		4,849	3,993	3,715									
	Percent of Calls Abandoned	**< 5%**	0.5%	0.2%	0.2%									
	Percent of Calls Answered within 30 Seconds	**85%**	96.4%	99.4%	99.3%									
	Average Wait Time	**< 2 minutes**	0.1	0.0	0.0									

Source: BCBS Report 2, M1-M3 CY24

DY11 Q1 Attachment D: Customer Service Summary (Jan 1 - Mar 31, 2024)

PHP CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			WSCC											
		CONTRACT STANDARD	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		24,475	19,850	17,871									
	Number of Calls Answered - All Queues		24,263	19,715	17,661									
	Percent of Calls Abandoned	**< 5%**	0.9%	0.7%	1.2%									
	Percent of Calls Answered within 30 Seconds	**85%**	91.1%	94.1%	90.5%									
	Average Wait Time	**< 2 minutes**	0.2	0.2	0.3									
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%									
Nurse Advice Line	Number of Calls Received - All Queues		2,268	1,983	1,931									
	Number of Calls Answered - All Queues		2,230	1,955	1,911									
	Percent of Calls Abandoned	**< 5%**	1.7%	1.4%	1.0%									
	Percent of Calls Answered within 30 Seconds	**85%**	95.3%	95.1%	96.1%									
	Average Wait Time	**< 2 minutes**	0.2	0.2	0.1									
Provider Services	Number of Calls Received - All Queues		5,026	4,188	4,002									
	Number of Calls Answered - All Queues		5,000	4,177	3,980									
	Percent of Calls Abandoned	**< 5%**	0.5%	0.3%	0.5%									
	Percent of Calls Answered within 30 Seconds	**85%**	88.0%	91.4%	88.7%									
	Average Wait Time	**< 2 minutes**	0.3	0.2	0.3									
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%									
UM Line	Number of Calls Received - All Queues		997	815	687									
	Number of Calls Answered - All Queues		992	813	685									
	Percent of Calls Abandoned	**< 5%**	0.5%	0.2%	0.3%									
	Percent of Calls Answered within 30 Seconds	**85%**	94.8%	98.2%	93.9%									
	Average Wait Time	**< 2 minutes**	0.1	0.1	0.1									

Source: PHP Report 2, M1-M3 CY24

DY11 Q1 Attachment D: Customer Service Summary (Jan 1 - Mar 31, 2024)

WSCC CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			WSCC											
		CONTRACT STANDARD	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		7,617	6,279	6,229									
	Number of Calls Answered - All Queues		7,506	6,172	6,071									
	Percent of Calls Abandoned	**< 5%**	1.5%	1.7%	2.5%									
	Percent of Calls Answered within 30 Seconds	**85%**	90.9%	91.1%	84.4%									
	Average Wait Time	**< 2 minutes**	0.4	0.4	0.7									
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%									
Nurse Advice Line	Number of Calls Received - All Queues		133	168	141									
	Number of Calls Answered - All Queues		128	165	137									
	Percent of Calls Abandoned	**< 5%**	3.8%	1.8%	2.8%									
	Percent of Calls Answered within 30 Seconds	**85%**	95.3%	94.5%	94.9%									
	Average Wait Time	**< 2 minutes**	0.2	0.2	0.2									
Provider Services	Number of Calls Received - All Queues		4,704	4,161	4,072									
	Number of Calls Answered - All Queues		4,660	4,092	4,008									
	Percent of Calls Abandoned	**< 5%**	0.9%	1.7%	1.6%									
	Percent of Calls Answered within 30 Seconds	**85%**	92.6%	85.8%	86.6%									
	Average Wait Time	**< 2 minutes**	0.3	0.5	0.5									
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%									
UM Line	Number of Calls Received - All Queues		1,357	1,032	1,105									
	Number of Calls Answered - All Queues		1,291	1,014	1,076									
	Percent of Calls Abandoned	**< 5%**	4.9%	1.7%	2.6%									
	Percent of Calls Answered within 30 Seconds	**85%**	79.7%	92.4%	94.3%									
	Average Wait Time	**< 2 minutes**	0.9	0.4	0.5									

Source: WSCC Report 2, M1-M3 CY24