CENTENNIAL CARE 2.0 DEMONSTRATION

Section 1115 Quarterly Report Demonstration
Demonstration Year: 6 (1/1/2019 – 12/31/2019)
Quarter: 2/2019

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INTRODUCTION

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

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

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

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

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

Status of Key Dates:

TOPIC	KEY DATE	STATUS
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	Pending CMS approval
Quality Strategy	Submitted to CMS on March 14, 2019	Pending CMS approval

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ENROLLMENT AND BENEFITS INFORMATION

QUARTER 2 MCO ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION (MCO)	3/31/2019 ENROLLMENT	6/30/2019 ENROLLMENT	PERCENT INCREASE/ DECREASE Q1
Blue Cross Blue Shield of New Mexico (BCBS)	229,123	232,545	+ 1%
Presbyterian Health Plan (PHP)	373,369	371,851	-1%
Western Sky Community Care (WSCC)	58,154	59,534	+ 3%

Source: Medicaid Eligibility Reports, Mar. 2019 & June. 2019

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment data and cost per unit data by programs is provided for April 2017 through March 2019. Please see Attachment A: April 2017 – March 2019 Statewide Dashboards.

MCO Enrollment

In aggregate, MCO enrollment is decreasing by 3% from the previous to current period. Approximately half of this decrease is attributable to program-wide member redetermination review. This decrease is comprised of the following:

- 4% decrease in physical health enrollment;
- 2% decrease in aggregate Long term services and supports enrollment. The 8% decrease to NF LOC Medicaid Only members is offset in part by the 14% increase in Self Directed enrollment; and
- 2% decrease in other adult group enrollment.

MCO Per Capita Medical Costs

- In aggregate, MCO per capita medical costs are increasing by 6% from the previous to current period, this consists of a 1% increase to pharmacy services and 6% increase to non-pharmacy services.
- The following fee and benefit changes have been implemented in the current period and are not reflected in previous period. These changes include fee increase as well as the addition of new benefits and contribute to the overall increase in program per capita costs:

Effective 7/1/2018
Physician Office Visit Reimbursement fee increase
Nursing Facility Fee increase
Assisted Living Reimbursement fee increase
Adult Day Health Reimbursement fee increase
Phase 1 Behavioral Health Benefit and Fee Changes

Effective 1/1/2019
Long-Acting Reversible Contraceptive Fee Increase
Community Benefit Fee increase
Child Accredited Residential Treatment Center Payment Change
New benefit for Home visiting pilot programs
New benefit for Brief Intervention, and Referral to Treatment Services
Phase 2 Behavioral Health Benefit and Fee Changes

- The LTSS populations display more volatility than observed in other populations. Drivers of these changes include program-wide enrollment review, improved MCO processing of Medicare-eligible claims, and changes in member classification over time. In aggregate, all LTSS populations combined have a per capita medical cost increase of 3% overall.

CENTENNIAL CARE 1.0 TO CENTENNIAL CARE 2.0 TRANSITION

UnitedHealthcare Community Plan Termination

United Healthcare Care (UHC) was not awarded selection in Centennial Care 2.0 and began the transition process in early 2018. UHC submitted a Centennial Care 1.0 Termination Plan to HSD on August 15, 2018, and its Centennial Care 1.0 membership was transferred to Presbyterian Health Plan (PHP) on September 1, 2018. The Transition Management Agreement identifies UHC's continued contractual obligations for reporting and claims management as described in section 7.6.8 of the Managed Care Services Agreement. UHC is current in all transition management requirements and continues to work though claims processing. HSD will continue to work with UHC on its contractual obligations through the remainder of 2019.

Molina Healthcare Plan Termination

Molina Healthcare of New Mexico (MHC) was not awarded selection in Centennial Care 2.0 and began the transition process in early 2018. MHC entered into Transition Management Agreements with HSD and the selected Centennial Care 2.0 MCOs on May 14, 2018. MHC submitted a Centennial Care 1.0 Termination Plan to HSD on March 15, 2018. MHC's Centennial Care 1.0 membership was transferred to the 2.0 Centennial Care MCOs on January 1, 2019. The Transition Management Agreement identifies MHC's continued contractual obligations for reporting and claims management as described in section 7.6.8 of the Managed Care Services Agreement. HSD is reviewing MHC's required transition plan to determine which items may closed. HSD anticipates working with MHC on its contractual obligations through the remainder of 2019.

CENTENNIAL CARE 2.0 TRANSITION MONITORING

Throughout the first quarter, HSD staff and leadership monitored key performance indicators, daily and weekly, for early indications of transition challenges or concerns. Weekly reporting was discontinued at the end of Q1 DY6 when regularly scheduled quarterly reports began. Data revealed that in Q1 BCBS's Guiding Care Platform had at least one concern related to care coordination assessment timeliness reporting. When an assessment is completed on time, but the data from the care coordinator is not uploaded until after the due date, the system recognizes the uploaded date rather than the completion date. BCBS developed an internal action plan for which two items are now closed and two are continuing. In addition to the care coordination system limitation, BCBS identified an issue with primary care physician (PCP) assignments for Centennial Care 2.0 transitioned members. Transitioned members had not been flagged as "new" to BCBS in the enrollment system, and PCP auto-assignment did not occur for those members who had not selected a PCP. BCBS provided HSD with a remediation plan on April 25, 2019 and has been providing weekly updates. BCBS completed its remediation efforts on May 17, 2019 and is currently working to finalize the requirements of the systematic PCP auto-assignment process and will then move into the next phases of development (see also Section 9 – Action Plans).

CENTENNIAL REWARDS

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

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

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

New Rewards for 2019:

- Adult PCP Visit
- Well-Child for ages Birth – 15 Month (aka W15)

The Pregnancy reward, rewarding pregnant members for joining the health plan's Prenatal program, has been replaced by the following new reward activities:

- Prenatal First Trimester Visit
- Postpartum Visit

Table 1: Centennial Care Rewards

CENTENNIAL CARE REWARDS (JANUARY – MARCH 2019)	
	Q1
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	74,110
Number of Members Registered in the Rewards Program this Quarter	4,215
Number of Members Who Redeemed Rewards this Quarter**	7,797

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

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ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

The following table outlines all 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. Also, the majority of disenrollments for this quarter are attributed to loss of eligibility, moved out of state, and death.

Demonstration Population		Total Number Demonstration Participants DY1 Q2 Ending - June 2019	**Current Enrollees (Rolling 12-Month Period)	Total Disenrollments During DY1 Q2
Population MEG1 – TANF and Related	0-FFS	34,206	48,274	756
	Molina	0	129,212	0
	Presbyterian	181,236	179,398	3,421
	United Healthcare	0	1,410	0
	Western Sky	30,542	2,035	648
	Blue Cross Blue Shield	108,059	85,624	2,171
	Summary	**354,043**	**445,953**	**6,996**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,096	2,781	26
	Molina	0	11,800	0
	Presbyterian	20,656	18,582	241
	United Healthcare	0	140	0
	Western Sky	3,412	88	33
	Blue Cross Blue Shield	11,298	7,586	134
	Summary	**37,462**	**40,977**	**434**
Population MEG3 - SSI and Related - Dual	0-FFS	0	62	0
	Molina	0	56	0
	Presbyterian	23,389	156	317
	United Healthcare	0	1	0
	Western Sky	2,284		38
	Blue Cross Blue Shield	10,496	72	203
	Summary	**36,169**	**347**	**558**

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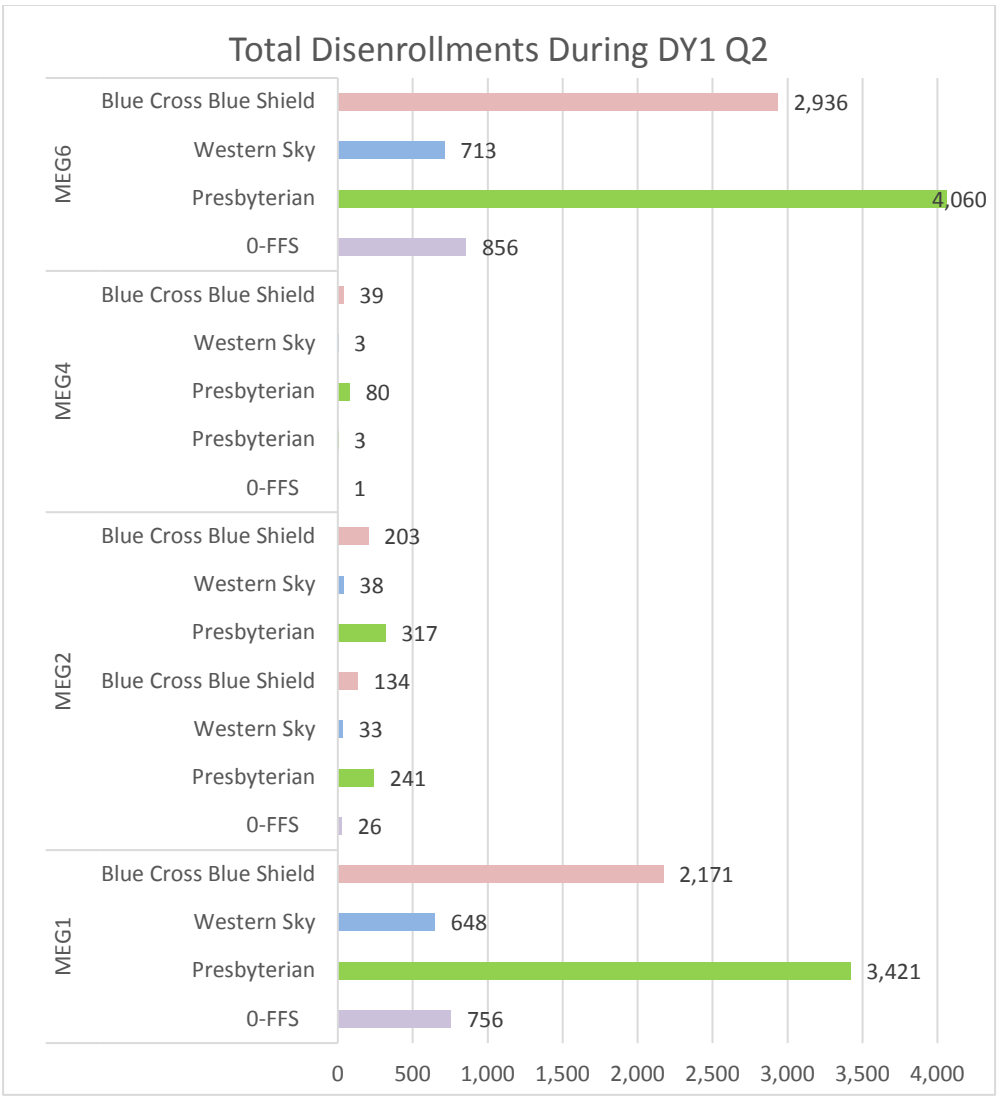
Population MEG4 - 217-like Group - Medicaid Only	**0-FFS**	7	62	1
	Molina	0	56	0
	Presbyterian	129	156	3
	United Healthcare	0	1	0
	Western Sky	15	0	0
	Blue Cross Blue Shield	93	72	0
	Summary	**244**	**347**	**4**
Population MEG5 – 217-like Group – Dual	**0-FFS**	0	12	0
	Molina	0	843	0
	Presbyterian	2,361	2,312	80
	United Healthcare	0	62	0
	Western Sky	217	13	3
	Blue Cross Blue Shield	1,603	1,059	39
	Summary	**4,181**	**4,301**	**122**
Population MEG6 - VIII Group (expansion)	**0-FFS**	23,612	28,528	856
	Molina	0	63,042	0
	Presbyterian	130,587	108,734	4,060
	United Healthcare	0	2,033	0
	Western Sky	21,030	1,967	713
	Blue Cross Blue Shield	92,651	71,544	2,936
	Summary	267,880	275,848	**8,565**
Summary		**699,979**	**767,773**	**16,679**


Total Disenrollments During DY1 Q2
MEG6
Blue Cross Blue Shield
Western Sky
Presbyterian
0-FFS
2,936
713
4,060
856
MEG4
Blue Cross Blue Shield
Western Sky
Presbyterian
Presbyterian
0-FFS
39
3
80
3
1
MEG2
Blue Cross Blue Shield
Western Sky
Presbyterian
Blue Cross Blue Shield
Western Sky
Presbyterian
0-FFS
203
38
317
134
33
241
26
MEG1
Blue Cross Blue Shield
Western Sky
Presbyterian
0-FFS
2,171
648
3,421
756
0
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1,000
1,500
2,000
2,500
3,000
3,500
4,000

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OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

OUTREACH AND TRAINING

In each reporting quarter of the Demonstration, HSD will report on marketing and outreach activities that were conducted in the current quarter. In DY6 Q1, HSD Outreaching and Training staff participated in the following statewide outreach activities and events:

- Participated and presented to the Medicaid Advisory Committee meeting, during a Public Hearing, the New Mexico Centennial Care 2.0 1115 Medicaid Demonstration amendment request to remove the following from the current demonstration program: co-payment requirements for Centennial Care 2.0 members; premiums for members of the Adult Expansion Group; and limitations on retroactive eligibility.

- Throughout this quarter HSD staff conducted monthly trainings for the Presumptive Eligibility (PE) Program and Presumptive Eligibility Determiners (PED) in the JUST Health Program. HSD also conducted YESNM-PE Demonstration trainings for PEDs. The purpose for these on-going trainings is to increase PED enrollment throughout New Mexico. Trainings take place in person, classroom environment and also via webinar.

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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 timeliness and 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 on a monthly basis to ensure consistency of numbers. In addition, HSD continues to monitor enrollment and any anomalies that may arise, so they are identified and addressed timely. HSD posts the monthly Medicaid Eligibility Reports (MERs) to the HSD website at: http:www.hsd.state.nm.us/LookingForInformation/medicad-eligibility.aspx. This report includes enrollment by MCOs and by population.

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OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments for DY6 Q2 reflect the rate updates that were effective on April 1, 2019 to account for full contracting with the state teaching hospital. The result is an increase in rates and reflect on the PMPM for MEGs 1, 2, 4 and 6.

HSD has also implemented rate updates effective on July 1, 2019 and October 1, 2019 to account for the various benefit and provider rate changes from the 54th NM State Legislature. These changes will affect the cost and PMPM of DY 6 for all the MEGs.

PATIENT CENTERED MEDICAL HOMES (PCMH)

HSD requires the MCOs to ensure engagement of PCMHs by including PCMH membership as part of a delivery system improvement project.

- For Legacy MCOs, HSD requires a minimum of a five percent (5%) increase of the MCO's members assigned to a PCP who is a provider with a Patient-Centered Medical Home (including both PCMHs that have achieved NCQA accreditation and those that have not). If the MCO achieves a minimum of fifty percent (50%) of membership being served by PCMHs, then the MCO must maintain that same minimum percentage at the end of the calendar year in order to meet this target.
- For non-Legacy MCOs, HSD requires a minimum of ten percent (10%) of the MCO's total membership be assigned to a PCP who is a provider with a Patient-Centered Medical Home (including both PCMHs that have achieved NCQA accreditation and those that have not) by the end of the calendar year.

HSD may impose a penalty if the MCO does not meet the Delivery System Improvement performance targets, however, the MCO may propose that any performance penalty amounts be spent on system improvement activities for provider network development and enhancement activities that will directly benefit members.

Table 2: PCMH Assignment

PCMH ASSIGNMENT				
Total Members Paneled to a PCMH				
	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
BCBS	93,726			
PHP	219,538			
WSCC	20,164			
Percent of Members Paneled to a PCMH				
BCBS	39.0%			
PHP	56.3%			
WSCC	34.4%			

CARE COORDINATION MONITORING ACTIVIES

Care Coordination Monitoring Activities	
2nd Quarter Activities	In DY6 Q1, HSD initiated monthly audits to monitor MCO compliance with contract and policy requirements when conducting care coordination activities. These audits include: 1) MCO compliance for the correct categorization of members who have been listed as Difficult to Engage, Unreachable or Refused care coordination (DUR); 2) Member files to confirm that members are correctly being referred for a Comprehensive Needs Assessment (CNA) if triggered by a completed Health Risk Assessment (HRA); 3) Correct placement of members in Care Coordination Level (CCL) based on information in the CNA and criteria outlined in the Managed Care Service Agreement; and 4) Transition of Care (TOC) files for members transitioning from an in-patient hospital stay or Nursing Facility to the community and members transitioning from a Nursing Facility to the community, confirming the TOC plan adequately addressed the member's needs. In DY6 Q2 HSD provided audit findings each month to the MCOs with requests for further information, updates on member issues, and targeted training for staff. HSD conducted monthly care

	coordination calls with each MCO to follow up with responses, answer questions or provide technical assistance. In DY6 Q2, HSD continued to conduct care coordination "ride-alongs" with MCO care coordinators to observe member assessments in the home setting. HSD staff conducted ride-alongs with BCBS, WSCC and PHP observing initial and follow-up CNAs. Particular emphasis was paid to the utilization by care coordinators of the Community Benefit Supplemental Questionnaire (CBSQ) and the Community Benefit Member Agreement (CBMA), to ensure the member agrees to accept or decline community benefits. In two "ride-alongs", the member accessed services through the Self-Directed Community Benefit (SDCB). The observed care coordinators adhered to, and often went beyond, all contractual obligations in their assessments.

DY6 Q1 audit results for the DUR are listed in Table 3: Care Coordination Categorization Audit. As a result of its findings, HSD requested specific members be recategorized as appropriate and be provided updates on additional follow-ups and outreach. Each MCO provided monthly, the updated recategorizations, steps taken to engage members and HSD requested follow-up information. HSD also conducted a training to all MCOs which included specifics on the correct categorization of members. HSD recommended that each MCO conduct internal trainings for staff on both categorization and documentation which all MCOs have reported completing. BCBS created a step-by-step guide for care coordinators to follow, PHP developed a weekly training bulletin with contract requirements outlined and WSCC created a quick guide for care coordinators with specifics for each categorization. In addition, WSCC now requires each member categorized as DUR to be reviewed by a manager prior to submission into their software system.

Table 3: Care Coordination Categorization Audit

DUR AUDIT	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
Difficult to Engage (DTE)				
Number of member files audited	**83**	**90**		
BCBS	30	30		
PHP	30	30		
WSCC	23	30		
Number of member files correctly categorized	**52**	**65**		
BCBS	27	17		
PHP	15	21		
WSCC	10	27		
% of member files correctly categorized	**63%**	**72%**		
BCBS	90%	57%		
PHP	50%	70%		
WSCC	43%	90%		
Unable to Reach (UTR)				
Number of member files audited	**90**	**90**		
BCBS	30	30		
PHP	30	30		
WSCC	30	30		
Number of member files correctly categorized	**61**	**54**		
BCBS	22	18		
PHP	19	13		
WSCC	20	23		
% of member files correctly categorized	**68%**	**60%**		
BCBS	73%	60%		
PHP	63%	43%		
WSCC	67%	77%		
Refused Care Coordination (RCC)				
Number of member files audited	**90**	**90**		
BCBS	30	30		
PHP	30	30		
WSCC	30	30		
Number of member files correctly categorized	**73**	**82**		
BCBS	25	27		
PHP	26	29		
WSCC	22	26		

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% of member files correctly categorized	**82%**	**91%**		
BCBS	83%	90%		
PHP	87%	97%		
WSCC	73%	87%		

DY6 Q1 audit results for the TOC are listed in Table 5: Transition of Care Audit. During monthly calls, HSD discussed contract requirements for Transition of Care plans, follow-up care and follow-up assessments with each MCO. HSD requested updates on specific members which the MCOs outlined in monthly responses. BCBS updated their TOC process and conducted a training for care coordination staff. PHP revised their post transition assessment to include expanded narrative. WSCC conducted a targeted training for staff on required elements of the TOC plan as well as the post transition assessment. HSD received updates on all requested members with specific steps on outreach and engagement.

Table 4: Transition of Care Audit

TOC AUDIT	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
Inpatient (IP)				
Number of member files audited	**74**	**44**		
BCBS	30	15		
PHP	28	14		
WSCC	16	15		
Number of member files meeting HSD contract requirements	**29**	**25**		
BCBS	14	8		
PHP	10	9		
WSCC	5	8		
% of member files meeting HSD contract requirements	**39%**	**57%**		
BCBS	47%	53%		
PHP	36%	64%		
WSCC	31%	53%		
Nursing Facility (NF)				
Number of member files audited	**43**	**32**		
BCBS	23	15		
PHP	20	15		
WSCC	0	2		
Number of member files meeting HSD contract requirements	**19**	**21**		
BCBS	15	10		
PHP	4	9		
WSCC	n/a	2		

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TOC AUDIT	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
% of member files meeting HSD contract requirements	**45%**	**66%**		
BCBS	65%	67%		
PHP	20%	60%		
WSCC	n/a	100%		

DY6 Q1 audit results for the HRA and CCL are listed in Table 6: Health Risk Assessment and Care Coordination Level Audit. Each MCO provided clarification for any discrepancies identified in the HRA and CCL audits. HSD requested follow-up be conducted with members requiring a CNA per HRA audits. For the CCL audit, HSD requested the MCO reassess identified members to determine the correct Care Coordination Level per contract and policy.

Table 5: Health Risk Assessment and Care Coordination Level Audit

HRA AUDIT	DY6 Q1	DY6 Q2	DY6 Q3	DY6 Q4
Number of member files audited	**90**			
BCBS	30			
PHP	30			
WSCC	30			
Number of member files correctly referred for a CNA	**87**			
BCBS	29			
PHP	30			
WSCC	28			
% of member files correctly referred for a CNA	**97%**			
BCBS	97%			
PHP	100%			
WSCC	93%			
CCL AUDIT				
Number of member files audited	**90**			
BCBS	30			
PHP	30			
WSCC	30			
Number of member files with correctly assigned CCL	**86**			
BCBS	28			
PHP	29			
WSCC	29			
% of member files with correctly assigned CCL	**96%**			
BCBS	93%			
PHP	97%			

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CCL AUDIT				
WSCC	97%			

HSD will continue to monitor the MCOs' Care Coordination programs and identify and address any trends and provide technical assistance as needed.

BEHAVORIAL HEALTH

In DY6 Q2, access standards continue to be met, statewide, for behavioral health (BH) services with few exceptions and little change in urban, rural and frontier areas. Rural and frontier access standards are met with limited exceptions, for the following: Community Mental Health Centers (CMHC), Core Service Agency (CSA), FQHC's with BH services, Intensive Outpatient Services (IOP), Independent BH Practitioners, Outpatient Provider Agencies, Psychiatrists, and Psychologists.

Rural and frontier access standards for Assertive Community Treatment (ACT), Multi-systemic Therapy (MST), Day Treatment, Non-Accredited Residential Treatment, Treatment Foster Care, Indian Health Services and Tribal 638s providing BH, Rural Healthcare Clinics providing BH services and hospital services are not met by the majority of MCOs although they are typically contracted with all available providers in these areas. MCOs continue to frequently be contracted with the entire available network for some services such as all approved Inpatient Psychiatric Hospitals and General BH Acute Hospitals in New Mexico although access standards are not met.

MCOs continue to work to strengthen their relationships with the existing BH providers in their networks, meeting routinely with them and with the State to enhance efforts and enhance provider agencies and workforce. The collaborative MCO efforts continue to increase accessibility through increased opportunities to expand use of telemedicine, maintain open panels, and expand reimbursement for extended hours.

MCOs are looking at value-based purchasing agreements with providers to increase access with appointment availability and working to increase High Fidelity Wrap around services to meet member's needs. MCO Network contracting teams monitor the out-of-network providers from the single case agreement files to recruit additional practitioners to participate in the Behavioral Health network. Ongoing assessments by MCOs have continued to also identify recruitment opportunities with out-of-state border facilities for Inpatient BH services to ensure access. The MCOs utilize additional border resources to provide members with access to services.

SUD IMPLEMENTATION

The New Mexico Human Services Department has initiated new improvements to the Centennial Care 2.0 program with up to $34 million in enhancements, intended to fill BH service gaps and expand services to include:

- Individual and Family Peer Support
- After hours, weekends and holiday service
- Assertive Community Treatment
- Comprehensive Community Support Services
- Crisis Treatment Center and Crisis Stabilization
- Intensive Outpatient Services
- Opioid Treatment Program
- Partial Hospitalization expansion/incentives
- Screening, Brief Intervention and Referral to Treatment
- Accredited Residential Treatment Centers

Most of these services are implemented and clients are receiving care. The state is working with multiple sites to build up the Crisis Treatment Center/Crisis Stabilization and Accredited Residential Treatment Centers services and help establish their accreditation and Medicaid rate setting.

BH INTEGRATION

Promoting Integration of Primary and Behavioral Health Care Grant (PIPBHC)

PIPBHC is a $10,000,000 five-year SAMHSA grant aimed at promoting the integration of primary and behavioral health care for adults with mental illness (MI) and/or substance use disorder (SUD) along with chronic physical health conditions. Grant goals are to increase collaboration between primary care and behavioral health provider to promote fully integrated care; provide integrated care by providing evidence-based screening, assessment and treatment that are culturally and linguistically responsive to improve functioning and quality of life; provide health prevention and promotion services that are often not available to individuals with MI and/or SUDs; increase workforce of peer support workers and community health workers to engage service recipients in health promotion activities and care coordination; and work to build an improved and sustainable comprehensive system of integrated care in NM.

Two providers – Hidalgo Medical Services and Guidance Center of Lea County – will provide PIPBHC services in Hidalgo, Grant, and Lea counties. The UNM Health Sciences Center's Community for Behavioral Health Division is tasked with directing the evaluation and developing a fidelity tool for assessment and improvement of evidence-based integrated care practice. A grant steering committee has been established and meets biweekly. During the first six months of the grant, the providers have focused on hiring and training staff, developing procedures for staffing integration, engaging community partners, and initiating outreach. Enrollment began successfully in February. To support broader statewide integration, the grant supports an Advisory Council, with state-level representation from behavioral and primary health, whose aim is to provide guidance and feedback for quality improvement, sustainability and scalability of the grant program.

Health Homes

On April 1, 2016 HSD launched the first two Health Homes, CareLink NM (CLNM), with a designated population of adults with serious mental illness (SMI) and children/adolescents with severe emotional disturbance (SED). On April 1, 2018 HSD implemented Health Homes services in eight additional counties to address the same target population. The CLNM model in all sites provides for enhanced care coordination and integration of primary, acute, behavioral health, long term care services and social supports.

Goals include: 1) Promoting acute and long-term health; 2) Preventing risk behaviors; 3) Enhancing member engagement and self-efficacy, 4) Improving quality of life for members with SMI and SED; and 5) Reducing avoidable utilization of emergency department, inpatient, and residential services. These goals serve as the foundation for establishing both quality process standards and evaluation criteria for outcomes.

Table 6: Number of Members Enrolled in Health Homes

NUMBER OF MEMBERS ENROLLED IN HEALTH HOMES	
Q1 (JANUARY – MARCH 2019	Q2 (APRIL – JUNE 2019)
2,540	2,814

Supportive Housing

A Center for Medicaid Services (CMS) has approved the supportive housing benefit in Centennial Care 2.0 for Medicaid eligible individuals enrolled in the Linkages Permanent Supportive Housing program. The benefit will include pre-tenancy and tenancy sustaining supports provided by peers of Linkages service providers. Linkages serves individuals with serious mental illness, who are homeless or precariously housed, extremely low income, and functionally impaired.

- Total projection for state fiscal year 2020 for waiver Demonstration
- Clients to be served approximately 180
- Monthly rate $450
- Annually $972,000
- Training for MCOs is scheduled for August 14, 2019

Program Manager provided training with MCOs on the following:

- Supportive Housing Program – client verification (no MCO prior authorization needed)
- Provide information about range of billable supports and requirement for the bundled rate
- Billing codes/fee schedule and Billing and Policy Manual
- Program Manager will provide technical assistance to providers and MCOs as needed to establish Medicaid Linkages Supportive Housing.

COMMUNITY HEALTH WORKERS (CHWS)

HSD established CY19 as the baseline year for the Centennial Care 2.0 Managed Care Organizations (MCOs) to provide 3% of total member enrollment with Community Health Workers (CHWs) and Community Health Representatives (CHRs) services, as part of the CHW Delivery System Improvement Performance Target (DSIPT). A total of 142 CHWs employed or contracted by the MCOs, was reported in the first quarter. Workforce titles include, CHWs, Community Health Representatives (CHRs), Community Paramedics, Family Support Specialists and Peer Support Workers (PSWs). CHRs are reported to serve members in the Navajo Nation area of the state with services that include native language translation. Please see Table 7: Summary of CHW Workforce by MCO.

Table 7: Community Health Worker Workforce

COMMUNITY HEALTH WORKER WORKFORCE (JANUARY – MARCH 2019)	
MCO	**TOTAL**
BCBS	61
PHP	43
WSCC	38
Total	142

CHW interventions provided in Q1 included the following types of services:

- Social Determinates of Health Assessment
- Health Assistance-including PCP appointments, HRAs, and preventative care
- Health Education
- Hepatitis C Treatment Outreach
- Smoking Cessation
- Recovery Support Assistance
- ED Education Post-Discharge Follow-ups
- Prenatal & Postpartum Care Program
- Translation Services

Unduplicated members served in rural, frontier and urban areas by MCO reached 9,199 for Q1CY19. Please see Table 8: Unduplicated Members Served by CHWs.

Table 8: Unduplicated Members Served by CHWs

UNDUPLICATED MEMBERS SERVED BY CHWS (JANUARY – MARCH 2019)	
MCO	**TOTAL**
BCBS	4,034
PHP	4,605
WSCC	560
Total	9,199

MCO reporting includes geographic utilization of CHW services by county of member residence in urban, rural and frontier regions of New Mexico. Please see region detail in Table 9: Geographic Utilization of Community Health Workers.

Table 9: Geographic Utilization of CHWs

GEOGRAPHIC UTILIZATION OF CHWS (JANUARY – MARCH 2019)			
MCO	URBAN	RURAL	FRONTIER
BCBS	2,443	1,308	283
PHP	3,000	1,320	285
WSCC	340	188	32
Total	5,783	2,816	600

Centennial Home Visiting (CHV) Pilot Program

In DY6 Q2, the numbers of CC MCO member enrollments for each home visiting (HV) program are as follows:

- **Nurse Family Partnership (NFP):** 6 members
  There was only one newly hired NFP nursing staff at the UNM Center for Development and Disability (UNM CDD) dedicated for the CHV Pilot Program. Per the NFP model, the UNM CDD NFP program had a capacity of 25 new families for which this new nurse can be responsible. After training, the new nurse started to provide services to families in the second quarter.

- **Parents as Teachers (PAT):** 3 members
  The capacity of UNM CDD and ENMRSH (the agency that contracts to provide services in Curry and Roosevelt counties) to provide the PAT HV services is 40 and 20 families, respectively.

Although receiving many referrals, both CHV providers (UNM CDD and ENMRSH) had identified some challenges in families enrolling with the CHV program as follows:

- Program startup costs as the agencies have to expand their infrastructure prior to being able to provide and bill for Medicaid services;

- Administrative requirements such as Medicaid provider application process, contracting processes between the agencies and each of the three Centennial Care MCO, billing process, referral process as the CHV is a new way for the two HV agencies to do business

to provide the newly waived, Medicaid-covered services;

- The families referred do not always accept and volunteer to sign up for the services;
- Some referred families are hard-to-contact or hard-to-locate; and
- Pregnancy diagnosis for low-income/Medicaid women may not always occur at a doctor's office, which makes first-trimester referral to some HV programs like NFP challenging.

HSD has worked with the New Mexico Children, Youth and Families Department (CYFD) to recruit new agencies who would contract with CYFD as well as serve as Medicaid CHV providers in a county-wide fashion to ensure that all NM families would not be denied HV services due to the lack of pay source, either because they are not eligible for Medicaid or because they lose Medicaid eligibility during their course of receiving HV services. Currently, CYFD and HSD are working with a Pueblo to expand CHV services to another county. HSD will report then number of enrollments in DY6 Q3, which are occurring at a higher rate than DY6 Q2.

Presumptive Eligibility Program

The NM HSD Presumptive Eligibility (PE) program continues to be an important part of the State's efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some NM State Agencies including the NM Department of Health (DOH), NM Children Youth and Families Department (CYFD) and the NM Corrections Department (NMCD). Currently, there are approximately 713 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assisting with on-going Medicaid application submissions.

Staff in the Medical Assistance Division's Communication and Education Bureau (CEB) 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 six PE certification trainings and four YESNM-PE demo refresher trainings.

PE approvals, ongoing application submissions, and resulting eligibility determinations that occur in a reporting quarter will be reported in the next reporting period. For example, data for DY6Q1 will be reported in DY6Q2. This will ensure eligibility and enrollment data that results from the PE program is accurately reflected for the reporting period.

Table 10: PE Approvals outlines the numbers of PE approvals granted and the total number of ongoing applications submitted and approved. NM PEDs are aware of the importance of on-going Medicaid coverage for their clients. This is reflected by the high number of PE approvals that also had an ongoing application submitted in DY6Q1 (99.2% in January and 100% in both February and March).

Table 10: PE Approvals

PE APPROVALS (JANUARY – MARCH 2019)				
MONTH	PES GRANTED	% PE GRANTED W/ONGOING APPLICATION SUBMITTED	TOTAL INDIVIDUALS APPLIED	INDIVIDUALS APPORVED
January	264	99.2%	1,888	1,535
February	175	100.00%	1,630	1,340
March	218	100.00%	1,771	1,448
Q1 Totals	656	99.69%	5,289	4,323

JUST HEALTH PROGRAM

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

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

It is HSD's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, Behavioral Health appointments, etc.) upon release. To help facilitate access to care and ensure smooth transitions from correctional facilities, HSD has established the Centennial Care JUST Health workgroup. The workgroup includes

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

The following table outlines the numbers of PE approvals granted and the total number of ongoing applications submitted and approved. In all three months of DY6 Q1, 100% of all PE approvals also had an ongoing application submitted.

Table 11: PE Approvals

PE APPROVALS (JANUARY – MARCH 2019)				
MONTH	PES GRANTED	% PE GRANTED W/ONGOING APPLICATION SUBMITTED	TOTAL INDIVIDUALS APPLIED	INDIVIDUALS APPORVED
January	11	100.00%	146	136
February	26	100.00%	147	138
March	22	100.00%	190	180
Q1 Totals	59	99.69%	483	454

7
HCBS REPORTING

Critical Incidents	
2nd Quarter Activities	HSD/MAD conducted a quarterly meeting with MCOs and external stakeholders to discuss critical incident reports (CIRs) expectations, barriers, and challenges. The discussion emphasized the MCOs responsibility in completing necessary follow-up activities that monitor members' health, safety and welfare until there is no longer a concern. The quarterly meeting also included discussion regarding the development of the annual provider CIR trainings to be held in September 2019. HSD/MAD conducted daily reviews of critical incidents submitted by MCOs and providers for the purpose of ensuring reports meet reporting requirements. HSD/MAD provided daily assistance to MCOs and providers to obtain access to the CIR Portal by establishing and/or resetting login credentials as well as deleting duplicate reports.

TOTAL CRITICAL INCIDENTS REPORTED (JANUARY – MARCH 2019)				
MCO	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	DY6 Q1 TOTAL
BCBS	1,501	75	96	1,672
PHP	4,263	137	293	4,693
WSCC	245	11	11	267
Total	6,009	223	400	6,632

BCBS (January - March 2019)				
CRITICAL INCIDENT TYPES	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	TOTAL FOR QUARTER
Abuse	70	15	3	88
Death	159	2	3	164
Elopement/Missing	6	2	1	9
Emergency Services	978	24	80	1082
Environmental Hazard	12	1	1	14
Exploitation	27	0	2	29
Law Enforcement	23	6	2	31
Neglect	226	25	4	255
All Incident Types	1,501	75	96	1672

PHP (January - March 2019)				
CRITICAL INCIDENT TYPES	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	TOTAL FOR QUARTER
Abuse	192	33	12	237
Death	330	5	11	346
Elopement/Missing	6	1	0	7
Emergency Services	2,914	33	238	3185
Environmental Hazard	66	4	5	75
Exploitation	42	3	4	49
Law Enforcement	41	11	4	56
Neglect	672	47	19	738
All Incident Types	4,263	137	293	4693

WSCC (January - March 2019)				
CRITICAL INCIDENT TYPES	CENTENNIAL CARE	BEHAVIORAL HEALTH	SELF DIRECTED	TOTAL FOR QUARTER
Abuse	22	4	2	28
Death	27	0	1	28
Elopement/Missing	1	1	0	2
Emergency Services	126	1	6	133
Environmental Hazard	13	1	1	15
Exploitation	1	0	0	1
Law Enforcement	0	0	0	0
Neglect	55	4	1	60
All Incident Types	245	11	11	267

Consumer Support Program

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

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

Table 12: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT (APRIL – JUNE 2019)	
TOPIC	**NUMBER OF CALLS**
Home/Community Based Care Waiver Programs	3,077
Long Term Care/Case Management	8
Medicaid Appeals/Complaints	5
Personal Care	314
State Medicaid Managed Care Enrollment Programs	75
Medicaid Information/Counseling	1,096

Table 13: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT (APRIL – JUNE 2019)			
COUNSELING SERVICES	**NUMBER OF HOURS**	**NUMBER OF NURSING HOME RESIDENTS**	**NUMBER OF CONTACTS**
Transition Advocacy Support Services		204	
*Medicaid Education/Outreach	2,257		
Nursing Home Intakes		92	
**LTSS Short-Team Assistance			232

*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.

Transition to Centennial Care 2.0

During this reporting period, all LTSS transition activities to Centennial Care 2.0 were completed and related issues were addressed. HSD meets monthly with the MCOs through the Centennial Care Long-Term Care (LTC) workgroup. In DY 6 Q2, topics included CC 2.0 transition and program changes, such as implementation of the ongoing NF LOC, and changes to the Self-Directed Community Benefit (SDCB). MCO reporting requirements and provider rate increases were also discussed.

Electronic Visit Verification (EVV)

In DY6 Q2, HSD, in partnership with the MCOs, continued to operate EVV for Agency-Based Personal Care Services. All parties are working towards implementation of EVV for the Self-Directed Community Benefit to meet the Cures Act requirements. Agency-Based Personal Care Services Please EVV data for DY6 Q1 is outlined in the table below. The MCOs reported that 76% of the total PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder were created through the First Data Authenticare app.

Table 14: EVV DATA

EVV (JANUARY – MARCH 2019)		
MCO	**AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD**	**NUMBER OF TOTAL CLAIMS THIS PERIOD**
BCBS	6,867	363,117
PHP	14,540	913,756
WSCC	1,254	88,811
TOTAL	22,661	1,365,684

Statewide Transition Plan

HSD continues to update the Statewide Transition Plan (STP) milestones as required by CMS. HSD plans to issue the STP for public comment in October 2019 and resubmit the plan to CMS by the end of the year.

Nursing Facility Level of Care (NF LOC)

HSD requires the MCOs to provide a summary of their internal audits of NF LOC Determinations. Each MCO conducts internal random sample audits of both Community Based and Facility Based determinations completed by their staff based on the HSD NF LOC Criteria and Instructions guidelines. The audit includes accuracy, timeliness, consistency and training of reviewers. The results and findings are reported quarterly to HSD along with any Quality Performance Improvement Plan. BCBS conducted 98 audits, PHP conducted 33, and WSCC conducted 36 audits of NF LOC Determinations during DY6 Q1. PHP indicated that during the months of January and February the Utilization Management Long Term Care team developed and refined the audit tools accounting for the months with a low number of audits. Beginning in Q2, PHP will be auditing 2 charts per reviewer per month, for a total of 6 per reviewer per quarter.

Table 15 –MCO Internal NF LOC Audits– Facility Based

Facility Based Internal Audits				
High NF Determinations	**Jan**	**Feb**	**Mar**	**DY6 Q1**
Total number of High NF LOC files audited	**1**	**5**	**3**	**9**
BCBS	1	3	1	5
PHP	-	-	-	-
WSCC	-	2	2	4
Total number with correct NF LOC determination	**1**	**5**	**3**	**9**
BCBS	1	3	1	5
PHP	-	-	-	-
WSCC	-	2	2	4
Percent of correct High NF LOC determinations	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	-	-	-	-
WSCC	-	100%	100%	100%
Low NF Determinations	**Jan**	**Feb**	**Mar**	**DY6 Q1**
Total number of Low NF LOC files audited	**11**	**6**	**17**	**34**
BCBS	7	5	7	19
PHP	-	-	5	5
WSCC	4	1	5	10
Total number with correct NF LOC determination	**11**	**6**	**17**	**34**
BCBS	7	5	7	19
PHP	-	-	5	5
WSCC	4	1	5	10
Percent of correct Low NF LOC determinations	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	-	-	100%	100%
WSCC	100%	100%	100%	100%

Timeliness of Determinations	Jan	Feb	Mar	DY6 Q1
Total number of High NF LOC determinations completed within required timeframes	**1**	**5**	**3**	**9**
BCBS	1	3	1	5
PHP	-	-	-	-
WSCC	-	2	2	4
Percent of High NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	-	-	-	-
WSCC	-	100%	100%	100%
Total number of Low NF LOC determinations completed within required timeframes	**11**	**6**	**17**	**34**
BCBS	7	5	7	19
PHP	-	-	5	5
WSCC	4	1	5	10
Percent of Low NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	-	-	100%	100%
WSCC	100%	100%	100%	100%

Table 16: Quarterly MCO Internal NF LOC Audit Report – Community Based

Community Based Internal Audits	Jan	Feb	Mar	DY6 Q1
Total number of Community Based NF LOC files audited	**33**	**31**	**60**	**124**
BCBS	24	26	24	74
PHP	-	-	28	28
WSCC	9	5	8	22
Total number with correct NF LOC determination	**33**	**31**	**60**	**124**
BCBS	24	26	24	74
PHP	-	-	28	28
WSCC	9	5	8	22
Percent of correct NF LOC determinations	**100%**	**100%**	**100%**	**100%**
BCBS	100%	100%	100%	100%
PHP	-	-	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations	**Jan**	**Feb**	**Mar**	**DY6 Q1**
Total number of Community Based determinations completed within required timeframes	**32**	**24**	**51**	**107**
BCBS	24	21	16	61
PHP	-	-	28	28
WSCC	8	3	7	18
Percent of Community Based determinations completed within required timeframes	**97%**	**77%**	**85%**	**86%**
BCBS	100%	81%	67%	83%
PHP	-	-	100%	100%
WSCC	89%	60%	88%	79%

External Quality Review Organization (EQRO) NF LOC

HSD requires that the MCOs report to the state quarterly, a monthly breakdown of all the NF LOC determinations/redeterminations that were conducted. This report includes the total number of NF LOC determinations completed, the number of determinations that were completed timely, and the number of assessments completed where the member did not meet LOC based on HSD NF LOC Criteria and Instructions.

Table 17: Quarterly MCO NF LOC Determinations- Facility Based

Facility Based Determinations				
HIGH NF Determinations	Jan	Feb	Mar	DY6 Q1
Total number of determinations/redeterminations completed for High NF LOC requests	**57**	**53**	**64**	**174**
BCBS	12	8	9	29
PHP	44	40	47	131
WSCC	1	5	8	14
Total number of determinations/redeterminations that met High NF LOC criteria	**46**	**46**	**60**	**152**
BCBSNM	12	8	9	29
PHP	33	33	43	109
WSCC	1	5	8	14
Percent of determinations/redeterminations that met High NF LOC criteria	**81%**	**87%**	**94%**	**87%**
BCBSNM	100%	100%	100%	100%
PHP	75%	83%	91%	83%
WSCC	100%	100%	100%	100%
Low NF Determinations	Jan	Feb	Mar	DY6 Q1
Total number of determinations/redeterminations completed for Low NF LOC requests	**492**	**415**	**497**	**1404**
BCBS	121	110	115	346
PHP	334	278	367	979
WSCC	37	27	15	79
Total number of determinations/redeterminations that met Low NF LOC criteria	**485**	**402**	**491**	**1378**
BCBSNM	121	110	115	346
PHP	327	265	361	953
WSCC	37	27	15	79
Percent of determinations/redeterminations that met Low NF LOC criteria	**99%**	**97%**	**99%**	**98%**
BCBSNM	100%	100%	100%	100%
PHP	98%	95%	98%	97%
WSCC	100%	100%	100%	100%
Timeliness Determinations	Jan	Feb	Mar	DY6 Q1
Total number of High NF LOC determinations/redeterminations completed within required timeframes	**23**	**33**	**40**	**96**
BCBS	4	4	4	12
PHP	18	26	28	72
WSCC	1	3	8	12
Percent of High NFLOC determinations/redeterminations completed within required timeframes	**40%**	**62%**	**63%**	**55%**
BCBS	33%	50%	44%	41%
PHP	41%	65%	60%	55%
WSCC	100%	60%	100%	86%
Total number of Low NF LOC determinations/redeterminations completed within required timeframes	**288**	**310**	**384**	**982**
BCBS	88	95	96	279
PHP	175	190	273	638
WSCC	25	25	15	65
Percent of Low NF LOC determinations/redeterminations completed within required timeframes	**59%**	**75%**	**77%**	**70%**
BCBS	73%	86%	83%	81%
PHP	52%	68%	74%	65%
WSCC	68%	93%	100%	82%

Table 18: Quarterly MCO NF LOC Determinations- Community Based

Community Based Determinations	Jan	Feb	Mar	DY6 Q1
Total number of determinations/redeterminations completed	**1909**	**2106**	**2493**	**6508**
BCBS	275	371	450	1096
PHP	1509	1518	1778	4805
WSCC	125	217	265	607
Total number of determinations/redeterminations that met NF LOC criteria	**1824**	**1987**	**2370**	**6181**
BCBSNM	275	371	450	1096
PHP	1424	1401	1661	4486
WSCC	125	215	259	599
Percent of determinations/redeterminations that met NF LOC criteria	**96%**	**94%**	**95%**	**95%**
BCBSNM	100%	100%	100%	100%
PHP	94%	92%	93%	93%
WSCC	100%	99%	98%	99%
Timeliness of Determinations	**Jan**	**Feb**	**Mar**	**DY6 Q1**
Total number of determinations/redeterminations completed within required timeframes	**896**	**842**	**956**	**2694**
BCBS	161	330	400	891
PHP	683	378	339	1400
WSCC	52	134	217	403
Percent of determinations/redeterminations completed within required timeframes	47%	40%	38%	41%
BCBS	59%	89%	89%	81%
PHP	45%	25%	19%	29%
WSCC	42%	62%	82%	66%

During DY6 Q2, HSD also followed up on EQRO determination disagreements identified in the previous quarter. The EQRO audit in DY6 Q1 indicated ten determination disagreements for BCBS, two for PHP and two for WSCC. HSD requested clarification for discrepancies identified in audit documentation, status updates on the identified members, and plans to improve the accuracy of determinations.

BCBS addressed discrepancies identified in ten audit files. For two audit files, BCBS provided missing documentation from the original submissions that were not submitted with the audit packet. For another file, BCBS provided clarification that an older version of the Minimum Data Set (MDS) was used for the NF LOC review rather than the most recent version and noted that the UM reviewer had been provided retraining regarding this requirement. BCBS also provided clarification for a HNF approval for behavioral issues and confirmed that HNF should not have been approved based the information in the audit packet, which did not indicate daily ongoing symptoms. BCBS indicated that the reviewer for this decision had received 1:1 coaching on the specific issues for this determination. For the six remaining audit files, BCBS acknowledged that these NF LOC requests lacked written documentation to support the Nursing Facilities' requests for late submissions. BCBS indicated that they have implemented a Late Log process, as prescribed in a pending letter of direction from HSD, to address these late submissions.

PHP provided clarification for two identified discrepancies for ongoing NF LOC approvals. The statement that is completed and signed by the member's PCP that documents the member's ongoing Activities of Daily Living (ADL) deficits related to the member's primary diagnosis was not found in either audit file. PHP provided clarification that they understood this as annual requirement for subsequent years and was not required for the initial approval. After review of the response, HSD provided clarification during the quarterly LTSSB workgroup meeting in June 2019 that the statement by the member's Primary Care Provider was also required for initial approval of ongoing NF LOC as well as for annual review.

WSCC provided clarification for discrepancies in two audit files. For one file, WSCC noted that an incorrect notification form had been uploaded with the audit packet. For the other file, WSCC provided clarification that an older MDS was uploaded with the audit file instead of the most recent MDS. WSCC stated that they would work with their audit team to ensure that the proper documents are validated prior to submission for review.

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.

8
AI/AN REPORTING

MCO	Date of Board Meeting	Issues/Recommendations
PHP	Chamisa Room, Presbyterian Espanola Hospital Espanola, NM April 26, 2019	• Issues with not connecting with Care Coordinator. These issues were referred to Ombudsman. • Traditional Medicine Benefit and how to obtain funding. The process was reiterated and information regarding assistance was provided.
BCBS	Zuni, New Mexico April 17, 2019	Native American Advisory Board meeting was held on April 17, 2019 in Zuni New Mexico. 90 attendees included: 55 Blue Cross Community Centennial members, 19 guests, 3 providers/community partners and 13 BCBSNM Staff. The agenda and presentation focused on: NAAB Orientation, Overview of Blue Cross Community Centennial, Care Coordination, Community Social Services, Behavioral Health/Peer Support, Dental Care, LogistiCare non-emergency medical transportation, Ombudsman/Virtual Visits and Health Education. Feedback from the meeting included: happy and satisfied with BCCC and the benefits. Recommendations included a request for a monthly newsletter to the community and training for services provided locally. Translation in the Zuni language was provided.
WSCC	Farmington, New Mexico March 27, 2019.	Originally the NAAB was to take place on April 2, 2019 at 5:00 pm, however due to scheduling conflicts with the hosting facility WSCC was given the alternate meeting date. WSCC considered switching the meeting to a later date, however necessary WSCC staff were not available. Invitations were verbally sent to local tribal leaders that included the Navajo Nation

		Office of the President, Navajo Nation Council Oversight Committee Health Education and Human Services Committee members and other local leaders. Providers from both the Northern Navajo Medical Center and the DzilthNaaHooDilthnee clinics were also invited to the board meeting. Western Sky Community Care Native American members within the local community area were invited through phone calls by tribal liaisons. There were thirteen Western Sky Community Care members that attended the event, in which they were provided with a dinner and $20 Wal-Mart incentive for attendance. Western Sky Community Care department representatives that attended the event consisted of Tribal Relations, Customer Service, Care Coordination, Provider Relations, and Quality Improvement. We also had a representative from San Juan Center for Independence in attendance. Presentation topics by the respective Western Sky Community Care representative included, Value Added Services, Customer Service, Care Coordination, Provider Relations, Quality Improvement, Cultural Competency, and Ombudsman. The overall tone of those individuals in attendance had provided positive feedback as we were able to provide one-on-one interaction with members after the presentation by reviewing their benefits and eligibility with on-site Western Sky Community Care staff. Western Sky Community Care staff onsite completed three Traditional Healing Benefit forms and assisted three members by reviewing their benefits and eligibility. Additional feedback and suggestions were to provide advance notice through flyers posted within the community and announcements be available over the radio, as

		many Native American member source of communication is through the air waves. It was also recommended that presentation be translated into the respective language.

Table 19: Status of Contracting with MCOs

MCO	Status
BCBS	BCBS continues to work with Okay Owingeh Health and Human Services Department, Santa Fe Indian Health Board, Pueblo of Zuni Council, San Felipe Pueblo, Laguna Pueblo, Pueblo of Acoma, and Pueblo CHR Association. In Q2, BCBS presented on care coordination delegation to the Zuni CHR group, Laguna CHR group and the CHR association in Ignacio. BCBS continues to treat non-contracted I/T/U providers as in network providers and they are included in the BCBS provider directory.
PHP	We met with the following I/T/Us and tribal programs. Navajo Nation Region 1 CHR Program Met with the SRSU CHR Supervisor and discussed developing their staff to document their work with our members to submit for invoicing. She has requested to meet with the Navajo Nation Director to discuss working with PHP to meet our member's needs. Tse Daa K'aan Chapter Discussed the SRSU CHRs account and submitting EFT documents for electronic funds transfers. First Nations Community Healthsource (FNCH) We met with FNCH's CEO and Medical Director to discuss the Hepatitis C Provider Incentive Program. They are interested in the program but are concerned with the challenges they have with their patients. They inquired about an incentive for their patients and ways to ease access to medication and treatment. Their HIV Program also does Hep C testing at their Farmington and Gallup satellites. We will continue to meet with them to develop this program. First Nations Community Healthsource (FNCH) Traditional Wellness Program We continue to meet with the FNCH staff to improve the referral process. As FNCH has developed collaboration with other tribal programs like the National Indian Youth Council (NIYC) for their first Summer Youth Wellness Program, we have collaborated with FNCH and NIYC to support their summer youth partnership. We have invited Blue Cross Blue Shield and

	Western Sky with these collaborative efforts to bring additional resources to these programs and the families they serve. National Indian Youth Council We had our first intern from the National Indian Youth Council (NIYC) start in November 2018. We have developed an agreement with NIYC to have their interns work at Presbyterian Health Plan. The first intern assisted the Native American Affairs program and the Government Programs Education and Outreach department. Our Education and Outreach department has been working with NIYC to continue the internship program at PHP and have requested the next intern for their program. Kewa Family Wellness Center (KFWC) We continue to work with the Executive Director to develop an agreement that the Governor and Tribal Council will approval to move this program forward with reimbursing for services provided to our members. KFWC is very interested in continuing their partnership with us and to help with developing agreements with the other MCOs. Native American Professional Parent Association (NAPPR) I have been meeting with the Executive Director and Program Managers about developing a partnership to assist with their work in tribal communities and with urban Indians. They are very interested in moving forward and identifying areas they would like to focus on for a pilot project. Native American Training Institute (NATI) They have identified areas they would like to focus on and need assistance with funding. We will provide technical assistance to the board to prepare for funding requirements. Mescalero Apache Tribe We will be meeting with the CHR Program to discuss their IT infrastructure, documentation, referral processes. New Mexico/Southern Colorado CHR Association We provided a joint presentation with BCBS and Western Sky at their 2nd quarter meeting and invited them to join the MCO/HSD Collaborative committee. They were receptive to this request and were open to continuing discussion and to meet with the Committee to develop agreements with the MCOs. Kewa Pueblo Health Corporation We continue to work with them as they expand their services and to provide technical assistance. As their staff continues to grow, we will provide training and support. We will meet with their leadership to continue discussion of developing a VBP arrangement with their health center.

WSCC	In the second quarter Western Sky Community Care's Tribal Relations department shifted our main focus from outreach to Tribal Leaders and Tribal programs on entering into contracts or agreements for Medicaid based services, to implementation and maintaining the contracts obtained in 2018 and in the first quarter of the year. At the beginning of the second quarter Western Sky Community Care had previously established full contracts for all services with Alamo Health Center (Navajo), Pueblo of Jemez Health Clinic, Fort Defiance Hospital (Navajo) and Ramah Health Center (Navajo). Also established were contracts for specific services such as Community Health Representatives, long Term Care Services and Supports and Behavioral Health, these included; Eight Northern Indian Pueblos Council, Five Sandoval Indian Pueblos inc., Pueblo of Isleta Elder Center, Pueblo of Zuni Home Health, and Pueblo of Santa Clara Behavioral Health program. Tribal Relations continued to meet with Tribes in which we still had extended contracts to as part of an ongoing dialogue with interested programs. These tribes included; Jicarilla Apache, Laguna Pueblo, Cochiti Pueblo, Acoma Pueblo, Ohkay Owingeh, Picuris Pueblo, Sandia Pueblo, Santo Domingo Pueblo, Zia Pueblo, and San Felipe Pueblo. On average Tribal Relations staff met with representatives from these tribes twice a month on contracting for services, these activities happened outside of our member outreach efforts. Outstanding obstacles continue to be: • Low education and understanding of Medicaid services as they relate to Tribal Programs by Tribal Leadership and tribal Administration staff. • Tribal Legal department's interpretation on contract language, length of contractual documents and information required to provide regarding credentialing providers. • Mistrust of Managed Care Organizations and the State of NM intent in offering contracts for services Western Sky Community Care continued to meet with non-Tribal Governmental entities such as the Albuquerque Area and Navajo Area Indian Health Service, the All Pueblo Council of Governors, the 10 Southern Governors Council, the Eight Northern Indian Pueblos Council inc., and the New Mexico Southern Colorado Community Health Representative Association. Western Sky Community Care discussed with these entities, needs of the community and received guidance on contract language and possible scope of work language for services that do not have corresponding CPT codes in the Medicaid program.

9

ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

MCO	ACTION PLAN	ISSUES	RESOLUTION
BCBS	Remediate Care Coordination Audit Findings Implementation Date: 7/19/2016 Completion Date: Open Item	Overall care coordination with focus on improved practice following the record review and the onsite review	The CNA compliance rate for DY6Q2 remains relatively consistent to DY6Q1 at 92%. BCBS leadership team continues to audit initial CNAs to ensure appropriate compliance. In addition, BCBS is in the process of implementing a caseload tracker that will give the staff a snapshot view of all upcoming CNAs to ensure timeliness. A training on utilization of the caseload tracker will occur by 7/30/19. Since the implementation of Centennial Care 2.0, several trainings related to HRA have occurred and with the HSD approved revised scope for the HRA, Q2 compliance was 92%. For Action Step 1, leveling of waiver members greatly improved from 56% to 90% in Q2. The increase in compliance is due to the implementation of a dedicated 1915 (c) waiver team that began training in December of 2018. This staff is now oriented and understands the appropriate assignment process for Level 2 and Level 3 members. BCBS will continue to work closely with 1915 (c) case managers to ensure adequate collaboration and touchpoints are occurring and the

MCO	ACTION PLAN	ISSUES	RESOLUTION
			members needs are adequately met. For Action Step 2, easily understood language in ABD letters, a UM denial audit was conducted for Q1. Denial letter language reading level and readability was at 97%. The Medical Directors continue to refine and update their denial verbiage tool. Monthly denial audits are ongoing. For Action Step 3, detailed disaster and back-up plans, an additional training was conducted in April 2019 and the Q2 audit results showed an improvement with an overall score of 90%. Additional trainings are scheduled on July 10th and July 18th for newly hired staff and to retrain any staff that did not score 100% on their audits.
BCBS	Care Coordination Activities Implementation Date: 12/21/2018 Completion Date: Open Item	This action plan includes the following areas that require improvement: 1. Compliance of Care Coordination Activities (Timeliness and clinical appropriateness) with HRA/CNA/NF LOC – **Closed** (In the first quarter of 2019, the Healthcare Management team focused on updating the processes for	The Oversight Action Plan continues to be monitored weekly to document progress towards resolution of open items (Action Items 2 and 3). The process document for the BCBS staff training evaluation and effectiveness plan is in the finalization stages and will be implemented in staff trainings targeted for Q3. Care coordination management staff is meeting weekly with reporting staff working to improve operational reports and

MCO	ACTION PLAN	ISSUES	RESOLUTION
		conducting HRAs and CNAs timely, worked on refining the auditing of care coordinators work related to timeliness and re-training staff on the updated processes and revised audit tool. BCBS is in the process of finalizing workflows for oversight of the Delegated Care Coordination Entities. BCBS is currently working with PMS to be contracted as a DCCE and an effective date not yet been determined.) 2. Staff Training Evaluation/ Effectiveness Plan 3. Reporting 4. Burndown Plan – **Closed** (HRA backlog was completed on 12/31/18, CNA and NFLOC backlog was completed on 4/22/19.)	ensure staff can effectively manage the business.
BCBS	PCP Auto Assignment Implementation Date: 4/25/2019 Completion Date: Open Item	BCBS identified an issue with PCP assignments for Centennial Care transition members. The enrollment system typically flags new members for auto-assignment, however	BCBS has provided HSD with weekly remediation plan updates since 4/25/2019 that outline the interim and long-term remediation efforts and timelines to remedy the PCP auto assignment issue. As of 5/17/2019, all interim remediation efforts were completed, which included; identification of impacted

MCO	ACTION PLAN	ISSUES	RESOLUTION
		the members did not get flagged as “new”, causing the auto-assign process to skip these members in the normal process.	members, development of an automated solution to assign all impacted members to a PCP, completion of user acceptance testing prior to deploying the automated solution, and production validation after the automated solution was deployed. Notification was sent to impacted members and ID cards were generated with the new PCP name. BCBS also implemented several new monitoring process' and completed an end-to-end review of the PCP assignment process to identify opportunities to improve systematic PCP auto assignment logic. BCBS is working with IT teams to finalize the requirements of the systematic PCP auto-assignment process, and then move into the next phases of development.
PHP	Vision Service Plan: Utilization Management Audit Area Implementation Date: 9/20/2018 Completion Date: Open Item	Annual Audit, 9/20/18	PHP and VSP disagree on the UM findings resulting from the audit conducted on 9/20/18. Therefore, the UM element received N/A (not applied) for scoring purposes. PHP will keep HSD apprised of its response.
PHP	Superior Medical Transportation (SMT) Implementation Date: 3/29/2019	Improvement Plan-wheelchair access issues	Measure: Ensure all members requiring wheelchair transportation are transported to and from appointments via appropriate wheelchair vehicles to meet members transportation needs. Goal: 100% compliant SMT updates as of 6/10/19:

MCO	ACTION PLAN	ISSUES	RESOLUTION
			SMT is working aggressively at building the wheelchair vehicle network throughout the State. SMT continues to evaluate the need for additional wheelchair units so they can strategically place wheelchair vans in areas where wheelchair units are scarce. The fleet expansion will fill the voids in the frontier and rural communities. SMT's update to this IP is due on/or before 7/25/19.
PHP	Superior Medical Transportation Implementation Date: 5/13/2019	Improvement Plan-Transportation Provider No Show	Measure: Ensure all members are picked up for their appointments and return home transports Goal: 100% compliant SMT updates as of 6/5/19: SMT is closely monitoring Provider No Shows by Contracted Transportation Providers (CTPs). SMT's on-going monitoring and process improvements of Provider No Shows are as follows: 1. CTPs are required to immediately provide an explanation to SMT for not picking up members. 2. When CTPs have 3 No Shows within a 2-week period, SMT will send a Provider Action Letter asking for written process improvements and timeline for correction. 3. If the CTP has 3 No Shows outside the 2-week period, SMT will address the issue with the CTP’s owners to discuss process improvements to identify a solution and resolve the issues.

MCO	ACTION PLAN	ISSUES	RESOLUTION
			4. SMT is re-educating SMT's CSRs & schedulers who have been the root cause of some of Superior Medivan's no shows. SMT's management is discussing back up plans with the Medivan Supervisor when drivers call off unexpectedly. SMT's update to this IP is due on/or before 7/25/19.
WSCC	Incorrect Fax Number Implementation Date: 2/8/2019 Completion Date: Open	An incorrect fax number was printed in the member handbook, welcome brochure, member grievance and appeal letters, UM and Pharmacy denial letters and on the member website.	WSCC has taken the following actions to investigate and mitigate the possible disclosure of personal or protected health information: • WSCC made numerous attempts using multiple avenues to identify the owner of the incorrect fax number. WSCC's communications carrier was able to contact the owner of the fax line, however the owner is not willing to communicate with WSCC. WSCC is continuing its efforts to contact the number owner. • WSCC posted a message on its member and provider website to make customers aware of the incorrect fax number. The posts provided the correct fax number. • WSCC initiated an outbound call campaign to notify members of the incorrect fax number. Outbound calls were made to anyone who received a letter with the incorrect fax number or to

MCO	ACTION PLAN	ISSUES	RESOLUTION
			any member who was mailed a handbook. 600 calls were placed and none of the members who were contacted identified using the incorrect fax number. • In Quarter Two, WSCC sent the owner of the fax line an official HIPAA Attestation letter advising the owner to acknowledge whether PHI was received and destroyed. The attestation was faxed. As of the end of the quarter, the owner of the fax number has not responded with the attestation. It is anticipated that this action plan will be closed in Quarter Three.
WSCC	SSN Data Breach Implementation Date 4/3/2019 Completion Date Open	On 4/3/2019, WSCC became aware that member ID cards had not been mailed to identified members but were mailed to different WSCC members. This erroneous mailing directly impacted 261 WSCC members.	WSCC alerted HSD on 4/3/2019 of its investigation of the unauthorized disclosure and provided an Incident Notification on 4/8/19. Based on its risk assessment, WSCC determined that a breach had occurred. The cause of the breach was determined, and a process review and staff training were implemented. The affected members were notified by letter within the timeframe identified in 45 CFR 164.404. In consultation with HSD, WSCC has developed a mitigation plan that will be implemented in Q3 and includes the following:

MCO	ACTION PLAN	ISSUES	RESOLUTION
			1. Notification to the PCPs of the affected members. The PCPs will receive a letter notifying them of an increased potential of ID card fraud and a reminder to validate the identity of patients. 2. Request to return ID Cards with Attestation: In a single envelope, WSCC will mail two letters to the recipients of the mis-mailed ID cards. One letter will ask the recipient to return the ID card that was received in error. The second letter will ask the recipient to sign and return an attestation affirming that the received ID card will not be used or copied, nor will any information on the card be shared. A self-addressed stamped envelope will be provided to the recipient to return the ID card and the attestation.

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FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

DY6 Q2 reflects the new capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid on December 28, 2018, and rate update for April 1, 2019. The PMPM for DY 6 is lower compared to DY 5 for MEGs 1, 3, and for 6; the PMPM for DY 6 is higher than those of DY 5 for MEGs 2, 4 and 5 (see Attachment B – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment B – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis shows DY 6 is 10.2% below the budget neutrality limit (Table 6.5) based on two quarters of payments.

11
MEMBER MONTH REPORTING

Member Months		2019
		2
MEG1	0-FFS	103,215
	Presbyterian	546,653
	Western Sky	91,425
	Blue Cross Blue Shield	324,066
	Total	**1,065,359**
MEG2	0-FFS	6,363
	Presbyterian	61,759
	Western Sky	10,173
	Blue Cross Blue Shield	33,710
	Total	**112,005**
	Presbyterian	68,997
	Western Sky	6,673
	Blue Cross Blue Shield	30,643
	Total	**106,313**
MEG4	0-FFS	27
	Presbyterian	375
	Western Sky	45
	Blue Cross Blue Shield	280
	Total	**727**
	Presbyterian	6,816
	Western Sky	630
	Blue Cross Blue Shield	4,643
	Total	**12,089**
MEG6	0-FFS	67,095
	Presbyterian	368,722
	Western Sky	59,073
	Blue Cross Blue Shield	261,441

January 1, 2019 – December 31, 2023

	Total	**756,331**
Total		**2,052,824**

12
CONSUMER ISSUES

Grievances

HSD/MAD reviewed and analyzed data submitted monthly by the MCOs related to grievance reason codes and timeliness response standards to ensure that grievances filed by members are addressed timely and appropriately. The results of this review are included below:

DY6Q2 (APRIL-JUNE 2019)			
GRIEVANCES	**BCBS**	**PHP**	**WSCC**
Number of Member Grievances	422	316	36
Top Two Primary Member Grievance Codes			
Transportation Ground Non-Emergency	312	132	7
Other Specialties	28	7	3
Variable Grievances	82	177	26

Appeals

HSD/MAD reviewed and analyzed data submitted monthly by the MCOs related to appeal response standards and reason codes to ensure that appeals filed by members are addressed timely and appropriately. The results of this review are included below:

DY6Q2 (APRIL-JUNE 2019)			
APPEALS	**BCBS**	**PHP**	**WSCC**
Number of Standard Member Appeals	223	456	7
Number of Expedited Member Appeals	111	5	4

January 1, 2019 – December 31, 2023

DY6Q2 (APRIL-JUNE 2019)			
APPEALS	BCBS	PHP	WSCC
Top Two Primary Member Appeal Codes			
Denial or limited authorization of a requested service	245	442	9
Denial in whole of a payment for a service	57	8	0
Variable Appeals	32	11	2

13
QUALITY ASSURANCE/MONITORING ACTIVITY

Advisory Board Activities

Under the terms of HSD's Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference Table 20: 2019 MCO Advisory Board Meeting Schedules below.

Table 20: 2019 MCO Advisory Board Meeting Schedules

BCBS 2019			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	3/21/2019	12:00 PM	Special Collections Library, Albuquerque, NM
BCBS	6/13/2019	12:00 PM	Adelante Development Center Inc., Albuquerque, NM
BCBS	9/19/2019	12:00 PM	Adelante Development Center Inc., Albuquerque, NM
BCBS	12/12/2019	12:00 PM	South Valley Multi-Purpose Senior Center, Albuquerque, NM
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	2/27/2019	12:00 PM	Frank O'Brien Papen Center, Las Cruces, NM
BCBS	7/11/2019	12:00 PM	Clovis Carver Public Library, Clovis, NM
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	2/7/2019	12:00 PM	Navajo Technical University, Crownpoint, NM
BCBS	4/17/2019	12:00 PM	Zuni Wellness Center, Zuni, NM
BCBS	7/25/2019	12:00 PM	Native American Community Academy, Albuquerque, NM

BCBS	10/17/2019	12:00 PM	Shiprock Chapter House, Shiprock, NM

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

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

PHP 2019

MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	3/8/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	6/7/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	9/6/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	12/6/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM

STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	9/6/2019	11:00 AM	La Posta Restaurant, Mesilla NM 88046
PHP	12/6/2019	11:00 AM	La Cueva Restaurant, Taos NM 87581

NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	3/8/2019	11:00 AM	Crownpoint Chapter House, Crownpoint NM
PHP	4/26/2019	11:00 AM	Espanola Presbyterian Hospital, Espanola, NM
PHP	8/2/2019	11:00 AM	San Juan College, Farmington NM

PHP	11/8/2019	11:00 AM	Presbyterian Cooper Administrative Center, Albuquerque NM

SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	TBD	TBD	TBD

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	3/12/2019	1:00 PM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	6/11/2019	1:00 PM	Presbyterian Cooper Administrative Center, Albuquerque NM
PHP	9/10/2019	1:00 PM	Presbyterian Cooper Administrative Center, Albuquerque NM

WSCC 2019			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	1/23/2019	5:30 PM	Las Cruces Convention Center, Las Cruces, NM
WSCC	4/10/2019	5:30 PM	CNM Workforce Training Center, Albuquerque, NM
WSCC	7/11/2019	5:30 PM	Hobbs Public Library, Hobbs, NM
WSCC	10/9/2019	5:30 PM	Española Public Library, Española, NM
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	1/23/2019	5:30 PM.	Las Cruces Convention Center, Las Cruces, NM
WSCC	7/11/2019	5:30 PM	Hobbs Public Library, Hobbs, NM
WSCC	10/9/2019	5:30 PM	Española Public Library, Española, NM
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	1/9/2019	11:00 AM	Gallup Community Service Center, Gallup, NM

WSCC	3/27/2019	5:00 PM	San Juan Community Center, Farmington, NM
WSCC	7/18/2019	1:00 PM	Santa Clara Senior Center, Santa Clara, NM
WSCC	11/15/2019	5:30 PM	Taylor Ranch Community Center, Albuquerque, NM

SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	6/22/2019	4:30 PM	Munson Senior Center, Las Cruces, NM

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	10/9/2019	4:30 PM	Española Public Library, Española, NM

Quality Assurance	
2nd Quarter Activities	HSD received the MCO Q1 CY19 tracking measure (TM) reports on April 25, 2019. HSD reviewed the reports for accuracy of reporting methodology and completeness. Q2 will be delivered on July 25, 2019, at which time HSD will review, analyze and compare Q2 data to Q1 data to evaluate and gauge performance of each tracking measure for CY19. HSD also received the MCO Audited HEDIS reports for CY18 on June 30, 2019. The data will be reviewed and analyzed for CY19 Q3 reporting. HSD held the Quarterly Quality Meeting with the MCOs on April 15, 2019. HSD presented aggregated results of the CY18 CAHPS survey to the MCOs. Findings of the survey along with MCO specific strategies aimed at improving member satisfaction were discussed. HSD provided responses and clarification to MCO questions regarding reporting methodologies of the CY19 TMs. EQRO Performance Improvement Project (PIP) validations and findings were discussed. MCOs provided details on some of the successful interventions implemented and barriers encountered that influenced the development or outcomes of the PIP.

	HSD continues to participate in EQRO weekly calls to review the status and discuss concerns of the various external quality review projects and activities. EQRO activities consisted of the delivery of final drafts for: 1) CY17 Compliance Review; 2) the CY17 Performance Improvement Projects Validation; and 3) the CY17 Performance Measure Validation. HSD continued discussions with the EQRO regarding the development of the Network Adequacy Validation project and report formatting. HSD reviewed and approved the EQRO Annual Technical Report (ATR) which included a summary of EQRO and preliminary findings of the CY2017 reviews. HSD posted the ATR to CMS Managed Care Quality TA <ManagedCareQualityTA@cms.hhs.gov> on April 22, 2019

Utilization

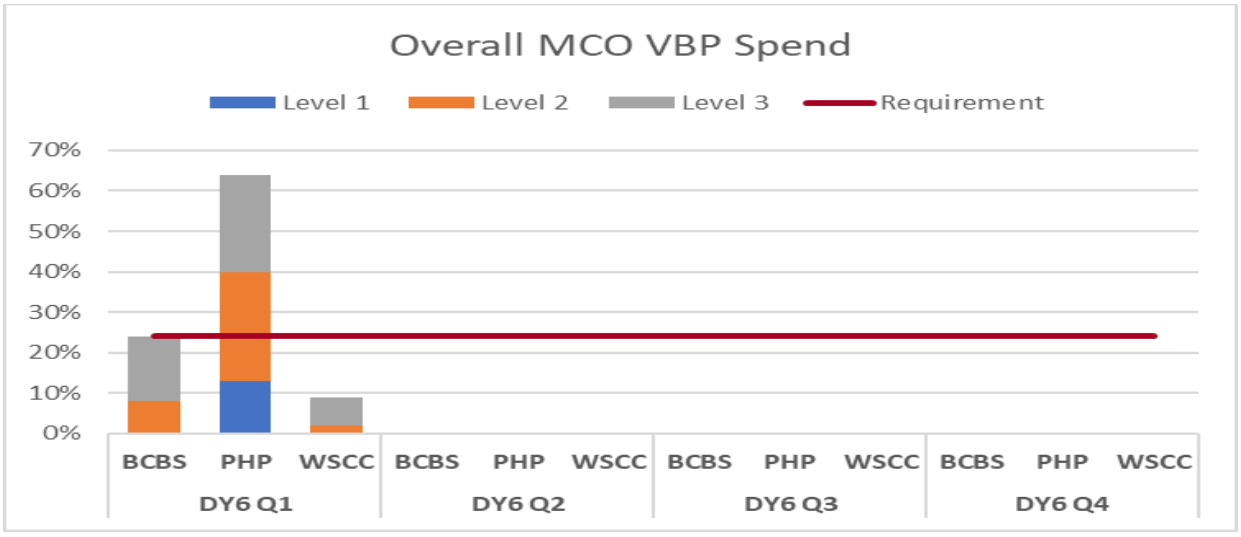
Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for April 2017 through March 2019. Please see Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group.

Value Based Purchasing

To support Centennial Care 2.0's value-based purchasing goals, HSD requires the MCOs to implement a Value Based Purchasing program that is based upon improved quality and/or Member healthcare outcomes. To accomplish this the MCO must meet minimum targets for three levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY6 requirements are as follows:

VBP Level	Level 1	Level 2	Level 3
Required Spend	8%	11%	5%
Required Provider Types	• Traditional PH Providers with at least 2 Small Providers • BH Providers • Long-Term Care Providers including Nursing Facilities	• Traditional PH Providers with at least 2 Small Providers • BH Providers • Actively build readiness for Long-Term Care Providers • Actively build readiness for Nursing Facilities	• Traditional PH Providers • Implement a MCO led BH provider level workgroup

For DY6 Q1, two of the MCOs have already met or exceeded the required VBP spend target of 24%. WSCC is currently negotiating VBP contracts with providers that will be retroactive to DY6 Q1.



Low Acuity Non-Emergent Care (LANE)

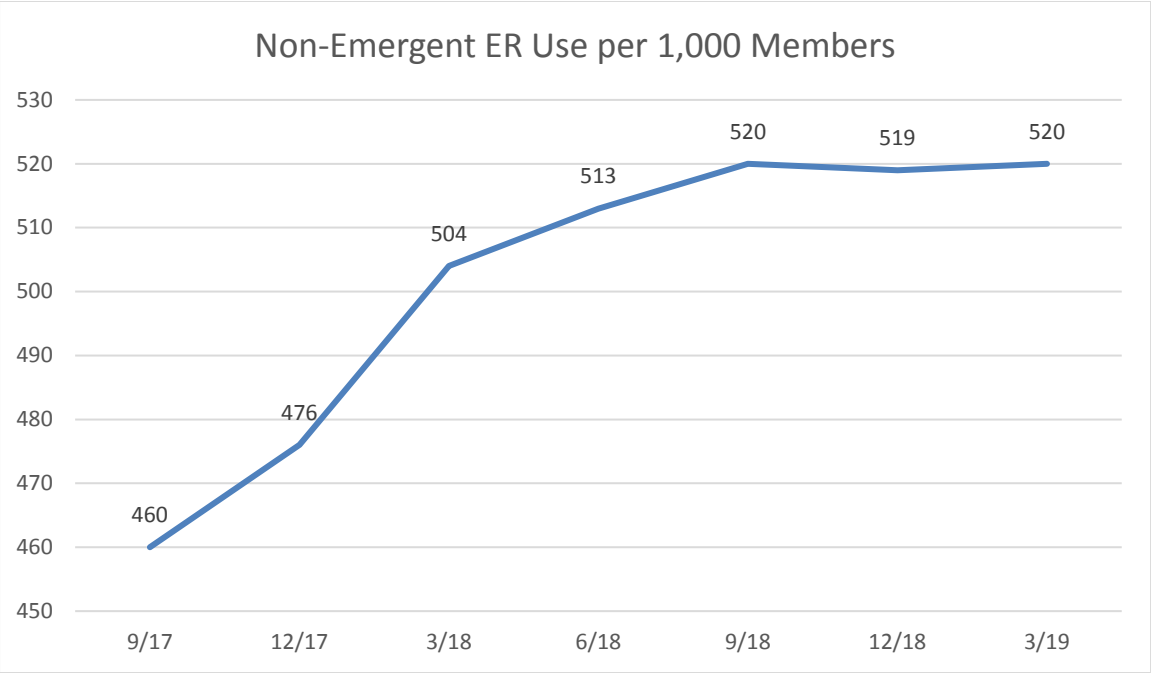
The measurement period above is defined as a 12-month rolling calendar year. Between September of 2017 and June 2018, the average number of visits to the emergency department for non-emergent care increased by 60 visits per 1,000 members, however, in July 2018 the trend stabilized.

In response to the increasing number of emergency room visits for non-emergent care, HSD incorporated requirements into its Managed Care Contracts requiring managed care organizations to monitor the usage of emergency rooms by their members and evaluate whether lesser acute care treatment options were available at the time services were provided. Through outreach efforts, care coordinators discuss appropriate utilization with the member and/or their provider and when appropriate conduct an assessment to update the member's care plan to better manage the member's health needs.

Under this requirement, MCOs have improved processes to identify high utilizer members by monitoring data such as diagnosis codes and emergency room visit encounters. The MCOs continue to implement member engagement initiatives to assist in identifying member challenges through system wide activities which include; outreach by care coordinators, peer-support specialists and community paramedics to ensure that members are taking medications on time

and as prescribed, using equipment appropriately and safely, and have scheduled follow-up visits with their primary care providers.

Table 20: Non-Emergent ER Use per 1,000 Members



14
MANAGED CARE REPORTING REQUIREMENTS

TRANSITION TO CENTENNIAL CARE 2.0 MCOs

HSD continued to monitor high risk member transitions from legacy MCOs to Centennial Care 2.0 MCOs in Q2 DY6. Weekly reporting was discontinued at the end of Q1 DY6 when regularly scheduled quarterly reports began. While BCBS closed an internal corrective action plan for call center performance metrics, HSD identified a deficiency in the Nurse Advice Line percent of calls answered within 30 seconds standard of 85% beginning in April and running through June. HSD is closely monitoring BCBS' efforts to remediate this area of non-compliance as well as the percentage of calls abandoned which exceeded the maximum amount of 5% of calls in June. The Nurse Advice Line is a critical emergency room diversion strategy and essential service for managed care enrolled members; therefore, contract managers will recommend monetary penalties for BCBS having fallen below performance standards for three consecutive months.

COMMUNITY HEALTH SYSTEMS (CHS) AND MCO CONTRACTING

PHP and BCBS extended negotiations for re-contracting with Community Health Systems (CHS) in the South Central and Southeast areas of the state into DY6 Q2. Providers, predominantly located in Dona Ana, Chaves, Eddy, and Lea counties, are an important part of the statewide healthcare system. WSCC was contracted with CHS going into Centennial Care 2.0, and in DY6 Q2, both PHP and BCBS were successful in their contracting efforts. The contingency plans that HSD and the MCOs developed were ultimately not required. However, due to some uncertainty during the extended negotiating period, HSD approved 176 enrollment changes from BCBS or PHP to WSCC in order to ensure continuity of care for members.

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in DY6 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. Centennial Care 2.0 is effective January 1, 2019 with the two legacy MCOs, PHP and BCBS, and one new to Centennial Care 2.0 MCO, WSCC.

Physical Health and Hospitals

The legacy MCOs demonstrated steady access with slight fluctuations.

- Legacy 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 are anticipated to be limited due to provider shortages in rural and frontier areas.

HSD found WSCC to be comparable to legacy MCOs in most provider types.

- WSCC reports transportation providers contracted county wide in 32 of 33 counties. Low member access percentages in the transportation category is related to learning what providers to include and how to report those providers. HSD found that WSCC reported in a conservative manner, which inaccurately reduced member access percentages.
- HSD anticipates that next quarter will be significantly more accurate as WSCC will be reporting according to revised report with greater clarity.

Centennial Care 2.0 Geographical Access report has been refined to improve clarity and continuity of reporting across all 3 MCOs. Report revisions will be applied to April to June of 2019 and validated for inclusion in the DY6 Q3 report. In addition, HSD continues to work with MCOs to validate data and increase network adequacy.

TRANSPORTATION

Non-emergency medical transportation is means for MCO for ensuring members have timely access to needed services particularly for specialty services and provider shortage areas. All 3 MCO identify transportation coverage in all counties across New Mexico. With significant increases in member counts legacy MCOs demonstrate high access to transportation services. As a new MCO, WSCC received guidance for HSD to ensure accurate reporting of member access to transportation. Through these collaborative efforts with WSCC HSD determined that WSCC is comparable to legacy MCOs.

HSD identified a special transportation initiative in DY6 Q1 report. This PHP pilot program is a test run of online scheduling for non-emergency medical transportation for member appointments. The single and widespread transportation vendor involved with this pilot project is also contract with BCBS. HSD will provide additional information on PHP’s pilot transportation program in DY6 Q3 report.

TELEMEDICINE DELIVERY SYSTEM IMPROVEMENT PERFORMANCE TARGET (DSPIT)

The Calendar Year (CY) 2019 Telemedicine Delivery System Improvement Performance Target (DSIPT) for Centennial Care 2.0 will count unduplicated members served in rural, frontier, and urban areas of New Mexico. The change was made from counting visits at the beginning of Centennial Care 1.0, from Calendar Years 2014 through 2018.

CY19 will serve as the Managed Care Organizations (MCOs) baseline year for the Telemedicine DSIPT. The new measurement will track unduplicated members with physical health and behavioral health telemedicine visits, and the member county of residence, for HSD evaluation and development for increasing telemedicine availability and utilization.

Other changes to the Telemedicine DSIPT include, the removal of underserved from the urban description to include outreach to all areas of urban regions statewide. Specialty was also removed from provider description to include a broader range of provider types and increase overall care access through telemedicine. Expanding member education, along with provider support will be MCO focus areas for DY6.

Table 21: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine (January – March 2019)			
MCO	Q1CY19 Behavioral Health Visits	Q1CY19 Physical Health Visits	Q1CY19 Total Unduplicated Members
BCBS	1,133	837	1,970
PHP	1,931	759	2,690
WSCC	329	20	348
Total	3,393	1,616	5,008

* Most telehealth services provided in New Mexico are for behavioral health diagnoses.

Behavioral Health visits represent highest visit utilization at 68% of telemedicine visits in Quarter 1.

15
DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
2nd Quarter Activities	HSD is awaiting CMS feedback and comment of the DY 1 through DY 4 1115 Demonstration Waiver Evaluation final report which was submitted on April 30, 2019. HSD's 1115 Demonstration Waiver Evaluation Design Plan workgroup continued work on the development of the Evaluation Design Plan for Centennial Care 2.0. The workgroup consisting of; HSD staff from the Medical Assistance and Behavioral Health Divisions and contracted external entities with expertise in developing 1115 Demonstration Waiver Evaluation Design Plans, and with the required CMS monitoring of the Substance Use Disorder 1115 Demonstration Waiver. The workgroup met weekly to develop the hypothesis and research questions, and to identify the measures to be used in the evaluation. The workgroup also met with the various programs and systems subject matter experts to discuss and identify the data sources, data collection methodologies, and technical specifications for each of the proposed measures. The final draft of the 1115 Demonstration Waiver Evaluation Design Plan was submitted to CMS on June 27, 2019 for review and approval. HSD has initiated the procurement process to secure an independent evaluator of the 1115 Demonstration Waiver Renewal and commenced with drafting the request for proposal (RFP).

ENTENNIALCARE

Key Utilization / Cost per Unit Statistics by Major Population Group

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Inpatient (Admissions)	94.5	81.8	$ 9,011	$ 8,488
Inpatient (Days)	407.6	335.6	$ 2,090	$ 2,069
Practitioner / Physician (Services)	8,493.9	7,826.9	$ 68	$ 70
Emergency Department (Visits)	577.6	529.6	$ 352	$ 364
Outpatient (Visits)	1,481.8	1,455.4	$ 279	$ 273
Pharmacy (Scripts)	4,901.1	4,850.2	$ 65	$ 61
Other (Services)[1]	9,006.2	8,252.1	$ 57	$ 58

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Brand	12.7%	11.8%	$ 373	$ 381
Generic	85.8%	86.7%	$ 19	$ 17
Other Rx[2]	1.5%	1.5%	$ 95	$ 94

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

Adult Expansion: Other Adult Group

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Inpatient (Admissions)	74.6	70.4	$ 15,226	$ 14,308
Inpatient (Days)	493.4	615.4	$ 2,302	$ 1,636
Practitioner / Physician (Services)	8,918.3	8,333.8	$ 77	$ 82
Emergency Department (Visits)	687.9	647.5	$ 503	$ 516
Outpatient (Visits)	2,171.9	2,118.4	$ 314	$ 306
Pharmacy (Scripts)	9,730.6	9,588.8	$ 78	$ 76
Other (Services)[1]	10,131.0	9,277.0	$ 64	$ 65

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Brand	10.7%	10.2%	$ 587	$ 607
Generic	87.4%	88.0%	$ 15	$ 15
Other Rx[2]	1.9%	1.8%	$ 92	$ 95

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

ENTENNIALCARE

Key Utilization / Cost per Unit Statistics by Major Population Group

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Inpatient (Admissions)	260.4	176.6	$ 3,006	$ 2,205
Inpatient (Days)	1,563.8	944.9	$ 500	$ 412
Nursing Home (Days)	336,884.4	255,004.5	$ 34	$ 41
Personal Care (Services / hr.)	736,132.8	667,425.7	$ 15	$ 15
Outpatient (Visits)	5,092.9	4,079.5	$ 141	$ 148
Pharmacy (Scripts)	1,355.4	1,190.3	$ 17	$ 24
HCBS (Services)	6,497.2	5,227.7	$ 135	$ 150
Other (Services)[1]	44,042.5	35,605.1	$ 44	$ 45

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Brand	21.8%	17.7%	$ 52	$ 101
Generic	75.4%	79.7%	$ 6	$ 6
Other Rx[2]	2.8%	2.5%	$ 54	$ 59

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Inpatient (Admissions)	335.0	291.1	$ 17,265	$ 16,858
Inpatient (Days)	2,288.2	1,998.2	$ 2,528	$ 2,456
Nursing Home (Days)	18,339.6	15,628.5	$ 154	$ 179
Personal Care (Services / hr.)	719,442.3	657,407.4	$ 15	$ 16
Outpatient (Visits)	7,661.0	7,058.6	$ 474	$ 490
Pharmacy (Scripts)	42,188.6	41,331.3	$ 89	$ 81
HCBS (Services)	13,902.0	10,770.4	$ 95	$ 89
Other (Services)[1]	64,264.6	57,634.5	$ 84	$ 87

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Brand	12.4%	11.8%	$ 579	$ 556
Generic	85.2%	86.0%	$ 18	$ 16
Other Rx[2]	2.4%	2.2%	$ 82	$ 89

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

ENTENNIALCARE

Key Utilization / Cost per Unit Statistics by Major Population Group

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Inpatient (Admissions)	228.3	154.8	$ 8,832	$ 8,997
Inpatient (Days)	1,540.4	940.0	$ 1,309	$ 1,482
Nursing Home (Days)	6,974.8	8,686.2	$ 17	$ 17
Personal Care (Services / hr.)	125.8	35.5	$ 15	$ 11
Outpatient (Visits)	6,706.0	5,804.1	$ 253	$ 280
Pharmacy (Scripts)	14,296.0	14,456.5	$ 129	$ 139
HCBS (Services)	301,500.6	272,308.9	$ 95	$ 91
Other (Services)[1]	58,318.6	46,145.6	$ 51	$ 53

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Brand	14.6%	14.3%	$ 669	$ 766
Generic	82.3%	82.9%	$ 33	$ 31
Other Rx[2]	3.1%	2.9%	$ 127	$ 131

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Inpatient (Admissions)	78.8	53.4	$ 4,276	$ 3,707
Inpatient (Days)	501.4	321.0	$ 672	$ 617
Practitioner / Physician (Services)	9,630.7	7,419.2	$ 25	$ 24
Emergency Department (Visits)	701.8	581.7	$ 162	$ 172
Outpatient (Visits)	2,996.8	2,389.2	$ 127	$ 135
Pharmacy (Scripts)	1,590.8	1,101.7	$ 32	$ 21
Other (Services)[1]	9,505.8	7,732.5	$ 93	$ 121

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Brand	22.6%	24.1%	$ 91	$ 59
Generic	74.9%	73.8%	$ 13	$ 8
Other Rx[2]	2.5%	2.1%	$ 60	$ 58

Notes:

1 - Other services include dental, transportation, vision.

2 - Other Rx includes diabetic supplies.

Key Utilization / Cost per Unit Statistics by Major Population Group

Behavioral Health Services - All Populations (PH, OAG, LTSS)				
	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Inpatient (Admissions)	40.9	37.5	$ 1,156	$ 1,215
Inpatient (Days)	120.9	108.8	$ 391	$ 419
BH Practitioner (services)	235.6	236.6	$ 118	$ 116
Core Service Agency (Services)	227.8	217.3	$ 111	$ 137
BH outpatient / clinic (Services)	3,184.0	3,181.3	$ 57	$ 57
Pharmacy (Scripts)	1,791.4	1,621.9	$ 57	$ 62
Residential Treatment Center (days)	87.1	52.5	$ 1,082	$ 1,559
Other (Services)[1]	130.8	126.1	$ 51	$ 48
	Script Utilization		Script Cost per Unit	
Pharmacy Classification	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019	Apr 2017 - Mar 2018	Apr 2018 - Mar 2019
Brand	6.6%	7.8%	$ 440	$ 467
Generic	93.4%	92.2%	$ 30	$ 28
Other Rx[2]	0.0%	0.0%	$ -	$ -

Notes:

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

2 - Other Rx includes diabetic supplies.

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ENCLOSURES/ATTACHMENTS

Attachment A: April 2017 – March 2019 Statewide Dashboards

Attachment B: Budget Neutrality Monitoring Spreadsheet

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

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STATE CONTACTS

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ADDITIONAL COMMENTS

MCO INTIATIVES

Peer Support Worker Outreach Initiatives

BCBS recognizes the value of recovery support and currently employs 20 certified Peer Support Workers (PSWs). These individuals identify as being in recovery from a substance use disorder and/or have experienced a mental health condition. After receiving proper training and state certification, these individuals connect with members, share relevant lived experience, model recovery, and assist in navigating New Mexico's behavioral health system. In Q2 DY6, BCBS implemented the use of PSWs to outreach to members utilizing the emergency department (ED) for behavioral health and substance use disorders. PSWs attempt to engage with the member while the member is in the ED and then continue to provide support post discharge. In addition to connecting to high/emerging risk members, recovery support staff also engage with members who have been identified as being newly diagnosed with a Substance Use Disorder. For these members, Peer Support staff work with members to assist in making and keeping provider appointments, offering support, encouragement, and motivation that is needed to pursue recovery.

Reporting Accuracy Initiatives

PHP completed extensive analysis for the recent HSD report modifications. Methodologies and output are checked, cross-referenced, and rerun in order to detect any anomalies since report changes took effect beginning in Q1 DY6. Having the highest number of enrolled members, PHP recognizes its responsibility to ensure the most consistent and accurate data and analysis for HSD consideration and oversight.

WSCC Provider Access Initiative

Western Sky Community Care (WSCC) has implemented its Provider Access Initiative. Twenty-eight New Mexico Providers applied for a Barrier Removal Fund (BRF) grant, requesting over $348,000 in accessibility improvements for members. Of those 28, 27 were determined to be eligible to apply for the grant. The BRF Committee approved 21 providers to receive funds totaling $148,421.00. One approved provider is on a waitlist, pending the availability of funds. Once funded, the grant recipients will make access modification(s) or purchase accessibility equipment. The providers must spend the funds by 9/30/2019. Beginning 10/25/19, WSCC will verify completion of the authorized accessibility improvements.

MEMBER SUCCESS STORIES

A BCBS member is a perfect example of changing outcomes. This 20-year-old woman faced many challenges- she is deaf, non-verbal, on the autism spectrum and has an extensive trauma history, cognitive impairment, and some other behavioral health diagnoses. The member's adoptive parents refused to allow her to return home following an inpatient stay at the University of New Mexico (UNM) Psychiatric Hospital. She was denied placement due to a history of aggressive behavior and there were no clear options for a post-discharge placement. Having no placement options, UNM discharged her to the Joy Junction Homeless Shelter. BCBS was able to secure placement for this member at the Onyx House Group Home where she has since thrived and was able to get her DD Waiver allocation expedited to secure long term placement. BCBS stepped up and utilized creative solutions to create the best outcome for this member.

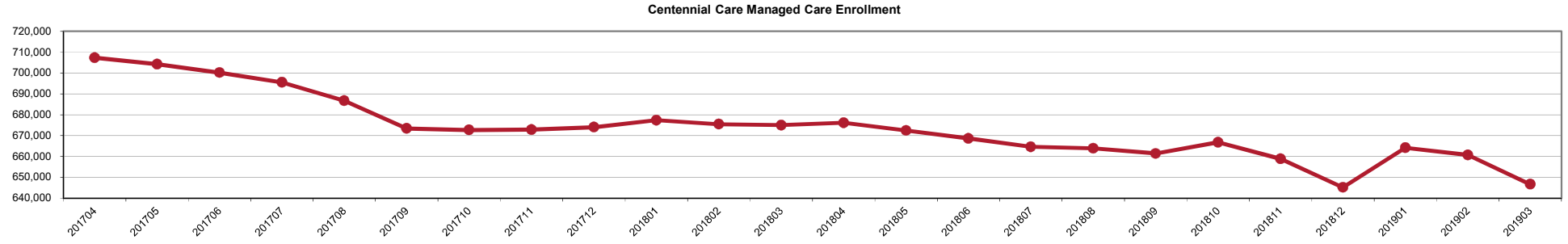
A PHP customer service representative reached out to a new member to complete a Health Risk Assessment. During the assessment, the member became emotional and expressed that she did not know what to do in her present situation. The customer service representative did a wonderful job connecting with the member, so the member felt comfortable telling the representative her story. The member needed assistance learning how to handle a sensitive situation that she recently left, and she needed help finding a place to stay. The customer service representative provided information on shelters and reached out to the member at a later time to make sure she was ok. The representative was able to get the member shelter, and she helped with transportation and contact information for the Albuquerque Police Department. The member wanted to thank everyone for their help and let them know she now has food, shelter and is in a safe place.

A WSCC member came to New Mexico from California with two small children and four service dogs. When the member arrived in New Mexico she was homeless with no money, no food, little clothing, and was staying in a homeless shelter. When the care coordinator first met with this member, her oldest child was in the hospital at UNM undergoing treatment for arthritis. The care coordinator spoke to the member about her barriers and needs and the member stated she was receiving Section 8 housing in California and was having trouble getting her package transferred to New Mexico. The member stated that she called the Housing Authority in California and was told they would be sending the package here. The member also expressed frustration about not being able to get to her appointments due to her service dogs not being allowed on the bus. The care coordinator noticed that having the dogs was a big barrier and talked to the member about possibly putting her dogs in a shelter until she was able to get her housing figured out. The member stated that she was willing to do that. She got her dogs into a shelter and got herself to the housing appointment. The member received a Section 8 voucher and assistance to help pay her deposit and application fee. The member stated that when she was in the shelter, they threw more than half of her clothes away and her money and bus passes were stolen. The care coordinator helped get the member a monthly bus pass and a clothing voucher. The member is currently staying at a hotel and is waiting to get into an apartment. The member has also been able to see a PCP and is starting therapy for herself and her two kids.

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

Reported Encounters for Enrolled Members as of: March 31, 2019
Previous Period: April 1, 2017 to March 31, 2018
Current Period: April 1, 2018 to March 31, 2019

1. Total Centennial Care Monthly Enrollment



2. Total Centennial Care Dollars and Member Months by Program

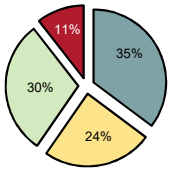
Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	4,843,499	4,652,136	-4%
Long Term Services and Supports	588,719	574,502	-2%
Other Adult Group	2,782,707	2,723,084	-2%
Total Member Months	**8,214,925**	**7,949,722**	**-3%**

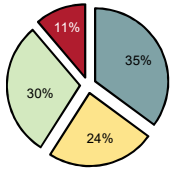
	Aggregate Medical Costs by Program			*Per Capita Medical Costs by Program (PMPM)*		
Programs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,223,932,568	$ 1,249,062,051	2%	$ 252.70	$ 268.49	6%
Long Term Services and Supports	$ 847,813,477	$ 851,596,024	0%	$ 1,440.10	$ 1,482.32	3%
Other Adult Group Physical Health	$ 1,036,010,985	$ 1,058,860,069	2%	$ 372.30	$ 388.85	4%
Behavioral Health - All Members	$ 366,633,688	$ 398,212,320	9%	$ 44.63	$ 50.09	12%
Total Medical Costs	**$ 3,474,390,718**	**$ 3,557,730,464**	**2%**	**$ 422.94**	**$ 447.53**	**6%**

Centennial Care Medical

Previous (Q2CY2017 - Q1CY2018)



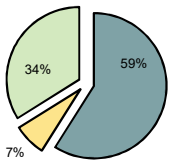
Current (Q2CY2018 - Q1CY2019)



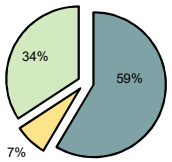
*See above for legend.

Centennial Care Member Months

Previous (Q2CY2017 - Q1CY2018)



Current (Q2CY2018 - Q1CY2019)



*See above for legend.

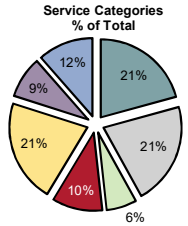
3. Total Program Medical/Pharmacy Dollars

	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 3,075,943,953	$ 3,168,068,891	3%	$ 374.43	$ 398.51	6%
Pharmacy	$ 398,446,765	$ 389,661,573	-2%	$ 48.50	$ 49.02	1%
Total	**$ 3,474,390,718**	**$ 3,557,730,464**	**2%**	**$ 422.94**	**$ 447.53**	**6%**

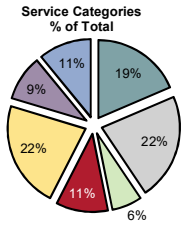
	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
Service Categories	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 720,387,606	$ 660,246,473	-8%	$ 87.69	$ 83.05	-5%
Acute Outp/Phy	$ 738,476,159	$ 783,986,266	6%	$ 89.89	$ 98.62	10%
Nursing Facility	$ 217,439,297	$ 220,626,067	1%	$ 26.47	$ 27.75	5%
Community Benefit/PCO	$ 361,307,782	$ 382,792,311	6%	$ 43.98	$ 48.15	9%
Other Services	$ 739,072,533	$ 785,786,740	6%	$ 89.97	$ 98.84	10%
Behavioral Health	$ 299,260,575	$ 334,631,034	12%	$ 36.43	$ 42.09	16%
Pharmacy (All)	$ 398,446,765	$ 389,661,573	-2%	$ 48.50	$ 49.02	1%
Total Costs	**$ 3,474,390,718**	**$ 3,557,730,464**	**2%**	**$ 422.94**	**$ 447.53**	**6%**

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

Previous (12 mon) service distribution



Current (12 mon) service distribution



4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. Other Services includes, but is not limited to, the following services: emergency department utilization, emergent transportation, non-emergent transportation, vision, and dental.
3. The current period (CY2018) figures represent dates of service for CY2018 through December 2018. The data includes estimates for unpaid claims liability based on MCO financial data. The data presented here may change when re-examined in a future period for actual paid claims.

State of New Mexico - All MCOs

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

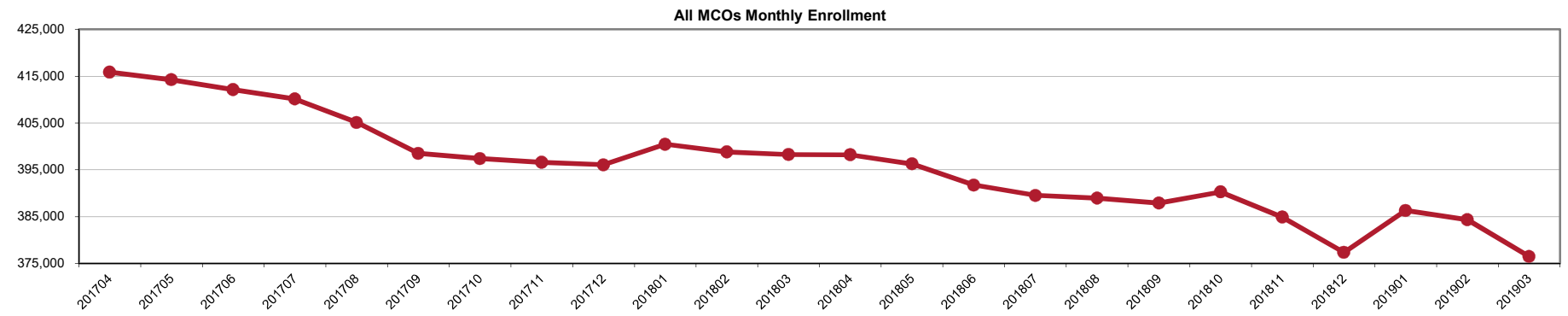
Physical Health Utilization and Cost Review

Reported Encounters for Enrolled Members as of: March 31, 2019

Previous Period: April 1, 2017 to March 31, 2018

Current Period: April 1, 2018 to March 31, 2019

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

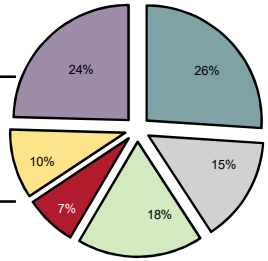
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,097,482,151	$ 1,127,231,908	3%
Pharmacy	$ 126,450,417	$ 121,830,143	-4%
Total	**$ 1,223,932,568**	**$ 1,249,062,051**	**2%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 358,346,811	$ 325,395,655	-9%
Outpatient (OP)	$ 167,113,811	$ 184,468,086	10%
Physician (PH)	$ 207,033,654	$ 220,462,818	6%
Emergency Department (ED)	$ 85,950,590	$ 89,933,107	5%
Pharmacy (RX)	$ 126,450,417	$ 121,830,143	-4%
Other (OTH)	$ 279,037,286	$ 306,972,242	10%
Total Population Costs	**$ 1,223,932,568**	**$ 1,249,062,051**	**2%**
Per Capita Cost (PMPM)	**$ 252.70**	**$ 268.49**	**6%**
Total Member Months	**4,843,499**	**4,652,136**	**-4%**

Service Categories % of Cost



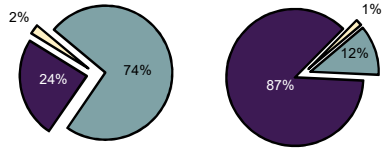
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

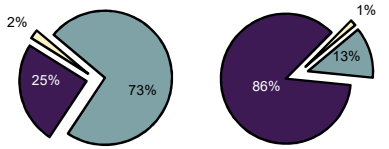
	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 92,550,270	$ 89,489,829	-3%
Generic	$ 31,102,285	$ 29,509,264	-5%
Other Rx	$ 2,797,861	$ 2,831,051	1%
Total	**$ 126,450,417**	**$ 121,830,143**	**-4%**

% of Rx Spend **% of Scripts**

Current



Previous



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

4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. The current period (CY2018) figures represent dates of service for CY2018 through December 2018. The data includes estimates for unpaid claims liability based on MCO financial data. The data presented here may change when re-examined in a future period for actual paid claims.

State of New Mexico - All MCOs

Total Population

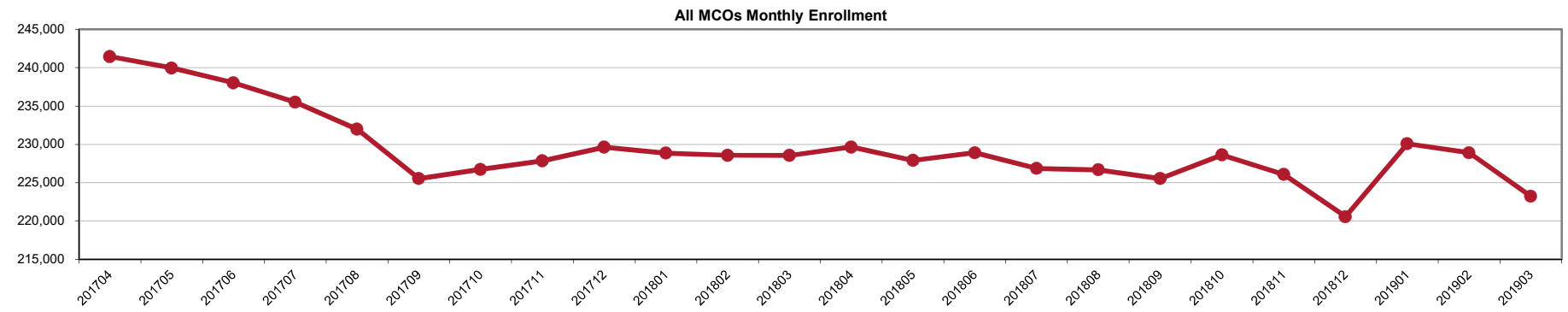
Other Adult Group Utilization and Cost Review

Reported Encounters for Enrolled Members as of: March 31, 2019

Previous Period: April 1, 2017 to March 31, 2018

Current Period: April 1, 2018 to March 31, 2019

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

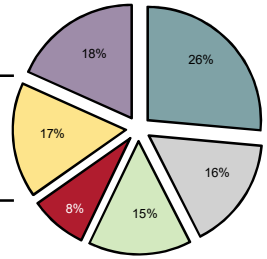
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 864,146,923	$ 884,796,677	2%
Pharmacy	$ 171,864,062	$ 174,063,392	1%
Total	**$ 1,036,010,985**	**$ 1,058,860,069**	**2%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 291,073,093	$ 279,796,920	-4%
Outpatient (OP)	$ 159,681,269	$ 170,231,041	7%
Physician (PH)	$ 147,603,716	$ 154,899,326	5%
Emergency Department (ED)	$ 80,979,202	$ 86,109,223	6%
Pharmacy (RX)	$ 171,864,062	$ 174,063,392	1%
Other (OTH)	$ 184,809,643	$ 193,760,167	5%
Total Population Costs	**$ 1,036,010,985**	**$ 1,058,860,069**	**2%**
Per Capita Cost (PMPM)	**$ 372.30**	**$ 388.85**	**4%**
Total Member Months	**2,782,707**	**2,723,084**	**-2%**

Service Categories % of Cost



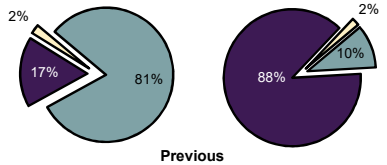
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

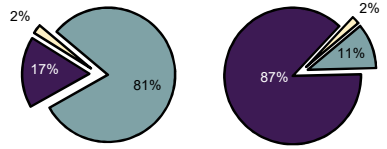
	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 138,779,448	$ 140,809,894	1%
Generic	$ 29,239,934	$ 29,286,563	0%
Other Rx	$ 3,844,680	$ 3,966,935	3%
Total	**$ 171,864,062**	**$ 174,063,392**	**1%**

% of Rx Spend **% of Scripts**

Current



Previous



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

4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. The current period (CY2018) figures represent dates of service for CY2018 through December 2018. The data includes estimates for unpaid claims liability based on MCO financial data. The data presented here may change when re-examined in a future period for actual paid claims.

State of New Mexico - All MCOs

LTSS - Healthy Dual Population

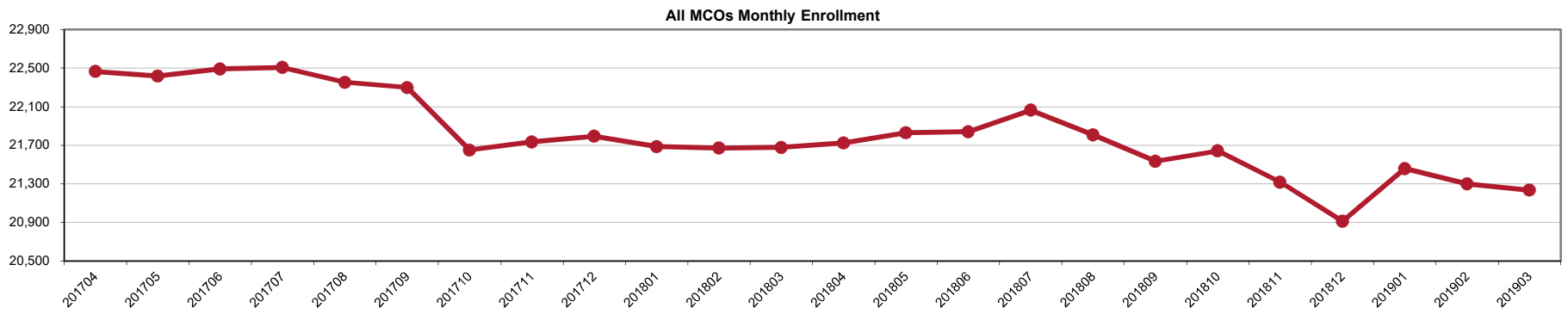
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: March 31, 2019

Previous Period: April 1, 2017 to March 31, 2018

Current Period: April 1, 2018 to March 31, 2019

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

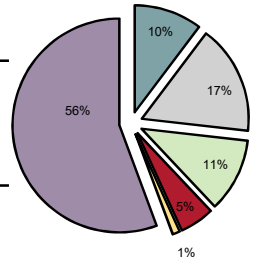
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 43,123,714	$ 41,863,542	-3%
Pharmacy	$ 987,855	$ 477,664	-52%
Total	**$ 44,111,570**	**$ 42,341,206**	**-4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 7,278,528	$ 4,351,235	-40%
Outpatient (OP)	$ 8,039,967	$ 6,992,083	-13%
Physician (PH)	$ 5,389,099	$ 4,735,551	-12%
Emergency Department (ED)	$ 2,388,737	$ 2,210,723	-7%
Pharmacy (RX)	$ 987,855	$ 477,664	-52%
Other (OTH)	$ 20,027,382	$ 23,573,950	18%
Total Population Costs	**$ 44,111,570**	**$ 42,341,206**	**-4%**
Per Capita Cost (PMPM)	**$ 166.62**	**$ 163.69**	**-2%**
Total Member Months	**264,749**	**258,670**	**-2%**

Service Categories % of Cost

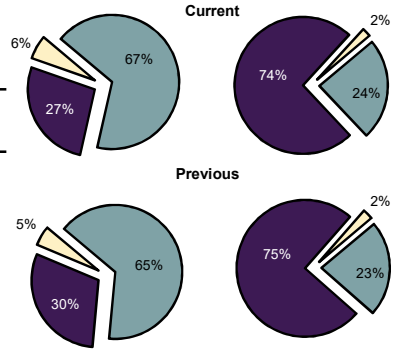


3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 645,649	$ 322,171	-50%
Generic	$ 295,182	$ 128,081	-57%
Other Rx	$ 47,024	$ 27,411	-42%
Total	**$ 987,855**	**$ 477,664**	**-52%**

% of Rx Spend **% of Scripts**



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

4. Notes

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2. The current period (CY2018) figures represent dates of service for CY2018 through December 2018. The data includes estimates for unpaid claims liability based on MCO financial data. The data presented here may change when re-examined in a future period for actual paid claims.

State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Dual Population

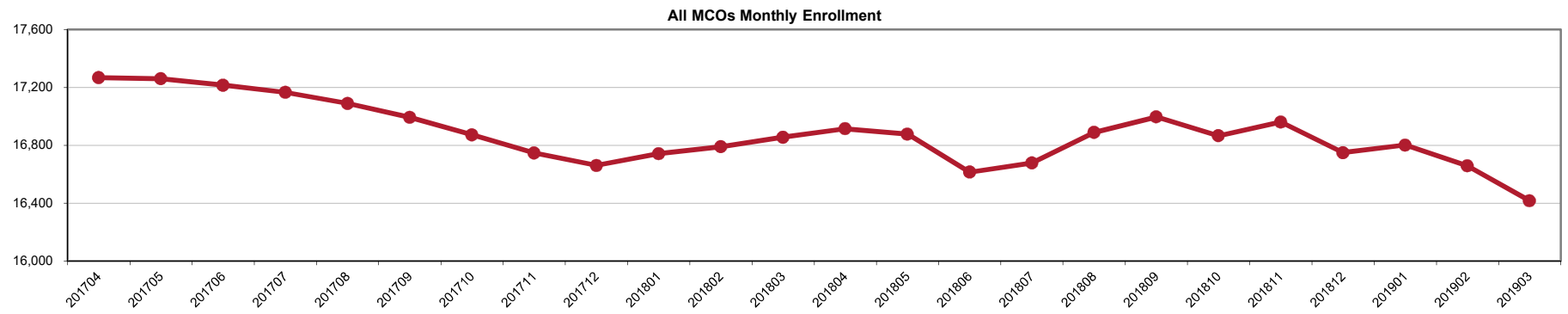
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: March 31, 2019

Previous Period: April 1, 2017 to March 31, 2018

Current Period: April 1, 2018 to March 31, 2019

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

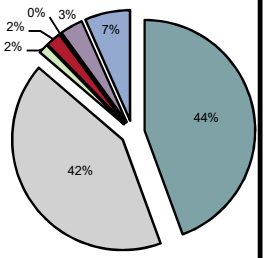
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 461,439,510	$ 467,780,103	1%
Pharmacy	$ 370,388	$ 519,115	40%
Total	**$ 461,809,898**	**$ 468,299,218**	**1%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 192,969,863	$ 208,009,532	8%
Nursing Facility (NF)	$ 193,820,907	$ 196,001,013	1%
Inpatient (IP)	$ 13,152,303	$ 6,695,506	-49%
Outpatient (OP)	$ 11,965,732	$ 10,225,412	-15%
Pharmacy (RX)	$ 370,388	$ 519,115	40%
HCBS	$ 15,369,706	$ 15,681,468	2%
Other (OTH)	$ 34,160,999	$ 31,167,172	-9%
Total Population Costs	**$ 461,809,898**	**$ 468,299,218**	**1%**
Per Capita Cost (PMPM)	**$ 2,267.54**	**$ 2,324.94**	**3%**
Total Member Months	**203,661**	**201,424**	**-1%**

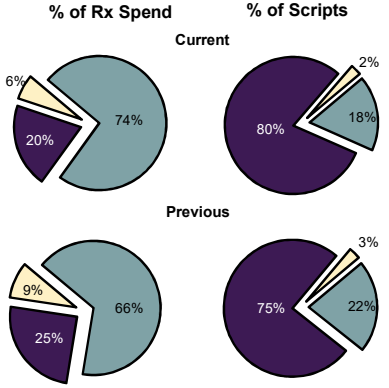
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 246,121	$ 383,301	56%
Generic	$ 91,951	$ 104,814	14%
Other Rx	$ 32,316	$ 31,001	-4%
Total	**$ 370,388**	**$ 519,115**	**40%**



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

4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. The current period (CY2018) figures represent dates of service for CY2018 through December 2018. The data includes estimates for unpaid claims liability based on MCO financial data. The data presented here may change when re-examined in a future period for actual paid claims.

State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Medicaid Only Population

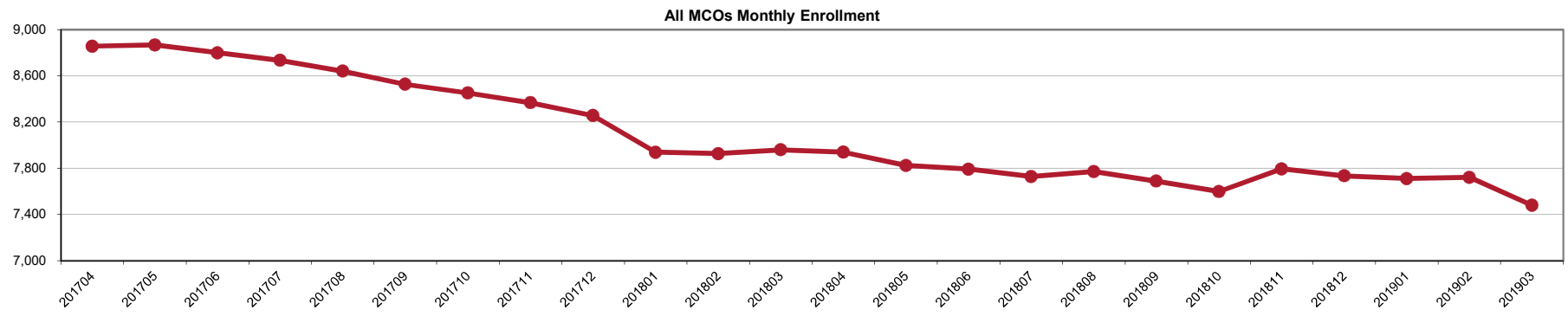
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: March 31, 2019

Previous Period: April 1, 2017 to March 31, 2018

Current Period: April 1, 2018 to March 31, 2019

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

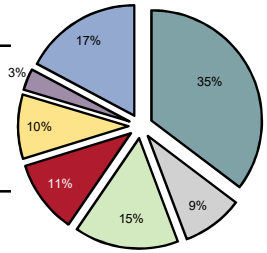
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 253,146,650	$ 245,476,476	-3%
Pharmacy	$ 28,757,045	$ 25,498,805	-11%
Total	**$ 281,903,694**	**$ 270,975,281**	**-4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 94,965,535	$ 95,644,178	1%
Nursing Facility (NF)	$ 23,428,123	$ 24,361,386	4%
Inpatient (IP)	$ 47,460,734	$ 41,373,683	-13%
Outpatient (OP)	$ 29,130,228	$ 28,907,801	-1%
Pharmacy (RX)	$ 28,757,045	$ 25,498,805	-11%
HCBS	$ 11,358,753	$ 8,535,047	-25%
Other (OTH)	$ 46,803,278	$ 46,654,381	0%
Total Population Costs	**$ 281,903,694**	**$ 270,975,281**	**-4%**
Per Capita Cost (PMPM)	**$ 2,781.98**	**$ 2,920.56**	**5%**
Total Member Months	**101,332**	**92,782**	**-8%**

Service Categories % of Cost



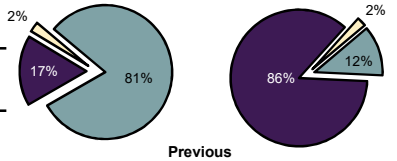
3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

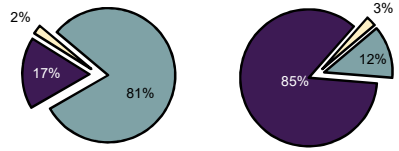
	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 23,169,391	$ 20,544,541	-11%
Generic	$ 4,943,088	$ 4,322,184	-13%
Other Rx	$ 644,566	$ 632,081	-2%
Total	**$ 28,757,045**	**$ 25,498,805**	**-11%**

% of Rx Spend **% of Scripts**

Current



Previous



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

4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. The current period (CY2018) figures represent dates of service for CY2018 through December 2018. The data includes estimates for unpaid claims liability based on MCO financial data. The data presented here may change when re-examined in a future period for actual paid claims.

State of New Mexico - All MCOs

LTSS - Self Directed Population

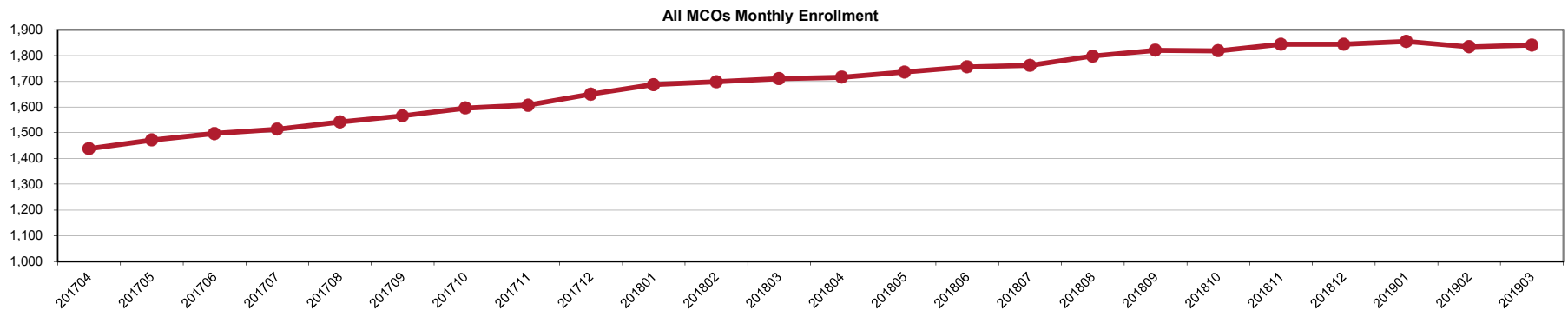
Utilization and Cost Review

Reported Encounters for Enrolled Members as of: March 31, 2019

Previous Period: April 1, 2017 to March 31, 2018

Current Period: April 1, 2018 to March 31, 2019

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

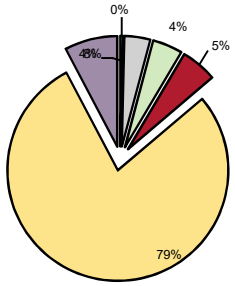
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 57,344,429	$ 66,289,151	16%
Pharmacy	$ 2,643,885	$ 3,691,167	40%
Total	**$ 59,988,315**	**$ 69,980,318**	**17%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 190,267	$ 263,667	39%
Inpatient (IP)	$ 3,076,137	$ 2,633,475	-14%
Outpatient (OP)	$ 2,518,684	$ 3,064,147	22%
Pharmacy (RX)	$ 2,643,885	$ 3,691,167	40%
HCBS	$ 46,643,925	$ 54,922,085	18%
Other (OTH)	$ 4,915,417	$ 5,405,776	10%
Total Population Costs	**$ 59,988,315**	**$ 69,980,318**	**17%**
Per Capita Cost (PMPM)	**$ 3,161.11**	**$ 3,235.93**	**2%**
Total Member Months	**18,977**	**21,626**	**14%**

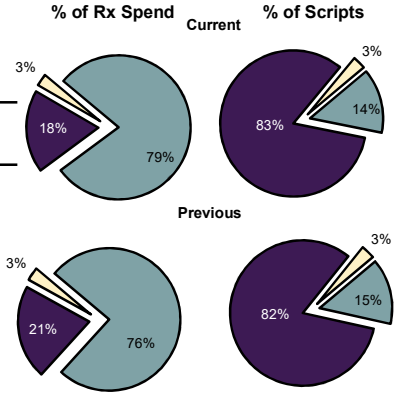
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 1,999,281	$ 2,906,669	45%
Generic	$ 564,437	$ 683,941	21%
Other Rx	$ 80,168	$ 100,558	25%
Total	**$ 2,643,885**	**$ 3,691,167**	**40%**



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

4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
2. The current period (CY2018) figures represent dates of service for CY2018 through December 2018. The data includes estimates for unpaid claims liability based on MCO financial data. The data presented here may change when re-examined in a future period for actual paid claims.

State of New Mexico - All MCOs

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

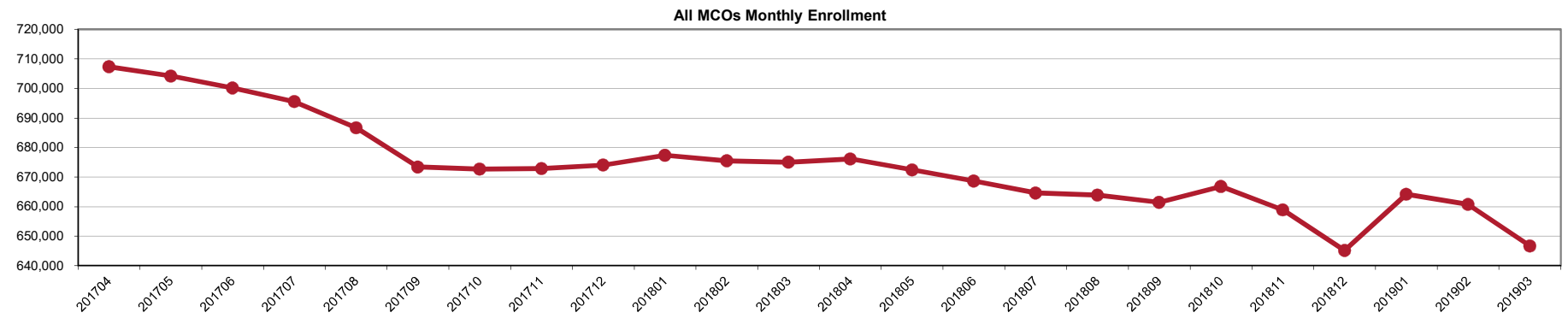
Behavioral Health Utilization and Cost Review

Reported Encounters for Enrolled Members as of: March 31, 2019

Previous Period: April 1, 2017 to March 31, 2018

Current Period: April 1, 2018 to March 31, 2019

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

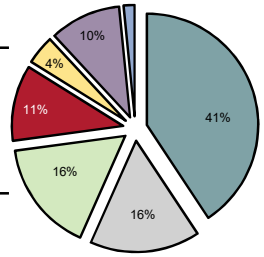
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 299,260,575	$ 334,631,034	12%
Pharmacy	$ 67,373,113	$ 63,581,286	-6%
Total	**$ 366,633,688**	**$ 398,212,320**	**9%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 130,819,217	$ 162,081,551	24%
Pharmacy (RX)	$ 67,373,113	$ 63,581,286	-6%
Res. Treatment Ctr. (RTC)	$ 67,484,118	$ 64,502,022	-4%
Behavioral Health Prov (BHP)	$ 36,665,736	$ 43,793,963	19%
Core Service Agencies (CSA)	$ 15,352,794	$ 16,849,793	10%
Inpatient (IP)	$ 43,244,773	$ 41,126,651	-5%
Other (OTH)	$ 5,693,936	$ 6,277,053	10%
Total Population Costs	**$ 366,633,688**	**$ 398,212,320**	**9%**
Per Capita Cost (PMPM)	**$ 44.63**	**$ 50.09**	**12%**
Total Member Months	**8,214,925**	**7,949,722**	**-3%**

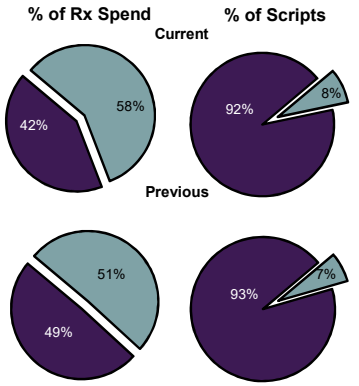
Services Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 34,153,080	$ 36,916,070	8%
Generic	$ 33,220,033	$ 26,665,216	-20%
Total	**$ 67,373,113**	**$ 63,581,286**	**-6%**



4. Notes

1. Data reflects medical and pharmacy expenditures only. The data relies on financial statements submitted by the managed care organizations. The expenditures exclude Indian Health Services, Tribal 638 and non-state plan services. Values are based on information currently available and subject to change as new information becomes available.
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