CENTENNIAL CARE 2.0 DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 10 (1/1/2023 – 12/31/2023)
Annual 2023

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INTRODUCTION

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

On December 14, 2018, CMS approved New Mexico's 1115 Demonstration Waiver, Centennial Care 2.0, effective January 1, 2019 through December 31, 2023, which featured an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care, pharmacy, behavioral health services, institutional services, and HCBS. On September 5, 2023, CMS approved a temporary extension of New Mexico's Centennial Care 2.0 demonstration extending the expiration date from December 31, 2023 to December 31, 2024 in order to allow New Mexico and CMS to continue negotiations over New Mexico's demonstration application submitted on December 15, 2022. On December 15, 2023, CMS approved an amendment to New Mexico's Centennial Care 2.0 demonstration effective January 1, 2024 through December 31, 2024 for a number of initiatives included in the state's demonstration extension application submitted on December 15, 2022 and negotiations continue over the remaining initiatives.

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

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

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

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

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

Status of Key Dates:

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

1115 Demonstration Amendment #2 Letter Amendment	Submitted to CMS on December 30, 2021.	Approved by CMS on March 28, 2023.
New Mexico Turquoise Care 1115 Waiver Renewal Application	Submitted to CMS on December 15, 2022.	CMS Completeness Letter received on December 29, 2022. Federal Comment Period occurred December 29, 2022 through January 28, 2023. CMS' Temporary Extension Approval received on September 5, 2023. CMS Amendment Approval received on December 15, 2023 for some waiver renewal initiatives. CMS and New Mexico continue negotiations.
SMI/SED Implementation Plan	Due to CMS June 26, 2023. Resubmission due January 31, 2024.	Submitted to CMS 6/26/2023. CMS feedback received July 17, 2023 and New Mexico resubmitted September 29, 2023. New Mexico resubmitted its plan on 10/18/2023 and CMS provided additional feedback on 10/31/2023. Pending New Mexico resubmission.
SMI/SED Monitoring Protocol	Due to CMS August 25, 2023.	On August 18, 2023, CMS extended the deadline to September 29, 2023. On September 1, 2023, CMS extended the deadline to January 31, 2024. On December 22, 2023, CMS extended the deadline to May 31, 2024. Deadlines will continue to be extended until CMS develops and issues new monitoring templates and guidance.
COVID-19 Draft Summative Evaluation Report	Due to CMS September 4, 2023.	On September 18, 2023, CMS granted New Mexico an extension to submit by October 31, 2023. On November 16, 2023, CMS granted New Mexico an extension to submit by February 29, 2024.

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

NEW MEXICO AND CMS WAIVER ACTIVITIES

New Mexico Centennial Care 2.0 Waiver Amendment #2

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

- Federal Financial Participation (FFP) for inpatient, residential and other services provided to otherwise-eligible Medicaid beneficiaries while they are short-term residents in Institutions for Mental Diseases (IMD) for diagnoses of Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). FFP will become available once CMS approves New Mexico's SMI/SED Implementation plan, which is currently due June 26, 2023.
- FFP for improvements to New Mexico's Home and Community Based Services (HCBS), including the increase of enrollment limits for the Community Benefit program and increase in service limits for Community Transition and Environmental

Modification services.

- FFP and expenditure authority for the implementation of a High-Fidelity Wrap Around (HFW) Intensive Care Coordination Benefit.

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

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

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

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

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

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

As New Mexico prepared its waiver renewal application, it held several stakeholder

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

Date	Meeting
April 26, 2022	Tribal Listening Session
May 4, 2022	Sister Agency and Partner Session
May 5, 2022	Large Stakeholder Session
May 11, 2022	Legislator Session
May 11, 2022	Legislative Finance Committee (LFC), Department of Finance Administration (DFA), and Governor's Office Listening Session
May 12, 2022	Tribal Meeting with Navajo Nation
May 13, 2022	Tribal Meeting with Zuni and Laguna Pueblo
July 18, 2022	Virtual Tribal Listening Session
July 19, 2022	Virtual Tribal Listening Session
July 21, 2022	Virtual Tribal Listening Session
September 30, 2022	Public Hearing
October 7, 2022	Public Hearing
October 14, 2022	Tribal Consultation

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

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

MISSION

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

GOALS

We help NEW MEXICANS

1. Improve the value and range of services we provide to ensure that every qualified New Mexican receives timely and accurate benefits.

We communicate EFFECTIVELY

2. Create effective, transparent communication to enhance the public trust.

We make access EASIER

3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We support EACH OTHER

4. Promote an environment of mutual respect, trust and open communication to grow and reach our professional goals.

In alignment with HSD's mission, Turquoise Care's goals and initiatives center on improving core health outcomes and attending to the social and economic determinants of health, particularly centered on addressing the needs of the State's historically underserved populations. HSD's vision is that every New Mexico Medicaid member has high-quality, well-coordinated, person-centered care to achieve their personally defined health and wellness goals. To advance on these opportunities and move closer to our vision, HSD will operate a data-driven Medicaid program that measures quality based on population health outcomes. To support this vision, the Turquoise Care waiver is constructed around three goals:

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

Turquoise Care has targeted initiatives focused on the following populations:

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

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

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

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

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

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

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

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

Updates for Q2 CY2023
CMS informed New Mexico of its intent to extend the existing Centennial Care 2.0 waiver to allow the state and CMS additional time to review and negotiate the state's demonstration application submitted December 15, 2022. New Mexico was advised that CMS is prioritizing the following proposals for an effective approval date of January 1, 2024:

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

Updates for Q3 CY2023
On September 5, 2023, CMS approved a temporary extension of New Mexico's Centennial Care 2.0 demonstration extending the expiration date from December 31, 2023 to December 31, 2024 in order to allow New Mexico and CMS to continue negotiations over New Mexico's demonstration application submitted on December 15, 2022.

During the COVID-19 public health emergency (PHE), the traditional provider workforce was diminishing leading to inadequate capacity to provide medically necessary services such as supporting activities of daily living. To alleviate this provider workforce shortage,

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

Updates for Q4 CY2023
On November 8, 2023, CMS approved a temporary extension of the COVID authorities that allow LRIs as paid caregivers under the Community Benefit and EPSDT benefit, extending the expiration date from November 12, 2023 to February 29, 2024. On December 15, 2023, CMS approved the following 1115 waiver renewal initiatives effective January 1, 2024 through December 31, 2024 as an amendment to New Mexico's existing 1115 demonstration waiver:

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

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

CENTENNIAL CARE 2.0 POST AWARD FORUMS

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

During the November 13, 2023 MAC meeting the following topics were addressed in support of the Centennial Care 2.0 waiver and Medicaid 1115 demonstration waiver renewal:

- Leadership update, which included an announcement of a new Deputy Director and Strategic Operations Manager.
- MCO Procurement and 1115 Demonstration Waiver updates, which included information on the following: Initiation of Turquoise Care Readiness period, on-site reviews, open enrollment, and ongoing negotiations.
- Community Health Workers updates, which included information on the reimbursement model.
- Letter of Direction updates which included Comprehensive Well Child Visits for Children in State Custody within 30 days, Human Donor Milk Billing and Guidance in an Inpatient Hospital, MCO Requirements Regarding the Expiration of the Public Health Emergency for COVID-19, Implementation of NM High-Fidelity Wraparound Program, and Coordination of Treatment Foster Care.

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

- April 15, 2019
- December 16, 2019
- January 27, 2020
- April 27, 2020
- August 3, 2020
- November 2, 2020

- January 19, 2021
- May 10, 2021
- August 9, 2021
- November 8, 2021
- January 24, 2022
- May 16, 2022
- August 8, 2022
- November 21, 2022
- February 13, 2023
- May 8, 2023
- August 21, 2023
- November 13, 2023

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

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: QUARTER 4 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	9/30/2023 ENROLLMENT	12/31/2023 ENROLLMENT	PERCENT INCREASE / DECREASE Q4
BlueCross BlueShield of New Mexico (BCBS)	258,642	260,299	0.6%
Presbyterian Health Plan (PHP)	370,750	371,569	0.2%
Western Sky Community Care (WSCC)	85,415	87,517	2.5%

Source: Medicaid Eligibility Reports, September 2023 and December 2023

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment and expenditure data by programs for October 2021 – September 2023 is available in Attachment A to this report.

MCO Enrollment

In aggregate, MCO enrollment decreased by 1% from the previous to current period. This decrease is comprised of the following:

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

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

MCO Per Capita Medical Costs:

In aggregate, total MCO per capita medical costs increased by 1% from the previous to

current period. This consists of a 10% increase to pharmacy services, while non-pharmacy services remained flat between periods.

On a dollar basis, the lower enrollment levels (-1%) have been offset by the increase in per capita medical costs (1%), driving the negligible increase in total medical expenses.

CENTENNIAL CARE 2.0 AND TURQUOISE CARE

CENTENNIAL REWARDS

The Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors. Beginning in DY10, New Mexico modified its 2023 Rewards Program as illustrated below.

Reward Activity	Age Requirement	2023 Modification
Address Update (supports PHE unwinding efforts)	Any	Added new reward activity
Adult Primary Care Provider (PCB) Checkup – Complete annual PCP wellness checkup	Ages 20+	Age requirement changed from Ages 22+ to 20+
Antidepressant Medication Management - Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	No Change
Breast Cancer Screening (BCS) – Complete mammogram	Ages 50-74	Added new reward activity
Cervical Cancer Screening (CCS) – Ages 21-64: Cervical cytology (pap test) Ages 30-64 high-risk women: HPV test and/or pap test	Ages 21-64	Added new reward activity
Childhood immunizations (CIS) – Complete immunization series	Age 2	Added new reward activity
Child & Adolescent Well-Care Visit - Complete annual wellness checkup with a PCP or an OB/GYN • Bonus: Adolescent Immunization Series – Complete adolescent immunization series by 13th birthday	Ages 3-21	No Change
COVID-19 Vaccine or Booster – Complete COVID-19 vaccine or booster	All ages, as advised by CDC	No change

Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	No change
Diabetes HbA1C Test – Completion of HbA1C Test • Bonus: Diabetes HbA1C Control – Attain HbA1c control (<8%)	Ages 10-75	Reward activity eliminated
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75	No change
Flu Shot - Receive flu vaccine	Ages 6 months+	No change
Follow-up After Emergency Dept. Visit for Mental Illness – Complete follow-up visit within 30 days of emergency department visit for mental illness or intentional self-harm diagnoses	Ages 6+	Reward activity eliminated
Follow-up After Hospitalization for Mental Illness - Complete follow-up visit within 30 days of hospitalization for mental illness or intentional self-harm diagnoses	Ages 6+	Reward activity eliminated
1st Prenatal Care Visit – Complete prenatal care visit in the first trimester or within 42 days of enrollment	All ages	No change
Postpartum Visit – Complete postpartum care visit between 7 and 84 days after delivery	All ages	No change
Schizophrenia Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	Reward activity eliminated
Smoking/Vaping Prevention – Complete vaping/smoking prevention learning module	Age under 18	Added new reward activity
Step-Up Challenge (FCHAL-SU-3)– Successfully complete 3-week Step-Up Challenge	Ages 10+	Added new reward activity
Well-Baby Checkups – Complete up to six well-child visits with a PCP during the first 15 months of life and up to two well-child visits with a PCP between 16-30 months of life • Bonus: Complete all eight well-child visits with a PCP between 0-30 months of life	0-30 months	No change

Centennial Rewards Participation

In DY10 Q4, there were 182,231 Centennial Care members participating in the Centennial Rewards Program. Registering for the Centennial Rewards program is not required to participate in the program but is required for reward redemption. Quality improvement and participation trends are demonstrated in the table below.

Table 2: Centennial Rewards

CENTENNIAL REWARDS				
	January - March 2023	April - June 2023	July - September 2023	October - December 2023
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	192,588	234,766	209,316	125,575
Number of Members Newly Registered in the Rewards Program this Quarter	4,345	4,497	4,612	6,497
Number of Members Who Redeemed Rewards this Quarter**	21,939	30,608	30,542	50,159

*Only includes rewards earned THIS quarter.
**Redeemed rewards could have been earned in any of the previous 24 reporting months.
Source: Finity Quarter 4 Report

Following is a summary of DY10 Q4 observations:

- Percentage of Medicaid Enrollees Participating in the Rewards Program this Quarter
  - Member participation has increased quarter over quarter throughout the life of the rewards program, reaching an all-time high in Q4 2023 of 76.8%.
- Number of Medicaid Enrollees Receiving a Centennial Care Reward Service this Quarter
  - This measure is typically highest at the beginning of the year as the majority of members have gaps-in-care at that time. This trend is in line with previous years.
- Number of Members Newly Registered in the Rewards Program this Quarter
  - Members only need to register to redeem rewards. Registration is typically lowest in the first half of the year as members save their reward points to spend when they have more buying power or during the holidays. This trend is consistent with previous years.
- Number of Members Who Redeemed Rewards this Quarter
  - In line with registration trends, reward redemptions are typically lowest in the first half of the year as members save their reward points to spend when they have more buying power or during the holidays. Earned rewards expire December 31st of the following year (e.g., rewards earned in 2023 expire on December 31, 2024). Rewards can be redeemed anytime during that period.

Centennial Care Rewards Multimedia Campaigns

In DY10 Q4, Finity conducted the below multimedia campaigns to encourage members to keep their preventative appointments, receive vaccinations, and complete targeted condition management activities that align with state performance. All multimedia communications align with HSD's strategic goals and promote the healthy activities that members are eligible to complete to earn rewards and close gaps-in-care.

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

- 326K texts sent in Q4 2023
- 197K emails sent in Q4 2023

Monthly Redemptions Campaign: Designed to notify members who have earned rewards that they have points to spend in the Centennial Rewards Catalog on essential items like oximeters, thermometers, cleaning supplies, diapers, nursing supplies, kitchen items, and more. Texts and emails were sent in November 2023. This is an ongoing campaign and Q4 2023 results are provided below:

- 88K texts sent in Q4 2023
- 70K emails sent in Q4 2023

Points Expiration Campaign: Designed to notify members who have earned rewards to spend their points before they expire. Texts and emails were sent in October through December. This is an annual Q4 campaign and results are provided below:

- 118K texts sent in Q4 2023

Well-Baby Immunization Campaign: Designed to encourage parents/guardians to complete immunizations for their babies ages 0-30 months. Campaign texts and emails were sent in October 2023. This is an ongoing campaign and DY10 Q4 results are provided below:

- 19K texts sent in Q4 2023
- 4K emails sent in Q4 2023

Women's Cancer Screening Campaign: Designed to encourage eligible members to complete breast and cervical cancer screenings. Campaign texts and emails were sent in October and November 2023. This is an ongoing campaign and DY10 Q3 results are

provided below:

- 222K texts sent in Q4 2023
- 159K emails sent in Q4 2023

Additional Key Statistics through DY10 Q4 2023:

- Member participation in DY10 Q4 2023 reached an all-time high of over 76.8%.
  - In DY10 Q4 2023, 126K members earned $2.4M in rewards by completing healthy activities and closing gaps-in-care. This represents the most Q4 healthy activity completions in program history; however, members earnings is lowest in Q4 in line with previous years, as most members close gas-in-care earlier in the year.
  - Overall, annual dollars earned through 2023 was up 13% compared to 2022.
- In Q3 2024, for the first quarter in program history, more than 50,000 members redeemed $2M in rewards during the holiday season.

Enhanced Customer Satisfaction Survey: The results of the DY10 Q4 2023 survey are listed in table 3.

Table 3: Centennial Rewards Customer Satisfaction Survey

Centennial Rewards Customer Satisfaction Survey												
	DY10 Q1			DY10 Q2			DY10 Q3			DY10 Q4		
	# OF RESPONDENTS 1,759			# OF RESPONDENTS 2,981			# OF RESPONDENTS 2,686			# OF RESPONDENTS 3,954		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Centennial Care?	97%	3%	n/a	96%	4%	n/a	97%	3%	n/a	96%	4%	n/a
Are you satisfied with your doctor?	87%	4%	9% I don't have a doctor	88%	4%	8% I don't have a doctor	88%	5%	7% I don't have a doctor	88%	5%	8% I don't have a doctor
Are you satisfied with your health plan?	97%	3%	n/a	95%	5%	n/a	95%	5%	n/a	96%	4%	n/a
Are you satisfied with the help provided by your care coordinator?	92%	7%	1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator	92%	8%	<1% I don’t have a care coordinator	92%	8%	<1% I don't have a care coordinator

Source: Finity Quarter 4 Report

TURQUOISE CARE

On January 25, 2023, HSD signed Intent to Award notifications for 4 Managed Care Organizations. The 4 MCOs selected were 2 incumbents, Blue Cross Blue Shield of New Mexico and Presbyterian Health Plan, and 2 new MCOs, Molina Healthcare of New Mexico and UnitedHealthcare Insurance Company. Centennial Care 2.0 MCO, Western Sky Community Care, Inc., was not selected. The Turquoise Care contracts were fully executed on November 7, 2023. Readiness Review activities launched January 8, 2024, and began with desk audits. Onsite Reviews are scheduled for March 12- 21, 2024. The Turquoise Care program will Go Live on July 1, 2024.

3

ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

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

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

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

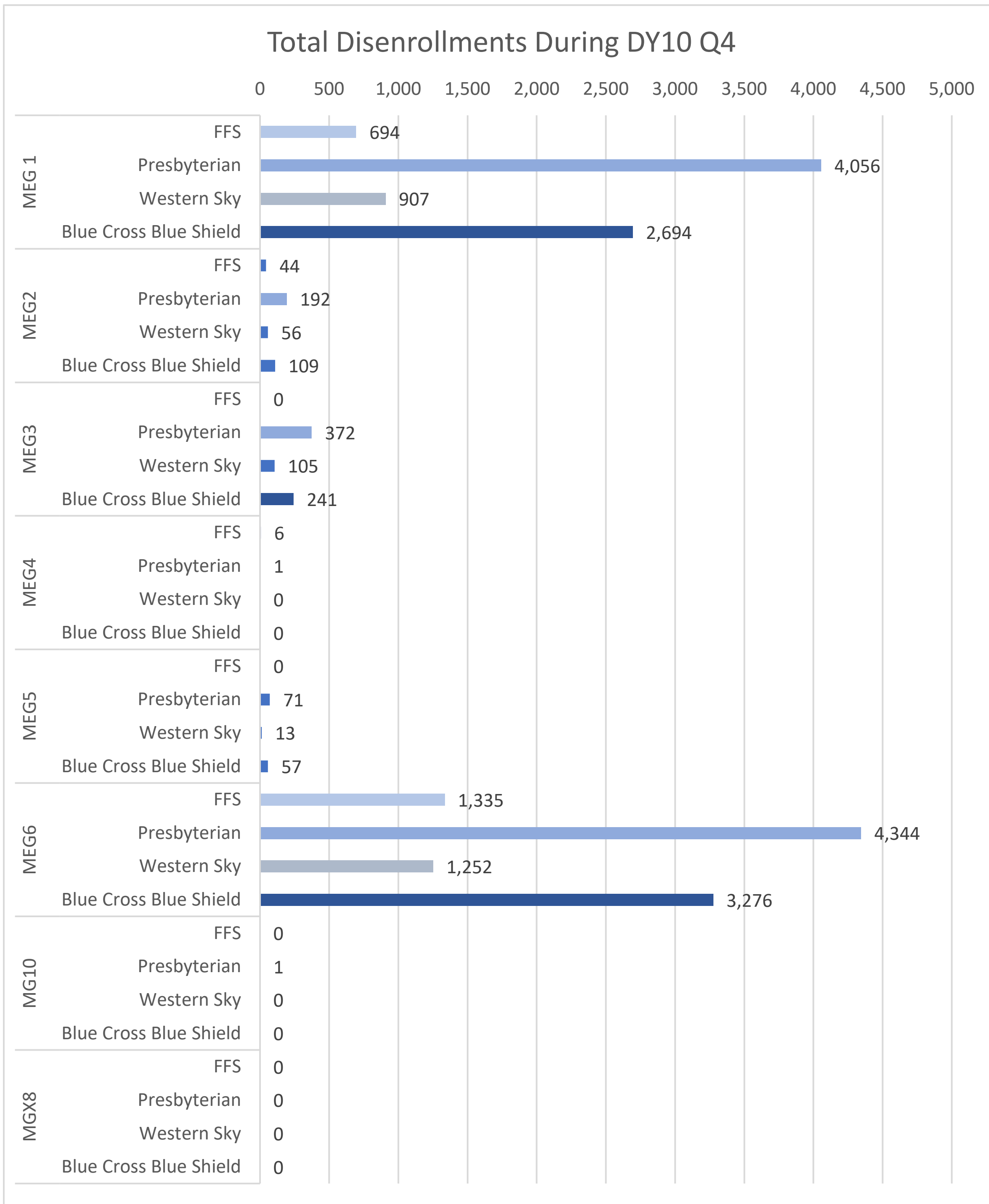
Due to Public Health Emergency (PHE) regarding Coronavirus (COVID-19), HSD meets the Maintenance of Effort (MOE) statutory requirements to receive the 6.2% increased Federal Medical Assistance Percentage (FMAP) by ensuring individuals are not terminated from Medicaid if they were enrolled in the program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

DY10 Q4 Data

Demonstration Population		Total Number Demonstration Participants DY10 Q4 Ending December 2023	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY10 Q4 (October-December 2023)
Population MEG1 - TANF and Related	0-FFS	32,771	340,151	694
	Presbyterian	188,559	29,455	4,056
	Western Sky	40,368	6,959	907
	Blue Cross Blue Shield	127,345	20,726	2,694
	Summary	**389,043**	**397,291**	**8,351**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,491	36,160	44
	Presbyterian	20,466	2,216	192
	Western Sky	4,152	550	56
	Blue Cross Blue Shield	12,650	1,313	109
	Summary	**39,759**	**40,239**	**401**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Presbyterian	21,823	23,845	372
	Western Sky	4,095	4,542	105
	Blue Cross Blue Shield	11,297	12,437	241
	Summary	**37,215**	**40,824**	**718**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	170	304	6
	Presbyterian	107	13	1
	Western Sky	13	4	0
	Blue Cross Blue Shield	79	17	0
	Summary	**369**	**338**	**7**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Presbyterian	3,139	3,552	71
	Western Sky	555	615	13
	Blue Cross Blue Shield	2,375	2,698	57
	Summary	**6,069**	**6,865**	**141**
Population MEG6 - VIII Group (expansion)	0-FFS	29,665	277,946	1,335
	Presbyterian	130,172	48,497	4,344
	Western Sky	37,286	13,824	1,252
	Blue Cross Blue Shield	102,011	38,749	3,276
	Summary	**299,134**	**379,016**	**10,207**
Population MEG10 - IMDSUD Group	0-FFS	10	36	0
	Presbyterian	69	505	1
	Western Sky	19	93	0
	Blue Cross Blue Shield	68	342	0
	Summary	**166**	**976**	**1**
Population MEGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Presbyterian	176	1,068	0
	Western Sky	67	325	0
	Blue Cross Blue Shield	228	991	0
	Summary	**471**	**2,384**	**0**
Summary		**772,226**	**867,933**	**19,826**

Source: Enrollee Counts Report

DY10 Q4 Complete Data



Source: Enrollee Counts Report

4

OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY10 Q4	In DY10 Q4, the Human Service Department (HSD), Medical Assistance Division (MAD) continued to provide coaching, outreach, and educational activities through webinars to Presumptive Eligibility Determiners (PEDs) in the Presumptive Eligibility (PE) and Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) programs to help PEDs better assist their clients in the completion of Medicaid eligibility applications, both online and telephonically. HSD staff provide a monthly newsletter called "PED Medicaid Monthly" it is electronically sent to active PEDs. The newsletter provides updates on HSD programs, policy changes, YESNM-PE system updates, tips and audit reminders for PEDs. The newsletter features a PED Hero section to allow active PEDs to nominate and feature one of their own. HSD also provided online PE certification and refresher demo training sessions for prospective and current PEDs. HSD staff participated in the NM 45th Annual Conference on Aging assisting New Mexicans apply for healthcare coverage and answering general Medicaid questions related to elderly individuals and other family concerns.

5

COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

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

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

6

OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments through DY10 Q4 reflected the Centennial Care 2.0 rates effective for the period from January 1, 2023 through December 31, 2023. The rates were developed with efficiency, utilization, trends, prospective program changes, and other factors as described in the rate certification reports; the rate certification reports for January 1 through December 31, 2023 were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 21, 2022. The rates were updated for the July 1, 2023 to December 2023 period and submitted to CMS on July 11, 2023.

During DY10 Q4, financial payments were made for University of New Mexico Medical Group (UNMMG) directed payment, University of New Mexico Hospital (UNMH) directed payment, hospital value-based payments, retroactive reconciliation, health care quality surcharge reconciliation, hepatitis C reconciliation, and recoupments for failure to reports.

The payments related to the public health emergency due to the Coronavirus (COVID-19) pandemic was $27.1 million during CY2022. The COVID-19 non-risk payments during CY2023 was $1.7 million through September 30, 2023. In addition, expenditures and member months for substance use disorder in an institution for mental diseases (SUD IMD) were reported for DY6 to DY10 for both fee-for-service and managed care.

SYSTEM ISSUES

There are no system issues to report for this quarter.

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

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

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

Following is a chronology of the renewals to date:

01/27/2020	04/26/2020	07/25/2020	10/23/2020	01/21/2021	04/21/2021	07/20/2021
• First Declaration	• 1st Renewal	• 2nd Renewal	• 3rd Renewal	• 4th Renewal	• 5th Renewal	• 6th Renewal
10/18/2021	01/16/2022	04/16/2022	07/15/2022	10/13/2022	01/11/2023	5/11/2023
• 7th Renewal	• 8th Renewal	• 9th Renewal	• 10th Renewal	• 11th Renewal	• 12th Renewal	• Final Extension as announced by Biden administration

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

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

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

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

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

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

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

New Mexico Disaster Relief State Plan Amendments (SPAs)

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

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

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

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

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

1135 Waiver

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

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

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

Appendix Ks

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

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

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

and suspending prior authorization requirements for waiver services, which are related to or resulting from this emergency).

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

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

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

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

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

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

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

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

1915c (Supports Waiver and Developmental Disabilities Waiver)

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

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

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

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

PATIENT CENTERED MEDICAL HOMES (PCMH)

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

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

Table 4 below reports the total number of members paneled to a PCMH per MCO. DY10 Q3 reflects an overall aggregate decrease in members receiving care through a PCMH compared

to DY10 Q2. The DY10 Q4 data will be reported in the DY11 Q1 CMS Quarterly Monitoring Report. This reduction in membership and subsequent paneling to PCMH can be attributed to the ending of the Public Health Emergency (PHE). As a result, members were required to renew their Medicaid financial eligibility. During the PHE, members eligibility was continuously renewed as approved by federal waiver. Members have been issued correspondence related to the ending of the PHE and several different options on how to renew their Medicaid.

Table 4: PCMH Assignment

PCMH ASSIGNMENT				
Total Members Paneled to a PCMH				
	DY9 Q4	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**
BCBS	154,635	167,746	161,328	151,385
PHP	271,339	269,447	267,851	225,734
WSCC	37,129	38,316	52,767	47,826
Percent of Members Paneled to a PCMH				
	DY9 Q4	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**
BCBS	51.20%	55.30%	52.70%	53.60%
PHP	63.60%	62.80%	66.10%	61.00%
WSCC	39.80%	40.10%	59.80%	51.40%

Source: MCO Report #48 DY10 Q3

MCO PCMH initiatives:

BCBS: To reduce ER utilization and hospital readmission for members in a PCMH, BCBS utilizes an array of transitions of care programs including a growing team of Care Coordinators (CC), Community Health Workers (CHW) and the paramedicine program. CCs and CHWs assist with care plans, locating services and resources in the members community, assistance with medications, arranging transportation to appointments, and visits with the member when they return from the hospital. In Q3, BCBS observed HEDIS outcomes for members paneled to a PCMH continue to improve as compared to members not paneled to a PCMH. BCBS's paramedicine program uses independent emergency technicians to visit members in their home following a hospital stay, provides home safety assessments, and can assist with obtaining medical equipment to improve outcomes for PCMH members.

PHP: In DY10 Q3, PHP reported the addition of 7 small volume groups to a PCMH program. PHP continues to monitor member visits to PCMH within 7 days following an emergency room visit and after hospital inpatient discharge to ensure that patients receive adequate care during their transition back home. PHP's VBP team continues to educate PCMH care teams on the

importance of timely care post-discharge. Monthly learning collaboratives continued in Q3, with training on pediatric and preventative care quality measure education. Additionally, quality improvement topics such as Medical Record Review (MRR) and Clinical Data Integration (CDI) continue to support PCMH groups.

WSCC: WSCC continued its efforts in DY10 Q3 to expand telehealth services via outreach campaigns providing options for telemedicine providers and offering night/weekend visits. WSCC's value-based programs are designed to incentivize providers to reduce healthcare costs and increase access for PCMH members. WSCC's VBP team continues to work with PCMH providers to review health screenings and priority outcome metrics for their membership to close gaps in care. WSCC's expansion of delegated care coordination continued in Q3, and partnerships will increase the number of care managers available to WSCC members in turn, increasing engagement with high-risk patients to ensure necessary support and follow-up care. The expansion supports resources to PCMH. WSCC continues to utilize Collective Medical Technologies reporting and monitors claims data for Emergency Department (ED) utilization and readmissions. WSCC also utilizes mPulse for members with high ED utilization to support scheduling appointments and finding resources. Additionally, providers can access self-evaluation reporting around cost, utilization, hospital/ED admissions, claims, and assigned membership statistics via WSCC's provider portal.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities	
DY10 Q4	HSD continued to monitor MCO enrollment and member engagement through the quarterly Care Coordination Report. This report includes data related to completion of required assessments and touchpoints within contract timeframes. The DY10 Q4 report contains data from DY10 Q3. DY10 Q4 data will be reported in DY11 Q1. The MCO aggregate results show performance benchmarks of 85% were met, or exceeded, for timely completion of Health Risk Assessments (HRAs) for 'new to Medicaid' members, members with a change in health condition, Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs). The aggregate completion rate for HRAs for 'new to Medicaid' members was 96% in DY10 Q2 and DY10 Q3. The aggregate completion rate for HRAs for members with a 'change in health condition' was at 99% in DY10 Q2 and DY10 Q3. Aggregate completion percentages for CNAs for CCL2 members decreased from 91% in DY10 Q2 to 90% in DY10 Q3. Aggregate completion percentages for CNAs for CCL3 members decreased from 90% in DY10 Q2 to 86% in DY10 Q3. MCOs noted that multiple rescheduled assessments and members not keeping scheduled appointments resulted in a decrease in timely completion of CNAs. MCOs will continue to monitor by utilizing daily operational oversight reports and tracking mechanisms to increase timely completion. Aggregate completion percentages of CCPs for CCL2 members was at 94% in DY10 Q2 and DY10 Q3. CCPs for CCL3 members increased from 95% in DY10 Q2 to 96% in DY10 Q3. In DY10 Q1, BCBS initiated a process improvement project to streamline CCP completion, decrease the completion time, allow for more detail, and be more member centric. In DY10 Q2, BCBS reported a 50% reduction in the time required to complete a CCP for those participating in the project, which allowed for a higher level of quality engagement with members. BCBS conducted targeted training with all care coordinators in DY10 Q3.

	The Care Coordination Report includes MCO strategies for engaging and retaining members. In DY10 Q3, MCOs reported on multiple strategies to retain engagement with members. BCBS's care coordinators have taken an active role in volunteering at health fairs to educate members on the services and benefits available through Care Coordination with a focus on expectant parents and encouraging them to participate in BCBS's Special Beginnings Program. PHP utilizes Community Health Workers (CHWs) and Peer Support Specialists (PSSs) who collaborate with community-based organizations to facilitate increased engagement. This is particularly effective in rural areas of the state. PHP has contracted with Albuquerque Ambulance to conduct outreach to members that have been unable to reach. A focus is on those members with a high number of low acuity emergency department visits. EMT staff conduct HRAs and connect members to a care coordinator to assist in providing the additional services they need. WSCC participates in numerous community events across the state, from school-based activities to cultural celebrations. WSCC partnered with New Mexico Community Care (NMCC), a statewide paramedicine program, to expand efforts to complete HRAs for members unable to be reached, outreach to members with a Notification of Pregnancy, provide education, and to complete A1C test administration for members who are non-compliant with their annual screening. NMCC was able to provide outreach to 5,000 member referrals each month statewide during the reporting quarter. HSD continues to monitor strategies and interventions for all MCOs to retain and increase compliance with performance benchmarks. The table below details aggregate and individual MCO performance from DY9 Q4 through DY10 Q3. DY10 Q4 data will be reported in DY11 Q1.

Table 5: Care Coordination Monitoring

MCO Performance Standards	DY9 Q4	DY10 Q1	DY10 Q2	DY10 Q3
HRAs for new Members	**97%**	**97%**	**96%**	**96%**
BCBSNM	97%	97%	95%	96%
PHP	96%	96%	95%	94%
WSCC	100%	100%	100%	100%
HRAs for Members with a change in health condition	**99%**	**99%**	**99%**	**99%**
BCBSNM	100%	99%	100%	100%
PHP	98%	98%	98%	96%
WSCC	100%	100%	100%	100%
CNAs for CCL2 Members	**94%**	**90%**	**91%**	**90%**
BCBSNM	89%	88%	88%	87%
PHP	96%	90%	92%	90%
WSCC	99.8%	99.7%	100%	100%
CNAs for CCL3 Members	**91%**	**86%**	**90%**	**86%**
BCBSNM	86%	86%	86%	83%
PHP	93%	85%	91%	85%
WSCC	100%	100%	100%	100%
CCPs for CCL2 Members	**96%**	**94%**	**94%**	**94%**
BCBSNM	88%	85%	85%	84%
PHP	99%	99%	99%	99%
WSCC	98%	96%	93%	97%
CCPs for CCL3 Members	**97%**	**95%**	**95%**	**96%**
BCBSNM	89%	86%	87%	90%
PHP	100%	99%	98%	99%
WSCC	98%	96%	94%	96%

Source: HSD DY9 Q4 to DY10 Q3 Report #6 –Care Coordination Report
Percentages in bold are MCO aggregate of the total assessments due and completed.

Care Coordination Audits

In DY10 Q3, HSD monitored MCO compliance with contract and policy by continuing to conduct Care Coordination audits. These audits monitor:

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

- Confirmation that members are being correctly referred for a Comprehensive Needs Assessment (CNA) if triggered by a completed Health Risk Assessment (HRA): Health Risk Assessment and Care Coordination Level Audit.
- Placement of members in the correct Care Coordination Level (CCL), based on information in the CNA and criteria outlined in contract: Health Risk Assessment and Care Coordination Level Audit.

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

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

The table below details the Transition of Care (TOC) Audit results from DY9 Q4 through DY10 Q3. DY10 Q4 data will be reported in DY11 Q1.

Table 6: Transition of Care Audit

Transition of Care	DY9 Q4	DY10 Q1	DY10 Q2	DY10 Q3
In-Patient	**91%**	**99%**	**90%**	**88%**
BCBS	90%	97%	97%	85%
PHP	89%	99%	97%	85%
WSCC	95%	100%	77%	93%
Nursing Facility	**93%**	**96%**	**90%**	**99%**
BCBS	95%	98%	93%	100%
PHP	100%	100%	100%	100%
WSCC	85%	90%	77%	96%

Source: HSD DY9 Q4 to DY10 Q3 Quarterly TOC Audits
Percentages in bold are MCO averages.

The aggregate compliance rate for IP to Community TOC files decreased from 91% in DY10 Q2 to 88% in DY10 Q3. The aggregate compliance for NF to Community TOC audited files increased from 90% in DY10 Q2 to 99% in DY10 Q3.

HSD provided detailed findings, reiterated contract requirements, and stressed the importance of comprehensive documentation. Additionally, HSD met with each MCO at

monthly meetings and discussed the findings.

Areas noted for discussions with MCOs:

- BCBS's compliance percentage for IP to community decreased from 97% in DY10 Q2 to 85% in DY10 Q3, due primarily to the 3-day post-discharge assessment being conducted by telephone rather than in-home as required. BCBS acknowledged this finding, conducted targeted training to staff, and ensured that this requirement will be adhered to going forward.
- PHP's compliance percentage for IP to community decreased from 99% in DY10 Q2 to 85% in DY10 Q3, primarily due to documentation issues and a lack of coordination with discharge planning teams. PHP acknowledged the findings and has conducted targeted training to stress the importance of collaboration and increase compliance with this requirement.
- WSCC's IP to community compliance increased from 77% in DY10 Q2 to 93% in DY10 Q3, due to an improvement in documentation and inclusion of all required elements in their TOC plans.
- BCBS and WSCC improved their NF to community compliance percentages significantly with improved documentation and comprehensive TOC plans and follow-up. PHP continued to conduct comprehensive and thorough TOC plans and assessments with timely follow-up in their members' place of residence.
- All MCOs collaborated with Community Reintegration staff to confirm all needed services were in place and ensure smooth transitions for their NF to community members.

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

The table below details the Health Risk Assessment and Care Coordination Level Audit results from DY9 Q4 through DY10 Q3. DY10 Q4 data will be reported in DY11 Q1.

Table 7: Health Risk Assessment and Care Coordination Level Audit

HRA/CCL Audit	DY9 Q4	DY10 Q1	DY10 Q2	DY10 Q3
Health Risk Assessment (HRA)	**99%**	**95%**	**98%**	**98%**
BCBS	99%	99%	99%	99%
PHP	99%	100%	99%	96%
WSCC	99%	86%	96%	99%
Care Coordination Level (CCL)	**95%**	**97%**	**95%**	**98%**
BCBS	93%	99.7%	90%	99%
PHP	94%	99.7%	100%	99%
WSCC	99%	92%	96%	97%

Source: HSD DY9 Q4 to DY10 Q3 HRA and CCL Audits
Percentages in bold are MCO averages

Results of the HRA Audit showed that the MCOs consistently met all contract requirements when completing HRAs. HSD noted that aggregate rates of compliance remained at 98% in DY10 Q2 and DY10 Q3. BCBS was at 99% compliance from DY10 Q1 to DY10 Q3, while PHP decreased from 99% in DY10 Q2 to 96% in DY10 Q3. WSCC increased compliance from 96% in DY10 Q2 to 99% in DY10 Q3.

Aggregate rates of compliance for the CCL Audit increased from 95% in DY10 Q2 to 98% in DY10 Q3. BCBS increased in compliance from 90% in DY10 Q2 to 99% in DY10 Q3, primarily due to improved documentation of members' HSD required Care Coordination Levels. PHP was at 100% in DY10 Q2 and 99% in DY10 Q3. HSD noted PHP's excellent documentation and comprehensive assessments. WSCC saw an increase from 96% in DY10 Q2 to 97% in DY10 Q3. WSCC acknowledged a finding of incorrect leveling for 1 member. They ensured that targeted re-training would occur on correct leveling criteria and that the member would be correctly re-leveled.

Care Coordination CNA Ride-Alongs

HSD conducted 3 CNA ride-alongs with MCO care coordinators in DY10 Q3, to observe completion of member assessments.

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

HSD determined whether care coordinators properly administered the Community Benefits Services Questionnaire (CBSQ) and the Community Benefits Member Agreement (CBMA) to ensure that members had appropriate access to Community Benefits.
HSD provided written feedback to the MCOs on the following findings:

- Care coordinators adhered to all contractual responsibilities in their assessments.
- Care coordinators were kind, thorough, and professional with the members.
- HSD noted care coordinators employing motivational interviewing with members.
- Care coordinators often went beyond contract requirements to assist members with locating and applying for additional resources and services.
- Care coordinators and members were adjusting to a return to in-home, face-to-face assessments after several years of conducting them virtually. Both the care coordinators and members had positive feedback and expressed feeling that an in-person assessment was beneficial.
- HSD recommended that MCOs conduct training on Medicare for increased knowledge with dual eligible members.

Care Coordination HRA Ride-Alongs
HSD conducted 14 virtual HRA ride-alongs with MCO care coordinators in DY10 Q3, to observe completion of member assessments. All HRAs observed were conducted telephonically.

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

- The majority of Assessors were friendly, thorough, and professional with the members.
- Assessors often explained to members that they could request Care Coordination in the future if they would like assistance.
- Assessors referred members to resources to address specific concerns.
- Assessors provided warm handoffs to customer service staff for needs such as additional insurance cards or to Care Coordination staff to schedule their Comprehensive Needs Assessment.
- HSD noted opportunities for improvement that included:
    - Ensuring that Assessors explain the purpose of the HRA;
    - Ensuring that Assessors thoroughly explain the services available through Care Coordination;
    - Ensuring all Assessors employ an unhurried demeanor with heightened listening skills; and
    - Ensuring all contract required topics are addressed in the HRA.

Care Coordination MCO Meetings

HSD conducts regular quarterly meetings with all MCOs to review data on member engagement, Care Coordination timeliness, performance analysis, and member outcomes. HSD held the DY10 Q3 Quarterly Meeting on September 21, 2023, and reviewed:

- Aggregate data from the following reports related to enrollment and compliance with assessment and touchpoint timeliness:
  - Care Coordination Report
  - Children in State Custody (CISC) Report
  - Comprehensive Addiction and Recovery Act (CARA) Report
  - Utilization Report
- Aggregate data from the Care Coordination and Children in State Custody Performance Measures (CC and CISC PMs)
- Results of the DY10 Q2 audits of member categorization, Health Risk Assessments (HRAs), Care Coordination Levels (CCLs) and compliance with Transition of Care (TOC) requirements
- Results of the DY10 Q2 audits of CISC Health Risk Assessments (HRAs) and Care Coordination Levels (CCLs)

HSD requested that the MCOs present on best practices that care coordinators, or their Care Coordination units use that have contributed to improved outcomes. Additionally, HSD requested they speak on areas that have been a challenge for their care coordinators or Care Coordination units.

- BCBS presented information on their Community Health Worker (CHW) team. CHWs are known as trusted frontline workers in their communities and members feel comfortable with these individuals. CHWs are able to increase health literacy by providing essential education, assisting in scheduling, and providing transportation to medical appointments as well as attending appointments with members if requested. CHWs work closely with care coordinators to conduct outreach, complete touchpoints, and encourage members to advocate for themselves. BCBS has been able to increase engagement by utilizing CHWs for members who otherwise might decline Care Coordination services.
- PHP provided information on their TytoCare home device for members, engaged in Care Coordination, who have had avoidable ED visits. PHP provides members with home equipment, trains members on how to use the equipment, and the member or parent can hold the device to the ear, heart, throat, listen to the lungs, etc. to obtain their vital signs. PHP has provided this device statewide with the intention of bridging gaps that exist in rural areas. Care coordinators conduct in-home follow up with members after these virtual visits and the information provided can assist the member and care coordinator in ensuring any additional needed services are provided.

- WSCC presented information on their paramedical providers that conduct outreach in communities across the state. These paramedics and EMTs are people in the community who members know and trust. The paramedical professionals focus on high risk members, members who have been unable to reach, or have multiple low-acuity ED usage. They conduct assessments, provide health education, connect them to needed services, and are adept at being a listening ear for members. Paramedicine professionals make referrals for home visiting, link the member to resources for food and utility services, provide A1C tests, and connect them with a care coordinator for continued services.

All MCOs expressed that connecting with members who have been unable to reach or difficult to engage is a challenge; however, the programs highlighted above have helped to bridge those gaps.

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

HSD also meets individually with each MCO twice per quarter to address Care Coordination issues related specifically to their MCO. In DY10 Q3, meeting topics included:

- Barriers to collaboration with Permanency Planning Workers for Children in State Custody and implementing additional assistance from HSD;
- Challenges in contracting with providers for Full Delegation and ways to increase Shared Functions Care Coordination Provider Sites;
- Discussion of HRA and CNA ride-along findings;
- Review of HSD systems data related to member Care Coordination Levels and ensuring alignment with MCO submitted enrollment data;
- Discussion of report revisions to the Quarterly Comprehensive Addiction and Recovery Act (CARA) report, the Quarterly Children in State Custody (CISC) report, and the Developmental Disabilities Care Coordination/Case Manager Contact List;
- Challenges to increasing member utilization of Native American Traditional Healing Benefits;
- Review and discussion with BCBS of their revised Full Delegation Provider audit tools;
- Discussion with PHP of the reasons for their decrease in members assigned to Full Delegation Care Coordination and what steps PHP is taking to contract with

additional provider sites; and
- Discussion with WSCC concerning noted revisions to their Transition of Care (TOC) plans, their system platform changes, and changes they can implement when submitting member files to ensure auditors locate all required elements.

BEHAVORIAL HEALTH

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

In DY10 Q3, a total of 32,896 Medicaid members received behavioral health services through telehealth. This quarter's total did see a decrease of 19.6% compared to the DY9 Q3 total of 40,931 persons served through this medium. Of those served in DY10 Q3 through telehealth,13,448 persons reside in rural or frontier counties. This accounts for 40.9% of those served and is reflective of client and provider preferences and the high value of telehealth in New Mexico's rural and frontier landscapes.

Service delivery over telephonic means continues to see a decrease over the past quarters. In DY10 Q3,17,035 members received services through this modality compared to 17,515 in DY10 Q2 which is a decrease of 480 people or 3%. BHSD continues to evaluate which behavioral health services are appropriate to continue delivery through telephone now that the public health emergency is over. This option was undoubtably a critical link to services during the COVID-19 crisis and now.

Due to the end of the Public Health Emergency, which was tied to COVID-19 mitigation efforts, the number of Medicaid beneficiaries utilizing telehealth and telephonic services have seen decreases quarter-to-quarter. As telehealth and telephonic services are available, the trend does indicate person-to-person treatment is widely preferred, but for capacity and access, telehealth continues to be a great tool and is still widely utilized.

TREAT FIRST

As depression, anxiety and other behavioral health needs surge from the stresses related to COVID-19, Treat First engages clients quickly in services that address their immediate needs. The 39 certified Treat First agencies have seen over 953 new clients during the first three months of 2024. With support from the Treat First agencies, 27.3% of these individuals were able to resolve their issues with solution focused interventions within 4 visits. The balance of those clients continued in services. The "No Show" for clients in this period was very low, only 8.5%.

When youth or adults were asked how they felt their Treat First visits were going, on average, both groups felt that the sessions were working very well to address their immediate needs. Youth rated sessions at 92.7% and adults at 87.0%.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an important evidence-based tool that can be used by virtually all primary care providers to identify problematic alcohol or drug use, depression, or trauma, and then refer a patient for additional treatment if appropriate. SBIRT was added to the state's Medicaid program for the first time in 2019, and since then, BHSD has conducted expanded outreach to providers as well as state-sponsored provider trainings around the state.

In DY10 Q3, SBIRT utilization increased 113.07% to 5,329 persons served during the quarter compared to 2,501 in DY10 Q2. The increased utilization of SBIRT is also noted in DY10 Q3 when compared to the same quarter of the prior year, where 3,810 persons were served, when compared to the current results, there was a 39.87% increase from that period.

On a monthly average, 739 persons received SBIRT in DY10 Q3 with the greatest utilization occurring in August with 949 persons screened. The current utilization trend in SBIRT for DY10 is greater than any of the DY9 quarterly results thus far; however, the trend may change as seen over prior years reporting.

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

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

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

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

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

In DY10 Q3, the total number of persons served with a SUD in an IMD was 3,880, which is an increase of 203 persons (or 5.52%) compared to DY10 Q2. When comparing DY10 Q3 result to DY10 Q2, the utilization remained stable with 1,610 persons served on a monthly average. As the latest trend for DY10 shows marginal increases compared to DY9, the results will continue to be reviewed and analyzed as the demonstration year continues.

SUD HEALTH IT

In DY10, HSD developed and maintain the necessary SUD Health IT capabilities and infrastructure to support member health outcomes and address the SUD goals of the demonstration. New Mexico SUD workgroup continues to review our Health IT plan to ensure the progress and support of each milestone.

Utilization of the New Mexico Prescription Monitoring Program (NM PMP) continues to increase the number of providers that are utilizing it with 89.52% of providers checking prescriptions, which is a 2.82% increase over the previous year at 87%. HSD continues to monitor with data as updated from the New Mexico Board of Pharmacy.

The New Mexico Fee for Service (FFS) Drug Utilization Review (DUR) Board conducted the Fee for Service Drug Utilization Review meeting on February 7, 2024. Attendees included board members (a quorum was met for voting purposes) and invited guests, including managed care organization representatives. Client counts for both FFS and Managed Care were reported with small decreases in total members enrolled. This was reported as an expected decrease correlating with the public health emergency unwinding. Prospective DUR edits targeted for fraud waste and abuse prevention and the SUPPORT Act were presented and quantitative reporting will begin for the second quarter 2024 at the DUR meeting. The edits presented are existing edits, and no new edits or changes are needed for the quarterly reporting. The State's Fiscal Agent presented an overview of the new data collection program "Hercules" which is anticipated to begin in winter 2024. The system will have more integrated analytics with respect to DUR reports and data, eliminating a portion of the manual reviews performed on data now. The fourth quarter 2023 intervention for patients diagnosed with hepatitis C and no record of medication treatment was mailed on December 4, 2023. A summary report for Antipsychotic Metabolic Monitoring Intervention was reported with a 7.1% response rate. This intervention was to ensure members are

receiving appropriate metabolic monitoring needed to avoid poor metabolic outcomes which can be associated with first and second generation antipsychotic treatment. The most common response was “patient is no longer under provider’s care”. Standing reports for SUPPORT Act were reported with no new trends or concerns. The Board approved the first quarter 2024 mailing of use of a glucagon-like peptide (GLP-1) inhibitor approved for therapy for treatment of type 2 diabetes without the clinical diagnosis of diabetes. The mailing also included education of GLP-1 inhibitors and FDA approved indications and education around the use of these products. A presentation of a proposed intervention for compliance with the SUPPORT Act targeted an intervention of Opioids concurrently prescribed with central nervous system depressants and a diagnosis of respiratory impairment. A second arm of this intervention would be to identify patients without a naloxone claim in the last 2 years. This intervention will be presented at the second quarter 2024 DUR meeting with populated data for a vote to approve the intervention for mailing. Work continues for removal of the prior authorization for treating naive or pan sensitive hepatitis C treatment medications.

In 2023, Project ECHO trained over 3,100 New Mexico healthcare providers. Thirty-six unique clinical, mental, and public health topic areas were addressed, including but not limited to: Diabetes Management in Primary Care, Improving Perinatal Health Opioid Use Disorders for Prescribers, Adverse Childhood Events, and Alcohol Use and Mental Health. HSD released a supplement to providers outlining opportunities to participate in ECHO case reviews. Additionally, recruitment for participation continues to expand, with particular emphasis on engaging rural, underserved, and tribal communities.

The New Mexico Bridge Program continues to expand its training on prescribing for Opioid Use Disorder (OUD) for hospital emergency departments, inpatient, and related clinics throughout the state. The New Mexico Bridge team conducts live trainings at hospitals and provides a virtual training series for hospitals and community members. The project has engaged with 11 hospitals since its inception in 2021. These hospitals have completed various stages of engagement and implementation. These include Holy Cross Medical Center, Gallup Indian Medical Center, Socorro General Hospital, Memorial Medical Center, University of New Mexico Hospital, and Lovelace Women’s Health Center. These six hospitals have started prescribing buprenorphine and the program has tracked 744 patients that have received this treatment to date from Taos, Memorial, Gallup, Socorro, and UNM Hospital (data collection from Lovelace is currently being gathered). Four hospitals participated in aspects of engagement and/or training, including Sierra Vista Hospital, Plains Region Medical Center, Northern Navajo Medical Center, and Gerald Champion Medical Center. NM Bridge started engagement and planning trainings with Christus St. Vincent Regional Medical Center, including both their emergency department and labor and delivery

department. NM Bridge is in discussion with other hospitals to plan engagement in the future, including San Juan Regional Medical Center, UNM Sandoval Regional Medical Center, and Lincoln County Medical Center. All hospitals serve patients in/from both rural and urban settings. Most of the work during this time period has been helping UNM Hospital and Lovelace complete their programs, as well as starting new programs with Sierra Vista and Christus St. Vincent. NM Bridge continues to work with Socorro to provide additional trainings. NM Bridge also continues to work with Taos Holy Cross to support their Women's Health Institute. NM Bridge is planning on-site trainings with Lovelace Women's Hospital in 2024, and providing monthly trainings remotely to hospitals. The NM Bridge trainings include buprenorphine initiation, responsible opioid prescribing, treatment in clinic settings, SUD and pregnancy, neurobiological basis of SUD, case reviews, toxicology updates, fentanyl updates, and more. NM Bridge continues to reach out statewide to encourage engagement. As part of this outreach, the NM Bridge team presented on the NM Bridge program to the New Mexico Hospital Association on November 11, 2023. The NM Bridge team also is working on adding a new team member who is a Certified Peer Support Specialist and a Peer Supervisor at Presbyterian Health Systems to support NM Bridge hospitals with the hiring and supervision of a peer. More information on the program can be found at www.nmbridge.com.

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

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

HSD and vendors for the new MMISR continue to design and implement enhanced data analytics in 2023. Smart phone apps are part of the MMISR unified public interface (UPI). HSD and vendors for the new MMISR continue to design and implement smart phone capabilities (UPI) in 2024. This initiative will assist in retention or treatment for OUD and other SUDS. HSD and vendors for the new MMISR are also designing and implementing data services to provide analytics for public health and clinical support for providers, which is in progress.

ADULT ACCREDITED RESIDENTIAL TREATMENT CENTERS (AARTC) SERVICES

During DY10 Q4, 1 AARTC provider application is still under review awaiting additional document submission. A new letter of intent was received alongside the 1 received in DY10 Q3. Submission of applications from those letters of intent is still in process. An AARTC provider has decided to stop providing services at all 3 of their locations as of March 26, 2024. A total of 24 AARTCs provider applications have been approved since the onset of the application process in December of 2019 (multiple providers have multiple locations).

Table 8: AARTC Client Counts

MEDICAID CLIENT COUNTS				
PROVIDER #	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
716	0	0	0	0
090	65	58	67	44
037	322	343	331	90
081	14	5	14	22
589	8	5	8	4
332	26	0	26	18
049	54	21	54	12
825	30	24	30	8
896	0	0	0	2
302	105	88	105	33
60	27	33	27	5
760	17	14	17	41
Unduplicated Total	**668**	**591**	**679**	**279**

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

There are 17 AARTCs in operation, approved to bill Medicaid. The data above identifies the total number of clients who received AARTC services during DY10 Q4. Client counts are impacted by a claim lag of up to 120 days following the end of the recent quarter. The provider number is a unique identifier and is used to correlate the number of members seen by each provider for each quarter. Providers who were not approved to bill Medicaid for previous quarters have NA in the data field to represent this. Although 12 provider sites are represented in the chart above, provider 037 has 4 sites represented in their data. All AARTC provider sites are actively in the process of receiving distinct identification numbers to ensure accuracy in client counts for each site.

Medicaid utilization decreased from 679 individuals in DY10 Q3, to 279 individuals in DY10 Q4. The decrease may be attributable to the 90 day claim lag for services provided during the time period. It is expected that numbers will fluctuate as actual counts are adjusted to account for claims lag. Further analysis is warranted to ensure counts are accurately

reported and represented for those providers. The table reflects refreshed numbers in all quarters.

Rates are assessed by acquiring 1 full year of utilization by each provider with a review of expenditure data collected to determine the actual costs of operation. Though 3 providers did complete the re-base process in DY10 Q2, refinement of the process is required to implement the adjusted rates as well as advance to next rebasing cluster.

HEALTH HOMES (HHs)

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

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

CareLink Health Homes (CLNM) Activities	
DY10 Q4 Activities	In Q4, the Behavioral Health Services Division (BHSD) continued onsite evaluation of the CLNM Health Home (HH) Program. The onsite evaluation report showed an increase in team culture, collaboration, family support engagement and stronger relationships among providers. The evaluation reports showed an increase in consistent and comprehensive care coordination with frequent touchpoints and regular client engagement (1-3 times a month) across all charts. There was also an increase in collaboration between the HH and the MCO liaison relationship and consistent collaboration between the members and care coordinators. The HHs have a passion for member care and identifying social needs. Home visits resumed in Q4, and demonstrated flexibility with members' needs for referrals, follow up care, community involvement. Care coordinators continued training in mental health first aid, teen mental

	health first aid and trauma informed care. BHSD is coordinating training for HH directors on improved documentation for care plans, Certified Needs Assessments and any other identified needs revealed at the site visits. One barrier for the HHs is that care plans, crisis plans, and safety plans are documented in two systems NM Star and the provider's electronic health records. The use of NM Star is not as consistent with entering all required information. HSD continues to work with Falling Colors, the NMStar developer, on solutions to reduce administrative burden. One HH location, PMS Farmington, discontinued their CLNM services; as they were unable to continue to meet their deliverables due to staffing and workforce issues. There are currently twelve HHs statewide.

Table 9: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY10 Q1 JAN - MAR	DY10 Q2 APR - JUNE	DY10 Q3 JUL - SEPT	DY10 Q4 OCT - DEC
4,211	4,102	3,868	3,692
% CHANGE	% CHANGE	% CHANGE	% CHANGE
2.04%	2.59%	5.70%	4.55%

Source: NMStar, CLNM Opt-in Report.

HIGH FIDELITY WRAPAROUND

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

The goal of the HFW program is to provide intervention to individuals with the most complex behavioral health needs to reduce the occurrence of placement in higher levels of care, detention, hospitalization, or institutionalization. HFW was approved as part of the

Centennial Care 2.0 demonstration effective March 28, 2023. Since that time the NM HFW Steering Committee, including representatives from the Human Services Department (HSD) Behavioral Health Services Division (BHSD) and Medical Assistance Division (MAD) as well as the Children Youth and Families Department (CYFD) has met weekly to review HFW provider certification applications as these providers transition from other funding sources to Medicaid enrolled providers. As part of this process, the HFW Steering Committee assessed the providers' readiness and adherence to the HFW model. The HFW Steering Committee also provides support and oversight on long-term strategies of the HFW model within the state including implementation and long-term objectives.

The HFW Steering Committee has transitioned the role of reviewing provider applications to CYFD Licensing and Certification Authority. The HFW Steering Committee will transition to focus primarily on program support, monitoring, and development of long-term strategies. Additionally, as part of the implementation process, HSD and CYFD are in process of developing claims data, provider level, and MCO reports to monitor program requirements including eligibility criteria outlined in STC 69 as well as provider employee requirements. Additionally, HFW treatment plans will receive clinical review through CYFD.

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

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

SUPPORTIVE HOUSING

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

each county of every state annually.

Linkages agencies have been able to bill Medicaid for comprehensive community support services (CCSS), but since the H0044 supportive housing services inclusion in the Centennial Care 2.0 waiver, BHSD continues to strongly encourage Linkages providers to shift to billing the supportive housing benefit directly. The H0044 benefit reimburses at a higher rate than CCSS. The Centennial Care 2.0 waiver requires that the services be provided by a certified peer support worker (CPSW) to align with the state's goals for building the peer support workforce. Last quarter, 1 Linkages provider who had 9 CPSWs assigned to deliver Linkages supportive housing services decreased to 4 CPSWs assigned to the Linkages program. Prior, the 9 CPSWs had clients in Linkages and various other programs that the agency provides. This provider decreased to 4 CPSWs to allow for the assigned CPSWs to have a Linkages specialized case load; case load size of the CPSWs remains similar but now with the Linkages client cases consolidated under 4 CPSWs. With a Linkages specific client base, the provider's intention is to optimize Linkages service provision and outcomes. CPSWs assigned to deliver Linkages supportive housing services currently include a CPSW Supervisor, a CPSW Lead, and 2 field CPSWs. This provider is consistently utilizing the H0044 code for reimbursement and is contracted with all 3 MCOs for reimbursement. A second Linkages provider has 3 CPSW full time positions, 2 CPSW field staff and 1 CPSW supervisor/manager. Since July 2023, 1 CPSW position was left unfilled due to agency funding changes. In December 2023, the other CPSW role who was assigned primarily to Linkages and as a back up to the SSI/SSDI Outreach, Access to Recovery (SOAR) program resigned. This provider is recruiting and plans to hire for the CPSW vacancies, including the CPSW that was unfilled. This second provider has been utilizing the H0044 code for reimbursement since January 2022 and is contracted with all 3 MCOs for reimbursement. A third Linkages provider has 5 CPSWs who render Linkages services with 1 CPSW fully dedicated to Linkages programming and billing H0044. The third provider has been utilizing the H0044 code for reimbursement since December 2021 and is contracted with all 3 MCOs for reimbursement. A fourth Linkages provider hired 1 CPSW in December 2021 and has been utilizing the H0044 code for reimbursement since July 2022. The delay with billing by the fourth provider was due to an MCO system issue with the modifier codes and required provider type; issues have since been resolved. A fifth Linkages provider has attempted to fill their Linkages position with a CPSW but has not been successful; therefore, this provider is not currently able to bill H0044 due to the current provider eligibility guidelines. This provider, however, built a housing bill code in their current electronic health records (EHR) system in preparation to bill upon hire of a CPSW and/or updates to the H0044 eligibility criteria to allow for Community Support Workers or Supportive Housing Coordinator roles. The Linkages providers that have secured a CPSW to render supportive housing services relative to H0044 have also updated their agency's

EHR systems to allow for appropriate documentation and revised workflows to clarify the process for H0044 delivery and billing.

There are 11 Linkages support service providers, and remaining Linkages providers (6) continue to consider hiring CPSW staff for Linkages programming and/or are actively seeking CPSWs to hire. In the meantime, these providers are utilizing case managers, community support workers, and/or supportive housing coordinators to render the supportive housing services. The interest of all providers not yet utilizing H0044 remains high and increases with the progress made by the providers who have established H0044 reimbursement. The BHSD Supportive Housing Coordinator and Supportive Housing Coordinator-Supervisor continue to support providers and work with the BHSD MCO Contract Managers and MCOs to ensure successful processing establishment and billing of H0044. MCOs submit quarterly Ad Hoc reports with H0044 encounters data.

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

HSD continues to promote the use of CPSWs to render Linkages support services; however, Linkages providers and providers of other behavioral health services have experienced continued challenges with vacancies, transition, turnover, and maintaining filled positions. Providers continue to receive information, education, and training about the value of Medicaid reimbursement through H0044 via Supportive Housing trainings, the Linkages policy manual, ongoing technical assistance (TA) from the BHSD Supportive Housing Coordinator to include monthly check-ins with each provider, and quarterly Statewide Linkages meetings. The Linkages TA developed a “Getting Started with H0044” guide, which was distributed to all Linkages providers along with data to show the potential monetary gain that could result from billing the code. The data includes information based on varying case load capacities and has served as a very useful promotional tool. The “Getting Started with H0044” guide is disseminated upon every inquiry about H0044 and to the entire Linkages provider network at least quarterly. Lastly, Linkages provider contracts since State Fiscal Year 2022 and currently include an item specific to Medicaid and H0044.

Table 10: Medicaid Supportive Housing Utilization

MEDICAID SUPPORTIVE HOUSING UTILIZATION (January 1, 2023 – December 31, 2023)			
DY10 Q1	DY10 Q2	DY10 Q3	DY10 Q4
*54	*70	*93	99
Unduplicated Total - 138			

*Per MCO Ad Hoc reports, totals increased for previous quarters.
Source: MCO Ad Hoc Quarterly Reports

As a result of legislative sessions, an increase of State General Funds (SGF) for State Fiscal Years (SFY) 2021, SFY2023, and SFY2024 have been and/or shall be applied to Linkages programming. The funding increases allow HSD to expand Linkages services that are not covered by Medicaid. HSD also utilizes these funds to support rental assistance vouchers for eligible Linkages clients. Since SFY2020, there has been an increase of 236 vouchers with increased SGF. In SGF 2024, the voucher capacity is 396; the voucher capacity was 338 in SFY2023. An individual does not need to be a Medicaid member to obtain a voucher or services; however, many Linkages clients are Medicaid members. Through this quarter in SFY2024, an average of 345 vouchers were issued or filled; the previous quarter had an average of 304. A filled voucher means housing has been secured. Therefore, 345 individuals and their households benefited from a voucher and housing stability.

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

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

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

efforts to enhance provider capacity and improve access to a continuum of SMI/SED evidence-based services at varied levels of intensity.

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

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

New Mexico's SMI/SED Implementation plan was submitted on June 25, 2023. CMS provided feedback to New Mexico on July 17, 2023 and New Mexico resubmitted its implementation plan on October 18, 2023. CMS provided feedback to New Mexico on October 31, 2023. New Mexico also provides assurance that Federal Financial Participation (FFP) will not be claimed until CMS approves the State's SMI/SED Implementation Plan.

Per STC requirements, the SMI/SED Monitoring Protocol was due on August 25, 2023; however, on August 18, 2023, CMS extended the deadline to September 29, 2023. On September 1, 2023, CMS extended the deadline to January 31, 2024 and indicated that deadlines would continue to be extended until CMS develops and issues new monitoring templates and guidance to states. On December 22, CMS extended the deadline to May 31, 2024. New Mexico will prepare its SMI/SED Monitoring Protocol following CMS' issuance of new templates and guidance.

CENTENNIAL HOME VISITING (CHV) PROGRAM

In DY10 Q4, the Centennial Home Visiting (CHV) program served 365 families. Following is DY10 Q4 data for each model:

Nurse Family Partnership (NFP) Model:

- University of New Mexico Center for Development and Disability (UNM CDD) NFP served a total of 80 unique families in Bernalillo County and Valencia Counties.

- Youth Development Inc. (YDI) served 0 families in DY10 Q4 in Bernalillo, Rio Arriba, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 17 unique families in DY10 Q4 in Bernalillo County.
- ENMRSH served 31 unique families in DY10 Q4 in Curry and Roosevelt Counties.
- Taos Pueblo served 1 family in DY10 Q4 in Taos County.
- MECA Therapies served 119 unique families in DY10 Q4 in Chaves, Curry, Doña Ana, Roosevelt, and Lea Counties.
- Aprendamos served 71 unique families in DY10 Q4 in Doña Ana, Sierra, and Otero Counties.
- Community Action Agency of Southern New Mexico served 20 unique families in DY10 Q4 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 19 unique families in DY10 Q4 in San Juan County.
- Tresco served 8 unique families in DY10 Q4 in Bernalillo and Santa Fe Counties.

The Centennial Home Visiting Program (CHV) program is expanding with more Medicaid members having access to services. This is due to increased enrollment of new providers and expansion of additional services available through the program. An example of a provider credentialing with HCA for expansion of services is:

- Guidance Center of Lea County is in the process of enrollment with NM Medicaid. They are approved for 20 families in Lea County.

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

PRESUMPTIVE ELIGIBILITY PROGRAM

The New Mexico HSD Presumptive Eligibility (PE) program continues to be an important part of the State’s efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some New Mexico State Agencies including the New Mexico Department of Health (DOH), New Mexico Children Youth and Families Department (CYFD), and the New Mexico Corrections Department (NMCD).

Currently, there are approximately 868 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assist with on-going Medicaid application submissions.

HSD staff conduct monthly PE certification trainings for employees of qualified entities that choose to participate in the PE program. PE certification requirements include active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct "Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE)" demo trainings. During demo trainings, the PEDs have the opportunity to take a refresher training on "How To" utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit ongoing Medicaid applications. PE program staff conducted 3 PE certification trainings and 3 YESNM-PE demo refresher trainings in DY10 Q4.

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

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

Access to the Baby Bot is available through a link located on the PED's home page in YESNM-PE. The Baby Bot platform operates as a webservice and sends the information electronically to ASPEN, HSD's eligibility system. Once the mother's eligibility has been electronically verified in ASPEN, the system automatically adds the newborn to the case. This allows immediate access to benefits for the newborn. Currently 279 active PEDs are certified to use the Baby Bot functionality with more trainings scheduled to increase participation.

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

- **Newborns Submitted**
    - Overall number of submissions through Baby Bot.

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

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

AVA Baby Bot (October - December 2023)					
Month	Newborns Submitted through AVA	Newborns Successfully Enrolled	Newborns Unsuccessfully Enrolled - Tasks Created	% of Newborns Successfully Enrolled	% of Newborns Unsuccessfully Enrolled
October	808	525	283	65%	35%
November	751	521	230	69%	31%
December	795	532	263	67%	33%
Total	**2,354**	**1,578**	**776**	**67%**	**33%**

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY10 Q4, 80 PEDs used the Baby Bot functionality. Program staff noticed a slight increase in the amount of PED participation during this reporting period in the number of newborns added through the Baby Bot functionality. In this reporting period, staff observed a slight decrease in the percentage of Newborns “Successfully Enrolled”. HSD program staff continue to work with PEDs and system developers to continue the increase of the number of newborn submissions as well as the number of successful submissions through the Baby Bot functionality.

Table 12: PE Approvals

PE APPROVALS (October - December 2023)				
Month	PEs Granted	% PE Granted with Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
October	446	97.98%	1026	385
November	329	96.35%	815	279
December	347	98.27%	782	356
Total	**1122**	**97.53%**	**2,623**	**1,020**

Source: Monthly PE001 Report from ASPEN and OmniCaid

Table 12 above outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. NM PEDs are aware of the importance of ongoing Medicaid coverage for their clients. In this reporting period we saw an increase in the number of PEs granted and PE approvals that also had an ongoing application submitted. In DY10 Q4, 98% of all PE approvals had an ongoing application submitted.

JUST HEALTH PROGRAM

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

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

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

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

The following table outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. HSD observed a slight increase in the amount of PE applications granted, and a slight decrease in the number of Medicaid applications submitted from jail or prison settings in DY10 Q4. Now that the PHE has ended and COVID-19 protocols in jails and prisons are lifted, we do expect to see the numbers of applications submitted increase over the next 2 years. The department continues to work on the relationships between the jails and prisons, and with the justice involved population. In DY10 Q4, 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 13: PE Approvals

PE APPROVALS – JUST HEATH (October - December 2023)				
Quarter	PEs Granted	% PE Granted w/ Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
October	3	100%	94	86
November	1	100%	69	58
December	6	100%	45	45
Total	**10**	**100%**	**208**	**189**

Source: Monthly PE001 Report from ASPEN and OmniCaid

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HCBS REPORTING

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

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

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

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

Consumer Support Program

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

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

Services Department (ALTSD), Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the broader public to access a variety of services. The type and number of issues identified and resolved through the Consumer Support Program for DY10 Q4 are listed in the tables below.

Table 14: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT October - December 2023	
TOPIC	**NUMBER OF CALLS**
Home/Community Based Care Waiver Programs	3,557
Long Term Care/Case Management	5
Medicaid Appeals/Complaints	3
Personal Care	14
State Medicaid Managed Care Enrollment Programs	7
Medicaid Information/Counseling	607

Source: SAMS Call Profiler Report; GSA I 7-630-8000-0001 CDA 93-778 State Fiscal Year 2024, Quarter 2 report

Table 15: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT October - December 2023			
COUNSELING SERVICES	**NUMBER OF HOURS**	**NUMBER OF NURSING HOME RESIDENTS**	**NUMBER OF CONTACTS**
Transition Advocacy Support Services		160	
*Medicaid Education/Outreach	2,718		
Nursing Home Intakes		64	
**LTSS Short-Team Assistance			99

*Care Transition Specialist team educates residents, surrogate decision makers, and facility staff about Medicaid options available to the resident and assist with enrollment.
**Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed decisions about appropriate long-term services and supports choices in the context of their personal needs, preferences, values, and individual circumstances.
Source: Care Transition Bureau (CTB) GSA I 7-630-8000-0001 CFDA 93-778 State Fiscal Year 2024, Quarter 2 report

Critical Incidents

Critical Incidents	
DY10 Q4	HSD conducts a quarterly meeting with MCOs to provide guidance and discuss findings related to the MCOs' critical incident reporting. The quarterly meeting was held on November 15, 2023. The primary discussion was regarding an increase in Critical Incident Reporting (CIR)s filed for neglect. Two of the 3 MCOs reported that the increase was attributed to agencies filing reports retroactively. MCOs reported the top neglect CIRs filed continue to be refusing services, insufficient staffing, and issues with hiring/firing caregivers. MCOs reported conducting outreach to the top agencies identified as having challenges with staffing services to members and that monthly and weekly meetings between the MCOs and provider agencies would continue. HSD conducts individual monthly meetings with each MCO. The goal of these meetings is to provide guidance and address any questions or concerns related to quarterly reports, critical incidents, and contract and policy requirements. A list of CIRs to be discussed on the call is sent to each MCO prior to the monthly call. During the Q3 MCO monthly meetings, HSD discussed that a review of the CIRs filed found that documentation of follow up was a continued area of concern in some reports. BCBS stated their critical incident team would send reminders to their care coordination team to enter documentation of follow up, PHP stated they had an internal training on documenting follow-up, and WSCC stated they would send a memo regarding procedures to their staff. HSD conducted daily reviews of critical incidents submitted by the MCOs and providers for the purpose of ensuring compliance with reporting requirements, identifying areas of concern, and monitoring members' health and safety. HSD provided daily assistance to MCOs and providers to obtain access to the CIR Portal by establishing and/or resetting login credentials as well as deleting duplicate reports. DY10 Q3 data was received on October 30, 2023. During DY10 Q3, a total of 44,085 CIRs were filed for Centennial Care which includes physical health (42,677), and subsets of behavioral health (732) and community benefit self-directed (676) members. In DY10 Q3 total Centennial Care critical incident reports decreased 13% from DY10 Q2. In DY10 Q3 total Behavioral Health critical incident reports decreased 10% from DY10 Q2. In DY10 Q2 total Self-Directed critical incident reports decreased 16% from DY10 Q2.

	The tables below represent a MCO summary of the critical incident reporting for DY10 Q3, Q2 and Q1. DY10 Q4 data will be received on Jan. 30, 2024 and be reflected in DY11 Q1 report.

Table 16: Critical Incidents Reported

CRITICAL INCIDENTS REPORTED (DY10 Q3)												
MCO	CENTENNIAL CARE (CC)			BEHAVIORAL HEALTH (BH)			SELF DIRECTED			YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	CC	BH	SD
BCBS	10,031	11,040	12,929	161	134	141	204	267	221	34,000	436	692
PHP	21,208	35,687	26,305	667	623	535	513	508	418	83,200	1,825	1,439
WSCC	1,859	2,282	3,443	56	52	56	132	25	37	7,584	164	194
Total	33,098	49,009	42,677	884	809	732	849	800	676	124,784	2,425	2,325

Source MCO quarterly report #36

BCBS (DY10 Q3)												
Critical Incident Types	Centennial Care			Behavioral Health			Self-Directed			Year-to-date Totals		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	CC	BH	SD
Abuse	110	108	83	25	17	13	13	8	6	301	55	27
Death	213	202	204	2	11	8	7	8	8	619	21	23
Elopement / Missing	7	5	3	0	1	0	0	1	0	15	1	1
Emergency Services	1,739	2,210	1,988	88	81	84	111	162	137	5,937	253	410
Environmental Hazard	35	37	25	2	2	2	2	4	2	97	6	8
Exploitation	30	83	22	1	1	0	0	0	1	135	2	1
Law Enforcement	29	36	29	7	6	8	1	5	8	94	21	14
Neglect	7,868	8,359	10,575	36	15	26	70	79	59	26,802	77	208
All Incident Types	10,031	11,040	12,929	161	134	141	204	267	221	34,000	436	692

Source MCO quarterly report #36

PHP (DY10 Q3)												
CRITICAL INCIDENT TYPES	**CENTENNIAL CARE**			**BEHAVIORAL HEALTH**			**SELF DIRECTED**			**YEAR TO DATE TOTALS**		
	Q1	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**CC**	**BH**	**SD**
Abuse	167	168	188	61	55	62	12	10	8	523	178	30
Death	428	398	316	8	16	11	16	13	13	1,142	35	42
Elopement/ Missing	18	20	15	1	2	0	0	1	1	53	3	2
Emergency Services	6,519	6,787	6,063	459	435	333	360	377	324	19,369	1,227	1,061
Environmental Hazard	68	109	100	5	6	5	6	6	6	277	16	18
Exploitation	51	65	46	0	3	2	10	12	3	162	5	25
Law Enforcement	56	63	63	10	10	18	3	11	5	182	38	19
Neglect	13,901	28,077	19,514	123	96	104	106	78	58	61,492	323	242
All Incident Types	21,208	35,687	26,305	667	623	535	513	508	418	83,200	1,825	1,439

Source MCO quarterly report #36

WSCC (DY10 Q3)												
CRITICAL INCIDENT TYPES	CENTENNIAL CARE			BEHAVIORAL HEALTH			SELF DIRECTED			YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	CC	BH	SD
Abuse	21	29	29	3	9	9	3	1	3	79	21	7
Death	42	27	29	1	2	2	5	1	1	98	5	7
Elopement/ Missing	4	4	3	0	2	0	1	0	0	11	2	1
Emergency Services	295	285	265	42	32	28	41	21	28	845	102	90
Environmental Hazard	5	12	56	0	0	0	1	0	0	73	0	1
Exploitation	16	8	5	2	1	1	2	0	1	29	4	3
Law Enforcement	13	8	11	2	1	6	4	2	2	32	9	8
Neglect	1,463	1,909	3,045	6	5	10	75	0	2	6,417	21	77
All Incident Types	1,859	2,282	3,443	56	52	56	132	25	37	7,584	164	194

Source MCO quarterly report #36

Community Benefit
In DY10 Q4, Community Benefit (CB) related projects have included: implementing rate increases for the direct care workforce in accordance with state minimum wage updates; reporting for the new tracking database for HSD approved Agency-Based Community Benefit (ABCB) providers; implementing EVV for ABCB respite services; increasing CB allocations; and MCO audits of CB providers and HCBS settings. Also, HSD continued to collaborate with providers, stakeholders, and state agencies to implement initiatives approved under its American Rescue Plan Act (ARPA) HCBS Spending Plan and Narrative.

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

- Implementing rate increases for PCS and other CB services to coincide with state and local minimum wage increases, and the paid sick leave requirement for NM employees per the Healthy Workforce Act.
    - HSD continues to monitor MCO accountability to ensure minimum wage increases and paid sick leave requirements are met with weekly MCO report updates. There were several local minimum wage increases effective in early 2024.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers. A quarterly 10% payment was issued in 2023, and a quarterly 5% payment will be issued in 2024. HSD requires that providers attest that they are using the funding in accordance with the CMS approved ARPA spending plan before any payments are made.
- Approving higher rates for certain caregivers in rural areas on a case-by-case basis.
- One MCO issued grants to PCS agencies through the NM Association for Home Health and Hospice Care. These grants will continue in 2024.
- Another MCO is implementing a LTSS provider stakeholder group to obtain feedback and develop solutions to address workforce shortages.

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

Electronic Visit Verification

HSD, in partnership with the MCOs, continued to operate EVV for Agency-Based Community Benefit (ABCB), SDCB, and EPSDT Personal Care Services. EVV for Home Healthcare Services was implemented in January 2024 and HSD continues to collaborate with the MCOs, providers, and CMS to ensure requirements are met. HSD completed certification review with CMS on March 14, 2024 and are awaiting results.

Electronic Visit Verification - HCBS

For DY10 Q4, the average number of SDCB caregivers using EVV is 66%. HSD is continuing to offer training and technical assistance for SDCB agencies and individual employees to encourage more SDCB providers to use EVV.

ABCB EVV data for DY10 Q4 is outlined in the table below. The MCOs reported that 76.5% of the total ABCB PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder of claims were created through the Fiserv Authenticare application.

Electronic Visit Verification - Physical Health

EPSDT PCS: From July through September 2023, MCOs reported that 99% of EPSDT PCS captured with EVV used either Fiserv Authenticare application (29%) or Interactive Voice Response (IVR) phone system (70%).

Home Healthcare Services: MCOs, providers, and CMS continue to collaborate to ensure requirements are met for January 2024 implementation.

Table 17: EVV DATA

EVV DATA (October - December 2023)		
MCO	AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD	NUMBER OF TOTAL CLAIMS THIS PERIOD
BCBS	7,434	458,851
PHP	14,434	1,171,902
WSCC	2,104	121,344
TOTAL	**23,972**	**1,752,097**

Source: MCO Report #35 DY10 Q4, October - December 2023

Statewide Transition Plan

HSD received approval of its Statewide Transition Plan (STP) on March 10, 2023. The 508 compliant version of the statewide transition plan has been posted online. The MCOs formed a workgroup and continue to collaborate on ongoing monitoring activities including provider training, attestations and care coordination tools. The MCOs audited all settings in DY10 Q4 and reported findings to HSD. HSD will include these findings in the DY11 Q1 monitoring report. HSD will receive an on-site review from CMS and New Editions in the second half of 2024. HSD has received limited preliminary information about the visit and will continue to meet with CMS to finalize plans as the time approaches.

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

HSD requires the MCOs to provide a quarterly summary of their internal audits of NF LOC Determinations. Each MCO conducts internal random sample audits of both community-based and facility-based determinations completed by their staff based on HSD's NF LOC criteria and guidelines. The audit includes accuracy, timeliness, consistency, and training of reviewers. The results and findings are reported quarterly to HSD along with any Quality Performance Improvement Plan. HSD is reporting DY10 Q3 audit results this quarter and audit findings for DY10 Q4 will be reported in DY11 Q1.

Total audits for DY10 Q3:

- BCBS conducted 102 total audits of NF LOC determinations, 18 facility-based and 84 community-based.
- PHP conducted 248 total audits of NF LOC determinations, 75 facility-based and 173 community-based.
- WSCC conducted 42 total audits of NF LOC determinations, 18 facility-based determinations and 24 community-based.

Audit results for NF LOC determinations for DY10 Q4:

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

Audit results for timeliness of determinations for DY10 Q4:

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

Aggregate results:

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

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

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

Facility-Based Internal Audits				
High NF Determinations	**July**	**August**	**September**	**DY10 Q3**
Total number of High NF LOC files audited	**8**	**7**	**8**	**23**
BCBSNM	3	3	3	**9**
PHP	5	3	5	**13**
WSCC	n/a	1	n/a	**1**
Total number of files with correct NF LOC determination	**8**	**7**	**8**	**23**
BCBSNM	3	3	3	**9**
PHP	5	3	5	**13**
WSCC	n/a	1	n/a	**1**
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	n/a	100%	n/a	**100%**
Low NF Determinations	**July**	**August**	**September**	**DY10 Q3**
Total number of Low NF LOC files audited	**29**	**30**	**29**	**88**
BCBSNM	3	3	3	**9**
PHP	20	22	20	**62**
WSCC	6	5	6	**17**
Total number of files with correct NF LOC determination	**29**	**30**	**29**	**88**
BCBSNM	3	3	3	**9**
PHP	20	22	20	**62**
WSCC	6	5	6	**17**
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Timeliness of Determinations	**July**	**August**	**September**	**DY10 Q3**
Total number of High NF LOC determinations completed within required timeframes	**8**	**7**	**8**	**23**
BCBSNM	3	3	3	**9**
PHP	5	3	5	**13**
WSCC	n/a	1	n/a	**1**
% of High NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	n/a	100%	n/a	**100%**
Total number of Low NF LOC determinations completed within required timeframes	**29**	**30**	**29**	**88**
BCBSNM	3	3	3	**9**
PHP	20	22	20	**62**
WSCC	6	5	6	**17**
% of Low NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**

Source: DY10 Q3 MCO Internal Audit Results

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

Community-Based Internal Audits	July	August	September	DY10 Q3
Total number of Community-Based NF LOC files audited	**96**	**93**	**92**	**281**
BCBSNM	28	28	28	**84**
PHP	60	57	56	**173**
WSCC	8	8	8	**24**
Total number with correct NF LOC determination	**96**	**93**	**92**	**281**
BCBSNM	28	28	28	**84**
PHP	60	57	56	**173**
WSCC	8	8	8	**24**
% with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Timeliness of Determinations	**July**	**August**	**September**	**DY10 Q3**
Total number of Community-Based determinations completed within required timeframes	**96**	**93**	**92**	**281**
BCBSNM	28	28	28	**84**
PHP	60	57	56	**173**
WSCC	8	8	8	**24**
% of Community-Based determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**

Source: DY10 Q3 MCO Internal Audit Results

MCO NF LOC Determinations

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

- The aggregated Facility Based High NF LOC determination/redetermination percentage for DY10 Q3 was 71%, a decrease from DY10 Q2 of 86%.
- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY10 Q3 was 93%, a decrease from DY10 Q2 of 98%.
- The aggregated Community Based determination/redetermination percentage for DY10 Q3 was 98%, remaining consistent from the 98% reported for DY10 Q2.

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

any trends and provide technical assistance as needed. MCO NF LOC determinations for DY10 Q4 will be reported in the DY11 Q1 report.

Table 20: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	**July**	**August**	**September**	**DY10 Q3**
Total number of determinations/redeterminations completed for High NF LOC requests	**69**	**62**	**74**	**205**
BCBSNM	39	35	33	**107**
PHP	20	18	27	**65**
WSCC	10	9	14	**33**
Total number of determinations/redeterminations that met High NF LOC criteria	**49**	**43**	**54**	**146**
BCBSNM	31	24	28	**83**
PHP	10	10	12	**32**
WSCC	8	9	14	**31**
% of determinations/redeterminations that met High NF LOC criteria	**71%**	**69%**	**73%**	**71%**
BCBSNM	79%	69%	85%	**78%**
PHP	50%	56%	44%	**49%**
WSCC	80%	100%	100%	**94%**
Low NF Determinations	**July**	**August**	**September**	**DY10 Q3**
Total number of determinations/redeterminations completed for Low NF LOC requests	**384**	**431**	**387**	**1202**
BCBSNM	149	123	128	**400**
PHP	210	260	215	**685**
WSCC	25	48	44	**117**
Total number of determinations/redeterminations that met Low NF LOC criteria	**375**	**398**	**345**	**1118**
BCBSNM	145	116	124	**385**
PHP	205	234	177	**616**
WSCC	25	48	44	**117**
% of determinations/redeterminations that met Low NF LOC criteria	**98%**	**92%**	**89%**	**93%**
BCBSNM	97%	94%	97%	**96%**
PHP	98%	90%	82%	**90%**
WSCC	100%	100%	100%	**100%**

Source: DY10 Q3 MCO NF LOC Determinations Report

Table 21: MCO NF LOC Determinations – Community-Based

Community Based Determinations	July	August	September	DY10 Q3
Total number of determinations/redeterminations completed	**2144**	**2158**	**1963**	**6265**
BCBSNM	983	517	633	**2133**
PHP	1028	1473	1194	**3695**
WSCC	133	168	136	**437**
Total number of determinations/redeterminations that meet NF LOC criteria	**2112**	**2118**	**1913**	**6143**
BCBSNM	972	505	616	**2093**
PHP	1009	1450	1166	**3625**
WSCC	131	163	131	**425**
% of determinations/redeterminations that meet NF LOC criteria	**99%**	**98%**	**97%**	**98%**
BCBSNM	99%	98%	97%	**98%**
PHP	98%	98%	98%	**98%**
WSCC	98%	97%	96%	**97%**

Source: DY10 Q3 MCO NF LOC Determinations Report.

External Quality Review Organization (EQRO) NF LOC

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

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

In DY10 Q3:
Aggregated results for NF LOC determinations from EQRO were 100% in agreement with High NF, 97% in agreement with Low NF. One disagreement with WSCC during the quarter and as result a deliverable was performed between the MCO and the Nurse Auditor to review findings from the disagreement, and 100% in agreement for Community Based.

HSD will continue to monitor the EQRO audit of MCO NF LOC determinations to identify and address any trends and provide technical assistance as needed. NF LOC determinations for DY10 Q4 will be reported in the DY11 Q1 report.

Table 22: EQRO NF LOC Review

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

Source: DY10 Q3 EQRO NF LOC Report.

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

- Administrative Authority: HSD developed 3 performance measures to monitor the HCBS Administrative Authority.
  - PM #1: Percentage of required HCBS reports submitted timely by the MCOs. DY10 Q4 results are reported below.
    - Report #4, *Community Benefit* – 100% compliance
    - Report #8, *Nursing Facility Level of Care* – 100% compliance
    - Report #35, *Electronic Visit Verification* – 100% compliance
  - PM #2: Percentage of required HCBS reports submitted accurately without an MCO Self-Identified Error
    - Report #4, *Community Benefit* – DY10 Q4 93% compliance
    - Report #8, *Nursing Facility Level of Care* – DY10 Q4 93% compliance
    - Report #35, *Electronic Visit Verification*- DY10 Q4 93% compliance
  - PM #3: Percentage of required HCBS reports submitted accurately without an HSD rejection.
    - Report #4, *Community Benefit* – DY10 Q4 87% compliance
    - Report #8, *Nursing Facility Level of Care* – DY10 Q4 87% compliance
    - Report #35, *Electronic Visit Verification* – DY10 Q4 87% compliance

  Overall, there was a decrease in report compliance in DY10 Q4 because the MCOs had errors in their reporting or did not follow report instructions correctly. HSD will continue to work with the MCOs to clarify reporting requirements and hold technical assistance calls with the MCOs as needed.

- Level of Care (LOC): MCOs submit quarterly LOC reports to HSD that identify the number of initial LOCs conducted in the quarter. The information to support that the initial LOC is conducted timely is reported above under the NF LOC reporting.

- Qualified Providers: In DY10 Q4, HSD continued to receive and review applications for incoming CB providers. HSD reviews and approves all Agency-Based Community Benefit (ABCB) providers to ensure that they meet all program requirements as outlined in Section 8 of the Managed Care Policy Manual.

Providers must obtain this program approval from HSD prior to enrolling with the state as a Medicaid provider, contracting with the MCOs and providing services to ABCB members. In the Self-Directed Community Benefit (SDCB), the MCOs contract with a single Fiscal Management Agency (FMA) to oversee provider enrollment. The FMA ensures that all providers meet program requirements as outlined in Section 9 of the managed Care Policy Manual. SDCB providers must meet all program requirements and be approved by the FMA prior to rendering services to SDCB members. 100% of providers meet the program requirements prior to providing services to members. HSD has directed the MCOs to audit all ABCB providers and the SDCB FMA on an annual basis, starting in DY10. The MCOs completed their annual 2023 audit of all CB providers and the SDCB FMA. HSD will report on these audit results in DY11 Q1.

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

On a quarterly basis, HSD's EQRO validates MCO compliance with federal requirements for HCBS service plans. These reviews are conducted virtually, in real time, and include MCO care coordination staff participation. For each record in the sample, the MCO staff display pertinent information in the MCO's care coordination systems to demonstrate compliance. Pertinent information includes, but is not limited to: the comprehensive needs assessment; HCBS service plan;

back-up plan; disaster plan; progress notes; claims; and eligibility data. A total of 8 performance measures are reviewed for each record. MCO agreement/acceptance of the review determination (met or not met) for each performance measure is captured prior to the conclusion of the review. Following is a summary of DY10 Q3 monitoring results:

- Statewide, 94 records are reviewed each quarter, which began January 1, 2023.
- DY10 Q3 indicates 100% compliance across all performance measures for WSCC. PHP indicates 98% on PM #3, #4 and #5, and 100% compliance for all other PMs. BCBS indicates 97% compliance on PM #1, and 100% compliance for all other PMs.

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

The tables below include a summary of the quarterly HCBS Service Plan data for DY10 Q3. The DY10 Q4 data will be reported on the DY11 Q1 CMS Quarterly Monitoring Report.

Table 23: HCBS Service Plan Review Summary

Eligible Population and Sample Size, DY10 Q3			
MCO	Eligible Population for DY10 Q3	MCO % of Entire HCBS Population in DY10 Q3	Number of HCBS Files Reviewed for DY10 Q3
BCBS	4,402	24%	34
PHP	12,544	68%	54
WSCC	1,522	8%	6
Centennial Care	**18,468**	**100%**	**94**

Service Plan Review Results DY10 Q3						
Performance Measure	**MCO**	**Total Files Reviewe**	**# of Files Met**	**# of Files Not Met**	**# of Files Not Applicable**	**% of Files Met**
Member's choice to receive HCBS services versus institutional care is documented	BCBS	34	33	1	0	97%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**93**	**1**	**0**	**99%**
Member's choice of HCBS services and providers are documented in a written comprehensive care plan	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's HCBS service plan adequately addressed his/her assessed needs	BCBS	34	34	0	0	100%
	PHP	54	53	1	0	98%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**93**	**1**	**0**	**99%**
Services authorized by the MCO were delivered in accordance with the HCBS service plan, including the type, scope, amount, duration, and frequency are specified in the HCBS service plan	BCBS	34	34	0	0	100%
	PHP	54	53	1	0	98%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**93**	**1**	**0**	**99%**
The HCBS service plan was revised, as needed, to address changing needs	BCBS	34	21	0	13	100%
	PHP	54	2	1	51	98%
	WSCC	6	0	0	6	100%
	Statewide	**94**	**23**	**1**	**70**	**99%**
A disaster preparedness plan specific to the member was in the HCBS service plan and documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's eligibility start and end dates are documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Linkages to protective services are documented	BCBS	34	0	0	34	100%
	PHP	54	1	0	53	100%
	WSCC	6	0	0	6	100%
	Statewide	**94**	**1**	**0**	**93**	**100%**

Source: DY10 Q3 External Quality Review Organization (EQRO) Quarterly HCBS Service Plan Report

- Health and Welfare of Enrollees: HSD has implemented a monitoring process for assuring the health and welfare of members enrolled in HCBS through quarterly MCO reporting on established performance measures. The critical incident performance measures listed below will identify, address, and seek to prevent instances of abuse, neglect, exploitation, and unexpected death. HSD staff will review and analyze the data to determine if the MCOs report any significant

changes from previous reporting periods. HSD findings are communicated to each MCO through Monthly Quality Bureau Critical Incident calls between HSD and each individual MCO and during the quarterly critical incident meeting with all MCOs.

In the DY10 Q3 Performance Measures (PMs), HSD observed the following notable fluctuations in the number of critical incidents reported as compared to DY10 Q2:

- PM #1: The number of all substantiated critical incidents decreased by 13%. PM #1c showed a decrease of 63% for exploitation and #1d had a 43% decrease for unexpected death.
- PM #3: The percentage of substantiated individual critical incidents where follow up was completed decreased by 14%.
- PM #4a: The percentage of substantiated individual critical incidents where follow up actions were completed to prevent future incidents decreased 30%. PM #4b showed a 42% decrease in the percentage of substantiated individual critical incidents where follow up actions included investigation and educating individuals and families was completed.
- PM #5a: The percentage of substantiated individual critical incidents where referrals to APS were completed decreased by 70%. This decrease is attributed to the APS training effort to educate agencies and care coordination on how to identify valid APS referrals during DY10 Q1 (March 29th) which clarified and reinforced the use of the drop-down option provided in the annual PCS training in DY9 Q4.

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

The table below is a summary of the quarterly data reported by the MCOs for DY10 Q3:

Table 24: Critical Incidents Performance Measures

Critical Incident Performance Measures (CI PM)				
CI PM	BCBS	PHP	WSCC	Total by Quarter
	Q3	Q3	Q3	Q3
The number of all substantiated critical incidents.	12,292	26,305	3,443	42,040
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #1: The percentage of substantiated critical incidents reported by category of abuse, neglect, exploitation and unexpected death:				
	Q3	Q3	Q3	Q3
1.a. Percentage of substantiated individual abuse incidents identified and reported.	0.64	0.71	0.84	0.78%
1.b. Percentage of substantiated individual neglect incidents identified and reported.	81.79	74.33	88.44	84.47%
1.c. Percentage of substantiated individual exploitation incidents identified and reported.	0.17	0.29	0.15	0.16%
1.d. Percentage of substantiated individual unexpected death incidents identified and reported.	0.32	0.18	0.2	0.22%
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #2: The percentage of substantiated critical incidents being reported within the required timeframe.				
	Q3	Q3	Q3	Q3
Percentage of substantiated critical incidents being reported within 24 hours.	94.69	86.83	96.57	92.70%
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #3: The percentage of substantiated individual critical incidents where follow up (safety plans, corrective action plans, etc.) was completed:				
	Q3	Q3	Q3	Q3
Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed.	86.36	98.54	13.07	65.99%

CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #4: The percentage of follow-up actions taken on the substantiated critical incidents on a systemic basis to prevent future incidents, such as investigation as well as educating individuals and families:				
	Q3	Q3	Q3	Q3
4.a. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents.	27.76	28.75	13.46	23.32%
4.b. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) included investigation and educating individuals and families was completed.	24.37	2.22	11.73	13.47%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #5: The percentage of the substantiated critical incidents with a referral to Adult Protective Services (APS) or Child Protective Services (CPS):				
	Q3	Q3	Q3	Q3
5.a. Percentage of substantiated individual critical incidents where referrals to APS were completed.	0.61	1.26	1.28	1.05%
5.b. Percentage of substantiated individual critical incidents where referrals to CPS were completed.	0.01	0.01	0.03	0.02%
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #6: The percentage of providers and MCO staff trained on reporting critical incidents into the HSD Portal:				
	Q3	Q3	Q3	Q3
6.a The percentage of contracted providers, agencies and MCO educated about reporting critical incidents to the HSD Portal initially at the start or at hire during the reporting period.	92.31	6.69	0.57	33.19%
6.b. The percentage of contracted providers, agencies and MCO that attended the annual training and were educated about reporting critical incidents to the HSD Portal. NOTE: THIS WILL ONLY BE REPORTED ONCE A YEAR IN THE QUARTER THE ANNUAL TRAINING IS HELD.				
CI PM	**BCBS**	**PHP**	**WSCC**	**Percentage by Quarter**
PM #7: The percentage of substantiated critical incidents for Members with Multiple critical incidents identified and reported:				
	Q3	Q3	Q3	Q3
The percentage of substantiated Members with Multiple critical incidents identified and reported.	65.74	88.95	91.72	82.14%

Source: MCO CI PM quarterly report.

- **Financial Accountability:** In DY10 Q1, the EQRO began reviewing MCO claims for financial accountability to ensure that Community Benefit claims were not overpaid. New Mexico has received data from all MCOs for DY10 Q1 through DY10 Q4 and is currently validating all data received for DY10. DY10 Q1 through DY10 Q4 data will be reported on the DY11 Q1 report.

8
AI/AN REPORTING

Access to Care

According to MCO Report #55, *Geographical Access Report* for Q4 2023:

- BCBSNM reported 96.4% access to behavioral health services in rural areas and 95.7% access in frontier areas. For physical health, BCBSNM reported 96.4% in rural areas and 97.1% in frontier areas.
- PHP reported 98.2% access to behavioral health services in rural areas and 98.7% access in frontier areas. For physical health, PHP reported 98.2% in rural areas and 98.6% in frontier areas.
- WSCC reported 96.6% access to behavioral health services in rural areas and 100.0% access in frontier areas. For physical health, WSCC reported 96.6% in rural areas and 100.0% in frontier areas.

The entire rural and frontier population was erroneously reported in DY10 Q3, when only the Native American population should be reported. This resulted in the reporting of lower percentages for each MCO. This quarter the correct percentages are reported.

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

Following are DY10 Q4 updates on contracting between MCOs and I/T/U providers.

MCO	Status of Contracting with MCOs
BCBSNM	BCBSNM does not have new contract efforts to report at this time. BCBSNM has had a difficult time getting I/T/Us to engage and/or interested in onboarding/contracting directly. BCBSNM currently pays the Federal OMB rates regardless of contract status. Incentives are based on value-based arrangements, not on contract status. BCBSNM has not received a signed I/T/U contract back from Tewa Roots Society at Nambe Pueblo but they will continue to conduct outreach for a response. BCBSNM plans to explore funding for telehealth, value-based contracting, and recruiting with Indian Health Service to help initiate contracts.

PHP	PHP utilizes Mutual Partnership Agreements (MPA) or Letters of Direction (LOD) rather than the term contract. PHP reports any discussions with potential Tribal partners involves Value Based Purchasing (VBP) agreements and other programs that address Native American health disparities. Jemez Health Center had discussions on a Memorandum of Agreement (MOA) for non-emergency transportation with PHP. Kewa Health Center and Family Wellness Center discussions have included VBP. San Felipe Health Center has a potential agreement with PHP to support Native American health disparities. First Nations Community Healthsource continues to receive incentives for their participation in the Hepatitis C Provider Incentive Program. PHP also supports their traditional wellness program. PHP has an agreement with Desert Vision Youth Wellness, an Arizona provider that provides services to PHP members residing along the state border.
WSCC	WSCC met with Five Sandoval Indian Pueblos in October to extend contract to include Community Health Rep (CHR), Behavioral Health, and Long Term Services and Supports billing. WSCC met with Jemez, Picuris, Zuni Pueblos and Ohkay Owingeh to discuss non-emergency transportation, CHR billing, and technical assistance on restructuring their health department. They also met with the Jicarilla Apache Tribe in November to discuss CHR and non-emergency transportation billing. In October, November, and December, WSCC met with Crownpoint IHS for a recurring meeting with the business office manager to address any provider relations issues.

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

According to MCO Report #47, *Claims Activity Report* for Q4 2023:

- BCBSNM processed 99.6% clean claims within 15 days and 99.8% clean claims within 30 days.
- PHP processed 98.6% clean claims within 15 days and 99.7% clean claims within 30 days.
- WSCC processed 98.4% clean claims within 15 days and 99.8% clean claims within 30 days.

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

Native American Technical Advisory Committee (NATAC) Issues and Recommendations

In 2023, the NATAC members requested to have more control over the meeting agenda. They wanted to move away from state "updates" and focus on billable services for Tribes, the Medicaid Unwinding, and Turquoise Care updates and additional items

the Tribes want to discuss. The December 18, 2023 NATAC discussed the following concerns:

- Waiver slots and linkage slots are funding mechanisms provided by the federal government to help more people through Medicaid. The requirement for receiving services remains unchanged.
- The OMB rate, which determines funding, is established by federal regulations and cannot be adjusted by the state. The Federal Medical Assistance Percentage (FMAP) is based on the type of facility/provider, such as Tribal 638s and IHS.
- The State Plan Amendment for CHR/CHW reimbursement was submitted in August but has been delayed, with the intended start date pushed back to 2023.
- It is suggested that funding a study on the issues arising from "unwinding" would benefit the state and may be addressed in the upcoming legislative session.

Following is the DY10 schedule for the Native American Technical Advisory Committee (NATAC) meetings.

Native American Technical Advisory Committee Schedule

Date	Time	Location
March 20, 2023	1:00 p.m. – 3:00 p.m.	Virtual
June 26, 2023	1:00 p.m. – 3:00 p.m.	Virtual
September 18, 2023	1:00 p.m. – 3:00 p.m.	Virtual
December 18, 2023	1:00 p.m. – 3:00 p.m.	Virtual

Native American Advisory Board (NAAB) Issues and Recommendations

The following issues were raised at the DY10 Q4 NAAB meetings:

MCO	DATE	Issues/Recommendations
BCBSNM	November 2, 2023 Hybrid meeting – Zuni Pueblo	Since this was a hybrid meeting, BCBSNM reported the attendance was low due to a COVID-19 outbreak in the community. There were 22 members in attendance. **Issue:** A question was asked about using the WalMart gift card for groceries even though the closest WalMart is 47 miles away. **Response:** BCBSNM said members could still get groceries delivered if WalMart isn't in their area. They can qualify for free shipping on non-perishable items. **Issue:** A member said she has a niece who is pregnant with 3 babies. Can she get 3 car seats? **Response:** A BCBSNM staff member followed up with the aunt and provided resource information for her to give to the niece. **Issue:** Another member stated when she calls MotivCare to request mileage reimbursement, she never gets reimbursed. **Response:** BCBSNM staff escalated this concern to MotivCare and MotivCare reached out to the member to address this issue.
PHP	November 30, 2023 Virtual meeting	This was a virtual meeting. There were 4 members in attendance. **Issue:** Member asked if the Tribal Liaison could assist with updating Tribal documents. **Response:** PHP Tribal Liaison informed member that the Liaison only focuses on PHP services and benefits. The Liaison did mention that she could go to the Crownpoint agency in NM to get her Tribal document updated. **Issue**: Member asked how far back she can enroll her children for the Baby Bonus-Well Baby program. **Response**: PHP informed member that she can enroll them up to 1 year after the birth of the baby. **Issue:** The question was asked what can be done for members in regard to substance abuse treatment? **Response:** PHP responded by saying a care coordinator can assist with the health risk assessment to get the process started. The member can call the toll free number to request help and a care coordinator will be assigned to assist with the process.
WSCC	December 9, 2023 Virtual meeting	The Native American Advisory Board meeting on December 9, 2023 was a virtual meeting. There were no members in attendance. Since this meeting was scheduled on a Saturday in December that may have had an impact on the turn out. WSCC reported that they mailed out 250 invitations and utilized Facebook and Twitter to notify members, providers, and Tribal leaders of the upcoming Native American Advisory Board meeting.

9

ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE	3/26/21
COMPLETION DATE	Open
ISSUES	ModivCare has been placed on a corrective action plan for not meeting the contractual timeliness measures for certain Customer Service Call Center metrics and other additional contractual requirements.
RESOLUTION	Due to continued service level failures, the action plan remains open. **DY10 Q4 update:** Plan of Action (POA) related to call center remains open. For Q4 2023, ModivCare met all metrics. BCBS continues to meet with ModivCare daily to discuss issues and/or concerns. HCSC/BCBSNM meets with ModivCare weekly to monitor the on-time performance measures. Below are the most current statistics: **September 2023 – December 2023 (average):** ASA = 00:17 seconds (Met) Abandonment Rate = 0.17% (Met) Service Level = 90.3% (Met) Member Satisfaction = 92.7% (Met) A-Leg Pick-up = 93.9% (Met) Provider No-Shows = 19.66 To reduce the number of provider no-shows, ModivCare continues to add other transportation providers to the network. BCBS is also working on adding UBER (rideshare) to ModivCare's options for transportation for those members who are ambulatory (can walk safely on their own to/from vehicle) and will start this service in specific counties. HSD receives bi-weekly updates and continues to carefully review the ModivCare remediation plan and progress.

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

work can begin.

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

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

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

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

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

	files now have the fields that were initially not available: ADA Compliance, Cultural Competency Training, Languages Spoken by Clinical and Non-Clinical Staff, Website URLs. Target date for all information to be populated is Q2 2024.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	Secure Transportation
IMPLEMENTATION DATE	03/04/21
COMPLETION DATE	12/31/23
ISSUES	Improvement Plan – Network Adequacy
RESOLUTION	Secure Transportation (ST) was placed on an improvement plan for network issues. Monthly meetings will be held between ST and PHP leadership to review issues/concerns. 09/13/21: Network concerns remained an issue for ST. PHP placed ST on a corrective action plan (CAP) as the issues are not resolved timely. ST will provide monthly updates on efforts to improve the network, the next update was due in October 2021. 02/15/22: ST added new providers to its network of drivers. PHP is working on increasing mileage reimbursement. Mileage reimbursement is offered at the front end of the scheduling process through care coordination to free up drivers for members who do not have supports for this option. ST is offering hiring bonuses and retention bonuses to help maintain the current network. 04/01/22: Areas that are remaining a focus of the CAP for ST. This CAP is to remain open until network adequacy is improved. Action Plan Items: • Risk Stratification – policy to identify and prioritize high risk members (dialysis, chemotherapy, radiation, pre or post operative care, surgery, high risk pregnancy related appointments and urgent care); and members at risk of being dropped by their provider for missed appointments • Network Adequacy Plan - include specifics to ensure statewide coverage including 100 miles from the NM state borders (excluding Mexico) • Recruiting Plan – include number of vehicles, candidates, and area serviced • Network Monitoring processes • Retention Plan • Incentive Plans - including incentive plans for resolving issue

regarding short distance trips

- Provider Issues – action plan to address providers regarding no-shows and those with excessive late pick-ups.

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

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

Additional policy and procedures were implemented in CY22 which are directing the improvements. PHP will continue to monitor critical care appointments daily.

Initiatives that are currently in progress include: per member per month (PMPM) rate review with guarantees, PHP contracting directly with Community Outreach Centers for partnering with transportation needs, and PHP contracting directly with tribal communities that offer transportation. Secure is adding additional vehicles to the fleet and looking to update correct scheduling platform/software for better performance.

06/30/23: May's report remains consistent with zero critical care trips that were unable to be scheduled and approximately 20 driver no shows/cancellations. May also had zero unable to schedule non-critical care appointments, down from 90 in April. Member no-shows have increased. PHP is working with care coordination to contact members who are missing and not cancelling appointments, specifically around critical care appointments and continued missed methadone appointments. Lyft ride share has been approved by the Public Regulation Commission (PRC). There will be a meeting with Secure and Clinical Operations to determine criteria and rollout plan.

09/30/23: Critical care appointments continue to be prioritized over other transportation types, and PHP remains consistent with zero trips unable to be scheduled. Implemented Lyft Transportation services as a backup, if available and only if the member is fully ambulatory and agrees to Lyft services. Provider-missed non-critical care appointments are also trending down. Member no-show and mileage reimbursement requests are trending higher than normal. PHP is implementing initiatives to target

	members that are missing scheduled appointments, including post card reminders about transportation and use of the transportation app, Itineris. PHP is working with care coordination and community health workers (CHWs) to outreach to members who missed a critical care appointment, confirming member had alternative transportation, inpatient status or other areas of concern. PHP Oversight Manager continues to monitor transportation daily, weekly, and monthly. The corrective action plan (CAP) with Secure will remain open for continued oversight. 12/31/23: PHP and Secure Transportation continue to monitor critical care appointment times working with internal teams as needed on initiatives for improvement. PHP has seen a significant decrease in missed trips for all transportation types and member grievances have reduced by 80% over the last 12-months. PHP engages the clinical ops team for additional member support as needed. PHP is contemplating moving its Corrective Action Plan (CAP) with Secure to an Improvement Plan (IP), PHP will continue monitoring only. Transportation will continue to be a focus for improvement initiatives and requirements.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Payment Error- Reprocessing and Recoupment of Payments
IMPLEMENTATION DATE	9/20/22
COMPLETION DATE	11/30/23
ISSUES	Payment Error- Reprocessing and Recoupment of Payments, Temporary Economic Recovery Payments increase for Home and Community Based Services (HCBS)
RESOLUTION	During a routine audit of payments issued through WSCC's accounts payable platform, a discrepancy was identified related to payments described in a Letter of Direction (LOD) that HSD sent to the MCOs. This LOD directed the MCOs to provide a temporary economic recovery payment increase for Home and Community Based Services. A misalignment occurred between the payable supplier ID and the amount due to the provider, creating over and under payments. WSCC is providing outreach to those providers impacted to ensure payments are issued for those providers who were underpaid, as well as working on repayment options for the providers who were issued overpayments. HSD is closely monitoring this through weekly detailed reports from WSCC. WSCC is at a 100% completion rate for underpaid providers and at a 97% completion rate for overpaid providers. In DY10 Q3, WSCC requested and received approval from HSD to extend the completion date of the plan to 11/30/23. WSCC is 100% complete for under and over payment completion.

10

FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY10 Q4 reflected the capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 21, 2022 and the updated rates submitted on July 11, 2023. On weighted average, the CY2023 rate was 4.37% higher than that of CY2022 due to higher rates for the July 1 through December 31, 2023 period; the fee-for-service claim payments for CY2023 were still lagging. In addition, data run-out for CYs 2022 and 2023 will continue and the PMPMs will continue to change as expenditures come in (see Attachment B – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). Attachment B – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis indicates that DY8 was 10.7% below the budget neutrality limit (Table 8.5) through 11 quarters of payments. For DY9, Table 9.5 showed a 7.9% below the budget neutrality limit with data through 8 quarters. Table 10.5 shows a 16.1% below the budget neutrality limit for DY10 with preliminary data of 4 quarters.

11

MEMBER MONTH REPORTING

Member Months		2023
		4
MEG1	0-FFS	96,908
	Presbyterian	571,097
	Western Sky	121,449
	Blue Cross Blue Shield	384,132
	Total	**1,173,586**
MEG2	0-FFS	7,551
	Presbyterian	61,216
	Western Sky	12,324
	Blue Cross Blue Shield	37,774
	Total	**118,865**
MEG3	0-FFS	0
	Presbyterian	64,198
	Western Sky	11,878
	Blue Cross Blue Shield	33,033
	Total	**109,109**
MEG4	0-FFS	527
	Presbyterian	324
	Western Sky	39
	Blue Cross Blue Shield	225
	Total	**1,115**
MEG5	0-FFS	
	Presbyterian	9,249
	Western Sky	1,637
	Blue Cross Blue Shield	6,957
	Total	**17,843**
MEG6	0-FFS	81,225
	Presbyterian	363,169
	Western Sky	104,499
	Blue Cross Blue Shield	285,362
	Total	**834,255**
MG10	0-FFS	12
	Presbyterian	80
	Western Sky	23
	Blue Cross Blue Shield	78
	Total	**193**
MGX8	0-FFS	
	Presbyterian	196
	Western Sky	75
	Blue Cross Blue Shield	267
	Total	**538**
Total		**2,255,504**

Source: Enrollee Counts Report.

12
CONSUMER ISSUES

GRIEVANCES

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

In DY10 Q4, the reports submitted by MCOs for October through December were reviewed and analyzed. It was determined reports were in compliance with contractual requirements. HSD observed in DY10 Q4, the top primary member grievance code continues to be Transportation Ground Non-Emergency. The year to date total demonstrated a 12.4% decrease from DY10 Q3.

The second top primary member grievance code reported was Other Specialties. The second top primary member grievance code reported is a change from Provider Specialist in DY10 Q3 and Q2, Personal Care Services in DY10 Q1. The table below is a summary of the quarterly data reported by the MCOs for DY10 Q4:

Table 25: Grievances Reported

Grievances Reported (January - December 2023)																
Grievances	BCBS				PHP				WSCC				TOTAL BY QUARTER			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Member Grievances	405	483	462	409	326	243	295	230	50	52	59	46	781	778	816	685
Top Two Primary Member Grievance Codes																
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER			
													Q1	Q2	Q3	Q4
Transportation Ground Non-Emergency	288	361	326	273	116	48	68	63	19	8	7	15	423	417	401	351
Provider Specialist	17	27	33	14	0	0	0	0	2	2	5	2	19	29	38	16
Variable Grievances	100	95	103	122	210	195	227	167	29	42	47	29	339	332	377	318

Source: MCO Report #37

APPEALS

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

DY10 Q4, the reports submitted by MCOs for October through December were reviewed and analyzed. It was determined reports were in compliance with contractual requirements. HSD observed in DY10 Q4, the top primary member appeals code continues to be denial or limited authorization of a requested service. The year to date total demonstrated a 13% decrease from DY10 Q3.

The second top primary member appeals code reported continues to be denial in whole of a payment for a service. The year to date total demonstrated a 44% decrease from DY10 Q3.

These 2 primary member appeals codes have remained consistent from DY9.The table below is a summary of the quarterly data reported by the MCOs for DY10 Q4.

Table 26: Appeals Reported

Appeals Reported (January - December 2023)																
APPEALS	BCBS				PHP				WSCC				TOTAL BY QUARTER			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Standard Member Appeals	534	588	409	333	627	582	581	489	56	56	71	38	1,217	1,226	1,061	860
Number of Expedited Member Appeals	35	29	32	31	23	28	17	30	12	11	9	10	70	68	58	71
Top Two Primary Member Appeal Codes																
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER			
													Q1	Q2	Q3	Q4
Denial or limited authorization of a requested service	397	410	366	327	624	583	568	502	65	60	71	45	1,086	1,053	1,005	874
Denial in whole of a payment for a service	165	199	63	32	15	12	12	10	0	0	0	0	180	211	75	42
Variable Appeals	7	8	12	5	11	15	18	7	3	7	9	3	21	30	39	15

Source: MCO Report #37

13
QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HSD's Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference the table below for 2023 MCO Advisory Board Meeting Schedules.

Table 27: 2023 MCO Advisory Board Meeting Schedules

BCBS 2023			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	03/16/2023	12:00-1:30 PM	Hybrid - Albuquerque - Metro
BCBS	04/13/2023	12:00-1:30 PM	Hybrid - Valencia or Socorro County - Central
BCBS	06/15/2023	12:00-1:30 PM	Hybrid - Albuquerque - Metro
BCBS	07/20/2023	12:00-1:30 PM	Hybrid - Albuquerque - Metro
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	09/21/2023	12:00-1:30 PM	Hybrid - Las Cruces (Dona Ana County) - Regional
BCBS	10/26/2023	12:00-1:30 PM	Hybrid - Santa Fe (Santa Fe County) - Regional
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	02/09/2023	12:00-2:00 PM	Virtual – Otero County (Mescalero) TBD
BCBS	05/04/2023	12:00-2:00 PM	Hybrid – McKinley County (Crownpoint) TBD
BCBS	08/10/2023	12:00-2:00 PM	Hybrid – Rio Arriba County (Dulce) TBD
BCBS	11/02/2023	12:00-2:00 PM	Hybrid – Albuquerque Blue Door Neighborhood Center
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	See above	See above	All above locations (SDCB included in each meeting)
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	See above	See above	All above locations (BH included in each meeting)

PHP 2023			
Meetings will be held virtually until state restrictions are lifted for in-person meetings. SDCB Subcommittee Member Advisory Board Meetings are currently on hold.			
MEMBER ADVISORY BOARD MEETING SCHEDULE (CENTRAL AREA)			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/10/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
PHP	06/02/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
PHP	09/08/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
PHP	12/06/2023	11:30 AM-1:30 PM	Presbyterian Rev. Cooper Center
STATEWIDE MEETINGS			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	TBD	TBD	There were no statewide meetings held in 2023.
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/09/2023	3:00 PM-5:00 PM	Virtual Meeting
PHP	06/01/2023	3:00 PM-5:00 PM	Virtual Meeting
PHP	08/31/2023	3:00 PM-5:00 PM	Virtual Meeting
PHP	11/30/2023	3:00 PM-5:00 PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	TBD	TBD	Meetings on hold in 2023 due to the low volume of self-directed members, PHP opted to fold these meetings into its broader Centennial Care 2.0 Member Advisory Board. Updates are provided at every meeting, presented by PHP’s LTC Care Coordination Manager.
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
PHP	03/13/2023	1:00 PM-2:30 PM	Virtual Meeting
PHP	06/07/2023	1:00 PM–2:30 PM	Virtual Meeting
PHP	09/13/2023	1:00 PM–2:30 PM	Virtual Meeting
PHP	12/13/2023	1:00 PM–2:30 PM	Virtual Meeting

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

Quality Assurance	
DY10 Q4	**Quarterly Quality Meeting** HSD holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HSD updates and guidance on required quality monitoring activities as well as relay HSD findings from the monthly, quarterly, and annual reports submitted by the MCOs. The DY10 Q4 meeting was held December 13, 2023. The MCOs were asked to present on the status of their respective Performance Measure rates for DY10 Q3 and discuss measure specific interventions implemented to meet the CY2023 HSD assigned target. All 3 MCOs reported they are on track to meet the respective HSD assigned targets for PM #1 Well Child Visits in the First 15 Months of Life, PM #3 Timeliness of Prenatal Care and PM #4 Postpartum Care. For PM #2 Counseling for Physical Activity for Children and Adolescents, and PM #5 Childhood Immunization Status – Combination 3, all 3 MCOs are at risk of not meeting HSD assigned targets. The MCOs described the overlap of continuity of care, and transition of care (TOC) opportunities relevant with these child and maternal health measures. As these are hybrid measures, MCOs stated year-round medical review is anticipated to determine administrative data combined with medical record review final cumulative rates for the calendar year. All 3 MCOs are reportedly on track to exceed the HSD assigned target for PM #7 Antidepressant Medication Management (AMM) – Continuation Phase. WSCC and BCBS reported they have exceeded the HSD assigned target for PM #8 Follow Up After Hospitalization for Mental Illness (FUH), while PHP reported they will implement clinical behavioral follow-up post discharge, including with nursing facilities, to improve their rate. BCBS and PHP reported they have exceeded the HSD assigned target for Follow-Up After Emergency Department Visit for Mental Illness (FUM), while WSCC reported they will implement a specific telehealth assessment by a clinician to help improve the FUM rate.

	The MCOs described their efforts in provider education, incentives, and conferences, as well as incentivizing members for refilling medications and/or mailing medications to members in rural locations to meet targets. The MCOs described year-round medical review is anticipated to determine administrative data combined with medical record review final cumulative rates for the calendar year. HSD discussed reporting expectations for Tracking Measure #7: Smoking Cessation. The MCOs were advised that HSD observed a significant decrease in the number of members receiving smoking and tobacco cessation products and services. HSD presented the first 3 cumulative quarters of DY10, which reported a decline in utilization and dollars spent when compared to DY9. Further, HSD asked the MCOs to explain the decline. All 3 MCOs attributed the decline in the recall and suspension of the high-cost smoking cessation drug Chantix. HSD also instructed the MCOs to track the number of members who call the MCO established quit lines, the number members reporting a successful cessation, any changes made to quit lines, and to discuss information about all outreach material sent to members withing the report analysis. **Monthly Performance Measure Monitoring Plan** In DY9 Q3, HSD introduced 3 measures to the Monthly Monitoring Plan for MCOs due to the observed decline in performance measure outcome rates. Well Child Visits within the first 15 months of life, Timeliness of Prenatal Care, and Childhood Immunization Status are now monitored monthly by HSD. HSD provides the MCOs with reporting instructions and a monitoring template which is submitted monthly to HSD. The report requires the MCO to give an account of the ongoing interventions, strategies, and barriers associated with improving performance outcomes for the selected measures. This allows HSD to monitor the progress towards improving outcomes and meeting the established PM targets. HSD established an annual target rate for DY10 for PM #1 – Well Child Visits in the First 15 Months of Life (W30) of 65.91%. Through DY10 Month 9 (M9), the MCOs reported the following average rates: BCBS 58.59%, PHP 58.43%, and WSCC 50.20%. The DY10 HSD annual target rate for PM #3 – Prenatal Care (PPC) is 84.75%. Through DY10 M9, the MCOs reported the following average rates for Timeliness of Prenatal Care: BCBS 59.74%, PHP 68.40%,

	and WSCC 54.25%. The DY10 HSD annual target rate for PM #5 – Childhood Immunization Status (CIS) is 71.78%. Through DY10 M9, the MCOs reported the following average rates for Combination 3 Immunizations: BCBS 56%, PHP 58.34%, and WSCC 50.91%. HSD expects to see these rates increase quarter over quarter. The final determination of whether the MCOs have met the established targets is reliant on the CY 2023 annual audited HEDIS report, which will be received in June 2024. **BCBS:** **W30**: M7 55.62%; M8 58.65%; M9 61.51%. Increase of 5.89 percentage points from M7 to M9. **Strategies and Interventions:** In DY10 Q3, BCBS's Quality Management (QM) staff assisted families with making future well-child appointments. BCBS also initiated a statewide member "6x15" education campaign intended to address the statewide healthcare literacy gap through encouraging 6 well child visits in the first 15 months of life. The campaign's radio ads now include English, Spanish, Navajo versions, and outdoor billboards. Providers who are committed to improving W30 rates are engaged through data lists, collaboration, dashboards to track progress, and encouragement to overlay the first 6 provider visits with the immunization schedule for CIS-3. Reminder post cards were mailed to members turning 1 year, 2 years, or 3 years of age monthly in M7, M8, and M9. BCBS hosted a Native American Advisory Board (NAAB) meeting in M8, a provider forum in M9, and another Member Advisory Board meeting in M9 to provide education on performance measure outcomes. **PPC**: M7 59.39%; M8 59.18%; M9 60.66%. Increase of 1.27 percentage points from M7 to M9. **Strategies and Interventions**: BCBS has a three-pronged approach to improve their rates for this measure, which includes a member, provider, and system approach. BCBS's member approach includes tracking data related to virtual doula health coaching and the Special Beginnings maternity program. BCBS collaborates with The Rhodes Group to collect data that identifies members early on in their first trimester to allow outreach to

	begin. BCBS offers provider incentives for improved timeliness of prenatal care rates. BCBS collaborated with OB-GYN providers by mailing targeted members a no cost blood pressure monitor and tracker to record readings. **CIS**: M7 55.25%; M8 55.93%; M9 56.82%. Increase of 1.57 percentage points from M7 to M9. **Strategies and Interventions**: BCBS's contracted providers participate in monthly joint operating committee meetings to collaborate on reducing barriers to monitor the effectiveness of the 6x15 member education campaign. Value based contracted providers are sent lists to close gaps and given dashboards to show their performance against target during meetings. BCBS reports, in M9, a provider forum was held in Albuquerque to promote the 6x15 initiative. BCBS is monitoring the effectiveness of their 6x15 postcard intervention to determine how many members received immunizations since deployment. **<u>PHP:</u>** **W30**: M7 54.64%; M8 58.61%; M9 62.03%. Increase of 7.39 percentage points from M7 to M9. **Strategies and Interventions**: PHP Care Coordinators and Community Health Workers refer members to the PHP Centennial Care Benefit for transportation to assist members with transportation to non-emergency, scheduled appointments. Member education is provided monthly in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) letters mailed to members in the W30 age group, explaining recommended well-care visits and immunizations. PHP's Baby Bonuses Reward Program provided a presentation to the New Mexico Children, Youth, and Families Department about the benefits of their reward program to be shared with members. PHP reported that in M8, 80 members were enrolled in Baby Bonuses Gift Card Reward Program. **PPC**: M7 68.49%; M8 68.01%; M9 68.69%. Increase of 0.2 percentage points from M7 to M9. **Strategies and Interventions**: PHP reports their high-risk pregnant members are assigned to maternal care coordination teams or the Comprehensive Addiction and Recovery Act (CARA) program to help navigate their prenatal and postpartum care or for help with substance abuse. Best practices are

	explored by PHP's Performance Improvement (PI) team collaborating with IT Development to improve the online portal for members to report pregnancies and enroll in the pregnancy program. PHP's Home Visiting Work Group meets regularly to share information and gather resources to better assist members with their care. The PHP baby benefits program rewards members for being compliant. The first step in the reward program is earning $150 for completing a prenatal visit. The second step is earning $75 for completing at least 10 prenatal care visits. The third step reward is $100 for completing a postpartum visit within 7-84 days after delivery. In DY10 Q3, the PI team conducted an analysis of PPC visit coding and found that recently added codes for compliant PPC visits were not being counted. PHP's PI and Analytics Organization (AO) staff audits for PPC compliance coding on an annual basis or more frequently as needed. **CIS**: M7 57.73%; M8 58.54%; M9 58.76%. Increase of 1.03 percentage points from M7 to M9. **Strategies and Interventions**: To ensure access to healthcare is available, PHP members are referred to SafeLink, Inc. for cell phone service in rural areas. Care Coordinators and Community Health Workers refer members to Secure Transport for non-emergent ride assistance. PHP members are educated about the purpose and importance of well child visits and immunizations through telephonic outreach and monthly Early Periodic Screening, Diagnostic, and Treatment (EPSDT) letter mailing outreach. PHP uses the statewide 'It's Time to Renew' campaign as an opportunity to update incorrect member contact information through their Medicaid renewal. In DY10 Q3, PHP participated in a back-to-school event held in Albuquerque, NM to promote vaccines. **<u>WSCC:</u>** **W30**: M7 46.92%; M8 50.23%; M9 53.44%. Increase of 6.52 percentage points from M7 to M9. **Strategies and Interventions:** In M9, WSCC contracted with Arkos Health for quality improvement in outreach and provider engagement. WSCC contracted providers meet monthly to discuss the W30 measure and distribute lists of non-compliant members for bi-weekly outreach. WSCC outreaches to parents/guardians of members via text message reminding them of their child's overdue visit with the ability to reply to receive further assistance. In the month of August, WSCC paid rewards to Medicaid

	members for completing well child visits and in M8 $2,250 in rewards were issued. WSCC's Quality Nurses conduct telephonic outreach to help parents schedule a well child visits while providing education on the importance of well child visits with a pediatrician. **PPC:** M7 53.50%; M8 54.15%; M9 55.10%. Increase of 1.6 percentage points from M7 to M9. **Strategies and Interventions:** Notifications of Pregnancy (NOP) are completed and submitted by members, providers, paramedicine professionals, and community partner groups for risk determination and enrollment in the Start Smart for Your Baby program. WSCC also sends text messages to pregnant members to provide prenatal care guidance and assistance with scheduling prenatal care appointments. In addition, WSCC provides lactation consulting and a virtual doula app for members to connect with doula services. **CIS**: M7 50.71%; M8 50.84%; M9 51.17%. Increase of 0.46 percentage points from M7 to M9. **Strategies and Interventions**: WSCC provides educational member material to help eliminate barriers on vaccine hesitancy that can be accessed at provider offices, community events, and community baby showers. WSCC's vendor, Arkos conducts targeted member outreach in-person, telephonically, or through telemedicine. WSCC's 'My Health' incentive program rewards members in the measurement age group for immunizations completed throughout the measurement year (MY) 2023. WSCC uses a phone service to locate and update personal phone numbers to members existing contact information. WSCC's Quality Reporting Specialists regularly engage with contracted providers to understand their offered initiatives and member incentives for the CIS measure and assist with solutions to barriers. WSCC ended the 'Farmbox' intervention in M9. **<u>Performance Measures (PMs)</u>** HSD Performance Measures (PMs) and targets are based on HEDIS technical specifications. Each MCO is required to meet the established performance targets. Each DY target is a result of the DY6 MCO aggregated Audited HEDIS data, calculating an average increase for each DY until reaching the DY6 Quality Compass Regional Average plus 1 percentage point. Failure to meet the HSD-designated target for individual performance measures during the DY will result in a

	monetary penalty based on 2% of the total capitation paid to the MCO for the agreement year. HSD requires the MCOs to submit quarterly reports that are used to monitor the performance of each PM to determine if MCOs are on track for meeting the established target. MCOs report any significant changes as well as interventions, strategies, and barriers that impact improved performance. HSD staff will review and analyze the data to determine if the MCOs are trending towards meeting the established targets. HSD findings are communicated to the MCOs through MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meeting (QQM). HSD expects to see rates increase quarter over quarter and the final determination of whether the MCOs have met the targets is reliant on the DY10 annual audited HEDIS report, which will be received in DY11 Q2. Below are the MCO quarterly rates and interventions for each PM and the established target for DY10. The following PMs show results for DY10 Q3 reporting. ***PM #1 (1 point) – Well-Child Visits in the First 15 Months of Life (W30)*** The percentage of members who turned 15 months old during the measurement year and had 6 or more well-child visits. **DY10 target is 65.91%.** • BCBS Q1 35.34%; Q2 51.93%; Q3 61.51%: Increase of 9.58 percentage points from Q2 to Q3 and 4.40 percentage points below the DY10 target. • PHP Q1 32.32%; Q2 49.88%; Q3 62.03%: Increase of 12.15 percentage points from Q2 to Q3 and is 3.88 percentage points below the DY10 target. • WSCC Q1 28.88*%; Q2 42.97%; Q3 53.08% Increase of 10.11 percentage points from Q2 to Q3 and is 12.83 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 33.02%; Q2 Total 49.78%; Q3 Total 60.69%: Increase of 10.91 percentage points from Q2 to Q3 and is 5.22 percentage points below the DY10 target. **MCO Strategies and Interventions:** • The BCBS Quality Department and Community Outreach teams provide education on the importance of childhood

	immunizations and well-child visits during hybrid Member Advisory Board (MAB) and Native American Advisory Board (NAAB) meetings. BCBS member outreach efforts include calls to assist members with scheduling well-child visits and childhood immunizations. BCBS mailed reminder postcards to parents/guardians to schedule an appointment with their healthcare provider or contact BCBS for assistance with scheduling an appointment. The Special Beginnings Care Coordinators discuss well-child visits and childhood immunizations with members when speaking about what happens after delivery. BCBS's "Better Care, Better Outcomes" forum included the following learning objectives: Member Provider Engagement, Data-Driven Decision Making, Collaborative Care, Continuous Quality Improvement, and Evidence-Based Practice. • PHP presented educational materials to their clinical and non-clinical staff informing them of the importance of timely well-care visits during the first 15 months of life. Members enrolled in the PHP Centennial Care Baby Bonuses incentive program are emailed to PHP providers quarterly. • WSCC continued the mPulse texting campaign reminding the members' parents/guardians to complete well child visits. WSCC Quality team conducts targeted member outreach to members who are due or overdue for visits. The team also assists in scheduling appointments and assisting members with barriers, i.e. lack of transportation. WSCC offered members incentives for completing well-child visits via My Health Pays (a WSCC-branded Visa gift card) and Centennial Rewards. WSCC's Value-Based and Provider Engagement team held monthly meetings to review scorecards and discuss barriers and interventions. They also review member gaps in care lists. WSCC has created a Well Child Visit Flyer for members' parents/guardians about the importance of well-child visits. ***PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*** The percentage of members ages 3 through 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.

	For this measure the National Committee for Quality Assurance (NCQA) offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 62.93%.** • BCBS Q1 12.76%; Q2 20.04%; Q3 28.10%: Increase of 8.06 percentage points from Q2 to Q3 and is 34.83 percentage points below the DY10 target. • PHP Q1 12.42%; Q2 15.31%; Q3 23.91%: Increase of 8.60 percentage points from Q2 to Q3 and is 39.02 percentage points below the DY10 target. • WSCC Q1 12.12%; Q2 16.40%; Q3 18.52%: Increase of 2.12 percentage points from Q2 to Q3 and is 44.41 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 12.53%; Q2 Total 17.13%; Q3 Total 24.79%: Increase of 7.66 percentage points from Q2 to Q3 and is 38.14 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS implemented initiatives to encourage members to complete well-care visits. This includes their Centennial Rewards program which offers 200 reward points ($20 value) per year for completing at least 1 child or adolescent well-care visit. BCBS Wellness Education Specialists conduct member outreach calls to parents/guardians offering assistance with scheduling visits and offer guidance on a healthy BMI for their child. BCBS has also implemented provider initiatives to educate providers and promote WCC measure performance. This includes incentivizing an increased payout rate for CPT code G0447. There are also joint operating committee meetings to educate providers and encourage them to assess children's physical activity and encourage proper coding. • PHP implemented strategies and interventions to increase and improve this measure. These interventions include presentations to their Care Coordinator staff and emails to providers giving recommendations for physical activity counseling. There are also member outreach efforts to educate members on recommended well-care visits and immunizations. PHP also promoted the NM “Got Shots?” campaign to encourage members to schedule well-care visits and

	immunizations. • WSCC's Quality Reporting Specialists and Value-Based Payment (VBP) team hosts monthly provider engagement meetings to review scorecards, and gap-in-care lists for members to complete well-care visits, including counseling for nutrition and physical activity. WSCC hosts community events throughout the state of New Mexico to provide sports physicals. WSCC also provides an incentive program for members who complete the requirements for the WSCC measure. ***PM #3 (1 point) – Prenatal and Postpartum Care (PPC)*** The percentage of member deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit as a member of the MCO in the first trimester or within 42 calendar days of enrollment in the contractor's MCO. **DY10 target is 84.75%.** • BCBS Q1 58.09%; Q2 58.80%; Q3 60.66%: Increase of 1.86 percentage points from Q2 to Q3 and is 24.09 percentage points below the DY10 target. • PHP Q1 66.68%; Q2 67.34%; Q3 68.69%: Increase of 1.35 percentage points from Q2 to Q3 and is 16.05 percentage points below the DY10 target. • WSCC Q1 55.82%; Q2 54.10%; Q3 55.05%: Increase of 0.95 percentage points from Q2 to Q3 and is 29.70 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 62.08%; Q2 Total 62.48%; Q3 Total 64.07%: Increase of 1.59 percentage points from Q2 to Q3 and is 20.68 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS offers an enhanced Special Beginnings Maternity Care Coordination Program (SB) which collaborates with vendors to offer virtual doula health coaching to pregnant members at no cost. Value Added Services also offers a car seat and crib to members who participate in the SB program. The BCBS Community Outreach Team collaborated with La Familia Dental to host a successful community baby shower in August 2023. BCBS has also implemented several interventions to engage providers which include educating providers on trends and timeliness of prenatal care performance measures. The "Better

	Care, Better Outcomes" forum engages providers and members informing them of quality improvement methodologies and provides tools and techniques to implement effective initiatives. On a system level BCBS has an ongoing collaboration with the Rhodes Group to identify pregnant members earlier in their pregnancy. • PHP's Performance Improvement (PI) team focuses on identifying coding discrepancies for prenatal visits. These coding inconsistencies cause compliant members to be excluded from the technical specifications. The Community Health Workers (CHW) teams continue outreach to members identified on the Early Identification of Pregnancy report informing them of the Baby Benefits rewards program. • WSCC provides incentives to members and providers for using the Notification of Pregnancy process to notify the WSCC of a member's pregnancy. Families First also complete NOPs for members as well. Start Smart for Your Baby (SSFB) is WSCC's OB Care Coordination program. SSFB Care Coordinators are registered nurses who conduct outreach to assist members with scheduling their prenatal visits. WSCC continues to send bi-weekly mPulse text messages to remind members to attend prenatal visits. Additionally, WSCC provides an in-person doula program through Health Connect One in Santa Fe, Bernalillo, Las Cruces, and Farmington. There is also a virtual doula program through Pacify which offers education and 24/7 on-demand access to virtual doulas. ***PM #4 (1 point) – Prenatal and Postpartum Care (PPC)*** The percentage of member deliveries that had a postpartum visit on or between 7 and 84 calendar days after delivery. For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 67.26%.** • BCBS Q1 46.45%; Q2 51.69%; Q3 54.18%: Increase of 2.49 percentage points from Q2 to Q3 and is 13.08 percentage

	points below the DY10 target. • PHP Q1 52.79%; Q2 58.49%; Q3 60.09%: Increase of 1.60 percentage points from Q2 to Q3 and is 7.17 percentage points below the DY10 target. • WSCC Q1 41.95%; Q2 46.98%; Q3 51.94%: Increase of 4.96 percentage points from Q2 to Q3 and is 15.32 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 49.06%; Q2 Total 54.49%; Q3 Total 56.95%: Increase of 2.46 percentage points from Q2 to Q3 and is 10.31 percentage points below the DY10 target. **MCO Strategies and Interventions:** • The BCBS Community Outreach Team collaborated with La Familia Health to host a successful community baby shower in August 2023. The Centennial Rewards Program offers reward points to members for attending a postpartum appointment, well-baby checkups, and updating their address. BCBS has also implemented several interventions to engage providers which include educating providers on trends and timeliness of prenatal care performance measures. The "Better Care, Better Outcomes" forum engages providers and members informing them of quality improvement methodologies and provides tools and techniques to implement effective initiatives. On a system level, BCBS has an ongoing collaboration with the Rhodes Group to identify pregnant members earlier in their pregnancy. BCBS uses data from the Rhodes group and data from the Emergency Department Information Exchange (EDIE) platform to identify recent deliveries. • PHP's Performance Improvement (PI) team is focusing on identifying coding errors for prenatal visits and submitting them for abstraction. The Community Health Workers (CHW) use the Early identification of pregnancy reports to contact pregnant members to inform them about the Baby Benefits Program. • WSCC conducts member outreach via its OB care coordination program, Start Smart for your Baby (SSFB) in which care coordinators assist with scheduling postpartum visits. WSCC also hosts virtual baby showers where they educate expecting parents on the importance of prenatal care. WSCC is also utilizing Pacify, a mobile application that gives members 24/7 access to the WSCC Nurse advice line, virtual lactation

consultation, and doula support. The Centennial Home Visiting Program (CHV) promotes maternal and infant health via home visits. This program provides a Parent as Teachers (PAT) curriculum and Nurse Family Partnership (NFP) which provides first time mothers with a personal nurse. Both programs focus on education around prenatal care, postpartum care, and early childhood development.

PM #5 (1 point) – Childhood Immunization Status (CIS): Combination 3

The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps and rubella (MMR); 3 haemophilus influenza type B (HiB); 3 hepatitis B (HepB); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their 2nd birthday.

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

DY10 target is 71.78%.

- BCBS Q1 48.03%; Q2 54.37%; Q3 56.82%: Increase of 2.45 percentage points from Q2 to Q3 and is 14.96 percentage points below the DY10 target.
- PHP Q1 43.76%; Q2 56.98%; Q3 58.76%: Increase of 1.78 percentage points from Q2 to Q3 and is 13.02 percentage points below the DY10 target.
- WSCC Q1 43.01%; Q2 50.59%; Q3 51.17%: Increase of .58 percentage points from Q2 to Q3 and is 20.61 percentage points below the DY10 target.
- MCO Aggregate: Q1 Total 45.20%; Q2 Total 55.25%; Q3 Total 57.13%: Increase of 1.88 percentage points from Q2 to Q3 and is 14.65 percentage points below the DY10 target.

MCO Strategies and Interventions:

- BCBS participated in the “Got Shots?” campaign to encourage members aged 1 month to 21 years old to receive immunizations prior to the beginning of each school year. BCBS member outreach efforts include calls to assist members with scheduling well-child visits and childhood immunizations.

	They also mailed reminder postcards to parents/guardians to schedule an appointment with their healthcare provider or contact BCBS for assistance with scheduling an appointment. BCBS provider outreach efforts include a "Better Care, Better Outcomes" provider forum. The forum included the following learning objectives: Member Provider Engagement, Data-Driven Decision Making, Collaborative Care, Continuous Quality Improvement, and Evidence-Based Practice. BCBS has also begun to implement a media campaign that promotes the 6x15 initiative to encourage the importance of well-child visits during the first 15 months of life. • PHP provider groups participated in the statewide "Got Shots?" campaign to encourage members of this age group to complete missed and recommended immunizations. PHP also provided providers with education to encourage members to complete immunizations. • WSCC continues to offer the Vaccine Adherence in Kids (VAK's) program. This program sends parents immunization reminders via text messages, postcards, and automated phone calls when immunizations are due or overdue. The Quality reporting specialists and Value-Based team conduct monthly provider engagement meetings to review provider scorecards, identify members with open care gaps, and discuss barriers. WSCC Quality nurses contact non-compliant members to inform them of overdue immunizations. WSCC also provides an incentive for members who complete immunizations related to the CIS measure via My Health Pays. WSCC quality reporting specialists collaborate with providers to discuss opportunities to increase childhood immunizations. ***<u>PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase</u>*** The number of members age 18 years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least 180 calendar days (6 months) of continuous treatment with an antidepressant medication. **DY10 target is 35.61%**. • BCBS Q1 33.59%; Q2 38.36%; Q3 41.98%: Increase of 3.62

	percentage points from Q2 to Q3 and is 6.37 percentage points above the DY10 target. • PHP Q1 40.87%; Q2 45.66%; Q3 50.16%: Increase of 4.50 percentage points from Q2 to Q3 and is 14.55 percentage points above the DY10 target. • WSCC Q1 35.87%; Q2 42.07%; Q3 45.86%: Increase of 3.79 percentage points from Q2 to Q3 and is 10.25 percentage points above the DY10 target. • MCO Aggregate: Q1 Total 37.46%; Q2 Total 42.47%; Q3 Total 46.66%: Increase of 4.19 percentage points from Q2 to Q3 and is 11.05 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS sent an SMS text message on September 15, 2023, informing members of the importance of consistency with antidepressant medication. Staff continue to call members to remind them to fill their antidepressant prescriptions. BCBS conducts an annual staff training to remind staff of the AMM measure. Members also receive an incentive to refill their medications. BCBS engages providers regarding medication adherence on the Blue Review and Life and Times Connect website. • PHP strategies to improve measure performance include member outreach efforts to provide members with education on medication adherence. Members who have comorbid conditions linked with high rates of depression, such as diabetes and cardiovascular disease were sent educational flyers about depression symptoms, treatment, and medication adherence. PHP also engaged providers with provider education opportunities such as an education conference, newsletters, Behavioral Health Townhall, and incentive programs. • WSCC continues to collaborate with Outcomes™ to educate members on the importance of taking their prescribed medications, getting wellness checks, health screenings, and immunizations, and effectively managing their medical and behavioral health needs. WSCC offers telemedicine to reduce barriers to care via Teladoc Health. Teladoc mental health experts assist members with a variety of services, including medication management with a psychiatrist. Transportation

	services through Secure Transportation are available and encouraged for members who are having difficulty getting to their appointments. WSCC provider interventions include Provider Quality Liaisons (PQLs) educating providers about behavioral health measures, such as providing member care gap lists and examining tools available to help practitioners overcome barriers. WSCC also leverages local, state, and federal expertise to offer no-cost training opportunities to behavioral health and integrated care practitioners. ***<u>PM #7 (1 point) – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation</u>*** The total percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment. **DY10 target is 47.54%**. • BCBS Q1 43.82%; Q2 45.25%; Q3 45.13%: Decrease of .12 percentage points from Q2 to Q3 and is 2.41 percentage points below the DY10 target. • PHP Q1 51.40%; Q2 51.81%; Q3 53.11%: Increase of 1.3 percentage points from Q2 to Q3 and is 5.57 percentage points above the DY10 target. • WSCC Q1 44.62%: Q2 45.91%; Q3 46.98%: Increase of 1.07 percentage points from Q2 to Q3 and is .56 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 47.61%; Q2 Total 48.56%; Q3 Total 49.46%: Increase of .90 percentage points from Q2 to Q3 and is 1.92 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS added a QR code to provide members access to an informational video to a member flyer on 7/31/23. There is ongoing value-based contracting with providers and enhanced payment initiatives. BCBS also offers provider education units to providers that attend training on synthetic opioids. BCBS staff utilized the Emergency Department Information Exchange (EDIE) system to provide immediate support and connect members with proper follow-up treatment. • PHP continues to increase provider enrollment in value-based programming through Behavioral Quality Incentive Program

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

- WSCC continues to conduct targeted outreach to members to increase access to and initiation of treatment after a new episode of substance abuse. WSCC is continuing its collaboration with NM Family Services (NMFS), to conduct an initial telehealth assessment with members who are experiencing substance use challenges. WSCC continues to use mPulse text messaging to contact members with high ED utilization. The Health Assistance, Linkage, and Outreach™ (HALO) program aims to enroll members who are already abusing drugs or alcohol into treatment. WSCC's 2023 Value Added Services include a sober living benefit and room and board at Heading Home's Respite Care Program facility with 24-hour care. WSCC also engages providers with Monthly and Quarterly Provider Engagement Meetings and provider training opportunities.

<u>PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness (FUH): 30 Day</u>
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

DY10 target is 53.80%.

- BCBS Q1 46.90%; Q2 53.33%; Q3 53.84%: Increase of .51 percentage points from Q2 to Q3 and is .04 percentage points above the DY10 target.
- PHP Q1 43.08%; Q2 48.10%; Q3 51.27%: Increase of 3.17 percentage points from Q2 to Q3 and is 2.53 percentage points below the DY10 target.
- WSCC Q1 39.91%; Q2 52.65%; Q3 53.84%: Increase of 1.19 percentage points from Q2 to Q3 and is .04 percentage points above the DY10 target.

	• MCO Aggregate: Q1 Total 44.01%; Q2 Total 50.79%; Q3 Total 52.62%: Increase of 1.83 percentage points from Q2 to Q3 and is 1.18 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS contracted 3 new facilities to participate in the BCBS facility incentive program during Q3. BCBS also held a provider training on Maternal Mental Health and discussed the FUH measure 30-day follow-up. Providers were offered continuing medical education units to participate in the training. BCBS continues the reserved appointment initiative providing members with 1 appointment for mental health therapy and 1 appointment for medication management needs. • PHP prioritized an inpatient pilot program to conduct clinical behavioral health (BH) follow-up appointments post-discharge. PHP initiated another inpatient pilot to provide a clinical BH follow-up appointment for BH members who are discharged to nursing facilities. PHP offers incentives to BH providers that provide BH telehealth services in geographic areas with low access. PHP BH network continues to recruit telepsychiatry groups into the network. They have continued an incentive program working with IP facilities to conduct a clinical call post-discharge and within 7 days. Additionally, PHP has initiated a pilot discharge planning program to improve the coordination of care for members who are discharged from an acute care facility. • WSCC Behavioral Health Utilization Management (BH UM) and Behavioral Health Facility Liaison (BH Liaison) teams provide transitional care coordination services for members admitted for an inpatient behavioral health hospital stay. WSCC continues to collaborate with TeamBuilders Behavioral Health (TBBH) to conduct an initial telehealth assessment with members who have recently completed an inpatient behavioral health stay. WSCC also utilizes the Choose Tomorrow® Program to engage members who have been recognized as being at high risk of suicide. WSCC also offers members access to NeuroFlow, Pyx Health, and MyStrength apps to support members in managing and improving their overall health and mental well-being. WSCC has reinstated the health plan member incentive for members who follow up with a

	behavioral health clinician within 30 days of being discharged from an inpatient BH hospitalization. ***<u>PM #9 (1 point) – Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Day</u>*** The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days of the ED visit. **DY10 target is 48.00%.** • BCBS Q1 43.26%; Q2 50.79%; Q3 55.46%: Increase of 4.67 percentage points from Q2 to Q3 and is 7.46 percentage points above the DY10 target. • PHP Q1 36.95%; Q2 41.85%; Q3 49.56%: Increase of 7.71 percentage points from Q2 to Q3 and is 1.56 percentage points above the DY10 target. • WSCC Q1 35.43%; Q2 45.13%; Q3 46.83%: Increase of 1.70 percentage points from Q2 to Q3 and is 1.17 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 39.35%; Q2 Total 45.45%; Q3 Total 51.24%: Increase of 5.79 percentage points from Q2 to Q3 and is 3.24 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS began to engage members by offering a gift card for attending a follow-up appointment after an emergency room visit. BCBS continues to reserve appointments for members at provider offices to increase follow-up visits. BCBS staff also conducts member outreach to assist with scheduling appointments. The Quality team offers providers an educational webinar on maternal mental health and the FUM measure. Providers earned continuing education credit for attending the training. • PHP continued provider training through a Provider Education Conference (PEC). They also continued to partner with the Value-Based Purchasing team to include the FUM metric for behavioral health outpatient providers in the Behavioral Quality Incentive Program (BQIP). The BH network team works to increase telehealth psychiatric providers to improve access to care. Another effort is to increase access to behavioral health

services by offering training in behavioral telehealth certification. PHP continues to educate providers on the FUM metric and encourages BH providers to partner with Emergency Departments (ED) to offer behavioral health follow-up appointments. Presbyterian Health Services provides onsite peer consult liaison services at the ED to support members in attending aftercare appointments.

- WSCC continues to conduct targeted outreach to increase access to follow-up care with a primary care or behavioral health provider after a mental health-related ED visit. WSCC also partners with UNM Hospital's Community Health Worker (CHW) program to connect with WSCC members while they are in the ED. WSCC also offers members access to NeuroFlow, Pyx Health, and MyStrength apps to support members in managing and improving their overall health and mental well-being. To reduce barriers to care, WSCC member-facing personnel continue encourage telemedicine and educate members about and encourage the use of Teladoc Health. WSCC also offers value added services including electroconvulsive therapy, reimbursement for ceremonial or spiritual healing for Native American members and a holistic care grant up $250 per household. WSCC also offers no-cost training opportunities to providers.

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

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

DY10 target is 82.78%.

- BCBS Q1 43.49%; Q2 61.44%; Q3 73.92%: Increase of 12.48 percentage points from Q2 to Q3 and is 8.86 percentage points below the DY10 target.
- PHP Q1 44.06%; Q2 64.32%; Q3 75.77%: Increase of 11.45 percentage points from Q2 to Q3 and is 7.01 percentage points below the DY10 target.
- WSCC Q1 35.31%; Q2 60.11%; Q3 72.67%: Increase of 12.56 percentage points from Q2 to Q3 and is 10.11 percentage

	points below the DY10 target. • MCO Aggregate: Q1 Total 42.56%; Q2 Total 62.61%; Q3 Total 74.67%: Increase of 12.06 percentage points from Q2 to Q3 and is 8.11 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS engages members with schizophrenia and bipolar disorder who are using antipsychotic medications. These members were sent an SMS text message to remind them of the need for a diabetes screening and offered an at-home test kit. The message also included a video with a Spanish translation. BCBS also calls members to encourage diabetes screening and offer A1C test kits as well. Letters are also sent to providers as a reminder to have members tested. Additionally, an annual staff training is held to inform staff of ways to increase the rate. • PHP continues member outreach efforts and provides point-of-service A1c test kits to prescribers. PHP identified geographic areas with a high volume of members with a gap in care. Gap in Care letters with a list of members were sent to providers in Q3. The value-based purchasing team contacts providers to recruit them into the Behavioral Quality Incentive Program (BQIP) program. Providers are continuously educated by the Medical Director on the SSD HEDIS measure and best practices in prescribing antipsychotics at the Behavioral Health Provider Education Conference (PEC) meeting. • WSCC continues to partner with Harmony Cares to provide members with in-home A1c test kits. WSCC's Quality Improvement Nurse conducts outreach to members in the SSD measure to provide education about the importance of A1c screenings when taking antipsychotic medications. WSCC continues to collaborate with Outcomes™ to educate members on the importance of taking their prescribed medications, getting wellness checks, health screenings, and immunizations, and effectively managing their medical and behavioral health needs. WSCC initiated a pilot initiative in June 2023 with NM Community Cares (NMCC), a community paramedicine service, to perform telephonic and face-to-face outreach to members in the SSD measure who need A1c screening. WSCC Provider Quality Liaisons (PQLs) continue to interact

| | with providers to address care gaps and improve performance. WSCC also offers no-cost training to behavioral health and integrated care practitioners.

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

The following TMs show results for DY10 Q3 reporting.
<u>TM #1 – Fall Risk Management</u>
The percentage of Medicaid members 65 years of age and older with an outpatient visit with a diagnosis of a fall or problems with balance/walking and were screened by a practitioner for fall risk on the date of the diagnosis. An increase in percentage indicates improvement for this measure.

• BCBS Q1 0.01%; Q2 0.03%; Q3 0.01%: Decrease of 0.02 percentage points from Q2 to Q3.
• PHP Q1 1.51%; Q2 1.08%; Q3 1.17%: Increase of 0.09 percentage points from Q2 to Q3.
• WSCC Q1 0.11%; Q2 0.10%; Q3 0.10%: No change in percentage point from Q2 to Q3.
• MCO Aggregate: Q1 Total 0.37%; Q2 Total 0.28%; Q3 Total 0.30%: Increase of 0.02 percentage points from Q2 to Q3.

MCO Strategies and Interventions:
• BCBS: Encouraged clinicians to code for fall risk assessment in order to capture the assessments that are being completed.

• PHP: Identified issues related to safety and fall risk via the comprehensive needs assessment (CNA). Issues are addressed on the plan of care with interventions that may include medical follow-up or treatment such as physical therapy, home health care, long-term services and supports |

(LTSS), durable medical equipment, environmental modifications, and natural support systems to reduce fall risk.

- WSCC: Reached out to members with fall risk to educate them on the NM Department of Health (DOH) fall prevention program and to provide referrals to the program and encourage these members to participate.

TM #2 – Diabetes Short-Term Complications Admission Rate
Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees ages 18 and older. Reported as a rate per 100,000 member months. A lower rate indicates improvement for this measure.

- BCBS Q1 20.78; Q2 22.02; Q3 23.95: Decline in performance of 1.93 per 100,000 member months from Q2 to Q3.
- PHP Q1 15.25; Q2 18.49; Q3 18.46: Improvement in performance of 0.03 per 100,000 member months from Q2 to Q3.
- WSCC Q1 13.21; Q2 12.62; Q3 10.81: Improvement in performance of 1.81 per 100,000 member months from Q2 to Q3.
- MCO Aggregate: Q1 Total 16.95; Q2 Total 19.05; Q3 Total 19.50: Decline in performance of 0.45 per 100,00 member months from Q2 to Q3.

MCO Strategies and Interventions:

- BCBS: In the 2023 in-home testing campaign, BCBS deployed 3,719 A1c in-home testing kits that focused on 2 groups. The first group focused on members ages 18 and older with a diabetes diagnosis that are enrolled in care coordination/condition management and had an A1c testing gap. The second group focused on Native Americans/Native Alaskans within New Mexico, as this population has the lowest A1c < 8 and the highest ≥ 9 values.

- PHP: PHP made 202 call attempts to the Centennial Care 2.0 population and completed 53 contacts in DY10 Q3 to remind members to check their Hemoglobin A1c or to discuss Hemoglobin A1c control resources with them.

- WSCC: WSCC offers members with diabetes the option to

	participate in the Diabetic Health Coaching program, which educates members on how to manage their diabetes and prevent complications as well as guide members on steps they should take to maintain a healthy lifestyle. *TM #3 – Screening for Clinical Depression* Percentage of Medicaid enrollees ages 18 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. An increase in percentage indicates improvement for this measure. • BCBS Q1 0.88%; Q2 1.19%; Q3 1.52%: Increase of 0.33 percentage points from Q2 to Q3. • PHP Q1 1.08%; Q2 1.29%; Q3 1.74%: Increase of 0.45 percentage points from Q2 to Q3. • WSCC Q1 0.93%; Q2 1.50%; Q3 1.61%: Increase of 0.11 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 1.00%; Q2 Total 1.28%; Q3 Total 1.66%: Increase of 0.38 percentage points from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: Continued monthly calls to members to educate them on the importance of following up after a depression screening and to offer resources as needed. • PHP: Via the Health Risk Assessment (HRA), members are provided educational materials on the symptoms of depression and treatment for depression. • WSCC: A $25 provider incentive is available up to 4 times per year for non-behavioral health care providers who complete the PHQ-9 depression screening tool (or a comparable screening tool) with WSCC members. *TM #4 – Follow-up after Hospitalization for Mental Illness* The percent of 7-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days. An increase in rate indicates improvement for this measure. • BCBS Q1 35.78%; Q2 38.48%; Q3 38.53%: Increase of 0.05

	percentage points from Q2 to Q3. • PHP Q1 32.31%; Q2 33.37%; Q3 35.09%: Increase of 1.72 percentage points from Q2 to Q3. • WSCC Q1 30.08%; Q2 32.65%; Q3 36.27%: Increase of 3.62 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 33.16%; Q2 Total 35.22%; Q3 Total 36.55%: Increase of 1.33 percentage points from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: A provider training on maternal mental health, including a discussion of the FUH measure, was conducted. The training, which provides continuing medical education units, was held live and is available on the provider website. • PHP: All Value Based Programs (VBP) continued in DY10 Q3, including the Model Facility Incentive Program (MFIP) for inpatient acute psychiatric facilities/units, the Behavioral Health Quality Incentive Program (BQIP) for outpatient behavioral health providers, the Provider Quality Incentive Program (PQIP), and the Patient Centered Medical Home (PCMH) incentives for physical health providers. • WSCC: WSCC's Member Connections team is comprised of Certified Peer Support Workers (CPSW) and Community Health Workers (CHW) who draw on their own personal experiences with mental health and substance use recovery to support members to overcome similar challenges. CPSWs and CHWs are specially trained to engage with members to help them address barriers, assist members in connecting with community resources, provide guidance in navigating systems, and help schedule follow-up appointments. *TM #5 – Immunizations for Adolescents (IMA)* The percentage of adolescents 13 years of age who had 1 dose of meningococcal vaccine, 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. An increase in percentage indicates improvement for this measure. • BCBS Q1 74.58%; Q2 77.50%; Q3 82.43%: Increase of 4.93 percentage points from Q2 to Q3. • PHP Q1 74.64%; Q2 76.87%; Q3 80.60%: Increase of 3.73 percentage points from Q2 to Q3.

	• WSCC Q1 71.39%; Q2 73.19%; Q3 59.14%: Decrease of 14.05 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 74.28%; Q2 Total 76.69%; Q3 Total 78.88%: Increase of 2.19 percentage points from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: The "Got Shots?" campaign took place in DY10 Q3 and was aimed at members ages 1 month to 21 years with the intent to ensure these members and school children receive immunizations prior to the beginning of the school year. The outcome of this campaign will be available in DY10 Q4. • PHP: PHP collaborates with New Mexico Alliance for School Based Heath Centers (NMASBHC) regarding performance improvement to increase health education on immunizations to school-based health centers statewide. • WSCC: WSCC offers the My Health Pays Rewards - an incentive program available for members who complete the required immunizations in the IMA measure. Points earned can be used to help cover monthly bills or items like cooking and fitness products. *TM #6 – Long-Acting Reversible Contraceptive (LARC)* Utilization of Long-Acting Reversible Contraceptives. The contractor shall report LARC insertion/utilization data for this measure. • BCBS Q1 182; Q2 330; Q3 482. • PHP Q1 293; Q2 596; Q3 917. • WSCC Q1 37; Q2 90; Q3 163. • MCO Aggregate: Q1 Total 512; Q2 Total 1,016; Q3 Total 1,562. *TM #7 – Smoking Cessation* The MCO shall report the number of successful quit attempts. The MCO shall monitor the use of smoking cessation products and counseling utilization. Total number of unduplicated members receiving smoking and tobacco cessation products/services. • BCBS Q1 1,080; Q2 1,963; Q3 2,681: Increase of 718 members from Q2 to Q3. • PHP Q1 1,364; Q2 3,043; Q3 4,136: Increase of 1,093 members from Q2 to Q3.

	• WSCC Q1 281; Q2 587; Q3 880: Increase of 293 members from Q2 to Q3. • MCO Aggregate: Q1 Total 2,725; Q2 Total 5,593; Q3 7,697 Total: Increase of 2,104 members from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: Included an article on the BCBS website and in the Medicaid member newsletter providing information on the BCBS Quit Program for those who want to quit vaping and using tobacco. • PHP: To expand Tobacco Cessation program enrollment, a PHP tobacco cessation flyer was completed in August 2023 for distribution to providers, members, and to the public during community events. The tobacco cessation flyer is also provided to members when their newborns test positive for nicotine. • WSCC: Newly available to WSCC members in DY10 Q3 is the option to participate in the telehealth Tobacco Cessation program through Teledoc. Teledoc offers ongoing support and follow-up from a tobacco cessation coach at regular intervals, a 24/7 support hotline, and a prescription for Food and Drug Administration (FDA)-approved tobacco cessation medication, if necessary. *TM #8 – Ambulatory Care Outpatient Visits* Utilization of outpatient visits reported as a rate per 1,000 member months. An increase in rate indicates improvement for this measure. • BCBS Q1 73.63; Q2 166.63; Q3 256.14: Increase of 89.51 per 1,000 member months from Q2 to Q3. • PHP Q1 52.55; Q2 140.10; Q3 197.77: Increase of 57.67 per 1,000 member months from Q2 to Q3. • WSCC Q1 68.51; Q2 137.41; Q3 164.28: Increase of 26.87 per 1,000 member months from Q2 to Q3. • MCO Aggregate: Q1 Total 61.89; Q2 Total 149.16; Q3 Total 213.45: Increase of 64.29 per 1,000 member months from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: The Transition of Care (TOC) team has been continuously working to decrease readmissions by providing

education on the importance of primary care, assisting with appointment scheduling, and following up with patients to monitor and address barriers.

- PHP: PHP continues to build on provider relationships to ensure members are receiving services at the appropriate level of care.

- WSCC: Offered members participation in care coordination. Care Coordinators assist members with identified healthcare needs, addressing barriers, and meeting members goals. Care Coordinators also encourage members to attend scheduled appointments with their primary care physician (PCP) and specialists.

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

- BCBS Q1 9.75; Q2 21.62; Q3 33.66: Decline in performance of 12.04 per 1,000 member months from Q2 to Q3.
- PHP Q1 7.01; Q2 18.37; Q3 25.57: Decline in performance of 7.20 per 1,000 member months from Q2 to Q3.
- WSCC Q1 10.96; Q2 21.21; Q3 24.65: Decline in performance of 3.44 per 1,000 member months from Q2 to Q3.
- MCO Aggregate: Q1 Total 8.44; Q2 19.85 Total; Q3 Total 28.18: Decline in performance of 8.33 per 1,000 member months from Q2 to Q3.

MCO Strategies and Interventions:
- BCBS: Emergency Department Information Exchange (EDIE) is a tool used by CHWs to monitor members who utilize the emergency room (ER). An EDIE report is generated when a member accesses the ER. Through the ED Reduction program members are contacted by a CHW who targets members who have visited the ED more than 6 times in the last 6 months.

- PHP: Aligned multi-department communication outreach activities to improve messaging and decrease duplication, which will ensure that all members needing outreach are contacted via an appropriate channel with appropriate resources.

	• WSCC: Utilized the mPulse texting program when members who have high ED utilization are seen in the ER. These members receive a text message to check in about follow-up care and members may respond with any needs. Members who respond indicating any needs receive telephonic outreach from either their assigned Care Coordinator, if applicable, or from the Member Connections team. *TM #9 – Annual Dental Visit (ADV)* The percentage of enrolled members ages 2 to 20 years who had at least 1 dental visit during the measurement year. An increase in percentage indicates improvement for this measure. • BCBS Q1 19.77%; Q2 35.56%; Q3 46.83%: Increase of 11.27 percentage points from Q2 to Q3. • PHP Q1 21.34%; Q2 44.59%; Q3 56.29%: Increase of 11.70 percentage points from Q2 to Q3. • WSCC Q1 17.30%; Q2 35.65%; Q3 51.03%: Increase of 15.38 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 20.37%; Q2 Total 40.59%; Q3 Total 52.64%: Increase of 12.05 percentage points from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: The CHWs continued to reach out to new refugee members to assist them with scheduling an initial dental exam. The CHW team also assists these members with setting up transportation to their medical and dental appointments. • PHP: A presentation to PHP Value Based Program Provider Quality Incentive Program (VBP PQIP) providers and medical staff on recommendations for this measure took place. In DY10 Q3, 44,147 Early Periodic Screening, Diagnostic, and Treatment (EPSDT) letters were mailed to members in this age group. • WSCC: Envolve Dental sends annual reminder postcards to members who are due for an annual dental visit and also sends members quarterly dental newsletters. *TM #10 – Controlling High Blood Pressure (CBP)* The percentage of members ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. An increase in percentage indicates

	improvement for this measure. BCBS Q1 15.92%; Q2 27.46%; Q3 32.71%: Increase of 5.25 percentage points from Q2 to Q3. • PHP Q1 25.39%; Q2 35.88%; Q3 41.28%: Increase of 5.40 percentage points from Q2 to Q3. • WSCC Q1 9.38%; Q2 18.85%; Q3 27.58%: Increase of 8.73 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 19.82%; Q2 Total 30.66%; Q3 Total 36.55%: Increase of 5.89 percentage points from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: Value-based care providers who expressed interest in improving their patients' blood pressure participated in a program where their patients were offered a blood pressure monitor for home use. In DY10 Q3, the participating providers were notified of the 319 members who opted in for the monitor so they could follow up with them. • PHP: In DY10 Q3, 39 members with a gap in blood pressure screening were called as part of a continued call campaign focusing on controlling blood pressure. Of the 39 members who were called, 22 were successfully contacted to get screened. • WSCC: WSCC's pharmacy staff monitors member data for blood pressure medication compliance and outreaches to members to assist with continued compliance. Members are encouraged to have 90-day medication fills to promote medication adherence. *TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)* Initiation Phase: The percentage of members ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had 1 follow-up visit with a practitioner with prescribing authority within 30 days of when the first ADHD medication was dispensed. An increase in rate indicates improvement for this measure. • BCBS Q1 45.44%; Q2 46.15%; Q3 46.22%: Increase of 0.07 percentage points from Q2 to Q3. • PHP Q1 28.70%; Q2 30.08%; Q3 30.32%: Increase of 0.24 percentage points from Q2 to Q3.

	• WSCC Q1 46.09%; Q2 50.22%; Q3 51.34%: Increase of 1.12 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 37.29%; Q2 Total 38.66%; Q3 Total 38.75%: Increase of 0.09 percentage points from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: An annual employee training was offered to help employees identify all measures including the ADD measure. • PHP: Since most prescribers of ADHD medications are PCPs, PHP collaborates with the VBPs team to increase provider enrollment in the Provider Quality Incentive Plan (PQIP) for the ADD measure. • WSCC: WSCC holds monthly and quarterly provider engagement meetings where Provider Quality Liaisons (PQLs) continue to interact with providers to address care gaps and improve performance. Behavioral health (BH) providers from across the state participate in the meetings to address topics such as member access to appointments, pay for performance metrics, and the best ways to provide the highest quality of care to members. *TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)* Continuation and Maintenance Phase: The percentage of members ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at least 2 follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure. • BCBS Q1 57.14%; Q2 60.67%; Q3 57.14%: Decrease of 3.53 percentage points from Q2 to Q3. • PHP Q1 36.04%; Q2 38.07%; Q3 39.65%: Increase of 1.58 percentage points from Q2 to Q3. • WSCC Q1 72.22%; Q2 66.67%; Q3 67.50%: Increase of 0.83 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 45.54%; Q2 Total 48.47%; Q3 Total 47.26%: Decrease of 1.21 percentage points from Q2 to Q3.

	MCO Strategies and Interventions: • BCBS: BCBS has increased member education efforts and support for medication compliance. • PHP: Educated providers on the ADD measure via the provider newsletter and encouraged providers to schedule follow-up appointments before the patient leaves the office when new ADHD medication is prescribed. • WSCC: WSCC is adding additional on-demand provider micro-learnings through the Quality Improvement program HEDIS webpage with topics related to optimizing the ADD HEDIS measure and enhancing member experience with behavioral health care services. *<u>TM #12 – Child and Adolescent Well-Care Visits (WCV)</u>* The percentage of members 3 to 21 years of age who had at least 1 comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. An increase in percentage indicates improvement for this measure. • BCBS Q1 9.68%; Q2 21.11%; Q3 36.77%: Increase of 15.66 percentage points from Q2 to Q3. • PHP Q1 7.67%; Q2 19.21%; Q3 34.97%: Increase of 15.76 percentage points from Q2 to Q3. • WSCC Q1 8.18%; Q2 16.36%; Q3 32.68%: Increase of 16.32 percentage points from Q2 to Q3. • MCO Aggregate: Q1 Total 8.41%; Q2 Total 19.54%; Q3 Total 35.30%: Increase of 15.76 percentage points from Q2 to Q3. **MCO Strategies and Interventions:** • BCBS: In September 2023 a provider forum called “Better Care, Better Outcomes” was held in Albuquerque, NM. Learning objectives included member and provider engagement, data driven decision making, collaborative care, continuous quality improvement, and evidence-based practice. During the presentation, BCBS encouraged providers to embrace value-based strategies to further promote preventative services. • PHP: Quarterly newsletter to PHP Centennial Care 2.0 members and providers contained articles on recommended immunization schedules and well-care visits.

	• WSCC: The Value Based team and quality reporting specialists host monthly provider engagement meetings to review provider scorecards and share gap in care lists for members that are due or overdue for a well-care visit. **External Quality Review** HSD holds bi-weekly meetings with the External Quality Review Organization (EQRO) to review monthly projects, provide feedback, offer support, and assess issues. This process ensures that deliverables are met and that desired outcomes are achieved within the established timeframe. The meetings facilitate identifying potential areas for improvement, reviewing and revising existing processes, and developing new strategies for optimal project performance. HSD's collaboration with the EQRO fosters a culture of continuous improvement. EQR Reviews and Validations in DY10 Q3 consisted of the below. DY8 EQR Reviews and Validations: • DY8 Performance Improvement Projects, posted to the HSD website. DY9 EQR Reviews and Validations • Validation of Performance Improvement Projects, draft report in development with the EQRO. • Validation of Performance Measures, posted to the HSD website. • Validation of Network Adequacy, received by HSD from the EQRO. • Compliance Review, draft report in development with the EQRO. • Annual Technical Report in development with the EQRO, due to HSD on February 28, 2024 for review and approval for submission by April 30, 2024.

UTILIZATION

- Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for October 2022 – September 2023. Please see Attachment C: Key Utilization/cost per Unit Statistics by Major Population Group.

- The underlying utilization and unit cost data is based on paid claims with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent months of the October 2022 – September 2023 time period.

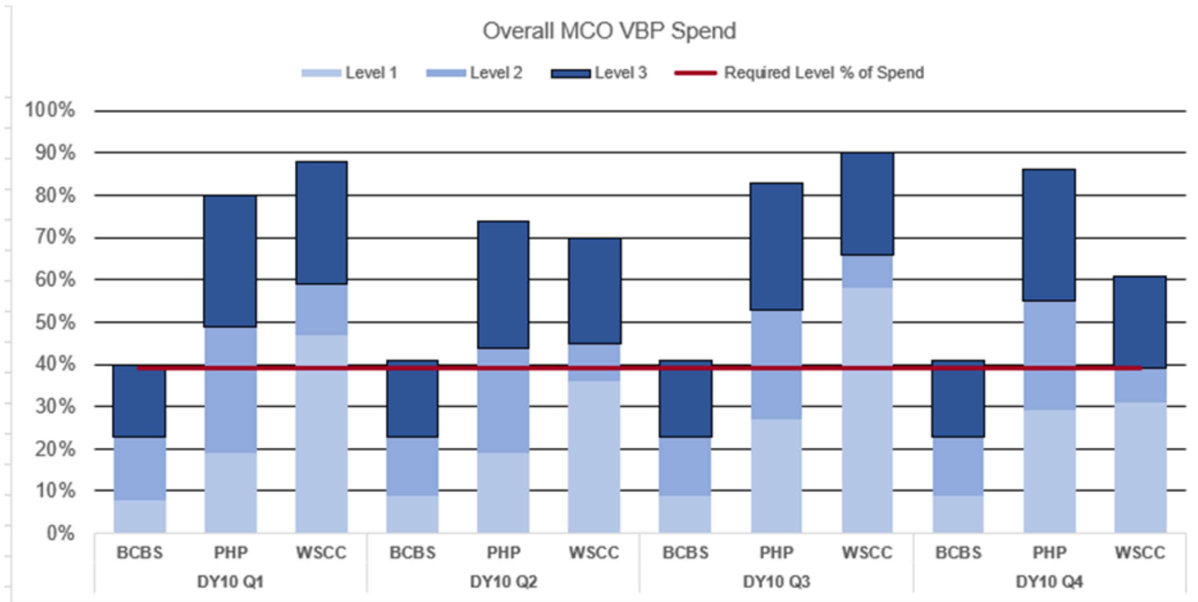
VALUE BASED PURCHASING

To support Centennial Care 2.0's value-based purchasing goals, HSD requires the MCOs to implement a Value Based Purchasing program that is based upon improved quality and/or member healthcare outcomes. To accomplish this, the MCO must meet minimum targets for 3 levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY10 requirements are as follows:

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

For DY10 Q4, BCBS, PHP, and WSCC exceeded the required VBP spend target of 39%.

Table 28: MCO VBP Spend



Source: MCO Calendar Year (CY) 2023 Quarter 4 VBP Financial Reports.

LOW ACUITY NON-EMERGENT CARE (LANE)

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

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

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

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

BCBS's digital texting campaign focusing on members visiting the ED will continue throughout 2023. Members who have visited the ED a minimum 2 times in the past 60 days are sent a text, with links to help find a PCP, location of the nearest Urgent Care Centers and the telephone number for the Nurse Advise Line. The goal is to provide early intervention prior to an established pattern of seeking care in an ED setting. Members listed as not having care coordination and reported on critical incident reports and showing a pattern of frequent ED visits will be referred to care coordination for follow-up and assessment.

PHP's 24/7 nurse advice line provides nurse triage and guidance concerning the most appropriate setting of care for specific clinical questions or concerns and provides education and resources to avoid low acuity ED utilization. PHP also initiated the TytoCare platform to reduce ED utilization for members and families with high ED utilization. When members agree to participate in TytoCare, they receive a TytoCare device allowing providers to conduct virtual assessments. Members can initiate a virtual visit with a provider who can diagnose and treat low acuity medical conditions through the TytoCare device.

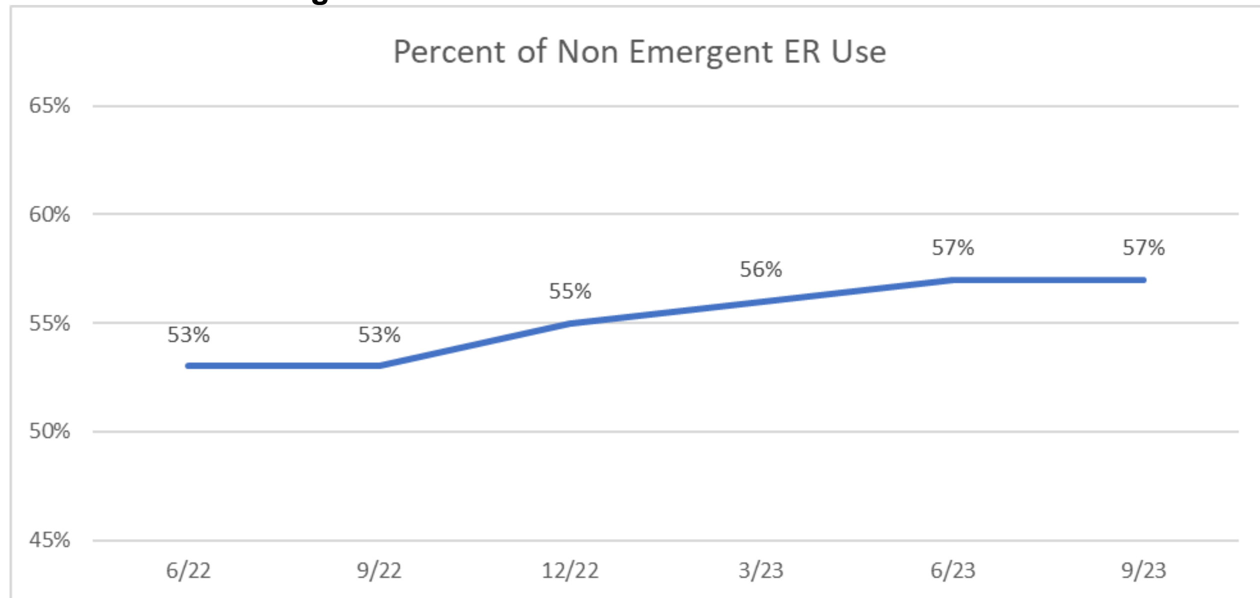
WSCC partners with Teambuilders, a community BH provider, to follow up with any member post ED visit for a mental health reason, to provide support and services. Members are incentivized with a $30 gift card for having a follow up visit within 14 days of an ED visit for substance abuse as well as educated about Centennial Rewards for members that have a follow up visit after being seen in the ED for a mental health reason.

WSCC has added the WSCC Care Coordinator's name and phone number to be viewed in the Collective Medical System by the hospital and emergency department staff so that they can connect WSCC members back to their care coordinator for support.

The percentage of emergency utilization that are considered low acuity increased from DY9 Q3 to DY10 Q3. In comparing low acuity ED visits from DY9 Q3 (53%) to DY10 Q3 (57%), the percentage of visits to the emergency department for non-emergent care increased by 4 percentage points. A lower rate indicates improvement for this measure. The trend for this measure indicates an increase in the number of low acuity ED visits.

The graph below reflects the percentage of members using the ER for non-emergent care between DY9 Q3 and DY10 Q3. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership. The data for DY10 Q4 will be reported in the DY11 Q1 CMS Quarterly Monitoring Report.

Table 29: Non-Emergent ER Use



Source: Mercer- Non-Emergent Emergency Room Utilization Report

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MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in DY10 with the requirement that at least 90% of members having access to certain provider types in urban, rural, and frontier geographic areas within a defined distance. Geographical Access is collected and validated on a quarterly basis.

Physical Health and Hospitals

Due to technical reporting errors DY10 Q4 complete and validated data is not available at this time. New Mexico intends to report both DY10 Q4 and DY11 Q1 in the DY11 Q1 report.

Transportation

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

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

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

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

ensure that all requested rides are provided for these appointments; 2) develop and submit for approval detailed operational plans for providing NEMT for Critical Care service appointments when the transportation vendors are unable to provide the service; 3) submit a NEMT monthly report that provides data on NEMT trips; and 4) in DY9 Q4, HSD provided performance targets to the MCOs for the number of trips that could not be scheduled, and for the number of scheduled trips that did not occur due to transportation provider actions, such as canceled or missed trips. The MCOs were informed that failure to meet the target level of performance would result in significant monetary penalties.

Customer Service Reporting

BCBS did not meet the Nurse Advice Line threshold of 85% Percent of Calls Answered within 30 seconds in December. This appears to have been due to a significant increase in call volume during flu season. The MCO needs to consider this seasonality when determining staffing levels for the call center. HSD will follow up with BCBS to ensure that seasonality is considered in call center staffing and ensure and to monitor BCBS's nurse advice line performance metrics in subsequent months .

PHP met all call center metrics for the reporting period, DY10 Q4.

WSCC met all call center metrics for the reporting period, DY10 Q4.

Telemedicine Delivery System Improvement Performance Target (DSIPT)

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

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

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

Table 30: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine	DY10 Q1	DY10 Q2	DY10 Q3	DY10 Q4
New Behavioral Health Members	**44,137**	**13,736**	**10,757**	**7,846**
BCBSNM	20,339	6,565	4,989	3,395
PHP	19,586	5,636	4,572	3,531
WSCC	4,212	1,535	1,196	920
New Physical Health Members	**39,919**	**21,660**	**14,883**	**12,377**
BCBSNM	11,058	5,894	4,419	3,793
PHP	25,365	13,605	9,202	7,346
WSCC	3,496	2,161	1,262	1,238
Total New Unduplicated Members	**78,461**	**30,725**	**21,562**	**16,800**
BCBSNM	29,488	10,891	7,930	5,940
PHP	41,697	16,615	11,522	9,027
WSCC	7,276	3,219	2,110	1,833
YTD* Unduplicated Members	**78,461**	**109,186**	**130,748**	**147,548**
BCBSNM	29,488	40,379	48,309	54,249
PHP	41,697	58,312	69,834	78,861
WSCC	7,276	10,495	12,605	14,438

Source: Telemedicine Delivery System Improvement Performance Target (DSIPT) data is refreshed quarterly* January – December 2023.

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
DY10 Q4	The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) continued to work together in DY10 Q4 to receive CMS approval on the Interim Evaluation Report. Revisions were made in the Evaluation Design to include components from the serious mental illness (SMI)/serious emotional disturbance (SED), high-fidelity wraparound (HFW), and home and community-based services (HCBS) Amendment, refined existing AIM 4 (improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder [SUD]) and Centennial Rewards measures, and personal care service (PCS) measures. HSAG continues to work on responding to and incorporating CMS' feedback into the revised Evaluation Design due to CMS by March 1, 2024. An invoicing schedule was received from HSAG reflecting a no-cost contract extension to continue waiver work through SFY 2027 due to the extension of Centennial Care 2.0 through December 2024. In Q4, HSD and HSAG developed a contract to evaluate the COVID-19 PHE vaccine amendment. HSAG began developing an evaluation approach to evaluate the COVID-19 PHE Vaccine Amendment and began preparing interview materials to conduct qualitative interviews with key stakeholders. HSD and HSAG will continue collaboration to discuss data needs for the Summative Evaluation Report, develop interview materials to collect qualitative information for use in evaluating the COVID-19 PHE Vaccine Amendment, calculate performance measures and develop analytic visualizations, and respond to and incorporate CMS' feedback into the revised Evaluation Design.

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ENCLOSURES/ATTACHMENTS

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

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STATE CONTACTS

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

HSD announced the appointment of Dana Flannery as the new Medicaid Director of the New Mexico Medicaid program in February 2024. Dana has a strong passion for Medicaid and believes that accessible and comprehensive healthcare is a necessary human right. She is excited to be part of the creation of the new Health Care Authority in New Mexico, which aims to shape a healthier and more inclusive future. Dana has extensive experience in strategic planning, managed care oversight, and intergovernmental relations. Her focus on person-centered, data-driven outcomes has allowed her to navigate governmental barriers and deliver positive health outcomes. She has made significant contributions during her tenure at Arizona's Medicaid agency, including leading the design of programmatic changes and implementing critical COVID-19 flexibilities. Dana also has a background as a behavioral health provider and has advocated for behavioral health integration and the development of peer and family support initiatives. She began her duties as Medicaid Program Director on March 1, 2024.

In April, 2024, Lorelei Kellogg departed from the Human Services Department after serving as Deputy Director of Programs with the Medical Assistance Division.

New Mexico will continue to update CMS on new points of contact as positions are permanently filled.

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ADDITIONAL COMMENTS

MCO INITIATIVES

<u>BCBS:</u>
Achievements
As part of BCBSNM's ongoing effort to increase access to well child visits, BCBSNM increased well child rates by 20% for visits provided after hours (evenings or weekends). BCBSNM contracted with 2 large pediatric provider groups, 1 in Albuquerque and 1 in Las Cruces, to reserve appointment slots during evenings or weekends for well child visits for members under 21 years of age. BCBSNM identified modifiers that providers add to their well child visit CPT codes that pay at the increased rates. This rate increase took effect on November 15, 2023. The providers expanded the hours they were open in the evenings and on weekends. This expansion resulted in a total of 1,752 reserved appointment slots. These rate increases incentivize providers to provide additional visits, and create greater access for members with parents and guardians who have difficulty attending appointments during regular business hours.

BCBS identified a need for specialized providers that focus on working with children with sexually maladaptive behaviors. A nationwide search was conducted to find potential providers who BCBS could contract with to provide much needed services for children in state custody. BCBS met with several providers and assisted them in navigating the registration process for Medicaid. As a result, BCBS was able to identify 5 new providers that were able to enroll in New Mexico Medicaid and can now provide in-network treatment for this specialized population.

<u>PHP</u>:
Achievements
Diabetes Prevention and Healthy Weight Programs
Since the Path for Wellness Program implementation in 2019 through December 2023, PHP had 401 Centennial Care Members enrolled and a total of 181 participants with logged individual sessions related to physical activity, healthy food choices, eating patterns, and daily weight management. In 2023, the program had a total of 64 new enrolled participants; 36 for the Diabetes Prevention Program (DPP), and 28 for the Healthy Weight Program. The program is offered for 12 months to eligible Members and is an evidence-based prevention program with oversight by the Centers for Disease Control

and Prevention. The program focuses on diabetes prevention and health weight management through weight loss and lifestyle changes.

NCQA Health Equity Accreditation
In 2023, PHP completed a gap analysis as part of its pursuit of National Committee for Quality Assurance (NCQA) Health Equity Accreditation. At the core of this accreditation is an understanding of the systemic and structural factors that disproportionately affect underserved populations. As part of the accreditation process, PHP is actively working towards improvements in a broad range of operational areas, including increasing diversity and inclusion in hiring processes, enhancing health equity data collection and analysis, increasing access to language services, ensuring a culturally responsive practitioner network, implementing interventions to address health care disparities, and establishing a Culturally and Linguistically Appropriate Services Program. PHP has begun gap mitigation to meet the NCQA requirements needed for accreditation, including beginning work with its NCQA consultant, and finalizing a survey.

Digital Wellbeing Tool
In 2023, PHP partnered with a new Population Health engagement vendor, NeuroFlow, to deliver a new digital wellbeing tool. As a part of the implementation, PHP constructed tailored healthcare journeys for at-risk populations; specifically, perinatal, adult behavioral health, and special-needs populations. The tool is scheduled for go-live in early 2024.

As mentioned above, PHP also updated The Path for Wellness Program eligibility file specifications to include new data sources and transitions between previous and current claims systems. Additionally, PHP enhanced file fields to identify at-risk populations and conduct tailored outreach; specifically, among native and tribal populations.

Coordinated Action Pilot Project
PHP actively participates in the Dona Ana and San Juan Counties Coordinated Action Pilot Project for transformation of CYFD and Behavioral Health Systems. Q4 CY2023 was the first full quarter that the San Juan County Pilot has been in effect. The Coordinated Action pilot developed agreements, chose co-chairs and identified challenges within systems for San Juan County. PHP Clinical Director Gabe Sena has been chosen as one of the co-chairs for the San Juan Pilot.

<u>WSCC:</u>
Pyx Health Program
Pyx Health is a free program for WSCC members to address loneliness, social isolation and Social Determinants of Health (SDoH) needs. Through the combination of an

engaging mobile app, as well as staff at the Compassionate Support Center, Pyx Health supports WSCC Members 24/7. The program went live for WSCC members in July 2022. As of Q4, 2023, 1,780 WSCC members have enrolled in the program and actively benefited from the Phone App or the live support to access health plan resources, community services, address general health care questions, urgent support, caregiver support, mental health, and substance abuse support, LGBTQIA services, and pregnancy support. Out of the 1,780 WSCC Members benefiting from the program: 40% are Hispanic, 33% are White, 6% are American Indian or Alaska Native, 4% are Black, 1% are Native Hawaiian or Other Pacific Islander, 3% are Other Race, and 26% are Unknown. WSCC's health outcomes for members that utilize Pyx Health has shown a 49% reduction in loneliness based on UCLA-3 scores as well as a 43% reduction in Depression and Anxiety based on the PHQ-4 scores.

Doula Services

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

NeuroFlow®

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

MEMBER SUCCESS STORIES

BCBS:

A Behavioral Health Transitions of Care Liaison has been working with a 13-year-old male member in CYFD custody since December 2021. He struggles with Depression, Reactive Attachment Disorder and has a history of trauma. This member's mother is deceased, and his father is in prison. The member has not been in regular contact with any of his siblings or other family members. This member is a self-professed "animal lover" and caring for and being around animals is one of his favorite activities. This member has been in many in-state acute settings, out-of-state residential treatment, foster care homes, group homes and shelters. Most recently he had been staying, sleeping and living in a Children, Youth and Families Department (CFYD) office, as no other placement was available. Recently, a resource couple was found in a nearby, small town, who were willing to take the member into their home. The couple has farm animals and indoor cats and dogs. This Liaison has seen member on Zoom calls previously in settings where he is unhappy and bored. However, at a recent call, the member was holding a kitten and smiling. Also, when asked what he had been up to, he replied that he had been outside with the goats, butting heads with them. The member said he was happy in the resource parent home.

PHP

A 35 year-old female member, who lives in the Albuquerque metro area, was assigned to a CHW for hepatitis-C outreach. This was the 4th time this member was assigned for hepatitis-C outreach over the past 2-years. The CHW was able to engage the member this time. The CHW was able to complete both the CHW Engagement Assessment and the Healthy Lifestyle Questionnaire with the member after reviewing updated information found in research. In the course of engaging with this member, it was disclosed that member's young son recently tested positive for hepatitis C. The CHW was not only able to get the original member re-engaged, re-established with medical care and specifically hepatitis-C treatment, but was also able to get the young child scheduled with the Presbyterian Pediatric Specialty clinic. This was to address the member's son's needs for medical follow-up and potential treatment for hepatitis-C. CHW will continue to follow both members and ensure that they are able to receive the medical care and specialty care they need.

WSCC:

A member with Western Sky Community Care (WSCC), called to express gratitude for the assistance she received from a Member Services Rep (MSR). The member and her family were homeless when they moved to New Mexico. The member enrolled with WSCC and

needed services. MSR referred the member to WSCC's care coordination team. She was contacted by WSCC's Housing Management Specialist (HMS) and was able to find a place to live and receive clothing and food. The MSR also assisted the member and her family in finding a provider. The member is grateful for WSCC and the personal service she received.

BCBS:

PHE Unwinding Outreach Actions, December 2023

Member Calls

Direct member (non-prerecorded) outbound calls: December 2023	BCBS
Members scheduled for direct calls	3357
Number of calls made	5851
Answered	3710
No answer	1018
Voicemail	1123
Hung up	20
Contact completed (member reached; information conveyed)	959
Average call duration	0:00:50
Member inbound calls related to recertification	911

Outreach Completed

Outreach Efforts Completed: December 2023	BCBS
Members targeted	5262
Special COEs/Groups targeted	N/A
Member letters/direct mail	3932
Email 1	N/A
Email 2	N/A
Postcards	1330
Text message 1	N/A
Text message 2	N/A
Text message 3	N/A
Text message 4	N/A
Robocalls	N/A
Efforts targeting the closed population	
Communications (emails and letters) have been sent to the Closed population received via the July, 2023 Termination file from HSD, urging members to not go uninsured but explore alternative Blue Cross and Blue Shield of New Mexico plan options at BeWellNM.com.	
Notes	
N/A	

PHP:

PHE Unwinding Outreach Actions, December 2023

Member Calls

Direct member (non-prerecorded) outbound calls: December 2023	PHP
Members scheduled for direct calls	1860
Number of calls made	1860
Answered	146
No answer	823
Voicemail	626
Hung up	243
Contact completed (member reached; information conveyed)	168
Average call duration	5m 2s
Member inbound calls related to recertification	323

Outreach Completed

Outreach Efforts Completed: December 2023	PHP
Members targeted	5872
Special COEs/Groups targeted	N/A
Member letters/direct mail	5751 (sent on 12/6)
Email 1	496 (sent on 12/13)
Email 2	N/A
Postcards	395
Text message 1	5872 (sent on 12/19)
Text message 2	N/A
Text message 3	N/A
Text message 4	N/A
Robocalls	N/A
Efforts targeting the closed population	

Notes
PHP sent 5751 letters to members on 12/6. Emails were sent to all members for which we had a valid email address on 12/13 (496 total) that mirrored the information relayed in the letter. Texts were sent out to 5872 members on 12/19. Discrepancies between the amount of texts sent and the amount of letters is due to householding the mailing and some invalid mailing addresses. Nineteen (19) Outreach events were conducted in December 2023. Recertifcations/Renewal/New Applications: Four (4) Recertifcations were completed; One (1) Referral were made; Five (5) conversations regarding NM Medicaid Recertifications and Renewals. Care Coordination completed outreach to 316 members

WSCC
PHE Unwinding Outreach Actions, December 2023
Member calls

Direct member (non-prerecorded) outbound calls December 2023	Western Sky
Members scheduled for direct calls	1061
Number of calls made	953
Answered	287
No answer	43
Voicemail	437
Hung up	105
Contact completed (member reached, information conveyed)	167
Average call duration	1.91
Member inbound calls related to recertification	69
Notes	
Wrong Number: 56 **Inbound Calls Activity:** Average Call Duration: 13.3 minutes Voicemails: 0 inbound voicemails In this month's telephonic outreach, Western Sky representatives assisting individuals with Medicaid renewal questions noticed an increase in expressed concerns about long hold times and calls dropped when reaching out to Member Services. Some PE Determiners are also still experiencing issues in being able to assist members when calling HSD or utilizing the chat. PEDs are being advised that if they're not on the case they may not be provided case status information.	

Outreach Completed

Outreach Efforts Completed December 2023	Western Sky
Members targeted	1128
Special COEs/Groups targeted	31, 300, 301, High Risk Care Coord. (CCL2, CCL 3, CCL4 & CCL5), 400, 401, 403
Member letters/direct mail	1128
Email 1	238
Email 2	226
Postcards	0
Text message 1	717
Text message 2	715
Text message 3	712
Text message 4	712
Robocalls	1585
Efforts targeting the closed population	

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

Notes

N/A

Program Changes Effective on or after 7/1/2021	
HCQS Per Diem and NF MBI Updates	The HCQS adjustment effective July 1, 2021 reflects an updated surcharge for NFs with over 60 beds. The NF MBI adjustment reflects an update to the MBI increase to all NFs. The MBI adjustment compounds with the total MBI percentage effective July 1, 2020.
Addition of New Home Visiting Providers	The Addition of New Home Visiting Providers adjustment reflects two new providers offering Nurse Family Partnership and Parents as Teachers programs effective October 1, 2021 and three new providers will offer Parents as Teachers programs effective November 1, 2021 under the Centennial Home Visiting program.
Proposal W.2 Temporary Economic Recovery Payment	The Temporary Home & Community Based Services (HCBS) Fee Increase reflects the cost of HSD's Proposal W.2 as outlined in their American Rescue Plan Act (ARPA) spending plan, as part of their efforts to "enhance, expand, or strengthen" the HCBS workforce. The rating adjustment applied as a 15.0% increase effective July 1, 2021.

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

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

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

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

State of New Mexico - All MCOs

All Centennial Care Populations

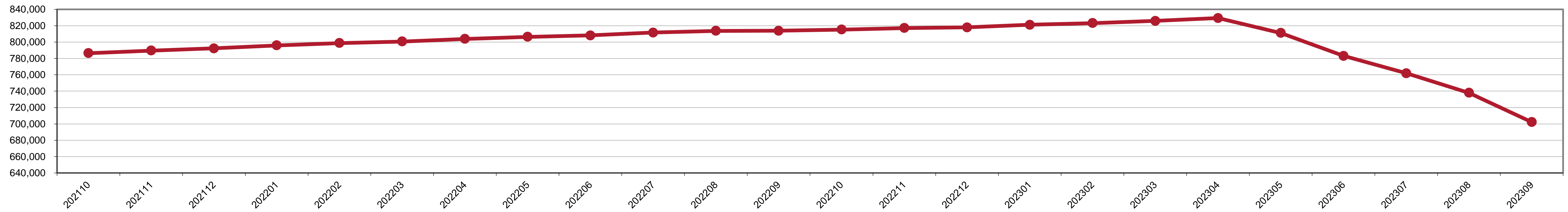
Centennial Care Cost Review

Reported Eligibility for Members Enrolled as of: September 30, 2023

Previous Period: October 1, 2021 to September 30, 2022

Current Period: October 1, 2022 to September 30, 2023

1. Total Centennial Care Monthly Enrollment



2. Total Centennial Care Dollars and Member Months by Program

Aggregate Member Months by Program

Population	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	5,790,403	5,729,085	-1%
Long Term Services and Supports	622,148	627,406	1%
Other Adult Group	3,208,655	3,189,596	-1%
Total Member Months	**9,621,206**	**9,546,087**	**-1%**

Programs	*Aggregate Medical Costs by Program* Previous (12 mon)	Current (12 mon)	% Change	*Per Capita Medical Costs by Program (PMPM)* Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,800,429,622	$ 1,725,505,591	-4%	$ 310.93	$ 301.18	-3%
Long Term Services and Supports	$ 1,241,084,474	$ 1,314,447,568	6%	$ 1,994.84	$ 2,095.05	5%
Other Adult Group Physical Health	$ 1,492,838,223	$ 1,446,272,844	-3%	$ 465.25	$ 453.43	-3%
Behavioral Health - All Members	$ 585,924,872	$ 652,217,673	11%	$ 60.90	$ 68.32	12%
Total Medical Costs	**$ 5,120,277,190**	**$ 5,138,443,676**	**0%**	**$ 532.19**	**$ 538.28**	**1%**

Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Admin, care coordination, Centennial Rewards	$ 425,412,767	$ 439,128,129	3%	$ 44.22	$ 46.00	4%
NMMIP Assessment	$ 92,500,350	$ 123,073,887	33%	$ 9.61	$ 12.89	34%
Premium Tax - Net of NIMMP Offset	$ 324,045,469	$ 354,819,424	9%	$ 33.68	$ 37.17	10%
Total Non-Medical Costs	**$ 841,958,586**	**$ 917,021,441**	**9%**	**$ 87.51**	**$ 96.06**	**10%**
Estimated Total Centennial Care Costs	**$ 5,962,235,776**	**$ 6,055,465,117**	**2%**	**$ 619.70**	**$ 634.34**	**2%**

Centennial Care Medical Expenditures

Previous (Q3CY2022 - Q2CY2023)

12% 35% 29% 24%

Current (Q4CY2022 - Q3CY2023)

13% 33% 28% 26%

**See above for legend.*

Centennial Care Member Months

Previous (Q3CY2022 - Q2CY2023)

33% 60% 7%

Current (Q4CY2022 - Q3CY2023)

33% 60% 7%

**See above for legend.*

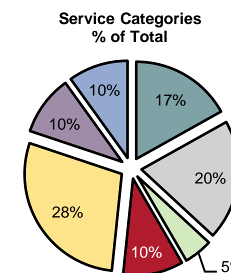
3. Total Program Medical/Pharmacy Dollars

	Aggregate Costs by Service Categories Previous (12 mon)	Current (12 mon)	% Change	*Per Capita Medical Costs by Service Categories (PMPM)* Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 4,612,177,666	$ 4,584,175,578	-1%	$ 479.38	$ 480.22	0%
Pharmacy	$ 508,099,524	$ 554,268,098	9%	$ 52.81	$ 58.06	10%
Total	**$ 5,120,277,190**	**$ 5,138,443,676**	**0%**	**$ 532.19**	**$ 538.28**	**1%**

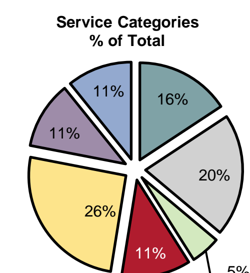
Service Categories	*Aggregate Costs by Service Categories* Previous (12 mon)	Current (12 mon)	% Change	*Per Capita Medical Costs by Service Categories (PMPM)* Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 864,926,310	$ 807,710,545	-7%	$ 89.90	$ 84.61	-6%
Acute Outp/Phy	$ 1,023,077,144	$ 1,047,337,253	2%	$ 106.34	$ 109.71	3%
Nursing Facility	$ 242,955,123	$ 253,521,401	4%	$ 25.25	$ 26.56	5%
Community Benefit/PCO	$ 513,164,367	$ 590,351,562	15%	$ 53.34	$ 61.84	16%
Other Services	$ 1,459,041,114	$ 1,310,766,819	-10%	$ 151.65	$ 137.31	-9%
Behavioral Health	$ 509,013,609	$ 574,487,998	13%	$ 52.91	$ 60.18	14%
Pharmacy (All)	$ 508,099,524	$ 554,268,098	9%	$ 52.81	$ 58.06	10%
Total Costs	**$ 5,120,277,190**	**$ 5,138,443,676**	**0%**	**$ 532.19**	**$ 538.28**	**1%**

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

Previous (12 mon) service distribution



Current (12 mon) service distribution



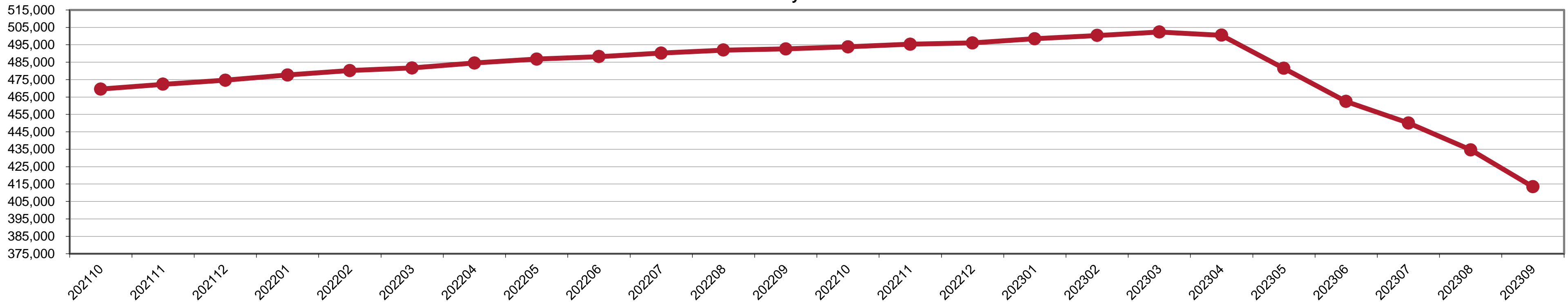
4. Notes

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

State of New Mexico - All MCOs
Total Population (TANF, Aged, Blind, Disabled, CYFD, Pregnant Women)
Physical Health Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: September 30, 2023
Previous Period: October 1, 2021 to September 30, 2022
Current Period: October 1, 2022 to September 30, 2023

1. Total Population Monthly Enrollment



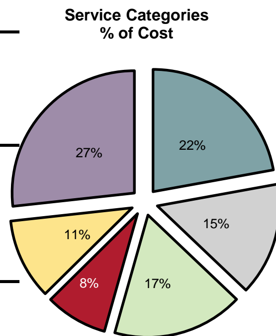
2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,630,154,908	$ 1,541,504,659	-5%
Pharmacy	$ 170,274,714	$ 184,000,932	8%
Total	**$ 1,800,429,622**	**$ 1,725,505,591**	**-4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 428,025,262	$ 382,154,895	-11%
Outpatient (OP)	$ 260,622,076	$ 257,952,434	-1%
Physician (PH)	$ 280,733,322	$ 298,176,371	6%
Emergency Department (ED)	$ 124,890,612	$ 141,983,165	14%
Pharmacy (RX)	$ 170,274,714	$ 184,000,932	8%
Other (OTH)	$ 535,883,636	$ 461,237,794	-14%
Total Population Costs	**$ 1,800,429,622**	**$ 1,725,505,591**	**-4%**
Per Capita Cost (PMPM)	**$ 310.93**	**$ 301.18**	**-3%**
Total Member Months	**5,790,403**	**5,729,085**	**-1%**



3. Retail Pharmacy Usage (Definitions in Glossary)

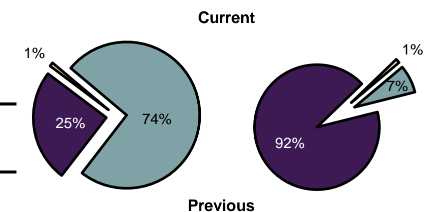
Total Generic / Brand Rx

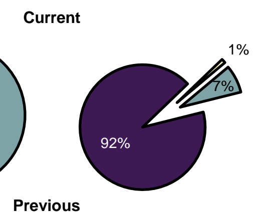
	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 126,653,832	$ 136,828,506	8%
Generic	$ 41,769,270	$ 45,596,150	9%
Other Rx	$ 1,851,612	$ 1,576,276	-15%
Total	**$ 170,274,714**	**$ 184,000,932**	**8%**

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

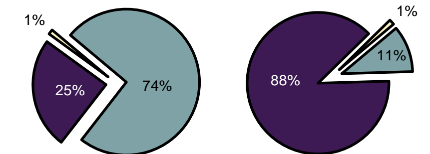
% of Rx Spend **% of Scripts**

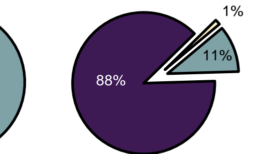
Current





Previous





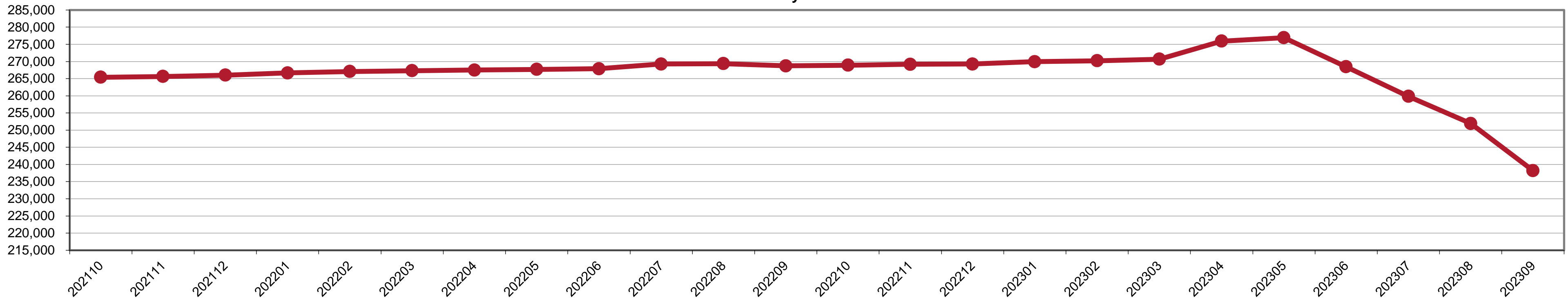
4. Notes

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

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

Reported Eligibility for Members Enrolled as of: September 30, 2023
Previous Period: October 1, 2021 to September 30, 2022
Current Period: October 1, 2022 to September 30, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

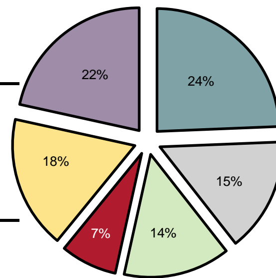
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,265,748,228	$ 1,193,138,399	-6%
Pharmacy	$ 227,089,995	$ 253,134,444	11%
Total	**$ 1,492,838,223**	**$ 1,446,272,844**	**-3%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 363,015,473	$ 352,314,320	-3%
Outpatient (OP)	$ 218,629,567	$ 217,444,807	-1%
Physician (PH)	$ 193,879,712	$ 203,699,672	5%
Emergency Department (ED)	$ 102,802,533	$ 107,736,715	5%
Pharmacy (RX)	$ 227,089,995	$ 253,134,444	11%
Other (OTH)	$ 387,420,941	$ 311,942,885	-19%
Total Population Costs	**$ 1,492,838,223**	**$ 1,446,272,844**	**-3%**
Per Capita Cost (PMPM)	**$ 465.25**	**$ 453.43**	**-3%**
Total Member Months	**3,208,655**	**3,189,596**	**-1%**

Service Categories % of Cost



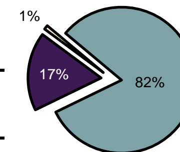
3. Retail Pharmacy Usage (Definitions in Glossary)

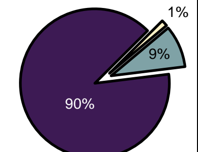
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 185,045,599	$ 206,749,860	12%
Generic	$ 39,344,446	$ 43,995,180	12%
Other Rx	$ 2,699,950	$ 2,389,404	-12%
Total	**$ 227,089,995**	**$ 253,134,444**	**11%**

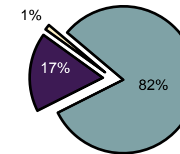
% of Rx Spend **% of Scripts**

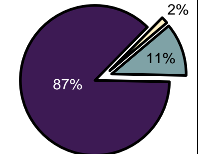
Current





Previous





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

4. Notes

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

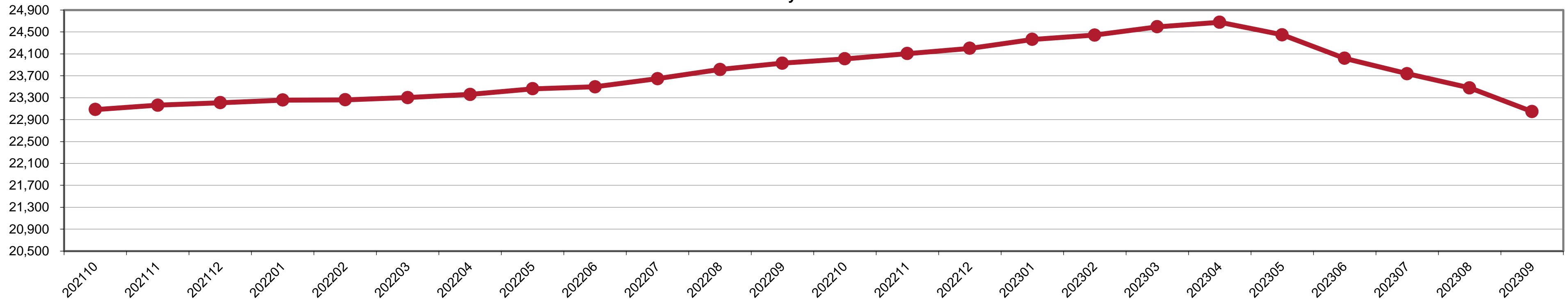
State of New Mexico - All MCOs

LTSS - Healthy Dual Population

Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: September 30, 2023
Previous Period: October 1, 2021 to September 30, 2022
Current Period: October 1, 2022 to September 30, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

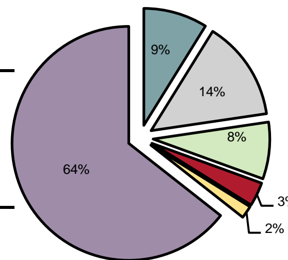
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 63,673,518	$ 64,315,452	1%
Pharmacy	$ 808,649	$ 1,145,118	42%
Total	**$ 64,482,167**	**$ 65,460,570**	**2%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 9,710,934	$ 5,792,950	-40%
Outpatient (OP)	$ 11,127,143	$ 9,050,385	-19%
Physician (PH)	$ 5,905,623	$ 5,139,558	-13%
Emergency Department (ED)	$ 2,356,980	$ 2,164,747	-8%
Pharmacy (RX)	$ 808,649	$ 1,145,118	42%
Other (OTH)	$ 34,572,837	$ 42,167,813	22%
Total Population Costs	**$ 64,482,167**	**$ 65,460,570**	**2%**
Per Capita Cost (PMPM)	**$ 229.48**	**$ 226.41**	**-1%**
Total Member Months	**280,989**	**289,126**	**3%**

Service Categories % of Cost



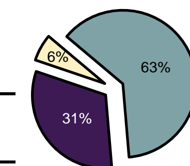
3. Retail Pharmacy Usage (Definitions in Glossary)

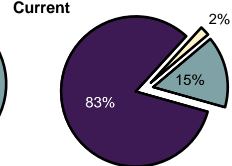
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 580,304	$ 716,224	23%
Generic	$ 192,501	$ 360,965	88%
Other Rx	$ 35,843	$ 67,929	90%
Total	**$ 808,649**	**$ 1,145,118**	**42%**

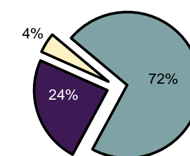
% of Rx Spend **% of Scripts**

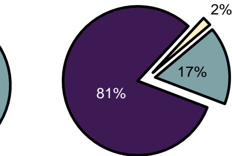
Current





Previous





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

4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
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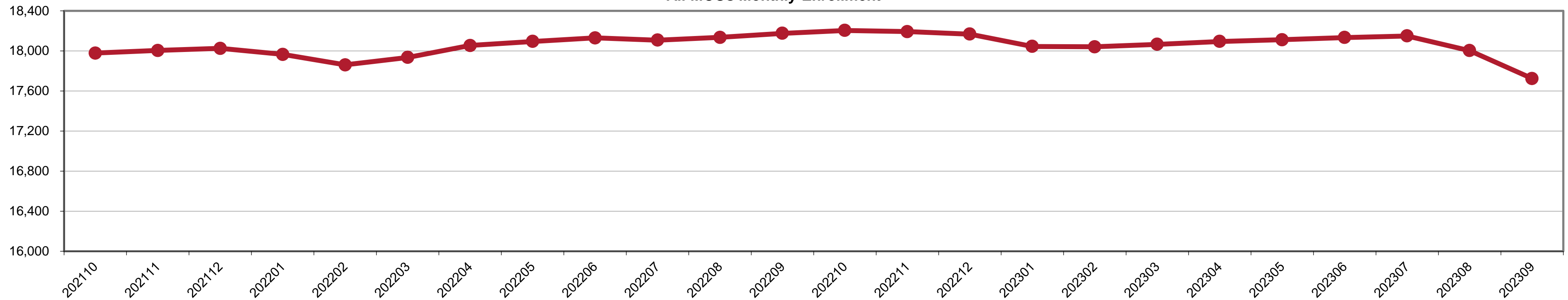
State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Dual Population

Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: September 30, 2023
Previous Period: October 1, 2021 to September 30, 2022
Current Period: October 1, 2022 to September 30, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

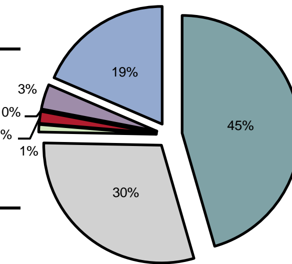
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 699,750,905	$ 738,345,959	6%
Pharmacy	$ 256,595	$ 297,055	16%
Total	**$ 700,007,500**	**$ 738,643,014**	**6%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 280,980,760	$ 336,379,379	20%
Nursing Facility (NF)	$ 213,920,658	$ 219,881,239	3%
Inpatient (IP)	$ 11,444,332	$ 7,584,806	-34%
Outpatient (OP)	$ 14,377,964	$ 12,151,016	-15%
Pharmacy (RX)	$ 256,595	$ 297,055	16%
HCBS	$ 24,107,230	$ 25,313,247	5%
Other (OTH)	$ 154,919,961	$ 137,036,273	-12%
Total Population Costs	**$ 700,007,500**	**$ 738,643,014**	**6%**
Per Capita Cost (PMPM)	**$ 3,233.83**	**$ 3,404.95**	**5%**
Total Member Months	**216,464**	**216,932**	**0%**

Service Categories % of Cost



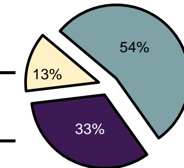
3. Retail Pharmacy Usage (Definitions in Glossary)

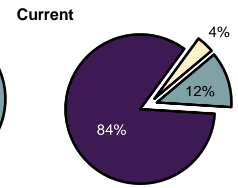
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 144,602	$ 160,517	11%
Generic	$ 80,867	$ 97,912	21%
Other Rx	$ 31,126	$ 38,626	24%
Total	**$ 256,595**	**$ 297,055**	**16%**

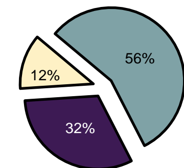
% of Rx Spend | **% of Scripts**

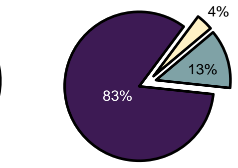
Current





Previous





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

4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
2. Amounts are based on expenditures for medical and pharmacy services only. Expenditures for Indian Health Services, Tribal 638, and non-state plan services are excluded.
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5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

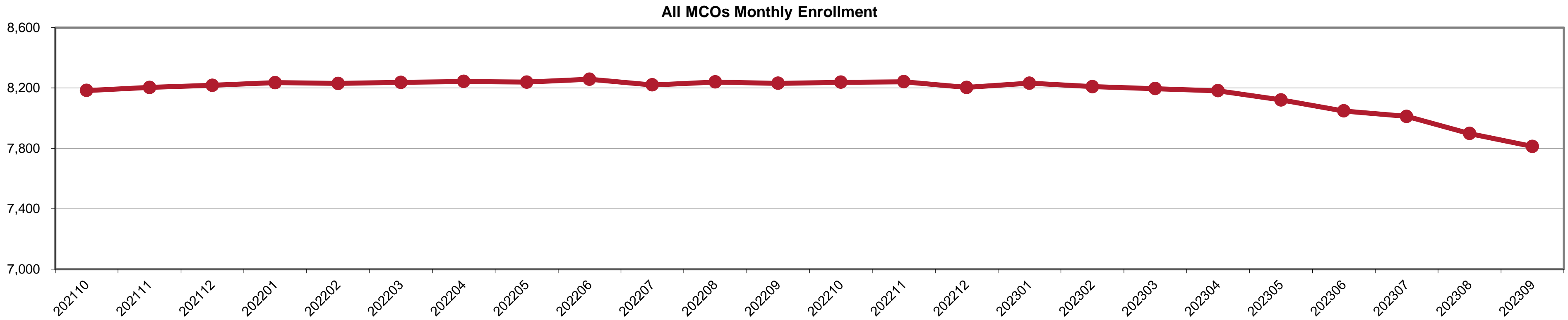
State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Medicaid Only Population

Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: September 30, 2023
Previous Period: October 1, 2021 to September 30, 2022
Current Period: October 1, 2022 to September 30, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

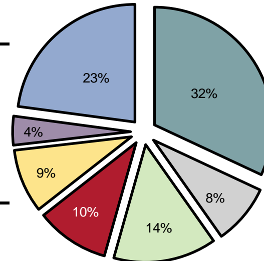
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 335,877,075	$ 365,582,059	9%
Pharmacy	$ 29,772,905	$ 35,060,553	18%
Total	**$ 365,649,980**	**$ 400,642,612**	**10%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 109,831,367	$ 128,044,802	17%
Nursing Facility (NF)	$ 28,646,496	$ 33,154,194	16%
Inpatient (IP)	$ 49,114,117	$ 56,615,515	15%
Outpatient (OP)	$ 34,204,359	$ 40,262,436	18%
Pharmacy (RX)	$ 29,772,905	$ 35,060,553	18%
HCBS	$ 14,971,677	$ 15,870,737	6%
Other (OTH)	$ 99,109,059	$ 91,634,375	-8%
Total Population Costs	**$ 365,649,980**	**$ 400,642,612**	**10%**
Per Capita Cost (PMPM)	**$ 3,703.23**	**$ 4,113.63**	**11%**
Total Member Months	**98,738**	**97,394**	**-1%**

Service Categories % of Cost



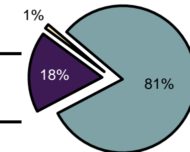
3. Retail Pharmacy Usage (Definitions in Glossary)

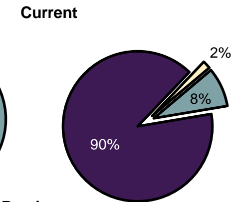
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 23,931,760	$ 28,479,267	19%
Generic	$ 5,441,086	$ 6,220,957	14%
Other Rx	$ 400,059	$ 360,329	-10%
Total	**$ 29,772,905**	**$ 35,060,553**	**18%**

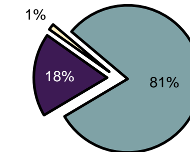
% of Rx Spend / **% of Scripts**

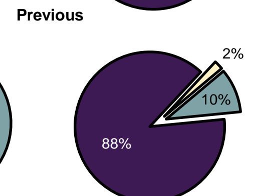
Current





Previous





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

4. Notes

1. Data source: MCO-submitted financial reports, including MCO estimates for unpaid claims liability. Values are based on information available at the time of this report and are subject to change as new information becomes available.
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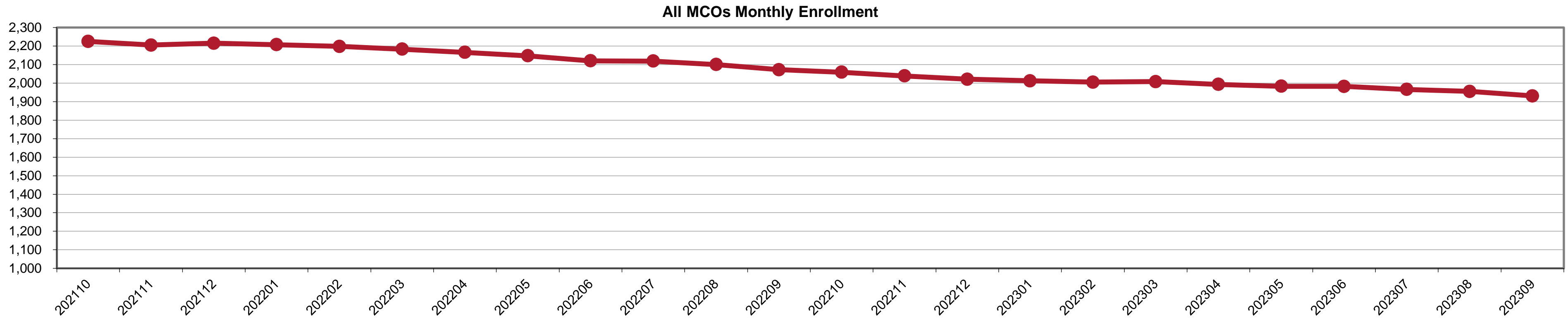
4. Amounts are reported based on dates of service within the previous and current periods.
5. Continuous updates to the underlying financial data are ongoing by the MCOs, as such, data is subject to change as revised information becomes available.

State of New Mexico - All MCOs
LTSS - Self Directed Population
Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: September 30, 2023
Previous Period: October 1, 2021 to September 30, 2022
Current Period: October 1, 2022 to September 30, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

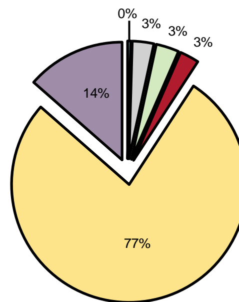
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 107,959,424	$ 106,801,053	-1%
Pharmacy	$ 2,985,403	$ 2,900,319	-3%
Total	**$ 110,944,828**	**$ 109,701,372**	**-1%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 387,969	$ 485,969	25%
Inpatient (IP)	$ 3,616,191	$ 3,248,060	-10%
Outpatient (OP)	$ 3,597,377	$ 3,460,576	-4%
Pharmacy (RX)	$ 2,985,403	$ 2,900,319	-3%
HCBS	$ 83,273,334	$ 84,743,397	2%
Other (OTH)	$ 17,084,553	$ 14,863,052	-13%
Total Population Costs	**$ 110,944,828**	**$ 109,701,372**	**-1%**
Per Capita Cost (PMPM)	**$ 4,274.18**	**$ 4,579.67**	**7%**
Total Member Months	**25,957**	**23,954**	**-8%**

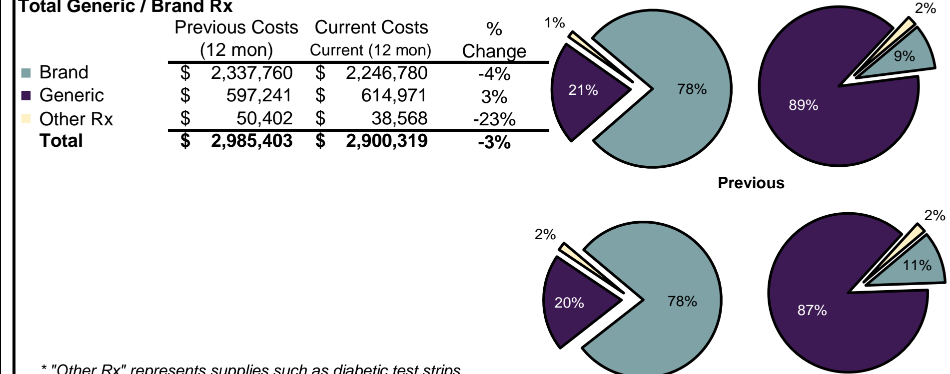
Service Categories
% of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 2,337,760	$ 2,246,780	-4%
Generic	$ 597,241	$ 614,971	3%
Other Rx	$ 50,402	$ 38,568	-23%
Total	**$ 2,985,403**	**$ 2,900,319**	**-3%**



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

4. Notes

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3. Other Services category includes, but is not limited to, the following services: emergent and non-emergent transportation, vision, dental, and directed payments.
4. Amounts are reported based on dates of service within the previous and current periods.
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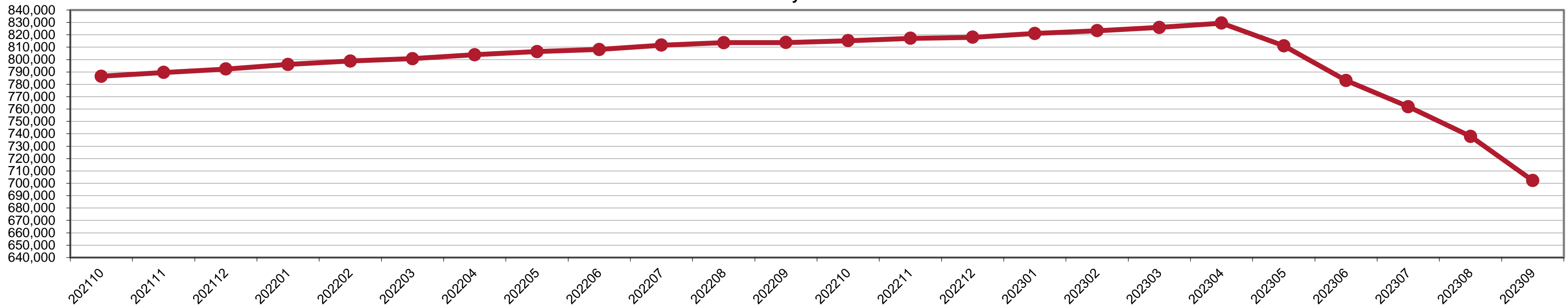
State of New Mexico - All MCOs

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

Behavioral Health Utilization and Cost Review

Reported Eligibility for Members Enrolled as of: September 30, 2023
Previous Period: October 1, 2021 to September 30, 2022
Current Period: October 1, 2022 to September 30, 2023

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

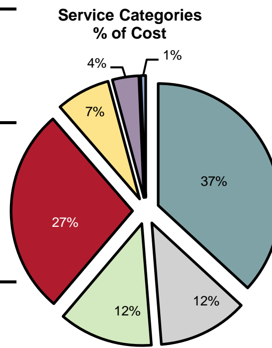
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 509,013,609	$ 574,487,998	13%
Pharmacy	$ 76,911,263	$ 77,729,675	1%
Total	**$ 585,924,872**	**$ 652,217,673**	**11%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 223,443,769	$ 240,189,907	7%
Pharmacy (RX)	$ 76,911,263	$ 77,729,675	1%
Res. Treatment Ctr. (RTC)	$ 93,442,954	$ 81,426,266	-13%
Behavioral Health Prov (BHP)	$ 137,628,963	$ 178,617,060	30%
Core Service Agencies (CSA)	$ 33,413,969	$ 46,946,524	40%
Inpatient (IP)	$ 19,089,837	$ 22,991,980	20%
Other (OTH)	$ 1,994,116	$ 4,316,261	116%
Total Population Costs	**$ 585,924,872**	**$ 652,217,673**	**11%**
Per Capita Cost (PMPM)	**$ 60.90**	**$ 68.32**	**12%**
Total Member Months	**9,621,206**	**9,546,087**	**-1%**

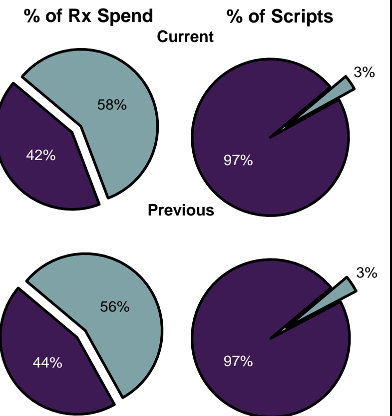
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 42,909,265	$ 45,179,353	5%
Generic	$ 34,001,998	$ 32,550,322	-4%
Total	**$ 76,911,263**	**$ 77,729,675**	**1%**



4. Notes

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

ATTACHMENT B
New Mexico Budget Neutrality Monitoring Spreadsheet
- PMPM Analysis
DY 10
Start Date: 01/01/2023
End Date: 12/31/2023

Quarter 4
Start Date:10/1/2023
End Date: 12/30/2023

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01	DY 01	DY 01	DY 02	DY 02	DY 03	DY 03	DY 04	DY 04	DY 05	DY 05	DY 06	DY 06
TANF & Related	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	4,621,656	5,092,636	4,623,475	5,132,359	4,422,938	4,974,487	4,313,641
PMPM	$ 385.80	$ 329.14	$ 400.77	$ 344.32	$ 416.32	$ 334.75	$ 432.47	$ 341.04	$ 449.25	$ 353.31	$ 460.00	$ 397.14
Dollars	$ 1,823,911,159	$ 1,486,786,187	$ 1,948,487,793	$ 1,533,690,296	$ 2,090,074,424	$ 1,547,091,436	$ 2,202,434,150	$ 1,576,787,544	$ 2,305,734,126	$ 1,562,668,928	$ 2,288,249,485	$ 1,713,137,701

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

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

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

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

MEG06	DY 01	DY 01	DY 02	DY 02	DY 03	DY 03	DY 04	DY 04	DY 05	DY 05	DY 06	DY 06
VIII Group - Medicaid Expansion	Cost Estimates	YTD - Actuals	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]	Cost Estimates	YTD - Actuals [2]
MMs [1]	1,632,968	1,887,728	1,788,895	2,748,632	1,800,808	3,078,074	1,763,748	3,143,890	1,773,299	3,019,164	3,299,404	3,070,895
PMPM	$ 577.87	$ 453.48	$ 607.34	$ 476.42	$ 638.31	$ 442.85	$ 670.87	$ 450.19	$ 705.08	$ 484.90	$ 738.22	$ 524.64
Dollars	$ 943,638,928	$ 856,045,974	$ 1,086,464,733	$ 1,309,500,952	$ 1,149,478,718	$ 1,363,113,600	$ 1,183,239,734	$ 1,415,361,896	$ 1,250,319,546	$ 1,463,979,757	$ 2,435,685,299	$ 1,611,116,548

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

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

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

Notes:
1.) Actual member months for Demonstration Year 10 include the reported member months for this Centennial Care Quarterly Report, Section XIV and Section IX.

2.) Expenditures as reported on the CMS-64 Schedule C, FFY2024 Quarter 1. Report pulled on 1/31/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 1

Start Date: 01/01/2014

End Date: 12/31/2014

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

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

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

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

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

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

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

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

Notes:
1.) Member months as of November 3, 2015.
2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 1 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 2

Start Date: 01/01/2015

End Date: 12/31/2015

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

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

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

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

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

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

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

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

Notes:

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

2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 3

Start Date: 01/01/2016

End Date: 12/31/2016

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

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

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

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

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

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

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

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

Notes:
1.) Member months as of October 3, 2017.
2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 1 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 4

Start Date: 01/01/2017

End Date: 12/31/2017

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

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

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

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

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

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

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

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

Notes:
1.) Member months as of October 4, 2018.
2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 1 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 5

Start Date: 01/01/2018

End Date: 12/31/2018

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

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

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

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

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

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

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

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

Notes:
1.) Member months as of October 3, 2019.
2.) As defined in STC 109 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2024 Quarter 1 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet
- Budget Neutrality Limit Analysis
DY 6

Start Date: 01/01/2019

End Date: 12/31/2019

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

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 460.00	4,313,641	$ 1,984,262,326	74.74%	$ 1,483,082,113	$ 1,713,137,701	$ 1,307,621,842
MEG02 - SSI & Related - Medicaid Only	$ 2,158.77	448,460	$ 968,123,620	74.74%	$ 723,597,281	$ 865,674,976	$ 633,227,846
MEG03 - SSI & Related - Dual Eligible	$ 2,057.62	433,415	$ 891,801,274	74.74%	$ 666,552,250	$ 557,052,123	$ 403,427,596
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.74%	$ 51,489,423	$ 68,889,316	$ 50,869,441
MEG09 HQII	NA	NA	$ 12,000,000	74.74%	$ 8,969,069	$ 12,000,002	$ 9,127,363
Grand Total			**$ 3,925,076,543**		**$ 2,933,690,136**	**$ 3,216,754,118**	**$ 2,404,274,088**

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

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

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

MEG	DY 6 - PMPM	DY 6 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 6 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 738.22	3,070,895	$ 2,266,995,241	93.12%	$ 2,110,918,305	$ 1,611,116,548	$ 1,500,195,215
Grand Total			**$ 2,266,995,241**		**$ 2,110,918,305**	**$ 1,611,116,548**	**$ 1,500,195,215**

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

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

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,933,690,136**
Federal Share (Title XIX) Actual Reported	$ 2,404,274,088
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,739,346
Total Actuals	$ 2,404,274,088
Difference (Actuals - Limit)	$ (529,416,048)
Percentage Difference	-18.0%

Notes:
1.) Member months as of October 4, 2021.
2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2021 Quarter 1 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

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New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 7

Start Date: 01/01/2020

End Date: 12/31/2020

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

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 477.48	4,593,472	$ 2,193,277,156	80.26%	$ 1,760,367,429	$ 1,952,260,029	$ 1,583,776,351
MEG02 - SSI & Related - Medicaid Only	$ 2,247.28	450,397	$ 1,012,169,676	80.26%	$ 812,387,310	$ 1,007,287,015	$ 798,931,047
MEG03 - SSI & Related - Dual Eligible	$ 2,141.98	433,319	$ 928,159,496	80.26%	$ 744,959,086	$ 625,562,128	$ 494,844,047
MEG08 Uncompensated Care Pool	NA	NA	$ -	80.26%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	80.26%	$ 9,631,436	$ 11,999,993	$ 9,559,194
Grand Total			**$ 4,145,606,329**		**$ 3,327,345,262**	**$ 3,597,109,165**	**$ 2,887,110,639**

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

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

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

MEG	DY 7 - PMPM	DY 7 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 7 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 772.92	3,276,975	$ 2,532,826,556	90.29%	$ 2,286,976,264	$ 1,976,286,180	$ 1,784,456,805
Grand Total			**$ 2,532,826,556**		**$ 2,286,976,264**	**$ 1,976,286,180**	**$ 1,784,456,805**

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

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

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,327,345,262**
Federal Share (Title XIX) Actual Reported	$ 2,887,110,639
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,115,778
Total Actuals	$ 2,887,110,639
Difference (Actuals - Limit)	$ (440,234,623)
Percentage Difference	-13.2%

Notes:

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

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2021 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

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New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 8

Start Date: 01/01/2021

End Date: 12/31/2021

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

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 495.62	5,134,916	$ 2,544,972,764	82.57%	$ 2,101,462,372	$ 2,365,065,229	$ 1,954,766,199
MEG02 - SSI & Related - Medicaid Only	$ 2,339.42	462,038	$ 1,080,901,844	82.57%	$ 892,533,934	$ 1,071,148,910	$ 875,396,341
MEG03 - SSI & Related - Dual Eligible	$ 2,229.80	436,655	$ 973,652,643	82.57%	$ 803,974,966	$ 670,754,817	$ 561,437,757
MEG08 Uncompensated Care Pool	NA	NA	$ -	82.57%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	82.57%	$ 9,908,769	$ 12,000,000	$ 9,559,194
Grand Total			**$ 4,611,527,251**		**$ 3,807,880,041**	**$ 4,118,968,956**	**$ 3,401,159,491**

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

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

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

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 809.24	3,504,683	$ 2,836,140,532	90.67%	$ 2,571,623,154	$ 2,189,384,872	$ 1,985,188,240
Grand Total			**$ 2,836,140,532**		**$ 2,571,623,154**	**$ 2,189,384,872**	**$ 1,985,188,240**

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

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

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,807,880,041**
Federal Share (Title XIX) Actual Reported	$ 3,401,159,491
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,079,471
Total Actuals	$ 3,401,159,491
Difference (Actuals - Limit)	$ (406,720,550)
Percentage Difference	-10.7%

Notes:
1.) Member months as of October 9, 2023.
2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2021 Quarter 1 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

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New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 9

Start Date: 01/01/2022

End Date: 12/31/2022

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 514.45	5,451,107	$ 2,804,321,996	72.62%	$ 2,036,567,974	$ 2,774,096,268	$ 1,954,766,199
MEG02 - SSI & Related - Medicaid Only	$ 2,435.34	474,778	$ 1,156,245,855	72.62%	$ 839,694,329	$ 1,181,037,562	$ 875,396,341
MEG03 - SSI & Related - Dual Eligible	$ 2,321.22	448,958	$ 1,042,130,289	72.62%	$ 756,820,784	$ 728,209,174	$ 561,437,757
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	72.62%	$ 50,029,130	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	72.62%	$ 8,723,305	$ -	$ 9,559,194
Grand Total			**$ 5,083,599,315**		**$ 3,691,835,521**	**$ 4,683,343,004**	**$ 3,401,159,491**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,300.37	3,113	$ 19,613,052	76.84%	$ 15,070,760	$ 11,072,102	$ 9,766,272
MEG 05 - "217 Like" Dual Eligible	$ 4,130.23	70,970	$ 293,122,423	76.84%	$ 225,236,636	$ 271,904,133	$ 207,673,986
Grand Total			**$ 312,735,475**		**$ 240,307,397**	**$ 282,976,235**	**$ 217,440,258**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 847.28	3,531,455	$ 2,992,131,192	83.87%	$ 2,509,369,834	$ 2,367,105,707	$ 1,985,188,240
Grand Total			**$ 2,992,131,192**		**$ 2,509,369,834**	**$ 2,367,105,707**	**$ 1,985,188,240**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 911.76	5,990	$ 5,461,442	79.47%	$ 4,340,346	$ 7,305,550	$ 5,805,905
Grand Total			**$ 5,461,442**		**$ 4,340,346**	**$ 7,305,550**	**$ 5,805,905**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,691,835,521**
Federal Share (Title XIX) Actual Reported	$ 3,401,159,491
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 1,465,559
Total Actuals	$ 3,401,159,491
Difference (Actuals - Limit)	$ (290,676,030)
Percentage Difference	-7.9%

Notes:

1.) Member months as of January 5, 2024.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2021 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

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New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 10

Start Date: 01/01/2023

End Date: 12/31/2023

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 534.00	5,157,670	$ 2,754,195,780	78.31%	$ 2,156,773,929	$ 2,408,730,032	$ 1,911,676,992
MEG02 - SSI & Related - Medicaid Only	$ 2,535.19	480,149	$ 1,217,268,943	78.31%	$ 953,227,051	$ 1,173,934,493	$ 904,304,319
MEG03 - SSI & Related - Dual Eligible	$ 2,416.39	449,061	$ 1,085,106,510	78.31%	$ 849,732,414	$ 730,109,684	$ 561,294,568
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	78.31%	$ 53,946,309	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	78.31%	$ 9,406,322	$ -	$ -
Grand Total			**$ 5,137,472,409**		**$ 4,023,086,024**	**$ 4,312,774,209**	**$ 3,377,275,879**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 04 - "217 Like" Medicaid Only	$ 6,496.31	3,877	$ 25,186,194	76.85%	$ 19,354,403	$ 11,996,053	$ 9,213,442
MEG 05 - "217 Like" Dual Eligible	$ 4,299.57	73,064	$ 314,143,782	76.85%	$ 241,404,687	$ 279,905,349	$ 215,099,024
Grand Total			**$ 339,329,976**		**$ 260,759,089**	**$ 291,901,402**	**$ 224,312,466**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG 06 - VIII Group - Medicaid Expansion	$ 887.10	3,488,367	$ 3,094,530,366	90.48%	$ 2,799,861,791	$ 2,289,411,562	$ 2,071,408,323
Grand Total			**$ 3,094,530,366**		**$ 2,799,861,791**	**$ 2,289,411,562**	**$ 2,071,408,323**

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

MEG	DY 9 - PMPM	DY 9 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 9 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG SUD/IMD	$ 949.14	5,483	$ 5,204,135	86.81%	$ 4,517,684	$ 6,612,811	$ 5,740,549
Grand Total			**$ 5,204,135**		**$ 4,517,684**	**$ 6,612,811**	**$ 5,740,549**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 4,023,086,024**
Federal Share (Title XIX) Actual Reported	$ 3,377,275,879
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 1,222,865
Total Actuals	$ 3,377,275,879
Difference (Actuals - Limit)	$ (645,810,145)
Percentage Difference	-16.1%

Notes:

1.) Member months as of January 5, 2024.

2.) As defined in STC 102 - Composite Federal Share Rate is calculated based on CMS-64, Schedule C, FFY 2021 Quarter 1 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2024 Quarter 1. Report pulled on 1/31/2024.

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 1/2024

Summary of Expenditures by Waiver Year
Waiver: 11W00285

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,486,786,187	1,533,690,296	1,547,091,436	1,576,787,544	1,562,668,928	1,713,137,701	1,952,260,029	2,365,065,229	2,774,096,268	2,408,730,032	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18,920,313,650	18,920,313,650
MEG2- SSI Medicaid Only	0	824,991,985	882,936,445	866,977,418	845,978,765	795,478,519	865,674,976	1,007,287,015	1,071,148,910	1,181,037,562	1,173,934,493	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9,515,446,088	9,515,446,088
MEG3- SSI DUAL	0	570,643,867	584,265,571	609,500,283	564,265,856	558,418,717	557,052,123	625,562,128	670,754,817	728,209,174	730,109,684	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,198,782,220	6,198,782,220
MEG4-217	0	6,662,064	5,591,208	7,580,640	12,512,314	12,068,447	11,383,232	12,139,659	11,711,889	11,072,102	11,996,053	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	102,717,608	102,717,608
MEG5- 217 DUAL	0	86,786,741	85,077,407	91,901,521	112,740,550	134,725,706	143,887,343	191,823,587	246,269,325	271,904,133	279,905,349	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,645,021,662	1,645,021,662
MEG6-VIII GROUP	0	856,045,974	1,309,500,952	1,363,113,600	1,415,361,896	1,463,979,757	1,611,116,548	1,976,286,180	2,189,384,872	2,367,105,707	2,289,411,562	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,841,307,048	16,841,307,048
MEG8-UHC-Uncompensated care	0	68,889,322	36,005,978	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	104,895,300	104,895,300
MEG9-HQII-Hospital Quality Improve Incentive	0	0	2,824,462	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,824,462	2,824,462
UC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	31,288,995	68,889,323	68,889,323	68,889,323	68,889,316	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	306,846,281	306,846,281
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	7,359,077	8,825,541	12,011,853	12,000,002	11,999,993	12,000,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	64,196,466	64,196,466
Centennial Care 2.0 Medicaid SUD/IMD	0	0	0	0	0	0	3,447,745	4,652,395	6,524,166	7,305,550	6,612,811																28,542,667	28,542,667
Total	**0**	**3,900,806,141**	**4,471,181,314**	**4,562,413,298**	**4,605,361,789**	**4,608,241,250**	**4,986,588,986**	**5,782,010,986**	**6,572,859,208**	**7,340,730,496**	**6,900,699,984**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**53,730,893,452**	**53,730,893,452**
Check		*3,900,806,141*	*4,471,181,314*	*4,562,413,298*	*4,605,361,789*	*4,608,241,250*	*4,986,588,986*	*5,782,010,986*	*6,572,859,208*	*7,340,730,496*	*6,900,699,984*																	
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																	

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG1-TANF & Related	0	1,070,423,106	1,116,190,075	1,137,287,812	1,174,583,317	1,180,619,329	1,307,621,842	1,583,776,351	1,954,766,199	2,291,268,108	1,911,676,992		0	0	0	0	0	0	0	0	0	0	0	0	0	0	14,728,213,131	14,728,213,131
MEG2- SSI Medicaid Only	0	574,950,391	619,379,415	614,385,717	606,610,371	576,982,272	633,227,846	798,931,047	875,396,341	951,667,018	904,304,319		0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,155,834,737	7,155,834,737
MEG3- SSI DUAL	0	395,585,750	408,061,166	430,111,909	402,851,084	403,163,956	403,427,596	494,844,047	561,437,757	590,566,413	561,294,568		0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,651,344,246	4,651,344,246
MEG4-217	0	4,617,656	3,906,915	5,353,671	8,934,265	8,714,682	8,248,128	9,603,953	9,766,272	8,981,356	9,213,442		0	0	0	0	0	0	0	0	0	0	0	0	0	0	77,340,340	77,340,340
MEG5- 217 DUAL	0	60,154,448	59,416,310	64,866,189	80,515,170	97,261,654	104,198,687	151,763,800	207,673,986	220,909,353	215,099,024		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,261,858,621	1,261,858,621
MEG6-VIII GROUP	0	856,020,190	1,309,439,632	1,362,203,902	1,346,722,655	1,378,951,928	1,500,195,215	1,784,456,805	1,985,188,240	2,143,554,353	2,071,408,323		0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,738,141,243	15,738,141,243
MEG8-UHC-Uncompensated care	0	47,671,411	25,207,785	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	72,879,196	72,879,196
MEG9-HQII-Hospital Quality Improve Incentive	0	0	1,987,574	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,987,574	1,987,574
UC	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Uncompensated Care "UC" Pool	0	1	21,781,306	48,608,306	49,178,612	50,084,411	50,869,441	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	220,522,077	220,522,077
Hospital Quality Improvement Incentive "HQII" Pool	0	0	0	5,234,511	6,368,511	8,679,765	9,127,363	9,559,194	9,589,200	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	48,558,544	48,558,544
Centennial Care 2.0 Medicaid SUD/IMD	0	0	0	0	0	0	3,183,354	4,177,407	5,805,905	6,430,408	5,740,549																25,337,623	25,337,623
Total	**0**	**3,009,422,953**	**3,565,370,178**	**3,668,052,017**	**3,675,763,985**	**3,704,457,997**	**4,020,099,472**	**4,837,112,604**	**5,609,623,900**	**6,213,377,009**	**5,678,737,217**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43,956,679,709**	**43,956,679,709**
Check		*3,009,422,953*	*3,565,370,178*	*3,668,052,017*	*3,675,763,985*	*3,704,457,997*	*4,020,099,472*	*4,837,112,604*	*5,609,623,900*	*6,213,377,009*	*5,678,737,217*																	
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																	

M-CHIP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	84,356,751	123,819,527	118,473,862	106,619,834	97,506,744	105,963,616	118,376,144	127,141,864	140,186,572	135,824,558	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,158,269,472	1,158,269,472
Total	**0**	**84,356,751**	**123,819,527**	**118,473,862**	**106,619,834**	**97,506,744**	**105,963,616**	**118,376,144**	**127,141,864**	**140,186,572**	**135,824,558**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,158,269,472**	**1,158,269,472**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
MEG7-CHIP GROUP	0	66,272,555	105,308,829	118,473,862	106,619,822	97,505,399	103,493,469	110,807,002	108,150,251	119,160,618	113,667,506	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,049,459,313	1,049,459,313
Total	**0**	**66,272,555**	**105,308,829**	**118,473,862**	**106,619,822**	**97,505,399**	**103,493,469**	**110,807,002**	**108,150,251**	**119,160,618**	**113,667,506**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,049,459,313**	**1,049,459,313**

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	109,509,693	0	0	0	8,558,331	196,959,429	236,056,796	215,438,573	233,949,809	346,653,605	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,347,126,236	1,347,126,236
MEG1-TANF & Related	0	1,954,350	65,528,478	65,128,092	75,672,882	80,475,712	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	288,759,514	288,759,514
MEG2- SSI Medicaid Only	0	0	7,492,116	7,098,152	8,204,996	8,455,296	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	31,250,560	31,250,560
MEG3- SSI DUAL	0	0	6,533,901	6,432,635	7,626,009	7,887,696	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28,480,241	28,480,241
MEG4-217	0	0	38,287	33,620	78,602	73,212	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	223,721	223,721
MEG5- 217 DUAL	0	0	408,067	443,667	673,384	847,932	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,373,050	2,373,050
MEG6-VIII GROUP	0	36,509,156	42,521,593	46,219,961	60,776,652	59,252,561	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	245,279,923	245,279,923
MEG7-CHIP GROUP	0	972,016	9,725,447	8,862,780	10,909,982	9,242,308	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	39,712,533	39,712,533
Total	**0**	**148,945,215**	**132,247,889**	**134,218,907**	**163,942,507**	**174,793,048**	**196,959,429**	**236,056,796**	**215,438,573**	**233,949,809**	**346,653,605**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,983,205,778**	**1,983,205,778**
Check		*148,945,215*	*132,247,889*	*134,218,907*	*163,942,507*	*174,793,048*	*196,959,429*	*236,056,796*	*215,438,573*	*233,949,809*	*346,653,605*																	
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																	

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Admin	0	72,320,580	0	0	0	6,523,508	129,519,032	155,939,388	141,935,766	157,142,926	228,386,940	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	891,768,140	891,768,140
MEG1-TANF & Related	0	1,033,347	40,960,378	40,581,487	48,575,411	50,855,108	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	182,005,731	182,005,731
MEG2- SSI Medicaid Only	0	0	4,682,951	4,421,346	5,263,719	5,343,838	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	19,711,854	19,711,854
MEG3- SSI DUAL	0	0	4,084,108	4,007,329	4,887,719	4,986,257	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,965,413	17,965,413
MEG4-217	0	0	23,899	21,025	50,385	46,287	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	141,596	141,596
MEG5- 217 DUAL	0	0	255,098	276,989	432,086	536,858	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,501,031	1,501,031
MEG6-VIII GROUP	0	24,041,491	26,579,123	28,804,937	38,875,056	37,448,951	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	155,749,558	155,749,558
MEG7-CHIP GROUP	0	644,187	6,078,767	5,514,776	6,957,623	5,840,810	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,036,163	25,036,163
Total	**0**	**98,039,605**	**82,664,324**	**83,627,889**	**105,041,999**	**111,581,617**	**129,519,032**	**155,939,388**	**141,935,766**	**157,142,926**	*228,386,940*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,293,879,486**	**1,293,879,486**
Check		*98,039,605*	*82,664,324*	*83,627,889*	*105,041,999*	*111,581,617*	*129,519,032*	*155,939,388*	*141,935,766*	*157,142,926*	*228,386,940*																	
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																	

Created On: Wednesday, January 31, 2024 7:31 AM

MEMBER MONTHS
CENTENNIAL CARE MEG REPORTING

Eligibility Group	CY 2016 Quarter					CY 2017 Quarter					CY 2018 Quarter				
	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total
Population 1 – TANF and Related	1,130,779	1,150,300	1,169,603	1,170,974	**4,621,656**	1,180,160	1,170,146	1,145,575	1,127,594	**4,623,475**	1,129,981	1,116,304	1,090,944	1,085,709	**4,422,938**
Population 2 – SSI and Related – Medicaid Only	123,597	122,633	123,728	123,619	**493,577**	124,408	125,136	122,027	116,227	**487,798**	116,043	115,944	114,284	113,559	**459,830**
Population 3 – SSI and Related - Dual	110,017	111,379	113,425	112,980	**447,801**	111,537	111,883	111,273	108,378	**443,071**	108,032	108,101	108,318	108,264	**432,715**
Population 4 – 217-like Group – Medicaid Only	566	1064	564	793	**2,987**	1,133	1,006	857	801	**3,797**	830	835	853	789	**3,307**
Population 5 – 217-like Group - Dual	6,938	8,390	7,911	8,627	**31,866**	9,714	10,023	10,181	10,491	**40,409**	11,050	11,820	12,257	12,311	**47,438**
Population 6 – VIII Group (expansion)	753,995	761,293	778,625	784,161	**3,078,074**	806,114	802,658	773,108	762,010	**3,143,890**	762,410	756,109	747,006	753,639	**3,019,164**
Population 7 - CHIP Group	151,824	140,006	134,983	132,292	**559,105**	133,031	130,727	123,340	117,212	**504,310**	117,719	113,236	109,585	111,810	**452,350**
Population 10 - SUD IMD															
Total	**2,277,716**	**2,295,065**	**2,328,839**	**2,333,446**	**9,235,066**	**2,366,097**	**2,351,579**	**2,286,361**	**2,242,713**	**9,246,750**	**2,246,065**	**2,222,349**	**2,183,247**	**2,186,081**	**8,837,742**

Eligibility Group	CY 2019 Quarter					CY 2020 Quarter				
	1	2	3	4	Total	1	2	3	4	Total
Population 1 – TANF and Related	1,078,850	1,077,954	1,079,500	1,077,337	**4,313,641**	1,080,904	1,121,423	1,179,371	1,211,774	**4,593,472**
Population 2 – SSI and Related – Medicaid Only	112,782	112,246	111,860	111,572	**448,460**	112,231	111,666	112,949	113,551	**450,397**
Population 3 – SSI and Related - Dual	108,143	108,378	108,509	108,385	**433,415**	108,324	108,074	108,273	108,648	**433,319**
Population 4 – 217-like Group – Medicaid Only	754	751	746	739	**2,990**	724	762	775	746	**3,007**
Population 5 – 217-like Group - Dual	12,167	12,422	12,828	13,350	**50,767**	14,040	14,723	15,545	16,256	**60,564**
Population 6 – VIII Group (expansion)	759,129	765,866	767,811	778,089	**3,070,895**	784,171	814,819	827,549	850,436	**3,276,975**
Population 7 - CHIP Group	113,954	111,660	112,480	115,511	**453,605**	118,810	114,070	118,310	119,859	**471,049**
Population 10 - SUD IMD	93	324	92	86	**595**	609	621	651	848	**2,729**
Total	**2,185,872**	**2,189,601**	**2,193,826**	**2,205,069**	**8,774,368**	**2,219,813**	**2,286,158**	**2,363,423**	**2,422,118**	**9,291,512**

Eligibility Group	CY 2021 Quarter					CY 2022 Quarter					CY 2023 Quarter				
	1	2	3	4	Total	1	2	3	4	Total	1	2	3	4	Total
Population 1 – TANF and Related	1,242,048	1,264,108	1,303,124	1,325,636	**5,134,916**	1,344,362	1,359,982	1,370,733	1,376,030	**5,451,107**	1,383,979	1,345,302	1,254,803	1,173,586	**5,157,670**
Population 2 – SSI and Related – Medicaid Only	114,465	115,066	115,626	116,881	**462,038**	117,425	118,920	118,793	119,640	**474,778**	120,287	120,569	120,428	118,865	**480,149**
Population 3 – SSI and Related - Dual	107,956	108,420	109,664	110,615	**436,655**	110,905	111,978	112,624	113,451	**448,958**	114,079	113,996	111,877	109,109	**449,061**
Population 4 – 217-like Group – Medicaid Only	779	779	727	713	**2,998**	764	762	788	799	**3,113**	834	905	1,023	1,115	**3,877**
Population 5 – 217-like Group - Dual	16,706	17,025	17,347	17,575	**68,653**	17,493	17,749	17,701	18,027	**70,970**	18,343	18,535	18,343	17,843	**73,064**
Population 6 – VIII Group (expansion)	866,005	871,996	879,825	886,857	**3,504,683**	887,606	880,616	881,366	881,867	**3,531,455**	885,359	902,750	866,003	834,255	**3,488,367**
Population 7 - CHIP Group	124,273	128,782	118,258	121,190	**492,503**	124,276	129,115	131,429	135,045	**519,865**	140,473	125,074	115,776	112,100	**493,423**
Population 10 - SUD IMD	1,192	1,305	1,101	1,183	**4,781**	1,330	1,460	1,672	1,528	**5,990**	1,677	1,650	1,425	731	**5,483**
Total	**2,473,424**	**2,507,481**	**2,545,672**	**2,580,650**	**10,107,227**	**2,604,161**	**2,620,582**	**2,635,106**	**2,646,387**	**10,506,236**	**2,665,031**	**2,628,781**	**2,489,678**	**2,367,604**	**10,151,094**

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Table #9 - Waiver Year 9 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
Admin		**346,653,605**
MEG01 - TANF & Related	$ 2,408,730,032	$ -
MEG02 - SSI & Related - Medicaid Only	$ 1,173,934,493	$ -
MEG03 - SSI & Related - Dual Eligible	$ 730,109,684	$ -
MEG04 - "217 Like" Medicaid Only	$ 11,996,053	$ -
MEG05 - "217 Like" Dual Eligible	$ 279,905,349	$ -
MEG06 - VIII Group - Medicaid Expansion	$ 2,289,411,562	$ -
MEG07 - CHIP	$ 135,824,558	$ -
Uncompensated Care "UC" Pool	$ -	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Centennial Care 2.0 Medicaid SUD/IMD	$ 6,612,811	N/A
Grand Total	**$ 7,036,524,542**	**$ 346,653,605**

Source: New Mexico CMS 64 Submission, FFY 2024, Quarer 1.

Key Utilization
Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Inpatient (Admissions)	82.3	70.8	$ 10,779	$ 9,752
Inpatient (Days)	380.3	317.5	$ 2,333	$ 2,175
Practitioner / Physician (Services)	7,291.8	6,768.9	$ 83	$ 84
Emergency Department (Visits)	517.1	521.6	$ 515	$ 511
Outpatient (Visits)	1,714.3	1,479.2	$ 281	$ 295
Pharmacy (Scripts)	4,350.1	4,270.3	$ 80	$ 88
Other (Services)1	8,915.5	8,423.3	$ 63	$ 65

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Brand	10.6%	7.2%	$ 562	$ 909
Generic	88.1%	91.7%	$ 22	$ 24
Other Rx2	1.2%	1.1%	$ 71	$ 69

Notes:
1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through September 30, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Adult Expansion: Other Adult Group

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Inpatient (Admissions)	73.0	68.6	$ 17,176	$ 17,158
Inpatient (Days)	612.4	891.7	$ 2,048	$ 1,320
Practitioner / Physician (Services)	7,882.9	7,167.9	$ 94	$ 98
Emergency Department (Visits)	577.2	540.0	$ 677	$ 683
Outpatient (Visits)	2,204.8	1,924.3	$ 339	$ 354
Pharmacy (Scripts)	7,667.9	7,311.6	$ 111	$ 128
Other (Services)1	9,333.7	8,523.9	$ 77	$ 81

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Brand	11.4%	9.2%	$ 796	$ 1,141
Generic	87.1%	89.5%	$ 22	$ 25
Other Rx2	1.5%	1.4%	$ 91	$ 89

Notes:
1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through September 30, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Key Utilization
Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members) October 2021 - September 2022	Utilization (per 1,000 Members) October 2022 - September 2023	Cost per Unit October 2021 - September 2022	Cost per Unit October 2022 - September 2023
Inpatient (Admissions)	219.2	239.6	$ 2,927	$ 1,626
Inpatient (Days)	1,518.5	1,616.1	$ 423	$ 241
Nursing Home (Days)	248,327.4	202,524.1	$ 49	$ 56
Personal Care (Services / hr.)	795,216.2	761,486.7	$ 20	$ 21
Outpatient (Visits)	5,985.1	4,873.4	$ 146	$ 123
Pharmacy (Scripts)	803.1	776.3	$ 19	$ 18
HCBS (Services)	7,698.8	10,419.0	$ 167	$ 116
Other (Services)1	45,543.8	36,397.5	$ 41	$ 47

Pharmacy Classification	Script Utilization October 2021 - September 2022	Script Utilization October 2022 - September 2023	Script Cost per Unit October 2021 - September 2022	Script Cost per Unit October 2022 - September 2023
Brand	12.8%	12.1%	$ 83	$ 78
Generic	83.5%	84.1%	$ 7	$ 7
Other Rx2	3.7%	3.8%	$ 62	$ 60

Notes:
1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through September 30, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

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

Service Grouping	Utilization (per 1,000 Members) October 2021 - September 2022	Utilization (per 1,000 Members) October 2022 - September 2023	Cost per Unit October 2021 - September 2022	Cost per Unit October 2022 - September 2023
Inpatient (Admissions)	332.2	311.5	$ 18,443	$ 18,607
Inpatient (Days)	2,718.3	2,421.1	$ 2,254	$ 2,394
Nursing Home (Days)	16,866.3	19,630.6	$ 208	$ 194
Personal Care (Services / hr.)	680,424.1	645,980.0	$ 20	$ 21
Outpatient (Visits)	8,084.4	7,375.5	$ 512	$ 541
Pharmacy (Scripts)	30,139.0	28,898.2	$ 126	$ 148
HCBS (Services)	26,950.6	26,544.6	$ 91	$ 92
Other (Services)1	61,458.2	57,725.4	$ 101	$ 105

Pharmacy Classification	Script Utilization October 2021 - September 2022	Script Utilization October 2022 - September 2023	Script Cost per Unit October 2021 - September 2022	Script Cost per Unit October 2022 - September 2023
Brand	9.5%	8.5%	$ 1,061	$ 1,423
Generic	88.5%	89.8%	$ 26	$ 29
Other Rx2	2.0%	1.7%	$ 87	$ 88

Notes:
1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through September 30, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Inpatient (Admissions)	190.9	202.4	$ 8,594	$ 6,997
Inpatient (Days)	1,324.5	1,390.7	$ 1,239	$ 1,018
Nursing Home (Days)	5,248.1	5,335.7	$ 32	$ 42
Personal Care (Services / hr.)	-	-	$ -	$ -
Outpatient (Visits)	7,206.4	5,754.5	$ 233	$ 240
Pharmacy (Scripts)	11,116.5	10,518.2	$ 130	$ 137
HCBS (Services)	280,368.8	256,832.8	$ 92	$ 93
Other (Services)1	51,674.8	43,280.5	$ 55	$ 62

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Brand	10.5%	9.1%	$ 964	$ 1,163
Generic	87.4%	89.0%	$ 30	$ 33
Other Rx2	2.1%	1.9%	$ 105	$ 94

Notes:
1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through September 30, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

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

Service Grouping	Utilization (per 1,000 Members)		Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Inpatient (Admissions)	73.5	51.3	$ 4,873	$ 5,320
Inpatient (Days)	524.3	384.9	$ 683	$ 708
Practitioner / Physician (Services)	8,359.5	6,763.5	$ 29	$ 30
Emergency Department (Visits)	597.0	498.9	$ 170	$ 163
Outpatient (Visits)	3,068.4	2,445.5	$ 161	$ 128
Pharmacy (Scripts)	1,322.2	1,267.4	$ 36	$ 27
Other (Services)1	7,485.5	6,618.4	$ 87	$ 113

Pharmacy Classification	Script Utilization		Script Cost per Unit	
	October 2021 - September 2022	October 2022 - September 2023	October 2021 - September 2022	October 2022 - September 2023
Brand	16.9%	15.4%	$ 152	$ 108
Generic	81.1%	82.5%	$ 11	$ 10
Other Rx2	2.0%	2.1%	$ 80	$ 77

Notes:
1. Other services include dental, transportation, vision.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through September 30, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

Key Utilization
Cost per Unit Statistics by Major Population Group

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

Service Grouping	Utilization (per 1,000 Members) October 2021 - September 2022	Utilization (per 1,000 Members) October 2022 - September 2023	Cost per Unit October 2021 - September 2022	Cost per Unit October 2022 - September 2023
Inpatient (Admissions)	39.0	35.9	$ 598	$ 554
Inpatient (Days)	89.2	78.4	$ 261	$ 253
BH Practitioner (services)	681.6	652.5	$ 159	$ 170
Core Service Agency (Services)	323.9	301.3	$ 184	$ 189
BH outpatient / clinic (Services)	3,386.3	3,001.4	$ 79	$ 82
Pharmacy (Scripts)	1,553.0	1,513.2	$ 64	$ 68
Residential Treatment Center (days)	37.3	38.4	$ 3,179	$ 2,536
Other (Services)1	12.3	10.4	$ 117	$ 143

Pharmacy Classification	Script Utilization October 2021 - September 2022	Script Utilization October 2022 - September 2023	Script Cost per Unit October 2021 - September 2022	Script Cost per Unit October 2022 - September 2023
Brand	3.4%	3.1%	$ 1,045	$ 1,274
Generic	96.6%	96.9%	$ 29	$ 29
Other Rx2	0.0%	0.0%	$ -	$ -

Notes:

1. Other services includes BMS, PSR and PES services.
2. Other Rx includes diabetic supplies.
3. Amounts are based on paid claims encounter data submitted through September 30, 2023, with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent month(s).

DY10 Q4 Attachment D: Customer Service Summary (Jan 1 - Dec 31, 2023)

BCBS CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

		CONTRACT STANDARD	WSCC JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		13,537	11,573	12,390	10,238	10,943	9,883	9,642	11,041	9,532	9,977	9,398	8,574
	Number of Calls Answered - All Queues		13,474	11,476	12,276	10,180	10,900	9,804	9,604	11,006	9,430	9,870	9,325	8,525
	Percent of Calls Abandoned	**< 5%**	0.5%	0.8%	0.9%	0.6%	0.4%	0.8%	0.4%	0.3%	1.1%	1.1%	0.8%	0.6%
	Percent of Calls Answered within 30 Seconds	**85%**	94.5%	89.9%	89.9%	92.9%	95.7%	94.1%	95.8%	97.5%	97.4%	96%	92%	96%
	Average Wait Time	**< 2 minutes**	0.1	0.2	0.3	0.2	0.1	0.2	0.1	0.1	0.1	0.2	0.2	0.1
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%
Nurse Advice Line	Number of Calls Received - All Queues		624	601	637	560	591	491	526	567	569	544	595	675
	Number of Calls Answered - All Queues		612	593	627	555	589	488	523	562	567	543	594	670
	Percent of Calls Abandoned	**< 5%**	1.9%	1.3%	1.6%	0.9%	0.3%	0.6%	0.6%	0.9%	0.4%	0.2%	0.2%	0.7%
	Percent of Calls Answered within 30 Seconds	**85%**	89.9%	89.4%	89.0%	91.4%	91.7%	91.2%	91.2%	86.3%	91.7%	90%	94%	79.7%
	Average Wait Time	**< 2 minutes**	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.1	0.2	0.1	0.4
Provider Services	Number of Calls Received - All Queues		6,355	5,814	6,391	5,747	6,240	6,361	5,346	6,497	6,002	6,737	6,099	5,910
	Number of Calls Answered - All Queues		6,322	5,762	6,345	5,725	6,213	6,329	5,332	6,477	5,977	6,724	6,075	5,898
	Percent of Calls Abandoned	**< 5%**	0.5%	0.9%	0.7%	0.4%	0.4%	0.5%	0.3%	0.3%	0.4%	0.2%	0.4%	0.2%
	Percent of Calls Answered within 30 Seconds	**85%**	93.7%	89.0%	89.2%	92.3%	95.5%	92.5%	94.9%	97.3%	96.3%	96%	91%	94%
	Average Wait Time	**< 2 minutes**	0.2	0.3	0.3	0.2	0.1	0.2	0.1	0.1	0.2	0.2	0.2	0.2
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%
UM Line	Number of Calls Received - All Queues		4,955	4,810	5,073	4,411	5,170	4,851	4,425	5,134	4,227	4,401	3,636	3,611
	Number of Calls Answered - All Queues		4,937	4,791	5,037	4,395	5,159	4,831	4,410	5,123	4,197	4,380	3,619	3,586
	Percent of Calls Abandoned	**< 5%**	0.4%	0.4%	0.7%	0.4%	0.2%	0.4%	0.3%	0.2%	0.7%	0.5%	0.5%	0.7%
	Percent of Calls Answered within 30 Seconds	**85%**	97.9%	98.3%	97.5%	98.6%	99.2%	98.9%	98.9%	99.4%	96.1%	98%	97%	94%
	Average Wait Time	**< 2 minutes**	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.0	0.4	0.3	0.4	0.1

Source: WSCC Report 2, M1-M12 CY23

DY10 Q4 Attachment D: Customer Service Summary (Jan 1 - Dec 31, 2023)

PHP CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

		CONTRACT STANDARD	PHP JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		23,433	18,763	19,051	16,428	17,437	17,911	17,137	19,376	16,145	16,931	16,049	14,908
	Number of Calls Answered - All Queues		23,036	18,605	18,786	16,266	17,185	17,597	16,880	19,005	15,883	16,659	15,834	14,715
	Percent of Calls Abandoned	**< 5%**	1.7%	0.8%	1.4%	1.0%	1.4%	1.8%	1.5%	1.9%	1.6%	1.6%	1.3%	1.3%
	Percent of Calls Answered within 30 Seconds	**85%**	90%	95%	90%	93.0%	91.0%	88.2%	88%	88%	88%	88%	88%	91%
	Average Wait Time	**< 2 minutes**	30%	20%	30%	20%	30%	40%	30%	40%	40%	30%	30%	30%
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%
Nurse Advice Line	Number of Calls Received - All Queues		2,319	2,111	2,611	2,101	2,168	1,974	1,977	2,003	1,923	1,882	1,836	2,065
	Number of Calls Answered - All Queues		2,284	2,052	2,553	2,054	2,139	1,957	1,958	1,979	1,896	1,856	1,811	2,025
	Percent of Calls Abandoned	**< 5%**	1.5%	2.8%	2.2%	2.2%	1.3%	0.9%	1.0%	1.2%	1.4%	1.4%	1.4%	1.9%
	Percent of Calls Answered within 30 Seconds	**85%**	97%	93%	94%	92%	97%	98%	98%	97%	98%	96%	96%	93%
	Average Wait Time	**< 2 minutes**	0.1	0.2	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Provider Services	Number of Calls Received - All Queues		3,929	3,700	6,227	5,462	5,204	4,976	4,599	5,292	4,150	4,084	3,782	3,640
	Number of Calls Answered - All Queues		3,897	3,686	6,196	5,417	5,187	4,955	4,580	5,275	4,135	4,065	3,762	3,624
	Percent of Calls Abandoned	**< 5%**	0.8%	0.4%	0.5%	0.8%	0.3%	0.4%	0.4%	0.3%	0.4%	0.5%	0.5%	0.4%
	Percent of Calls Answered within 30 Seconds	**85%**	93%	96%	90%	89.3%	90.7%	90.4%	93%	92%	89%	90%	86%	90%
	Average Wait Time	**< 2 minutes**	20%	10%	20%	20%	20%	20%	10%	20%	20%	20%	30%	20%
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%
UM Line	Number of Calls Received - All Queues		971	844	1,283	1,061	851	937	786	936	714	729	723	637
	Number of Calls Answered - All Queues		966	836	1,277	1,056	847	933	782	924	710	722	717	634
	Percent of Calls Abandoned	**< 5%**	0.5%	0.9%	0.5%	0.5%	0.5%	0.4%	0.5%	1.3%	0.6%	1.0%	0.8%	0.5%
	Percent of Calls Answered within 30 Seconds	**85%**	90%	92%	96%	94%	91%	91%	94%	91%	92%	89%	90%	94%
	Average Wait Time	**< 2 minutes**	0.2	0.2	0.1	0.1	0.2	0.2	0.1	0.2	0.1	0.2	0.2	0.1

Source: PHP Report 2, M1-M12 CY23

DY10 Q4 Attachment D: Customer Service Summary (Jan 1 - Dec 31, 2023)

WSCC CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Meets Standard | Does Not Meet

			WSCC											
		CONTRACT STANDARD	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Member Services	Number of Calls Received - All Queues		5,740	4,868	5,509	4,585	5,154	5,305	4,951	5,741	5,205	5,467	5,264	4,763
	Number of Calls Answered - All Queues		5,604	4,735	5,405	4,547	5,111	5,277	4,894	5,683	5,085	5,350	5,141	4,671
	Percent of Calls Abandoned	< 5%	2.4%	2.7%	1.9%	0.8%	0.8%	0.5%	1.2%	1.0%	2.3%	2.1%	2.3%	1.9%
	Percent of Calls Answered within 30 Seconds	85%	86.7%	86.9%	91.6%	97.2%	97.7%	97.9%	95.8%	96.9%	91.1%	89%	87%	91%
	Average Wait Time	< 2 minutes	0.5	0.4	0.3	0.1	0.1	0.1	0.5	0.2	0.5	0.4	0.6	0.4
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%
Nurse Advice Line	Number of Calls Received - All Queues		162	134	159	138	153	158	126	151	145	158	152	176
	Number of Calls Answered - All Queues		158	132	158	135	151	156	124	150	139	154	151	173
	Percent of Calls Abandoned	< 5%	2.5%	1.5%	0.6%	2.2%	1.3%	1.3%	1.6%	0.7%	4.1%	2.5%	0.7%	1.7%
	Percent of Calls Answered within 30 Seconds	85%	96.2%	93.9%	93.7%	93.3%	97.4%	97.4%	96.0%	96.7%	98.6%	94%	95%	94%
	Average Wait Time	< 2 minutes	0.7	0.1	0.2	0.2	0.1	0.2	0.1	0.1	0.1	0.3	0.3	0.3
Provider Services	Number of Calls Received - All Queues		4,122	4,163	4,283	3,960	4,605	4,377	4,202	5,273	4,364	5,178	4,438	3,985
	Number of Calls Answered - All Queues		4,044	4,052	4,204	3,887	4,505	4,294	4,157	5,189	4,270	5,083	4,358	3,909
	Percent of Calls Abandoned	< 5%	1.9%	2.7%	1.8%	1.8%	2.2%	1.9%	1.1%	1.6%	2.2%	1.8%	1.8%	1.9%
	Percent of Calls Answered within 30 Seconds	85%	90.9%	84.3%	88.5%	89.9%	91.1%	86.9%	90.1%	86.9%	86.2%	85%	85%	85%
	Average Wait Time	< 2 minutes	0.3	0.6	0.4	0.4	0.3	0.5	0.3	0.6	0.5	0.5	0.7	0.6
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%	100%	100%	100%
UM Line	Number of Calls Received - All Queues		1,552	1,435	1,691	1,516	1,650	1,551	1,481	1,782	1,406	1,580	1,616	1,354
	Number of Calls Answered - All Queues		1,524	1,408	1,657	1,465	1,601	1,492	1,402	1,765	1,386	1,570	1,608	1,333
	Percent of Calls Abandoned	< 5%	1.8%	1.9%	2.0%	3.4%	3.0%	3.8%	5.3%	1.0%	1.4%	0.6%	0.5%	1.6%
	Percent of Calls Answered within 30 Seconds	85%	94.4%	92.2%	91.7%	87.3%	88.1%	85.7%	83.4%	97.3%	97.5%	97%	98%	91%
	Average Wait Time	< 2 minutes	0.3	0.4	0.4	0.3	0.3	0.3	0.4	0.1	0.2	0.1	0.1	0.4

Source: WSCC Report 2, M1-M12 CY23