



CENTENNIAL CARE 2.0 DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 9 (1/1/2022 – 12/31/2022)
Quarter 3 of 2022

January 17, 2023

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INTRODUCTION

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

In Centennial Care 2.0, the state 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:

- Improve continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, increasing utilization of preventive services, and promoting administrative simplification and fiscal sustainability of the Medicaid program;
- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;
- Build upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

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

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

Status of Key Dates:

TOPIC	KEY DATE	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.	Completeness Letter Received on March 25, 2021.
1115 Demonstration Amendment #2 Letter Amendment	Submitted to CMS on December 30, 2021.	Under CMS Review.

New Mexico's current 1115 demonstration waiver expires December 31, 2023. The Human Services Department (HSD) will submit a 5-Year 1115 demonstration waiver renewal application to CMS in 2022 for an anticipated effective date of January 1, 2024. HSD has held several stakeholder engagements to obtain valuable input on the current Centennial Care 2.0 Medicaid program and innovations that can be explored for the future Medicaid program. New Mexico is preparing its draft application for formal public comment, including public hearings and tribal consultation.

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: QUARTER 1 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	6/30/2022 ENROLLMENT	9/30/2022 ENROLLMENT	PERCENT INCREASE / DECREASE Q3
BlueCross BlueShield of New Mexico (BCBS)	294,768	297,063	0.8%
Presbyterian Health Plan (PHP)	425,521	426,837	0.3%
Western Sky Community Care (WSCC)	87,211	89,095	2.2%

Source: Medicaid Eligibility Reports, June 2022 and September 2022

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment and expenditure data by programs for July 2020 - June 2022 is available in Attachment A to this report.

MCO Enrollment

In aggregate, MCO enrollment increased by 6% from the previous to current period. This increase is comprised of the following:

- 8% increase in Physical Health enrollment.
- 2% increase in Long-Term Services and Supports enrollment.
- 3% increase in Other Adult Group enrollment.

Physical Health and Other Adult Group enrollment experienced continued growth due to the Maintenance of Effort (MOE) requirements during the Public Health Emergency (PHE). Enrollment numbers are expected to decline once the PHE ends. 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., June 30, 2022). Historically, this decrease in the last month changes to an increase in subsequent quarter due to additional runoff.

MCO Per Capita Medical Costs:

In aggregate, total MCO per capita medical costs increased by 2% from the previous to current period. This consists of a 2% increase to non-pharmacy services and a 1% increase to pharmacy services. On a dollar basis, higher enrollment levels are the primary driver of the 8% year over year increase in total medical expenses.

CENTENNIAL CARE 1.0 TO CENTENNIAL CARE 2.0 TRANSITION***Molina Healthcare Plan Termination***

Molina Healthcare (MHC) was required to comply with all duties and obligations incurred prior to the contract termination date of December 31, 2018, as well as continuing obligations following termination. During DY8, MHC provided monthly updates on the progress of its termination plan. HSD identified that MHC had \$1,926,347.83 in financial obligations. In DY8 Q4, MHC was notified of the payable amount due, and provided payment in the amount of \$1,926,347.00, which was accepted by the state. On August 15, 2022, HSD notified MHC by letter that it had fulfilled all its continuing obligations under the contract. MHC acknowledged receipt of the letter and had no questions.

CENTENNIAL REWARDS

Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors. Beginning in DY9, New Mexico modified its 2022 Rewards Program as illustrated below.

Reward Activity	Age Requirement	2022 Modification
Adult Primary Care Provider (PCP) Checkup – Complete annual PCP wellness checkup	Ages 22+	Age requirement changed from Ages 19+ to 22+
Asthma Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 5-17	Reward activity eliminated
Bipolar Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 18-64	Reward activity eliminated
COVID-19 Vaccine or Booster – Complete COVID-19 vaccine or booster	All ages, as advised by CDC	Added booster
Dental Checkup (Adult) – Complete annual dental checkup	Ages 18+	Reward activity eliminated
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	Age requirement changed from 2-17 to 2-20

Diabetes HbA1C Test – Completion of HbA1C Test <ul style="list-style-type: none"> Bonus: Diabetes HbA1C Control – Attain HbA1c control (<8%) 	Ages 10-75	Added new bonus reward activity
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75	No change
Diabetes Nephropathy Exam – Completion of diabetic nephropathy exam	Ages 10-75	Reward activity eliminated
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
Schizophrenia Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	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 <ul style="list-style-type: none"> Bonus: Complete all eight well-child visits with a PCP between 0-30 months of life 	0-30 months	Combined Well-Baby Checkup activities and added new bonus reward activity
3-week Step-Up Challenge – Successfully complete 3-week Step-Up Challenge	Ages 10+	Reward activity eliminated
9-week Step-Up Challenge – Successfully complete 9-week Step-Up Challenge	Ages 10+	Reward activity eliminated
Antidepressant Medication Management - Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	Added new reward activity
Child & Adolescent Well-Care Visit - Complete annual wellness checkup with a PCP or an OB/GYN <ul style="list-style-type: none"> Bonus: Adolescent Immunization Series – Complete adolescent immunization series by 13th birthday 	Ages 3-21	Added new reward activity
Follow-up After Emergency Dept. Visit for Mental Illness – Complete follow-up visit within 30 days of emergency department visit for mental illness or intentional self-harm diagnoses	Ages 6+	Added new reward activity
Follow-up After Hospitalization for Mental Illness - Complete follow-up visit within 30 days of hospitalization for mental illness or intentional self-harm diagnoses	Ages 6+	Added new reward activity

As of DY9 Q3 there are 822,060 Centennial Care members were eligible and participating in the Centennial Rewards Program. Active Centennial Rewards program enrollment is not required to participate in the program but is required for reward redemption. Quality

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improvement and participation trends are demonstrated in the table below.

Table 2: Centennial Rewards

CENTENNIAL REWARDS				
	October - December 2021	January - March 2022	April - June 2022	July - September 2022
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	91,978	161,053	186,917	159,246
Number of Members Newly Registered in the Rewards Program this Quarter	6,508	3,793	3,954	5,416
Number of Members Who Redeemed Rewards this Quarter**	46,079	22,540	27,751	30,754

*Only includes rewards earned THIS quarter.

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

Source: Finity Quarter 3 Report

Electronic Engagement Reward Alert Campaign

In DY9 Q3, Finity conducted the following multimedia campaigns to support members.

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

- 24K texts sent in Q3 2022
- 24K emails sent in Q3 2022

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

- 65K texts sent in Q3 2022
- 57K emails sent in Q3 2022

COVID Immunization Campaign: Designed to encourage all members ages 6 months and over to receive their COVID vaccine. This is a self-attestation campaign with a \$20 value worth 200 reward points. Texts and emails were sent July through August.

- 67K texts sent in Q2 2022
- 38K emails sent in Q2 2022

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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, PPE, diapers, nursing supplies, toilet paper, and more. Texts and emails were sent July through September. This is an ongoing campaign and Q3 results are provided below:

- 310K texts sent in Q3 2022
- 240K emails sent in Q3 2022

Native American Program Engagement Campaign: Designed to encourage Native American members to self-attest to reward activities they've completed by either going on the Centennial Rewards Portal or calling the call center. Texts and emails were sent August through September.

- 28K texts sent in Q3 2022
- 13K emails sent in Q3 2022

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

- 28K texts sent in Q3 2022
- 4K emails sent in Q3 2022

Additional Key Stats through Q2 2022:

- Member participation in Q3 2022 reached an all-time high of over 75.2%.
- In Q3 2022, members earned over \$3.73M in rewards by completing healthy activities.

Enhanced Customer Satisfaction Survey: Finity enhanced the Centennial Rewards member satisfaction survey in 2021 by adding new questions that were approved by HSD. The results of the DY9 Q3 2022 survey are listed below:

Table 3: Centennial Rewards Customer Satisfaction Survey

Centennial Rewards Customer Satisfaction Survey									
DY9 Q1				DY9 Q2			DY9 Q3		
	# OF RESPONDENTS 1,713			# OF RESPONDENTS 2,577			# OF RESPONDENTS 3,340		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Centennial Care?	97%	3%	n/a	97%	3%	n/a	98%	2%	n/a
Are you satisfied with your doctor?	86%	3%	9% I don't have a doctor	88%	5%	7% I don't have a doctor	89%	4%	7% I don't have a doctor
Are you satisfied with your health plan?	96%	4%	n/a	96%	4%	n/a	96%	4%	n/a
Are you satisfied with the help provided by your care coordinator?	97%	3%	n/a	97%	3%	n/a	85%	7%	9% I don't have a care coordinator

Source: Finity Quarter 3 Report

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ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

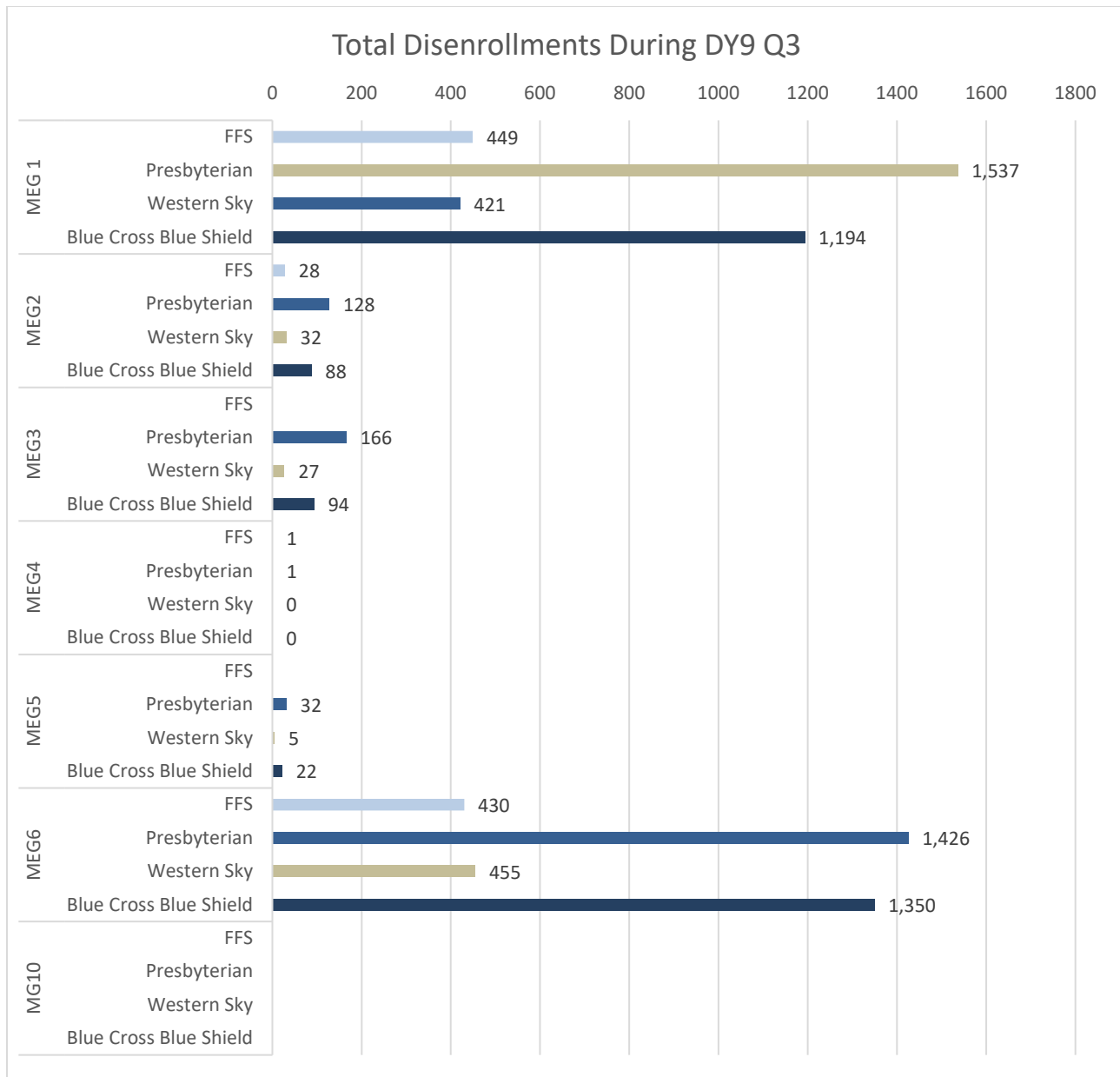
The following tables outline quarterly enrollment and disenrollment activity under the demonstration.

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

The disenrollment for this quarter is attributed to incarceration, death, and members moving out of state.

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 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.

Demonstration Population		Total Number Demonstration Participants DY9 Q3 Ending September 2022	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY9 Q3
Population MEG1 - TANF and Related	0-FFS	37,413	38,704	449
	Presbyterian	226,870	220,922	1,537
	Western Sky	43,227	42,529	421
	Blue Cross Blue Shield	149,884	146,121	1,194
	Summary	457,394	448,276	3,601
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,549	2,450	28
	Presbyterian	20,845	20,750	128
	Western Sky	3,819	3,817	32
	Blue Cross Blue Shield	12,602	12,432	88
	Summary	39,815	39,449	276
Population MEG3 - SSI and Related - Dual	0-FFS			
	Presbyterian	22,624	23,968	166
	Western Sky	3,424	3,648	27
	Blue Cross Blue Shield	11,370	12,105	94
	Summary	37,418	39,721	287
Population MEG4 - 217- like Group - Medicaid Only	0-FFS	223	172	1
	Presbyterian	101	112	1
	Western Sky	16	18	
	Blue Cross Blue Shield	73	81	
	Summary	413	383	2
Population MEG5 - 217- like Group - Dual	0-FFS			
	Presbyterian	2,999	3,348	32
	Western Sky	512	563	5
	Blue Cross Blue Shield	2,324	2,559	22
	Summary	5,835	6,470	59
Population MEG6 - VIII Group (expansion)	0-FFS	27,662	38,568	430
	Presbyterian	131,761	141,627	1,426
	Western Sky	33,793	36,374	455
	Blue Cross Blue Shield	106,285	113,869	1,350
	Summary	299,501	330,438	3,661
Population MG10 - IMDSUD Group	0-FFS	16	49	
	Presbyterian	113	472	
	Western Sky	5	48	
	Blue Cross Blue Shield	71	290	
	Summary	205	859	
Population MGX8 - IMDSUD VIII Group	0-FFS			
	Presbyterian	227	1,011	
	Western Sky	27	125	
	Blue Cross Blue Shield	200	846	
	Summary	454	1,982	
Summary		841,035	867,578	7,886



Source: Enrollee Counts Report

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OUTREACH/ INNOVATIVE ACTIVITIES TO ASSURE ACCESS

OUTREACH AND TRAINING	
DY9 Q3	<p>In DY9 Q3, HSD staff participated in remaining statewide town hall events known as “Cabinet in Your Community.” The purpose of these events is to meet with constituents and community leaders to resolve issues and provide on-site assistance and support from HSD staff and Cabinet Secretary or Deputy.</p> <p>HSD provided coaching, outreach and educational activities via webinars to Presumptive Eligibility Determiners (PEDs) in the Presumptive Eligibility and JUST Health Programs to help them better assist their clients in the completion of Medicaid eligibility applications, both on-line and telephonically. HSD also provided on-line certification and refresher training sessions for prospective and current PEDs.</p> <p>HSD is participating in the New Mexico Health Marketing Coalition Committee, now bi-weekly and lead by the NM Department of Tourism (NMDT), to promote outreach for new COVID-19 Vaccine and Booster Campaigns developed by the NMDT and their contractor. The campaigns are designed to encourage New Mexicans to get the COVID-19 Vaccine immunization series. The New Mexico Department of Health, HSD’s Managed Care Organizations and other healthcare stakeholders comprise this coalition.</p> <p>HSD staff are participating in the HSD COVID-19 Vaccination Workgroup and the Department of Health (DOH) COVID Provider Update Workgroup. The purpose of these meetings is to communicate and discuss COVID-19 Vaccine efforts, upcoming statewide events, review federal guidelines and outline operational procedures during the PHE.</p>

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COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

The MCOs submit encounters daily and/or weekly to stay current with encounter submissions, including encounters that are or not accepted by HSD. HSD meets regularly with the MCOs to address specific issues and to provide guidance. HSD regularly monitors encounters by comparing encounter submissions to financial reports to ensure completeness. HSD monitors encounters by extracting data monthly to identify the accuracy of encounter submissions and shares this information with MCO's. HSD extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. Based on the most recent quarterly data extracted, the MCO's are compliant with encounter submissions.

Data is extracted monthly to identify Centennial Care enrollment by MCO and for various populations. Any discrepancies that are identified, whether due to systematic or manual error, are immediately addressed. Eligibility and enrollment reports are run monthly to ensure consistency of numbers. In addition, HSD continues to monitor enrollment and any anomalies that may arise, so they are identified and addressed timely. HSD posts the monthly Medicaid Eligibility Reports (MERs) to the HSD website at: <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 DY9 Q2 reflect the Centennial Care 2.0 rates effective on January 1, 2022. The rates are developed with efficiency, utilization, trends, prospective program changes, and other factors as described in the rate certification reports. The rate certification reports for January 1 through December 31, 2022 were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 31, 2021.

During DY9 Q2, financial payments were made for the University of New Mexico Medical Group (UNMMG) directed payment, University of New Mexico Hospital (UNMH) directed payment and payment for quality, hospital access payment (HAP), health care quality surcharge (HCQS), COVID-19 vaccine non-risk payment, and temporary increase for hospital directed payment. The UNMMG directed payments, UNMH directed payment and payment for quality, and the COVID-19 vaccine non-risk payments partially contributed to the PMPM increase for MEGs 1, 2, and 6 of DY8. Similarly, UNMMG directed payment, hospital access payment, temporary rate increase hospital directed payment, and quality payment for health care quality surcharge contributed to the PMPM change for MEGs 1, 2, and 6 of DY9.

The fiscal impact of the public health emergency due to the Coronavirus (COVID-19) pandemic may be minimal in the financial activities during Quarter 2 of CY 2022. In addition, expenditures and member months for substance use disorder in an institution for mental diseases (SUD IMD) were reported for DY6 to DY9 for both fee-for-service and managed care.

COVID-19 PUBLIC HEALTH EMERGENCY (PHE) 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 Secretary Xavier Becerra renewed the COVID-19 PHE declaration for COVID-19 on October 13, 2022. The PHE will be evaluated next by January. Following is a chronology of the renewals to date:

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Renewing the public health emergency declaration ensures health care providers and state and territorial health departments have continued flexibility to respond to the pandemic, helping save lives. These flexibilities support efforts such as rapid patient care during emergencies, including waivers from the Centers for Medicare and Medicaid Services for certain requirements under [section 1135](#) of the Social Security Act. Examples of such requirements include preapproval requirements and [temporarily reassignment](#) of state, territorial, tribal or local staff who typically are funded by federal grants in order to respond to the emergency.

HHS will provide states and territories with 60 days' notice prior to the termination of the public health emergency declaration for COVID-19.

On May 9, 2022 the Health and Human Services Secretary, Xavier Becerra, declared a public health emergency for the State of New Mexico to aid the State in regions impacted by wildfires and straight-line winds.

In response to the COVID-19 PHE, HSD requested several federal waiver authorities and were approved for the following:

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,

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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.

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.

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- Temporarily allowing legally responsible individuals to provide PCS services to children under the EPSDT benefit.

Appendix Ks

HSD submitted one Appendix K this quarter and received CMS approval. Following is a comprehensive listing of approved Appendix Ks:

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

- 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.

1115 Demonstration Waiver for Home Community Benefit Services (HCBS)

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

setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

- Implementing retainer payments for personal care services.

1915c (Supports 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)

- 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.

PATIENT CENTERED MEDICAL HOMES (PCMH)

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

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

Table 4 below reports the total number of members paneled to a PCMH for DY9 Q2, which reflects an overall decrease in members receiving care through a PCMH. The DY9 Q3 data will be reported in the DY9 Q4 report.

Table 4: PCMH Assignment

P C M H A S S I G N M E N T				
Total Members Paneled to a PCMH				
	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
BCBS	154,450	138,596	137,858	135,065
PHP	262,428	269,646	273,786	277,943
WSCC	37,621	38,421	38,772	37,344
Percent of Members Paneled to a PCMH				
	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
BCBS	53.60%	47.20%	46.30%	45.30%
PHP	62.90%	63.90%	64.70%	65.30%
WSCC	44.50%	44.50%	44.40%	42.30%

Source: MCO Report #48 DY9 Q2

MCO PCMH initiatives:

BCBS: Current initiatives for BCBS include regular discussions with PCMH clinical teams on the importance of reducing visits to the Emergency Department (ED), and by encouraging them to refer their high utilizing patients to the care coordination team. BCBS care coordinators also provide guidance to members on the importance of calling their Primary Care Provider (PCP) office rather than going to the ED. BCBS’s community paramedicine program, in which they partner with several paramedic companies to outreach to members and provide home visits, is focused on the cohort of members who are high ED utilizers or who have a high risk of being readmitted.

PHP: PHP held discussions with PCMH groups in DY9 Q2. The VBP team included the PHP Performance Improvement (PI) team to discuss how to partner with groups to mitigate barriers.

PI Program Managers provided education for screening event partnerships, interventionist teams, etc. PHP VBP team continues to provide information and education on current and upcoming health equity training courses available during the year as well as CEU/CME opportunities. PHP stated quality measure tip sheets, member education opportunities and utilization of telehealth are reviewed during monthly meetings. PHP states that member education opportunities reviewed include nurse advice line, in home screening options, extending walk-in hours, etc. Overall, these have assisted in reducing utilization for PCMHs.

WSCC: WSCC states the Value Based Purchasing (VBP) program works with PCMH providers to review health screening and outcome metrics to improve overall member care using daily inpatient census and discharge reports on the provider portal. WSCC also offers a Value-Added Home Respite Bed service, focused on reducing inpatient psychiatric hospital readmissions. Through this program, eligible WSCC members have access to room and board at the Heading Home's Respite Care Program Facility with 24-hour care including assisting the member to manage their medication, individual and group sessions, transportation to appointments, case management focused on discharge planning, financial stability, housing, and access to community resources. WSCC BH Liaison/Care Coordinators are assigned to members during their stay and partner with the Heading Home staff to support a safe and successful transition back to the community.

CARE COORDINATION MONITORING ACTIVIES

Care Coordination Monitoring Activities	
DY9 Q3	<p>HSD continued to monitor MCO enrollment and member engagement through the quarterly Care Coordination Report. This report includes data related to completion of required assessments and touchpoints within contract timeframes. The DY9 Q3 report contains data from DY9 Q2. DY9 Q3 data will be reported in DY9 Q4. 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).</p> <p>The aggregate completion rate for HRAs for 'new to Medicaid' members was 97% in DY9 Q2, up from 72% in DY9 Q1. The aggregate completion rate for HRAs for members with a 'change in health condition' increased from 98% in DY9 Q1 to 99% in DY9 Q2</p> <p>Aggregate completion percentages for CNAs for CCL2 members decreased from 96% DY9 Q1 to 95% in DY9 Q2. Aggregate completion percentages for CNAs for CCL3 members decreased from 95% in DY9 Q1 to 93% in DY9 Q2.</p> <p>Aggregate completion percentages of CCPs for CCL2 members remained at 95% from DY9 Q1 to DY9 Q2. Aggregate completion rates for CCPs for CCL3 members remained at 96% from DY9 Q1 to DY9 Q2.</p> <p>Report 6 includes MCO strategies for engaging and retaining members. Consistent and timely assessment and touchpoint completion is vital to engendering member trust. In DY9 Q2, MCOs reported on multiple strategies to retain engagement with members, many who have never had face to face interactions with their care coordinators due to the Public Health Emergency (PHE). All MCOs reported conducting motivational interviewing training several times in DY9 Q2. BCBS care coordinators met with management to discuss their member engagement strategies which include earlier outreach attempts and developing a trusting rapport with members on their first successful</p>

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	<p>PHP care coordinators worked to ensure that member care plans are individualized and focus on needs important to the member. WSCC utilized various systems to confirm valid contact information for their members: PRISM, Impact Pro, CVS Caremark, Collective Medical, TruCare, SYNCRONYS, etc. All MCOs organized and led, or participated in, community outreach events distributing Personal Protective Equipment (PPE), food boxes, baby car seats, and supplies for newborns as well as school backpacks and supplies in DY9 Q2.</p> <p>HSD continues to monitor strategies and interventions for all MCOs to retain and increase compliance with performance benchmarks. The table below details aggregate and individual MCO performance for DY8 Q3 through DY9 Q2. DY9 Q3 data will be reported in DY9 Q4.</p>
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Table 5 – Care Coordination Monitoring

MCO Performance Standards	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
HRAs for new Members	99.5%	99.7%	72%	97%
BCBSNM	99.8%	99.9%	99.9%	98%
PHP	96%	96%	45%	96%
WSCC	100%	100%	100%	100%
HRAs for Members with a change in health condition	90%	92%	98%	99%
BCBSNM	100%	100%	100%	100%
PHP	86%	90%	98%	99%
WSCC	100%	100%	100%	100%
CNAs for CCL2 Members	94%	96%	96%	95%
BCBSNM	85%	90%	92%	90%
PHP	97%	98%	98%	98%
WSCC	99.8%	99.7%	100%	99%
CNAs for CCL3 Members	91%	94%	95%	93%
BCBSNM	77%	86%	88%	87%
PHP	96%	97%	98%	96%
WSCC	100%	100%	100%	100%
CCPs for CCL2 Members	96%	97%	95%	95%
BCBSNM	88%	91%	87%	87%
PHP	99.6%	100%	99%	99%
WSCC	99%	98%	99%	98%
CCPs for CCL3 Members	97%	97%	96%	96%
BCBSNM	93%	92%	90%	91%
PHP	99.6%	99%	99%	99%
WSCC	98%	97%	100%	97%

Source: HSD Report #6 – Quarterly Care Coordination Report

Percentages in bold are MCO aggregate of the total assessments due and completed.

In DY9 Q2, HSD continued to monitor the ongoing impact of the Public Health Emergency (PHE) and engagement of members in Care Coordination through a bi-weekly ‘Telephonic In-Lieu of Face-to-Face Visits’ report. This report monitors compliance of the MCOs’ use of telephonic and video visits for Comprehensive Needs Assessments (CNAs) and required touchpoints. The report identifies whether MCOs are able to continue to provide Care

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Coordination by completing assessments and touchpoints for members telephonically. The MCOs report CNAs and touchpoints that have been completed/not completed due to member-driven COVID-19 concerns. These member-driven concerns include the absence of privacy in the member's home to discuss Protected Health Information (PHI) and a lack of sufficient minutes on a member's cell phone. Aggregate MCO completion rates in DY9 Q2 were above 90% for all assessments and touchpoints conducted telephonically. In subsequent months, the MCOs attempt to conduct assessments and touchpoints that were not completed in prior months. The table below details the MCOs' DY9 Q2 completion of Bi-Weekly Telephonic In Lieu of Face-To-Face visits. DY9 Q3 data will be reported in DY9 Q4.

Table 6 - Telephonic In Lieu of Face-To-Face Visits

TELEPHONIC IN LIEU OF FACE TO FACE VISITS	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
Initial CNAs completed	2,056	2,318	1,999	2,485
BCBSNM	917	995	887	959
PHP	964	1,116	946	1,339
WSCC	175	207	166	187
Initial CNAs not completed due to COVID-19	39	58	107	131
BCBSNM	37	51	50	38
PHP	2	7	57	93
WSCC	0	0	0	0
Annual CNAs completed	5,765	6,496	6,105	7,538
BCBSNM	2,267	2,439	2,317	2,750
PHP	3,021	3,627	3,329	4,239
WSCC	477	430	459	549
Annual CNAs not completed due to COVID-19	618	616	635	708
BCBSNM	240	239	212	163
PHP	378	377	423	545
WSCC	0	0	0	0
Semi-annual CNAs completed	544	577	436	595
BCBSNM	212	197	153	233
PHP	281	305	216	286
WSCC	51	75	67	76
Semi-annual CNAs not completed due to COVID-19	48	44	22	32
BCBSNM	42	39	19	22
PHP	5	5	3	10
WSCC	1	0	0	0

Quarterly in-person visits completed	1,385	1,734	1,314	1,974
BCBSNM	576	716	508	803
PHP	748	968	758	1,073
WSCC	61	50	48	98
Quarterly in-person visits not completed due to COVID-19	67	125	93	137
BCBSNM	5	6	1	4
PHP	62	119	92	133
WSCC	0	0	0	0
Semi-annual in-person visits completed	6,744	7,184	4,924	6,590
BCBSNM	964	1,113	847	1,201
PHP	5,294	5,536	3,670	4,961
WSCC	486	535	407	428
Semi-annual in-person visits not completed due to COVID-19	559	689	427	556
BCBSNM	5	4	3	3
PHP	554	685	424	553
WSCC	0	0	0	0

Source: HSD DY9 Q2 MCO Ad Hoc Report: Bi-Weekly Telephonic in Lieu of Face-To-Face Report
Percentages in bold are MCO aggregate of the total assessments completed or not completed.

Care Coordination Audits

In DY9 Q2, HSD monitored MCO compliance with contract and policy by conducting quarterly Care Coordination audits. These audits monitor:

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

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

Care Coordination staff.

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

The table below details the Care Coordination Categorization Audit results for DY9 Q2. DY9 Q3 data will be reported in DY9 Q4.

Table 7 - Care Coordination Categorization Audit

Care Coordination Categorization	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
Difficult to Engage (DTE)	87%	88%	100%	84%
BCBS	93%	97%	100%	93%
PHP	70%	73%	100%	72%
WSCC	98%	93%	100%	87%
Unable to Reach (UTR)	44%	89%	92%	98%
BCBS	0%	86%	X*	X*
PHP	33%	87%	X*	X*
WSCC	99%	93%	92%	98%
Refused Care Coordination (RCC)	93%	96%	92%	89%
BCBS	93%	87%	93%	83%
PHP	100%	100%	87%	85%
WSCC	85%	100%	95%	100%

Source: HSD DY9 Q2 Care Coordination Categorization Audits

Percentages in bold are MCO averages

*See below for details regarding BCBS/PHP UTR IAPs

HSD implemented Individual Action Plans (IAP), in DY9 Q1, for both BCBS and PHP due to the consistent decrease in audited Unable to Reach (UTR) Member files meeting requirements. HSD has directed BCBS and PHP to update HSD, quarterly, on the training, oversight, and follow-up that is occurring to ensure contract requirements are being met. HSD has directed BCBS and PHP to complete quarterly internal audits of their UTR Membership and report the audit results and the steps they are taking to ensure consistency and increase compliance. During this IAP, BCBS and PHP UTR audits have been suspended. Both BCBS and PHP achieved over 85% compliance in their DY9 Q2 IAP reports.

HSD noted that DY9 Q2 Care Coordination Categorization audit results showed an increase in compliance from DY8 for Unable to Reach (UTR) members – from 92% to 98% and a decrease in compliance for Difficult to Engage (DTE) members – from 100% to 84% - and members Refusing Care Coordination (RCC) – from 92% to 89%.

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In addition to HSD submitted audit findings, a discussion of DY9 Q2 audit results occurred with all MCOs, at the Quarterly Care Coordination Meeting, to clarify HSD expectations and requirements. Specific areas addressed were:

- Member files being incorrectly included in audit universes
- Inconsistent documentation on timeliness of outreach
- Conflicting documentation on member Care Coordination Levels

Based on HSD audit findings and recommendations, the MCOs conducted additional outreach to members, updated member file documentation and increased training of Care Coordination staff. HSD requested and received follow-up on audit files that did not meet compliance.

Additionally, HSD met with each MCO at monthly meetings and discussed the decrease in compliance for DTE members with PHP and the decrease in compliance for RCC members with both BCBS and PHP.

PHP acknowledged that 25% of DTE member files and 13% of RCC member files had been included in the submitted universes in error. HSD requested PHP conduct additional oversight prior to submitting monthly audit universes. BCBS noted an error in the risk stratification set by a care coordinator which was addressed with targeted stratification re-training and updates to the member files.

HSD notes that all MCOs are conducting additional, targeted outreach to members who have been UTR or DTE for a significant amount of time. These projects have been successful in engaging additional members and categorizing them appropriately. HSD directed MCOs to increase the clarity of documentation to ensure member files include notation of the special outreach project.

The table below details the Transition of Care Audit results for DY9 Q2. DY9 Q3 data will be reported in DY9 Q4.

Table 8 - Transition of Care Audit

Transition of Care	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
In-Patient	93%	98%	99%	99%
BCBS	87%	95%	98%	100%
PHP	99%	100%	98%	98%
WSCC	x*	100%	100%	100%
Nursing Facility	96%	98%	99.9%	99.0%
BCBS	99%	97%	99.7%	99.7%
PHP	99%	97%	100%	99%
WSCC	91%	100%	X*	97%

Source: HSD DY9 Q2 Quarterly TOC Audits

Percentages in bold are MCO averages.

*WSCC had no IP transitions in DY8 Q3 and no NF transitions in DY9 Q1.

Results of the DY9 Q2 TOC Quarterly Audits showed improvement in the quality of documentation in member files.

Areas that needed improvement were related to:

- Files for members outside of the audit scope being incorrectly included in the audit universe
- Post-discharge assessments being completed prior to discharge

HSD provided detailed findings, reiterated contract requirements, and stressed the importance of comprehensive documentation. HSD noted that aggregate rates of compliance remained at 99% for IP to Community TOC members from DY9 Q1 to DY9 Q2 and decreased slightly for NF to the Community members from DY9 Q1 (99.9%) to DY9 Q2 (99%). HSD requested, and received, updates on specific audited members and ongoing training provided to Care Coordination staff.

The table below details the Health Risk Assessment and Care Coordination Level Audit results for DY9 Q2. DY9 Q3 data will be reported in DY9 Q4.

Table 9 - Health Risk Assessment and Care Coordination Level Audit

HRA/CCL Audit	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
Health Risk Assessment (HRA)	97%	96%	95%	99%
BCBS	100%	99%	98%	100%
PHP	98%	90%	88%	99%
WSCC	94%	99%	100%	99%
Care Coordination Level (CCL)	91%	94%	94%	100%
BCBS	91%	93%	99%	100%
PHP	99%	93%	99%	100%
WSCC	82%	96%	83%	100%

Source: HSD DY9 Q2 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 increased from DY9 Q1 (95%) to DY9 Q2 (99%). Points were deducted for incomplete documentation. HSD requested, and received, updates on specific audited members and ongoing training provided to Care Coordination staff.

Aggregate rates of compliance for the CCL Audit increased from 94% in DY9 Q1 to 100% in DY9 Q2. Discrepancies identified in the Care Coordination (CCL) Audit were related to inconsistent documentation. HSD reiterated the need for robust documentation and MCOs conducted additional, targeted training with care coordinators to ensure the accuracy of documentation.

Care Coordination CNA Ride-Alongs

HSD conducted 4 virtual CNA ride-alongs with MCO care coordinators in DY9 Q2 to observe completion of member assessments. The MCOs began utilizing telephonic or virtual visits in lieu of in-home, in-person touchpoints in DY7 Q1 to reduce the risk of spreading COVID-19 through face-to-face contact.

HSD attended annual virtual CNAs conducted by all 3 MCOs.

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:

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- 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 Coordination HRA Ride-Alongs

HSD conducted 10 virtual HRA ride-alongs with MCO care coordinators in DY9 Q2 to observe completion of member assessments. All HRAs observed were conducted telephonically.

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

- The majority of Assessors were friendly, thorough, and professional with the members
- Assessors often explained to members that they could request Care Coordination in the future if they would like assistance
- Assessors referred members to resources to address specific concerns
- HSD noted opportunities for improvement that included:
 - Ensuring that Assessors explain the purpose of the HRA
 - Ensuring that Assessors thoroughly explain the services available through Care Coordination
 - Ensuring all contract required topics are addressed in HRA

Care Coordination All MCO Meetings

HSD conducts regular quarterly meetings with the MCOs to review data on member engagement, Care Coordination timeliness, performance analysis and member outcomes. HSD held the DY9 Q2 Quarterly Meeting on June 29, 2022 and reviewed:

- Aggregate data from the following reports related to enrollment and compliance with assessment and touchpoint timeliness:
 - Quarterly Care Coordination Report
 - Children in State Custody (CISC) Report
- Results of the DY9 Q1 audits of member categorization, Health Risk Assessments (HRAs), Care Coordination Levels (CCLs) and compliance with Transition of Care (TOC) requirements

Results of the DY9 Q1 audits of CISC Health Risk Assessments (HRAs) Care Coordination Levels (CCLs)

HSD informed the MCOs that revisions to the HSD standardized HRA had been completed and were ready for MCO implementation in DY9 Q3. Changes included adding clarifying

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questions related to a member's gender identity and additional guidelines for the assessors when detailing the services available through Care Coordination.

HSD discussed ideas for expanding ways to measure member outcomes through Care Coordination. All MCOs noted that member surveys were being developed that care coordinators will conduct when a member is leveled down from CCL3 to CCL2 or is no longer in need of Care Coordination services. MCOs will provide updates on these surveys in DY9 Q4.

BEHAVIORAL HEALTH

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

As stated in the DY9 Q2 report, due to claims lag (minimally 90 days) and timing of the quarterly report, the data historically doesn't appropriately reflect performance of behavioral health activities in the following areas: telehealth, telephonic service delivery and supportive housing. To address this issue HSD made the decision to reflect the time period prior to the current reporting quarter beginning with DY9 Q3. For this reporting period, telehealth, telephonic service delivery and supportive housing will submit data as reflected on July 31, 2022, for the time period April – June, 2022. DY9 Q3 will reflect *refreshed* data for the time period April – June, 2022.

In DY9 Q2, a total of 38,082 Medicaid Members received behavioral health services through telehealth. This quarter's total did see a slight decrease of 9.5 percent compared to the Q1 total of 42,088 persons served through this medium. Of those served in DY9 Q2 through telehealth, 15,313 persons reside in rural or frontier counties. This accounts for 40 percent of those served and is reflective of client and provider preferences and the high value of telehealth in New Mexico's rural and frontier landscapes

Service delivery over telephonic means continues to see growth. In DY9 Q2, 27,433 Members received services through this modality compared to 29,445 in Q1 which is a decrease of 4,710 people or a decrease of 16%. As the timing of this report occurs soon after the end of the quarter, the results reported at this time are not final for telehealth nor telephonic services and will be refreshed next quarter when claim lag is no longer present so the result of those served during Q2 will likely increase. BHSD continues to evaluate which behavioral health services are appropriate to continue delivery through telephone when the

public health emergency is over. This option has undoubtedly been a critical link to services during the COVID-19 crisis.

All MCOs reported significant increases in telehealth services to all age groups, in urban, rural and frontier counties, and to all populations of SMI, SED and SUD clients. In addition to increased utilization, behavioral health providers around the state are reporting qualitative improvements – a decline in no-shows and cancellations, clients less stressed because they have not had to leave their homes or children, and therapists more informed about their clients because they can see more of their lives. However, some providers are also reporting ‘zoom fatigue’ and greater difficulty keeping some clients engaged.

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. Treat First agencies have seen 2,540 new clients during the first six months of 2022. With support from the Treat First agencies, 23.8% 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 7.0%. This is impressive particularly during the pandemic and significantly lower than before agencies started the Treat First Approach.

When youth or adults were asked how they felt their Treat First visits were going, on average, both groups felt that the sessions were working very well to address their immediate needs.

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 DY9 Q2, SBIRT utilization increased 8% to 1,569 persons served compared to 1,454 in the prior quarter. On a monthly average, 551 persons received SBIRT in Q2 whereas in the prior quarter the average was 518 per month. In the midpoint of DY9, a total of 2,811 beneficiaries have received screening, brief intervention, and referral to treatment services. There is likely minimal claim lag represented in these results, so the performance may exceed the current increase, however this will be noted in the refreshed totals in next quarter’s report.

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

The Centennial Care 2.0 program includes new and expanded services for Medicaid

recipients with substance use disorder (SUD). In DY9, the State continued efforts to implement Crisis Treatment Centers (CTC). Provider-specific cost-based rates are established for three CTC providers in the state and are now delivering in-patient and outpatient CTC services. Expansion of CTCs continues as the state expands the 988 Crisis Now initiatives.

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

As part of the SUD 1115 Waiver, services have been approved for specific substance abuse populations in an Institution for Mental Disease (IMD.) An IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating substance use disorders (SUD) that is not part of a certified general acute care hospital. 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 ASAM admission criteria. Covered services include withdrawal management (detoxification) and rehabilitation.

In DY9 Q2, the total number of persons served with a SUD in an IMD was 3,558, which is a 1.6 percent increase compared to DY9 Q1 (3,493 persons). On a month-to-month average during the first two quarters of DY9, 1,514 persons were served in an IMD with a substance use disorder, with the greatest utilization occurring in March of 2022 where 1,646 persons were served. The unduplicated total of persons served during the first two quarters of the report period is, 5,240.

SUD Health IT

For DY9 HSD continues actively working to develop the necessary SUD Health IT capabilities to support member health outcomes and address the SUD goals of the demonstration. New Mexico has developed a workgroup to review our Health IT plan to ensure the progress and support of each milestone.

Utilization of the New Mexico Prescription Monitoring Program (NM PMP) continues to increase the number of providers that are utilizing it. 89.52% of providers have been checking prescriptions which is a 2.82% increase over the previous year which was 87%.

The Drug Utilization Review committee led by HSD's pharmacist continues to meet quarterly to review the program developed to monitor controlled substance prescribing through information technology against Medicaid claims data. It is attended by all MCOs as well as

the Medicaid Management Information System (MMIS) staff.

Project ECHO continues to train providers on pain management, however DY9 showed a 39% decrease in the number of providers attending, from 459 to 282, but showed an increase of 54% in the number of sessions held: from 33 to 72. Advertising for these sessions is expanding to multiple web sites and list serves. The next reporting period is March 2023.

ECHO trainings, the New Mexico Bridge Project expanded training on prescribing for opioid use disorder for hospital emergency departments, inpatient and related clinics throughout the state. The Project completed training in 5 rural hospitals, including 2 that are Indian Health Services. The Project is working with 4 additional hospitals in rural settings to provide trainings. As part of this project all prescribing practitioners have attained their waivers to prescribe buprenorphine. The trainings include buprenorphine initiation, responsible opioid prescribing, treatment in clinic settings, OUD in pregnancy, neurobiological basis of SUD, case reviews, toxicology updates, “blue” fentanyl updates, and more. Prescribing practitioners attain waivers to prescribe buprenorphine upon training completion. More information on the Project can be found here: <https://nmbridge.org/>.

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 established 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.

The Centennial Care MCOs worked together on the Drug Utilization Review (DUR) committee to develop a standard monitoring program for controlled substance utilization. The DUR meets quarterly to accomplish monitoring parameters and receive input requiring action from the MCOs. This includes development of enhanced supports for clinician review of patient's history of controlled substance prescriptions provided through the PDMP.

HSD and vendors for the new MMIS will be designing and implementing enhanced data analytics targeted for 2022. Smart phone apps are part of the Medicaid Management Information System (MMIS) unified public interface (UPI). HSD and vendors for the new MMIS will be designing and implementing smart phone capabilities (UPI) in 2022. This initiative will assist in retention for treatment for OUD and other SUDs. HSD and vendors

for the new MMIS will be designing and implementing data services to provide analytics for public health and clinical support for providers is also targeted for 2022.

ADULT ACCREDITED RESIDENTIAL TREATMENT CENTERS (AARTC) SERVICES

A total of 16 AARTCs have been approved since the onset of the application process through eight providers. In DY9 Q2 another provider ceased operations and closed. During DY9 Q3 BHSD worked with four providers in completing the AARTC application. Three providers are in various stages of the application process and are submitting required documentation for review. One provider has received approval of interim rates and has continued the process of contracting with the Managed Care Organizations (MCOs) for reimbursement.

Table 10 – AARTC Client Counts

MEDICAID CLIENT COUNTS				
PROVIDER #	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
716	0	0	0	0
090	35	44	52	21
037	321	340	296	173
081	0	9	5	2
589	0	14	7	3
332	N/A	0	23	21
049	N/A	21	21	6
825	N/A	0	4	6
896	N/A	2	2	0
302	NA	1	37	56
Unduplicated Total	356	431	447	288

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

For the 12 existing AARTCs in operation who are approved to bill Medicaid, the data above identifies the total number of clients who received AARTC services during Q4 of DY8 and Q1, Q2, and Q3 of DY9. Clients counts for DY9 Q1 have been adjusted to reflect actual number of clients served. Client counts may be impacted by claim lag up to 120 days following the end of the recent quarter. The provider number is a unique identifier in this table 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 date field to represent this. Although 10 provider sites are represented in the chart above, provider 037 has three sites that are being represented through their 037 data. All AARTC provider sites are actively in process to receive distinct identification numbers to ensure accuracy in client counts for each site. Two provider sites are not represented on the chart as they are in process of contracting with MCOs for reimbursement.

The utilization of the Medicaid services shows a decrease from DY9 Q2 to DY9 Q3, which may be attributed to the 90-day lag in claims submitted for DY9 Q3. It is expected that numbers will increase as actuals counts are adjusted in DY9 Q4 to account for claim lag. Further analysis is warranted to ensure counts are accurately reported and represented for those providers.

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

HEALTH HOMES

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

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

CLNM Health Home Activities

DY9 Q3 Activities	<p>Insufficient staffing levels remain of high concern; especially for those positions requiring independently licensed staff, such as the supervisors. There is a dearth of these clinicians across all of New Mexico. Requests from the health homes to change the requirement from independent licensure, to master level clinicians with experience has not yet resulted in a positive response. A policy change for acceptance of remote supervision is approved but not yet put in place. Low staffing resulted in a 2.7% decrease in membership. Two factors that attribute to a decrease in membership include: members are discharged once they reach a high level of self-sufficient maintenance of their chronic conditions and an aging population that have left Medicaid and are now enrolled in Medicare.</p> <p>The education series conducted by the varying health homes continues with four superlative presentations taking place this quarter. The first session was on transitional services by the University of New Mexico Hospital (UNMH), our largest health home. UNMH developed a transition of care team (TOC) that “strives to provide health home members, families, and care givers with the support and resources they need to reduce hospital readmissions, improve patient safety, and successfully transition back into the community”. SMI patients are at high risk for readmission 30 days post inpatient hospitalization, so this early and more intensive intervention has proven beneficial. The TOC obtains a list of qualifying members from the psychiatric center inpatient unit and educates them to the CLNM services. If interested, they opt them in, complete a comprehensive needs assessment, a safety plan, and care plan with the individual <i>while on the inpatient unit</i>. They then support the individual and family with discharge planning and continue their intensive support for 90 days at which time they transfer the patient to the long-term care coordinators. Within the last 14 months they worked with 326 patients; 229 opted in, 90 declined, and 7 chose to stay with their MCO care coordinator.</p> <p>The second learning session; the role of the community liaison and the referral process. This session was presented by another larger health homes, Mental Health Resources (MHR). MHR has four sites in four rural and frontier counties. They emphasized that even though clinical resources are scarce in rural and frontier areas, the “take care of each other attitude” in these communities makes it possible for the needed connections and referrals. The community liaison positions work with local health clinics, churches, regional hospitals, health councils, the Chamber of Commerce, the United Way, the Salvation</p>
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	<p>Army, and the Eastern Plains Community Action Agency. This treating the “whole person” approach allows, through the above resources, supply individuals with Thanksgiving and Christmas food boxes, health & hygiene packs, backpacks and shelter blankets for the homeless, bus passes. Through the United Way, bicycles are given to those without transportation. It was an inspiring presentation.</p> <p>The third session was on the development of safety plans for patients with suicide or depression risk. This health home, New Mexico Solutions, has a substantial population of individuals with the most intense behavioral health conditions. The safety plans are completed in the electronic health system and will become a feature of the annual on-site evaluation process.</p> <p>The fourth learning session was about documentation in the specialized health home information system (BHSDStar) and making a part of their daily workflow. It was informative for all the new staff.</p> <p>All new staff members take an ASAM course conducted by the University of New Mexico. The ASAM assessments are done by either the care coordinators or agency clinical staff and become part of the placement criteria for each member with an SUD.</p> <p>Other activities within this quarter were 1) a session with Falling Colors Technology, the administrator if the health home information system (BHSDStar) to determine interface potential between BHSDStar and the varying EHRs. The purpose is to eliminate the need for duplicative charting. 2) a session on planning the on-site evaluations.</p> <p>As shown on Table 11 below, there is a slight decrease of 2.7% in member enrollment from 4,338 to 4,222.</p>
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Table 11: Number of Members Enrolled in Health Homes

NUMBER OF MEMBERS ENROLLED IN HEALTH HOMES									
DY8 Q3 JUL - SEPT	% CHANGE	DY8 Q4 OCT - DEC	% CHANGE	DY9 Q1 JAN - MAR	% CHANGE	DY9 Q2 APR- JUNE	% CHANGE	DY9 Q3 JUL-SEPT	% CHANGE
4,264	1.90%	4,367	2.40%	4,384	0.40%	4,338	0.48%	4,222	2.7%%

Source: NMStar, CLNM Opt-in Report,

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SUPPORTIVE HOUSING

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

Linkages agencies can bill Medicaid for comprehensive community support services (CCSS); but now that supportive housing services are included in the CC 2.0 waiver, BHSD continues to strongly encourage Linkages providers to shift to billing directly for supportive housing. The CC 2.0 waiver requires the services be provided by a certified peer support worker (CPSW) to align with the state's goals for building the peer support workforce. One Linkages provider has 9 CPSWs assigned to deliver Linkages supportive housing services; this provider actively and consistently utilizes the H0044 code for reimbursement. Another Linkages provider has 1 CPSW to render Linkages support services; this provider amended their existing contracts with MCOs to allow for H0044 reimbursement and began billing in January 2022. A third provider identified 1 CPSW to render Linkages support services, amended their existing contracts with MCOs to allow for H0044 reimbursement and began billing in December 2021; this provider intends to expand utilization of H0044. A fourth Linkages provider hired 1 CPSW in December 2021 and worked with the MCOs to amend their contracts to allow for H0044 reimbursement and began billing. A fifth Linkages provider met with BHSD to further discuss next steps to pursue utilization of H0044 code; this provider met with their agency leadership team, are actively seeking to hire a CPSW, and plans to contact the MCOs to amend their contracts.

The Linkages providers that have secured a CPSW to render supportive housing services relative to H0044 have also updated their agency's electronic health record (EHR) systems to allow for appropriate documentation and revised workflows to clarify the process for H0044 delivery and documentation for billing. The remaining Linkages providers (6) continue to consider hiring CPSW staff for Linkages programming and/or are actively seeking CPSWs to hire, while utilizing case managers, community support workers, and supportive housing coordinators to render these services. There are 11 Linkages support service providers, and the interest of all providers not yet utilizing H0044 has increased with the progress made by the providers who have established H0044 reimbursement. The BHSD Supportive Housing Coordinator has been working with the BHSD MCO Contract Managers and MCOs to ensure successful processing establishment and billing of H0044

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for the providers, as well as the MCOs submit a quarterly Ad Hoc report 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 to 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 hiring and vacancies within their agencies during the COVID-19 pandemic. Providers continue to receive information, education, and training about the value of CPSW utilization and shifting to Medicaid reimbursement through Supportive Housing trainings, the Linkages policy manual, on-going technical assistance from the BHSD Supportive Housing Coordinator and Linkages TA who meet with each provider monthly, 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 for State Fiscal Year 2022 and 2023 include an item specific to Medicaid and H0044.

Table 12: Medicaid Supportive Housing Utilization

MEDICAID SUPPORTIVE HOUSING UTILIZATION (January 1, 2022 – September 30, 2022)			
DY9 Q1	DY9 Q2	DY9 Q3	DY9 Q4
68	66	66	
Unduplicated Total - 76			

* DY9 Q3 number is actually the Q2 data to account for claims lag. Q4 will have Q3 data.

Source: Medicaid Data Warehouse

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As a result of legislative sessions, an increase of State General Funds (SGF) for State Fiscal Years (SFY) 2021 and 2023 was 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. In SFY20, funding allowed for 160 households to receive a rental assistance voucher and support services; in SFY21, the funding increased to support a capacity of 318 households. In SFY22, the funding remained equivalent to SFY22 and continued to support a capacity of 318 households. In SFY23, the capacity of households to be served with a voucher is 338. An individual does not need to be a Medicaid member to obtain a voucher or services; however, many Linkages clients are Medicaid members. By the end of this quarter, 310 vouchers have been issued or filled; a filled voucher means housing has been secured.

In SFY21, Linkages expanded from six to eight sites with Curry and McKinley as new Linkages sites. In SFY22 and SFY23, the Linkages budget will maintain the SFY21 site expansion. The increased funding in FY23 will support increased rent costs.

CENTENNIAL HOME VISITING (CHV) PROGRAM

In DY9 Q2, the Centennial Home Visiting (CHV) pilot program served 299 families. The models are as follows:

Nurse Family Partnership (NFP) Model:

- University of New Mexico Center for Development and Disability (UNM CDD) NFP served a total of 86 unique families in Bernalillo County and Valencia County.
- Youth Development Inc. (YDI) served 41 unique families in Bernalillo, Rio Arriba, Torrance, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 34 unique families in Bernalillo and Valencia County.
- ENMRSH still served 19 unique families in Curry County and Roosevelt County at their capacity.
- Taos Pueblo/Tiwa Babies served 12 unique families in Taos County.
- MECA Therapies served 119 unique families in Chaves, Curry, Dona Ana, and Lea Counties.

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

- Community Action Agency of Southern New Mexico's program Thriving Kids Home Visiting is working through the enrollment with managed care organizations. One contract is complete and 2 are pending. This program will be serving Doña Ana and Otero Counties.
- Presbyterian Medical Services (PMS) has completed the contract amendments with the managed care organizations and is waiting for their first referrals from the MCOs.
- Cariño Home Visiting is ready for Medicaid enrollment and has hired two staff. The staff also needs to complete PAT training. This provider will be serving Otero and Doña Ana Counties.
- Day One Home Visiting Tresco is in the process of hiring staff. They will serve Bernalillo and Santa Fe Counties.
- Guidance Center of Lea County has just started the onboarding process. They are approved for 20 families in Lea County.

A workgroup made up of CHV providers, MCOs, program participants and stakeholders continue to meet on monthly basis to for case study discussion, technical assistance, process discussions, referral, and program capacity updates. Medicaid with its partnering organization Early Childhood Education and Care Department is working to create a centralized referral system and provider manual located on the Human Services Department website.

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 802 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assisting with on-going Medicaid application submissions.

HSD staff conduct monthly PE Certification trainings for employees of qualified entities that chose to participate in the PE program. PE certification requirements include; active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct "Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE)" demo trainings. During demo trainings, the PEDs have the opportunity to

take a refresher training on “How To” utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit on-going Medicaid applications. PE program staff conducted 3 PE certification trainings and 5 YESNM-PE demo refresher trainings in DY9 Q3.

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 New Mexico for Presumptive Eligibility). The chat session can help facilitate adding the newborn to the Medicaid-enrolled mother’s case.

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

Access to the Baby Bot is available through a link located on the PED’s home page in YESNM-PE. The Baby Bot platform operates as a webservice and sends the information electronically to ASPEN, HSD’s eligibility system. Once the mother’s eligibility has been electronically verified in ASPEN, the system automatically adds the newborn to the case. This allows immediate access to benefits for the newborn. Currently 243 active PEDs are certified to use the Baby Bot functionality with more trainings scheduled to increase participation.

- **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 13: Medicaid-eligible newborns submitted through Baby Bot on YESNM-PE

AVA Baby Bot (July - September 2022)					
Month	Newborns Submitted through AVA	Newborns Successfully Enrolled	Newborns Unsuccessfully Enrolled - Tasks Created	% of Newborns Successfully Enrolled	% of Newborns Unsuccessfully Enrolled
July	792	488	304	62%	38%
August	832	504	328	61%	39%
September	810	503	307	62%	38%
Total	2,434	1,495	939	61%	39%

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY9 Q3, 55 PEDs used the Baby Bot functionality. Although, there is steady use of PED participation, we noticed a slight increase in the number of newborns added through Baby Bot. In this reporting period staff saw an increase with 61% of Newborns Successful Enrolled". HSD program staff continue to work with PEDs and system developers to increase the number of newborn submissions as well as the number of successful submissions through the Baby Bot.

Table 14: PE Approvals

PE APPROVALS (July - September 2022)				
Month	PEs Granted	% PE Granted with Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
July	128	99.22%	513	330
August	165	98.79%	574	460
September	131	98.47%	525	400
Total	424	98.82%	1,612	1,190

Source: Monthly PE001 Report from ASPEN and OmniCaid

PE approvals outline the numbers of PE approvals granted and the total number of on-going applications submitted and approved. NM PEDs are aware of the importance of on-going Medicaid coverage for their clients. This is reflected by the increase of PE approvals that also had an ongoing application submitted in DY9 Q3. In DY9 Q3 98.82% of all PE approvals also had an ongoing application submitted.

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

The following table outlines the numbers of PE approvals granted and the total number of ongoing applications submitted and approved. HSD did see a slight decrease in the amount of PE applications submitted. However, the number of on-going applications submitted remained the same in the jail/prison setting. In DY9 Q3 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 15: PE Approvals

PE APPROVALS – JUST HEATH (July - September 2022)				
Month	PEs Granted	% PE Granted w/ Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
July	2	100%	35	32
August	1	100%	37	32
September	2	100%	51	44
Total	5	100.00%	123	108

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.

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

Table 17: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT July - September 2022	
TOPIC	NUMBER OF CALLS
Home/Community Based Care Waiver Programs	2,171
Long Term Care/Case Management	1
Medicaid Appeals/Complaints	1
Personal Care	120
State Medicaid Managed Care Enrollment Programs	12
Medicaid Information/Counseling	566

Source: SAMS Call Profiler Report; GSA I 7-630-8000-0001 CDA 93-778 State Fiscal Year 2022, Quarter 4 report

Table 18: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT July - September 2022			
COUNSELING SERVICES	NUMBER OF HOURS	NUMBER OF NURSING HOME RESIDENTS	NUMBER OF CONTACTS
Transition Advocacy Support Services			157
*Medicaid Education/Outreach	3,418		
Nursing Home Intakes		71	
**LTSS Short-Term Assistance			57

*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.

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Critical Incidents

Critical Incidents	
DY9 Q3	<p>HSD conducts a quarterly meeting with MCOs. The goal of the quarterly meeting is to provide guidance and discuss findings of the MCO's reporting of critical incidents.</p> <p>The quarterly meeting was held on August 17, 2022. The primary discussion was regarding Neglect Refusing Services and Neglect Insufficient Staffing COVID-19 critical incident reports. Each MCO reported the primary issue contracted agencies experience is insufficient staff. In general, agencies reported low salary and stressful work environment attributed to recruiting staff. The MCOs provided details of various actions taken to support the agencies.</p> <p>HSD conducted daily reviews of critical incidents submitted by the MCOs and providers for the purpose of ensuring compliance with reporting requirements.</p> <p>HSD provided daily assistance to MCOs and providers to obtain access to the Critical Incident Reporting (CIR) Portal by establishing and/or resetting login credentials as well as deleting duplicate reports.</p> <p>DY9 Q2 data was received on July 30,2022. During DY9 Q2, a total of 60,247 CIRs were filed for Centennial Care which includes physical health (57,195), and subsets of behavioral health (1,438) and community benefit self-directed (1,614) members. In DY9 total Centennial Care critical incident reports increased 15% in DY9 Q2 from DY9 Q1. In DY9 total Behavioral Health critical incident reports decreased 16% in DY9 Q2 from DY9 Q1. In DY9 total Self-Directed critical incident reports decreased 4% in DY9 Q2 from DY9 Q1.</p> <p>HSD observed an increase in CIRs reported under Environmental Hazard by each MCO. Environmental Hazard typically comprises a very small percentage of CIRs submitted. A prescribed burn was initiated near the area</p>

The table below represents a MCO summary of the critical incident reporting for DY9 Q2. DY9 Q3 data will be received on October 30,2022 and be reflected in DY9 Annual report.

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Table 16: Critical Incidents Reported

CRITICAL INCIDENTS REPORTED (DY9 Q1 - DY9 Q2)															
MCO	CENTENNIAL CARE (CC)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
BCBS	7,695	9,376			230	143			174	177			17,071	373	351
PHP	17,322	19,422			500	454			608	573			36,744	954	1,181
WSCC	1,580	1,800			52	59			40	42			3,380	111	82
Total	26,597	30,598			782	656			822	792			57,195	1,438	1,614

Source MCO quarterly report #36

BCBS (DY9 Q1 - DY9 Q2)															
Critical Incident Types	Centennial Care				Behavioral Health				Self-Directed				Year-to-date Totals		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	103	104			7	14			6	7			207	21	13
Death	293	230			9	4			7	7			523	13	14
Elopement / Missing	2	2			0	0			0	0			4	0	0
Emergency Services	1,289	1,413			98	81			90	102			2,702	179	192
Environmental Hazard	19	53			3	1			1	4			72	4	5
Exploitation	35	47			2	4			1	4			82	6	5
Law Enforcement	26	36			2	2			6	3			62	4	9
Neglect	5,928	7,491			109	37			63	50			13,419	146	113
All Incident Types	7,695	9,376			230	143			174	177			17,071	373	351

Source MCO quarterly report #36

PHP (DY9 Q1 - DY9 Q2)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	191	217			47	49			29	18			408	96	47
Death	520	411			19	10			26	20			931	29	46
Elopement/ Missing	17	15			2	1			1	1			32	3	2
Emergency Services	5,955	6,508			281	287			391	422			12,463	568	813
Environmental Hazard	62	117			2	6			3	3			179	8	6
Exploitation	60	47			6	2			5	4			107	8	9
Law Enforcement	57	37			17	3			5	2			94	20	7
Neglect	10,460	12,070			126	96			148	103			22,530	222	251
All Incident Types	17,322	19,422			500	454			608	573			36,744	954	1,181

Source MCO quarterly report #36

WSCC (DY9 Q1 - DY9 Q2)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	27	16			10	4			2	2			43	14	4
Death	41	39			4	1			3	3			80	5	6
Elopement/ Missing	6	1			3	0			0	0			7	3	0
Emergency Services	245	254			13	23			28	23			499	36	51
Environmental Hazard	16	20			0	1			1	4			36	1	5
Exploitation	6	12			0	0			1	0			18	0	1
Law Enforcement	6	11			2	1			0	1			17	3	1
Neglect	1,233	1,447			20	29			5	9			2,680	49	14
All Incident Types	1,580	1,800			52	59			40	42			3,380	111	82

Source MCO quarterly report #36

Community Benefit

In DY9 Q3, Community Benefit (CB) related projects have included updating the Statewide Transition Plan as requested by CMS, developing a new tracking database for HSD approved Agency-Based Community Benefit (ABCB) providers, and the Self-Directed Community Benefit (SDCB) vendor transition. HSD continued to collaborate with providers, stakeholders, and state agencies to amend our proposed plan for the American Rescue Plan Act (ARPA) increased HCBS for submission to CMS. HSD requested and received approval for 200 additional CB slots to be able to serve more members who are not otherwise Medicaid eligible. We increased allocation efforts to fill the new slots as quickly as possible.

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:

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- 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. We are planning for another statewide minimum wage increase that will occur in January 2023.
 - HSD continues to monitor MCO accountability to ensure minimum wage increases and paid sick leave requirements are met with weekly MCO report updates.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers.
 - Issued 10% increase in September 2022.
- Approving higher rates for certain caregivers in rural areas on a case-by-case basis.

Electronic Visit Verification

HSD, in partnership with the MCOs, continued to operate EVV for Agency-Based Community Benefit (ABCB), SDCB and EPSDT Personal Care Services. HSD will be submitting a Good Faith Effort Exemption request to CMS for Home Health Services. For DY9 Q3, the average number of SDCB caregivers using EVV is 72%.

Please see ABCB EVV data for DY9 Q2 outlined in the table below. The MCOs reported that 71.7% of the total ABCB PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder of claims were created through the Fiserv Authenticare application.

Table 19: EVV DATA

EVV DATA (April 2022 - June 2022)		
MCO	AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD	NUMBER OF TOTAL CLAIMS THIS PERIOD
BCBS	7,745	548,456
PHP	14,822	857,524
WSCC	1,865	112,094
TOTAL	24,432	1,518,074

Source: MCO Report #35 DY9 Q2 April – June 2022

Statewide Transition Plan

In DY9 Q2, HSD continues to update the Statewide Transition Plan (STP) milestones as required by CMS. HSD issued the STP for public comment in October 2021 and submitted to CMS on January 14, 2022. CMS completed its review and submitted questions to HSD on February 23, 2022. NM sent an updated plan to CMS in June 2022, and CMS sent additional questions in July 2022. NM had two technical assistance calls with CMS to help with clarifying feedback and making updates to the plan. NM responded to the CMS feedback, updated the plan and sent it back to CMS in October 2023.

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

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

In Q2 DY9

- BCBS conducted 106 total internal audits of NF LOC determinations: 18 Facility Based and 88 Community Based
- PHP conducted 242 total internal audits of NF LOC determinations: 66 Facility based and 176 Community Based determinations.
- WSCC conducted 60 total internal audits of NF LOC determinations: 12 Facility Based and 48 Community Based determinations.
- Audit results for NF LOC determinations for DY9 Q2:
 1. BCBS reported 100% agreement, with reviewer determinations for High and Low Facility Based and 99% for Community Based determinations.
 2. WSCC reported 100% agreement with reviewer determinations for High and Low Facility Based and for Community Based determinations.
 3. PHP had 100% agreement with reviewer for determinations for High and Low Facility Based and Community Based determinations
- Audit results for Timeliness of determinations for DY9 Q2:
 1. All MCOs reported 100% in Timeliness of determinations for High Facility Based.

2. BCBS and WSCC reported 100% Timeliness of determinations for Low Facility Based. PHP reported 97.6% Timeliness of determinations for Low Facility Based.
- Aggregate results:
 1. High and Low Facility NFLOC Determination aggregate results is 100%
 2. Community NFLOC Determination aggregate results is 99.7% slightly lower from DY9 Q1 of 100%.
 3. Aggregate results for High Facility Based Timeliness of determinations is 100%
 4. Aggregate results for Low Facility Based Timeliness of determinations is 98.3% slightly lower from DY9 Q1 of 100%.
 5. Aggregate results for Community Based Timeliness of determinations is 100%

HSD found errors in all 3 MCO's first internal audit submissions. Deliverable were sent to the MCO requesting resubmission with corrections to their audit report. BCBS and WSCC submitted revised and correct audit reports. PHP did correct some of the errors in the audit report but not all. The second submitted audit report was rejected. PHP requested a TA call which occurred on 8-12-22. HSD identified the error to PHP and in a SOU PHP stated they would be submitting a correct audit report. PHP did correct the error identified by HSD but failed to correct the quarterly aggregate. The report was rejected a second time. PHP did submit a final DY9Q2 internal audit report with corrections and an explanation of changes in reporting numbers. HSD accepted the corrections and explanation.

HSD Audit Nurse has completed the audit reporting template for all MCOs to utilize for future reporting of internal NF LOC audits. The audit reporting template provides MCOs areas for:

- MCO NF LOC Quarterly Internal Audits report results
- Member information on files audited by MCO in Quarterly submission
- The Audit Nurse will request random samples of members audited by MCOs to ensure assessments are being conducted in accordance with HSD NF LOC criteria.

Deliverables will be sent to all MCOs for review and comments of the audit reporting template. Review and comments period will be followed by a TA call to discuss the submitted review and comments by the MCOs. The process should be completed for MCO Internal NF LOC audits for Q3 DY9.

HSD will continue to monitor the MCOs' internal audits of NF LOC determinations and identify and address any concerns. The Nurse Auditor will provide technical assistance to the MCO internal auditors as needed. Additionally, the Nurse Auditor will report quarterly findings and recommendations in the CMS monitoring report commencing in DY9 Q3.

Table 20: MCO Internal NF LOC Audits– Facility-Based

Facility-Based Internal Audits	April	May	June	DY9 Q2
High NF Determinations				
Total number of High NF LOC files audited	11	13	11	35
BCBSNM	3	3	3	9
PHP	6	8	6	20
WSCC	2	2	2	6
Total number of files with correct NF LOC determination	11	13	11	35
BCBSNM	3	3	3	9
PHP	6	8	6	20
WSCC	2	2	2	6
% 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				
Total number of Low NF LOC files audited	21	19	21	61
BCBSNM	3	3	3	9
PHP	16	14	16	46
WSCC	2	2	2	6
Total number of files with correct NF LOC determination	21	19	21	61
BCBSNM	3	3	3	9
PHP	16	14	16	46
WSCC	2	2	2	6
% 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				
Total number of High NF LOC determinations completed within required timeframes	11	13	11	35
BCBSNM	3	3	3	9
PHP	6	8	6	20
WSCC	2	2	2	6

% 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	21	18	21	60
BCBSNM	3	3	3	9
PHP	16	13	16	45
WSCC	2	2	2	6
% of Low NF LOC determinations completed within required timeframes	100%	95%	100%	98%
BCBSNM	100%	100%	100%	100%
PHP	100%	93%	100%	98%
WSCC	100%	100%	100%	100%

Source: DY9 Q2 MCO Internal Audit Results

Total percentage rows contain average percentages

Table 20: MCO Internal NF LOC Audit Report – Community-Based

Community-Based Internal Audits	April	May	June	DY9 Q2
Total number of Community-Based NF LOC files audited	102	105	105	312
BCBSNM	28	30	30	88
PHP	58	59	59	176
WSCC	16	16	16	48
Total number with correct NF LOC determination	101	105	105	311
BCBSNM	27	30	30	87
PHP	58	59	59	176
WSCC	16	16	16	48
% with correct NF LOC determination	99%	100%	100%	100%
BCBSNM	96%	100%	100%	99%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations	April	May	June	DY9 Q2
Total number of Community-Based determinations completed within required timeframes	102	104	105	311
BCBSNM	28	30	30	88
PHP	58	59	59	176
WSCC	16	16	16	48
% of Community-Based 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: DY9 Q1 MCO Internal Audit Results

Total percentage rows contain aggregate percentages

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. HSD's External Quality Review Organization (EQRO) compiles this information into the table below and provides the following assessment of the review:

- The aggregated Facility Based High NF LOC determination percentage is 86% a 7% increase from Q1 which was 79%.
- The aggregated Facility Based Low NF LOC determination percentage is 96% consistent with Q1.

- The aggregated Community Based determination percentage is 98%, consistent with Q1.

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

Table 21: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations	April	May	June	DY9 Q2
High NF Determinations				
Total number of determinations/redeterminations completed for High NF LOC requests	53	42	71	166
BCBSNM	15	14	30	59
PHP	27	24	34	85
WSCC	11	4	7	22
Total number of determinations/redeterminations that met High NF LOC criteria	46	34	63	143
BCBSNM	10	10	25	45
PHP	25	22	31	78
WSCC	11	2	7	20
% of determinations/redeterminations that met High NF LOC criteria	87%	81%	89%	86%
BCBSNM	67%	71%	83%	76%
PHP	93%	92%	91%	92%
WSCC	100%	50%	100%	91%
Low NF Determinations	Aril	May	June	DY9 Q2
Total number of determinations/redeterminations completed for Low NF LOC requests	478	439	469	1386
BCBSNM	157	141	149	447
PHP	280	253	271	804
WSCC	41	45	49	135
Total number of determinations/redeterminations that met Low NF LOC criteria	448	422	457	1327
BCBSNM	150	139	147	436
PHP	257	238	261	756
WSCC	41	45	49	135
% of determinations/redeterminations that met Low NF LOC criteria	94%	96%	97%	96%
BCBSNM	96%	99%	99%	98%
PHP	92%	94%	96%	94%
WSCC	100%	100%	100%	100%

Source: DY9 Q2 External Quality Review Organization (EQRO) Quarterly MCO NF LOC Determinations Report
Total percentage rows contain average percentages

Table 22: MCO NF LOC Determinations – Community-Based

Community Based Determinations	April	May	June	DY9 Q2
Total number of determinations/redeterminations completed	2,321	2,356	2,580	7,257
BCBSNM	665	724	676	2,065
PHP	1,501	1,452	1,710	4,663
WSCC	155	180	194	529
Total number of determinations/redeterminations that did not meet NF LOC criteria	2,275	2,318	2,544	7,137
BCBSNM	650	717	670	2,037
PHP	1,471	1,421	1,681	4,573
WSCC	154	180	193	527
% of determinations/redeterminations that did not meet NF LOC criteria	98%	98%	99%	98%
BCBSNM	98%	99%	99%	99%
PHP	98%	98%	98%	98%
WSCC	99%	100%	99%	100%

Source: DY9 Q2 External Quality Review Organization (EQRO) Quarterly MCO NF LOC Determinations Report. Total percentage rows contain average percentages

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 determination and denials were reviewed for Facility Based and Community Based.

In Q2 DY9

- Aggregate results for High NF Determinations was 100% consistent with Q1 DY9 determinations
 - Aggregate results for Low NF Determinations was 97% a decrease from Q1 DY9 of 100%
- HSD reviewed the one Low Facility Based determination denial identified in the EQRO review, which resulted in a 97% aggregated total. The MCO did not provide all supporting documentation for initial stay low NFLOC. The missing document, the Preadmission Screening and Resident Review (PASRR). HSD sent a deliverable to the MCO requesting all supporting documents for determination of low NFLOC. Documents received from MCO did not include the PASRR. A TA call scheduled 7/6/22 with the MCO, did result with HSD obtaining the PASRR, and therefore all supporting documents for initial stay Low NFLOC are in place.

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- Aggregate results for Community Based Determinations was 100% consistent with Q1 DY9 determinations.
HSD will continue to monitor the EQRO audit of MCO NF LOC determinations.

Table 23: EQRO NF LOC Review

Facility-Based High NF Determination	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
Number of Member files audited	18	19	16	18
BCBSNM	6	7	6	6
PHP	6	6	5	6
WSCC	6	6	5	6
Number of Member files the EQRO agreed with the determination	18	19	16	18
BCBSNM	6	7	6	6
PHP	6	6	5	6
WSCC	6	6	5	5
% 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%
Low NF Determination	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
Number of Member files audited	36	35	38	36
BCBSNM	12	11	12	12
PHP	12	12	13	12
WSCC	12	12	13	12
Number of Member files the EQRO agreed with the determination	36	35	38	35
BCBSNM	12	11	12	12
PHP	12	12	13	12
WSCC	12	11	13	11
% of Member files the EQRO agreed with the determination	100%	100%	100%	97%
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	92%
Community-Based	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
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: EQRO NF LOC Report for CMS. Total percentage rows contain aggregate percentages.
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Waiver Assurance Performance Measures

New Mexico has developed and initiated performance measure (PM) indicators to comply with STC requirement 43 and will begin reporting on HCBS Assurances in DY9 Q3 as follows: Administrative Authority; Level of Care (LOC); Qualified Providers; Service Plan; Health and Welfare of Enrollees; and Financial Accountability. New Mexico anticipates including DY9 Q1 data in the DY9 Q3 CMS Monitoring Report and will report subsequent quarterly audits as data is validated. This project was initiated in DY9 Q1 and a regular reporting schedule will be established once preliminary data has been fully vetted. New Mexico is providing the following updates for each requirement below.

- Administrative Authority: In DY9 Q2, HSD developed 3 performance measures to monitor the HCBS Administrative Authority. HSD is in the process of reviewing data for the following performance measures:
 - PM #1: Percentage of required HCBS reports submitted timely by the MCOs.
 - PM #2: Percentage of required HCBS reports submitted accurately without an MCO Self-Identified Error.
 - PM #3: Percentage of required HCBS reports submitted accurately without an HSD rejection.
- Level of Care (LOC): MCOs submit quarterly LOC reports to HSD that identify the number of initial LOCs conducted in the quarter. Subsequent reports will include information to support that the initial LOC is conducted timely.
- Qualified Providers: In DY9 Q2, HSD began to work on developing measures to monitor the HCBS Qualified Provider requirements. HSD has no concerns in this area and will finalize the measures in DY9 Q3. HSD reviews and approves all Agency-Based Community Benefit (ABCB) providers to ensure that they meet all program requirements as outlined in Section 8 of the Managed Care Policy Manual. Providers must obtain this program approval from HSD prior to contracting with the MCOs and providing services to ABCB members. In the Self-Directed Community Benefit (SDCB), the MCOs contract with a single Fiscal Management Agency (FMA) to oversee provider enrollment. The FMA ensures that all providers meet program requirements as outlined in Section 9 of the Managed Care Policy Manual. SDCB providers must meet all program requirements and be approved by the FMA prior to providing services to SDCB members.

- Service Plan: In DY9 Q2, HSD developed 8 performance measures to monitor the HCBS Service Plan requirements. HSD is in the process of reviewing data for the following performance measures:
 - 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: Members 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.

Table 24: HCBS SERVICE PLAN REVIEW SUMMARY

Eligible Population and Sample Size, 2022 Q2			
MCO	Eligible Population for 2022 Q2	MCO % of Entire HCBS Population in 2022 Q2	Number of HCBS Files Reviewed for 2022 Q2
BCBS	4,956	29%	34
PHP	12,084	70%	54
WSCC	158	1%	6
Centennial Care	17,198	100%	94

Service Plan Review Results 2022 Q2						
Performance Measure	MCO	Total Files	# of Files Met	# of Files Not Met	# of Files Not	% 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	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
The HCBS service plan was revised, as needed, to address changing needs	BCBS	34	23	0	11	100%
	PHP	54	38	1	15	97.40%
	WSCC	6	5	0	1	100%
	Statewide	94	66	1	27	98.50%
A disaster preparedness plan specific to the member was in the HCBS service plan and documented	BCBS	34	33	1	0	97.10%
	PHP	54	53	1	0	98.10%
	WSCC	6	6	0	0	100%
	Statewide	94	92	2	0	97.90%
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	3	0	31	100%
	PHP	54	1	0	53	100%
	WSCC	6	0	0	6	NA
	Statewide	94	4	0	90	100%

Note: MCO agreement/acceptance of the review determination (met or not met) for each performance measure is captured prior to the conclusion of the review.

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- Health and Welfare of Enrollees: HSD has implemented a monitoring process for assuring the health and welfare of members enrolled in HCBS through quarterly MCO reporting on established performance measures. The critical incident performance measures listed below will identify, address, and seek to prevent instances of abuse, neglect, exploitation, and unexpected death. The BCBS data presented for DY9 Q1 CI PM#3 and also Q1 CI PM#4b includes only March 2022 data. The table below is a summary of the quarterly data reported by the MCOs for DY9 Q1:

Table 25: Critical Incidents Performance Measures

Critical Incident Performance Measures (CI PM)				
CI PM	BCBS	PHP	WSCC	Total by Quarter
	Q1	Q1	Q1	Q1
The number of all substantiated critical incidents.	7695	17322	1580	26597
PM #1: The percentage of substantiated critical incidents reported by category of abuse, neglect, exploitation and unexpected death:				
	Q1	Q1	Q1	Percentage by Quarter Q1
1.a. Percentage of substantiated individual abuse incidents identified and reported.	1.34	1.1	1.71	1.38%
1.b. Percentage of substantiated individual neglect incidents identified and reported.	77.04	60.39	78.04	71.82%
1.c. Percentage of substantiated individual exploitation incidents identified and reported.	0.45	0.35	0.38	0.39%
1.d. Percentage of substantiated individual unexpected death incidents identified and reported.	3.81	0.5	0.25	1.52%
TOTALS	82.64	62.34	80.38	0.7512
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #2: The percentage of substantiated critical incidents being reported within the required timeframe.				
	Q1	Q1	Q1	Q1
Percentage of substantiated critical incidents being reported within 24 hours.	89.67	85.85	91.27	88.93%
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
plans, etc.) was completed:				
	Q1	Q1	Q1	Q1
Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed.	100	94.86	84.49	93.12%

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CI PM	BCBS	PHP	WSCC	Percentage by Quarter
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future incidents, such as investigation as well as educating individuals and families:

	Q1	Q1	Q1	Q1
4.a. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents.	37.99	31.23	97.66	55.63%
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.	57.17	3.5	82.15	47.61%
TOTALS	95.16	34.73	179.81	1.03

CI PM	BCBS	PHP	WSCC	Percentage by Quarter
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Protective Services (CPS):

	Q1	Q1	Q1	Q1
5.a. Percentage of substantiated individual critical incidents where referrals to APS were completed.	19.99	50.98	60.44	43.80%
5.b. Percentage of substantiated individual critical incidents where referrals to CPS were completed.	0.84	1.06	0.7	0.87%
TOTALS	20.83	52.04	61.14	0.4467

CI PM	BCBS	PHP	WSCC	Percentage by Quarter
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PM #6: The percentage of providers and MCO staff trained on reporting critical incidents into the HSD Portal:

	Q1	Q1	Q1	Q1
6.a The percentage of providers and MCO staff educated about reporting critical incidents to the HSD Portal initially at the start or at hire during the reporting period.	100	2.98	100	67.66%
6.b. The percentage of providers and MCO staff 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.	0	0	0	0.00%
TOTALS	100	2.98	100	0.6766

CI PM	BCBS	PHP	WSCC	Percentage by Quarter
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reported:

	Q1	Q1	Q1	Q1
The percentage of substantiated Members with Multiple critical incidents identified and reported.	62.01	73.22	64.62	66.62%

- Financial Accountability: In DY9 Q2, HSD began to work on developing measures to monitor HCBS Financial Accountability requirements. MCOs send

encounters to HSD for all Community Benefits services. In DY9 Q3, HSD is still working with the EQRO to finalize the measures.

8

AI/AN REPORTING

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	August 25, 2022 Virtual meeting	<p>BCBS shared that many, many invitations that were sent out statewide to members and providers announcing the Native American Advisory Board meeting.</p> <p>The meeting began with virtual housekeeping information for attendees, an opening prayer, introductions, and agenda review. The speaker also stated if anyone has a PHI question, to ask it after the meeting. The speaker explained the reason for the meeting was to share Centennial Care benefit information, receive feedback from members on their Centennial Care services and how to resolve issues that come up.</p> <p><u>Issue:</u> One member asked if a transportation provider can refuse to transport a COVID-19 positive patient.</p> <p><u>Response:</u> BCBS transportation vendor MotivCare responded that the member needs to inform the driver ahead of time that they are COVID-19 positive so that MotivCare can come with the proper vehicle that keeps the driver at a safe distance.</p> <p><u>Issue:</u> Another person asked when the next meeting is and when will they get their gift card for attendance.</p> <p><u>Response:</u> BCBS responded that the next virtual meetings are September 29 and November 17, 2022. The gift cards are sent within 3-6 days after the member returns their feedback form.</p> <p>Two other follow up questions were how to obtain a BCBS replacement card and how to contact a care coordinator for her husband. BCBS sent both requests to member services for follow up. Notes indicate that both members were followed up by member services.</p>

PHP	September 8, 2022 Virtual meeting	<p>PHP sent 594 letters of invitation through the mail to members in Dulce, Taos, El Prado, Raton, Ruidoso, Los Alamos and Chama to name a few.</p> <p>There were no questions asked at the Native American Consumer Advisory Board meeting but a new PHP member said it was great information and helpful to get the phone numbers of PHP staff. She appreciated the meeting as she is new to PHP and recently was diagnosed with diabetes. She plans to take advantage of the program.</p>
WSCC	September 2, 2022 Virtual meeting	<p>WSCC had 38 members in attendance at their virtual Native American Advisory Board meeting. They did not indicate how many invitations were sent out.</p> <p><u>Issue:</u> A staff member stated that a member is in need of a laptop or tablet to help with job development for writing a resume and applying for a job. Are there any resources to help this member?</p> <p><u>Response:</u> The Tribal liaison responded that she knows of a community resource called Outreach Program Services of America. They will provide a brief presentation on how individuals on state and/or federal assistance programs can receive a tablet and 25GB of T-Mobile service for 5 years at the end of the agenda.</p> <p><u>Issue:</u> A member's son was prescribed Pedisure because he is on a feeding tube and cannot eat solid foods. At the time, there was a national shortage of formula, and they were unable to fill the prescription and had to pay out of pocket. He wanted to know if he could get reimbursed for paying out of pocket.</p> <p><u>Response:</u> WSCC staff referred him to the Member Relief Fund. A request was submitted September 8, 2022 to request funds for reimbursement of formula. Also his name was forwarded to care coordination for follow up after receiving permission from the parent.</p> <p><u>Issue:</u> A member said her roof had a hole in it from all the rain and she is unable to fix it. She is on dialysis</p>

		<p>and has other health needs. She asked if there was help for her to get her roof fixed.</p> <p><u>Response:</u> WSCC will have her assigned Care Coordinator reach out to her regarding the environmental modifications for her home offline.</p> <p><u>Issue:</u> A member asked if there are qualification to join the Cultural Competency and Health Committee since she is a RN (Registered Nurse).</p> <p><u>Response:</u> WSCC informed her there are not qualifications for joining the Cultural Competency and Health Committee. Staff will reach out to her to provide more information.</p>
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MCO	Status of Contracting with MCOs
BCBS	<p>BCBS is pending signature from the following provider:</p> <ul style="list-style-type: none"> • Laguna Healthcare Corporation <p>Discussions are in progress for BCBS with the following providers:</p> <ul style="list-style-type: none"> • San Ildefonso Pueblo • Laguna Behavioral Health
PHP	<p>Active Negotiations:</p> <ul style="list-style-type: none"> • Kewa Pueblo Health Corporation/Kewa Health Center - The Behavioral Health Division at the Kewa Family Wellness Center has been loaded as participating into the PHP Network. PNO provides technical assistance to the Wellness Center as requested. • First Nations Community Healthsource/Traditional Wellness Program - PHP is conducting ongoing discussions with FNCH regarding collaboration on PHP Health Disparity projects. Collaboration meeting with FNCH have also been rescheduled to bi-monthly starting in late October. • Pueblo of Nambe/Tewa Roots Society - This is a Tribal 638 program and has been successfully loaded into the PHP Provider Network as participating. Provider Network Operations has commenced providing technical assistance regarding billing capacity. This organization is successfully billing.

WSSC	<ul style="list-style-type: none"> • WSSC continues to follow up with Tribal communities such as the Navajo Nation, Acoma Pueblo, Zuni Pueblo and Taos Pueblo. No new contracts were indicated, but WSSC met with the Corrections Department for Navajo Nation to discuss implementation of Just Health. • WSSC maintains monthly claims meetings with IHS and Tribal 638 providers billing staff to resolve any concerns the service units have with billing WSSC for services.
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ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE:	3/26/21
COMPLETION DATE:	Open
ISSUES	ModivCare has been placed on a corrective action plan for not meeting the contractual timeliness measures for certain Customer Service Call Center metrics and other additional contractual requirements.
RESOLUTION	<p>Due to continued service level failures, the action plan remains open.</p> <p>Service Level (85% or more calls answered by a live person within 30 seconds) = Failed in February 2022 80.4%; however, BCBS subcontractor addressed this and increased service level to 87.5% in March 2022. Closed</p> <p>Nurse Advice Line (85% or more calls answered by a live person within 30 seconds) = Failed in January 2022 at 83.8% due to an increase in calls but was brought into compliance in February 2022 and March 2022. Closed</p> <p>Provider Services line (85% of calls answered within 30 Seconds) = Failed in February 2022 76.7% and in March 2022 84.6%. BCBS found a root cause in the increased call volume from providers not utilizing the Interactive Voice Response (IVR) system and BCBS provided feedback along with instructions to those top provider offices with information on how to use the automated system. In the meantime, all BCBS Customer Advocates are trained to take both member and provider calls. BCBS new-hire Customer Advocates are currently taking calls, and this will increase our ability to meet our contract standards. Closed</p> <p>DY9 Q3 updates: Plan of Action (POA) related to call center remains open. BCBS is continuing to monitor the call center stats that includes A-Leg (On Time Performance), Provider No Shows and member satisfaction. For DY9 Q3, ModivCare has improved overall and has increased the number of customer service staff, drivers, vehicles and changed the member satisfaction survey questions to be easier and focus on members overall trip satisfaction. BCBS anticipates seeing an improvement in DY9 Q4. Below are the most current stats:</p>

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August 2022:

- ASA = 8 seconds (met)
- Service Level = 92.3% (met)
- Member Satisfaction = 86.1% (not met)
- A Leg Pick Up = 90.44% (met)
- Provider No Shows = 100 (decrease from previous months);
- Total # of completed trips = 47,861

To reduce the number of provider no-shows, ModivCare continues to add other transportation providers to the network.

BCBS is also working on adding UBER (rideshare) to ModivCare's option of transportation for those members that are ambulatory (can walk safely on their own to/from vehicle) and will start this service in specific counties.

HSD receives bi-weekly updates and continues to carefully review the ModivCare remediation plan and their progress.

BLUE CROSS BLUE SHIELD

ACTION PLAN

DentaQuest (Quality of Care Process Improvement)

IMPLEMENTATION DATE:

7/15/22

COMPLETION DATE:

Open

ISSUES

A NM Medicaid member received in-office dental services that involved sedation. The member encountered respiratory difficulties, was transported to a higher level of care, and subsequently passed away. Initially, DentaQuest reviewed the medical records and determined that there were no quality-of-care concerns. Health Care Service Corporation (HCSC) requested that DentaQuest conduct a second review on the case, due to an internal clinical review, and upon doing so DentaQuest ultimately terminated the provider and will be reporting their findings to the National Practitioner Data Bank (NPDB) as well as the NM Dental Board. DentaQuest did not thoroughly review the medical records to identify quality-of-care concerns, the original review of medical records and second review had markedly different outcomes. Additionally, DentaQuest did not appropriately and timely terminate the provider resulting in potential quality-of-care concerns for NM Medicaid members.

RESOLUTION

On 7/15/2022 BCBS initiated a Plan of Action against DentaQuest's Quality of Care (QOC) Review process. Action Plan included: DentaQuest will need to take the following actions to ensure quality-of-care processes are handled appropriately.

1. Review the process, for the BCBSNM Medicaid case, that the DentaQuest Medical Director utilized to determine that no quality-of-care concerns existed. Identify the root cause of the oversight, correct the issue, and provide documentation of the corrective action taken to prevent future occurrences.

2. Audit and provide results of all clinical and non-clinical quality of care complaints/inquiries for 2021 and 2022 (Q1, Q2), identify trends and tracking for those complaints and provide a prospective plan for continued monitoring of clinical and non-clinical complaints/inquiries for our NM Medicaid members. DentaQuest is expected to provide supporting documentation by 9/9/2022.

-- On 9/8/2022, DentaQuest provided all supporting documents that included:

Policies and Procedures, list of Quality of Cares (QOCs) and National

Practitioner Data Bank (NPDB) notice of provider on dental board registry.

-- BCBS Quality team reviewed list and determined no other noted issues of any other QOCs reviewed

-- BCBS did not accept all of DentaQuest's responses and submitted information back to DentaQuest.

HSD will continue to receive updates from BCBS and will continue to monitor the progress. This item will be removed in DY9 Annual Report.

BLUE CROSS BLUE SHIELD

ACTION PLAN

DentaQuest (Annual Provider Satisfaction Survey)

IMPLEMENTATION DATE:

4/1/22

COMPLETION DATE:

8/17/22

ISSUES

DentaQuest NM failed their annual provider satisfaction survey hitting 88% with a goal of 90%.

RESOLUTION

DentaQuest has proactively arranged provider trainings in DY9 Q1.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	PHP
IMPLEMENTATION DATE:	03/01/21
COMPLETION DATE:	In Progress
ISSUES	2020 Provider Directory Audit
RESOLUTION	<p>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.</p> <p>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.</p> <p>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.</p> <p>12/31/21 - PCP CAP is continuing to be reviewed monthly and is working on the system build and provider adoption.</p> <p>02/21/22 - Final scope document completed and being presented to leadership for sign off next week.</p> <p>04/04/22 - Project team had a meeting on April 1 to discuss leadership feedback and questions.</p> <p>05/18/22 - Project scope was approved and is moving forward.</p> <p>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.</p> <p>06/22/22 - IT and internal stakeholders very nearly have the final budget and scope statement ready for signature so work can begin.</p>

09/15/22 - VP of Finance reviewing final budget, approval pending.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	Secure Transportation
IMPLEMENTATION DATE:	03/04/21
COMPLETION DATE:	In Process
ISSUES	Improvement Plan – Network Adequacy
RESOLUTION	<p>Secure Transportation (ST) was placed on an improvement plan for the network issues. Monthly meetings will be held between ST and PHP leadership to review issues/concerns.</p> <p>09/13/21 Update: Network concerns remained an issue for ST. PHP placed ST on a corrective action plan (CAP) as the issues are not resolved timely. ST will provide monthly updates on efforts to improve the network, the next update was due in October 2021.</p> <p>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.</p> <p>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.</p> <p>Action Plan Items:</p> <ul style="list-style-type: none"> • Risk Stratification – policy to identify and prioritize high risk members (dialysis, chemotherapy, radiation, pre or post OP, 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 <ul style="list-style-type: none"> ○ 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.

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PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	Home and Community Based Services (HCBS) Settings
IMPLEMENTATION DATE:	09/01/22
COMPLETION DATE:	In Process
ISSUES	Not conducting onsite inspections of Personal Care Service Agency Offices
RESOLUTION	09/01/22 - PHP Provider Network Operations is working on getting in-person visits conducted by October 2022.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	Personal Care Service Agency Employee File Auditing
IMPLEMENTATION DATE:	09/01/22
COMPLETION DATE:	In Process
ISSUES	Not reviewing PCS Agency policies and employee records for accuracy and all requirements.
RESOLUTION	09/01/22 - An internal audit is being conducted to pilot the process for reviewing PCS agencies for their contractual and regulatory requirements. The plan is to send out a request for information from 20 randomly chosen PCS agencies representing all 5 regions of NM. With a sampling of 5 randomly chosen employee records to review from each agency. Audit start date is tentatively scheduled for 10/17/2022.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Provider Directory
IMPLEMENTATION DATE:	9/20/22
COMPLETION DATE:	Open item
ISSUES	2020 Provider Directory Audit

RESOLUTION	There were 8 findings from an external audit related to the completeness, accuracy, and consistency of information included in the provider directory when compared to the requirements in Sections 4.14.5.1 and 4.14.5.4 of the Managed Care Agreement. In DY8 Q3, WSCC provided a detailed action plan with timelines for resolution of each finding. WSCC is providing additional information related to the tracking of provider issues and how they are resolved to HSD. HSD will continue to receive updates on the progress of WSCC's action plan. Closure is anticipated in DY9 Q4.
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WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Payment Error- Reprocessing and Recoupment of Payments
IMPLEMENTATION DATE:	9/20/22
COMPLETION DATE:	Open item
ISSUES	Payment Error- Reprocessing and Recoupment of Payments, Temporary Economic Recovery Payments increase for Home and Community Based Services (HCBS)
RESOLUTION	During a routine audit of payments issued via WSCC's accounts payable platform, a discrepancy was identified for LOD #79 payment, 3 dates of services 4-1-22 / 6-30-22 (with run-out for 5-1-21/ 3-31-22). A misalignment occurred between the payable supplier ID and the amount due to the provider creating over and under payments. WSCC is providing outreach to those providers impacted to ensure payments are issued for those providers who were underpaid, as well as working on payment options that work for the providers who were issued overpayments. HSD is closely monitoring this via weekly detailed reports from WSCC. WSCC also has measures in place to ensure they are internally reviewing supplier IDs on file that are used for issuing payments via their accounts payable platform and reviewing all the payments received and issued to ensure there is an 15% increase on private duty nursing and personal care services, as well as Agency-Based Community Benefit and Self-Directed Community Benefit procedure codes. Lastly, WSCC Finance team has created new steps in the validation process for the mitigation efforts on new accounts payable uploads. HSD is closely monitoring this via weekly detailed reports from WSCC. Closure is anticipated in DY9 Q4.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Provider Satisfaction Survey
IMPLEMENTATION DATE:	8/26/22
COMPLETION DATE:	Open item
ISSUES	2021/2022 Provider Satisfaction Survey

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RESOLUTION

WSCC did not send the approved Provider Satisfaction Survey from HSD to Providers for the calendar year 2021 or 2022. Additionally, WSCC fielded the wrong survey name as “physician satisfaction” and not the “provider satisfaction” survey. WSCC sent a new survey for review and approval that was approved in September. WSCC is re-fielding the 2022 survey and the survey results will be provided to HSD by November 23, 2022. WSCC has additional resources delegated to re-fielding this survey including calling providers who may have already completed the inaccurate survey to ensure they complete the survey again as the initial survey that was fielded left out one claims question. WSCC is submitting weekly reports to HSD pertaining to the re-fielding of the 2022 survey. Closure is anticipated in DY9 Q4.

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FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ISSUES

DY9 Q1 reflects the capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 31, 2021. On average, the CY 2022 rate was higher than that of CY 2021; however, fee-for-service claim payments during CY 2022 were still lagging, and they affected the PMPMs. In addition, data run out for CY 2022 will continue and the PMPMs will continue to change as expenditures come in (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis indicates that DY7 is 12.0% below the budget neutrality limit (Table 7.5) through 10 quarters of payments. For DY8, Table 8.5 shows a 11.8% below the budget neutrality limit with data through six (6) quarters. Table 9.5 shows 21.1% below the budget neutrality limit for DY9 with preliminary data of two quarters of payments.

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MEMBER MONTH REPORTING

Member Months		2022
		3
MEG1	0-FFS	108,265
	Presbyterian	682,398
	Western Sky	128,860
	Blue Cross Blue Shield	449,109
	Total	1,368,632
MEG2	0-FFS	7,593
	Presbyterian	62,470
	Western Sky	11,410
	Blue Cross Blue Shield	37,646
	Total	119,119
MEG3	Presbyterian	67,274
	Western Sky	10,082
	Blue Cross Blue Shield	33,656
	Total	111,012
MEG4	0-FFS	622
	Presbyterian	305
	Western Sky	48
	Blue Cross Blue Shield	220
	Total	1,195
MEG5	Presbyterian	8,861
	Western Sky	1,506
	Blue Cross Blue Shield	6,848
	Total	17,215
MEG6	0-FFS	79,232
	Presbyterian	390,338
	Western Sky	99,532
	Blue Cross Blue Shield	313,053
	Total	882,155
MEG10	0-FFS	19
	Presbyterian	121
	Western Sky	5
	Blue Cross Blue Shield	75
	Total	220
MGX8	0-FFS	
	Presbyterian	248
	Western Sky	27
	Blue Cross Blue Shield	216
	Total	491
Total		2,500,039

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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 DY9 Q3, the reports submitted by MCOs for July and August were reviewed and analyzed to determine compliance with contractual requirements. HSD has adjusted WSCC data in the Number of Member Grievances for DY9 Q2. The DY9 Q2 Year to Date Total reported includes the changes. HSD observed in DY9 Q3 the second top primary member grievance code reported was Dental. This is a change from Provider Specialist in Q2 and MCO Operational Issues in Q1. The table below is a summary of the quarterly data reported by the MCOs for DY9 Q3:

Table 26: Grievances Reported

Grievances reported (January - September 2022)																
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	485	431	283		434	458	437		39	44	47		958	933	767	
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	346	312	168		180	175	226		15	13	18		541	500	412	
Dental	15	11	11		0	14	25		2	2	2		17	27	38	
Variable Grievances	124	108	104		254	269	186		22	29	27		403	406	317	

Source: MCO Report #37

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APPEALS

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

In DY9 Q3, the reports submitted by MCOs for July and August were reviewed and analyzed to determine compliance with contractual requirements. The table below is a summary of the quarterly data reported by the MCOs for DY9 Q3:

Table 27: Appeals Reported

Appeals Reported (January - September 2022)																
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	369	363	354		484	484	566		23	30	43		876	877	963	
Number of Expedited Member Appeals	35	46	49		28	25	36		6	3	5		69	74	90	
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	327	412	360		497	494	572		29	25	42		853	931	974	
Denial in whole of a payment for a service	70	19	36		7	15	29		0	0	0		77	34	65	
Variable Appeals	7	-22	7		8	0	1		0	8	6		15	-14	14	

Source: MCO Report #37

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QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HSD's Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference Table 19: 2021 MCO Advisory Board Meeting Schedules below.

Table 28: 2022 MCO Advisory Board Meeting Schedules

BCBS 2022			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	03/03/2022	12:00-1:30 PM	Virtual - Albuquerque - Central
BCBS	04/07/2022	3:30-5:00 PM	Virtual - Valencia and Socorro Counties - Central
BCBS	06/16/2022	12:00-1:30 PM	Virtual – Albuquerque - Central
BCBS	07/21/2022	12:00-1:30 PM	Virtual – Albuquerque - Central
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	09/29/2022	12:00-1:30 PM	Virtual - Las Cruces (Dona Ana County) - Regional
BCBS	10/20/2022	12:00-1:30 PM	Virtual - Santa Fe (Santa Fe County) - Regional
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	02/10/2022	12:00-1:30 PM	Virtual - Sandoval and Bernalillo Counties
BCBS	05/05/2022	3:30-5:00 PM	Virtual - McKinley (Crownpoint)
BCBS	08/25/2022	12:00-1:30 PM	Virtual - Eight Northern Pueblos

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BCBS	11/17/2022	12:00-1:30 PM	Virtual - McKinley (Zuni, Ramah and Pine Hill)
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 2022			
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	03/04/2022	1:30-3:30 PM	Virtual Meeting
PHP	06/03/2022	1:30-3:30 PM	Virtual Meeting
PHP	09/09/2022	1:30-3:30 PM	Virtual Meeting
PHP	12/02/2022	1:30-3:30 PM	Virtual Meeting
RURAL AREA MEETINGS			
MCO	DATE	TIME	LOCATION
PHP	09/16/2022	10:00-12:00 PM	Virtual Meeting (Deming)
PHP	10/19/2022	12:30 – 2:30 PM	Virtual Meeting (Alamogordo)
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
PHP	03/24/2022	3:00-5:00 PM	Virtual Meeting
PHP	06/09/2022	3:00-5:00 PM	Virtual Meeting
PHP	09/08/2022	3:00-5:00 PM	Virtual Meeting
PHP	12/08/2022	3:00-5:00 PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			

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MCO	DATE	TIME	LOCATION
PHP	TBD	TBD	<p>Meetings On Hold</p> <ul style="list-style-type: none"> Due to the low volume of self-directed members, PHP opted to fold these meetings into its broader Centennial Care 2.0 Member Advisory Board. Updates are provided at every meeting, presented by PHP's LTC Care Coordination Manager.

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
PHP	03/08/2022	1:00 PM-2:30 PM	Virtual Meeting
PHP	06/07/2022	1:00 PM-2:30 PM	Virtual Meeting
PHP	09/13/2022	1:00 PM-2:30 PM	Virtual Meeting
PHP	12/13/2022	1:00 PM-2:30 PM	Virtual Meeting

WSCC 2022

MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	02/11/2022	2:00-4:00 PM	Virtual Meeting
WSCC	05/14/2022	10:00 AM-12:00 PM	Virtual Meeting
WSCC	08/18/2022	11:00 AM- 1:00 PM	Virtual Meeting
WSCC	12/08/2022	2:00-4:00 PM	Virtual Meeting

STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	04/14/2022	4:00-6:00 PM	Virtual Meeting
WSCC	10/12/2022	3:00-5:00 PM	Virtual Meeting

NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	03/03/2022	11:00 AM- 1:00 PM	Virtual Meeting
WSCC	06/02/2022	4:00-6:00 PM	Virtual Meeting
WSCC	09/02/2022	11:00 AM-1:00 PM	Virtual Meeting

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WSCC	12/02/2022	4:00-6:00 PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
WSCC	08/18/2022	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	10/12/2022	3:00-5:00 PM	Virtual Meeting (Included in Statewide)
COMMUNITY ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
WSCC	06/15/2022	3:00-5:00 PM	Virtual Meeting

Quality Assurance

DY9 Q3

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 Quality Bureau, Performance Measure Unit, QQM for DY9 Q3 was held on September 29, 2022. The 3 MCOs presented an overview of all 10 Performance Measures (PMs) identifying the measures at-risk for not meeting target. The MCOs discussed the interventions in place and plans for future initiatives to ensure targets are met by the end of DY9.

Each MCO included a visual graph displaying their own DY9 Q2 rate compared to the HSD DY9 targets. According to the rates reported at the meeting, BCBS reported 3 PMs over target, PHP reported 4 PMs over target, and WSCC reported 3 PMs over target. Aggregately, the PMs with better performance outcomes is occurring for PM #6 (AMM – Continuation Phase), PM #7 (IET – Initiation Phase), PM #8 (FUH 30 Day), and PM #9 (FUM 30 Day). PM #9 (FUM) was reported as the performance measure with successful rates for all MCOs, all at 52% or greater. PM #9 (FUM) DY9 target is 46.50%.

The PMs below targets for all MCOs were PM #1 (W30), PM #2 (WCC-Physical Activity), PM #3 (PPC-Prenatal), PM #4 (PPC – Postpartum), PM #5 (CIS-Combination 3), and PM# 10 (SSD). For each PM acknowledged as at-risk for not meeting contracted target rates, the MCOs described their various interventions. For example, PM #2 (WCC) is reported with the lowest rates. For PM #2, BCBS reported top intervention is vendor outreach calls.

PHP's slide for PM #2 was marked with an upward arrow indicating the measure is projected to meet goal by the end of the year. WSCC acknowledged PM #2 is at risk and their intervention is quality improvement nurses conduct member outreach specifically for this measure.

Lastly, HSD announced the PM and TM report templates are being modified and improved to ensure more meaningful and accurate

reporting.

Monthly Performance Measure Monitoring Plan

In DY7, HSD Quality Bureau initiated a Monthly Monitoring Plan to address the decline in Healthcare Effectiveness Data and Information Set (HEDIS) rates from DY4 to DY5 for FUH and FUM performance measures. Due to ongoing efforts to improve member outcomes and noticeable improvement all 3 MCOs have made as a result of the Monthly Monitoring Plan, HSD ceased monthly submissions of the FUH and FUM measures effective with completion of their DY9 M3 submissions.

In DY9 Q3, HSD introduced 3 new measures to the Monthly Monitoring Plan for MCOs due to the decline in rates for PM #1 (W30), PM #3 (PPC-Prenatal) and PM #5 (CIS – Combination 3).

HSD provided the MCOs with directions and a monitoring tool to provide a monthly account of the ongoing interventions, strategies, and barriers associated with improving performance outcomes to ensure progress is being monitored and PM targets are met by the end of DY9 and DY10. The first report of DY9 Q3 data will be reported in the DY9 Q4 report.

Performance Measures (PMs)

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

HSD requires the MCOs to submit quarterly reports that are used to monitor the performance of each PM to determine if MCOs are on track for meeting the established target. MCOs report any significant changes as well as interventions, strategies, and barriers that impact improved performance. HSD staff will review

and analyze the data to determine if the MCOs are trending towards meeting the established targets. HSD findings are communicated to the MCOs through MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meeting (QQM). HSD expects to see rates increase quarter over quarter and the final determination of whether the MCOs have met the targets is reliant on the DY9 annual audited HEDIS report, which will be received in DY10 Q2.

Below are the MCO quarterly rates and interventions for each Performance Measure (PM) and their established target for DY9.

The following PMs show results for DY9 Q2 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.

DY9 target is 64.82%.

BCBS Q1 36.81%; Q2 50.94%: Increase of 14.13 percentage points from Q1 to Q2 and is 13.88 percentage points below the DY9 target.

PHP Q1 52.11%; Q2 52.75%: Increase of .64 percentage points from Q1 to Q2 and is 12.07 percentage points below the DY9 target.

WSCC Q1 30.31%; Q2 39.45%: Increase of 9.14 percentage points from Q1 to Q2 and is 25.37 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 38.54%; Q2 Total 49.61%: Increase of 11.07 percentage points from Q1 to Q2 and is 15.21 percentage points below the DY9 target.

MCO Strategies and Interventions:

BCBS: BCBS Quality Measure (QM) Specialist contacts members telephonically to encourage parents/guardians to schedule and complete well child visits in the first 15 months of life. The BCBS Member Handbook is sent to all newly enrolled members and is also available on the member BCBS website introducing benefit

information regarding well-child visits 0-15 months. Community Health Workers (CHWs) tool: Wellness Guidelines and Information, provides talking points encouraging guardians of members newborn to 15 months to schedule and complete well-child visits routinely. This tool continues to be utilized by CHW staff. Special Beginnings Care Coordinators conducted telephonic calls utilizing a script explaining the Special Beginnings benefit that discusses what happens after delivery along with the importance of well child visits and childhood immunizations. BCBS Quality Department contributed to the Member Advisory Board (MAB) and Native American Advisory Board (NAAB) meetings in DY9 Q2 where health education information on the importance of well child visits was presented at these meetings.

PHP: PHP's Performance Improvement (PI) team is working to identify pockets of noncompliance and risk scoring for members. This will allow targeted call campaigns rather than blanket ones. In addition, the Baby Bonus reward has been increasing in population. PI looks for ways to introduce this program to members and providers. One method is through community events that are attended by PI team members.

WSCC: WSCC implemented a weekly meeting in collaboration with various departments throughout Western Sky. This meeting is design to track data and trends for priority measures, discuss all interventions for each of the identified priority measures, and implement any changes that are required to ensure the measures are on the correct path.

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

	<p>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 June 2023.</p> <p>DY9 target is 58.14%.</p> <p>BCBS Q1 10.56%; Q2 15.73%: Increase of 5.17 percentage points from Q1 to Q2 and is 42.41 percentage points below the DY9 target.</p> <p>PHP Q1 11.02%; Q2 14.63%: Increase of 3.61 percentage points from Q1 to Q2 and is 43.51 percentage points below the DY9 target.</p> <p>WSCC Q1 8.92%; Q2 10.32%: Increase of 1.40 percentage points from Q1 to Q2 and is 47.82 percentage points below the DY9 target.</p> <p>MCO Aggregate: Q1 Total 10.60%; Q2 Total 14.65%: Increase of 4.05 from Q1 to Q2 and is 43.49 percentage points below the DY9 target.</p> <p>MCO Strategies and Interventions:</p> <p>BCBS: BCBS is pursuing a text and email message intervention is scheduled to be deployed sometime in DY9 Q3. Text and email messages that will be sent to parents who have children ages 3 through 17 years that encourages them to schedule an appointment with a primary care provider or OB-GYN. This visit would provide an opportunity for the child or teen to receive counseling for nutrition and physical activity/exercise and be assessed for any other needed care or treatment. BCBS also attributes improvement this quarter to the efforts of the Clinical Value Consultant team who have been educating provider practices on the current provider incentive for coding for exercise counseling, when appropriate, and ongoing provider education on individual clinic performance with relation to this measure. The Clinical Value Consultant team appears to be having a sustained impact on the noted improvement. During this reporting period (DY9 Q2) the Clinical Value Consultants provided information through joint operating and quality meetings to 21 provider groups.</p> <p>PHP: PHP continues to expand and refine Clinical Data Integration (CDI) processes to ensure that the changes in coding and HEDIS measures are incorporated. In addition, the abstraction team is expanding the electronic medical records they can access without</p>
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	<p>traveling to the centers. This allows faster and expanded data collection throughout the year.</p> <p>WSSC: WSSC implemented a weekly meeting in collaboration with various departments throughout Western Sky. This meeting is designed to track data and trends for priority measures, discuss all interventions for each of the identified priority measures, and implement any changes that are required to ensure the measures are on the correct path. WSSC also implemented two new interventions. The first new intervention implemented in DY9 Q2 is Quality Registered Nurses conduct member outreach to work with members to come into compliance with this measure. The team assists members with scheduling an appointment (if needed), educates the member of the importance of monitoring weight, physical activity and nutrition, and explains any resources or benefits that Western Sky has in place. Western Sky's Quality team works with Provider Quality Liaisons to conduct and educate providers on their quality scorecards for this measure and has created Quick Reference Guides (QRGs) for providers to reference.</p> <p><u>PM #3 (1 point) – Prenatal and Postpartum Care (PPC)</u></p> <p>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.</p> <p>DY9 target is 82.73%.</p> <p>BCBS Q1 59.50%; Q2 58.47%: Decrease of 1.03 percentage points from Q1 to Q2 and is 24.26 percentage points below the DY9 target.</p> <p>PHP Q1 61.98%; Q2 61.02%: Decrease of 0.96 percentage points from Q1 to Q2 and is 21.71 percentage points below the DY9 target.</p> <p>WSSC Q1 52.23%; Q2 52.92%: Increase of 0.69 percentage points from Q1 to Q2 and is 29.81 percentage points below the DY9 target.</p> <p>MCO Aggregate: Q1 Total 54.21%; Q2 Total 59.25%: Increase of</p>
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	<p>5.04 percentage points from Q1 to Q2 and is 23.48 percentage points below the DY9 target.</p> <p>MCO Strategies and Interventions:</p> <p>BCBS: BCBS reports that collaboration continues to evolve with Finity, the Centennial Rewards program vendor. Finity has a program called BabySmart. BCBS has leveraged the BabyFirst platform and is scheduled for deployment later this measurement year. BCBS is working with Families First to engage pregnant members in the program to improve outcomes of deliveries and maternal care. BCBS Quality team also collaborates with the Community Outreach team to hold a series of multiple community baby showers in different New Mexico cities providing education and support to mothers-to-be. As part of value-based contracting with provider groups, BCBS Clinical Value Consultants continue to educate providers about the prenatal and postpartum measure, sharing gap lists and performance for their attributed members. Additional interventions include the Special Beginnings Maternity Program, the Centennial Home Visiting Program, member newsletter articles pertaining to pregnancy related topics and pregnancy related educational information available on Blue Cross Blue Shield social media site "Connect Community".</p> <p>PHP: PHP is working to understand Social Determinants of Health (SDOH) for members to develop strategies to address needs by beginning at the community level. PHP's PI Program Manager Lead outreaches to community resources in attempts to assist with prenatal care of PHP's Centennial Care 2.0 members.</p> <p>WSCC: WSCC implemented a weekly meeting in collaboration with various departments throughout Western Sky. This meeting is designed to track data and trends for priority measures, discuss all interventions for each of the identified priority measures, and implement any changes that are required to ensure the measures are on the correct path. WSCC also implemented two new interventions. The first new intervention implemented in DY9 Q2 is Quality Registered Nurses conduct member outreach to work with members to come into compliance with this measure. The team assists members with scheduling an appointment (if needed),</p>
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	<p>educates the member of the importance of prenatal visits, and explains any resources or benefits that Western Sky has in place. Western Sky's Quality team works with Provider Quality Liaisons to conduct and educate providers on their quality scorecards for this measure and has created Quick Reference Guides (QRGs) for providers to reference. The Western Sky Provider Quality Liaisons continue to conduct Provider meetings, to encourage Provider outreach to assigned or attributed members. WSCC continued its member texting campaign (MPulse) in DY9 Q2. Start Smart for Baby (SSFB) continues to be available for all expecting mothers, upon completion of the Notification of Pregnancy form.</p> <p><u>PM #4 (1 point) – Prenatal and Postpartum Care (PPC)</u></p> <p>The percentage of member deliveries that had a postpartum visit on or between 7 and 84 Calendar Days after delivery.</p> <p>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 June 2023.</p> <p>DY9 target is 65.95%.</p> <p>BCBS Q1 42.11%; Q2 49.60%: Increase of 7.49 percentage points from Q1 to Q2 and is 16.35 percentage points below the DY9 target.</p> <p>PHP Q1 50.98%; Q2 55.56%: Increase of 4.58 percentage points from Q1 to Q2 and is 10.39 percentage points below the DY9 target.</p> <p>WSCC Q1 40.11%; Q2 44.80%: Increase of 4.69 percentage points from Q1 to Q2 and is 21.15 percentage points below the DY9 target.</p> <p>MCO Aggregate: Q1 Total 52.37%; Q2 52.25%: Decrease of 0.12 percentage points from Q1 to Q2 and is 13.70 percentage points below the DY9 target.</p> <p>MCO Strategies and Interventions:</p> <p>BCBS: Collaboration continues to evolve with Finity, the Centennial Rewards program vendor. Finity has a program called</p>
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	<p>BabySmart. BCBS has leveraged the BabyFirst platform and is scheduled for deployment later this measurement year. As part of value-based contracting with provider groups, BCBS Clinical Value Consultants continue to educate providers about the prenatal and postpartum measure, sharing gap lists and performance for their attributed members. Additional interventions include the Special Beginnings Maternity Program, the Centennial Home Visiting Program, member newsletter articles pertaining to pregnancy related topics and pregnancy related educational information available on Blue Cross Blue Shield social media site "Connect Community".</p> <p>PHP: PHP's Performance Improvement (PI) Program Manager and team are reviewing outreach methodologies for post-partum follow up. Looking at ways to identify and outreach to members who are more likely to miss post-partum appointments. PHP is also contacting community resources across New Mexico in attempts to set up partnerships and provide education/support to ensure members have the knowledge and resources within their communities.</p> <p>WSCC: WSCC has implemented new interventions in DY9. The first intervention implemented in DY9 Q2 is Quality Registered Nurses conduct member outreach to work with members to come into compliance with this measure. The team assists members with scheduling an appointment (if needed), educates the member of the importance of postpartum visits, and explains any resources or benefits that Western Sky has in place. Western Sky's Quality team works with Provider Quality Liaisons to conduct and educate providers on their quality scorecards for this measure and has created Quick Reference Guides (QRGs) for providers to reference. The WSCC Provider Quality Liaisons continue to conduct provider meetings, to encourage provider outreach to assigned or attributed members. Western Sky continued its member texting campaign (MPulse) in Q2 CY22. Start Smart for Baby (SSFB) continues to be available for all new mothers including the Pacify App.</p> <p><u>PM #5 (1 point) – Childhood Immunization Status (CIS):</u></p>
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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 June 2023.

DY9 target is 70.53%.

BCBS Q1 40.41%; Q2 55.52%: Increase of 15.11 percentage points from Q1 to Q2 and is 15.01 percentage points below the DY9 target.

PHP Q1 62.63%; Q2 62.97%: Increase of 0.34 percentage points from Q1 to Q2 and is 7.56 percentage points below the DY9 target.

WSCC Q1 41.83%; Q2 48.60%: Increase of 6.77 percentage points from Q1 to Q2 and is 21.93 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 45.26%; Q2 Total 56.96%: Increase of 11.70 percentage points from Q1 to Q2 and is 13.57 percentage points below the DY9 target.

MCO Strategies and Interventions:

BCBS: BCBS's Community Health Workers (CHWs) tool: Wellness Guidelines and Information, provides talking points encouraging parent/guardians of children 2 years of age complete Combo 3 Immunizations. This tool continues to be utilized by CHW staff. Members are being contacted telephonically to encourage parents/guardians to complete immunizations as needed. Assistance in scheduling an appointment is also offered to members. BCBS's Quality Department contributed to the Member Advisory Board (MAB) and Native American Advisory Board (NAAB) meetings held in DY9 Q2 where health education information on the importance of childhood immunizations was

presented. BCBS's Quality Department is developing a member texting and emailing intervention for implementation in DY9 Q3 with a goal to bring awareness to parents on the importance of childhood immunizations while offering support in scheduling appointments. Member engagement will continue to progress in DY9, encouraging childhood immunizations and assisting in scheduling appointments as needed. The "Got Shots?" Campaign is scheduled for this upcoming quarter (DY9 Q3), which is geared toward members ages 1 month to 21 years with the intent to ensure school-aged children receive immunizations prior to the beginning of the school year. Member outreach calls have taken place and members have been scheduled for this upcoming event.

PHP: PHP continues to send Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and educational letters to members as well as telephonic outreach. PHP's Performance Improvement (PI) team are looking at interventions to augment current outreach. Items in discussion include partnering with community resources to encourage provision of immunizations at special events, evaluating the use of pharmacies, stronger working relationship with the "Got Shots?" campaign, and working with larger provider clinics for special outreach to members.

WSCC: WSCC has implemented a weekly meeting in collaboration with various departments throughout Western Sky. This meeting is designed to track data and trends for priority measures, discuss all interventions for each of the identified priority measures, and implement any changes that are required to ensure the measures are on the correct path. In DY9 Q2, Quality RNs conduct member outreach working with members to come into compliance with this measure. The team assists members with scheduling appointments (if needed), educates the member of the importance of vaccinations and staying up to date, and explains any resources or benefits that Western Sky has in place. Western Sky's Quality team works with Provider Quality Liaisons to conduct and educate providers on their quality scorecards for this measure and has created Quick Reference Guides (QRGs) for providers to reference. Western Sky is also expanding an initiative already in place by inviting members to complete their child's vaccinations at

scheduled events. WSCC is also looking to implement incentives for members who complete the required vaccinations for compliance with the CIS measure.

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.

DY9 target is 35.19%.

BCBS Q1 32.36%; Q2 37.30%: Increase of 4.94 percentage points from Q1 to Q2 and is 2.11 percentage points above the DY9 target. PHP Q1 46.17%; Q2 44.55%: Decrease of 1.62 percentage points from Q1 to Q2 and is 9.36 percentage points above the DY9 target. WSCC Q1 33.18%; Q2 35.03%: Increase of 1.85 percentage points from Q1 to Q2 and is 0.16 percentage points below the DY9 target. MCO Aggregate: Q1 Total 36.57%; Q2 Total 39.99%: Increase of 3.42 percentage points from Q1 to Q2 and is 4.80 percentage points above the DY9 target.

MCO Strategies and Interventions:

BCBS: BCBS states that a member-based incentive is being explored to further increase medication adherence for antidepressants and a member video on medication adherence has been created and is near distribution once approvals occur. In addition, BCBS interventions continued in DY9 Q2 included a provider educational webinar on depression and treatment, refills reminder calls, and value-based contracting with many provider groups which includes the AMM measure.

PHP: PHP implemented a Performance Improvement Project for Management of Clinical Depression continued in DY9 Q2. DY9 Q2 activities included obtaining approval for educational brochures on depression and comorbid conditions (such as diabetes and cardiovascular disease) and identifying targeted groups of members for distribution through Gap in Care lists. Additionally, a new procedure was created to make depression educational brochures available for mailing to members during the Health and

	<p>Risk Assessment process. PHP sent out a provider e-blast during Q2 to primary care providers. Providers were emailed an educational flyer on how best to treat depression in a primary care setting. Incentivization of AMM and Depression Screening Codes continued in DY9 Q2 through the Value Based Purchasing Provider Quality Incentive Program (VBP PQIP). VBP programs were promoted as planned during the DY9 Q2 Provider Education Conference (PEC). Eligible providers were encouraged to enroll in PQIP AMM or Depression Screening metrics. Additionally, a presentation regarding the importance of depression screening was delivered during the PEC in DY9 Q2. Member rewards continued in DY9 Q2 for members who filled their antidepressant medication within AMM measure timeframes.</p> <p>WSCC: WSCC continues to partner with Envolve to provide outreach to members monthly through their Clinical Pharmacist Medication Therapy Management program. Members identified for the outreach program receive a call from a pharmacist who counsels members and addresses antidepressant medication adherence and barriers. WSCC Pharmacy Coordinators continue to call and fax providers and pharmacies to help refill members' medications and inform of the option for 90-day supply prescriptions. WSCC has entered a pilot project with Walgreen's for member outreach. Based on a weekly list of members provided to Walgreen's by WSCC, Walgreen's clinical staff reaches out to the member for counseling on their antidepressant medication and will address any barriers or concerns. WSCC also continues to refer members to the Behavioral Health Disease Management Program, through which members receive monthly (or more frequent) telephonic support from a WSCC Health Coach who is a Registered Nurse. The BH Disease Management Health Coach provides education and resources and assists with coordinating care. Additionally, the PHQ-9 depression assessment is completed monthly with members to identify and address any decompensating mental health symptoms. WSCC member facing staff continue to receive training to educate members about the MyStrength program, which is available to members online and as an app they can download onto their phone or tablet. The program provides individualized self-care and coping strategies based on the member's responses to questions each time the member accesses the program. The program also sends newsletters with helpful strategies and information to members who opt in to receive these</p>
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communications via email.

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.

DY9 target is 46.14%.

BCBS Q1 41.26%; Q2 43.73%: Increase of 2.47 percentage points from Q1 to Q2 and is 2.41 percentage points below the DY9 target.

PHP Q1 47.16%; Q2 49.75%: Increase of 2.59 percentage points from Q1 to Q2 and is 3.61 percentage points above the DY9 target.

WSCC Q1 45.30%; Q2 46.44%: Increase of 1.14 percentage points from Q1 to Q2 and is 0.30 percentage points above the DY9 target.

MCO Aggregate: Q1 Total 44.74%; Q2 Total 47.14%: Increase of 2.40 percentage points from Q1 to Q2 and is 1 percentage point above the DY9 target.

MCO Strategies and Interventions:

BCBS: BCBS reports that a member video supporting substance use disorder treatment is in development with plans to make available to members in DY9 Q3. Other continued interventions include enhanced payment incentive, value-based contracting with multiple provider groups, an educational provider webinar on substance use disorders and outreach by Recover Support Assistants to support members post ER discharge.

PHP: PHP continues utilizing Value Based Purchasing (VBP) programs that incentivize IET appointments continued in DY9 Q2. Both the Provider Quality Incentive Program (PQIP) and Behavioral Health Quality Incentive Program (BQIP) offer incentives with completion of either initiation or engagement appointments. VBP programs were promoted during the DY9 Q2 Provider Education Conference (PEC) and the DY9 Q2 BH Provider Town Hall. Eligible providers were encouraged to enroll in either the PQIP or BQIP IET metrics, however there was only 1 new enrollee in BQIP in DY9 Q2. Member outreach for members within the IET measure continued in DY9 Q2 by the Community

	<p>Health Worker (CHW) teams. PHPs CHW team is notified of a member who was in the ED for AOD use and the CHW will attempt engagement with the member. If engagement is successful, the CHW will complete the Healthy Lifestyles Questionnaire to assess the member's needs and refer the member to the appropriate level of care. Certified peer support workers continued to be stationed in 5 emergency departments (some EDs operating with only virtual peer services) within the PHS delivery system in DY9 Q2. The peers primary focus is to engage individuals with opioid overdose or opioid related episodes into recovery and treatment, however they also will assist members with alcohol related episodes.</p> <p>WSCC: Daily reports are utilized to identify members for outreach. Members who are not engaged with an outpatient provider are referred to NM Family Services for outreach and engagement in treatment. Members are referred by NM Family Services to the WSCC Member Connections Team to provide Peer Support and encourage participation in Care Coordination services as needed. NM Family Services staff collaborates with members' assigned care coordinators to ensure continuity of care and access to appropriate services. Care Coordinators work with members who are enrolled in care coordination services to address gaps in care, provide member education, connect members with providers, and assist with transportation or other barriers members experience with getting to appointments. Members in the IET measure who have high ED utilization receive text messages via the mPulse texting program, which checks in with members about follow-up care and allows members to respond with any needs they may have. Members who respond with questions or needs receive telephonic outreach from either their assigned Care Coordinator, if applicable, or the Member Connections Team. WSCC staff are in the final training stages and implementation of HALO (Health Assistance, Linkage, & Outreach), expected to launch by DY9 Q3. Fueled by lift predictive modeling, HALO expands the care of OpiEnd by addressing use of alcohol, amphetamines, opioids, and other substances to identify and prevent members at risk of developing a substance use disorder and treat those already abusing substances to avoid worsening of symptoms by connecting members to necessary care. Member facing staff are trained to educate members about the MyStrength program, which</p>
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January 1, 2019 – December 31, 2023

is available to members online and as an app they can download onto their phone or tablet. The program provides individualized self-care and coping strategies based on the member's responses to questions each time the member accesses the program. The program also sends newsletters with helpful strategies and information to members who opt in to receive these communications via email. Members who complete an initial assessment with NM Family Services within 14 days of the new alcohol or other drug abuse episode or engage in at least two treatment encounters within 34 days of initiating the treatment receive a \$30 gift card as an incentive to continue engagement.

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.

DY9 target is 52.02%.

BCBS Q1 48.30%; Q2 53.12%: Increase of 4.82 percentage points from Q1 to Q2 and is 1.1 percentage points above the DY9 target.

PHP Q1 49.22%; Q2 52.59%: Increase of 3.37 percentage points from Q1 to Q2 and is 0.57 percentage points above the DY9 target.

WSCC Q1 50.23%; Q2 54.57%: Increase of 4.34 percentage points from Q1 to Q2 and is 2.55 percentage points above the DY9 target.

MCO Aggregate: Q1 Total 49.03%; Q2 Total 53.03%: Increase of 4 percentage points from Q1 to Q2 and is 1.01 percentage points above the DY9 target.

MCO Strategies and Interventions:

BCBS: BCBS completed a member video regarding follow-up care and is anticipated to be available in DY9 Q3. BCBS has various interventions in place such as value-based contracting with provider groups, provider educational webinars covering FUH occurred in DY9 Q1 and Q2, the Reserved Appointment Initiative also continued along with the Outpatient Incentive Program, the Facility Incentive Program, and Transition of Care support for members.

	<p>PHP: PHP continues to utilize VBP programs in DY9 Q2, including the Model Facility Incentive Program (MFIP) for inpatient acute psychiatric facilities/units, the BH Quality Incentive Program (BQIP) for outpatient behavioral health providers, and the Provider Quality Incentive Program (PQIP) for physical health providers. Recruitment efforts continued into DY9 Q2 to recruit more providers into both the BQIP and PQIP FUH measures. VBP programs were promoted during the DY9 Q2 Provider Education Conference (PEC) and the DY9 Q2 BH Provider Town Hall. There were no new providers within BQIP in DY9 Q2. In DY9 Q2, the VBP team met with almost all enrolled MFIP facilities during quarterly engagement meetings. MFIP meetings are used to problem-solve any barriers to performance and includes input from different departments across the health plan and inpatient organization to help address strengths and specific gaps identified. Collaboration will continue between utilization management, hospital discharge planning staff, and Care Coordination teams. Routine inpatient Care Coordination (IPCC) activities continued in DY9 Q2. IPCC activities include contacting members who were hospitalized and offering Care Coordination services, including discharge planning assistance.</p> <p>WSCC: Members receive outreach during their inpatient stay and after discharge by BH Liaisons based on daily admissions/discharge lists. Members are offered support from Member Connections Team (Certified Peer Support Workers and Certified Community Health Workers). Difficult to Engage or Unable to Reach members are referred to Member Connections Team for additional outreach efforts. Members are referred to TeamBuilders Behavioral Health by BH Liaisons and Facility Discharge Planners within 7 days of discharge for completion of initial telehealth assessment by licensed mental health clinician. TeamBuilders Behavioral Health clinicians assist in connecting members with an outpatient mental health counselor for ongoing care. Utilization of Teladoc is encouraged by BH Liaisons and Customer Service staff. Member facing staff are trained to educate members about the MyStrength program, which is available to members online and as an app they can download onto their phone or tablet. The program provides individualized self-care and coping strategies based on the member's responses to questions each time the member accesses the program. The program also sends newsletters with helpful strategies and information to members who opt in to receive these</p>
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communications via email. Members who complete their 7 day follow up appointment with a mental health counselor receive a \$30 gift card. This includes members who complete the telehealth assessment with TeamBuilders Behavioral Health. Monthly and quarterly meetings are held with small practices, individual providers, and VBP BH providers across the state to address issues such as member access to appointments within 7 days of discharge, Pay for Performance metrics, and best practices for providing the highest quality care. Provider Roadshows have taken place throughout the state to offer opportunities for providers to engage with WSCC and receive education and support. Telehealth Behavioral Health Discharge Incentive Program works to provide incentives for continuous improvement of discharge coordination and collaborative efforts between psychiatric hospitals and community behavioral health providers. BH Clinical Training Curriculum: BH Providers have been given an “At-a-Glance” BH Provider Toolkit which contains BH HEDIS measure details, tips, and best practice strategies. The kit is being updated with DY9 specs and will be redistributed upon completion. BH Clinical Training Series, which provides education and best practices on gap closure and quality patient care, has been approved and is available to providers through the WSCC Training Team.

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.

DY9 target is 46.50%.

BCBS Q1 46.85%; Q2 51.18%: Increase of 4.33 percentage points from Q1 to Q2 and is 4.68 percentage points above the DY9 target.
 PHP Q1 60.71%; Q2 59.18%: Decrease of 1.53 percentage points from Q1 to Q2 and is 12.68 percentage points above the DY9 target.
 WSCC Q1 48.78%; Q2 54.60%: Increase of 5.82 percentage points from Q1 to Q2 and is 8.10 percentage points above the DY9 target.
 MCO Aggregate: Q1 Total 53.31%; Q2 Total 55.47%: Increase of 2.16 percentage points from Q1 to Q2 and is 8.97 percentage points above the DY9 target.

	<p>MCO Strategies and Interventions:</p> <p>BCBS: Two webinars that offered continuing education units were held covering the FUM measure in DY9 Q1 and Q2. A member educational video on the importance of treatment and follow-up was created and is anticipated for release in DY9 Q3. Other continued interventions include BH staff outreach after ER visits, provider educational webinars, and value-based contracting with provider groups.</p> <p>PHP: PHP continued VBP programs in DY9 Q2, including the BH Quality Incentive Program (BQIP) for outpatient behavioral health providers, and the Provider Quality Incentive Program (PQIP) for physical health providers. Recruitment efforts continued into DY9 Q2 to recruit more providers into both the BQIP and PQIP FUM measures. VBP programs were promoted during the DY9 Q2 Provider Education Conference (PEC) and the DY9 Q2 BH Provider Town Hall. There were 4 providers who opted into the FUM BQIP in DY9 Q2. Presbyterian Healthcare Services (PHS) Consult Liaison Services provided psychiatry services via telemedicine technology at identified EDs and Urgent Care-EDs within the PHS delivery system. Telemedicine psychiatry appointments are conducted on the same day that the member is in the ED, thus meeting FUM HEDIS technical specifications for follow-up care. Routine Critical Incident Report (CIR) processing continued in DY9 Q2. CIRs for members seen in the ED (including for mental illness) contribute a large percentage of overall behavioral health CIRs.</p> <p>WSCC: Daily lists from Collective Medical and Interpreta are utilized to identify members for outreach. Members who are not engaged with an outpatient provider are referred to TeamBuilders Behavioral Health to complete an initial mental health assessment. TeamBuilders Behavioral Health clinicians assist in connecting members with an outpatient mental health counselor for ongoing care and help with finding community resources. Members are referred by TeamBuilders Behavioral Health to the WSCC Member Connections Team to provide additional support and encourage participation in Care Coordination services as needed. TeamBuilders Behavioral Health clinicians collaborate with members' assigned care coordinators to ensure continuity of care</p>
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	<p>and access to appropriate services. Care Coordinators work with members who are enrolled in care coordination services to address gaps in care, provide member education, connect members with providers, and assist with transportation or other barriers members experience with getting to appointments. In April DY9, members at high risk for suicide began receiving outreach from the Member Connections Team as part of the Choose Tomorrow: A Zero Suicide Prevention Program, which focuses on early identification, screening, and specialized ongoing support for at-risk individuals. Members in the FUM measure who have high ED utilization receive text messages via the mPulse texting program, which checks in with members about follow-up care and allows members to respond with any needs they may have. Member who respond with questions or needs receive telephonic outreach from either their assigned Care Coordinator, if applicable, or from the Member Connections Team. Utilization of Teladoc is encouraged by BH Liaisons and Customer Service staff. Member facing staff are trained to educate members about the MyStrength program, which is available to members online and as an app they can download onto their phone or tablet. The program provides individualized self-care and coping strategies based on the member's responses to questions each time the member accesses the program. The program also sends newsletters with helpful strategies and information to members who opt in to receive these communications via email. PCPs are notified of members' behavioral health diagnoses through WSCC's Rapid Fax Program. Members who complete the initial mental health assessment with TeamBuilders Behavioral Health within 30 days of the ED visit receive a \$30 gift card. This program will be retired upon implementation of the FUM Centennial Rewards program through the State. This will allow all members who complete their follow up appointment within 7 days of their ED visit to be incentivized. Provider Engagement: Provider Quality Liaisons (PQLs) continue to work with providers to provide education and support regarding gap closure. Monthly and quarterly meetings with small practices, individual providers, and VBP BH providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care. Provider Roadshows have taken place throughout the state to offer opportunities for providers to engage with WSCC and receive education and support. BH Clinical Training Curriculum: BH Providers have been given an "At-a-Glance" BH Provider Toolkit which contains BH HEDIS measure details, tips, and best practice</p>
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strategies. The kit is being updated with DY9 specs and will be redistributed upon completion. BH Clinical Training Series, which provides education and best practices on gap closure and quality patient care, has been approved and is available to providers through the WSCC Training Team.

PM #10 (1 point) – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

DY9 target is 82.07%.

BCBS Q1 40.76%; Q2 61.41%: Increase of 20.65 percentage points from Q1 to Q2 and is 20.66 percentage points below the DY9 target.

PHP Q1 41.50%; Q2 61.08%: Increase of 19.58 percentage points from Q1 to Q2 and is 20.99 percentage points below the DY9 target.

WSCC Q1 40.10%; Q2 54.19%: Increase of 14.09 percentage points from Q1 to Q2 and is 27.88 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 41.07%; Q2 Total 60.57%: Increase of 19.50 percentage points from Q1 to Q2 and is 21.50 percentage points below the DY9 target.

MCO Strategies and Interventions:

BCBS: BCBS reports that outreach to members encouraging their screenings resumed in DY9 Q2. Continuing education webinars that included SSD were offered to providers and the BCBS Pharmacy Department completed provider outreach notifying them of their members who need to be screened. BCBS continues to offer and send home test kits to members who do not want to be screened in a clinic.

PHP: PHP continued SSD abstraction in DY9 Q2, with 48 hospital records abstracted for inclusion in the SSD numerator. There were 39 records pending finalization at the end of DY9 Q2. The abstraction process involves cross referencing gap-in-care lists with inpatient hospitalization records to secure lab results that

likely took place during inpatient hospitalization. A provider e-blast was distributed during DY9 Q2 to PCPs. Providers were emailed an educational flyer on antipsychotic medication prescribing best practices. Direct peer to peer outreach between PHP's behavioral health medical director and prescribers within the SSD measure occurred in DY9 Q2. The BH medical director conducted 5 meetings with SSD prescribers, informing them of the SSD measure requirements and offering educational assistance. Incentivization of SSD appointments as part of the Value Based Purchasing Provider Quality Incentive Program (PQIP) and Behavioral Health Quality Incentive Program (BQIP) continued in DY9 Q2. VBP programs were promoted during the DY9 Q2 Provider Education Conference (PEC) and the DY9 Q2 BH Provider Town Hall. Eligible providers were encouraged DY9 Q2 to enroll in either the PQIP or BQIP SSD metrics. There were 5 providers who opted into the SSD BQIP in DY9 Q2. In DY9 Q2, work began on promoting lab testing kits at prescriber's office within the SSD measure. Providers who are contracted with a local lab vendor will be given lab kits to use in office when a member presents for normal follow-up appointments. PHP believes that providers performing the simple A1C lab test kit in office with the member will produce better outcomes than mailing at-home test kits to members in this population. A provider educational letter for SSD approved for distribution in DY9 Q2. Due to delays in the gap in care list revisions, the provider letters were postponed until July DY9. The provider letter will include member-specific information about which members are still missing lab testing. The BH QI team concluded a Treatment Record Review (TRR) for members diagnosed with schizophrenia. The purpose of this specific TRR was to increase educational opportunities to BH providers on best practices for prescribing antipsychotics to members diagnosed with schizophrenia and schizoaffective disorder. Final data on the TRR exercise was not available at the time of this report.

WSSC: Lab2U A1c screening kits were shipped to members May of DY9. Telephonic outreach by QI staff was conducted to educate members about the kits. Updated addresses were provided to Lab2U in June DY9 based on members who were successfully reached during outreach. New kits were sent out to members at that time. Lab2U conducted calls to remind members about the kits in June and July of DY9. Care Coordinators work with members who are enrolled in care coordination services to address gaps in care,

provide member education, connect members with providers, and assist with transportation or other barriers members experience with getting to appointments. Provider Engagement: Provider Quality Liaisons (PQLs) continue to work with providers to provide education and support regarding gap closure. Monthly and quarterly meetings with small practices, individual providers, and VBP BH providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care. Provider Roadshows have taken place throughout the state to offer opportunities for providers to engage with WSCC and receive education and support. BH Clinical Training Curriculum: BH Providers have been given an “At-a-Glance” BH Provider Toolkit which contains BH HEDIS measure details, tips, and best practice strategies. The kit is being updated with DY9 specs and will be redistributed upon completion. BH Clinical Training Series, which provides education and best practices on gap closure and quality patient care, has been approved and is available to providers through the WSCC Training Team.

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 DY9 Q2 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 0.04%: Increase of 0.03 percentage points

	<p>from Q1 to Q2 PHP Q1 3.49%; Q2 3.64: Increase of 0.15 percentage points from Q1 to Q2 WSSC Q1 0.52%; Q2 0.50%: Decrease of 0.02 percentage points from Q1 to Q2 MCO Aggregate: Q1 0.91%; Q2 0.93%: Increase of 0.02 percentage points from Q1 to Q2</p> <p>MCO Strategies and Interventions: BCBS: BCBS continues to educate clinicians reminding them of the need to perform a fall risk assessment when they evaluate a member aged 65 or over who has had a fall and ensure the correct coding is being used to capture the assessment.</p> <p>PHP: Interventions include a wide array of actions such as home safety evaluation, evaluation of durable medical equipment needs, review of medications that may increase fall risk, physical or occupational therapy, and other interventions designed to reduce fall risk.</p> <p>WSSC: For members with care coordination, Western Sky addresses medication(s) to ensure they are not causing dizziness that may cause a fall. Care Coordination also works with members to educate for prevention on daily activities or behaviors that may cause a fall and to assist with scheduling an appointment with a Primary Care Provider (PCP) for examination.</p> <p><u><i>TM #2 – Diabetes Short-Term Complications Admission Rate</i></u> Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees ages eighteen (18) and older. Reported as a rate per 100,000 member months. A lower rate indicates improvement for this measure.</p> <p>BCBS Q1 19.17; Q2 23.00: Decline in performance of 3.83 per 100,000 member months from Q1 to Q2 PHP Q1 14.90; Q2 15.17: Decline in performance of 0.27 per 100,000 member months from Q1 to Q2 WSSC Q1 1.22; Q2 7.56: Decline in performance of 6.34 per 100,000 member months from Q1 to Q2 MCO Aggregate: Q1 Total 14.87; Q2 Total 17.10: Decline in performance of 2.23 per 100,000 member months from Q1 to Q2</p> <p>MCO Interventions:</p>
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	<p>BCBS: The summer edition of Blue for Your Health member newsletter included an article titled “Put the Brakes on Diabetes Complications” illustrating the need for members to monitor and manage their A1c testing scores with their health care provider, and tips to assist the member in further discussions with their health care provider for enhanced diabetes management.</p> <p>PHP: PHP is reviewing population based on social determinants and use of risk scores to adjust outreach. The goal is to stratify populations and develop outreach activities based on the identified needs within geographical areas.</p> <p>WSCC: WSCC is working different provider engagement opportunities to further address access to care for our members with chronic health needs, such as Diabetes Short-Term Complications Admission.</p> <p><u><i>TM #3 – Screening for Clinical Depression</i></u></p> <p>Percentage of Medicaid enrollees ages eighteen (18) and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. An increase in percentage indicates improvement for this measure.</p> <p>BCBS Q1 0.80%; Q2 1.33%: Increase of 0.53 percentage points from Q1 to Q2</p> <p>PHP Q1 1.02%; Q2 1.76%: Increase of 0.74 percentage points from Q1 to Q2</p> <p>WSCC Q1 0.96%; Q2 1.28%: Increase of 0.32 percentage points from Q1 to Q2</p> <p>MCO Aggregate: Q1 Total 0.94%; Q2 Total 1.57%: Increase of 0.63 percentage points from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: A webinar titled “Differential Diagnoses of Depression: Assessment and Treatment” is offered as part of provider education and providers who attended the live or recorded webinar were offered continuing medical education and continuing education credit.</p>
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	<p>PHP: Incentivization of Depression Screening Codes continued in DY9 Q2 through the Value Based Purchasing Provider Quality Incentive Program (VBP PQIP). VBP programs were promoted as planned during the DY9 Q2 Provider Education Conference (PEC). Eligible providers were encouraged to enroll in PQIP Depression Screening metrics.</p> <p>WSCC: The importance of depression screenings and follow-up plans for positive screenings has been discussed with providers and training has been made available through the provider portal.</p> <p><u>TM #4 – Follow-up after Hospitalization for Mental Illness</u></p> <p>The percent of seven-day follow-up visits into community-based Behavioral Health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days. An increase in rate indicates improvement for this measure.</p> <p>BCBS Q1 32.99%; Q2 33.53%: Increase of 0.54 percentage points from Q1 to Q2</p> <p>PHP Q1 36.33%; Q2 36.63%: Increase of 0.30 percentage points from Q1 to Q2</p> <p>WSCC Q1 15.38%; Q2 45.55%: Increase of 30.17 percentage points from Q1 to Q2</p> <p>MCO Aggregate: Q1 Total 32.22%; Q2 36.39%: Increase of 4.17 percentage points from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: The following interventions continued such as the Reserved Appointment Initiative, the Outpatient Incentive Program, and the Facility Incentive Program. In DY9 Q2, the Facility Incentive Program was approved to expand adding two additional facilities to the program.</p> <p>PHP: A new follow up after hospitalization for mental illness (FUH) appointment strategy initiated in DY9 Q2 in which inpatient, rostered, master's level or higher, providers are reimbursed for completing telehealth FUH appointments between days 2-7 post discharge.</p> <p>WSCC: Members are referred to Team Builders Behavioral Health by BH Liaisons and Facility Discharge Planners within 7 days of discharge for completion of initial telehealth assessment by licensed</p>
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	<p>mental health clinician.</p> <p><u><i>TM #5 – Immunizations for Adolescents (IMA)</i></u></p> <p>The percentage of adolescents thirteen (13) years of age who had one (1) dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. An increase in percentage indicates improvement for this measure.</p> <p>BCBS Q1 71.25%; Q2 76.89%: Increase of 5.64 percentage points from Q1 to Q2 PHP Q1 73.61%; Q2 76.23%: Increase of 2.62 percentage points from Q1 to Q2 WSCC Q1 20.92%; Q2 69.61%: Increase of 48.69 percentage points from Q1 to Q2 MCO Aggregate: Q1 Total 67.43%; Q2 75.77%: Increase of 8.34 percentage points from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: BCBS collaborates with New Mexico immunization coalition each year to plan the “Got Shots?” campaign to ensure school children receive immunization prior to the beginning of the school year.</p> <p>PHP: A combination of education around the importance of immunizations, additional community resources, and increased number of children being taken to physical visits where immunizations can be provided (as opposed to video/telehealth visits) has impacted positive movement in immunizations.</p> <p>WSCC: WSCC continues to use the VBP (Value Based Payment) and PQL (Provider Quality Liaisons) teams to review scorecards and member gap lists with VBP Providers and assist with any barriers providers are seeing.</p> <p><u><i>TM #6 – Long-Acting Reversible Contraceptive (LARC)</i></u></p> <p>Utilization of Long-Acting Reversible Contraceptives. The contractor shall report LARC insertion/utilization data for this measure.</p> <p>BCBS Q1 168; Q2 368 PHP Q1 299; Q2 615 WSCC Q1 42; Q2 103 MCO Aggregate: Q1 Total 509; Q2 Total 1,086</p>
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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 919; Q2 1,783: Increase of 864 members

PHP Q1 1,547; Q2 2,915: Increase of 1,368 members

WSCC Q1 251; Q2 534: Increase of 283 members

MCO Aggregate: Q1 Total 2,717; Q2 5,232: Increase of 2,515 members

MCO Interventions:

BCBS: Pharmaceutical Service Reimbursement was in June of DY9, which BCBS believes will increase smoking cessation counseling and efforts by pharmacies to be reimbursed for the services along with the products.

PHP: PHP is working on enhancing the tobacco cessation program. PHP continues to work with Clickotine and providers to ensure that all members are aware of services offered by PHP. PHP Case Management and PHP Disease Management collaborate on ensuring members receive information on all avenues of tobacco cessation and appropriate referrals to resources.

WSCC: The Puff Free Pregnancy program provides telephonic outreach, education, and support services to reduce the health risks associated with smoking during pregnancy, such as low birth weight and perinatal mortality, by reducing the use of tobacco products.

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 73.54; Q2 160.47: Increase of 86.93 per 1,000 member months from Q1 to Q2

PHP Q1 65.72; Q2 142.30: Increase of 76.58 per 1,000 member months from Q1 to Q2

WSCC Q1 33.32; Q2 105.31: Increase of 71.99 per 1,000 member months from Q1 to Q2

MCO Aggregate: Q1 Total 64.93; Q2 144.68: Increase of 79.75 per

	<p>1,000 member months from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: BCBS partners with MDLIVE to provide additional access to services and to increase utilization of telehealth services. MDLIVE is a virtual visits vendor.</p> <p>PHP: PHP continues to support members in receiving services at the appropriate level be it telehealth vs. in person physician visits or urgent care vs. ED visits. Care Coordinators work closely with members, providers, and community resources to support care being provided in the appropriate settings.</p> <p>WSCC: Care Coordinators work with members who are enrolled in care coordination services to address gaps in care, provide member education, connect members with providers, and assist with transportation or other barriers members experience with getting to appointments.</p> <p><u>TM #8 – Ambulatory Care Emergency Department Visits</u></p> <p>Utilization of emergency department (ED) visits reported as a rate per 1,000 member months. A lower rate indicates improvement for this measure.</p> <p>BCBS Q1 9.15; Q2 20.29: Decline in performance of 11.14 per 1,000 member months from Q1 to Q2</p> <p>PHP Q1 8.31; Q2 18.92: Decline in performance of 10.61 per 1,000 member months from Q1 to Q2</p> <p>WSCC Q1 5.31; Q2 15.75: Decline in performance of 10.44 per 1,000 member months from Q1 to Q2</p> <p>MCO Aggregate: Q1 Total 8.28; Q2 Total 19.06: Decline in performance of 10.78 per 1,000 member months from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: BCBS contracts with the Emergency Department Information Exchange (EDIE), a key tool that allows our peer support and community health workers to monitor members utilizing the emergency room in a crisis. The EDIE report is generated when a member accesses the emergency room. If a member is hospitalized, care coordination is alerted.</p>
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	<p>PHP: PHP has not seen negative changes, but the normal progression of rates throughout the year. Continued monitoring looks to identify any aberrant movement allowing for immediate action when concerns are identified.</p> <p>WSCC: WSCC continues to utilize the MPulse mobile texting program to engage members via text message after an ED visit. This program is targeted to members with high ED utilization and was expanded to include members seen in the ED for non-emergent needs beginning in May of DY9.</p> <p><u>TM #9 – Annual Dental Visit (ADV)</u></p> <p>The percentage of enrolled Members ages two (2) to twenty (20) years who had at least one (1) dental visit during the measurement year. An increase in percentage indicates improvement for this measure.</p> <p>BCBS Q1 19.66%; Q2 31.75%: Increase of 12.09 percentage points from Q1 to Q2</p> <p>PHP Q1 22.46%; Q2 42.11%: Increase of 19.65 percentage points from Q1 to Q2</p> <p>WSCC Q1 8.88%; Q2 32.88%: Increase of 24.00 percentage points from Q1 to Q2</p> <p>MCO Aggregate: Q1 Total 20.09%; Q2 Total 37.63%: Increase of 17.54 percentage points from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: In DY9 Q2, BCBS continues to hold dental health fair days scheduled in collaboration with Familia Dental and the BCBS Community Outreach team in an attempt to improve measure compliance.</p> <p>PHP: Two factors have been important. The first is the easing and then removal of COVID 19 restrictions within New Mexico. This has opened appointments allowing routine dental clinic visits to occur. PHP has continued multi directive campaigns around children's health that includes well-visits with physicians, routine eye exams, regular dental checkups, and complete immunizations.</p> <p>WSCC: In DY9 Q2, Western Sky Community Care (WSCC) completed six Dental Days clinics with Familia Dental. Members</p>
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	<p>who complete their free screening will receive Western Sky gifts as well as an in-person Walmart gift card of \$20.</p> <p><u><i>TM #10 – Controlling High Blood Pressure (CBP)</i></u></p> <p>The percentage of Members ages eighteen (18) to eighty-five (85) who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. An increase in percentage indicates improvement for this measure.</p> <p>BCBS Q1 8.37%; Q2 12.59%: Increase of 4.22 percentage points from Q1 to Q2</p> <p>PHP Q1 19.35%; Q2 29.12%: Increase of 9.77 percentage points from Q1 to Q2</p> <p>WSCC Q1 3.16%; Q2 6.94%: Increase of 3.78 percentage points from Q1 to Q2</p> <p>MCO Aggregate: Q1 Total 13.52%; Q2 Total 20.46%: Increase of 6.94 percentage points from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: In DY9 Q2, BCBS Quality Department provided annual CBP HEDIS measure training to all care coordination staff along with deskside handbook used to aid in conversation with members encouraging appointment scheduling with new or existing providers.</p> <p>PHP: PHP has increased member communications provided by Performance Improvement, Disease Management, and Care Coordination to ensure uniform messaging to members.</p> <p>WSCC: Western Sky Community Care receives LAB2U communications directly of any results that are abnormal or high level; this allows for the Quality member outreach team (RNs) to reach out to address all health concerns with the member and to connect them with their PCP/Specialist. LAB2U vendor sends in-home test kits.</p> <p><u><i>TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i></u></p> <p>Initiation Phase: The percentage of members ages six (6) to twelve (12) newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had one follow-up visit with a practitioner with prescribing authority within 30 days of when the first ADHD</p>
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	<p>medication was dispensed. An increase in rate indicates improvement for this measure.</p> <p>BCBS Q1 46.09%, Q2 46.46%; Increase of 0.37 percentage points from Q1 to Q2</p> <p>PHP Q1 26.77%, Q2 27.65%; Increase of 0.88 percentage points from Q1 to Q2</p> <p>WSCC Q1 45.62%, Q2 50.23%; Increase of 4.61 percentage points from Q1 to Q2</p> <p>MCO Aggregate: Q1 Total 35.95%, Q2 Total 37.04%; Increase of 1.09 percentage points from Q1 to Q2</p> <p>MCO Interventions:</p> <p>BCBS: BCBS created a member education video that is awaiting final approval and expected to be available in DY9 Q3. The video includes education on the importance of medication compliance, which applies to ADD medications. The ADD measure will continue to be included in provider education webinars.</p> <p>PHP: The ADD measure is included in the Value Based Purchasing Provider Quality Incentive Program (VBP PQIP). In DY9 Q2, VBP programs were promoted during the quarterly Provider Education Conference (PEC).</p> <p>WSCC: WSCC continues to utilize the process for Psychiatric Medication Utilization Review where cases are further reviewed for members prescribed 2 or more concomitant stimulants or alpha agonists.</p> <p><u><i>TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i></u></p> <p>Continuation and Maintenance Phase: The percentage of members ages six (6) to twelve (12) newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at least two follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure.</p> <p>BCBS Q1 60.29%; Q2 60.83%; Increase of 0.54 percentage points from Q1 to Q2</p> <p>PHP Q1 37.97%; Q2 38.10%; Increase of 0.13 percentage points</p>
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	<p>from Q1 to Q2 WSCC Q1 58.33%; Q2 65.52%: Increase of 7.19 percentage points from Q1 to Q2 MCO Aggregate: Q1 Total 48.30%; Q2 Total 48.31%: Increase of 0.01 percentage point from Q1 to Q2</p> <p>MCO Interventions: BCBS: Efforts have continued to educate providers about the ADD measure. The recording of the webinar that included the ADD measure has remained available for providers to view and to receive continuing education credit in DY9 Q2.</p> <p>PHP: Targeted provider educational letters for prescribers of ADHD medication within the ADD measure were mailed during DY9 Q2. These letters contained member specific information and informed providers of the measure and encouraged providers to complete Continuation phase appointments within the measure timeline.</p> <p>WSCC: Monthly and quarterly meetings with small practices, individual providers, and VBP BH providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care.</p> <p><u>TM #12 – Child and Adolescent Well-Care Visits (WCV)</u> The percentage of members three (3) to twenty-one (21) years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. An increase in percentage indicates improvement for this measure.</p> <p>BCBS Q1 8.83%; Q2 19.22%: Increase of 10.39 percentage points from Q1 to Q2 PHP Q1 7.46%; Q2 15.84%: Increase of 8.38 percentage points from Q1 to Q2 WSCC Q1 4.53%; Q2 13.02%: Increase of 8.49 percentage points from Q1 to Q2 MCO Aggregate: Q1 Total 7.62%; Q2 Total 16.68%: Increase of 9.06 percentage points from Q1 to Q2</p> <p>MCO Interventions: BCBS: One of the most effective interventions for 3-11 age band is member engagement. A one-on-one telephonic call with the</p>
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	<p>parent/guardian has proven to be most effective.</p> <p>PHP: PHP is working from a generic overall outreach plan to a more targeted approach. This will consider pockets of low compliance throughout New Mexico, member risk stratification scores, and social determinants of needs.</p> <p>WSCC: WSCC has a new program for members that need to get their well care visit completed. FarmBox is a box of healthy snacks, recipes, and reading material to keep children making healthy choices.</p> <p><u>External Quality Review</u></p> <p>HSD conducts bi-weekly meetings with the External Quality Review Organization (EQRO) to review monthly projects, provide consistent feedback and communication, provide assistance and support, and to assess issues.</p> <p>EQRO Reviews and Validations in DY9 Q3 consisted of the following:</p> <p><u>DY6 EQR Reviews and Validations:</u></p> <p>2019 Network Adequacy Validation posted to the HSD Website 2019 Validation of Performance Improvement Projects is in final review by the EQRO and HSD Leadership. <i>*This validation report had previously been posted to the HSD website in Q2 but was removed due to MCO rebuttal/questions with findings by the EQRO.</i></p> <p><u>DY7 EQR Reviews and Validations:</u></p> <p>2020 Validation of Performance Improvement Projects posted to the HSD Website 2020 Network Adequacy Validation posted to the HSD Website.</p>
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UTILIZATION

- Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for July 2020 – June 2022. Please see Attachment B: Key Utilization/Cost per Unit Statistics by Major Population Group.

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- 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 July 2021 – June 2022 time period.
- Year over year changes in costs per unit for inpatient services are impacted by a large temporary fee increase for inpatient hospital services that was effective April 2020 – September 2020. This temporary fee increase resulted in an increase to costs per unit for inpatient services during the July 2020 – June 2021 time period which did not carry over to the subsequent 12-month time period.

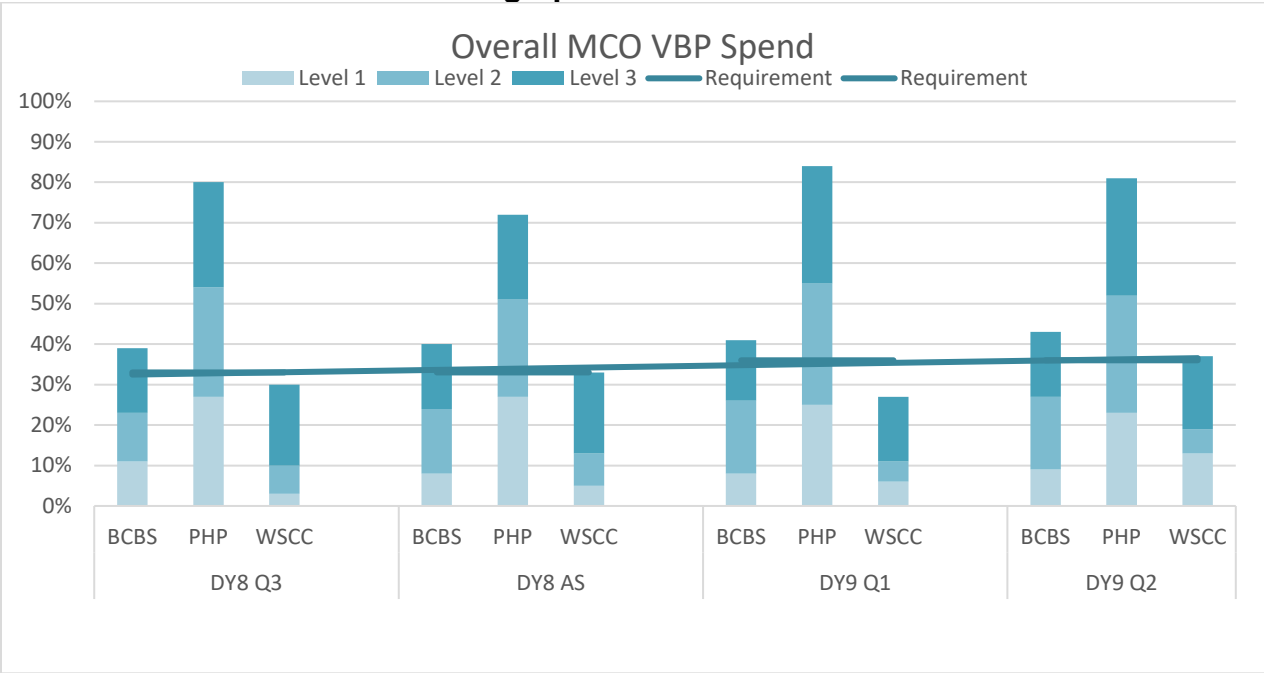
VALUE BASED PURCHASING

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 three levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY9 requirements are as follows:

VBP Level	Level 1	Level 2	Level 3
Required Spend	12%	15%	9%
Required ProviderTypes	<ul style="list-style-type: none"> • Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. 	<ul style="list-style-type: none"> • Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. 	<ul style="list-style-type: none"> • 8% with traditional PH Providers. • 1% with Providers who are primarily BH (whose primary services are BH). • Actively build Long-Term Care Providers including nursing facilities full-risk

For DY9 Q2, BCBS, PHP, WSCC exceeded the required VBP spend target of 36%.

Table 29: Value Based Purchasing Spend



Source: MCO Calendar Year (CY) 2022 Quarter 2 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 implemented rule changes in DY7 resulting in a provider rate increase for outpatient settings, including Evaluation & Management codes, dispensing fees to community-based pharmacies, Long-Term Services and Supports providers, and supportive housing benefits for people with Serious Mental Illness. There also were increases in payment rates to governmental and investor-owned hospitals, as well as hospitals serving a high share of members who identify as Native American.

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 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.

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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 began an evidence-based program to ensure members are established with a Primary Care Provider (PCP). BCBS pulls weekly reports which identify members who have had 6 or more ED visits in 6 months. The BCBS Community Health Worker (CHW) team calls members to provide education about the importance of seeing their doctor rather than returning to the ER. The CHW team also helps the member become established with a PCP. Additionally, BCBS's digital teams sends non-PHI texts to members using Collective Medical real-time data, while the member is in the emergency room, suggesting options such as urgent care or primary care. The goal of digital outreach is so there is immediate response and follow-up action or encouragement for the member.

PHP interventions for preventing non-emergent ER utilization include monitoring Collective Medical real-time data for high utilizer or chronic utilizers in order to notify a CHW or peer support specialist when a member has arrived in the ED and prompts a live outreach option. Interventions include issuing educational materials, partnerships within the PHS

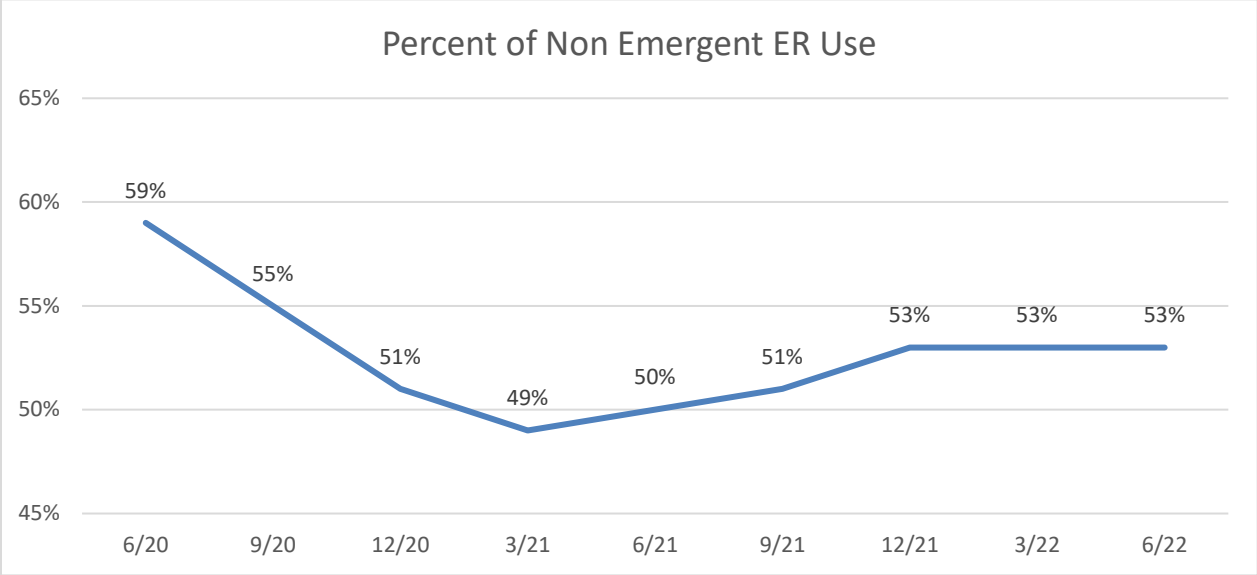
delivery system and their partnership with Albuquerque Ambulance for Paramedicine. PHP has 2 unique programs, first is statewide outreach for the difficult-to-engage population and second is a high-risk task force reviewing claims and calling entities who have rapport with members to intervene. PHP VBP groups discuss barriers to improve access to care and high ED utilization while Long Term Services and Support (LTSS) programs collaborate with TOC teams for hospitalization discharge to prevent readmissions and completing in-home nurse practitioner visits. PHP also helps sponsor rural providers to gain access to pre-manage real-time systems and offers provider incentives when they provide after-hours care.

WSCC has a texting campaign utilizing Collective Medical real-time data providing follow up or connecting members to WSCC Member Connections (MC) teams that consist of peer support specialists and CHWs with the outcome of connecting to PCPs, urgent care, or nurse advice line. WSCC Care Coordinators use Collective Medical real-time data and are trained to receive alerts on emergency usage and provide support following the ER visit, provide educational flyers, and distribute magnets with contact information. WSCC providers also call members to follow-up after an ED mental health visit.

As a result of the MCO strategies and interventions in DY8, which focused on reducing ED visits for non-emergent care, the percentage of emergency utilization that are considered low acuity remained stable from DY8 Q4 to DY9 Q2. In comparing low acuity ED visits from June of 2021 (50%) to June of 2022 (53%), the percentage of visits to the emergency department for non-emergent care increased by 3 percentage points. A lower rate indicates improvement for this measure. The trend for this measure indicates a steady increase in the number of low acuity ED visits.

The graph below reflects the percentage of members using the ER for non-emergent care between DY8 Q2 and DY9 Q2. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership. The data for DY9 Q3 will be reported in the DY9 Q4 CMS Quarterly Monitoring Report.

Table 30: Non-Emergent ER Use



Source: Mercer- Non-Emergent Emergency Room Utilization Report

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MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in DY9 with the requirement that at least 90% of members having access to certain provider types in urban, rural, and frontier geographic areas within a defined distance. Geographical Access is collected and validated on a quarterly basis.

Physical Health and Hospitals

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

- MCOs performance in access to general hospitals, PCPs, pharmacies, and most specialties in urban, rural and frontier areas were met.
- Geographic access for dermatology, endocrinology, rheumatology, and urology services as well as access to neurosurgeons were and are anticipated to be limited due to provider shortages in rural and frontier areas, however, access has been maintained. MCOs closely monitor these services and employ ongoing efforts to ensure member access such as targeted recruitments, referral training, provider enrollment training, and value-based contract arrangements.

Table 31: Physical Health Geographical Access

Geo Access PH DY9 Q3 (April - June 2022)									
	Urban			Rural			Frontier		
PH - Standard 1	BCBS	PHP	WSCC	BCBS	PHP	WSCC	BCBS	PHP	WSCC
PCP including Internal Medicine, General Practice, Family Practice	100.00%	100.0%	100.0%	99.50%	100.0%	100.0%	100.0%	99.9%	100.0%
Pharmacies	100.00%	100.0%	100.0%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%
FQHC - PCP Only	100.00%	100.0%	100.0%	90.60%	91.1%	99.4%	96.9%	89.2%	98.7%
PH - Standard 2									
Cardiology	99.30%	98.9%	99.0%	99.8%	100.0%	100.0%	99.9%	99.9%	99.8%
Certified Nurse Practitioner	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Certified Midwives	99.20%	98.9%	94.1%	87.3%	88.3%	99.2%	99.8%	98.6%	98.1%
Dermatology	99.20%	98.9%	98.9%	70.9%	73.5%	90.4%	85.3%	89.4%	98.2%
Dental	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	99.20%	98.9%	98.9%	74.1%	65.0%	87.0%	84.2%	88.9%	92.7%
ENT	99.10%	98.8%	98.9%	86.3%	88.0%	100.0%	95.1%	88.5%	97.2%
FQHC	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/Oncology	99.20%	98.9%	98.9%	99.6%	94.4%	99.4%	99.3%	97.9%	93.0%
Neurology	99.20%	98.9%	99.0%	98.9%	93.1%	92.1%	93.9%	93.0%	95.4%
Neurosurgeons	99.10%	82.9%	98.9%	39.7%	75.2%	40.8%	67.8%	87.8%	81.3%
OB/Gyn	99.30%	98.9%	99.0%	99.7%	99.7%	100.0%	99.8%	99.8%	99.8%
Orthopedics	99.20%	98.9%	98.9%	99.7%	93.9%	100.0%	96.4%	98.3%	99.7%
Pediatrics	100.00%	98.9%	99.0%	99.8%	100.0%	99.9%	99.8%	98.7%	100.0%
Physician Assistant	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.20%	98.9%	99.1%	99.7%	99.7%	94.2%	96.6%	99.9%	100.0%
Rheumatology	87.90%	98.9%	83.1%	75.0%	83.6%	70.3%	89.0%	85.3%	74.6%
Surgeons	99.30%	98.9%	99.1%	100.0%	100.0%	100.0%	99.9%	99.9%	99.8%
Urology	99.10%	98.8%	98.9%	91.0%	93.3%	91.1%	89.3%	93.2%	90.4%
LTC - Standard 2									
Personal Care Service Agencies	100.00%	100.0%	100.0%	100.00%	99.8%	99.7%	100.0%	100.0%	100.0%
Nursing Facilities	99.30%	93.1%	99.4%	99.7%	97.5%	99.1%	99.9%	99.9%	99.8%
General Hospitals	99.20%	98.9%	98.9%	99.7%	99.3%	99.9%	100.0%	99.9%	99.8%
Transportation	100.00%	100.0%	100.0%	87.4%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: MCO Report #55 GeoAccess Q2CY22

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.

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

Initiatives:

HSD has received approval from CMS through a Disaster State Plan Amendment (SPA # 22-0001) to temporarily increase provider reimbursement to NEMT providers by 6.81% for all transportations made between January 1, 2022, through June 30, 2022. HSD will establish a post payment adjustment process that will identify these transports so that the provider will be reimbursed the additional 6.81%.

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 is unable to provide the service; 3) submit an NEMT monthly report that provides data on NEMT trips. HSD will closely monitor.

Customer Service Reporting

BCBS met all call center metrics for the reporting period, DY9 Q3.

PHP met all call center metrics for the reporting period, DY9 Q3.

WSCC met all call center metrics for the reporting period, DY9 Q3.

Telemedicine Delivery System Improvement Performance Target (DSIPT)

The MCOs shall use the end of CY21 as the baseline for CY22, 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.

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 MCOs provide quarterly reports to HSD with the number of unique members served through telemedicine visits and an analysis of trends observed.

The MCO Telemedicine DSIPT report revisions were recently finalized to make the instruction clear and ensure the baseline is reviewed accurately. Data for DY9 Q1, Q2 and Q3 will be reported in the CMS DY9 Q4 Quarterly Monitoring report.

Table 32: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Served with Telemedicine	DY8 Q3	DY8 Q4	DY9 Q1	DY9 Q2
New Behavioral Health Members	9,963	7,505		
BCBSNM	3,800	2,793		
PHP	5,014	3,870		
WSCC	1,149	842		
New Physical Health Members	25,757	21,070		
BCBSNM	9,519	6,993		
PHP	14,379	12,442		
WSCC	1,859	1,635		
Total New Unduplicated Members	29,444	23,364		
BCBSNM	10,911	7,915		
PHP	15,999	13,368		
WSCC	2,534	2,081		
YTD* Unduplicated Members	188,954	216,420		
BCBSNM	69,785	80,147		
PHP	104,593	119,316		
WSCC	14,576	16,957		

Source: Telemedicine Delivery System Improvement Performance Target (DSIPT) *

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan

DY9 Q3

The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) continued to work together to develop and review the draft interim evaluation report and prepare the report for submission to the Centers for Medicare & Medicaid Services (CMS).

HSAG finalized the calculations, statistical modeling, and analyses of 54 performance measures for inclusion in the draft interim evaluation report. HSAG also completed the cost-effectiveness analysis for the draft interim evaluation report (the interim evaluation report cost-effectiveness analyses are not the same as the formal budget neutrality tests required under the Section 1115 Waiver Demonstration program). During this reporting period, HSD and HSAG have not encountered any evaluation or technical challenges. HSAG will continue to collaborate with HSD to finalize the draft interim evaluation report for submission to CMS. HSAG and HSD will begin discussions on the evaluation activities associated with the summative evaluation.

HSD and HSAG continued discussions on the impacts of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) on the Waiver Demonstration. In addition, HSAG utilized a range of methodologies in measure analyses to control for COVID-19 impacts on the demonstration results. Specifically, HSAG utilized indicator variables where possible as statistical controls to account for time periods impacted by COVID-19. These were employed primarily in interrupted time series (ITS) analyses. The COVID-19 PHE had an impact on outcomes and performance throughout the healthcare system, including both the rates of substance use disorders (SUD) and the availability of treatment for SUD. Telehealth rates also saw a significant increase during the COVID-19 PHE. Additionally, there was a cost spike in 2021, most likely attributable to the pent-up demand caused by COVID-19.

HSAG conducted analyses for 54 evaluation measures. Conclusions from the most recent draft of the interim report presented in this section are organized

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ENCLOSURES/ATTACHMENTS

Attachment A: July 2020 – June 2022 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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ADDITIONAL COMMENTS

MCO INITIATIVES

BCBS:

Behavioral Health (BH) Value Bases Program (VBP)

BCBS has contracted with 5 behavioral health provider agencies for a new behavioral health Value Bases Program (VBP) that incentivizes the providers to integrate care with physical health providers. The program also includes quality measures related to follow-up after behavioral health hospitalization and improvement in avoidable emergency department and behavioral health inpatient services. In addition, the program incentivizes the provider to register and use the Emergency Department Information Exchange system that will provide real-time notifications to the provider when one of their patients seeks emergency department services.

PHP:

Wellness and Health Education

PHP continued to support Centennial Care Members with identified risks for developing type 2 diabetes through the Diabetes Prevention Program (DPP). PHP continued to offer healthy weight and lifestyle change program activities for DPP participants. Additionally, PHP explored and selected a new DPP vendor, and began contracting and implementation processes. PHP has prioritized the following activities of focus to enhance the DPP. These include but are not limited to:

- Continue to deploy an incentives program for DPP participants to encourage uptake and engagement.
- Update a communication plan to promote DPP as an interactive support program and resource for members and providers.
- Develop a new member self-referral process (landing page) for obesity-related support programs.
- Continue to leverage an annual PHP population assessment to validate ongoing burdens of disease on the PHP population.

Diabetes Prevention Program

Since the Diabetes Prevention Program (DPP) implementation in 2019 through September 2022, PHP had 334 Centennial Care members enrolled and a total of 113 participants with logged individual sessions related to physical activity, healthy food choices, eating patterns, and daily weight management. The 12-month DPP is offered to eligible members and is an evidence-based prevention program with oversight by the Centers for Disease Control and Prevention. The program focuses on diabetes through weight loss and lifestyle changes. Of the PHP enrolled participants, 49 have experienced

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an average weight loss of 9% body weight and 20 have improved their body mass index (BMI) classification.

A total of 11 Centennial Care members have successfully completed the program (remained engaged for 12-consecutive months and completed all 26 DPP sessions). These Members lost an average of 12.27 pounds per person, with one member losing a total of 53 lbs., a 20.9% weight loss. Overall, DPP graduates experienced a total average weight loss of 5.13% total body weight per person. PHP remains extremely proud of these member's achievements and the ongoing success of all members who are enrolled in the program.

WSCC:

Member Satisfaction

A Western Sky Community Care (WSCC) member suffers from a traumatic brain injury (TBI). Member stated that she is restless, in pain, and has trouble expressing what she is thinking. Member does have a psychiatrist and sees a doctor for her pain. Member's care coordinator (CC), reached out to the New Mexico Brain Institute (NMBI) navigation program on behalf of Member; it is a three-part program where member will be assessed by phone and recommended providers and support groups. Member has made contact and is now part of a support group. Member is grateful for the assistance she received from her CC.

Value Based Purchasing:

Western Sky Community Care (WSCC) Value Based Purchasing (VBP) has joined the state's efforts to create a Hospital Managed Care Organization (MCO) VBP program. Funding for Safety Net Care Pool hospitals will now be used to finance the MCO Hospital VBP program and will be based on hospitals' quality measure performance. The program became effective January of 2022 and is focused on hospital data and quality reporting. The data intermediary was selected with input from provider hospital stakeholders, the NM Hospital Association and the MCOs which is Net Health/Guidehouse. The combined MCO Statement of Work for the data intermediary, was executed in July of 2022. Some of the measures are as follows; Follow-Up after Emergency Room Department Visit for Mental Illness (FUM) for those 6 years or older, Follow up after Emergency Department (ED) visit for Substance Use (FUA), for those over 13 years old, Hospital Consumer Assessment of Healthcare providers and Systems HCAHPs- Communication with doctors and Communication with nurses to see how clearly doctors and nurses explain things clearly, listen careful, and treat the patient with courtesy and respect, median time from ED arrival to ED departure for discharged ED patients, Influenza immunization inpatient 6 months and older discharged during October- March who are screened for influenza status and vaccine prior to discharge.

Provider Outreach and Education

In DY9 Q3, Provider Outreach and Education offered education to our providers, caregivers, and community stakeholders. Below are some highlights:

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Highlights:

- WSCC Clinical Provider Trainers offered 79 trainings on long-term care, foster care, behavioral health, and/or integrated health care related topics with an average Net Promoter Score of 87 in DY9 Q3 at the time of this report. At least 243 participants attended these training events.
- 59 trainings offered were eligible for Continuing Education in DY9 Q3.
- Amongst the trainings offered, WSCC offered the Stress-Busting Program for Family Caregivers of Persons with Chronic Illness™ (SBP). SBP is an evidence-based 9-week wellness training program that supports unpaid and partially paid family caregivers of adults living with chronic illness. There were 5 caregivers registered for the SBP group this quarter. Out of the 5 caregivers who registered, 3 participated, and 1 of these 3 caregivers completed the program. The program was well-received with an average NPS of 78 for the 9 weeks. In DY9 Q3, the Substance Use Disorders – An Overview for Health Care Providers was launched for behavioral health and Long-Term Care providers.

All provider training can be accessed on WSCC Training and Education Page.

MEMBER SUCCESS STORIES**BCBS:**

A member who is primary Spanish speaking, has had difficulty navigating the health systems, including making medical appointments and accessing transportation. When he was diagnosed with prostate cancer, he was very concerned about how to get the treatment he needed. The Behavioral Health Care Coordinator and member worked together to get his chemotherapy schedule set up, and then contacted the transportation provider to arrange trips to the clinic. They also worked together to set up rides for him to get the lab tests completed that his provider ordered for him. It has been a long road, but he is now in remission, and doing very well. He continues to see his providers regularly and is actively engaged in care coordination.

PHP:

An elderly PHP Member with dementia began to have issues with wandering outside of her home. She lives with her daughter-in-law, who is her main caregiver, but at times the member's daughter-in-law had trouble keeping track of the member's wandering. The member was not left home alone, but the daughter-in-law might have been on the phone or distracted doing something else in the home. Member's care coordinator requested the wander guard as a value-added service, and it was approved. Traditional emergency response services require a member to be able to push an alert button for assistance and

do not provide monitoring and alerts about the member's location for family/caregivers. Phillips told us the device would be available in 3 to 6 months; they were the only potential vendor at the time. After patiently waiting, we were then told that there was no available contracting provider, and the member was not going to get the device at all. Some/most of this was related to COVID-19. The member's daughter-in-law and care coordinator began doing research and identified a wander guard vendor. The vendor provides wander guard services for children with autism and adults with dementia. It provides information and alerts, via an app, about the member's location; thus, when they "wander" outside a certain area, the caregiver or family member is alerted and notified of their location. That way, caregivers can find them and can assist them to a safe location. The care coordinator was able to get the device, not only for this member, but other PHP members. The entire process took about a year; much of that time was spent waiting on the device from Phillips. The device has been very helpful, and the member's daughter-in-law is very thankful to have it. During the day, the daughter-in-law can clip the device inside the member's clothing, so she does not notice it. An associated app provides alerts and information about where the member is located and notifies the caregiver/daughter-in-law if the member goes outside of set parameters. This has given the daughter peace of mind and the ability to relax and focus on other things. It has given the member a little more freedom in the home, overall improving the quality and situation in the home for both member and caregiver/daughter-in-law.

WSCC:

A Western Sky Community Care (WSCC) member was referred to the Behavioral Health Disease Management (BH DM) program by her diabetes health coach. Member enrolled in the BH DM program and identified having anxiety, depression, difficulty sleeping, and was stressed about managing her diabetes. The member identified goals of self-care and areas she would like to focus on in the program. BH DM Registered Nurse (RN), provided educational materials on managing diabetes, and assisted member with locating a new PCP and dentist. The member stated this helped to alleviate a lot of stress and anxiety. The member is making significant progress and continues to work with her health coach for ongoing support.

MCO COVID-19 RELIEF EFFORTS

BCBS:

Grants

- There were no COVID-19 related grants received or issued in DY9 Q3.

Donations

- BCBSNM donated 170 tote bags, 250 foldable fans and 250 and lip balm to the Chaves County Health Expo.

Events

- Premier Medical Group COVID-19 Vaccine Clinic, July 17th
- Mountain View Apartments COVID-19 Vaccine Clinic, July 18th
- Premier Medical Group COVID-19 Vaccine Clinic, July 19th
- Premier Medical Group COVID-19 Vaccine Clinic, July 23rd
- Los Lunas Encantada COVID-19 Vaccine Clinic, July 27th
- Los Griegos Health Fair, August 4th
- Chaves County Health Council Expo, August 6th
- Affinity at Albuquerque Health Fair, September 9th
- BCBSNM & La Familia Community Baby Shower, September 10th
- Laguna Pueblo Feast Days, September 18th-19th
- Premier Medical Group COVID-19 Vaccine Clinic, September 20th
- Supported the following COVID-19 Vaccination Events across the state and in tribal communities:
 - Clovis Back to School Health Center Celebration, in August
 - Portales Back to School Health Center Celebration, in August
 - Familia Dental/BCBSNM Community Baby Shower, in August
 - Southwestern Indian Polytechnic Institute Resource Fair, in September
 - Indigenous Community Day-Santa Fe Indigenous Center, in September
 - New Mexico Mission of Mercy (MOM), in September

PHP:

Supporting Members

- Presbyterian Health Plan (PHP) continues to offer the Meals on Wheels delivery program for COVID-19 positive members with food insecurity. PHP has coordinated a total of 12,198 meals for members with food insecurity who required support following a COVID-19 diagnosis.
- PHP leadership continues to participate in ongoing weekly collaboration with NM Department of Health (NMDOH), NM Human Services Department, and other stakeholders to coordinate COVID-19 initiatives and heat maps are updated weekly to ensure PHP can view areas of focus.
- PHP's Outreach team collaborated with community partners to organize and staff health fairs, Listen and Learn events, food distribution events, information booths where information on COVID-19 vaccination sites and plan benefits were shared. Some of PHP's statewide partners included numerous Native American chapter houses, pueblo administration centers, Joy Junction, Albuquerque Indian Center, NM Primary Care Association, First Nations, beWell NM, community centers,

January 1, 2019 – December 31, 2023

health and wellness centers, and multiple homeless shelters. They attend the Expo NM Flea Market weekly where COVID-19 vaccines are administered.

- Provided support to members by assisting with scheduling for a COVID-19 test prior to a scheduled procedure or for general testing needs, via the testing line in Patient Services.
- PHP Care Coordinators continue to promote boosters with appropriate members meeting criteria, educating them on the benefits of the vaccine and assisting in directing them to vaccination resources.
- PHP published articles promoting COVID-19 vaccine including specific promotion for kids in quarterly Newsletter.
- PHP developed “Myth Busters for Kids” special mailer dispelling misinformation about the vaccine specifically related to children. The mailer was sent to all member households with children.
- PHP regularly promotes COVID-19 vaccinations via social media and other public service informational campaigns including as a participant in the State’s COVID-19 Marketing Group.
- PHP continues to educate Care Coordination staff to inquire about COVID-19 vaccine status as part of all routine touchpoints to ensure ongoing member education concerning COVID-19 vaccines, boosters and available resources.
- PHP’s analytics department continues to update COVID-19 data tracking as changes occur related to vaccines. PHP updated CPT codes to capture boosters for members aged 5-11 and have plans to update the data capture process to include boosters for younger age groups.
- PHP conducts outreach to all members who had been previously identified as homebound and eligible for COVID-19 vaccines. Answered questions, provided information, and educated homebound members concerning access to COVID-19 vaccine. PHP continues to track homebound members to ensure members who wish to obtain COVID-19 vaccines have access to them.
- PHP Community Health Workers have coordinated with food pantries to provide emergency food boxes to members who are in immediate need of food and who are COVID-19 positive.

Peer Support COVID-19 Efforts

- PHP Certified Peer Supports continue to work directly with Help New Mexico, Inc. by filling out applications for people seeking housing assistance. The program offers support with foreclosure and rental assistance, utility payments, childcare assistance, and clothing and food assistance. Peers also refer to other programs for rent and utility help like the City of Albuquerque’s Health and Social Service Centers, St Vincent de Paul, ECHO in Farmington, Community Action Agencies in

Midwest, Southern, Southeast, and Eastern Plains New Mexico and many other agencies throughout the state.

- PHP Housing Manager attends the New Mexico Coalition to End Homelessness (NMCEH) and NMDOH meetings, which is now meeting bi-weekly, to identify housing options across the state to prevent the spread of COVID-19 within the homeless population known to have been exposed to COVID-19. They assisted in providing personal protective equipment and cleaning supplies to homeless and domestic violence shelters, funded hotel stays for COVID-19 positive and vulnerable populations in rural NM and worked with cities across the state to open wellness hotels and find alternative shelter when the existing shelters were closed.
- PHP's Medical Director, Dr. David Yu, presented on Long COVID-19 in the PHP Clinical Operations Cares Training session on March 22, 2022. This training is mandatory for Clinical Operations Care Coordination and Community Health Worker (CHW) staff. The objectives were to discuss Long COVID-19 symptoms and clinical implications on Nursing Facility Level of Care (NFLOC) criteria.

Supporting Native Americans

- Provided guidance for COVID-19 testing and resources during the Q1 Native American Consumer Advisory Board.
- Participated in the National Indian Health Board discussion on "Disparities of COVID-19 Transmission Among American Indian/Alaskan Native Populations".
- Provided ongoing guidance and support for tribal leaders for on-site COVID-19 testing.
- Offered on-line opportunities to educate members of available services and benefits.
- Facilitated communications for specific complex cases. Engaged with pueblo and Indian Health Services resources on guidance in returning critical care member to a community that is experiencing large COVID-19 surge and lack of medical providers.
- Updated the tribal liaison team on the Presbyterian Mobile Testing Unit locations. Schedule allowed for referrals when mobile unit is in tribal communities.

Supporting Providers

- Continue to send monthly lists to Primary Care Providers (PCP) of their paneled members who have not received the COVID-19 vaccine.
- Created reports that identified PCP's with no or low volume of COVID-19 vaccination claims and outreached to them to identify barriers in delivering the vaccine to their patients or in submitting claims to PHP. Assisted with billing inquiries.

WSCC:

- WSCC has been collaborating with the other MCOs and community partners to make COVID-19 vaccination a part of childhood immunization events and outreach.
- WSCC partnered with Dona Ana Community College for a Back-to-School Event July 16th, over 2,000 people attended this event where WSCC donated 1,000 of the 20,000 backpacks full of school supplies.
- WSCC attended the Inez Elementary Health and Wellness Fair in Albuquerque on September 24 to provide initial and booster doses. Over 100 people attended the event.
- WSCC attended the Health Happens Here back to school edition event July 30th, 300 people attended the event.
- WSCC sponsored a Shoes for Shots event in Ruidoso August 8th, WSCC donated 100 backpacks full of school supplies for the event.

Program Changes Effective on or after 7/1/2020	
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%.
Pharmacy Clinicians Adjustment	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 Pharmacy Clinicians adjustment accounts for the increased rates from the incentive fees paid prior to July 1, 2020 to procedure code 99213.
OTP Adjustment	The Opioid Treatment Program (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.
RHC 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.
Air Ambulance Rate Increase	The air ambulance 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.

Program Changes Effective on or after 1/1/2021	
Minimum Wage effective 1/1/2021	The Minimum Wage effective 1/1/2021 reflects New Mexico's average minimum wage increasing from \$9.00 to \$10.50 per hour effective January 1, 2021.
Crisis Triage Center (CTC) Adjustment	The CTC adjustment reflects the expectation that two additional CTC providers will be providing CTC adult outpatient services by January 1, 2021.

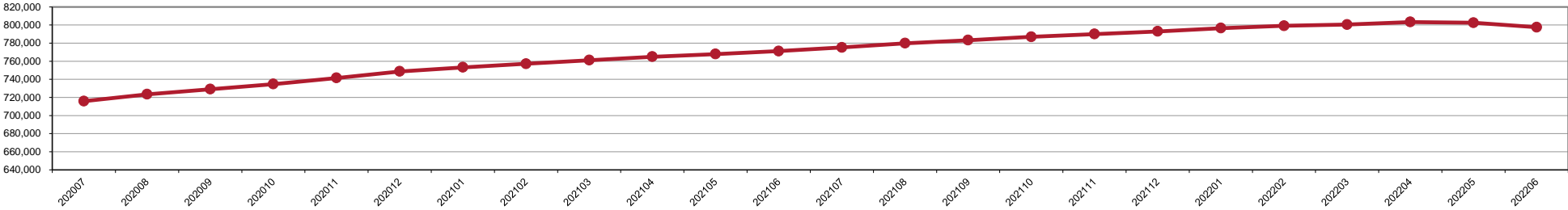
Program Changes Effective on or after 7/1/2021	
HCQS Per Diem and NF MBI Updates	The HCQS adjustment effective July 1, 2021 reflects an updated surcharge for NFs with over 60 beds. The NF MBI adjustment reflects an update to the MBI increase to all NFs. The MBI adjustment compounds with the total MBI percentage effective July 1, 2020.
Addition of New Home Visiting Providers	Effective July 1, 2021, two additional providers will offer Nurse Family Partnership and Parents as Teachers programs under the Centennial Home Visiting program which is expected to lead to higher utilization of these services.

Program Changes Effective on or after 1/1/2022	
COVID-19 Temporary Fee Increase - Federally Qualified Health Centers (FQHC)	The COVID-19 Temporary Fee Increase - FQHC adjustment reflects a \$15.00 per-claim increase to FQHC services effective January 1, 2022 through June 30, 2022.
COVID-19 Temporary Fee Increase - Nursing Facility	The COVID-19 Temporary Fee Increase - Nursing Facility adjustment reflects a 8.10% increase to reimbursement levels for nursing facility services effective January 1, 2022 through June 30, 2022.
COVID-19 Temporary Fee Increase - Non-Emergency Medical Transportation (NEMT)	The COVID-19 Temporary Fee Increase - NEMT adjustment reflects a 6.81% increase to reimbursement levels for NEMT services effective January 1, 2022 through June 30, 2022.
COVID-19 Temporary Fee Increase – Hospital	The COVID-19 Temporary Fee Increase – Hospital is a \$137.6 million uniform dollar increase separate payment term directed payment. The uniform dollar increase will vary for frontier/rural and urban hospitals for both inpatient and outpatient services. The separate payment term directed payment will be paid quarterly during the January 1, 2022 through June 30, 2022 time period.
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.
Minimum Wage effective 1/1/2022	The Minimum Wage effective 1/1/2022 reflects New Mexico's average minimum wage increasing from \$10.50 to \$11.50 per hour effective January 1, 2022.



1. Total Centennial Care Monthly Enrollment

Centennial Care Managed Care Enrollment



2. Total Centennial Care Dollars and Member Months by Program

Population	Aggregate Member Months by Program		
	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	5,266,993	5,695,744	8%
Long Term Services and Supports	601,935	614,529	2%
Other Adult Group	3,100,169	3,197,632	3%
Total Member Months	8,969,097	9,507,905	6%

Programs	Aggregate Medical Costs by Program		
	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	\$ 1,504,337,012	\$ 1,701,804,935	13%
Long Term Services and Supports	\$ 1,095,442,558	\$ 1,180,362,215	8%
Other Adult Group Physical Health	\$ 1,409,694,363	\$ 1,463,056,995	4%
Behavioral Health - All Members	\$ 554,130,880	\$ 584,942,515	6%
Total Medical Costs	\$ 4,563,604,813	\$ 4,930,166,660	8%

Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	% Change
	\$ 386,068,924	\$ 425,184,064	10%
Admin, care coordination, Centennial Rewards	\$ 95,011,256	\$ 81,271,943	-14%
NMMP Assessment	\$ 168,553,813	\$ 275,789,738	64%
Premium Tax - Net of NIMMP Offset	\$ 649,633,993	\$ 782,245,744	20%
Total Non-Medical Costs	\$ 649,633,993	\$ 782,245,744	20%

Estimated Total Centennial Care Costs	Previous (12 mon)	Current (12 mon)	% Change
	\$ 5,213,238,806	\$ 5,712,412,405	10%

Per Capita Medical Costs by Program (PMPM)	Previous (12 mon)	Current (12 mon)	% Change
	\$ 285.62	\$ 298.79	5%
Physical Health	\$ 1,819.87	\$ 1,920.76	6%
Long Term Services and Supports	\$ 454.72	\$ 457.54	1%
Other Adult Group Physical Health	\$ 61.78	\$ 61.52	0%
Behavioral Health - All Members	\$ 508.81	\$ 518.53	2%

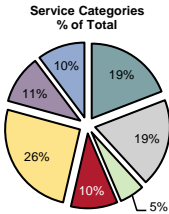
3. Total Program Medical/Pharmacy Dollars

	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	\$ 4,094,713,101	\$ 4,430,172,102	8%	\$ 456.54	\$ 465.95	2%
Pharmacy	\$ 468,891,712	\$ 499,994,558	7%	\$ 52.28	\$ 52.59	1%
Total	\$ 4,563,604,813	\$ 4,930,166,660	8%	\$ 508.81	\$ 518.53	2%

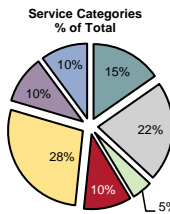
Service Categories	Previous (12 mon)	Current (12 mon)	% Change	Per Capita Medical Costs by Service Categories (PMPM)		
	\$ 873,326,236	\$ 754,180,382	-14%	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	\$ 868,760,602	\$ 1,064,384,732	23%	\$ 97.37	\$ 79.32	-19%
Acute Outp/Phy	\$ 246,362,957	\$ 219,171,496	-11%	\$ 96.86	\$ 111.95	16%
Nursing Facility	\$ 458,691,851	\$ 508,002,709	11%	\$ 27.47	\$ 23.05	-16%
Community Benefit/PCO	\$ 1,169,437,040	\$ 1,375,906,448	18%	\$ 51.14	\$ 53.43	4%
Other Services	\$ 478,134,416	\$ 508,526,334	6%	\$ 130.39	\$ 144.71	11%
Behavioral Health	\$ 468,891,712	\$ 499,994,558	7%	\$ 53.31	\$ 53.48	0%
Pharmacy (All)	\$ 468,891,712	\$ 499,994,558	7%	\$ 52.28	\$ 52.59	1%
Total Costs	\$ 4,563,604,813	\$ 4,930,166,660	8%	\$ 508.81	\$ 518.53	2%

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

Previous (12 mon) service distribution



Current (12 mon) service distribution



4. Notes

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



State of New Mexico - All MCOs

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

Physical Health Utilization and Cost Review

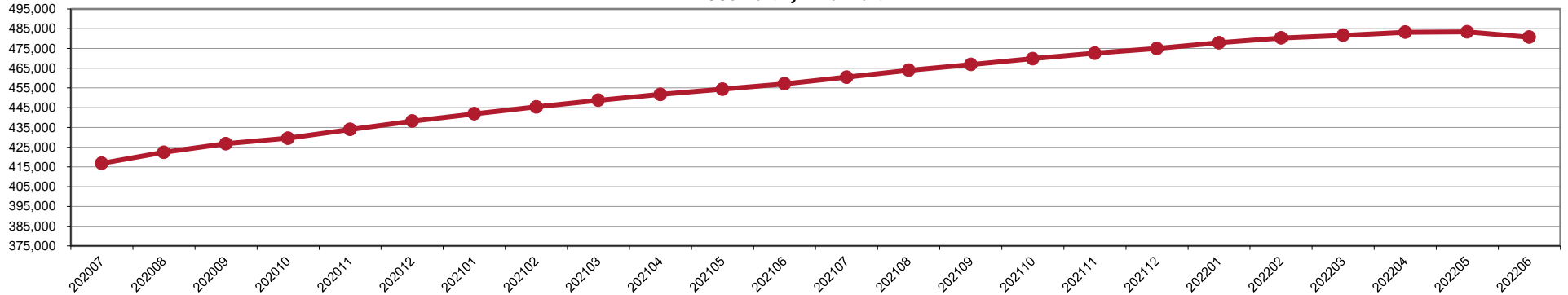
Reported Eligibility for Members Enrolled as of: June 30, 2022

Previous Period: July 1, 2020 to June 30, 2021

Current Period: July 1, 2021 to June 30, 2022

1. Total Population Monthly Enrollment

All MCOs Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

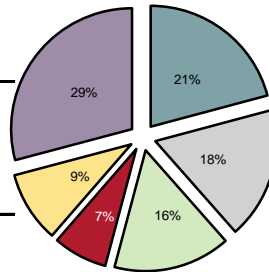
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	\$ 1,367,063,889	\$ 1,540,376,887	13%
Pharmacy	\$ 137,273,124	\$ 161,428,049	18%
Total	\$ 1,504,337,012	\$ 1,701,804,935	13%

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	\$ 414,760,473	\$ 354,660,678	-14%
Outpatient (OP)	\$ 212,666,489	\$ 300,326,651	41%
Physician (PH)	\$ 214,731,964	\$ 266,379,094	24%
Emergency Department (ED)	\$ 92,943,305	\$ 123,313,883	33%
Pharmacy (RX)	\$ 137,273,124	\$ 161,428,049	18%
Other (OTH)	\$ 431,961,658	\$ 495,696,581	15%
Total Population Costs	\$ 1,504,337,012	\$ 1,701,804,935	13%
Per Capita Cost (PMPM)	\$ 285.62	\$ 298.79	5%
Total Member Months	5,266,993	5,695,744	8%

Service Categories
% of Cost



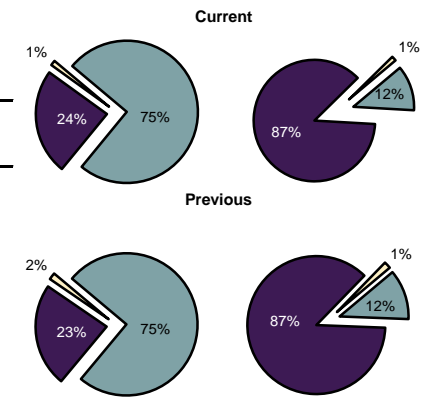
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	\$ 102,871,890	\$ 120,787,161	17%
Generic	\$ 32,267,297	\$ 38,767,589	20%
Other Rx	\$ 2,133,937	\$ 1,873,299	-12%
Total	\$ 137,273,124	\$ 161,428,049	18%

% of Rx Spend

% of Scripts



* "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.
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State of New Mexico - All MCOs

Total Population

Other Adult Group Utilization and Cost Review

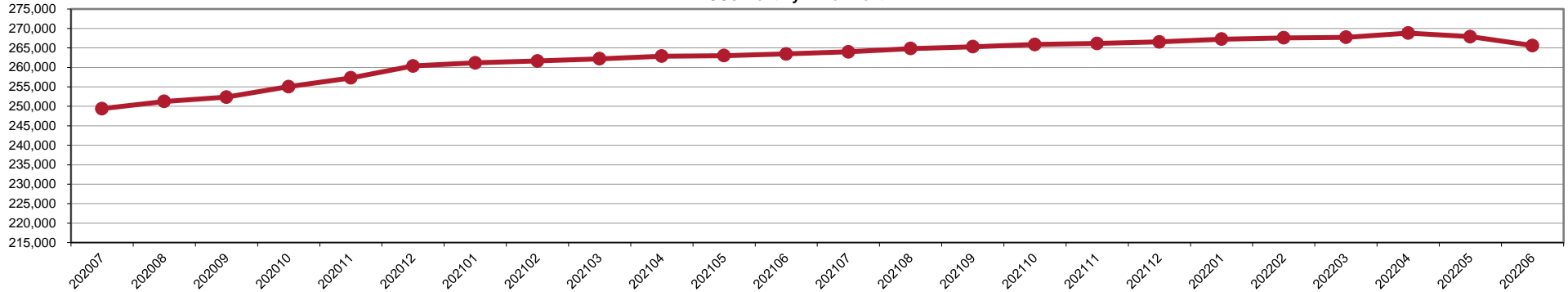
Reported Eligibility for Members Enrolled as of: June 30, 2022

Previous Period: July 1, 2020 to June 30, 2021

Current Period: July 1, 2021 to June 30, 2022

1. Total Population Monthly Enrollment

All MCOs Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	\$ 1,188,300,897	\$ 1,233,324,629	4%
Pharmacy	\$ 221,393,465	\$ 229,732,366	4%
Total	\$ 1,409,694,363	\$ 1,463,056,995	4%

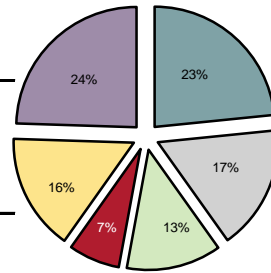
Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	\$ 385,217,518	\$ 342,339,660	-11%
Outpatient (OP)	\$ 204,441,730	\$ 245,204,667	20%
Physician (PH)	\$ 174,332,575	\$ 186,516,208	7%
Emergency Department (ED)	\$ 101,384,532	\$ 100,918,380	0%
Pharmacy (RX)	\$ 221,393,465	\$ 229,732,366	4%
Other (OTH)	\$ 322,924,542	\$ 358,345,714	11%
Total Population Costs	\$ 1,409,694,363	\$ 1,463,056,995	4%

Per Capita Cost (PMPM) \$ 454.72 \$ 457.54 1%

Total Member Months 3,100,169 3,197,632 3%

Service Categories
% of Cost

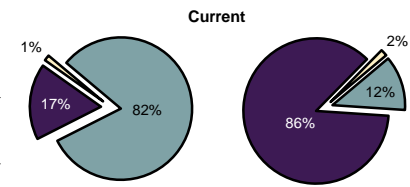


3. Retail Pharmacy Usage (Definitions in Glossary)

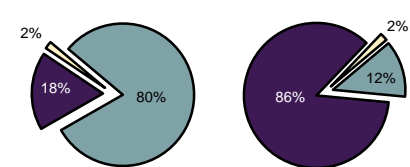
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	\$ 178,484,777	\$ 187,070,878	5%
Generic	\$ 39,123,709	\$ 39,658,405	1%
Other Rx	\$ 3,784,980	\$ 3,003,083	-21%
Total	\$ 221,393,465	\$ 229,732,366	4%

% of Rx Spend



% of Scripts



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

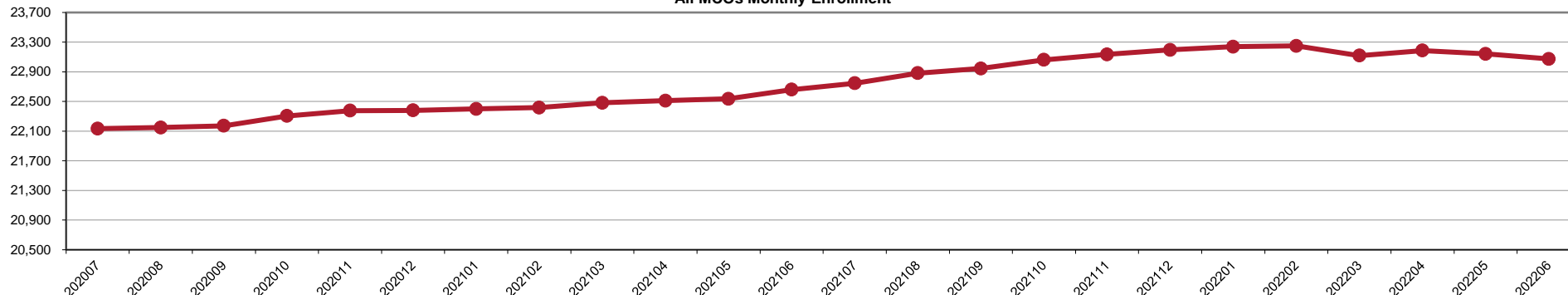
4. Notes

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



1. Total Population Monthly Enrollment

All MCOs Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

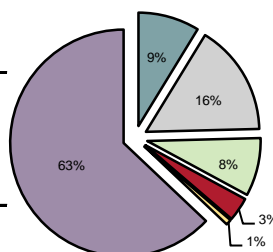
	Previous (12 mon)	Current (12 mon)	% Change
Medical	\$ 50,922,245	\$ 50,183,985	-1%
Pharmacy	\$ 616,500	\$ 403,084	-35%
Total	\$ 51,538,745	\$ 50,587,068	-2%

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	\$ 7,837,866	\$ 4,420,486	-44%
Outpatient (OP)	\$ 8,706,353	\$ 8,018,854	-8%
Physician (PH)	\$ 4,187,945	\$ 4,193,048	0%
Emergency Department (ED)	\$ 2,066,578	\$ 1,713,304	-17%
Pharmacy (RX)	\$ 616,500	\$ 403,084	-35%
Other (OTH)	\$ 28,123,503	\$ 31,838,294	13%
Total Population Costs	\$ 51,538,745	\$ 50,587,068	-2%

Per Capita Cost (PMPM) \$ 191.94 \$ 182.64 -5%

Total Member Months 268,521 276,971 3%

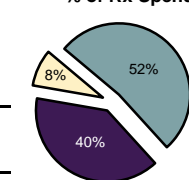
Service Categories
% of Cost

3. Retail Pharmacy Usage (Definitions in Glossary)

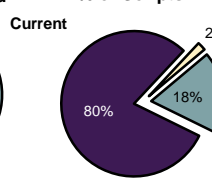
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	\$ 390,718	\$ 210,157	-46%
Generic	\$ 189,809	\$ 159,155	-16%
Other Rx	\$ 35,973	\$ 33,772	-6%
Total	\$ 616,500	\$ 403,084	-35%

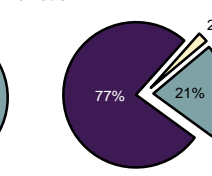
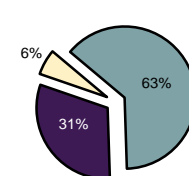
% of Rx Spend



% of Scripts



Previous



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

4. Notes

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



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

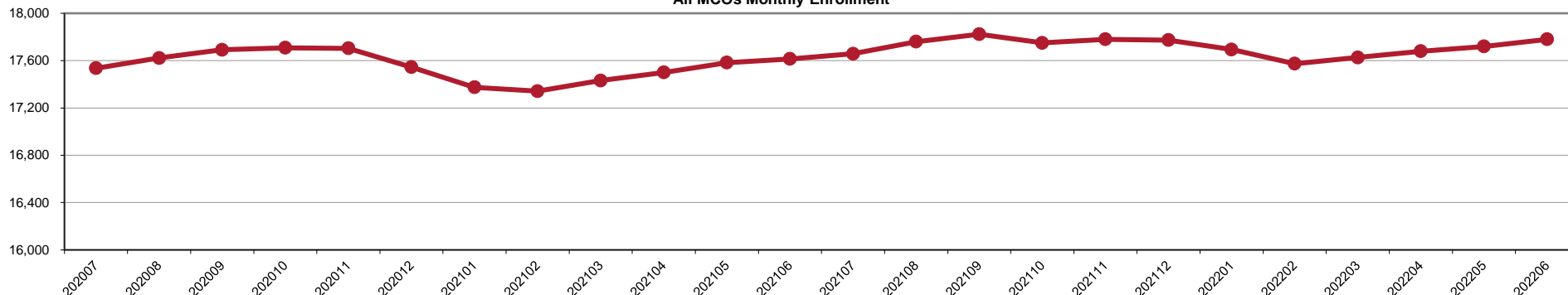
Reported Eligibility for Members Enrolled as of: June 30, 2022

Previous Period: July 1, 2020 to June 30, 2021

Current Period: July 1, 2021 to June 30, 2022

1. Total Population Monthly Enrollment

All MCOs Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

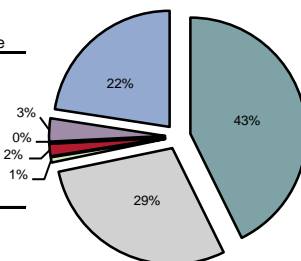
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	\$ 631,142,086	\$ 665,109,060	5%
Pharmacy	\$ 192,261	\$ 195,094	1%
Total	\$ 631,334,347	\$ 665,304,154	5%

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	\$ 260,554,660	\$ 284,152,212	9%
Nursing Facility (NF)	\$ 216,781,872	\$ 193,097,223	-11%
Inpatient (IP)	\$ 12,810,562	\$ 4,892,179	-62%
Outpatient (OP)	\$ 13,532,150	\$ 11,430,153	-16%
Pharmacy (RX)	\$ 192,261	\$ 195,094	1%
HCBS	\$ 20,773,124	\$ 21,469,195	3%
Other (OTH)	\$ 106,689,718	\$ 150,068,098	41%
Total Population Costs	\$ 631,334,347	\$ 665,304,154	5%
Per Capita Cost (PMPM)	\$ 2,997.08	\$ 3,129.12	4%
Total Member Months	210,650	212,617	1%

Service Categories
% of Cost

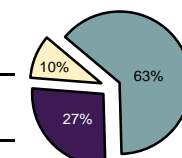


3. Retail Pharmacy Usage (Definitions in Glossary)

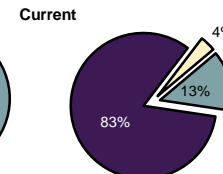
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	\$ 120,828	\$ 123,788	2%
Generic	\$ 53,505	\$ 52,046	-3%
Other Rx	\$ 17,928	\$ 19,261	7%
Total	\$ 192,261	\$ 195,094	1%

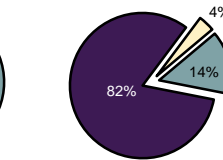
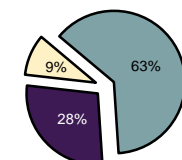
% of Rx Spend



% of Scripts



Previous



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

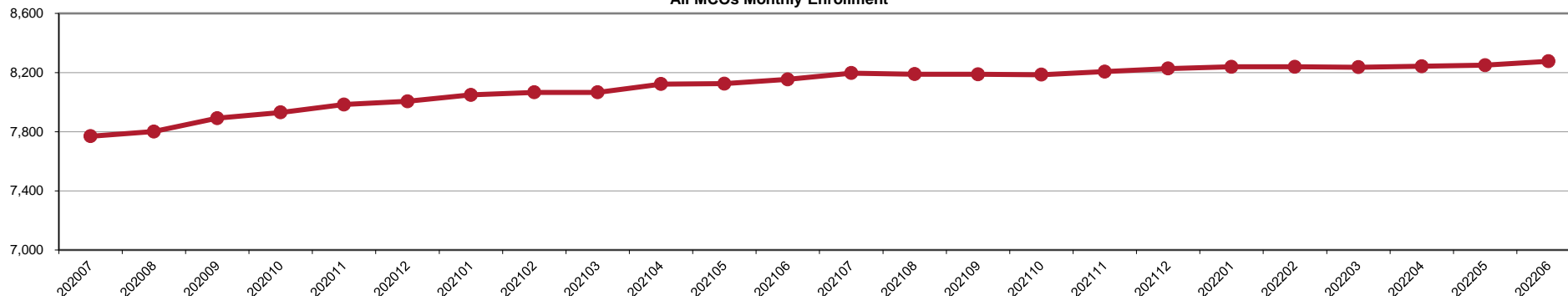
4. Notes

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.



1. Total Population Monthly Enrollment

All MCOs Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

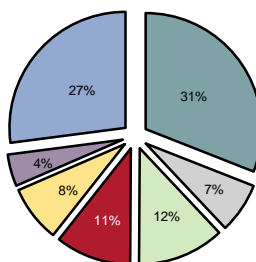
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	\$ 297,697,149	\$ 337,876,945	13%
Pharmacy	\$ 29,955,692	\$ 28,855,751	-4%
Total	\$ 327,652,841	\$ 366,732,696	12%

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	\$ 105,817,067	\$ 113,545,815	7%
Nursing Facility (NF)	\$ 29,235,583	\$ 25,759,550	-12%
Inpatient (IP)	\$ 48,249,587	\$ 44,424,758	-8%
Outpatient (OP)	\$ 32,410,649	\$ 38,645,241	19%
Pharmacy (RX)	\$ 29,955,692	\$ 28,855,751	-4%
HCBS	\$ 11,482,310	\$ 16,281,677	42%
Other (OTH)	\$ 70,501,953	\$ 99,219,903	41%
Total Population Costs	\$ 327,652,841	\$ 366,732,696	12%
Per Capita Cost (PMPM)	\$ 3,414.40	\$ 3,716.65	9%
Total Member Months	95,962	98,673	3%

Service Categories
% of Cost

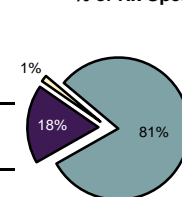


3. Retail Pharmacy Usage (Definitions in Glossary)

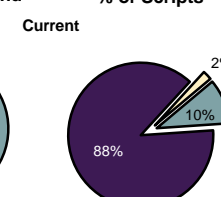
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	\$ 24,033,755	\$ 23,283,410	-3%
Generic	\$ 5,378,990	\$ 5,147,668	-4%
Other Rx	\$ 542,947	\$ 424,673	-22%
Total	\$ 29,955,692	\$ 28,855,751	-4%

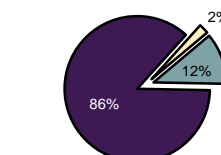
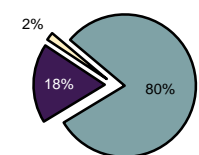
% of Rx Spend



% of Scripts



Previous



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

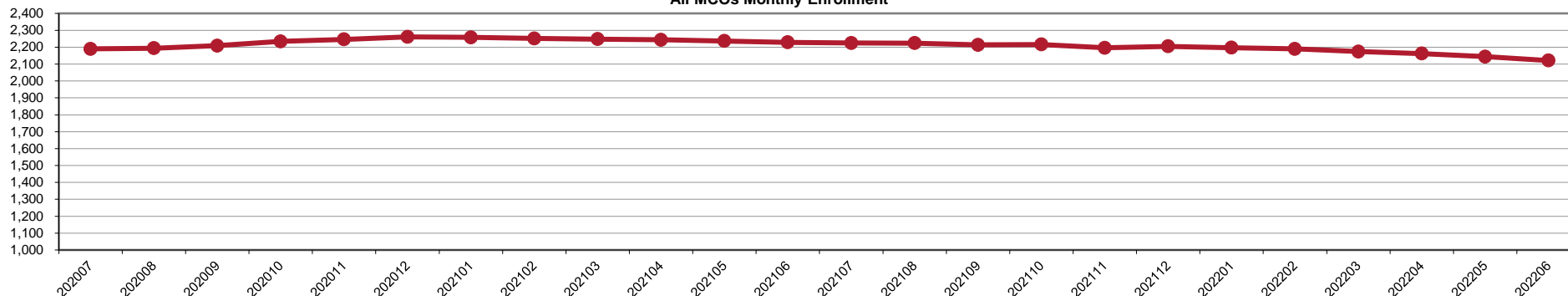
4. Notes

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.
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1. Total Population Monthly Enrollment

All MCOs Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

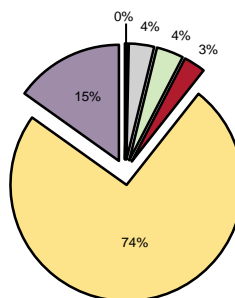
	Previous (12 mon)	Current (12 mon)	% Change
Medical	\$ 81,452,420	\$ 94,774,262	16%
Pharmacy	\$ 3,464,206	\$ 2,964,035	-14%
Total	\$ 84,916,626	\$ 97,738,297	15%

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	\$ 345,502	\$ 314,723	-9%
Inpatient (IP)	\$ 4,450,230	\$ 3,442,621	-23%
Outpatient (OP)	\$ 3,750,746	\$ 3,670,817	-2%
Pharmacy (RX)	\$ 3,464,206	\$ 2,964,035	-14%
HCBS	\$ 60,064,690	\$ 72,553,809	21%
Other (OTH)	\$ 12,841,252	\$ 14,792,292	15%
Total Population Costs	\$ 84,916,626	\$ 97,738,297	15%

Per Capita Cost (PMPM) \$ 3,168.29 \$ 3,720.81 17%

Total Member Months 26,802 26,268 -2%

Service Categories
% of Cost

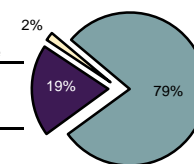
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	\$ 2,628,795	\$ 2,337,336	-11%
Generic	\$ 769,024	\$ 573,957	-25%
Other Rx	\$ 66,386	\$ 52,742	-21%
Total	\$ 3,464,206	\$ 2,964,035	-14%

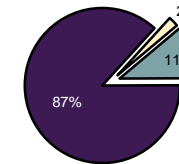
% of Rx Spend

Current

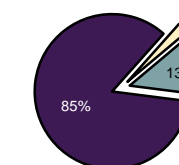
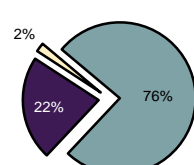


% of Scripts

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

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

Behavioral Health Utilization and Cost Review

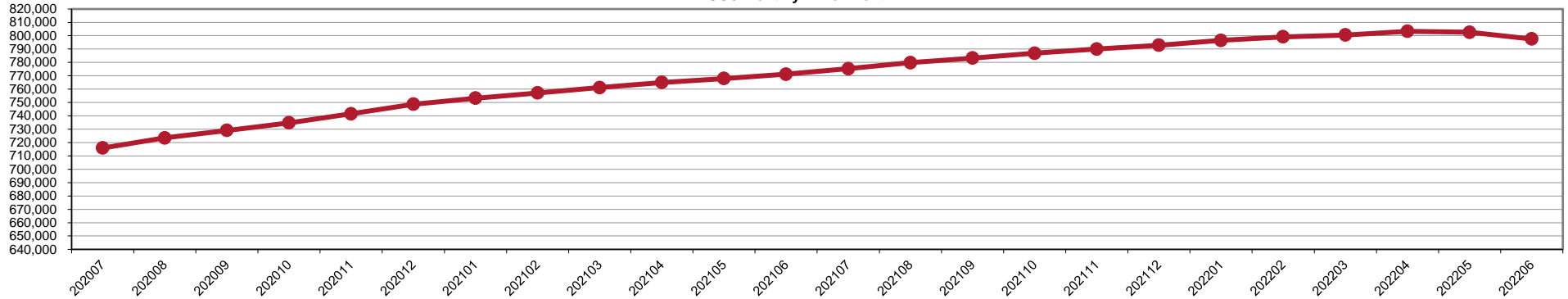
Reported Eligibility for Members Enrolled as of: June 30, 2022

Previous Period: July 1, 2020 to June 30, 2021

Current Period: July 1, 2021 to June 30, 2022

1. Total Population Monthly Enrollment

All MCOs Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

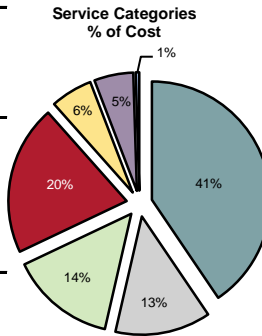
	Previous (12 mon)	Current (12 mon)	% Change
Medical	\$ 478,134,416	\$ 508,526,334	6%
Pharmacy	\$ 75,996,464	\$ 76,416,180	1%
Total	\$ 554,130,880	\$ 584,942,515	6%

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	\$ 201,316,542	\$ 237,067,423	18%
Pharmacy (RX)	\$ 75,996,464	\$ 76,416,180	1%
Res. Treatment Ctr. (RTC)	\$ 86,463,006	\$ 84,025,718	-3%
Behavioral Health Prov (BHP)	\$ 113,767,875	\$ 119,795,822	5%
Core Service Agencies (CSA)	\$ 24,016,667	\$ 33,497,533	39%
Inpatient (IP)	\$ 48,535,026	\$ 31,260,612	-36%
Other (OTH)	\$ 4,035,300	\$ 2,879,227	-29%
Total Population Costs	\$ 554,130,880	\$ 584,942,515	6%

Per Capita Cost (PMPM) \$ 61.78 \$ 61.52 0%

Total Member Months 8,969,097 9,507,905 6%

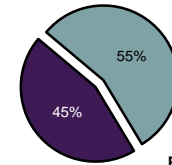


3. Retail Pharmacy Usage (Definitions in Glossary)

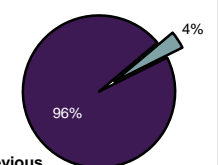
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	\$ 40,115,563	\$ 42,224,083	5%
Generic	\$ 35,880,902	\$ 34,192,097	-5%
Total	\$ 75,996,464	\$ 76,416,180	1%

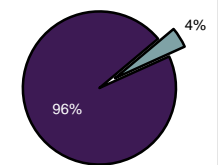
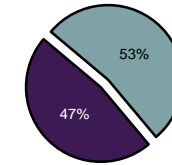
% of Rx Spend



% of Scripts



Previous



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.



PRA Disclosure Statement

PRA Disclosure Statement - The 1115 PMDA application offers a source of high quality and timely data to improve the Center for Medicaid & CHIP Services (CMCS) ability to monitor demonstrations for the achievement of desired outcomes and projected cost savings. The states will upload and submit their budget neutrality workbook to CMCS via PMDA. Eventually PMDA will also be integrated into the Medicaid and CHIP Program (MACPro) System, which currently allows CMS and states to collaborate online to process State Plan Amendments (SPA), 1915 waivers, Quality Measures reports, advance planning documents, and other initiatives. The goal of the PMDA application is to: Collect programmatic quality and other performance metrics, related reports and other information associated with selected 1115 demonstrations; Validate and track performance-based incentive payments for 1115 demonstrations that include them; Provide electronic reports that support CMCS oversight, monitoring and evaluation of 1115 demonstration performance, particularly on quality and other performance metrics, and on related incentive payments (if any); Produce analytic files to support demonstration evaluation. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 CMS-10398 #56. Public burden for all of the collection of information requirements under this control number is estimated to take about 7.5 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Budget neutrality is a Federal policy that governs the Federal expenditures for 1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., "with waiver" expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., "without waiver" expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration's approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus throughout the workbook, including the list of active waivers for the demonstration.

Data Entry Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

Pre-populated values in the downloaded Budget Neutrality workbook template

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PMPM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

Calculating With Waiver (WW) numbers

WW numbers for each active DY of a demonstration are calculated based on a combination of actual WW expenditures, projected future expenditures, and any adjustments entered by a State User. The actual WW expenditures are copied from the Schedule C of the MBES CMS-64 report to the workbook (C Report tab). These numbers are automatically transferred to the C Report Grouper tab, where waiver expenditures are grouped by MEGs. The numbers are also transferred to the WW Spending Actual tab, which factors in adjustments entered on the Total Adjustments tab to calculate total actual WW expenditures. The WW Spending Total tab displays the actual WW expenditures plus future projected expenditures (transferred from the WW Spending Projected tab). Finally, the total WW actual and projected numbers are transferred to the Summary TC (Total Computable) tab (into the With-Waiver Total Expenditures section).

Calculating Without Waiver (WOW) numbers

WOW numbers can be obtained either one of two ways: using Aggregate or Per Capita calculations. If total projected expenditures for a MEG is known and the expenditure calculation type is defined as 'Aggregate' on the MEG Def tab, the total projected expenditure amount is entered for each active DY. However, if the expenditure calculation type is defined as 'Per Capita', total projected expenditures are derived by multiplying per member per month (PMPM) costs by the actual number of member months.

Both Aggregate and PMPM numbers are populated on the WOW PMPM & Agg tab. The number of actual member months (number of beneficiaries times the number of months enrolled) are entered by a State User on the MemMon Actual tab for each DY. On the MemMon Projected tab, State User enters projected numbers. The totals for actual and projected member months are calculated on the MemMon Total tab. WOW aggregate, PMPM and member month data is then moved to the the Without-Waiver Total Expenditures section of the Summary TC tab, where final calculations are performed.

Based on information from all tabs, the WW and WOW numbers are compared to determine the budget neutrality status of the demonstration.

Below are the definitions for the tabs of the workbook which require data entries from State User.

On top of the C Report tab, enter data in the following highlighted cells:

'Data Pulled On' - enter the date the source file used to enter data on this tab was pulled
'For the Time Period Through' - enter the date through which the source file data was pulled
Reporting DY - enter the Demonstration Year (DY) for which data is being reported. Entered DY value must align with DYs from the DY Def tab.
Reporting Quarter - enter a number of the quarter (values 1 through 4) for which data is being reported.

Notes:

- Dates must be entered in the following format: mm/dd/yyyy
- Reporting DY and Reporting Quarter entries affect which portion of the 'Medicaid Aggregate' and 'Medicaid Aggregate - WOW only' amounts for a DY will be calculated as Actuals, and which will be calculated as Projected
- Entry for each of these four fields is required for the workbook submission. If any field is not populated, you will receive an error and the document will not be uploaded to the system.

State User enters information on the following tabs:

C Report Tab

Open Schedule C of the CMS 64 Expenditure Report. Under your state, locate expenditure data for the specific demonstration. From this location on the CMS 64 Expenditure Report, copy expenditure data cells for all DYs (active and non-active). On the C Report tab, paste the data into the correct cell/row. Repeat the copy and paste process for MAP Waivers section (Total Computable and Federal Share) and ADM Waivers section (if applicable). Verify that the pasted numbers are correctly aligned with the Waiver Name values.

Total Adjustments tab

When adjustments are relevant for a demonstration, enter the actual numbers of total contributions to the reported expenditures, per each MEG, for the reporting quarter. Add new reported adjustments to any existing numbers for previous quarters for the reported DY.

Note: Any adjustments that reduce expenditures must be entered as negative numbers (for example, -\$10,000).

WW Spending Projected tab

Enter projected annual expenditures for each MEG for the active DYs of a demonstration.

For each reporting quarter, update the projected numbers so they reflect only future quarter projections. Please see the example for the MemMon Projected tab.

MemMonth Actual tab

For each MEG, calculate the actual number of member months for the reported quarter and add this number to the previously entered number for the same DY. For example, for Q3 reporting period, add Q3 member months to the existing number for the same MEG and DY and enter the result into the same cell.

MemMonth Projected tab

For each MEG, enter projected (future) annual member months for all active DYs of the demonstration. Adjust future DY numbers as needed.

For the current DY, enter only the number that reflects future quarters. For example, for Q3 reporting, only enter the projected number for Q4. There should be no projected numbers for completed (actual) DYs.

Summary TC tab

In the Net Variance section, for each DY, enter estimated numbers in row '1115A Dual Demonstration Savings (state preliminary estimate)'.

In the next row, '1115A Dual Demonstration Savings (OACT certified)' enter certified numbers.

Both estimated and certified numbers must be negative, as dual demonstration savings numbers reduce the Net Variance amount.

Demonstration Years Definitions

DY	1	2	3	4	5	6	7	8	9	10
Start Date	1/1/2014	1/1/2015	1/1/2016	1/1/2017	1/1/2018	1/1/2019	1/1/2020	1/1/2021	1/1/2022	1/1/2023
End Date	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023

Enter any general comments / notes:

MEG Definitions

[illegible]

WOW PMPMs and Aggregates

		6	7	8	9	10
Medicaid Per Capita						
<i>TANF and Related</i>	1	\$460.00	\$477.48	\$495.62	\$514.45	\$534.00
<i>SSI Medicaid Only</i>	2	\$2,158.77	\$2,247.28	\$2,339.42	\$2,435.34	\$2,535.19
<i>SSI Dual</i>	3	\$2,057.62	\$2,141.98	\$2,229.80	\$2,321.22	\$2,416.39
Medicaid Aggregate - WOW only						
<i>UPL Payments</i> □	1	\$80,901,176.00	\$80,901,176.00	\$80,901,176.00	\$80,901,176.00	\$80,901,176.00

		6	7	8	9	10
Hypothetical 1 Per Capita						
<i>217-like Medicaid</i>	1	\$5,747.30	\$5,926.04	\$6,110.34	\$6,300.37	\$6,496.31
<i>217-like Group-Dual</i>	2	\$3,661.18	\$3,811.29	\$3,967.56	\$4,130.23	\$4,299.57

		6	7	8	9	10
Hypothetical 2 Per Capita						
<i>VIII Group</i>	1	\$738.22	\$772.92	\$809.24	\$847.28	\$887.10

		6	7	8	9	10
Hypothetical 3 Per Capita						
<i>SUD/IMD</i>	1	\$808.21	\$841.35	\$875.85	\$911.76	\$949.14

		6	7	8	9	10
Hypothetical 4 Per Capita						
<i>CHV</i>	1		\$708.33	\$708.33	\$708.33	\$708.33
<i>Tenancy</i>	2		\$450.00	\$450.00	\$450.00	\$450.00

Program Spending Limits

						TOTAL
Program Name and Associated MEGs	6	7	8	9	10	
Spending Cap						
<i>Uncompensated Care Pool</i>	\$68,889,323					\$ 413,335,938
Expenditures Subject to Cap						
<i>UC</i>	\$68,889,316					
Variance	\$7					\$ 1,594,357
Over or Under	.					.

						TOTAL
Program Name and Associated MEGs	6	7	8	9	10	
Spending Cap						
Hospital Quality Improvement Incentive Pool	\$12,000,000	\$12,000,000	\$12,000,000			\$ 65,426,586
Expenditures Subject to Cap						
<i>HQII</i>	\$12,000,002	\$11,999,993	\$12,000,000			
Variance	(\$2)	\$7				\$ (1,594,342)
Over or Under	Over	Over

3. **ACDM Waivers** are applicable to the demonstration. Complete two more rounds of coordination starting from the cell in column A (Waiver Name)
 - ACDM Waivers' Total Computable section - cell A330
 - ACDM Waivers' Federal Share section - cell A400

Financial Data			Quarterly Performance (Q1-Q4)																												Total Data				
Category	Metric	Unit	Quarterly Data																												Total	Average			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
Regional Sales	North America	\$M	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390	400	1600	160		
	Europe	\$M	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	230	900	90	
	Asia Pacific	\$M	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	200	700	70	
	South America	\$M	30	32	34	36	38	40	42	44	46	48	50	52	54	56	58	60	62	64	66	68	70	72	74	76	78	80	82	84	86	88	90	350	35
	Africa & ME	\$M	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	200	20
Product Sales	Electronics	\$M	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390	400	410	420	430	440	450	1800	180
	Software	\$M	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	1050	105
	Services	\$M	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	750	75
	Consulting	\$M	40	42	44	46	48	50	52	54	56	58	60	62	64	66	68	70	72	74	76	78	80	82	84	86	88	90	92	94	96	98	100	400	40
	Other Products	\$M	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	200	20
Operational Data	Production Volume	Units	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	2500	2600	2700	2800	2900	3000	3100	3200	3300	3400	3500	3600	3700	3800	3900	4000	15000	1500
	Inventory Levels	Units	500	550	600	650	700	750	800	850	900	950	1000	1050	1100	1150	1200	1250	1300	1350	1400	1450	1500	1550	1600	1650	1700	1750	1800	1850	1900	1950	2000	7500	750
	Customer Satisfaction	Score	4.5	4.6	4.7	4.8	4.9	5.0	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	6.0	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.9	7.0	7.1	7.2	7.3	7.4	7.5	6.5	6.5
	Employee Turnover	%	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	20	20
	Operational Efficiency	%	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	105	105

C Report Grouper

MAP Waivers Only

Total Computable

MEG Names		C Report Waiver Names	6	7	8	9	10
<u>Medicaid Per Capita</u>							
TANF and Related	1	MEG1-TANF & Related	\$1,713,268,114	\$2,002,559,452	\$2,390,789,512	\$1,842,747,779	
SSI Medicaid Only	2	MEG2- SSI Medicaid Only	\$865,759,378	\$1,006,496,530	\$1,070,861,800	\$852,577,526	
SSI Dual	3	MEG3- SSI DUAL	\$557,061,667	\$625,745,431	\$670,401,310	\$540,913,981	
<u>Medicaid Aggregate - WW only</u>							
UC	1	Uncompensated Care "UC" Pool	\$68,889,316				
UC	1	MEG8-UHC-Uncompensated care					
UC	1	UC					
HQII	2	Hospital Quality Improvement Incentive "HQII" Pool	\$12,000,002	\$11,999,993	\$12,000,000		
HQII	2	MEG9-HQII-Hospital Quality Improve Incentive					
<u>Hypothetical 1 Per Capita</u>							
217-like Medicaid	1	MEG4-217	\$11,383,232	\$12,139,659	\$11,732,716	\$8,540,995	
217-like Group-Dual	2	MEG5- 217 DUAL	\$143,887,343	\$191,782,440	\$243,727,931	\$200,387,610	
<u>Hypothetical 2 Per Capita</u>							
VIII Group	1	MEG6-VIII GROUP	\$1,611,492,050	\$1,974,111,193	\$2,168,905,645	\$1,741,584,163	
<u>Hypothetical 3 Per Capita</u>							
SUD/IMD	1	Centennial Care 2.0 Medicaid SUD/IMD	\$3,448,086	\$4,652,746	\$6,397,878	\$4,526,556	
<u>Hypothetical 4 Per Capita</u>							
CHV	1	CHV					
Tenancy	2	Tenancy					
TOTAL			\$4,987,189,188	\$5,829,487,444	\$6,574,816,792	\$5,191,278,610	

Adjustments made to the reported expenditures

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.

Positive adjustments increase expenditures, and negative adjustments decrease expenditures.

Enter adjustments for every MEG for which adjustments were made or are planned.

Helpful Hint: Remember to enter total adjustments as positive or negative (for example, -\$10,000 reflects a decrease in expenditures).

		6	7	8	9	10	Description (type of collection, time period, CMS-64 reporting line, etc.)
<u>Medicaid Per Capita</u>							
TANF and Related	1	\$872,706	\$468,059	\$425,303	\$287,423		SUD IMD Adjustment
SSI Medicaid Only	2	\$528,611	\$280,663	\$245,491	\$166,102		SUD IMD Adjustment
SSI Dual	3	\$179,528	\$94,993	\$83,984	\$56,756		SUD IMD Adjustment
<u>Medicaid Aggregate - WW only</u>							
UC	1						
HQII	2						
<u>Hypothetical 1 Per Capita</u>							
217-like Medicaid	1	\$4,987	\$1,727	\$1,615	\$1,041		SUD IMD Adjustment
217-like Group-Dual	2	\$14,961	\$8,636	\$6,460	\$4,166		SUD IMD Adjustment
<u>Hypothetical 2 Per Capita</u>							
VIII Group	1	\$1,366,409	\$1,502,624	\$1,672,679	\$1,129,907		SUD IMD Adjustment
<u>Hypothetical 3 Per Capita</u>							
SUD/IMD	1	-\$2,967,201	-\$2,356,702	-\$2,435,533	-\$1,645,394		SUD IMD Adjustment
<u>Hypothetical 4 Per Capita</u>							
CHV	1						
Tenancy	2						

WW Spending - Actual

Total Computable

		6	7	8	9	10
<u>Medicaid Per Capita</u>						
TANF and Related	1	\$1,714,140,820	\$2,003,027,511	\$2,391,214,815	\$1,843,035,202	
SSI Medicaid Only	2	\$866,287,989	\$1,006,777,193	\$1,071,107,291	\$852,743,628	
SSI Dual	3	\$557,241,195	\$625,840,424	\$670,485,294	\$540,970,737	
<u>Medicaid Aggregate - WW only</u>						
UC	1	\$68,889,316				
HQII	2	\$12,000,002	\$11,999,993	\$12,000,000		
<u>Hypothetical 1 Per Capita</u>						
217-like Medicaid	1	\$11,388,219	\$12,141,386	\$11,734,331	\$8,542,036	
217-like Group-Dual	2	\$143,902,304	\$191,791,076	\$243,734,391	\$200,391,776	
<u>Hypothetical 2 Per Capita</u>						
VIII Group	1	\$1,612,858,459	\$1,975,613,817	\$2,170,578,324	\$1,742,714,070	
<u>Hypothetical 3 Per Capita</u>						
SUD/IMD	1	\$480,885	\$2,296,044	\$3,962,345	\$2,881,162	
<u>Hypothetical 4 Per Capita</u>						
CHV	1					
Tenancy	2					
TOTAL		\$4,987,189,188	\$5,829,487,444	\$6,574,816,792	\$5,191,278,610	

WW Spending - Projected

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.

Enter the projected annual expenditures for each DY per MEG for the active DYs.

For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

Total Computable

		6	7	8	9	10
<u>Medicaid Per Capita</u>						
TANF and Related	1				\$942,109,720	\$2,762,514,667
SSI Medicaid Only	2				\$247,371,198	\$1,156,772,350
SSI Dual	3				\$199,025,655	\$772,294,907
<u>Medicaid Aggregate - WW only</u>						
UC	1					
HQII	2					
<u>Hypothetical 1 Per Capita</u>						
217-like Medicaid	1				\$4,687,785	\$14,184,968
217-like Group-Dual	2				\$86,824,555	\$327,487,401
<u>Hypothetical 2 Per Capita</u>						
VIII Group	1				\$675,673,442	\$2,250,714,487
<u>Hypothetical 3 Per Capita</u>						
SUD/IMD	1				\$1,354,875	\$4,010,116
<u>Hypothetical 4 Per Capita</u>						
CHV	1					
Tenancy	2					

WW Spending - Total

Total Computable

		6	7	8	9	10
<u>Medicaid Per Capita</u>						
TANF and Related	1	\$1,714,140,820	\$2,003,027,511	\$2,391,214,815	\$2,785,144,922	\$2,762,514,667
SSI Medicaid Only	2	\$866,287,989	\$1,006,777,193	\$1,071,107,291	\$1,100,114,826	\$1,156,772,350
SSI Dual	3	\$557,241,195	\$625,840,424	\$670,485,294	\$739,996,392	\$772,294,907
<u>Medicaid Aggregate - WW only</u>						
UC	1	\$68,889,316				
HQII	2	\$12,000,002	\$11,999,993	\$12,000,000		
<u>Hypothetical 1 Per Capita</u>						
217-like Medicaid	1	\$11,388,219	\$12,141,386	\$11,734,331	\$13,229,821	\$14,184,968
217-like Group-Dual	2	\$143,902,304	\$191,791,076	\$243,734,391	\$287,216,331	\$327,487,401
<u>Hypothetical 2 Per Capita</u>						
VIII Group	1	\$1,612,858,459	\$1,975,613,817	\$2,170,578,324	\$2,418,387,512	\$2,250,714,487
<u>Hypothetical 3 Per Capita</u>						
SUD/IMD	1	\$480,885	\$2,296,044	\$3,962,345	\$4,236,037	\$4,010,116
<u>Hypothetical 4 Per Capita</u>						
CHV	1					
Tenancy	2					
TOTAL		\$4,987,189,188	\$5,829,487,444	\$6,574,816,792	\$7,348,325,840	\$7,287,978,896

Member Months - Actual

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.

For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual member months.

Note: Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be applied consistently.

Helpful Hint: When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustments may affect the entries.

		6	7	8	9	10
<u>Medicaid Per Capita</u>						
TANF and Related	1	4313466	4592930	5135010	4072843	
SSI Medicaid Only	2	448354	450072	461498	354548	
SSI Dual	3	433379	433209	435813	332559	
<u>Hypothetical 1 Per Capita</u>						
217-like Medicaid	1	2989	3005	3601	3267	
217-like Group-Dual	2	50764	60554	68032	51906	
<u>Hypothetical 2 Per Capita</u>						
VIII Group	1	3070621	3275235	3505466	2651854	
<u>Hypothetical 3 Per Capita</u>						
SUD/IMD	1	595	2729	4524	3160	
<u>Hypothetical 4 Per Capita</u>						
CHV	1					
Tenancy	2					

Member Months - Projected

Enter/adjust projected member months based on reported actuals.

Enter projected number of member months for each active DY per MEG for the demonstration.

For the current DY, enter only the number that reflects projections for future quarters of the DY.

Do not include member months for either the current reporting quarter or past quarters.

		6	7	8	9	10
<u>Medicaid Per Capita</u>						
TANF and Related	1				1437601	5246172
SSI Medicaid Only	2				101178	458612
SSI Dual	3				102785	435211
<u>Hypothetical 1 Per Capita</u>						
217-like Medicaid	1				470	3867
217-like Group-Dual	2				20620	79068
<u>Hypothetical 2 Per Capita</u>						
VIII Group	1				931914	3150868
<u>Hypothetical 3 Per Capita</u>						
SUD/IMD	1				1486	4225
<u>Hypothetical 4 Per Capita</u>						
CHV	1					
Tenancy	2					

Member Months - Total

		6	7	8	9	10
<u>Medicaid Per Capita</u>						
TANF and Related	1	4,313,466	4,592,930	5,135,010	5,510,444	5,246,172
SSI Medicaid Only	2	448,354	450,072	461,498	455,726	458,612
SSI Dual	3	433,379	433,209	435,813	435,344	435,211
<u>Hypothetical 1 Per Capita</u>						
217-like Medicaid	1	2,989	3,005	3,601	3,737	3,867
217-like Group-Dual	2	50,764	60,554	68,032	72,526	79,068
<u>Hypothetical 2 Per Capita</u>						
VIII Group	1	3,070,621	3,275,235	3,505,466	3,583,768	3,150,868
<u>Hypothetical 3 Per Capita</u>						
SUD/IMD	1	595	2,729	4,524	4,646	4,225
<u>Hypothetical 4 Per Capita</u>						
CHV	1					
Tenancy	2					

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the "Revert to Default" button will reset the Reporting QY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start QY	6
Budget Neutrality Reporting End QY	10

Actuals > Proposed

		Without-Waiver Total Expenditures					Total
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

		With-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,714,140,820	\$ 2,003,027,511	\$ 2,381,214,816	\$ 2,785,144,022	\$ 2,792,514,687
		PMFM	\$ 685,287,869	\$ 1,008,777,153	\$ 1,071,102,291	\$ 1,100,114,826	\$ 1,100,772,300
		Mem-Mem	\$ 1,028,852,951	\$ 994,250,358	\$ 1,310,112,525	\$ 1,685,029,196	\$ 1,691,742,387
SIS Medicaid Only	2	Total	\$ 587,241,105	\$ 628,840,424	\$ 670,485,204	\$ 730,958,302	\$ 772,254,907
		PMFM	\$ 58,880,316	\$ 5	\$ -	\$ -	\$ -
		Mem-Mem	\$ 528,360,789	\$ 623,835,419	\$ 670,485,204	\$ 730,958,302	\$ 772,254,907
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,218,084,331	\$ 3,697,648,121	\$ 4,144,897,208	\$ 4,686,256,148	\$ 4,687,861,254

		Without-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

		Without-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

		Without-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

		Without-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

		Without-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

		Without-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

		Without-Waiver Total Expenditures					TOTAL
		6	7	8	9	10	
Medicaid Per Capita							
FANF and Related	1	Total	\$ 1,084,184,360	\$ 2,193,032,216	\$ 2,545,013,006	\$ 2,824,847,916	\$ 2,801,455,848
		PMFM	\$ 500,000	\$ 507,800	\$ 510,000	\$ 511,440	\$ 504,100
		Mem-Mem	\$ 584,184,360	\$ 1,685,224,416	\$ 2,035,013,006	\$ 2,313,406,476	\$ 2,297,351,748
SIS Medicaid Only	2	Total	\$ 967,883,165	\$ 1,011,437,804	\$ 1,079,637,801	\$ 1,108,947,757	\$ 1,102,899,006
		PMFM	\$ 52,158,771	\$ 52,247,238	\$ 52,339,421	\$ 52,430,34	\$ 52,520,19
		Mem-Mem	\$ 915,724,394	\$ 959,190,566	\$ 1,027,298,380	\$ 1,056,517,417	\$ 1,050,378,816
SIS Dual	3	Total	\$ 881,733,288	\$ 927,925,014	\$ 971,773,627	\$ 1,010,523,200	\$ 1,001,630,808
		PMFM	\$ 52,037,62	\$ 51,141,88	\$ 52,238,86	\$ 51,321,22	\$ 51,414,38
		Mem-Mem	\$ 829,695,667	\$ 876,783,136	\$ 919,534,767	\$ 959,201,978	\$ 950,216,420
Medicaid Ancillary - WOV only (FTE Personnel)	1	Total	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176	\$ 80,501,176
TOTAL			\$ 3,004,717,989	\$ 4,311,938,210	\$ 4,677,325,311	\$ 5,026,126,048	\$ 5,006,885,888

Yes No

Yes

No

Per Capita or Aggregate

Per Capita

Aggregate

Phase-Down

No Phase-Down

Savings Phase-Down

Actuals and Projected

Actuals Only

Actuals + Projected

MAP ADM

MAP+ADM Waivers

MAP Waivers Only

Waiver List**MAP WAIVERS**

Not Applicable

Centennial Care 2.0 Medicaid SUD/IMD

Hospital Quality Improvement Incentive "HQII" Pool

MEG1-TANF & Related

MEG2- SSI Medicaid Only

MEG3- SSI DUAL

MEG4-217

MEG5- 217 DUAL

MEG6-VIII GROUP

MEG8-UHC-Uncompensated care

MEG9-HQII-Hospital Quality Improve Incentive

UC

Uncompensated Care "UC" Pool

CHV

Tenancy

ADM WAIVERS**Demonstration Reporting Start DY**

6

Demonstration Reporting End DY

10

Reporting Net Variance

\$

879,783,364

BCBS CALL CENTER STANDARDS AND PERFORMANCE MEASURES

			Meets Standard					Does Not Meet						
			BCBS											
CONTRACT STANDARD			January	February	March	April	May	June	July	August	September	October	November	December
Member Services	Number of Calls Received - All Queues		14,395	12,311	13,778	11,325	11,778	11,779	10,756	14,017	12,038			
	Number of Calls Answered - All Queues		14,236	12,092	13,638	11,201	11,702	11,690	10,646	13,923	11,955			
	Percent of Calls Abandoned	< 5%	1.1%	1.8%	1.0%	1.1%	0.6%	0.8%	1.0%	0.7%	0.7%			
	Percent of Calls Answered within 30 Seconds	85%	85.9%	80.4%	87.4%	86.6%	91.3%	93.2%	89.1%	93.8%	95.7%			
	Average Wait Time	< 2 minutes	0.3	0.6	0.3	0.3	0.2	0.2	0.3	0.2	0.2			
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	89.5%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%			
Nurse Advice Line	Number of Calls Received - All Queues		917	586	715	635	782	691	720	754	680			
	Number of Calls Answered - All Queues		904	584	711	627	775	685	711	746	672			
	Percent of Calls Abandoned	< 5%	1.4%	0.3%	0.6%	1.3%	0.9%	0.9%	1.3%	1.1%	1.2%			
	Percent of Calls Answered within 30 Seconds	85%	83.8%	93.5%	90.0%	85.0%	91.6%	90.4%	91.6%	87.9%	92.6%			
	Average Wait Time	< 2 minutes	0.4	0.2	0.2	0.3	0.1	0.2	0.2	0.1	0.2			
Provider Services	Number of Calls Received - All Queues		5,072	5,541	6,142	5,579	5,433	5,834	5,674	6,083	5,639			
	Number of Calls Answered - All Queues		5,022	5,476	6,080	5,532	5,394	5,789	5,642	6,054	5,616			
	Percent of Calls Abandoned	< 5%	1.0%	1.2%	1.0%	0.8%	0.7%	0.8%	0.6%	0.5%	0.4%			
	Percent of Calls Answered within 30 Seconds	85%	86.1%	76.7%	84.7%	83.9%	89.4%	91.8%	87.5%	91.6%	92.2%			
	Average Wait Time	< 2 minutes	0.3	0.8	0.4	0.5	0.3	0.3	0.4	0.3	0.3			
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	84.6%	100.0%	100.0%	95.9%	100.0%	100.0%	100.0%	100.0%			
UM Line	Number of Calls Received - All Queues		5,798	5,459	5,701	5,496	4,989	5,280	4,524	5,561	5,340			
	Number of Calls Answered - All Queues		5,725	5,361	5,621	5,405	4,931	5,219	4,481	5,513	5,283			
	Percent of Calls Abandoned	< 5%	1.3%	1.8%	1.4%	1.7%	1.2%	1.2%	1.0%	0.9%	1.1%			
	Percent of Calls Answered within 30 Seconds	85%	89.9%	92.5%	92.8%	90.7%	91.5%	94.9%	93.8%	95.6%	93.3%			
	Average Wait Time	< 2 minutes	0.3	0.3	0.2	0.4	0.4	0.3	0.2	0.2	0.2			

Source: BCBS Report 2, M1-M9 CY22

PHP CALL CENTER STANDARDS AND PERFORMANCE MEASURES

			Meets Standard					Does Not Meet						
			PHP											
CONTRACT STANDARD			January	February	March	April	May	June	July	August	September	October	November	December
Member Services	Number of Calls Received - All Queues		22,002	18,337	19,460	17,542	17,465	18,863	17,757	21,608	18,866			
	Number of Calls Answered - All Queues		21,590	17,965	19,177	17,301	17,264	18,551	17,482	21,283	18,560			
	Percent of Calls Abandoned	< 5%	1.9%	2.0%	1.5%	1.4%	1.2%	1.7%	1.5%	1.5%	1.60%			
	Percent of Calls Answered within 30 Seconds	85%	86.8%	89.6%	90.0%	88.8%	90.8%	86.8%	88.6%	86.1%	87.30%			
	Average Wait Time	< 2 minutes	0.5	0.3	0.3	0.3	0.2	0.3	0.3	0.3	0.3			
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%			
Nurse Advice Line	Number of Calls Received - All Queues		3,449	2,120	2,381	2,524	2,586	2,378	2,612	2,567	2,088			
	Number of Calls Answered - All Queues		3,347	2,079	2,352	2,457	2,512	2,335	2,529	2,506	2,046			
	Percent of Calls Abandoned	< 5%	3.0%	1.9%	1.2%	2.7%	2.9%	1.8%	3.2%	2.4%	2.00%			
	Percent of Calls Answered within 30 Seconds	85%	89.9%	95.6%	96.4%	95.7%	93.9%	94.0%	91.6%	94.7%	96.00%			
	Average Wait Time	< 2 minutes	0.3	0.1	0.1	0.2	0.2	0.2	0.3	0.2	0.2			
	Provider Services	Number of Calls Received - All Queues		2,960	2,860	4,132	3,396	3,194	3,521	3,137	3,865	3,507		
Number of Calls Answered - All Queues			2,932	2,828	4,115	3,375	3,168	3,490	3,116	3,846	3,478			
Percent of Calls Abandoned		< 5%	0.9%	1.1%	0.4%	0.6%	0.8%	0.9%	0.7%	0.5%	0.80%			
Percent of Calls Answered within 30 Seconds		85%	86.6%	86.6%	87.8%	88.8%	88.5%	86.4%	87.2%	86.4%	88.00%			
Average Wait Time		< 2 minutes	0.4	0.3	0.3	0.2	0.2	0.3	0.2	0.3	0.2			
Percent of Voicemails Returned by Next Business Day		100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%			
UM Line	Number of Calls Received - All Queues		1,106	1,062	1,146	1,032	1,019	997	853	1,050	923			
	Number of Calls Answered - All Queues		1,095	1,052	1,144	1,030	1,017	991	851	1,047	918			
	Percent of Calls Abandoned	< 5%	1.0%	0.9%	0.2%	0.2%	0.2%	0.6%	0.2%	0.3%	0.50%			
	Percent of Calls Answered within 30 Seconds	85%	88.6%	93.3%	92.0%	88.7%	92.5%	88.0%	96.9%	90.4%	90.00%			
	Average Wait Time	< 2 minutes	0.3	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2			

Source: PHP Report 2, M1-M3 CY22

WSSC CALL CENTER STANDARDS AND PERFORMANCE MEASURES

			Meets Standard						Does Not Meet						
			WSSC												
			CONTRACT STANDARD	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
88	Number of Calls Received - All Queues		5,277	4,296	4,960	4,109	4,110	4,073	3,688	4,723	4,362				
	Number of Calls Answered - All Queues		5,093	4,188	4,678	4,007	3,908	3,975	3,608	4,588	4,283				
	Percent of Calls Abandoned	< 5%	3.5%	2.5%	5.7%	2.5%	4.9%	2.4%	2.2%	2.9%	1.8%				
	Percent of Calls Answered within 30 Seconds	85%	77.4%	86.3%	75.8%	90.7%	93.6%	95.9%	96	89	95.5%				
	Average Wait Time	< 2 minutes	0.9	0.6	1.1	0.4	0.3	0.2	0.2	0.5	0.2				
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100				
Nurse Advice Line	Number of Calls Received - All Queues		212	119	164	170	191	175	161	135	160				
	Number of Calls Answered - All Queues		206	118	159	170	188	173	159	136	157				
	Percent of Calls Abandoned	< 5%	2.8%	0.8%	3.0%	0.0%	1.6%	1.1%	1.2%	0.0%	1.9%				
	Percent of Calls Answered within 30 Seconds	85%	74.8%	89.0%	93.7%	91.8%	95.7%	96.5%	94.3%	97.8%	98.1%				
	Average Wait Time	< 2 minutes	0.5	0.2	0.2	0.2	0.2	0.1	0.2	0.1	0.2				
Provider Services	Number of Calls Received - All Queues		4,036	3,846	4,529	3,990	3,771	4,105	3,721	4,394	3,750				
	Number of Calls Answered - All Queues		3,853	3,591	4,142	3,881	3,626	3,994	3,588	4,261	3,635				
	Percent of Calls Abandoned	< 5%	4.5%	6.6%	8.5%	2.7%	3.8%	2.7%	3.6%	3.0%	3.1%				
	Percent of Calls Answered within 30 Seconds	85%	63.6%	63.9%	61.9%	88.3%	89.3%	91.20%	85.7%	85.7%	89.6%				
	Average Wait Time	< 2 minutes	1.9	1.9	2.9	0.4	0.3	0.3	0.4	0.4	0.3				
	Percent of Voicemails Returned by Next Business Day	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%				
UM Line	Number of Calls Received - All Queues		1,510	1,984	1,678	1,605	1,498	1,536	1,547	1,793	1,463				
	Number of Calls Answered - All Queues		1,474	1,554	1,634	1,560	1,452	1,489	1,514	1,733	1,412				
	Percent of Calls Abandoned	< 5%	2.4%	1.9%	2.6%	2.8%	3.1%	3.1%	2.1%	3.3%	3.5%				
	Percent of Calls Answered within 30 Seconds	85%	90.8%	91.2%	89.3%	90.1%	86.6%	85.8%	87.5%	89.6%	88.9%				
	Average Wait Time	< 2 minutes	0.6	0.5	0.7	0.5	0.8	0.7	0.6	0.5	0.7				