CENTENNIAL CARE 2.0 DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 10 (1/1/2023 – 12/31/2023)
Quarter 3 of 2023

March 29, 2024

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INTRODUCTION

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

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

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 and New Mexico in active negotiations.
SMI/SED Implementation Plan	Due to CMS June 26, 2023.	Submitted to CMS 6/26/2023. CMS feedback received July 17, 2023 and New Mexico resubmitted September 29, 2023.
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. 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.
Centennial Care 2.0 Amended Evaluation Design	Due to CMS September 25, 2023.	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.
Centennial Care 2.0 Public Health Emergency Amendment for Legally Responsible Individuals Final Report	Due to CMS November 11, 2024. Reporting Period: May 11, 2023 – November 11, 2023	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.

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:

HUMAN SERVICES DEPARTMENT

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.

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 August 31, 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 Behavioral Health Division Director.

- Public Health Emergency (PHE) update, which included information on the following: Medicaid renewals
- beWellnm updates, which included information on the unwinding plan and unwinding outreach and marketing campaign.
- Legislative updates, which included information on Senate Bill (SB) 7 – Rural Healthcare Delivery Fund and SB0425 Non-Emergency Medical Transportation (NEMT) Network Companies.
- Rate Increase in accordance with House Bill (HB) 2, which included updates on the following: provider rate increases, and MCO oversight and compliance.
- FY22, FY23, and FY24 Budget Overview with 4-month Maintenance of Effort (MOE) Unwinding, which included updates on the following: Medicaid budget expenditures; Medicaid budget revenues; and Federal revenue supporting Medicaid program
- Enrollment projection update related to 4-month MOE redeterminations (May 2023), which included information on the following: NM Medicaid enrollment projection FY22; NM Medicaid enrollment projection FY23; NM Medicaid enrollment projection FY24; NM Medicaid Managed Care enrollment FY22; NM Medicaid Managed Care enrollment FY23; and NM Medicaid Managed Care Enrollment FY24.
- Medicaid Dashboards, which included information on the following: current and previous 12 months of 2021, 2022 and 2023 data; data run-out through March 2023; general observations for managed care enrollment, medical costs, and service categories; Community Benefit Personal Care Services and Home and Community-Based Services expenses and continuous shift in setting of care utilization; and behavioral health service observations for enrollment, expenditures, and service categories.
- MCO Procurement and 1115 Demonstration Waiver updates, which included information on the following: Turquoise Care 1115 Waiver Renewal timeline and proposals; Turquoise Care MCO awards.
- Community Health Workers updates, which included information on the following: 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

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 3 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	6/30/2023 ENROLLMENT	9/30/2023 ENROLLMENT	PERCENT INCREASE / DECREASE Q3
BlueCross BlueShield of New Mexico (BCBS)	282,822	258,642	-8.5%
Presbyterian Health Plan (PHP)	405,333	370,750	-8.5%
Western Sky Community Care (WSCC)	91,157	85,415	-6.3%

Source: Medicaid Eligibility Reports, June 2023 and September 2023

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

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

MCO Enrollment

In aggregate, MCO enrollment increased by 2% from the previous to current period. This increase is comprised of the following:

- 3% increase in Physical Health enrollment.
- 2% increase in Long-Term Services and Supports enrollment.
- 1% increase 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., March 31, 2023). Historically, this decrease in the last month changes to an increase in subsequent quarter due to additional runout.

MCO Per Capita Medical Costs:

In aggregate, total MCO per capita medical costs decreased by 4% from the previous to current period. This consists of a 5% decrease to non-pharmacy services and a 9%

increase to pharmacy services.

On a dollar basis, higher enrollment levels have been offset by the decrease in per capita medical costs, driving the 1% year over year decrease in total medical expenses.

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

As of DY10 Q3, there were 244,470 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				
	October - December 2022	January - March 2023	April - June 2023	July - September 2023
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	120,552	192,588	234,766	209,316
Number of Members Newly Registered in the Rewards Program this Quarter	6,609	4,345	4,497	4,612
Number of Members Who Redeemed Rewards this Quarter**	49,202	21,939	30,608	30,542

*Only includes rewards earned THIS quarter.
**Redeemed rewards could have been earned in any of the previous 24 reporting months.
Source: Finity Quarter 3 Report

Following is a summary of DY10 Q3 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 Q3 2023 of 76.7%.
- 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 Q3, 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, including Legislative Finance Committee (LFC) and HEDIS measures. All multimedia communications align with HSD's strategic goals and promote the healthy activities that members are eligible to complete to earn rewards and close gaps-in-care.

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

- 48K texts sent in Q3 2023
- 49K emails sent in Q3 2023

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

- 50K texts sent in Q3 2023
- 43K emails sent in Q3 2023

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.

- 150K texts sent in Q3 2023
- 102K emails sent in Q3 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 July through September 2023. This is an ongoing campaign and Q3 2023 results are provided below:

- 275K texts sent in Q3 2023
- 203K emails sent in Q3 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 September. This is an annual Q3 campaign and results are provided below:

- 50K texts sent in Q3 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 August 2023. This is an ongoing campaign and DY10 Q3 results are provided below:

- 21K texts sent in Q3 2023
- 4K emails sent in Q3 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 July through September 2023. This is an ongoing campaign and DY10 Q3 results are provided below:

- 355K texts sent in Q3 2023
- 249K emails sent in Q3 2023

Additional Key Statistics through DY10 Q3 2023:

- Member participation in DY10 Q3 2023 reached an all-time high of over 76.7%.
    - In DY10 Q3 2023, 209k members earned $4.7M in rewards by completing healthy activities and closing gaps-in-care. This represents the largest Q3 earnings in program history.
    - Annual dollars earned through Q3 2023 is up 16% compared to the same period in 2022.
- In Q3 2023, members redeemed $1.06M on health items from the rewards catalog. Redemption totals in Q3 remain stable year over year.

Enhanced Customer Satisfaction Survey: The results of the DY10 Q3 2023 survey are listed in table 3.

Table 3: Centennial Rewards Customer Satisfaction Survey

Centennial Rewards Customer Satisfaction Survey												
	DY9 Q4			DY10 Q1			DY10 Q2			DY10 Q3		
	# OF RESPONDENTS 3,961			# OF RESPONDENTS 1,759			# OF RESPONDENTS 2,981			# OF RESPONDENTS 2,686		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Centennial Care?	97%	3%	n/a	97%	3%	n/a	96%	4%	n/a	97%	3%	n/a
Are you satisfied with your doctor?	88%	4%	8% I don't have a 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
Are you satisfied with your health plan?	96%	4%	n/a	97%	3%	n/a	95%	5%	n/a	95%	5%	n/a
Are you satisfied with the help provided by your care coordinator?	90%	8%	2% I don't have a care coordinator	92%	7%	1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator

Source: Finity Quarter 3 Report

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, and death. In DY10 Q2, New Mexico refined its reporting by including two months of available disenrollment data for the quarter. Due to the lag in data available each quarter, New Mexico will refresh its previous reporting each quarter to include the complete three months of data and analyses. This quarter, New Mexico is refreshing its disenrollment data for DY10 Q2 to include three months of data and is providing completed data for DY10 Q3.

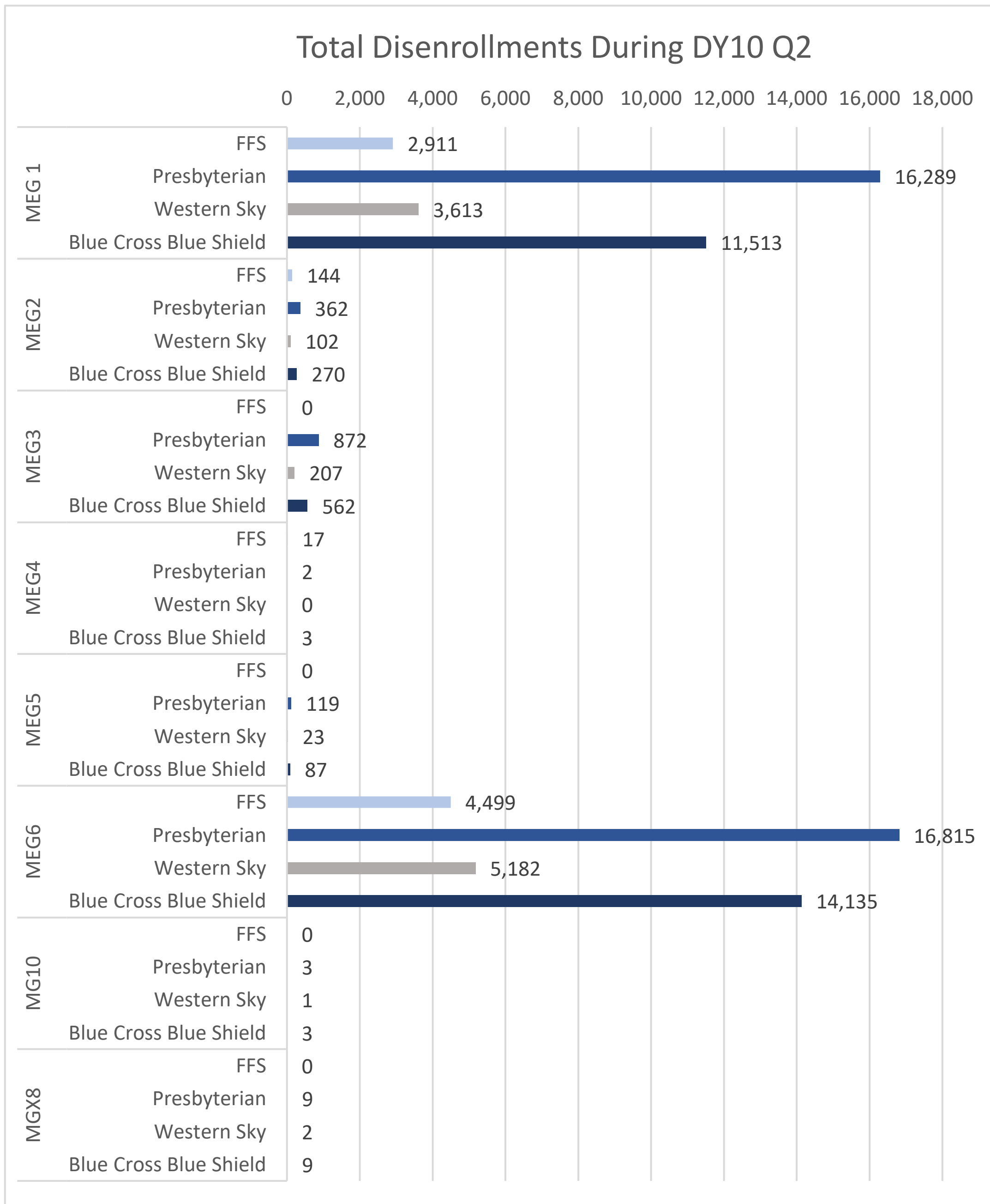
Due to Public Health Emergency (PHE) regarding Coronavirus (COVID-19), HSD meets the Maintenance of Effort (MOE) statutory requirements to receive the 6.2% increased Federal Medical Assistance Percentage (FMAP) by ensuring individuals are not terminated from Medicaid if they were enrolled in the program 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.

Refreshed DY10 Q2 Data

Demonstration Population		Total Number Demonstration Participants DY10 Q2 Ending June 2023	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY10 Q2 (April-June 2023)
Population MEG1 - TANF and Related	0-FFS	33,101	37,077	2,911
	Presbyterian	229,751	217,495	16,289
	Western Sky	45,687	44,427	3,613
	Blue Cross Blue Shield	152,117	144,746	11,513
	Summary	**460,656**	**443,745**	**34,326**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,297	2,526	144
	Presbyterian	20,912	20,805	362
	Western Sky	4,075	4,088	102
	Blue Cross Blue Shield	12,788	12,681	270
	Summary	**40,072**	**40,100**	**878**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Presbyterian	22,813	23,853	872
	Western Sky	3,918	4,212	207
	Blue Cross Blue Shield	11,688	12,289	562
	Summary	**38,419**	**40,354**	**1,641**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	138	184	17
	Presbyterian	103	106	2
	Western Sky	14	15	0
	Blue Cross Blue Shield	74	77	3
	Summary	**329**	**382**	**22**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Presbyterian	3,210	3,474	119
	Western Sky	558	600	23
	Blue Cross Blue Shield	2,481	2,633	87
	Summary	**6,249**	**6,707**	**229**
Population MEG6 - VIII Group (expansion)	0-FFS	25,351	35,721	4,499
	Presbyterian	130,872	146,318	16,815
	Western Sky	37,247	41,514	5,182
	Blue Cross Blue Shield	106,466	117,954	14,135
	Summary	**299,936**	**341,507**	**40,631**
Population MEG10 - IMDSUD Group	0-FFS	11	40	0
	Presbyterian	222	613	3
	Western Sky	35	97	1
	Blue Cross Blue Shield	129	373	3
	Summary	**397**	**1,123**	**7**
Population MEGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Presbyterian	425	1,185	9
	Western Sky	95	307	2
	Blue Cross Blue Shield	339	925	9
	Summary	**859**	**2,417**	**20**
Summary		**846,917**	**876,335**	**77,754**

Source: Enrollee Counts Report

Refreshed DY10 Q2 Data



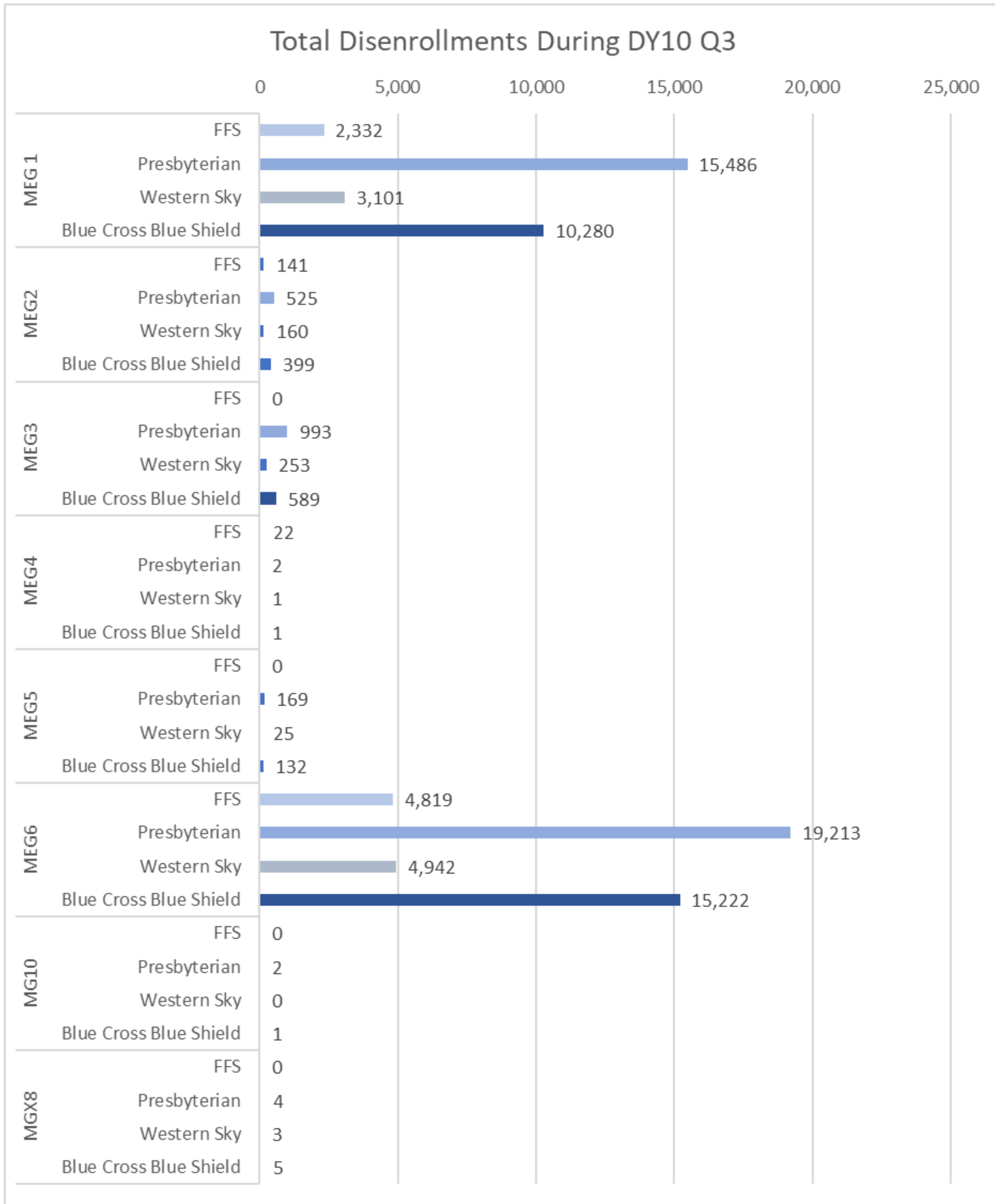
Source: Enrollee Counts Report

DY10 Q3 Data

Demonstration Population		Total Number Demonstration Participants DY10 Q2 Ending September 2023	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY10 Q3 (July-September 2023)
Population MEG1 - TANF and Related	0-FFS	28,012	30,393	2,332
	Presbyterian	200,391	207,148	15,486
	Western Sky	42,013	43,944	3,101
	Blue Cross Blue Shield	133,820	138,800	10,280
	Summary	**404,236**	**420,285**	**31,199**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,149	2,468	141
	Presbyterian	20,749	20,772	525
	Western Sky	4,157	4,212	160
	Blue Cross Blue Shield	12,807	12,689	399
	Summary	**39,862**	**40,141**	**1,225**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Presbyterian	22,247	24,027	993
	Western Sky	4,075	4,462	253
	Blue Cross Blue Shield	11,471	12,499	589
	Summary	**37,793**	**40,988**	**1,835**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	105	79	22
	Presbyterian	109	102	2
	Western Sky	14	15	1
	Blue Cross Blue Shield	78	83	1
	Summary	**306**	**279**	**26**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Presbyterian	3,207	3,581	169
	Western Sky	572	619	25
	Blue Cross Blue Shield	2,445	2,717	132
	Summary	**6,224**	**6,917**	**326**
Population MEG6 - VIII Group (expansion)	0-FFS	24,922	33,001	4,819
	Presbyterian	132,979	157,162	19,213
	Western Sky	37,739	44,918	4,942
	Blue Cross Blue Shield	105,200	125,104	15,222
	Summary	**300,840**	**360,185**	**44,196**
Population MEG10 - IMDSUD Group	0-FFS	12	33	0
	Presbyterian	66	534	2
	Western Sky	16	95	0
	Blue Cross Blue Shield	72	366	1
	Summary	**166**	**1,028**	**3**
Population MEGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Presbyterian	210	1,102	4
	Western Sky	68	311	3
	Blue Cross Blue Shield	220	959	5
	Summary	**498**	**2,372**	**12**
Summary		**789,925**	**872,195**	**78,822**

Source: Enrollee Counts Report

DY10 Q3 Complete Data



Source: Enrollee Counts Report

4

OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY10 Q3	In DY10 Q3, 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 continue to participate in HSD's COVID-19 Vaccination Workgroup and a DOH COVID-19 Provider Update Workgroup. The purpose of these meetings is to communicate and discuss COVID-19 vaccine efforts, upcoming statewide events, review federal guidelines, and outline operational procedures during the PHE. HSD staff participated in the United States Department of Agriculture (USDA) Benefits Outreach event assisting New Mexicans apply for healthcare coverage and answering general Medicaid questions related to individual and 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.

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OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments through DY10 Q3 reflect the Centennial Care 2.0 rates effective for the period from January 1, 2023 through December 31, 2023. The rates are developed with efficiency, utilization, trends, prospective program changes, and other factors as described in the rate certification reports; the rate certification reports for January 1 through December 31, 2023 were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 21, 2022.

During DY10 Q3, 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, and COVID-19 non-risk payments.

The payments related to the PHE due to the COVID-19 pandemic was $27.1 million during CY 2022. The COVID-19 non-risk payments during CY 2023 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 January, 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 one 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.

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.

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.

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 five 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 within the MCO that are paneled to a PCMH as well as the initiatives to promote participation in the PCMH service delivery model.

Table 4 below reports the total number of members paneled to a PCMH per MCO. DY10 Q2 reflects an overall aggregate increase in members receiving care through a PCMH compared to DY10 Q1. The DY10 Q3 data will be reported in the DY10 Q4 CMS Quarterly Monitoring Report.

Table 4: PCMH Assignment

PCMH ASSIGNMENT				
Total Members Paneled to a PCMH				
	DY9 Q3	**DY9 Q4**	**DY10 Q1**	**DY10 Q2**
BCBS	156,969	154,635	167,746	161,328
PHP	272,903	271,339	269,447	267,851
WSCC	36,433	37,129	38,316	52,767
Percent of Members Paneled to a PCMH				
	DY9 Q3	**DY9 Q4**	**DY10 Q1**	**DY10 Q2**
BCBS	51.90%	51.20%	55.30%	52.70%
PHP	63.90%	63.60%	62.80%	66.10%
WSCC	40.20%	39.80%	40.10%	59.80%

Source: MCO Report #48 DY10 Q2

MCO PCMH initiatives:
BCBS: Following a hospital stay, BCBS refers members to their community paramedicine program so that independent emergency technicians can visit members in their home. The focus for the paramedicine program is to assist members that are being served by a PCMH, reduce their high emergency department utilization and their hospital readmissions. BCBS also has a range of transitions of care programs that include a continuous growing team of care coordinators as well as community health workers.

PHP: For subsequent reporting, PHP Value Based Purchasing (VBP) team is working together with innovative rural and frontier PCMH groups to increase the overall number of unique members paneled to PCMH. PHP is also enhancing member education which is being implemented in an ongoing effort to lower emergency department (ED) utilization rates as well as to accommodate patient and member needs. PHPs overall readmission rates along with their ED utilizations have decreased, which shows a positive impact for members being served by a PCMH.

WSCC: By selecting several new partners, that include PCMH clinics, WSCC expanded their delegated care coordination to help reduce high ED utilization and hospital readmission. WSCC also selected a new transportation vendor that provides adequate fleet access to PCMH clinics and in addition, care coordination can assist in scheduling rides on behalf of the member. WSCC focuses on community engagement across the state to improve access and education with preventative care and hosted their first ever Baby Expo, along with several community events, which include immunization clinics and community health fairs. By focusing on all measures implemented to address ED utilization and hospital readmissions, WSCC is improving health outcomes, reducing healthcare costs, and providing more efficient patient-centered care.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities	
DY10 Q3	HSD continued to monitor MCO enrollment and member engagement through the quarterly Care Coordination Report. This report includes data related to the completion of required assessments and touchpoints within contract timeframes. The DY10 Q3 report contains data from DY10 Q2. DY10 Q3 data will be reported in DY10 Q4. The MCO aggregate results show performance benchmarks of 85% were met, or exceeded, for timely completion of Health Risk Assessments (HRAs) for 'new to Medicaid' members, members with a change in health condition, Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs). The aggregate completion rate for HRAs for 'new to Medicaid' members decreased from 97% in DY10 Q1 to 96% in DY10 Q2. The aggregate completion rate for HRAs for members with a 'change in health condition' was at 99% in DY10 Q1 and DY10 Q2. Aggregate completion percentages for CNAs for CCL2 members increased from 90% in DY10 Q1 to 91% in DY10 Q2. Aggregate completion percentages for CNAs for CCL3 members increased from 86% in DY10 Q1 to 90% in DY10 Q2. MCOs noted that members are adjusting to the return to face-to-face assessments and have expressed that in-person contact with their care coordinators was positive and beneficial. Aggregate completion percentages of CCPs for CCL2 members was at 94% in DY10 Q1 and DY10 Q2. CCPs for CCL3 members was at 95% in DY10 Q1 and DY10 Q2. 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 that staff participating in the project saw a 50% decrease in the time it took for them to complete a CCP, which allowed for a higher level of quality engagement with members.

	BCBS intends to conduct targeted training with all care coordinators in DY10 Q3 and continue to measure outcomes and the benefits of the project. The Care Coordination Report includes MCO strategies for engaging and retaining members. In DY10 Q2, MCOs reported on multiple strategies to retain engagement with members. BCBS's Care Coordination Unit has been unable to reach some members. The Care Coordination Unit has been collaborating with their customer service department to identify members who call into their main customer service line for information or assistance, to ask questions, or to request referrals, and connect them back to their care coordinator. Customer service representatives conduct a warm transfer to the BCBS Care Coordination Unit to assist the member and complete an initial Health Risk Assessment (HRA). 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. WSCC participates in community events across the state, from school-based activities to cultural celebrations. WSCC partnered with Pro Football Hall of Famers, the University of New Mexico, and the New Mexico Activities Association to work with high school students and encourage healthier mental, physical, and educational habits. 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 Q3 through DY10 Q2. DY10 Q3 data will be reported in DY10 Q4.

Table 5: Care Coordination Monitoring

MCO Performance Standards	DY9 Q3	DY9 Q4	DY10 Q1	DY10 Q2
HRAs for new Members	**97%**	**97%**	**97%**	**96%**
BCBSNM	98%	97%	97%	95%
PHP	97%	96%	96%	95%
WSCC	100%	100%	100%	100%
HRAs for Members with a change in health condition	**98%**	**99%**	**99%**	**99%**
BCBSNM	100%	100%	99%	100%
PHP	96%	98%	98%	98%
WSCC	100%	100%	100%	100%
CNAs for CCL2 Members	**95%**	**94%**	**90%**	**91%**
BCBSNM	92%	89%	88%	88%
PHP	97%	96%	90%	92%
WSCC	99%	99.80%	99.70%	100.00%
CNAs for CCL3 Members	**93%**	**91%**	**86%**	**90%**
BCBSNM	88%	86%	86%	86%
PHP	95%	93%	85%	91%
WSCC	100%	100%	100%	100%
CCPs for CCL2 Members	**96%**	**96%**	**94%**	**94%**
BCBSNM	89%	88%	85%	85%
PHP	99%	99%	99%	99%
WSCC	99%	98%	96%	93%
CCPs for CCL3 Members	**96%**	**97%**	**95%**	**95%**
BCBSNM	88%	89%	86%	87%
PHP	99%	100%	99%	98%
WSCC	98%	98%	96%	94%

Source: HSD DY10 Q2 Report #6 –Care Coordination Report
Percentages in bold are MCO aggregate of the total assessments due and completed.

Care Coordination Audits

In DY10 Q2, 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 Q3 through DY10 Q2. DY10 Q3 data will be reported in DY10 Q4.

Table 6: Transition of Care Audit

Transition of Care	DY9 Q3	DY9 Q4	DY10 Q1	DY10 Q2
In-Patient	**91%**	**91%**	**99%**	**90%**
BCBS	98%	90%	97%	97%
PHP	91%	89%	99%	97%
WSCC	83%	95%	100%	77%
Nursing Facility	**88%**	**93%**	**96%**	**90%**
BCBS	100%	95%	98%	93%
PHP	90%	100%	100%	100%
WSCC	75%	85%	90%	77%

Source: HSD DY10 Q2 Quarterly TOC Audits
Percentages in bold are MCO averages.

The aggregate compliance rate for IP to Community TOC files decreased from 99% in DY10 Q1 to 90% in DY10 Q2. The aggregate compliance for NF to Community TOC audited files decreased from 96% in DY10 Q1 to 90% in DY10 Q2.

HSD noted similar areas of concern in DY10 Q2 as in DY10 Q1.

Areas that needed improvement were related to:

- Documentation not germane to the audit
- Post discharge assessments not including all required elements
- Coordination of discharge planning documentation not including all required elements
- Assigned Care Coordination Levels not aligning with MCO to HSD Interface File data
- Three-day post discharge assessments conducted telephonically instead of in-person

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. BCBS's IP audit scores remained at 97% from DY10 Q1 to DY10 Q2, primarily due to excellent documentation. BCBS's NF audit scores decreased from 98% in DY10 Q1 to 93% in DY10 Q2, due to insufficient documentation with discharge planning teams and some in-home assessments lacking all required elements. PHP's IP audit scores decreased from 99% in DY10 Q1 to 97% in DY10 Q2 due to inconsistent documentation and not including all required elements in their Transition of Care Plans. PHP's NF scores remained at 100% from DY10 Q1 to DY10 Q2. HSD acknowledged PHP's revised assessment templates which were succinct and included all required elements. WSCC's IP scores decreased significantly from 100% in DY10 Q1 to 77% in DY10 Q2. WSCC's NF scores decreased from 90% in DY10 Q1 to 77% in DY10 Q2. WSCC had fewer enrollees; therefore there are fewer transitions. WSCC had just 4 IP files and 3 NF files audited, which negatively affected their total score. WSCC implemented a new documentation application in DY10 Q2. Documentation submitted from the new application did not contain some HSD required elements. WSCC acknowledged the issue and ensured future documentation would adhere to HSD requirements. WSCC acknowledged the requirement to complete post-discharge assessments in-person and will provide additional training to ensure this requirement is met.

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 documentation training for all staff, each quarter, 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 Q3 through DY10 Q2. DY10 Q3 data will be reported in DY10 Q4.

Table 7: Health Risk Assessment and Care Coordination Level Audit

HRA/CCL Audit	DY9 Q3	DY9 Q4	DY10 Q1	DY10 Q2
Health Risk Assessment (HRA)	**99%**	**99%**	**95%**	**98%**
BCBS	99%	99%	99%	99%
PHP	100%	99%	100%	99%
WSCC	98%	99%	86%	96%
Care Coordination Level (CCL)	**96%**	**95%**	**97%**	**95%**
BCBS	100%	93%	99.70%	90%
PHP	100%	94%	99.70%	100%
WSCC	88%	99%	92%	96%

Source: HSD DY10 Q2 HRA and CCL Audits
Percentages in bold are MCO averages

Results of the HRA Audit showed that the MCOs consistently met all contract requirements when completing HRAs. HSD noted that aggregate rates of compliance increased from 95% in DY10 Q1 to 98% in DY10 Q2. BCBS was at 99% compliance from DY10 Q1 to DY10 Q2, while PHP decreased from 100% in DY10 Q1 to 99% in DY10 Q2. WSCC increased compliance from 86% in DY10 Q1 to 96% in DY10 Q2 due to improved documentation.

Aggregate rates of compliance for the CCL Audit decreased from 97% in DY10 Q1 to 95% in DY10 Q2. BCBS decreased in compliance from 99.7% in DY10 Q1 to 90% in DY10 Q2, primarily due to no documentation of members' HSD required Care Coordination Levels. BCBS acknowledged that their new DxCG claims mining model assigns predictive risk scores and care coordinators assign expected risk scores; however, in future audit submissions, BCBS will include the required care coordination levels in their documentation. PHP scores increased from 99.7% in DY10 Q1 to 100% in DY10 Q2. HSD noted PHP's excellent documentation and comprehensive assessments. WSCC saw an increase from 92% in DY10 Q1 to 96% in DY10 Q2. WSCC acknowledged a finding of incorrect leveling for one 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 4 CNA ride-alongs with MCO care coordinators in DY10 Q2, to observe completion of member assessments.

HSD attended annual CNAs conducted by BCBS, PHP, and WSCC.

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 member
- HSD noted care coordinators employing motivational interviewing with member
- 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 8 virtual HRA ride-alongs with MCO care coordinators in DY10 Q2, to observe completion of member assessments. All HRAs observed were conducted telephonically.

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

- The majority of Assessors were friendly, thorough, and professional with the members
- Assessors often explained to members that they could request care coordination in the future if they would like assistance
- Assessors referred members to resources to address specific concerns
- 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 contract required topics are addressed in the HRA
    - Ensuring assessments are thorough without being overly lengthy

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 Q2 Quarterly Meeting on June 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 Q1 audits of member categorization, Health Risk Assessments (HRAs), Care Coordination Levels (CCLs) and compliance with Transition of Care (TOC) requirements
- Results of the DY10 Q1 audits of CISC Health Risk Assessments (HRAs) and Care Coordination Levels (CCLs)

HSD requested that the MCOs present projects and initiatives they have implemented that have had successful outcomes.

- BCBS presented information related to their Transitional Living Services Value Added Service. This initiative:
  - Is designed to assist members leaving a higher level of care
  - Provides transitional housing
  - Provides access to services and care for members who otherwise would be unable to access them due to homelessness or difficult living situations
  - Authorizes stays in 30-day increments with clinical review of the member situation and review of progress towards being self-supporting
  - Has assisted 113 unique members and approved 6,695 days of transitional living since the programs' inception with the average stay being 59 days
  - Has seen a 64% increase in outpatient care with a PCP or specialist for engaged members
  - Has seen a 58% decrease in emergency room (ER) utilization for engaged members.
- PHP provided information on their initiative to reduce low acuity ER utilization.
  - PHP partnered with Albuquerque Ambulance and now provide them a monthly report of members with low acuity ER utilization for targeted outreach
  - Paramedics meet with members in their homes, discuss identified healthcare

needs, and educate on the alternatives to the ER
    - Data available shows a 54% decrease in low acuity ER visits for members Albuquerque Ambulance was able to engage with
- WSCC presented information on their Pyx Health mobile application that is available at no cost to their members and addresses social isolation and loneliness.
    - WSCC's Pyx is available 24/7 and includes a warm line, assistance with housing, food, BH services, and a nurse advice line
    - As of DY10 Q2, 1,110 WSCC members had enrolled and were actively benefiting from the program
    - WSCC members reported a 35% reduction from initial loneliness scores as well as a 35% reduction in initial depression scores
    - The Pyx program loops members back to WSCC for additional assistance when appropriate

HSD also meets individually with each MCO twice per quarter to address care coordination issues related specifically to their MCO. In DY10 Q2, meeting topics included:

- Continuing discussions on the effectiveness of claims/data mining processes specifically for high needs populations
- 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 in Care Coordination provider sites
- Discussion of HRA and CNA ride-along findings
- Discussion concerning the Comprehensive Addiction and Recovery Act, (CARA), including the high percentage of members who refuse care coordination, collaboration with Neonatal Intensive Care Unit (NICU) hospital staff, and engaging with pregnant members with substance use related claims
- Updates on the return to in-home, face-to-face assessments
- Update from BCBS on their new DxCG risk model and its ability to pull data related to Social Determinants of Health (SDoH)
- Clarification from PHP on disparities between PCP, ED, and IP utilization data provided in their Utilization Report vs. Report 6 analysis
- Discussion with WSCC concerning leveling members through data mining, reviewing specific member examples

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 Q2, a total of 30,629 Medicaid members received behavioral health services through telehealth. This quarter's total did see a decrease of 19.6% compared to the DY9 Q2 total of 38,082 persons served through this medium. Of those served in DY10 Q2 through telehealth, 12,088 persons reside in rural or frontier counties. This accounts for 39% 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 has seen a decrease over the past quarters. In DY10 Q2, 17,515 members received services through this modality compared to 22,134 in DY10 Q1 which is a decrease of 4,619 people or 21%. 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 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 5,153 new clients during the twelve months of 2023. With support from the Treat First agencies, 29.7% 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 10.1%. This is impressive particularly during the pandemic and significantly lower than before agencies started the Treat First Approach.

When youth or adults were asked how they felt their Treat First visits were going, on average, both groups felt that the sessions were working very well to address their immediate needs. Youth rated sessions at 92.9% and adults at 88.2%.

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 Q2, SBIRT utilization increased 123.6% to 3,568 persons served during the quarter compared to 1,596 in DY10 Q1. The increased utilization of SBIRT is also noted in DY10 Q2 when compared to the same quarter of the prior year, where 2,501 persons were served, when compared to the current results, there was a 42.7% increase from that period.

On a monthly average, 701 persons received SBIRT in DY10 Q2 with the greatest utilization occurring in June with 757 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 continues efforts to implement Crisis Treatment Centers (CTC). Provider-specific cost-based rates are established for 3 CTC providers in the state and are now delivering in-patient and outpatient CTC services. Expansion of CTCs continues as the state expands the 988 Crisis Now initiatives. In DY10, the State continues to explore additional models for crisis receiving and stabilization services such as a Community Crisis Partner whereas services are embedded within and emergency department or a Crisis Calming Center. A Crisis Calming Center is a 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 Q2, the total number of persons served with a SUD in an IMD was 3,751, which is a slight decrease of 46 persons (or 1.21%) compared to DY10 Q1. When comparing DY10 Q2 result to DY10 Q1, the utilization remained stable with 1,657 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 DY10 Q3 meeting on August 16, 2023. Attendees included board members and invited guests, including managed care organization representatives. Client counts for both FFS and MCO were reported with small decreases in total members enrolled for FFS and MCO members as expected with the public health emergency unwinding. An overview of the role Conduent performs with retrospect to the New Mexico FFS program for both prospective and retrospective DUR was presented, including a comprehensive review of the requirements for DUR including with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. The final outcomes report for the COVID-19 newsletter summary report and diabetic newsletter were presented and closed. Quarter 2 intervention of the antipsychotic metabolic monitoring intervention was reported as mailed for provider response on May 18, 2023. Intervention responses will be reported in future meetings. This intervention is 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. Standing reports for SUPPORT Act were reported with no new trends or concerns reported. The Board approved the third quarter targeted intervention for patients diagnosed with Hepatitis C and no record of medication treatment on record. Discussion for future interventions included targeting fraud, waste, and abuse by analyzing patients without a type 2 diabetes diagnosis on glucagon-like peptide (GLP-1) inhibitors. Possible intervention discussion also included a clinical outcomes intervention targeted intervention of patients with heart failure, diabetes with the goal of targeting increased outcomes for the heart failure with sodium-

glucose cotransporter-2 (SGLT) inhibitors. Work continues to eliminate the prior authorization for treating naive or pan sensitive hepatitis C treatment medications.

Project ECHO continues to train providers, DY10 Q1 shows 163 case reviews. The number of sessions remain consistent. HSD released a Supplement to providers outlining the reimbursement opportunities to attend and continue case reviews. Additionally, advertising for these sessions continues to expand to multiple websites and list-serves (recruitment listings). In DY10 Q3, Project Echo continued to train providers across the state including rural areas which helps increase care to enrollees. Current ECHO programs include, but are not limited to, Diabetes Management in Primary Care, Improving Perinatal Health, Opiate Use Disorders for Prescribers, and Alcohol use and Mental Health.

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 6 hospitals have started prescribing buprenorphine and the program has tracked 620 patients that have received this treatment to date from Taos, Memorial, Gallup and Socorro (data collection from UNM and Lovelace is currently being gathered). Three hospitals participated in aspects of engagement and/or training, including Plains Region Medical Center, Northern Navajo Medical Center, and Gerald Champion Medical Center. NM Bridge has recently started engagement and started planning trainings with Sierra Vista Hospital and Christus St. Vincent Regional Medical Center. NM Bridge is in discussion with other hospitals to plan engagement in the future, including UNM Sandoval Regional, San Juan 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 training and assist with hiring a peer support worker. NM Bridge also continues to work with Taos Holy Cross to support their Women's Health Clinic with trainings and other resources. 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, 2013. 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 MMIS continue to design and implement enhanced data analytics in 2023. Smart phone apps are part of the MMIS unified public interface (UPI). HSD and vendors for the new MMIS 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 MMIS 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 Q3, 4 AARTC provider applications were received with 1 in review awaiting pending documents to be submitted before granting approval. One application received approval on October 27, 2023 to provide additional levels of care that can start immediately since the rate development phase was completed from the previous application submission. Two applications received approval on November 1, 2023 and November 13, 2023 for the new locations. The previous application from DY10 Q2 was approved on October 18, 2024, after additional supportive documents were submitted, and is currently in the rate development phase. A submission of a letter of intent was received and the submission of the application submission is in process. 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 #	DY9 Q4	DY10 Q1	DY10 Q2	DY10 Q3
716	0	0	0	0
090	61	65	58	67
037	309	322	343	331
081	11	14	5	14
589	9	8	5	8
332	31	26	0	26
049	28	54	21	54
825	1	30	24	30
896	3	0	0	0
302	90	105	88	105
60	15	27	33	27
760	11	17	14	17
Unduplicated Total	**569**	**668**	**591**	**679**

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 Q2 and DY10 Q3. 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 037 data. All AARTC provider sites are actively in process to receive distinct identification numbers to ensure accuracy in client counts for each site.

The Utilization Medicaid services illustrates an increase from 591 in DY10 Q2 to 679 in DY10 Q3 of clients served, which may be attributed to the 90-day claim lag submitted in DY10 Q2 and DY10 Q3. 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 Q3 Activities	In Q3, the Behavioral Health Services Division (BHSD) started the onsite evaluation of the CareLink Health Home Program. It was apparent that in most Health Homes, there is a positive culture where staff are eager to engage, learn, and improve. Health Home staff show the passion that they have for their members, along with identifying social needs. There are also detailed service plans and updates to referrals that are being made internally and, in the community, which are also very detailed and thorough. Findings show that goals include both behavior and physical health and are evident in the service plan. There is extensive evidence of care coordination, including a variety of resources for non-medical concerns such as transportation, food from community resources, and housing through peer support and the voucher program. Some of the Health Home’s peer support staff work together with the LADAC in support of client’s needs, facilitating training around parenting, and NARCAN training. The peer support staff conduct home visits to render peer services. The Health Home’s offer SUD education, parenting classes, monthly seminars for adults and adolescents, and family nights.

	Transportation barriers and long waiting periods for specialist appointments were identified as a significant challenge. Hiring new Health Home staff has also been a challenge and has resulted in high levels of care coordination to member ratios and a reduction in adding new members.

Table 9: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY9 Q4 OCT - DEC	DY10 Q1 JAN - MAR	DY10 Q2 APR - JUNE	DY10 Q3 JUL - SEPT
4,125	4,211	4,102	3,868
% CHANGE	% CHANGE	% CHANGE	% CHANGE
2.30%	2.04%	2.59%	5.70%

Source: NMStar, CLNM Opt-in Report.

HIGH FIDELITY WRAP

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 assesses 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 reviews provider applications to ensure that agencies interested in providing HFW services meet provider requirements and adherence to the HFW model. 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. We anticipate draft measures to be available in March 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 had 9 CPSWs assigned to deliver Linkages supportive housing services; the 9 CPSWs have clients in Linkages and various other programs that the agency provides. Next quarter this provider

plans to decrease to 4 CPSWs who will specialize in a Linkages specific client base to optimize Linkages service provision and outcomes. The plan includes transitioning 4 of the 9 CPSWs, a CPSW Supervisor, a CPSW Lead, and 2 field CPSWs. Rather than each of the 9 CPSWs who each have Linkages clients and clients of other programming, the Linkages case load will be consolidated to be under the 4 CPSWS who will have a case load size similar to their current case load size but will maintain the entire Linkages client base. 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. This provider is actively recruiting to fill the roles. One CPSW will staff the primary Linkages role and the other CPSW will provide Linkages back-up and assist clients/members in need of support with Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI). 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 one 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 – September 30, 2023)			
DY10 Q1	DY10 Q2	DY10 Q3	DY10 Q4
49	*57	72	
Unduplicated Total - 97			
*The information provided last quarter was the unduplicated members served for the year rather than the quarter. The entry has been updated.			

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 304 vouchers were issued or filled; a filled voucher means housing has been secured. Therefore 304 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 September 29, 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. New Mexico will prepare its SMI/SED Monitoring Protocol following CMS' issuance of new templates and guidance.

CENTENNIAL HOME VISITING (CHV) PROGRAM

New Mexico has encountered reporting delays and will submit its DY10 Q2 and DY10 Q3 data with its DY10 Q3 report. For reference, in DY10 Q1, the Centennial Home Visiting (CHV) program served 406 families. Following is DY10 Q2 and Q3 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 86 unique families in DY10 Q2 and 80 unique families in DY10 Q3 in Bernalillo County and Valencia Counties.
- Youth Development Inc. (YDI) served 61 families in DY10 Q2 and 77 families in DY10 Q3 in Bernalillo, Rio Arriba, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 30 unique families in DY10 Q2 and 28 unique families in DY10 Q3 in Bernalillo County.
- ENMRSH served 20 unique families in DY10 Q2 and 27 unique families in DY10 Q3 in Curry and Roosevelt Counties.
- Taos Pueblo served 2 unique families in DY10 Q2 and 2 unique families in DY10 Q3 in Taos County.

- MECA Therapies served 134 unique families in DY10 Q2 and 133 unique families in DY10 Q3 in Chaves, Curry, Doña Ana, Roosevelt, and Lea Counties.
- Aprendamos served 18 unique families in DY10 Q2 and 26 unique families in DY10 Q3 in Doña Ana, Sierra, and Otero Counties.
- Community Action Agency of Southern New Mexico served 24 unique families in DY10 Q2 and 25 unique families in DY10 Q3 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 8 unique families in DY10 Q2 and 10 unique families in DY10 Q3 in San Juan County.

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

- Day One Home Visiting Tresco has completed enrollment in NM Medicaid. They are in the process of creating contracts with the 3 MCOs. They will serve Bernalillo and Santa Fe Counties.
- 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 NFP agencies starting in July.

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 866 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 Q3.

HSD continues to maintain the virtual assistant program to help automate the process of adding newborns to existing Medicaid cases. The “Baby Bot” functionality utilizes our contractor, Accenture’s, virtual assistant (AVA) software. AVA allows providers to start a Baby Bot chat session in YESNM-PE (Your Eligibility System 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 270 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 (July - September 2023)					
Month	Newborns Submitted through AVA	Newborns Successfully Enrolled	Newborns Unsuccessfully Enrolled - Tasks Created	% of Newborns Successfully Enrolled	% of Newborns Unsuccessfully Enrolled
July	713	478	235	67%	33%
August	948	671	277	71%	29%
September	746	502	244	67%	33%
Total	**2,407**	**1,651**	**756**	**69%**	**31%**

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY10 Q3, 72 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 increase 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 (July - September 2023)				
Month	PEs Granted	% PE Granted with Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
July	227	97.36%	705	303
August	295	94.92%	882	313
September	430	100%	1,102	395
Total	**952**	**98%**	**2,689**	**1,011**

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 PE approvals that also had an ongoing application submitted. In DY10 Q3, 98% of all PE approvals had an ongoing application submitted.

JUST HEALTH PROGRAM

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

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

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

The following table outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. HSD observed a decrease in the amount of PE approvals, and a slight decrease in the number of Medicaid applications submitted from jail or prison settings in DY10 Q3. 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 Q3, 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 13: PE Approvals

PE APPROVALS – JUST HEATH (July - Septmber 2023)				
Quarter	PEs Granted	% PE Granted w/ Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
July	0	0%	85	79
August	2	100%	91	79
September	4	100%	146	140
Total	**6**	**100%**	**322**	**298**

Source: Monthly PE001 Report from ASPEN and OmniCaid

7
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 Q3 are listed in the tables below.

Table 14: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT July - September 2023	
TOPIC	**NUMBER OF CALLS**
Home/Community Based Care Waiver Programs	2,942
Long Term Care/Case Management	11
Medicaid Appeals/Complaints	3
Personal Care	8
State Medicaid Managed Care Enrollment Programs	4
Medicaid Information/Counseling	647

Source: SAMS Call Profiler Report; GSA I 7-630-8000-0001 CDA 93-778 State Fiscal Year 2024, Quarter 1 report

Table 15: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT July - September 2023			
COUNSELING SERVICES	**NUMBER OF HOURS**	**NUMBER OF NURSING HOME RESIDENTS**	**NUMBER OF CONTACTS**
Transition Advocacy Support Services		163	
*Medicaid Education/Outreach	2,731		
Nursing Home Intakes		82	
**LTSS Short-Team Assistance			146

*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 1 report

Critical Incidents

Critical Incidents	
DY10 Q3	HSD conducts a quarterly meeting with MCOs. The goal of the quarterly meeting is to provide guidance and discuss findings of the MCO's reporting of critical incidents. The quarterly meeting was held on August 16, 2023. The primary discussion was regarding MCO contracted agencies reporting insufficient staffing critical incidents and are unable to provide services to members. HSD requested information on the issues the contracted agencies were experiencing and the actions being taken by each MCO to address and mitigate the issues identified for 2023 Q2. MCOs reported a variety of challenges in recruiting staff, such as: 1) agencies reported applicants were applying for positions to keep unemployment benefits; 2) applicants were hired but did not show up for training, and individuals were not interested in taking on members with an allocation of 15 hours or less per week due to the time to travel and cost of gas. MCOs reported all counties of the State were identified as having staffing issues. MCOs also indicated that they have conducted outreach to the top agencies identified as having challenges with staffing services to members and monthly and weekly meetings have been initiated. HSD has initiated conducting monthly meetings with MCOs. The goal of the monthly meeting is to provide individual guidance, address and clarify any questions concerning quarterly reports, concerns identified of critical incidents reported, contract and policy requirements. Items of discussion during the Q2 MCO monthly meetings were: BCBS- review of critical incident reports filed identified "No current follow-up diary entry to address Members health and safety" as a continued area of concern. A list of CIRs discussed on the call is sent as a separate attachment prior to the monthly call. BCBS stated a diary entry follow-up by the care coordinator is between two and six weeks to be entered into the HSD Portal. The critical incident team will follow up with care coordination and send a reminder within two weeks.

	• PHP- review of critical incident reports filed identified "No current follow-up diary entry to address Members health and safety" as a continued area of concern. A list of CIRs discussed on the call is sent as a separate attachment prior to the monthly call. PHP stated the critical incident team does intake within 24 hours of receiving a critical incident. They then send the critical incident report to the appropriate team for follow-up, such as behavioral health critical incident team, physical health, care coordinator or other associated partners. The follow up diary entries can take up to two weeks to be entered into the HSD Portal. • WSCC- review of critical incident reports filed identified "No current follow-up diary entry to address Members health and safety" as a continued area of concern. A list of CIRs discussed on the call is sent as a separate attachment prior to the monthly call. WSCC stated the critical incident team reviews their internal system, TruCare, to assess members needs within 24 hours of receiving a critical incident. If needed, the critical incident team will reach out to the care coordinator or the provider to fill in gaps of information on the member. WSCC care coordination team is given two weeks for diary entry follow-up to be entered into the HSD Portal. The critical incident team will send a reminder email to the care coordination manager and care coordinator requesting follow up as soon as possible.

	HSD conducted daily reviews of critical incidents submitted by the MCOs and providers for the purpose of ensuring compliance with reporting requirements. HSD provided daily assistance to MCOs and providers to obtain access to the Critical Incident Reporting (CIR) Portal by establishing and/or resetting login credentials as well as deleting duplicate reports. DY10 Q2 data was received on July 30,2023. During DY10 Q2, a total of 50,618 CIRs were filed for Centennial Care which includes physical health (49,009), and subsets of behavioral health (809) and community benefit self-directed (800) members. In DY10 Q2 total Centennial Care critical incident reports increased 48% from DY10 Q1. In DY10 Q2 total Behavioral Health critical incident reports decreased 8% from DY10 Q1. In DY10 Q2 total Self-Directed critical incident reports decreased 10% from DY10 Q1. DY10 Q3 critical incident monitoring activities will be reported in the CY10 Q4 report. The tables below represent a MCO summary of the critical incident reporting for DY10 Q1 and Q2. DY10 Q3 data will be received on Oct. 30, 2023, and be reflected in DY10 Q3 report.

Table 16: Critical Incidents Reported

CRITICAL INCIDENTS REPORTED (DY10 Q2)															
MCO	CENTENNIAL CARE (CC)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
BCBS	10,031	11,040			161	134			204	267			21,071	295	471
PHP	21,208	35,687			667	623			513	508			56,895	1,290	1,021
WSCC	1,859	2,282			56	52			132	25			4,141	108	157
Total	33,098	49,009			884	809			849	800			82,107	1,693	1,649

Source MCO quarterly report #36

BCBS (DY10 Q2)															
Critical Incident Types	**Centennial Care**				**Behavioral Health**				**Self-Directed**				**Year-to-date Totals**		
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**CC**	**BH**	**SD**
Abuse	110	108			25	17			13	8			218	42	21
Death	213	202			2	11			7	8			415	13	15
Elopement / Missing	7	5			0	1			0	1			12	1	1
Emergency Services	1,739	2,210			88	81			111	162			3,949	169	273
Environmental Hazard	35	37			2	2			2	4			72	4	6
Exploitation	30	83			1	1			0	0			113	2	0
Law Enforcement	29	36			7	6			1	5			65	13	6
Neglect	7,868	8,359			36	15			70	79			16,227	51	149
All Incident Types	10,031	11,040			161	134			204	267			21,071	295	471

Source MCO quarterly report #36

PHP (DY10 Q2)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	167	168			61	55			12	10			335	116	22
Death	428	398			8	16			16	13			826	24	29
Elopement/ Missing	18	20			1	2			0	1			38	3	1
Emergency Services	6,519	6,787			459	435			360	377			13,306	894	737
Environmental Hazard	68	109			5	6			6	6			177	11	12
Exploitation	51	65			0	3			10	12			116	3	22
Law Enforcement	56	63			10	10			3	11			119	20	14
Neglect	13,901	28,077			123	96			106	78			41,978	219	184
All Incident Types	21,208	35,687			667	623			513	508			56,895	1,290	1,021

Source MCO quarterly report #36

WSCC (DY10 Q2)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	21	29			3	9			3	1			50	12	4
Death	42	27			1	2			5	1			69	3	6
Elopement/ Missing	4	4			0	2			1	0			8	2	1
Emergency Services	295	285			42	32			41	21			580	74	62
Environmental Hazard	5	12			0	0			1	0			17	0	1
Exploitation	16	8			2	1			2	0			24	3	2
Law Enforcement	13	8			2	1			4	2			21	3	6
Neglect	1,463	1,909			6	5			75	0			3,372	11	75
All Incident Types	1,859	2,282			56	52			132	25			4,141	108	157

Source MCO quarterly report #36

Community Benefit

In DY10 Q3, Community Benefit (CB) related projects have included: provider rate increases; finalization and 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 Self-Directed Community Benefit (SDCB) program improvements. 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. A 4.68% rate increase for all Community Benefit Services was implemented effective July 1, 2023.

   - HSD continues to monitor MCO accountability to ensure minimum wage increases and paid sick leave requirements are met with weekly MCO report updates.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers. 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. HSD received CMS approval for our Good Faith Effort Exemption request to CMS for Home Health Services. EVV for Home Healthcare Services was implemented in January 2024 and we continue collaborating with the MCOs, providers, and CMS to ensure requirements are met.

Electronic Visit Verification - HCBS

For DY10 Q3, 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 Q3 is outlined in the table below. The MCOs reported that 73.4% 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 (July - September 2023)		
MCO	AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD	NUMBER OF TOTAL CLAIMS THIS PERIOD
BCBS	7,559	458,698
PHP	14,063	1,059,245
WSCC	2,091	120,547
TOTAL	23,713	1,638,490

Source: MCO Report #35 DY10 Q3, July – September 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 will audit all settings by the end of 2023 to ensure continued compliance. They will report any findings to HSD.

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 Q2 audit results this quarter and audit findings for DY10 Q3 will be reported in DY10 Q4.

Total audits for DY10 Q2:

- BCBS conducted 108 total audits of NF LOC determinations, 18 facility-based and 90 community-based.
- PHP conducted 250 total audits of NF LOC determinations, 75 facility-based and 175 community-based.
- WSCC conducted 24 total audits of NF LOC determinations, 6 facility-based determinations and 18 community-based.

Audit results for NF LOC determinations for DY10 Q2:

- 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 99% 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 Q2:

- 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 Community Based NF LOCs.
- WSCC reported 67% timeliness of determinations for Low Facility Based, there were no files audited for High 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 99.6% for Community Based NF LOCs.
- Timeliness of determinations aggregate results are 100% for High and 97% for Low - Facility Based and 99% for Community Based.

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

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

Facility-Based Internal Audits				
High NF Determinations	**April**	**May**	**June**	**DY10 Q2**
Total number of High NF LOC files audited	**9**	**13**	**8**	**30**
BCBSNM	3	3	3	9
PHP	6	10	5	21
WSCC	0	0	0	0
Total number of files with correct NF LOC determination	**9**	**13**	**8**	**30**
BCBSNM	3	3	3	9
PHP	6	10	5	21
WSCC	0	0	0	0
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	0%	0%	0%	0%
Low NF Determinations	**April**	**May**	**June**	**DY10 Q2**
Total number of Low NF LOC files audited	**24**	**20**	**25**	**69**
BCBSNM	3	3	3	9
PHP	19	15	20	54
WSCC	2	2	2	6
Total number of files with correct NF LOC determination	**24**	**20**	**25**	**69**
BCBSNM	3	3	3	9
PHP	19	15	20	54
WSCC	2	2	2	6
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations	**April**	**May**	**June**	**DY10 Q2**
Total number of High NF LOC determinations completed within required timeframes	**9**	**13**	**8**	**30**
BCBSNM	3	3	3	**9**
PHP	6	10	5	**21**
WSCC	0	0	0	**-**
% of High NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	0%	0%	0%	0%
Total number of Low NF LOC determinations completed within required timeframes	**24**	**19**	**24**	**67**
BCBSNM	3	3	3	9
PHP	19	15	20	54
WSCC	2	1	1	4
% of Low NF LOC determinations completed within required timeframes	**100%**	**95%**	**96%**	**97%**
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	50%	50%	67%

Source: DY10 Q2 MCO Internal Audit Results

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

Community-Based Internal Audits	April	May	June	DY10 Q2
Total number of Community-Based NF LOC files audited	**94**	**97**	**92**	**283**
BCBSNM	30	30	30	90
PHP	58	61	56	175
WSCC	6	6	6	18
Total number with correct NF LOC determination	**94**	**96**	**92**	**282**
BCBSNM	30	30	30	90
PHP	58	60	56	174
WSCC	6	6	6	18
% with correct NF LOC determination	**100%**	**99.00%**	**100.00%**	**100%**
BCBSNM	100%	100%	100%	100%
PHP	100%	98%	100%	99%
WSCC	100%	100%	100%	100%
Timeliness of Determinations	**April**	**May**	**June**	**DY10 Q2**
Total number of Community-Based determinations completed within required timeframes	**94**	**96**	**90**	**280**
BCBSNM	30	29	28	87
PHP	58	61	56	175
WSCC	6	6	6	18
% of Community-Based determinations completed within required timeframes	**100%**	**99%**	**98%**	**99%**
BCBSNM	100%	97%	93%	97%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%

Source: DY10 Q2 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 Q2 was 86%, an increase from DY10 Q1 of 83%.
- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY10 Q2 was 98% and remained consistent from DY10 Q1 of 98%.
- The aggregated Community Based determination/redetermination percentage for DY10 Q2 was 98% and remained consistent with 98% reported for DY10 Q1.

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 Q3 will be reported in the DY10 Q4 report.

Table 20: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	**April**	**May**	**June**	**DY10 Q2**
Total number of determinations/redeterminations completed for High NF LOC requests	**73**	**104**	**105**	**282**
BCBSNM	17	38	30	85
PHP	48	55	66	169
WSCC	8	11	9	28
Total number of determinations/redeterminations that met High NF LOC criteria	**68**	**89**	**86**	**243**
BCBSNM	13	30	16	59
PHP	47	49	61	157
WSCC	8	10	9	27
% of determinations/redeterminations that met High NF LOC criteria	**93%**	**86%**	**82%**	**86%**
BCBSNM	76%	79%	53%	69%
PHP	98%	89%	92%	93%
WSCC	100%	91%	100%	96%
Low NF Determinations	**April**	**May**	**June**	**DY10 Q2**
Total number of determinations/redeterminations completed for Low NF LOC requests	**370**	**396**	**424**	**1190**
BCBSNM	93	123	163	379
PHP	245	240	229	714
WSCC	32	33	32	97
Total number of determinations/redeterminations that met Low NF LOC criteria	**364**	**386**	**412**	**1162**
BCBSNM	90	118	152	360
PHP	242	235	228	705
WSCC	32	33	32	97
% of determinations/redeterminations that met Low NF LOC criteria	**98%**	**97%**	**97%**	**98%**
BCBSNM	97%	96%	93%	95%
PHP	99%	98%	100%	99%
WSCC	100%	100%	100%	100%

Source: DY10 Q2 MCO NF LOC Determinations Report

Table 21: MCO NF LOC Determinations – Community-Based

Community Based Determinations	April	May	June	DY10 Q2
Total number of determinations/redeterminations completed	**2,055**	**2,184**	**2,409**	**6,648**
BCBSNM	594	535	587	1,716
PHP	1,385	1,555	1,629	4,569
WSCC	76	94	193	363
Total number of determinations/redeterminations that meet NF LOC criteria	**2,020**	**2,139**	**2,366**	**6,525**
BCBSNM	588	517	568	1,673
PHP	1,357	1,529	1,613	4,499
WSCC	75	93	185	353
% of determinations/redeterminations that meet NF LOC criteria	**98%**	**98%**	**98%**	**98%**
BCBSNM	**99%**	**97%**	**97%**	**97%**
PHP	**98%**	**98%**	**99%**	**98%**
WSCC	**99%**	**99%**	**96%**	**97%**

Source: DY10 Q2 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 Q2:
Aggregated results for NF LOC determinations from EQRO were 89% in agreement with High NF. The EQRO had one disagreement on a determination in April and May of the quarter for WSCC, 92% in agreement with Low NF. One disagreement with BCBS in April and one in May with WSCC, 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 Q3 will be reported in the DY10 Q4 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**		
BCBSNM	6	6		
PHP	6	6		
WSCC	6	6		
Number of Member files the EQRO agreed with the determination	**18**	**16**		
BCBSNM	6	6		
PHP	6	6		
WSCC	6	4		
% of Member files the EQRO agreed with the determination	**100%**	**89%**		
BCBSNM	100%	100%		
PHP	100%	100%		
WSCC	100%	67%		
Low NF Determination	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**36**	**36**		
BCBSNM	12	12		
PHP	12	12		
WSCC	12	12		
Number of Member files the EQRO agreed with the determination	**36**	**33**		
BCBSNM	12	11		
PHP	12	12		
WSCC	12	10		
% of Member files the EQRO agreed with the determination	**100%**	**92%**		
BCBSNM	100%	92%		
PHP	100%	100%		
WSCC	100%	83%		
Community-Based	**DY10 Q1**	**DY10 Q2**	**DY10 Q3**	**DY10 Q4**
Number of Member files audited	**90**	**90**		
BCBSNM	30	30		
PHP	30	30		
WSCC	30	30		
Number of Member files the EQRO agreed with the determination	**90**	**90**		
BCBSNM	30	30		
PHP	30	30		
WSCC	30	30		
% of Member files the EQRO agreed with the determination	**100%**	**100%**		
BCBSNM	100%	100%		
PHP	100%	100%		
WSCC	100%	100%		

Source: DY10 Q2 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. The DY10 Q2 results for PM #2 and PM #3 are reported in New Mexico's DY10 Q3 report below.
    - PM #1: Percentage of required HCBS reports submitted timely by the MCOs
        - 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 Q2 100% compliance, DY10 Q3 100% compliance
        - Report #8, *Nursing Facility Level of Care* – DY10 Q2 100% compliance, DY 10 Q3 100% compliance
        - Report #35, *Electronic Visit Verification*- DY10 Q2 100% compliance, DY10 Q3 100% compliance
    - PM #3: Percentage of required HCBS reports submitted accurately without an HSD rejection.
        - Report #4, *Community Benefit* – DY10 Q2 100% compliance, DY10 Q3, DY10 Q3 83% compliance (one MCO's report was rejected one time)
        - Report #8, *Nursing Facility Level of Care* –DY10 Q2 100% compliance, DY10 Q3 100% compliance
        - Report #35, *Electronic Visit Verification* – DY10 Q2 100% compliance, DY10 Q3 100% compliance

- 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 DY9 Q2, HSD began to work on developing measures to monitor the HCBS Qualified Provider requirements. In DY9, there were a total of 304 approved Community Benefit providers. In DY10 Q1, HSD continued to receive and review applications for incoming CB providers. HSD reviews and approves all Agency-Based Community Benefit (ABCB) providers to ensure that

they meet all program requirements as outlined in Section 8 of the Managed Care Policy Manual. Providers must obtain this program approval from HSD prior to 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. In late DY10 Q3, the MCOs began their annual 2023 audit of all CB providers. HSD will report on these audit results in DY11.

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

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

back-up plan; disaster plan; progress notes; claims; and eligibility data. A total of 8 performance measures are reviewed for each record. MCO agreement/acceptance of the review determination (met or not met) for each performance measure is captured prior to the conclusion of the review. Following is a summary of DY10 Q2 monitoring results:

- Statewide, 94 records are reviewed each quarter, which began January 1, 2023.
- DY10 Q2 indicates 100% compliance across all performance measures for PHP and WSCC. BCBS indicates 97% compliance on PM #4 and PM #6, and 100% compliance for all other PMs.

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

The tables below include a summary of the quarterly HCBS Service Plan data for DY10 Q2. The DY10 Q3 data will be reported on the DY10 Q4 CMS Quarterly Monitoring Report

Table 23: HCBS Service Plan Review Summary

Eligible Population and Sample Size, DY10 Q2			
MCO	Eligible Population for DY10 Q2	MCO % of Entire HCBS Population in DY10 Q2	Number of HCBS Files Reviewed for DY10 Q2
BCBS	4,654	25%	34
PHP	12,723	67%	54
WSCC	1,534	8%	6
Centennial Care	**18,911**	**100%**	**94**

Service Plan Review Results DY10 Q2						
Performance Measure	**MCO**	**Total Files Reviewe**	**# of Files Met**	**# of Files Not Met**	**# of Files Not Applicable**	**% of Files Met**
Member's choice to receive HCBS services versus institutional care is documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's choice of HCBS services and providers are documented in a written comprehensive care plan	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's HCBS service plan adequately addressed his/her assessed needs	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Services authorized by the MCO were delivered in accordance with the HCBS service plan, including the type, scope, amount, duration, and frequency are specified in the HCBS service plan	BCBS	34	33	1	0	97%
	PHP	54	54	0	0	100%
	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	13	0	21	100%
	PHP	54	9	0	45	100%
	WSCC	6	0	0	6	100%
	Statewide	**94**	**22**	**0**	**72**	**100%**
A disaster preparedness plan specific to the member was in the HCBS service plan and 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 eligibility start and end dates are documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Linkages to protective services are documented	BCBS	34	0	0	34	100%
	PHP	54	0	0	54	100%
	WSCC	6	0	0	6	100%
	Statewide	**94**	**0**	**0**	**94**	**100%**

Source: DY10 Q2 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 and during the Quarterly Critical Incident Meeting.

In DY10 Q2, HSD observed the following as compared to DY10 Q1: For the number of all substantiated critical incidents identified, an increase of 48%. For Performance Measure #1d, a 42% decrease for Unexpected Death. For Performance Measure #4b, a 23% decrease for follow up actions (safety plans, corrective action plans, etc.) included investigation and educating individuals and families was completed. For Performance Measure #5a 87% decrease for the percentage of substantiated individual critical incidents where referrals to APS were completed. 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. For Performance Measure #6a, HSD has adjusted BCBS data for the percentage of providers and MCO staff educated about reporting critical incidents to the HSD Portal initially at the start or at hire during the reporting period due to updates to the number of providers attending the trainings. The DY10 Q2 Total by Quarter includes those changes. 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 Q2:

Table 24: Critical Incidents Performance Measures

Critical Incident Performance Measures (CI PM)				
CI PM	BCBS	PHP	WSCC	Total by Quarter
	Q2	Q2	Q2	Q2
The number of all substantiated critical incidents.	11,040	35,687	2,282	49,009
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:				
	Q2	Q2	Q2	Q2
1.a. Percentage of substantiated individual abuse incidents identified and reported.	0.98	0.47	1.27	0.91%
1.b. Percentage of substantiated individual neglect incidents identified and reported.	75.72	78.68	83.65	79.35%
1.c. Percentage of substantiated individual exploitation incidents identified and reported.	0.75	0.18	0.35	0.43%
1.d. Percentage of substantiated individual unexpected death incidents identified and reported.	0.4	0.15	0.31	0.29%
CI PM	BCBS	PHP	WSCC	Percentage by Quarter
PM #2: The percentage of substantiated critical incidents being reported within the required timeframe.				
	Q2	Q2	Q2	Q2
Percentage of substantiated critical incidents being reported within 24 hours.	92.51	56.02	95.31	81.28%
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:				
	Q2	Q2	Q2	Q2
Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed.	83.74	98.6	47.41	76.58%

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:				
	Q2	Q2	Q2	Q2
4.a. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents.	31.88	21.32	47.41	33.54%
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.	27.15	2.65	40.01	23.27%
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):				
	Q2	Q2	Q2	Q2
5.a. Percentage of substantiated individual critical incidents where referrals to APS were completed.	2.3	4.21	4.03	3.51%
5.b. Percentage of substantiated individual critical incidents where referrals to CPS were completed.	0.08	0.06	0	0.05%
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:				
	Q2	Q2	Q2	Q2
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.	92.11	10.05	1.3	34.49%
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:				
	Q2	Q2	Q2	Q2
The percentage of substantiated Members with Multiple critical incidents identified and reported.	62.18	84.85	88.83	78.62%

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 compiled partial data for DY10 Q1 and is working with the MCOs to obtain regular and consistent reporting for review by the EQRO for all quarters, therefore reporting for financial accountability is pending. Below is a partial reporting from one MCO. HSD will present DY10 data for all MCOs in the next quarterly report.
    - For DY10 Q1, NM has data for BCBS only. Of the 1,727 DY10 Q1 claims reviewed, 100% of claims were not overpaid.

8
AI/AN REPORTING

Access to Care

According to MCO Report #55, *Geographical Access Report* for Q3 2023:

- BCBSNM reported 46.9% access to behavioral health services in rural areas and 79.5% access in frontier areas. For physical health, BCBSNM reported 46.9% in rural areas and 81.9% in frontier areas.
- PHP reported 66.4% access to behavioral health services in rural areas and 88.3% access in frontier areas. For physical health, BCBSNM reported 66.4% in rural areas and 88.4% in frontier areas.
- WSCC reported 43.4% access to behavioral health services in rural areas and 87.4% access in frontier areas. For physical health, WSCC reported 43.4% in rural areas and 87.4% in frontier areas.

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

Following are DY10 Q3 updates on contracting between MCOs and I/T/U providers.

MCO	Status of Contracting with MCOs
BCBS	BCBS reports they are open and willing to contract with any I/T/U provider. However, they have been unsuccessful in contracting with Navajo Area IHS. Additional information has been requested from BCBS about the lack of success in contracting with Navajo Area IHS. An update will be provided in the Q4 report.
PHP	PHP reports they are providing benefit education sessions at several Tribal sites and introductory meetings to discuss mutual partnership agreements. They also provide technical assistance as requested by Tribes on billing or developing their program initiatives. For the larger Tribal facilities PHP has discussed VBP agreements.
WSCC	WSCC is working with Tribes and IHS on developing additional services, building out their scope of work with the Tribal CHR program as well as reimbursement discussions. WSCC is working on Letters of Agreement with Tribal programs, working on contracting with an assisted living program, and focusing on quality outcomes for HEDIS measures.

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

According to MCO Report #47, *Claims Activity Report* for Q3 2023:

- BCBSNM processed 99.6% clean claims within 15 days and 100% clean claims within 30 days.
- PHP processed 98.4% clean claims within 15 days and 99.6% clean claims within 30 days.
- WSCC processed 99.1% clean claims within 15 days and 99.7% clean claims within 30 days.

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

Native American Technical Advisory Committee (NATAC) Issues and Recommendations

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 September 18, 2023 NATAC discussed the following concern:

- Tribes voiced concern over a recent fund that appropriated money to rural counties for funding to help defray operating losses for new or expanded services. To apply for this funding, the county had to have a population below 100,000. There are some counties in New Mexico that have both urban and rural populations within the geographic area of the county therefore they were exempt from applying for the funds. Sandoval County is considered an urban county, yet they have at least seven Tribes in that county that are rural and frontier.

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 Issues and Recommendations

The following issues were raised at the September 2023 NATAC meeting.

MCO	DATE	Issues/Recommendations
BCBSNM	August 10, 2023 Hybrid meeting – Shiprock Dine Youth Complex	Since this was a hybrid meeting, BCBSNM reported 16 attendees. **Issue:** One member asked "How do I qualify for the Walmart delivery benefit?" **Response:** BCBSNM staff asked if the individual had a care coordinator. The response was "yes" so the staff member contacted the care coordinator to help the family process their Walmart delivery request. **Issue:** A member said she was having trouble using the ModivCare app for transportation. The member tried calling ModivCare but they didn't answer and didn't return the member's call. **Response:** A BCBSNM staff member followed up with ModivCare to address the member'. **Issue:** Another member asked how to go about getting a wheelchair. **Response:** BCBSNM staff reached out to the power of attorney for the member to explain the process to get a wheelchair. (This conversation was in the Navajo language.)
PHP	August 31, 2023 Virtual meeting	This was a virtual meeting. There were 16 members in attendance. **Issue:** Member said she changed her address in April and was told to call ISD with the address change. **Response:** PHP Tribal Liaison walked member through the process of getting her address updated. PHP posted a link with instructions on how to change their address. **Issue**: Member indicated they have been waiting for a care coordinator since April. **Response**: PHP got in touch with member ASAP. The care coordinator contacted the member and completed the HRA.
WSCC	August 25, 2023 Virtual meeting	The Native American Advisory Board meeting on August 25, 2023 was a virtual meeting. There were 4 members in attendance and 20 guests. **Issue**: WSCC informed the audience that due to the RFP process WSCC will not be an MCO under Turquoise Care which begins July 1, 2024.The only question that was asked at the meeting was "How long will the program (WSCC) last?" **Response:** WSCC responded that they will continue to serve members now through July of 2024.

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. Service Level (85% or more calls answered by a live person within 30 seconds), Nurse Advice line (85% or more calls answered by a live person within 30 seconds), Provider Services line (85% of calls answered within 30 Seconds) were all in compliance as of February and March 2022. **Closed** **DY10 Q3 update:** Plan of Action (POA) related to call center remains open. BCBS continues to monitor the call center metrics that include: A-Leg Pick-ups (ride provided from a members residence to doctors appointment or from appointment to appointment), provider no shows, and member satisfaction. For Q3 2023, ModivCare met all metrics except A-Leg Pick-ups. A-Leg Pick-up was not met during this reporting period due to Digital Timekeeping Errors, Digital App Error, and Standing Order Set Up which was identified in mid-July and corrected. BCBSNM saw a 2% improvement from Q3. 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 which includes A-Leg Pick-ups. BCBSNM continues to monitor A-Leg Pick-ups closely. Metrics for ASA (average speed of answer), Abandonment Rate and Service level did not meet standards in September 2023. During the period between September 7 – September 12, 2023, the intelligent virtual agent (IVA) was not activated in the system. This misstep caused an overflow in call volume, leading to the higher wait times. Those 4 days (Sept 7 – 12) impacted ModivCare's Contact Center SLAs for the month of September 2023. Below are the most current statistics: **July 2023 – September 2023 (average):** ASA = 00:18 seconds (Met) Abandonment Rate = 0.44% (Met)

	Service Level = 91.3% (Met) Member Satisfaction = 92.7% (Met) A-Leg Pick-up = 88.6% (**Not Met**) Provider No-Shows = 35.66 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 that are ambulatory (can walk safely on their own to/from vehicle) and will start this service in specific counties. HSD receives bi-weekly updates and continues to carefully review the ModivCare remediation plan and 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.

PRESBYTERIAN HEALTH PLAN	
ACTION PLAN	Secure Transportation
IMPLEMENTATION DATE	03/04/21
COMPLETION DATE	In Process
ISSUES	Improvement Plan – Network Adequacy
RESOLUTION	Secure Transportation (ST) was placed on an improvement plan for the network issues. Monthly meetings will be held between ST and PHP leadership to review issues/concerns. 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.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Secure Transportation 2022 Annual Audit
IMPLEMENTATION DATE	03/17/23
COMPLETION DATE	07/24/23
ISSUES	Secure 2022 Annual Audit noncompliance with credentialing and recredentialing process and procedures
RESOLUTION	Secure 2022 annual audit resulted in a determination of noncompliance related to their credentialing and recredentialing process and procedures. A Corrective Action Plan was begun in DY10 Q1 was closed 7/24/23. The 2023 annual audit will be conducted in November 2023.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Payment Error- Reprocessing and Recoupment of Payments
IMPLEMENTATION DATE	9/20/22
COMPLETION DATE	Open item
ISSUES	Payment Error- Reprocessing and Recoupment of Payments, Temporary Economic Recovery Payments increase for Home and Community Based Services (HCBS)
RESOLUTION	During a routine audit of payments issued 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.

	WESTERN SKY COMMUNITY CARE
ACTION PLAN	Secure Transportation No-Show Remediation Plan
IMPLEMENTATION DATE	11/17/22
COMPLETION DATE	07/24/23
ISSUES	Secure Transportation (Secure) has not met performance measures for driver no-shows for critical care appointments for the period beginning in July 2022.
RESOLUTION	The expectation is that driver no-shows are reduced to 1% of total monthly critical care trips. Secure provided a remediation plan to WSCC. The plan includes Secure, WSCC, and Uber Health working to gain approval for Uber Health (and other rideshare providers) to be able to operate in the state. This plan also includes initiatives with Secure senior leadership team to analyze the network and provide feedback on matching capacity to demand, discussion around reimbursement rates, and reducing the number of driver no-shows. HSD approved WSCC plans and is closely monitoring this. WSCC determined that Secure did not meet the required metrics for the remediation plan. Financial penalties were assessed, the plan was closed 7/24/23, and WSCC continues to monitor Secure's performance. On 9/6/23, WSCC informed HSD that the notice of termination of the WSCC contract with Secure was withdrawn, and that WSCC will continue to contract with Secure for NEMT services through the end of the contract period, 6/30/24.

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FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY10 Q3 reflects the capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 21, 2022. On weighted average, the CY 2023 rate is slightly lower than that of CY 2022 and fee-for-service claim payments for CY 2023 are still lagging. In addition, data runs out for CYs 2022 and 2023 will continue and the PMPMs will continue to change as expenditures come in (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). Attachment A – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis indicates that DY8 is 10.9% below the budget neutrality limit (Table 8.5) through 11 quarters of payments. For DY9, Table 9.5 shows a 7.1% below the budget neutrality limit with data through seven (7) quarters. Table 10.5 shows a 18.4% below the budget neutrality limit for DY10 with preliminary data of 3 quarters.

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MEMBER MONTH REPORTING

Member Months		2023
		3
MEG1	0-FFS	83,644
	Presbyterian	598,390
	Western Sky	124,234
	Blue Cross Blue Shield	398,157
	Total	**1,204,425**
MEG2	0-FFS	6,446
	Presbyterian	62,257
	Western Sky	12,373
	Blue Cross Blue Shield	38,331
	Total	**119,407**
MEG3	0-FFS	0
	Presbyterian	65,444
	Western Sky	11,799
	Blue Cross Blue Shield	33,566
	Total	**110,809**
MEG4	0-FFS	335
	Presbyterian	334
	Western Sky	48
	Blue Cross Blue Shield	242
	Total	**959**
MEG5	0-FFS	0
	Presbyterian	9,327
	Western Sky	1,659
	Blue Cross Blue Shield	7,081
	Total	**18,067**
MEG6	0-FFS	68,404
	Presbyterian	364,353
	Western Sky	104,290
	Blue Cross Blue Shield	288,931
	Total	**825,978**
MG10	0-FFS	17
	Presbyterian	75
	Western Sky	17
	Blue Cross Blue Shield	78
	Total	**187**
MGX8	0-FFS	0
	Presbyterian	239
	Western Sky	75
	Blue Cross Blue Shield	248
	Total	**562**
Total		**2,280,394**

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 Q3, the reports submitted by MCOs for July through September were reviewed and analyzed. It was determined reports were in compliance with contractual requirements. HSD observed in DY10 Q3, the top primary member grievance code continues to be Transportation Ground Non-Emergency. The year to date total demonstrated a 3.8% decrease from DY10 Q2.

The second top primary member grievance code reported was Provider Specialist. The year-to-date total demonstrated a 31% increase from DY10 Q2. The table below is a summary of the quarterly data reported by the MCOs for DY10 Q3:

Table 25: Grievances Reported

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

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 Q3, the reports submitted by MCOs for July through September were reviewed and analyzed. It was determined reports were in compliance with contractual requirements. HSD observed in DY10 Q3, the top primary member appeals code continues to be Denial or limited authorization of a requested service. The year to date total demonstrated a 5% decrease from DY10 Q2.

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 64% decrease from DY10 Q2. BCBS data reflects the notable change. BCBS contributes the decrease to a change in

the timeframe to submit transportation reimbursement forms from 30 days to 60 days to allow member's more time to complete and submit required forms.

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 Q3.

Table 26: Appeals Reported

Appeals Reported (January - September 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		627	582	581		56	56	71		1,217	1,226	1,061	
Number of Expedited Member Appeals	35	29	32		23	28	17		12	11	9		70	68	58	
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		624	583	568		65	60	71		1,086	1,053	1,005	
Denial in whole of a payment for a service	165	199	63		15	12	12		0	0	0		180	211	75	
Variable Appeals	7	8	12		11	15	18		3	7	9		21	30	39	

Source: MCO Report #37

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QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HSD's Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference 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 Q3	**Quarterly Quality Meeting** HSD holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HSD updates and guidance on required quality monitoring activities as well as relay HSD findings from the monthly, quarterly, and annual reports submitted by the MCOs. HSD's Quality Bureau, Performance Measures Unit, held the QQM for DY10 Q3 on September 27, 2023. HSD reviewed findings of the quarterly and monthly monitoring of performance and provided information on how performance measures were trending towards meeting the HSD performance measure targets. HSD reviewed the State Fiscal Year 2024 (SFY24) Legislative Finance Committee (LFC) PMs and their assigned targets. MCO provided guidance on the measure reporting and requested the MCO include details of strategies, interventions, and barriers in the report analysis tab. HSD reviewed and discussed the DY9 performance outcomes for the quality measures assigned for each of the hospital directed payment initiatives. The MCOs were directed to reach out to the participating hospitals to collaborate on how to improve inpatient quality of care, improve member outcomes, and address follow-up care after the members discharge from the hospital. HSD provided an update on all EQRO activities ongoing reviews and validation for both 2022 and 2023 and the status of reports for 2022. HSD presented findings of the quarterly Tracking Measure reporting and provided measure specific reviews of areas of concern such as TM #7 Smoking Cessation. HSD requested the MCO develop a means by which to track successful cessations for members receiving cessation counseling

through the MCO sponsored Quitline.

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 3 (M3), the MCOs reported the following average rates: BCBS 30.40%, PHP 27.05%, and WSCC 26.16%.

The DY10 HSD annual target rate for PM #3 – *Prenatal Care* (PPC) is 84.75%. Through DY10 M3, the MCOs reported the following average rates for Timeliness of Prenatal Care: BCBS 58.50%, PHP 66.71%, and WSCC 56.87%.

The DY10 HSD annual target rate for PM #5 – *Childhood Immunization Status* (CIS) is 71.78%. Through DY10 M3, the MCOs reported the following average rates for Combination 3 Immunizations: BCBS 29.9%, PHP 45.44%, and WSCC 41.47%.

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.

	<u>BCBS:</u> **W30:** M4 40.66%; M5 46.32%; M6 51.93%. Increase of 11.27 percentage points from M4 to M6. **Strategies and Interventions:** Quality Management (QM) staff continue to perform member telephonic outreach, which helps support BCBS in the scheduling of member well child visits and serves as a reminder to the parent/guardian that their child may be due for a well child visit. QM Specialists make 3 call attempts for members who are unable to be reached the first time and BCBS has witnessed that more than 1 call attempt continues to be more effective in connecting with members to assist parent/guardian in scheduling and completing well child visits in the first 15 months of life. Well-child visit reminder post cards for Spanish speaking members that may be due for a well-visit, along with immunizations, are currently awaiting Spanish translation and distribution to the parent/guardian. To better understand how many members went on to complete their visit, the efforts will be monitored by a list of members who received the reminder postcard. **PPC:** M4 58.24%; M5 58.82%; M6 58.80%. Increase of .56 percentage points from M4 to M6. **Strategies and Interventions**: Through value-based contracts, BCBS continues to socialize and provide incentives during provider joint operating committee meetings where scorecards are analyzed to resolve gaps in care and concerns for the PPC TOPC measure. BCBS Special Beginnings Program (SB) continues to collaborate with their 2 vendors, Finity Baby Smart and Families First, to be more inclusive in addressing the pregnant and high-risk populations. With ongoing monthly reports being submitted to BCBS, Tricore and SB continue their collaboration on acknowledging newly identified pregnant members who are early in their first trimester. **CIS:** M4 51.81%; M5 53.02%; M6 54.37%. Increase of 2.56 percentage points from M4 to M6.

	Strategies and Interventions: BCBS QM Specialists are supporting the members parent/guardian in discovering new providers and assisting them in scheduling appointments with their newly referred provider. BCBS Quality and Operations Staff continue to work with each provider group by closing gaps to reduce barriers and improve CIS-3 rates. BCBS "Got Shots?" campaign is currently in place and is tailored for members ages 1 month to 21 years to ensure those members who are attending school have received their immunization prior to the beginning of the school year. **<u>PHP:</u>** **W30:** M4 38.64%; M5 44.88%; M6 49.88%. Increase of 11.24 percentage points from M4 to M6. **Strategies and Interventions**: PHP continues social media outreach by utilizing their Facebook platform where they post 2 messages encouraging members to schedule well-care visits and complete immunizations. PHP social media posts are monitored by quarterly data from their internal social media and Quality Communications team and show the number of followers who view, share and like specific posts. PHP also continues their ongoing telephonic outreach to members by reminding them to schedule and attend recommended well-care visits. PHP creates newsletters and emails, that they send to members quarterly, reminding them to schedule well-care visits along with reminders about the Baby Bonuses gift card reward program. **PPC:** M4 67.48%; M5 67.27%; M6 67.34%. Decrease of 0.14 percentage points from M4 to M6. **Strategies and Interventions**: With new innovative methods and techniques, PHP continues working on and moving towards a more user-friendly Baby Benefits portal that keeps the program easy to use, understand and overall improves the member's experience which in turn helps keep the member engaged in prenatal and postpartum care. PHP also monitors the number of enrollments of

	participation in the Baby Benefits program to increase community, member, and provider education. To further promote the Baby Benefits program, PHPs Performance Improvement team presented Baby Benefits at the Native American Consumer Advisory Meeting and Medicaid Consumer Advisory Board PHP also created verbiage for new member platforms that educate members on the importance of prenatal and postpartum care. **CIS:** M4 54.29%; M5 55.99%; M6 56.98%. Increase of 2.69 percentage points from M4 to M6. **Strategies and Interventions**: PHP Provider Network Operations have sent emails out to contracted providers reminding them of the 2023 New Mexico Department of Health “Got Shots?” campaign along with reminding providers to encourage members to schedule and complete their needed CIS-3 immunizations. PHP Community Health Workers as well as Care Coordinators continue to refer members in need, to the Secure Transport PHP Centennial Care Benefit that conducts transportation requests for members who have scheduled non-emergency transport ride assistance. PHP continues to send out monthly mailings of Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters that are mailed out to members for this age group reminding them to complete their age-appropriate immunizations. PHP has also increased member education on this measure by collaborating and networking with New Mexico Women, Infant and Children (WIC) offices, New Mexico Children’s Medical Services Division and Presbyterian Health Plan Provider Network Operations on the importance of child immunizations. **WSCC:** **W30:** M4 35.41%; M5 39.52%; M6 42.97%. Increase of 7.56 percentage points from M4 to M6. **Strategies and Interventions:** To make members aware of the My Health Pays Reward program, which provides incentives for those members who are compliant with the W30 measure, WSCC informs

	members through outreach and provides materials shared at community events. WSCC continues their efforts on member outreach by utilizing mPulse to assist with members that are identified as having a gap in care and ensures every avenue has been taken to obtain members information and demographics. Along with member interaction at community health fairs and other local events, WSCC also works with Phone Append to gather alternate member information to make contact with those members and encourage them to schedule their well-child visits. **PPC:** M4 54.64%; M5 54.43%; M6 54.01%. Decrease of 0.63 percentage points from M4 to M6. **Strategies and Interventions:** WSCC continues to refer their pregnant members to the Centennial Home Visiting (CHV) program, which has shown that members participating in the program have had an overall higher compliance rate compared to those outside of the program. WSCC Virtual Baby Showers continue to be conducted where WSCC educates members on how to obtain access, the importance of timely prenatal and post-partum care, as well as incentives that the members may be eligible for. WSCC has also partnered with Families First where they conduct member outreach in addition to referring pregnant members to WSCCs Start Smart For Your Baby (SSFB) program. **CIS:** M4 47.18%; M5 49.39%; M6 50.59%. Increase of 3.41 percentage points from M4 to M6. **Strategies and Interventions**: WSCC continues collaborating with providers who lack the bandwidth to conduct member outreach, to narrow non-compliant members by having the WSCC HEDIS team obtain charts to identify those members as being compliant within the measure. Providers work with WSCC Quality Report Specialists to assist members in conducting outreach as well as scheduling appointments and other visits with the members. WSCC Quality Reporting Specialists are also making in person visits with targeted providers across the state where they share

	tip sheets with one another along with sharing members' information on the CIS measure. **<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 Q2 reporting. ***<u>PM #1 (1 point) – Well-Child Visits in the First 15 Months of Life (W30)</u>*** 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%: Increase of 16.59 percentage points from Q1 to Q2 and 13.98 percentage points below the DY10 target. • PHP Q1 32.32%; Q2 49.88%: Increase of 17.56 percentage points from Q1 to Q2 and is 16.03 percentage points below the DY10 target. • WSCC Q1 28.88*%; Q2 42.97%; Increase of 14.09 percentage points and is 22.94 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 33.02%; Q2 Total 49.78%: Increase of 16.76 percentage points and is 16.13 percentage points below the DY10 target. *Please note corrected WSCC quarterly data rate due to correction made by WSCC on reporting. **MCO Strategies and Interventions:** • BCBS quality management staff continue to call members encouraging parents/guardians to schedule and complete well-child visits and help with scheduling appointments. Member lists were sent to each provider with the goal of reducing barriers and improving rates with quality and operations staff collaborating with each provider group to close the gaps. Performance goal targets continue to be monitored through dashboard data trends ensuring that positive progress toward the target is made. BCBS is working to get a 6x15 member campaign branded and trademarked to deploy a state-wide member education campaign. The 6x15 logo encourages the importance of overlaying a child's first 6 visits within the first 15 months of life. • PHP had two Facebook social media posts regarding Presbyterian Health Services for community members on well-care visits and age-appropriate immunizations. A quarterly email was sent to 565 PHP contracted providers with recommendations for completing 6 visits before 15 months of age and two additional visits before 30 months of age. PHP also increased education for providers, case managers, community

	health workers, and statewide school-based health center clinical and non-clinical staff to educate on recommended well-care visits and timeline for this measure. • WSCC value-based and provider engagement meetings are set monthly to discuss well-child visit interventions, best practices, and share provider scorecards. WSCC QI team has created a well-child flyer to disseminate across various platforms to provide awareness and educate members and their families on the importance of routine 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%: Increase of 7.28 percentage points from Q1 to Q2 and is 42.89 percentage points below the DY10 target. • PHP Q1 12.42%; Q2 15.31%: Increase of 2.89 percentage points from Q1 to Q2 and is 47.62 percentage points below the DY10 target. • WSCC Q1 12.12%; Q2 16.40%: Increase of 4.28 percentage points from Q1 to Q2 and is 46.53 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 12.53%; Q2 Total 17.13%: Increase of 4.6 percentage points from Q1 to Q2 and is

	45.80 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS sponsored an event in DY10 M6, where 124 kids and adults participated in exercises and games educating the children and parents about the importance of a healthy weight. BCBS's Fall Member Newsletter will feature a chart giving parents ideas on keeping their children active and eating nutritious meals and snacks. Existing value-based contracting arrangements with provider groups promoted WCC measure performance as well as the CPT code G0447 continues to be incentivized, offering an increased rate. • PHP emailed providers guidance on recommendations for physical activity counseling. PHP had two social media posts on Facebook to community members on the recommendations to schedule and attend well-care visits and complete age-appropriate immunizations. PHP provided outreach and education to members on the upcoming NM Statewide "Got Shots?" campaign encouraging community members to schedule well-care visits and immunizations. • WSCC is collaborating with providers for back-to-school events to get sports physicals completed. My Health Pays Reward program provides incentives for members who are compliant within the WCC measure. Members receive a WSCC branded Visa gift card that is reloadable when the member completes WCC measures. ***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%: Increase of 0.71

	percentage points from Q1 to Q2 and is 25.95 percentage points below the DY10 target. • PHP Q1 66.68%; Q2 67.34%: Increase of 0.66 percentage points from Q1 to Q2 and is 17.41 percentage points below the DY10 target. • WSCC Q1 55.82%; Q2 54.10%: Decrease of 1.72 percentage points from Q1 to Q2 and is 30.65 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 62.08%; Q2 Total 62.48%: Increase of 0.40 percentage points from Q1 to Q2 and is 22.27 percentage points below the DY10 target. **MCO Strategies and Interventions:** • The Special Beginnings maternity program offered to pregnant members continues to collaborate with Finity Baby Smart and Families First. BCBS clinical value consultants collaborate with value-based providers, offering member gap lists and trainings which allows providers to pull their own up to date gap lists, as well as measure compliance review using scorecards to track and trend progress towards goals identified in their contract. • PHP began preparation for Neuroflow, a new member mobile platform, with a launch date set for DY10 Q3. Referrals for care coordination and community health worker services from the home visiting program, Families First began in DY10 Q2. PHP started the revisions and improvements process to the Baby Benefits program for better member experience and continued research into better identification of early pregnancy. • WSCC partners with Families First to complete Notification of Pregnancy's (NOP) which provides pregnant members access to prenatal care in a timely manner, enrolls them into the Start Smart for Your Baby program and provides care coordination engagement upon pregnancy identification. WSCC members are educated on safe sleep practices, smoking cessation through WSCC Puff Free Pregnancy program, and are

	provided $250 Holistic Care Grants (when available) to put toward the purchase of a crib or any equipment needed for the baby. WSCC educates members on incentives that they may be eligible for, and how to access them as well as the importance of timely prenatal and post-partum care. ***PM #4 (1 point) – Prenatal and Postpartum Care (PPC)*** The percentage of member deliveries that had a postpartum visit on or between 7 and 84 calendar days after delivery. For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY11 M6. **DY10 target is 67.26%.** • BCBS Q1 46.45%; Q2 51.69%: Increase of 5.24 percentage points from Q1 to Q2 and is 15.57 percentage points below the DY10 target. • PHP Q1 52.79%; Q2 58.49%: Increase of 5.7 percentage points from Q1 to Q2 and is 8.77 percentage points below the DY10 target. • WSCC Q1 41.95%; Q2 46.98%: Increase of 5.03 percentage points from Q1 to Q2 and is 20.28 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 49.06%; Q2 Total 54.49%: Increase of 5.43 percentage points from Q1 to Q2 and is 12.77 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS continues with the Special Beginnings maternity program and collaboration with Tricore to identify members early in their pregnancy so that Care Coordination can reach out to the member. The Centennial Rewards program allows BCBS members to accrue points when completing prenatal and postpartum care health activities to redeem points using

	the program catalog which encourages members to obtain the necessary prenatal and postpartum care they require. • PHP began preparation for Neuroflow, a new member mobile platform, with a launch date set for DY10 Q3. Referrals for care coordination and community health worker services from home visiting program Families First began in DY10 Q2. PHP started the revisions and improvements process to the Baby Benefits program for better member experience and continued research into better identification of early pregnancy. • WSCC's mPulse app sends bi-weekly texts reminding postpartum members of their postpartum appointments, status checks, and inquires if members are experiencing barriers. SSFB is available for expecting moms, giving them educational material of all the programs available to them through WSCC. SSFB also provides case management which gives support to mom during and after pregnancy. ***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%: Increase of 6.34 percentage points from Q1 to Q2 and is 17.41 percentage points below the DY10 target.

	• PHP Q1 43.76%; Q2 56.98%: Increase of 13.22 percentage points from Q1 to Q2 and is 14.80 percentage points below the DY10 target. • WSCC Q1 43.01%; Q2 50.59%: Increase of 7.58 percentage points from Q1 to Q2 and is 21.19 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 45.20%; Q2 Total 55.25%: Increase of 10.05 percentage points from Q1 to Q2 and is 16.53 percentage points below the DY10 target. **MCO Strategies and Interventions:** • In DY10 Q2, BCBS continued the “Got Shots?” campaign where staff called members to notify them of campaigns in their area and schedule an appointment. The campaign is aimed at members ages 1 month to 21 years with the intent to ensure school aged children receive immunizations prior to the beginning of the school year. There are currently 85 providers registered to participate in 27 counties in this campaign. Community Health Workers continue to use aWellness Guideline and Information tool to encourage parents/guardians to schedule a well-child visit and immunizations. Member gap lists were sent to each provider group along with quality and operations staff to collaborate on closing the gaps. Performance goals were also measured using dashboards to identify trending progress towards the CIS-3 target goal rate. • PHP’s Presbyterian Healthcare Services (PHS), Presbyterian Medical Group (PMG) and provider groups are participating in the statewide “Got Shots?” campaign encouraging eligible members to complete missed and recommended immunizations for this age group. PHP provided education to value-based programs, the Provider Education Council and PHS clinical operations case managers encouraging provider engagement to members and patients to complete this measure. • WSCC Quality Reporting Specialists and value-based program teams meet monthly with providers for

	engagement meetings. Provider scorecards are reviewed with providers, member gap lists are shared, giving providers the opportunity to conduct member outreach to schedule members for appointments. WSCC partnered with Pfizer for VAKs (Vaccine Adherence in Kids), a national Pfizer program that WSCC takes part in, where members are sent a reminder to make their PCP appointments to complete their immunizations within that calendar year. ***PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase*** The number of members age 18 years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least 180 calendar days (6 months) of continuous treatment with an antidepressant medication. **DY10 target is 35.61%**. • BCBS Q1 33.59%; Q2 38.36%: Increase of 4.77 percentage points from Q1 to Q2 and is 2.75 percentage points above the DY10 target. • PHP Q1 40.87%; Q2 45.66%: Increase of 4.79 percentage points from Q1 to Q2 and is 10.05 percentage points above the DY10 target. • WSCC Q1 35.87%; Q2 42.07%: Increase of 6.2 percentage points from Q1 to Q2 and is 6.46 percentage points above the DY10 target. • MCO Aggregate: Q1 Total 37.46%; Q2 Total 42.47%: Increase of 5.01 percentage points and is 6.86 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS's posted communications with providers including tip sheets on their Blue Review and Life and Times Connect site to help providers encourage medication adherence. BCBS staff continued outreach calls in DY10 Q2, reminding members to refill their anti-depressant medication. BCBS continued a member refill

	incentive for members who meet the AMM measure criteria encouraging ongoing medication adherence and maintaining overall well-being. • PHP is analyzing data on AMM by race, age, and gender to identify members who are not likely to continue with medication adherence for educational outreach. PHP's provider interventions range from education to incentive programs with education occurring through the Provider Education Conference, the Provider Newsletter, and the Behavioral Health Townhall. Gap in care letters were also sent to providers during DY10 Q2. • WSCC provides the MyStrength program, which is accessible online and has a mobile app that can be downloaded by members. The program helps develop personal strategies for a variety of areas, such as depression, anxiety, stress, trauma, and mindfulness, by utilizing evidence-based methodologies such as Cognitive Behavioral Therapy, Behavioral Activation, and Acceptance and Commitment Therapy. The program includes simple tools, weekly exercises, mood trackers and daily inspirational quotes and videos. WSCC staff continue to inform members and promote the use of Teladoc Health, a contracted telemedicine vendor that offers virtual appointments for behavioral and physical health 7 days a week. Teladoc behavioral health providers help members with a wide range of needs including access to medication management services with a psychiatrist. ***<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%: Increase of 1.43 percentage points from Q1 to Q2 and is 2.29

	percentage points below the DY10 target. • PHP Q1 51.40%; Q2 51.81%: Increase of 0.41 percentage points from Q1 to Q2 and is 4.27 percentage points above the DY10 target. • WSCC Q1 44.62%: Q2 45.91%: Increase of 1.29 percentage points from Q1 to Q2 and is 1.63 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 47.61%; Q2 Total 48.56%: Increase of 0.95 percentage points from Q1 to Q2 and is 1.02 percentage points above the DY10 target. **MCO Strategies and Interventions:** • BCBS staff continues outreach to members utilizing the Emergency Department Information Exchange (EDIE) system for early notification of an ED admission to provide immediate support and connect members with the proper follow up treatment. Provider interventions include value-based contracting with participating provider groups as well as the IET enhanced payment initiative. • PHP continues their provider education on this measure using IET incentives and identifying the gap of services through a Provider Education Conference and e-mail blasts. PHP has identified geographic areas that have the highest rates of lack of services to incentivize increased provider capacity in these areas. • WSCC continues to collaborate with NM Family Services (NMFS), to perform telephonic outreach to members to complete a telehealth evaluation and engage in treatment. NMFS's team of Certified Peer Support Workers and Licensed Mental Health Clinicians also assist members in connecting with care coordination services and community resources. In DY10 Q2, NMFS's team began educating members about a $30 gift card incentive available to those who complete a telephonic assessment with a positive response. WSCC's Member Connections Team, a specialized team of certified peer support and community health workers, connects with adolescent

members and engages them in follow-up care, connects them and their families with community resources, supports them in navigating systems, and empowers them to take charge of their health and recovery.

<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%: Increase of 6.43 percentage points from Q1 to Q2 and is 0.47 percentage points below the DY10 target.
- PHP Q1 43.08%; Q2 48.10%: Increase of 5.02 percentage points from Q1 to Q2 and is 5.70 percentage points below the DY10 target.
- WSCC Q1 39.91%; Q2 52.65%: Increase of 12.74 percentage points from Q1 to Q2 and is 1.15 percentage points below the DY10 target.
- MCO Aggregate: Q1 Total 44.01%; Q2 Total 50.79%: Increase of 6.78 percentage points from Q1 to Q2 and is 3.01 percentage points below the DY10 target.

MCO Strategies and Interventions:

- In DY10 Q2, BCBS conducted a new provider training on the topic of Maternal Mental Health, which included discussion on the 30 day follow up after hospitalization measure and offered providers a continuing medical education (CME) or continuing education unit (CEU). This training is made accessible for providers who were not in attendance. BCBS continues to offer the reserved appointment initiative to members to secure one appointment for mental health therapy and one appointment for medication management needs.
- PHP is incentivizing BH providers to provide BH

	telehealth services in geographic locations with low access. PHP is also working with their BH provider network to recruit more telepsychiatry groups. PHP is also piloting a discharge planning program to improve coordination of care in members after they are discharged from an acute care facility. • WSCC continues its partnership with TeamBuilders Behavioral Health (TBBH), a contracted behavioral provider, to complete an initial telehealth evaluation with members who have just completed an inpatient behavioral health stay. WSCC has partnered with Sierra Vista Hospital EMS team and Olive Tree to implement WSCC's BH on Board program in the Truth or Consequences (T or C) community and surrounding counties. BH on Board equips first responders from Sierra Vista Hospital with cellular-enabled tablets loaded with a virtual visit platform for on-demand crisis support. WSCC also promotes the use of Teladoc Health, a contracted telemedicine vendor that offers virtual appointments for behavioral and physical health. ***PM #9 (1 point) – Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Day*** The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days of the ED visit. **DY10 target is 48.00%.** BCBS Q1 43.26%; Q2 50.79%: Increase of 7.53 percentage points from Q1 to Q2 and is 2.79 percentage points above the DY10 target. PHP Q1 36.95%; Q2 41.85%: Increase of 4.90 percentage points from Q1 to Q2 and is 6.15 percentage points below the DY10 target. WSCC Q1 35.43%; Q2 45.13%: Increase of 9.70 percentage points from Q1 to Q2 and is 2.87 percentage points below the

	DY10 target. MCO Aggregate: Q1 Total 39.35%; Q2 Total 45.45%: Increase of 6.10 percentage points from Q1 to Q2 and is 2.55 percentage points below the DY10 target. **MCO Strategies and Interventions:** • In DY10 Q2, BCBS trained staff to assist members with follow up care and improve the FUM measure. Clinical and non-clinical staff continue to call members in the second quarter offering assistance with follow-up care and mental health treatment needs. • PHP continues to educate BH providers on the FUM metric and encourage BH providers to partner with EDs to offer behavioral health follow-up appointments. Presbyterian Health Services provides onsite peer consult liaison services at the ED to support members in attending after care appointments. • WSCC receives daily notifications from PointClickCare (PCC), when a member is seen in the ED and a diagnosis indicates the visit was primarily related to mental health concerns. Discharges within 24 to 48 hours may benefit from contact by internal health plan personnel, contracted providers, community partners, or other behavioral health partner programs. WSCC reviews daily claims-based care gap data to identify individuals in the FUM measure who have not yet followed up with an outpatient clinician. WSCC continues to conduct targeted outreach to members to increase access to and engagement in follow up care with a primary care or behavioral health provider after an ED visit for mental health related reasons. ***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%: Increase of 17.95 percentage points from Q1 to Q2 and is 21.34 percentage points below the DY10 target. • PHP Q1 44.06%; Q2 64.32%: Increase of 20.26 percentage points from Q1 to Q2 and is 18.46 percentage points below the DY10 target. • WSCC Q1 35.31%; Q2 60.11%: Increase of 24.80 percentage points from Q1 to Q2 and is 22.67 percentage points below the DY10 target. • MCO Aggregate: Q1 Total 42.56%; Total Q2 62.61%: Increase of 20.05 percentage points from Q1 to Q2 and is 20.17 percentage points below the DY10 target. **MCO Strategies and Interventions:** • BCBS's new member SSD text campaign helps members get a diabetes at-home test kit or connect with a care coordinator for assistance. The text message also includes a video educating members on the SSD measure along with a Spanish translation. The text campaign is set to be distributed in DY10 Q3. Additionally, the SSD quality measure was included during an annual staff training update for staff awareness to help improve member outcomes. The pharmacy team continues to send letters to providers reminding them to schedule appropriate blood glucose or diabetes testing for members. • PHP continues working with their value-based programs team to recruit providers into the Behavioral Quality Incentive Program. PHP offers continuous provider education on SSD and best practices in prescribing antipsychotics through training provided by the medical director and education at the Behavioral Health Townhall and Provider Education Conference meetings for providers. • WSCC implemented a pilot project to assist homeless

	members who do not have a mailbox with completing their screenings and getting connected with care by making in-home A1c test kits available at local homeless shelters in Albuquerque. The Member Connect (MC) Team has gift cards on hand so members can receive their incentive gift card onsite upon completion of testing. WSCC continues to work to build rapport, provide education about the importance of health screenings, and discuss the benefits and convenience of having onsite screening kits easily accessible to individuals who would otherwise struggle to access these types of screenings. WSCC initiated another pilot initiative in DY10 Q2 with NM Community Cares (NMCC), a community paramedicine service, to perform telephonic and face-to-face outreach to members in the SSD measure in need of an A1c screening. The pilot initiative includes Albuquerque, Las Cruces, and Roswell, with plans to expand throughout New Mexico in the future. WSCC provides A1c test kits to NMCC's staff so they can conduct A1c screenings with members in their homes. NMCC will mail the sample to the lab on the member's behalf using the postage-paid envelope included with the kit. **Tracking Measures (TMs)** HSD requires the MCOs to submit quarterly reports for the Tracking Measures listed in the MCO contract. HSD Quality Bureau reviews and analyzes the reports for completeness and accuracy and to gauge positive or negative outcomes and trends. The MCOs report interventions, strategies, and barriers that impact performance outcomes. HSD's review findings are communicated to the MCOs through scheduled MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meetings (QQMs). Numbers and rates reported are cumulative from quarter to quarter for all TMs except for TM #1, which is reported on a 12-month rolling period. The following TMs show results for DY10 Q2 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%: Increase of 0.02 percentage points from Q1 to Q2. • PHP Q1 1.51%; Q2 1.08%: Decrease of 0.43 percentage points from Q1 to Q2. • WSCC Q1 0.11%; Q2 0.10%: Decrease of 0.01 percentage point from Q1 to Q2. • MCO Aggregate: Q1 Total 0.37%; Q2 Total 0.28%: Decrease of 0.09 percentage points from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: Care coordinators, community social workers, community health workers, and the Community Paramedicine program continued to perform fall risk assessments, home safety assessments, and help with durable medical equipment needs for safe mobility and ambulation. • PHP: Care coordination conducted outreach to all members who had been admitted to an inpatient facility to attempt to engage members by developing a transition of care-care plan that implemented proactive interventions to address home safety, fall risk, and any injury that resulted in an inpatient admission. • WSCC: Continued to offer members to participate in care coordination. Care coordinators discussed medications with the potential to increase risk for falls and reminded members to review these medications with their provider. Care coordinators completed an assessment with members, identifying risk for falls and provided education on fall prevention, including monitoring their environment for fall hazards.

	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: Decline in performance of 1.24 per 100,000 member months from Q1 to Q2. • PHP Q1 15.25; Q2 18.49: Decline in performance of 3.24 per 100,000 member months from Q1 to Q2. • WSCC Q1 13.21; Q2 12.62: Improvement in performance of 0.59 per 100,000 member months from Q1 to Q2. • MCO Aggregate: Q1 Total 16.95; Q2 Total 19.05: Decline in performance of 2.10 per 100,00 member months from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: In DY10 Q2 the Quality Improvement Department mailed a new personalized member flyer directly to 11,786 members ages 18 and above with a diagnosis of diabetes to assist members who may have difficulty managing their diabetic condition. The flyer was mailed to members noted to have one of the following: a recent STCA event, A1c testing result >8, or no A1c test in the prior year. The flyer contains education on A1c testing frequency, diabetes complications associated with an A1c test result greater than 8, tips to help manage diabetes, and diabetic resources available including a link to NM HSD's Paths to Health. • PHP: A "Taking Care of Diabetes" link provided to members in email and social media communications was updated in DY10 Q2 to target members with diabetes. • WSCC: Offered members with diabetes to participate in the Diabetic Disease Management program, which

coaches and educates members on management of their diabetes and preventing diabetic complications and hospitalizations.

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%: Increase of 0.31 percentage points from Q1 to Q2.
- PHP Q1 1.08%; Q2 1.29%: Increase of 0.21 percentage points from Q1 to Q2.
- WSCC Q1 0.93%; Q2 1.50%: Increase of 0.57 percentage points from Q1 to Q2.
- MCO Aggregate: Q1 Total 1.00%; Q2 Total 1.28%: Increase of 0.28 percentage points from Q1 to Q2

MCO Strategies and Interventions:

- BCBS: Quick Response (QR) codes were added to existing provider news articles to link providers to an educational video about appropriate billing of depression screenings to help improve the rates of this measure.
- PHP: Performance Improvement Project (PIP) interventions to increase screening for depression in the Primary Care Provider (PCP) environment continued in DY10 Q2.
- WSCC: All providers had access to provider toolkits on WSCC's comprehensive provider-focused website, including subjects such as anxiety, bipolar disorder, depression, health equity, integrated care, substance use disorders, and social determinants of health.

	TM #4 – Follow-up after Hospitalization for Mental Illness The percent of seven-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days. An increase in rate indicates improvement for this measure. • BCBS Q1 35.78%; Q2 38.48%: Increase of 2.70 percentage points from Q1 to Q2. • PHP Q1 32.31%; Q2 33.37%: Increase of 1.06 percentage points from Q1 to Q2. • WSCC Q1 30.08%; Q2 32.65%: Increase of 2.57 percentage points from Q1 to Q2. • MCO Aggregate: Q1 Total 33.16%; Q2 Total 35.22%: Increase of 2.06 percentage points from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: In DY10 Q2, the Quality Department conducted an annual employee training to help employees recognize the Follow-up after Hospitalization for Mental Illness (FUH) measure and how to assist these members released from inpatient psychiatric hospitals. • PHP: A specialized Incentive Program Task team comprised of inpatient care coordination, peer support, and medical director, continued to meet in DY10 Q2 to discuss and coordinate care to reduce rehospitalization rates for individual members with high utilization rates. • WSCC: Continued its partnership with TeamBuilders Behavioral Health (TBBH), a contracted behavioral provider, to complete an initial telehealth evaluation with members who had just completed an inpatient behavioral health stay. Teambuilders' licensed clinicians provided an initial assessment, encouraged members to attend planned aftercare appointments, and, if necessary, connected members with other community resources or behavioral health providers in the member's local neighborhood. During the months of April and May 2023, TBBH successfully engaged 23%

	of members and completed 56 assessments. *<u>TM #5 – Immunizations for Adolescents (IMA)</u>* 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%: Increase of 2.92 percentage points from Q1 to Q2. • PHP Q1 74.64%; Q2 76.87%: Increase of 2.23 percentage points from Q1 to Q2. • WSCC Q1 71.39%; Q2 73.19%: Increase of 1.80 percentage points from Q1 to Q2. • MCO Aggregate: Q1 Total 74.28%; Q2 Total 76.69%: Increase of 2.41 percentage **MCO Strategies and Interventions:** • BCBS: Outreach calls began in June 2023 to schedule and notify members of the "Got Shots?" campaign in their area to ensure school children receive immunizations prior to the beginning of the school year. • PHP: Early Periodic Screening Diagnostic and Treatment (EPSDT) monthly letters were mailed to 2,295 members in DY10 Q2. • WSCC: WSCC partnered with Pfizer for VAKs (Vaccine Adherence in Kids), a national Pfizer program where members were sent a reminder to make their PCP appointments to complete their immunizations within that calendar year. *<u>TM #6 – Long-Acting Reversible Contraceptive (LARC)</u>* Utilization of Long-Acting Reversible Contraceptives. The contractor shall report LARC insertion/utilization data for this measure. • BCBS Q1 182; Q2 148.

	- PHP Q1 293; Q2 596. - WSCC Q1 37; Q2 90. - MCO Aggregate: Q1 Total 512; Q2 Total 834. *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: Increase of 883 members from Q1 to Q2. - PHP Q1 1,364; Q2 3,043: Increase of 1,679 members from Q1 to Q2. - WSCC Q1 281; Q2 587: Increase of 306 members from Q1 to Q2. - MCO Aggregate: Q1 Total 2,725; Q2 Total 5,593: Increase of 2,868 members from Q1 to Q2. **MCO Strategies and Interventions:** - BCBS: Members once again had access to the generic drug Chantix after the recall ended so more members are utilizing Chantix as well as other nicotine products such as the patch. - PHP: All members who used tobacco were offered the Tobacco Cessation program if they were enrolled in care coordination or were identified for disease management health coaching. - WSCC: Continued to offer members access to the Pyx app to encourage members to begin tobacco cessation and educate members on first steps to quitting. Pyx is a member engagement app that addresses loneliness and healthcare needs for the member. *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: Increase of 93.00 per 1,000 member months from Q1 to Q2. • PHP Q1 52.55; Q2 140.10: Increase of 87.55 per 1,000 member months from Q1 to Q2. • WSCC Q1 68.51; Q2 137.41: Increase of 68.90 per 1,000 member months from Q1 to Q2. • MCO Aggregate: Q1 Total 61.89; Q2 Total 149.16: Increase of 87.27 per 1,000 member months from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: BCBS partnered with the MDLIVE telehealth service to help provide additional access to services by increasing utilization of telehealth services. • PHP: Offered the option for at home and remote visits to meet an expanding need for virtual care. • WSCC: Offered members care coordination to assist members with addressing health care needs and barriers. Care coordinators educated members to maintain their health by taking prescribed medications, attending scheduled appointments, and communicating concerns to providers. Care coordinators assisted members with addressing any barriers members may have had with access to care. *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: Decline in performance of 11.87 per 1,000 member months from Q1 to Q2. • PHP Q1 7.01; Q2 18.37: Decline in performance of 11.36 per 1,000 member months from Q1 to Q2. • WSCC Q1 10.96; Q2 21.21: Decline in performance of 10.25 per 1,000 member months from Q1 to Q2.

	• MCO Aggregate: Q1 Total 8.44; Q2 19.85: Decline in performance of 11.41 per 1,000 member months from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: Medical directors and utilization management partnered with care coordination to determine appropriate ED discharges and identified and linked members to outpatient providers to help reduce readmissions. • PHP: The expansion of the Tyto Care at-home PCP and urgent care device, which can perform heart, lung, throat, and skin exams, offers members and patients the option for improved at-home care which may decrease the need for escalated ED visits due to delayed care. • WSCC: Offered members the option for a telehealth appointment with Teladoc. In some cases, this allows a member to avoid ED visit by having their medical concern addressed via a telehealth appointment. *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%: Increase of 15.79 percentage points from Q1 to Q2. • PHP Q1 21.34%; Q2 44.59%: Increase of 23.25 percentage points from Q1 to Q2. • WSCC Q1 17.30%; Q2 35.65%: Increase of 18.35 percentage points from Q1 to Q2. • MCO Aggregate: Q1 Total 20.37%; Q2 Total 40.59%: Increase of 20.22 percentage points from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: Member Advisory Board (MAB) meetings took

	place to provide members with resources to ensure members are completing an annual dental exam. • PHP: Member outreach occurred on social media via PHP's Facebook platform, reminding members of annual dental visits and other wellness appointments. • WSCC: WSCC partnered with Familia Dental for "Dental Days" events and sent Familia Dental a list of non-compliant members for outreach to those members. Familia Dental has several locations around the state and invited these members to complete their annual exam at "Dental Days" in their area. *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%: Increase of 11.54 percentage points from Q1 to Q2. • PHP Q1 25.39%; Q2 35.88%: Increase of 10.49 percentage points from Q1 to Q2. • WSCC Q1 9.38%; Q2 18.85%: Increase of 9.47 percentage points from Q1 to Q2. • MCO Aggregate: Q1 Total 19.82%; Q2 Total 30.66%: Increase of 10.84 percentage points from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: In DY10 Q2, 905 adult members diagnosed as overweight or obese and with hypertension were offered a blood pressure monitor for home use between provider appointments. Approximately 35% of these members expressed interest in having a blood pressure monitor and on June 12, 2023, the blood pressure monitors were mailed to the members who opted in. • PHP: A mailing was sent to 1,550 members in need of blood pressure testing and control in April 2023.

	- WSCC: Offered members with hypertension to participate in the Cardiac Disease Management program. The program allowed members to work with a registered nurse health coach to help members manage cardiac conditions including hypertension. Health coaches promoted adherence to cardiac guidelines, provided medication education, improved medication compliance, educated members about their hypertension diagnosis, promoted heart-healthy nutrition habits, and promoted weight management. *<u>TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)</u>* 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%: Increase of 0.71 percentage points from Q1 to Q2. - PHP Q1 28.70%; Q2 30.08%: Increase of 1.38 percentage points from Q1 to Q2. - WSCC Q1 46.09%; Q2 50.22%: Increase of 4.13 percentage points from Q1 to Q2. - MCO Aggregate: Q1 Total 37.29%; Q2 Total 38.66%: Increase of 1.37 percentage points from Q1 to Q2. **MCO Strategies and Interventions:** - BCBS: A provider article on ADD in the Blue Review news was linked to a HEDIS tip sheet made available to help educate providers on this measure. - PHP: Continued education for providers on the initiation phase of this measure, including the provider newsletter. - WSCC: Staff informed members and promoted the use of Teladoc Health, a contracted telemedicine vendor.

	Teladoc offers virtual appointments for behavioral and physical health 7 days a week. Teladoc behavioral health providers help members with a wide range of needs including access to medication management services with a psychiatrist. As of May 2023, there have been 261 mental health and medication management visits completed. *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 two 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%: Increase of 3.53 percentage points from Q1 to Q2. • PHP Q1 36.04%; Q2 38.07%: Increase of 2.03 percentage points from Q1 to Q2. • WSCC Q1 72.22%; Q2 66.67%: Decrease of 5.55 percentage points from Q1 to Q2. • MCO Aggregate: Q1 Total 45.54%; Q2 Total 48.47%: Increase of 2.93 percentage points from Q1 to Q2. **MCO Strategies and Interventions:** • BCBS: An annual employee training was offered to help employees identify all the measures including the ADD measure. • PHP: PHP 2023 outreach campaign to members to remind them to schedule follow-up visits related to ADHD medications. • WSCC: For members who were experiencing difficulties getting to their appointments, transportation services through Secure Transportation were offered

and encouraged. As of May 2023, 4,465 WSCC members had utilized Secure Transportation.

TM #12 – Child and Adolescent Well-Care Visits (WCV)
The percentage of members 3 to 21 years of age who had at least 1 comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. An increase in percentage indicates improvement for this measure.

- BCBS Q1 9.68%; Q2 21.11%: Increase of 11.43 percentage points from Q1 to Q2.
- PHP Q1 7.67%; Q2 19.21%: Increase of 11.54 percentage points from Q1 to Q2.
- WSCC Q1 8.18%; Q2 16.36%: Increase of 8.18 percentage points from Q1 to Q2.
- MCO Aggregate: Q1 Total 8.41%; Q2 Total 19.54%: Increase of 11.13 percentage points from Q1 to Q2.

MCO Strategies and Interventions:

- BCBS: The Quality Management staff conducted telephonic outreach to members to remind and encourage the parent/guardian to schedule and complete well-child visits and to help members schedule an appointment.
- PHP: PHP completed presentations on recommended well-care visits and age-appropriate immunizations to: New Mexico Department of Health Children's Medical Services in May 2023, PHP Native American Consumer Advisory Board in June 2023, Presbyterian Health Services (PHS) Clinical Operations in June 2023, and the PHS Provider Education Council in June 2023.
- WSCC: The My Health Pays Reward program provided an incentive for members who were compliant with the WCV measure. As members completed targeted measures, the members received a WSCC-branded Visa gift card that is reloadable as the member completed the targeted measures.

	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 under final HSD review. DY9 EQR Reviews and Validation • Compliance review, draft report in development with EQRO • Validation of Performance Improvement Projects, In process with EQRO • Validation of Performance Measures, in process with EQRO • Validation of Network Adequacy, in process. DY9 Annual Technical Report in development, 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 July 2021 – June 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 July 2022 – June 2023 time period.

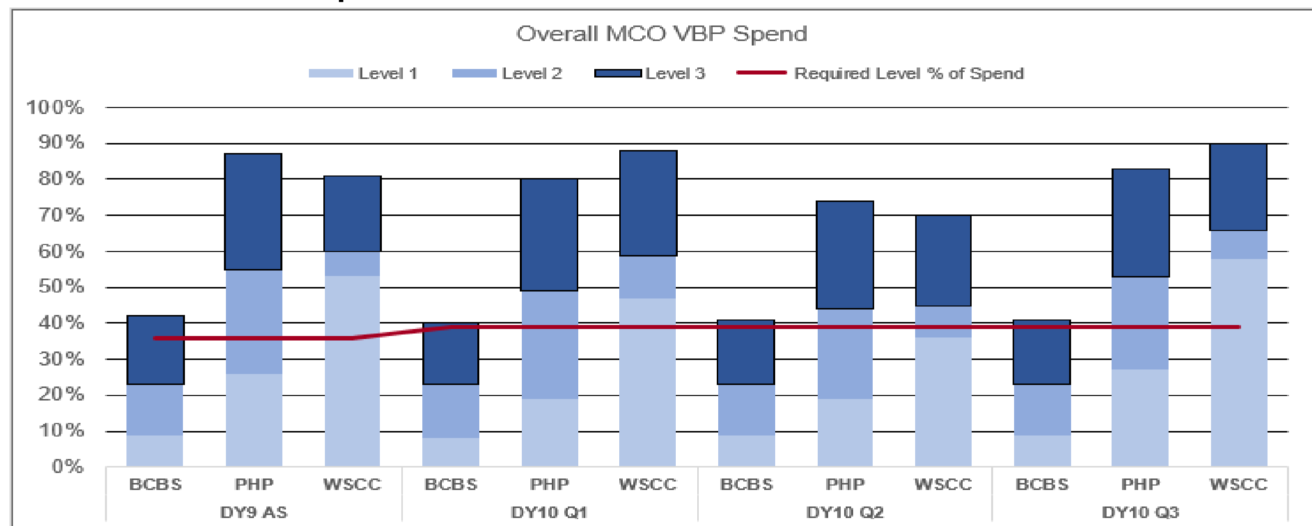
VALUE BASED PURCHASING

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 Q3, BCBS, PHP, and WSCC exceeded the required VBP spend target of 39%.

Table 28: MCO VBP Spend



Source: MCO Calendar Year (CY) 2022 Annual Supplement (AS) and (CY) 2023 Quarter 3 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 Emergency Department (ED) Reduction Program targets members who have visited the ED more than 6 times in the last 6 months. Targeted members are contacted by a community health worker. The goal is to ensure the member is established with a Primary

Care Provider (PCP). Education is provided on the importance of being connected to outpatient care. BCBS's digital texting campaign targets members visiting the ED and will continue throughout DY10. Members who have visited the ED at a minimum of 2 times in the past 60 days are sent a text, with links helping with finding a PCP, location of the nearest urgent care centers and a telephone number for the Nurse Advise Line. This target membership goal is to provide early intervention prior to an established pattern of seeking care in an ED setting. Using an evidenced based approach, lies an opportunity to promote behavior change by the member understanding the importance of being established with PCP care. Critical Incident reports that show a pattern of frequent ED visits, who are not listed as having a care coordinator assigned, will then be referred to care coordination for follow-up an assessment.

PHP members who engage in care coordination are contacted by care coordinators after every ER visit to assess needs, ensure appropriate follow up occurs and to discuss alternatives. Care coordinators conduct ongoing education concerning appropriate ER use, and ensure members are engaged with appropriate providers to minimize ER use when possible. PHP has a peer support ER diversion process that focuses on members with substance use disorder (SUD) who utilize the ER frequently. This program is designed to address the unique needs of members who have a SUD history and, often, have housing insecurity or other social determinants of health (SDOH) needs. PHP's ER diversion program works with the community health worker (CHW) team to address SDOH needs, educate members about alternatives to the ER and support members to seek more appropriate care settings when possible. PHP has a 24/7 nurse advice line that 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 ER utilization. PHP's customer service team is dedicated to assisting members with identifying appropriate providers and scheduling appointments when members have barriers with scheduling. This team ensures that members can access the care they need in a timely manner to avoid unnecessary ER utilization due to issues with provider access. Following hospital admission, the transition of care team engages members to ensure they have access to appropriate post-hospitalization follow up and medical care, such as durable medical equipment. PHP also partners with Albuquerque Ambulance to conduct outreach to members who have a pattern of utilizing the ER for low acuity needs and engages members providing education concerning appropriate ER use and alternatives to ER utilization. They are also able to provide guidance and education concerning specific medical conditions which can help members better understand when ER use is appropriate and when it is better to seek alternative care. PHP encourages the use of the PRESNow facilities, which provide 24/7 access to urgent care, and can provide emergent care when appropriate. For future interventions, PHP plans to leverage TytoCare, which is a platform

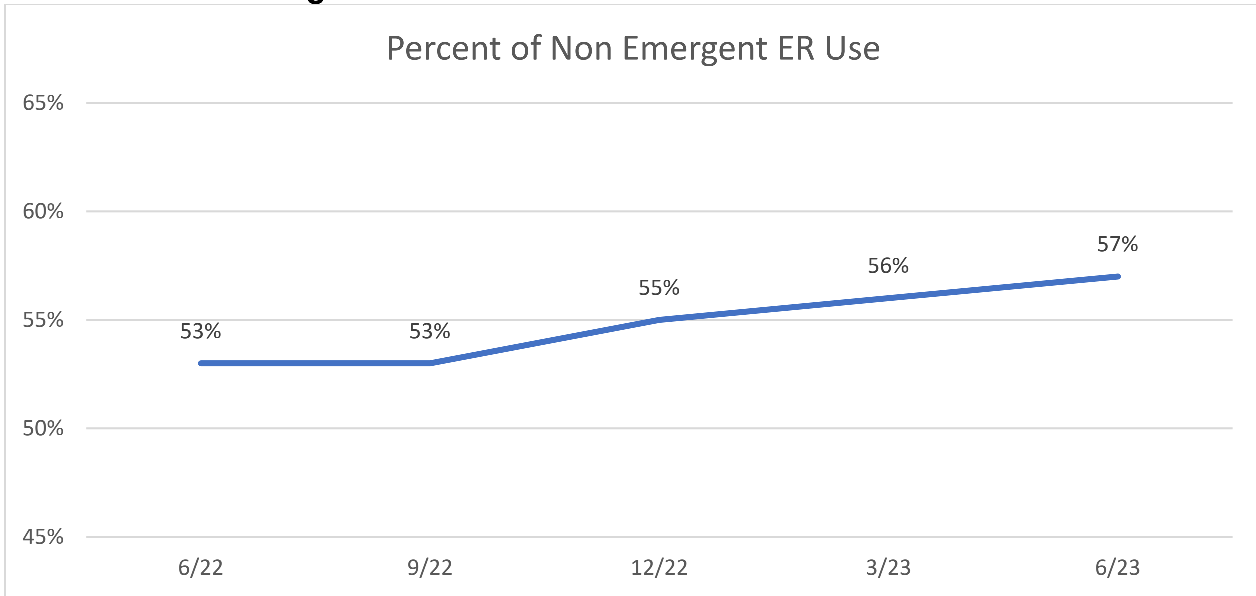
that facilitates electronic visits for low acuity needs. PHP plans to provide TytoCare devices to members who have utilized the ER inappropriately and may reduce ER utilization if they can seek care by using TytoCare rather than going to the ER.

WSCC continues to send text messages to members that utilized the ED through their mPulse program to check in about follow-up care post ED visit, educate about the use of Primary Care, versus urgent care versus emergency department and allows members to access resources through text messages and to respond with any needs they may have. As of June 2023, 1,713 members have received a text message after their ED Visit, 122 members responded that they already had a follow up visit or had one scheduled. Members who respond indicating they have a need for assistance receive telephonic outreach from WSCC either from their assigned care coordinator, if applicable, or from the WSCC Member Connections Team (CHWs/Peer Supports). WSCC care coordinators set alerts, when applicable, in Collective Medical to receive emails when one of their members has an ED visit, to address gaps in care, provide member education, connect members with providers, and assist with transportation or other barriers. WSCC also partners with UNM CHW program for face-to-face emergency department outreach for WSCC members that visit the UNM EDs to engage members prior to leaving the ED and provide education and support as well as a hand off back to the WSCC team for continued follow up. WSCC also 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 also incentivized through a WSCC $30 dollar gift card for having a follow up visit within 14 days of an ED visit for substance abuse as well as educate 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 room 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 Q2 to DY10 Q2. In comparing low acuity ED visits from DY9 Q2 (53%) to DY10 Q2 (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 a steady increase in the number of low acuity ED visits.

The graph below reflects the percentage of members using the ER for non-emergent care between DY8 Q2 and DY10 Q2. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership. The data for DY10 Q3 will be reported in the DY10 Q4 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

All 3 MCOs demonstrated steady access with slight fluctuations during this quarter.

- MCOs performance in access to general hospitals, PCPs, pharmacies, and most specialties in urban, rural, and frontier areas were met.
- Provider shortages have impacted geographic access; however, access has been maintained. MCOs closely monitor the following services and employ ongoing efforts to ensure member access such as targeted recruitments, referral training, provider enrollment training, telehealth options and value-based contract arrangements.
    - Rural areas did not meet standards for certified midwives, with two MCOs.
    - For FQHC – PCP only, 1 MCO did not meet the standards for Rural areas.
    - For dermatology, 1 MCO did not meet the standards for Urban areas and 2 MCOs did not meet the standards for Rural and Frontier areas.
    - For endocrinology, Rural areas did not meet standards and Frontier areas did not meet standards with 2 MCOs.
    - For Ear, Nose, and Throat (ENT), 1 MCO did not meet standards for Rural areas and another MCO did not meet standards for Frontier areas.
    - For Urology, 1 MCO did not meet standards for Frontier areas.
    - For Neurosurgeons, 1 MCO did not meet standards for Urban areas and none of the MCOs met the standards for Rural and Frontier areas.
    - For Rheumatology, 1 MCO did not meet standards for Urban areas and none of the MCOs met the standards for Rural and Frontier areas.

Table 30: Physical Health Geographical Access

Geo Access PH DY10 Q3 (July - September 2023 Data)									
	Urban			Rural			Frontier		
PH - Standard 1	BCBS	PHP	WSCC	BCBS	PHP	WSCC	BCBS	PHP	WSCC
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%	99.9%	100.0%
Pharmacies	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.8%
FQHC - PCP Only	100.0%	100.0%	100.0%	90.3%	79.7%	99.4%	98.8%	90.1%	99.0%
PH - Standard 2									
Cardiology	99.2%	99.0%	99.0%	99.8%	100.0%	100.0%	99.9%	99.9%	99.7%
Certified Nurse Practitioner	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Certified Midwives	99.1%	98.9%	98.9%	81.4%	87.9%	99.9%	99.5%	98.6%	99.7%
Dermatology	79.4%	98.9%	98.8%	70.6%	71.6%	90.1%	85.2%	88.0%	97.9%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	99.1%	98.9%	98.8%	74.1%	65.1%	87.3%	84.0%	84.3%	92.9%
ENT	99.1%	98.8%	98.8%	82.6%	84.9%	100.0%	89.5%	83.7%	97.0%
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/ Oncology	99.10%	98.9%	98.8%	99.6%	94.7%	99.5%	99.4%	98.1%	93.6%
Neurology	99.10%	99.0%	99.0%	99.0%	96.2%	92.1%	93.9%	93.1%	95.6%
Neurosurgeons	99.10%	83.00%	98.80%	39.50%	67.40%	41.10%	67.70%	86.10%	82.20%
OB/Gyn	99.20%	98.9%	98.9%	99.8%	99.8%	100.0%	99.8%	98.1%	99.7%
Orthopedics	99.20%	98.9%	98.8%	95.4%	94.2%	100.0%	96.5%	98.4%	100.0%
Pediatrics	100.00%	98.9%	99.0%	100.0%	100.0%	99.9%	99.9%	98.7%	100.0%
Physician Assistant	100.00%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.20%	98.9%	99.0%	99.8%	99.7%	99.9%	96.7%	98.7%	100.0%
Rheumatology	99.10%	98.9%	98.6%	77.5%	83.6%	74.7%	82.1%	85.5%	79.5%
Surgeons	99.20%	99.0%	99.0%	100.0%	100.0%	100.0%	99.9%	99.9%	99.7%
Urology	99.10%	98.8%	98.8%	91.2%	93.4%	91.4%	89.2%	93.3%	90.7%
LTC - Standard 2									
Personal Care Service Agencies	100.0%	100.0%	100.0%	100.00%	99.7%	99.8%	100.0%	100.0%	100.0%
Nursing Facilities	99.3%	93.0%	99.3%	99.8%	97.7%	99.8%	99.9%	99.9%	99.7%
General Hospitals	99.2%	98.9%	98.8%	99.8%	99.5%	100.0%	100.0%	99.9%	99.7%
Transportation	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: MCO Report #55 GeoAccess Q3 CY22

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 met all call center metrics for the reporting period, DY10 Q3.

PHP met all call center metrics for the reporting period, DY10 Q3.

Except for the Utilization Management line for July, WSCC met all call center metrics for the reporting period, DY10 Q3. In July, the abandonment rate was 5.3% (Standard <5%) and the percentage of calls answered within 30 seconds was 83.4% (Standard 85%). WSCC attributed this performance issue to the shortage of available agents due to absence. WSCC addressed this staffing issue and all metrics were met in subsequent months.

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 Q3.

Table 31: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine	DY9 Q4	DY10 Q1	DY10 Q2	DY10 Q3
New Behavioral Health Members	**6,669**	**41,322**	**12,683**	**8,386**
BCBSNM	2,470	20,353	6,556	4,158
PHP	3,296	16,746	4,603	3,212
WSCC	903	4,223	1,524	1,016
New Physical Health Members	**17,694**	**39,881**	**21,452**	**12,454**
BCBSNM	6,910	11,066	5,823	3,375
PHP	9,235	25,309	13,480	7,969
WSCC	1,549	3,506	2,149	1,110
Total New Unduplicated Members	**19,923**	**75,410**	**29,610**	**17,728**
BCBSNM	7,531	29,516	10,817	6,385
PHP	10,343	39,219	15,837	9,524
WSCC	2,049	6,675	2,956	1,819
YTD* Unduplicated Members	**184,843**	**66,573**	**99,478**	**123,611**
BCBSNM	68,005	26,217	38,394	46,718
PHP	100,411	33,681	50,881	64,580
WSCC	16,427	6,675	10,203	12,313

Source: Telemedicine Delivery System Improvement Performance Target (DSIPT) data is refreshed quarterly* July - October 2023.

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
DY10 Q3	The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) continued to work together to revise the Evaluation Design to include components from the serious mental illness (SMI) 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. The revised Evaluation Design was submitted to CMS on September 25, 2023. HSD and HSAG will continue discussions on the impacts of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) on the Waiver Demonstration for inclusion in the Summative Evaluation Report. HSD has contracted with HSAG to develop and conduct the required monitoring and evaluation for the time limited COVID-19 Vaccine Administration Public Health Emergency demonstration amendment. HSAG is currently in process collecting data and interviewing staff. The final draft report is due to CMS on February 29, 2024.

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ENCLOSURES/ATTACHMENTS

Attachment A: July 2021 – June 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
Kari Armijo Cabinet Secretary and Acting Medicaid Director HSD/Medical Assistance	505-249-8773	Kari.Armijo@hsd.nm.gov
Lorelei Kellogg Deputy Director of Programs HSD/Medical Assistance	505-629-2938	lorelei.kellogg@hsd.nm.gov
Elisa Walker-Moran Deputy Director of Finance HSD/Medical Assistance	505-470-9330	Elisa.Walker-Moran@hsd.nm.gov
TBD Deputy Director of Systems HSD/Medical Assistance	TBD	TBD
Michal Hayes Deputy Director of Contracts HSD/Medical Assistance	505-699-5859	Michal.Hayes@hsd.nm.gov
Alanna Dancis Chief Medical Officer HSD/Medical Assistance	505-470-9334	alanna.dancis@hsd.nm.gov

At the end of January 2023, New Mexico's Medicaid Director, Nicole Comeaux J.D. MPH, departed from the Human Services Department after serving as Director of the Medical Assistance Division since January 2019. Medicaid's Deputy Director of Programs, Lorelei Kellogg was appointed acting Medicaid Director. Lorelei is leading our unwinding activities and has worked for the Department in different roles for 10 years.

In March 2023, New Mexico's Deputy Director of Programs, Erica Archuleta and Deputy Director of Systems, Linda Gonzales departed from the Human Services Department. Annabelle Martinez, serving as the Bureau Chief of Benefits and Reimbursement was appointed acting Deputy Director of Programs. The Bureau Chief of Systems in collaboration with our Acting Medicaid Director have continued system monitoring and

oversight activities.

In November 2023, Michal Hayes filled one of New Mexico’s vacant Deputy Director positions. Michal has practiced as an attorney for the State of New Mexico for 20 years working with a variety of State agencies.

In February 2024, Lorelei Kellogg returned to her role as Deputy Director of Programs for the Medicaid program. New Mexico’s Cabinet Secretary, Kari Armijo will serve as Acting Medicaid Director as New Mexico works on appointing a permanent Director, which remains a top priority for the State of New Mexico. Kari has spent her entire 23-year career with New Mexico Human Services Department. Prior to leading the Department, Secretary Armijo worked for the Department for more than 2 decades. Named Acting Secretary in January 2023, she previously served as Deputy Secretary from 2020 to 2023. During her tenure with the New Mexico Medicaid program, spanning 20 years, Secretary Armijo held the position of Deputy Director, where she also served as the Affordable Care Act Implementation Director. Her responsibilities encompassed directing and coordinating Medicaid policy and program operations, including eligibility and enrollment, benefit package design, and provider rate-setting. Additionally, she served as the Special Projects Director and directed Medicaid child/adolescent health and school-based health center programs, culminating in her role as the Affordable Care Act Implementation Director since the law’s passage in 2010.

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

BCBS:

Achievements

BCBSNM worked on goals to increase engagement and to offer care coordination to high-risk members. A new risk stratification model, via claims data mining, has been implemented to identify members who have experienced a change in health condition. The model provides a more robust and relevant member view and enhances the experience with the care provided. Social Determinants of Health factors will be included by end of calendar year 2023, which will increase capabilities to optimize care coordination outreach. Expected value is an improved member experience and improved coordination of care.

Following the model implementation and identification of members, outreach to conduct a Health Risk Assessment began in late June 2023.

Total members successfully contacted	Total members accepting care coordination	Member accepted care coordination percentage
6,654	634	9.12%

BCBSNM introduced a new Maternity Episode of Care (EOC) value-based purchasing program to a select group of providers. This is a shared savings model with a quality component that modifies the percentage of shared savings a provider can earn (e.g., higher quality score results in a higher percentage of shared savings earned). The quality components include:

- Timeliness of prenatal care
- Gestational diabetes screening
- Timeliness of postpartum care
- Stratification of quality metrics by race, ethnicity, and language

BCBSNM works with the Member Care Fund (MCF), which has helped members fill the social determinant of health gaps identified through the care coordination process. In Quarter 3 the program served 77 members (BH 34) (PH 43) of which 34 are of Latino

descent, 28 white, 7 Native American, 2 African-American and 6 whose race/ethnic identify were unknown. By gender, 35 were females and 42 were males.

The program has helped 36 members access basic needs, 36 to improve member health and well-being, 4 to improve compliance with treatment, and 1 to an appointment follow through. Items provided consisted of basic hygiene items, clothing, basic household furniture and cleaning products, as well as small appliances to help member make and keep food fresh. Other uses of these funds include member auto repairs, so the member was able to access transportation for medical appointments and employment, and the deep clean of members' homes so PCS Agencies would provide services.

Risk Stratification			
Month	**High**	**Moderate**	**Total Members**
July 2023	5%	23%	28
August 2023	7%	23%	30
September 2023	6%	13%	19

PHP:
Achievements
In Q3 2023, PHP continued prospective partnership efforts with a new Population Health engagement vendor to deliver a digital wellbeing tool. As a part of the early-implementation phase, PHP is constructing tailored healthcare journeys for at-risk populations; specifically, perinatal, adult behavioral health, and special-needs populations.

PHP expanded health and wellness support programs and services through the addition of a Healthy Weight Program. The program is a designed to support at-risk populations through the importance of maintaining a healthy weight and healthy lifestyle modifications. This work included, but was not limited to:

- Enhancements to eligibility criteria and communication materials for PHP's DPP and Healthy Weight Programs.
- Deployment self-referral options via a landing page with real-time eligibility functionality.
- Deployment of a member and provider communication campaign to promote health and wellness programs; as well as information about how members can participate.

As of Q3 2023, the Diabetes Prevention Program (DPP) enrolled 23 new participants; committing to a 12-month structured curriculum and coaching schedule. Since implementation, PHP had 360 Centennial Care Members enrolled and a total of 160

participants with logged individual sessions related to physical activity, healthy food choices, eating patterns, and daily weight management. The 12-month DPP is offered to eligible members and is an evidence-based prevention program with oversight by the Centers for Disease Control and Prevention.

Learning Collaboratives
PHP continued its themed learning collaboratives for 2023. Each month, starting in June, PHP hosts various learning collaboratives for all contracted providers. The goal is to provide education and resources to provider groups around many topics. July's session was focused on perinatal health, August's session was focused on pediatric care, and September was overall adult health. Learning Collaboratives allow providers to gain information from PHP and provide a forum to share best practices. PHP also invites VBP-enrolled provider groups to foster a partnership between groups to help promote excellence.

Presbyterian's VBP team is building a site to store all past learning collaborative resources for providers. This site will be all-encompassing, allowing groups to see upcoming training, register, and review materials at their leisure. The site will also be linked once active in PHP's provider newsletter for easy access.

WSCC:
Innovation Project for Member Satisfaction
In 2023, WSCC partnered with Medallia to initiate a pilot program for post-visit surveys that provide real time data on member experience. The Medallia program has been initiated for Medicaid and Marketplace member populations. The program utilizes methodology of text and email surveys sent to members to evaluate their experience from a recent provider visit. This survey asks questions related to satisfaction with their healthcare experience, access to care, timeliness of appointments, coordination of care, and provider communication. Medallia provides the survey responses to WSCC, which affords the opportunity to review this data through a service recovery lens, and proactively resolve concerns by members who reported negative experiences. Both Medicaid and Marketplace lines of business went live in second quarter of 2023. In Quarter 3 of 2023, WSCC focused on the responses of 28 members. WSCC attempted to contact all members and successfully engaged 16 members. WSCC inquired further about their experiences and whether the members had any service needs. All feedback was shared with internal teams of WSCC for review for potential improvement opportunities. WSCC continues to review Medallia survey feedback during biweekly Consumer Assessment of Healthcare Providers and Systems (CAHPS) Work Group meetings for improvement opportunities for member experience.

Community Outreach
The Baby Expo on July 15, 2023 was a success with over 150 community members in attendance. WSCC hosted over 30 vendors offering maternal and parental resources including legal services, NM Community Care provided CPR and Choking Hazard Education, and NM Department of Health administered Immunizations. Expectant mothers received diaper bags filled with various baby items. WSCC also raffled 3 infant car seats, 4 strollers, and 3 baby monitors.

MEMBER SUCCESS STORIES

BCBS:
A 65-year-old Hispanic female member has conditions including osteoporosis with limited range of motion, pain, shoulder dislocation and history of breast cancer. During the Care Coordinator's (CC) recent contact with the member, she expressed feeling overwhelmed about the condition of her home, which had broken windows and other environmental issues needing to be addressed. The member stated she resides in an old house and does not have the physical or financial ability to address the repairs and needed services. Care Coordinator (CC) and member discussed how environmental modification benefits may address her home environment, safety, and accessibility needs. CC informed the member of external resources which would have the possibility of helping cover repairs and/or purchase of appliances. The member was nervous and reluctant to be referred to such programs due to being Spanish-speaking only and not able to complete an application online. The member also lacked confidence in her ability to complete a paper application correctly. CC requested Community Health Worker (CHW) assistance with completion of an application. CC explained the member's needs and challenges in applying for such services. CHW delivered a paper application, helped her with completion of the application, and hand-delivered it to the appropriate agency.

As a result of CC and CHW assistance and collaboration in addressing member's needs, she received the necessary assistance to apply for programs which addressed her home environmental concerns. She was approved for the program services and received assistance with weatherization services and the replacement of the boiler, stove, and refrigerator. The member expressed gratitude for CC and CHW assistance and their willingness to ensure her home's environmental needs were addressed, which would allow her to continue living in a safe place for many years to come. She was happy to know that her insurer genuinely cares about her wellbeing.

PHP
A community health worker (CHW) received a referral to assist a Spanish-speaking member in navigating the health care system, specifically to assist member with obtaining

a specialty care medical appointment. The member had been utilizing the emergency department because his underlying medical needs had not been addressed, and he was experiencing significant pain. The CHW was able to assist the member first with finding a primary care provider. Then, the CHW worked to establish the member with a specialty care provider. After some difficulty getting an appointment with a urologist, the CHW discovered there was a referral for the member, but the member had not yet been contacted. The CHW worked through barriers to establish a timely follow-up appointment. The member successfully received a next-day appointment and stated that he was very appreciative of the CHW's assistance. The CHW was able to address this member's needs, establish significant rapport with this member, and successfully assist Member with healthcare navigation in a way that was culturally responsive to the member's needs.

WSCC:

A member enrolled in the Start Smart for Your Baby Program (SSFB) with her first pregnancy (with twins). At 30 weeks gestation, member was seen in OB triage for heart palpitations, shortness of breath, and anemia. She was started on weekly iron infusions but had an adverse reaction (rash on legs/ankles), and the infusions were stopped. The member delivered twin boys via C-section at 34 weeks due to pre-eclampsia. Due to prematurity, the babies were admitted into the NICU on supplemental oxygen, with IV and feeding tubes. The member completed a post-natal depression screening and believed she was experiencing post-partum depression due to infants being hospitalized, and her separation from them. The member's care coordinator (CC), assisted with scheduling postpartum visits, and scheduling further evaluation from the OB provider. CC also assisted member with getting established with a pediatrician. The infants completed NICU Transition of Care and member successfully completed SSFB program. The member is thankful for the assistance she received from her CC and WSCC.

MCO COVID-19 Relief Efforts and Unwinding Activities

BCBS:

Grants

- There were no COVID-19 related grants received or issued in DY10 Q3.

Donations

- There were no donations issued in DY10 Q3.

Events

- Sunland Park COVID-19 Vaccine Clinic, July 18
- City of Albuquerque Care Van Series, July 26

- Cobre School System Summerfest, July 29
- Church of God in Christ Event, July 29
- Santa Fe Community Health Day, August 19
- Sunland Park COVID-19 Vaccine Clinic, August 22
- American Lung Association Health Fair, September 9

PHE Unwinding Outreach Actions, September 2023
Member Calls

Direct member (non-prerecorded) outbound calls: September 2023	BCBS
Members scheduled for direct calls	5909
Number of calls made	5935
Answered	5024
No answer	784
Voicemail	127
Hung up	20
Contact completed (member reached; information conveyed)	1102
Average call duration	0:00:50
Member inbound calls related to recertification	741

Outreach Completed

Outreach Efforts Completed: September 2023	BCBS
Members targeted	10288
Special COEs/Groups targeted	N/A
Member letters/direct mail	3525
Email 1	N/A
Email 2	N/A
Postcards	6763
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, September 2023

Member Calls *

Direct member (non-prerecorded) outbound calls: September 2023	PHP
Members scheduled for direct calls	2,246
Number of calls made	22.46
Answered	283
No answer	1,698
Voicemail	205
Hung up	60
Contact completed (member reached; information conveyed)	283
Average call duration	2m 13s
Member inbound calls related to recertification	295

Outreach Completed

Outreach Efforts Completed: September 2023	PHP
Members targeted	12
Special COEs/Groups targeted	n/a
Member letters/direct mail	11,498 (mailed beginning 9/5)
Email 1	1,035 (sent on 9/13)
Email 2	n/a
Postcards	4,227
Text message 1	11,965 (sent beginning 9/26)
Text message 2	n/a
Text message 3	n/a
Text message 4	n/a
Robocalls	0
Efforts targeting the closed population	
Notes	
Targeted outbound calls to Medicaid members on the SEPTEMBER 2023 CLOSURE REPORT in the 5-county area (Bernalillo, Sandoval, Santa Fe, Torrence, and Valencia) Care Coordination followed up with 276 Members on the Maintenance of Effort (MOE)/Non-MOE lists. We also notified delegates and provided them with the respective information for follow up. Overall MOE and Non-MOE population: 11,498 letters were sent to members beginning on SEPTEMBER 5. Emails were sent to all members for which we had a valid email address on 8/13 (1,035 total) that mirrored the information relayed in the letter. Text messages were sent in two batches, beginning on 8/26 (11,965 total members).	

Discrepancies between the number of texts sent and the number of letters is due to householding the mailing and some invalid mailing addresses.
*Postcards to members in the 5-county area on the MOE and Non-MOE file

Outreach Events:
Twelve (12) Outreach events were conducted in September 2023. One event out of 12, PHP collaborated and partnered with HSD and ISD to conduct NM Medicaid

Recertifications/Renewal/New Applications. Five Recertifications were completed; 23 Referrals were made; 101 conversations regarding NM Medicaid Recertifications and Renewals.

WSCC.
WSCC offered COVID vaccinations at a back to school event in Las Cruces, and incorporated COVID-related activities into events with partners concerning flu prevention.

PHE Unwinding Outreach Actions, September 2023
Member calls

Direct member (non-prerecorded) outbound calls September 2023	Western Sky
Members scheduled for direct calls	599
Number of calls made	599
Answered	57
No answer	22
Voicemail	128
Hung up	13
Contact completed (member reached, information conveyed)	121
Average call duration	1.28
Member inbound calls related to recertification	121

Notes

Answered: references individuals that answered, but could not complete call at the time.
Wrong Number or Disconnected: 118
Inbound Calls Activity:
Average Call Duration: 12.6 minutes
Voicemails: 1 inbound voicemail

Outreach Completed

Outreach Efforts Completed September 2023	Western Sky
Members targeted	6973
Special COEs/Groups targeted	31, 300, 301, High Risk Care Coord. (CCL2 & CCL3), 400, 401, 403
Member letters/direct mail	3486
Email 1	2434
Email 2	2193
Postcards	3486
Text message 1	5833
Text message 2	5253
Text message 3	5253
Text message 4	4991
Robocalls	2963

Efforts targeting the closed population

For the Closed population, Western Sky completed a mailer included with the campaign targeting MOE & Non-MOE members. Text , email and robo campaign has been initiated to all termed membership. All termed membership is also invited to participate at local events and renewal events - such as the movie night. Marketplace educational emails have also been deployed to disenrolled members (closure report) due to income eligibility.

Notes

In September, we continue our non-automated telephonic outreach to identified High Risk children. 200 children were identified under a pop-health category such as health coaching, physical health, behavioral health or acute episodic. With this outreach, we want to support the efforts towards the identified risk of children losing their Medicaid coverage.

We partnered at several events throughout the month, educating on redetermination and hosted another Western Sky - Redetermination Resource Night to educate and assist individuals in person with their Medicaid application renewal. Majority were individuals enrolled with Western Sky, and a few enrolled with Presbyterian. For this Resource Night, Western Sky partnered with Doña Ana Community College to provide access to the computer labs to facilitate the process of renewal for attending individuals. Next event will be hosted earlier in the day to allow for accessibility to the chat and support line, if needed.

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.

State of New Mexico - All MCOs

All Centennial Care Populations

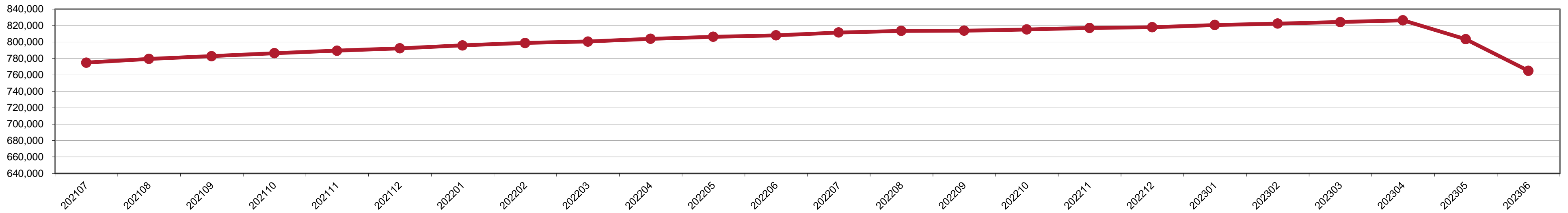
Centennial Care Cost Review

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

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

Current Period: July 1, 2022 to June 30, 2023

1. Total Centennial Care Monthly Enrollment



2. Total Centennial Care Dollars and Member Months by Program

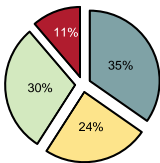
	Aggregate Member Months by Program		
Population	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	5,706,537	5,888,855	3%
Long Term Services and Supports	618,297	627,716	2%
Other Adult Group	3,194,457	3,234,906	1%
Total Member Months	**9,519,291**	**9,751,477**	**2%**

	Aggregate Medical Costs by Program			*Per Capita Medical Costs by Program (PMPM)*		
Programs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Physical Health	$ 1,771,303,952	$ 1,720,038,015	-3%	$ 310.40	$ 292.08	-6%
Long Term Services and Supports	$ 1,248,188,927	$ 1,261,562,753	1%	$ 2,018.75	$ 2,009.77	0%
Other Adult Group Physical Health	$ 1,513,714,249	$ 1,421,762,991	-6%	$ 473.86	$ 439.51	-7%
Behavioral Health - All Members	$ 575,914,453	$ 640,070,729	11%	$ 60.50	$ 65.64	8%
Total Medical Costs	**$ 5,109,121,581**	**$ 5,043,434,488**	**-1%**	**$ 536.71**	**$ 517.20**	**-4%**

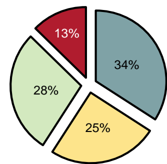
Aggregate Non-Medical Costs	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Admin, care coordination, Centennial Rewards	$ 419,657,517	$ 446,002,896	6%	$ 44.08	$ 45.74	4%
NMMIP Assessment	$ 85,626,336	$ 119,969,955	40%	$ 9.00	$ 12.30	37%
Premium Tax - Net of NIMMP Offset	$ 278,467,776	$ 350,565,688	26%	$ 29.25	$ 35.95	23%
Total Non-Medical Costs	**$ 783,751,629**	**$ 916,538,538**	**17%**	**$ 82.33**	**$ 93.99**	**14%**
Estimated Total Centennial Care Costs	**$ 5,892,873,209**	**$ 5,959,973,026**	**1%**	**$ 619.05**	**$ 611.19**	**-1%**

Centennial Care Medical Expenditures

Previous (Q2CY2022 - Q1CY2023)



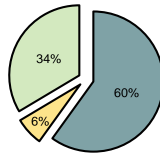
Current (Q3CY2022 - Q2CY2023)



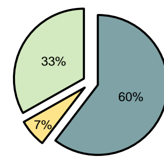
*See above for legend.

Centennial Care Member Months

Previous (Q2CY2022 - Q1CY2023)



Current (Q3CY2022 - Q2CY2023)



*See above for legend.

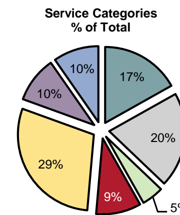
3. Total Program Medical/Pharmacy Dollars

	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 4,614,135,087	$ 4,492,134,383	-3%	$ 484.71	$ 460.66	-5%
Pharmacy	$ 494,986,493	$ 551,300,105	11%	$ 52.00	$ 56.54	9%
Total	**$ 5,109,121,581**	**$ 5,043,434,488**	**-1%**	**$ 536.71**	**$ 517.20**	**-4%**

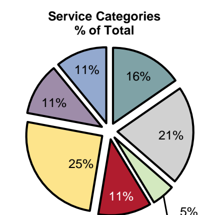
	Aggregate Costs by Service Categories			*Per Capita Medical Costs by Service Categories (PMPM)*		
Service Categories	Previous (12 mon)	Current (12 mon)	% Change	Previous (12 mon)	Current (12 mon)	% Change
Acute Inpatient	$ 861,444,685	$ 775,166,064	-10%	$ 90.49	$ 79.49	-12%
Acute Outp/Phy	$ 1,034,953,877	$ 1,059,646,708	2%	$ 108.72	$ 108.67	0%
Nursing Facility	$ 239,054,994	$ 248,690,324	4%	$ 25.11	$ 25.50	2%
Community Benefit/PCO	$ 489,777,248	$ 570,352,927	16%	$ 51.45	$ 58.49	14%
Other Services	$ 1,489,291,743	$ 1,277,071,732	-14%	$ 156.45	$ 130.96	-16%
Behavioral Health	$ 499,612,540	$ 561,206,628	12%	$ 52.48	$ 57.55	10%
Pharmacy (All)	$ 494,986,493	$ 551,300,105	11%	$ 52.00	$ 56.54	9%
Total Costs	**$ 5,109,121,581**	**$ 5,043,434,488**	**-1%**	**$ 536.71**	**$ 517.20**	**-4%**

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

Previous (12 mon) service distribution



Current (12 mon) service distribution



4. Notes

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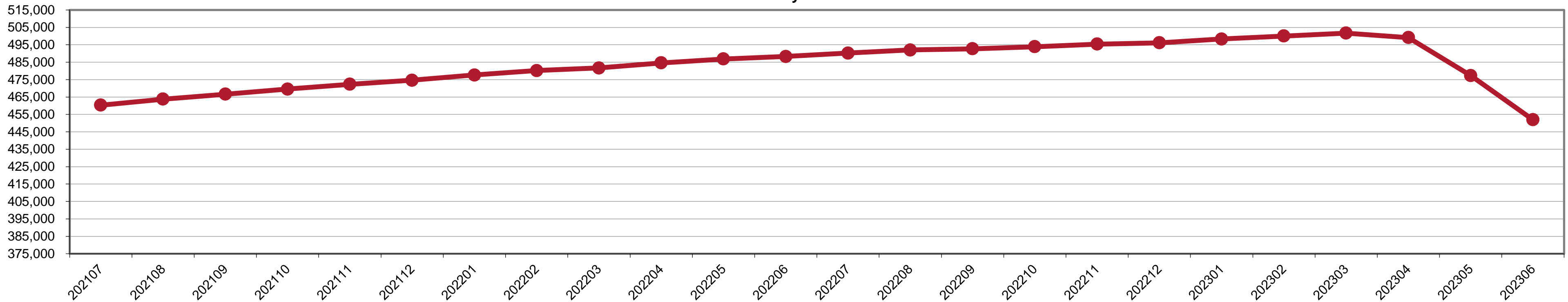
State of New Mexico - All MCOs

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

Physical Health Utilization and Cost Review

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

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

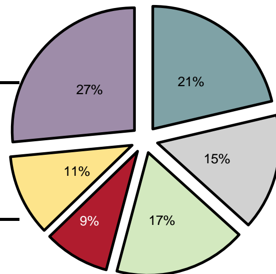
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,607,131,172	$ 1,535,677,136	-4%
Pharmacy	$ 164,172,779	$ 184,360,879	12%
Total	**$ 1,771,303,952**	**$ 1,720,038,015**	**-3%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 420,595,588	$ 367,278,245	-13%
Outpatient (OP)	$ 271,517,072	$ 263,329,562	-3%
Physician (PH)	$ 272,482,887	$ 300,503,444	10%
Emergency Department (ED)	$ 111,861,225	$ 148,810,579	33%
Pharmacy (RX)	$ 164,172,779	$ 184,360,879	12%
Other (OTH)	$ 530,674,400	$ 455,755,305	-14%
Total Population Costs	**$ 1,771,303,952**	**$ 1,720,038,015**	**-3%**
Per Capita Cost (PMPM)	**$ 310.40**	**$ 292.08**	**-6%**
Total Member Months	**5,706,537**	**5,888,855**	**3%**

Service Categories % of Cost



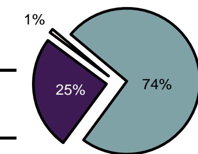
3. Retail Pharmacy Usage (Definitions in Glossary)

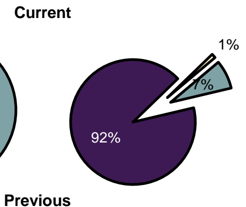
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 122,878,345	$ 136,364,215	11%
Generic	$ 39,396,135	$ 46,318,061	18%
Other Rx	$ 1,898,299	$ 1,678,603	-12%
Total	**$ 164,172,779**	**$ 184,360,879**	**12%**

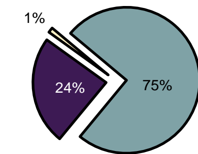
% of Rx Spend **% of Scripts**

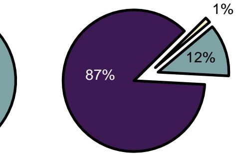
Current





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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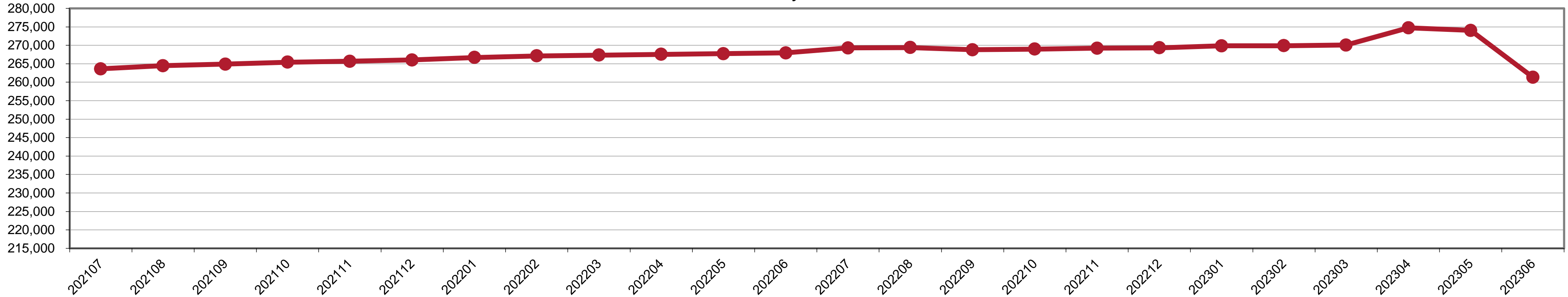
State of New Mexico - All MCOs

Total Population

Other Adult Group Utilization and Cost Review

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

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

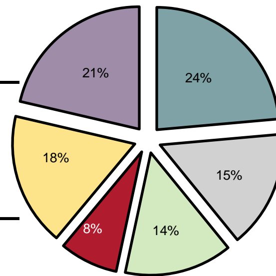
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 1,292,248,244	$ 1,171,967,626	-9%
Pharmacy	$ 221,466,005	$ 249,795,364	13%
Total	**$ 1,513,714,249**	**$ 1,421,762,991**	**-6%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 372,512,945	$ 335,456,163	-10%
Outpatient (OP)	$ 230,210,659	$ 220,775,527	-4%
Physician (PH)	$ 192,731,750	$ 202,391,482	5%
Emergency Department (ED)	$ 97,126,732	$ 109,578,048	13%
Pharmacy (RX)	$ 221,466,005	$ 249,795,364	13%
Other (OTH)	$ 399,666,158	$ 303,766,406	-24%
Total Population Costs	**$ 1,513,714,249**	**$ 1,421,762,991**	**-6%**
Per Capita Cost (PMPM)	**$ 473.86**	**$ 439.51**	**-7%**
Total Member Months	**3,194,457**	**3,234,906**	**1%**

Service Categories % of Cost



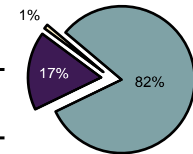
3. Retail Pharmacy Usage (Definitions in Glossary)

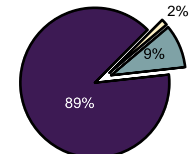
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs (12 mon)	% Change
Brand	$ 180,391,507	$ 204,194,353	13%
Generic	$ 38,199,328	$ 43,146,470	13%
Other Rx	$ 2,875,171	$ 2,454,542	-15%
Total	**$ 221,466,005**	**$ 249,795,364**	**13%**

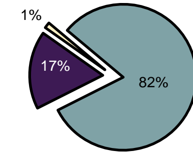
% of Rx Spend **% of Scripts**

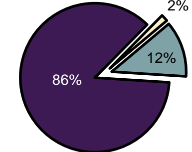
Current





Previous





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

4. Notes

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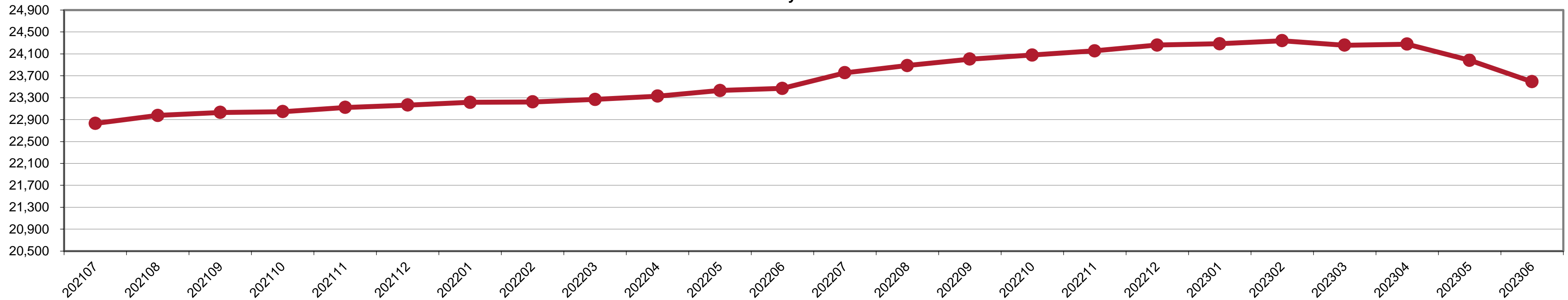
State of New Mexico - All MCOs

LTSS - Healthy Dual Population

Utilization and Cost Review

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

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

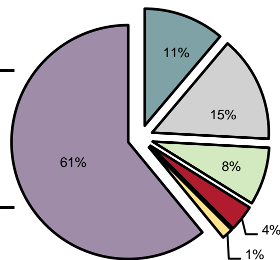
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 61,384,102	$ 62,389,951	2%
Pharmacy	$ 709,736	$ 984,557	39%
Total	**$ 62,093,838**	**$ 63,374,508**	**2%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Inpatient (IP)	$ 8,777,408	$ 7,086,073	-19%
Outpatient (OP)	$ 11,022,278	$ 9,291,536	-16%
Physician (PH)	$ 5,776,030	$ 5,075,427	-12%
Emergency Department (ED)	$ 2,096,255	$ 2,300,569	10%
Pharmacy (RX)	$ 709,736	$ 984,557	39%
Other (OTH)	$ 33,712,131	$ 38,636,346	15%
Total Population Costs	**$ 62,093,838**	**$ 63,374,508**	**2%**
Per Capita Cost (PMPM)	**$ 223.27**	**$ 219.38**	**-2%**
Total Member Months	**278,107**	**288,876**	**4%**

Service Categories % of Cost



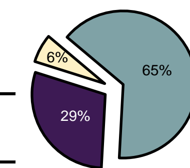
3. Retail Pharmacy Usage (Definitions in Glossary)

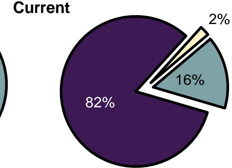
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 490,906	$ 637,431	30%
Generic	$ 185,574	$ 285,560	54%
Other Rx	$ 33,256	$ 61,566	85%
Total	**$ 709,736**	**$ 984,557**	**39%**

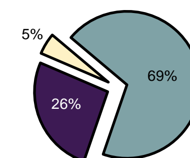
% of Rx Spend / **% of Scripts**

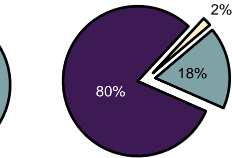
Current





Previous





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

4. Notes

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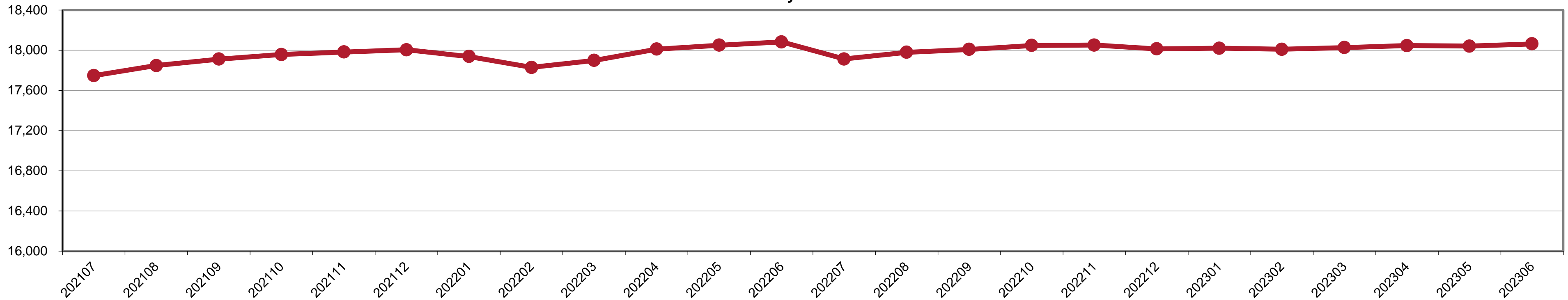
State of New Mexico - All MCOs

LTSS - Nursing Facility Level of Care Dual Population

Utilization and Cost Review

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

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

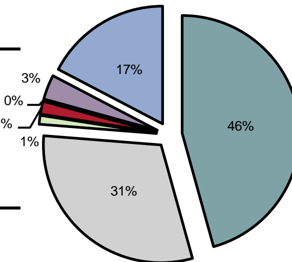
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 702,907,955	$ 708,872,128	1%
Pharmacy	$ 293,281	$ 232,238	-21%
Total	**$ 703,201,236**	**$ 709,104,366**	**1%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 265,830,037	$ 324,054,714	22%
Nursing Facility (NF)	$ 210,692,358	$ 216,629,089	3%
Inpatient (IP)	$ 10,160,178	$ 8,618,840	-15%
Outpatient (OP)	$ 14,129,340	$ 12,612,273	-11%
Pharmacy (RX)	$ 293,281	$ 232,238	-21%
HCBS	$ 22,776,436	$ 24,011,287	5%
Other (OTH)	$ 179,319,606	$ 122,945,925	-31%
Total Population Costs	**$ 703,201,236**	**$ 709,104,366**	**1%**
Per Capita Cost (PMPM)	**$ 3,266.78**	**$ 3,279.55**	**0%**
Total Member Months	**215,258**	**216,220**	**0%**

Service Categories
% of Cost



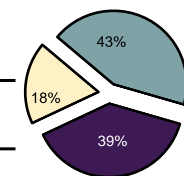
3. Retail Pharmacy Usage (Definitions in Glossary)

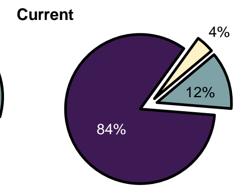
Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 184,658	$ 100,658	-45%
Generic	$ 80,775	$ 89,601	11%
Other Rx	$ 27,848	$ 41,980	51%
Total	**$ 293,281**	**$ 232,238**	**-21%**

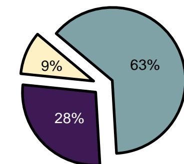
% of Rx Spend | **% of Scripts**

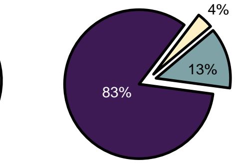
Current





Previous





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

4. Notes

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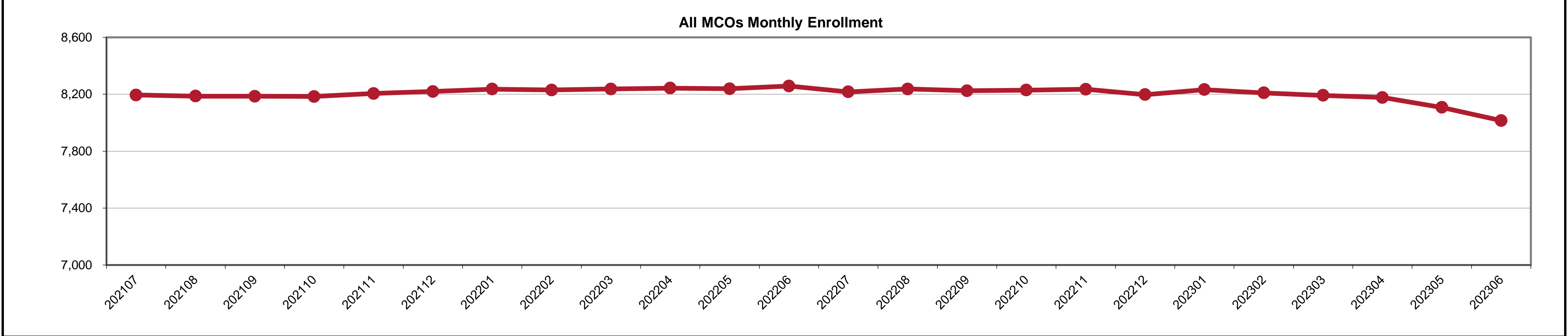
1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 338,187,768	$ 347,998,906	3%
Pharmacy	$ 29,012,632	$ 34,170,951	18%
Total	**$ 367,200,400**	**$ 382,169,856**	**4%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Personal Care (PCO)	$ 105,783,326	$ 124,188,739	17%
Nursing Facility (NF)	$ 28,001,531	$ 31,694,843	13%
Inpatient (IP)	$ 46,005,832	$ 53,290,255	16%
Outpatient (OP)	$ 33,558,814	$ 41,908,151	25%
Pharmacy (RX)	$ 29,012,632	$ 34,170,951	18%
HCBS	$ 14,642,420	$ 15,228,680	4%
Other (OTH)	$ 110,195,846	$ 81,688,237	-26%
Total Population Costs	**$ 367,200,400**	**$ 382,169,856**	**4%**
Per Capita Cost (PMPM)	**$ 3,723.42**	**$ 3,888.78**	**4%**
Total Member Months	**98,619**	**98,275**	**0%**

Service Categories % of Cost

33%
8%
14%
11%
9%
4%
21%

3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 23,407,811	$ 27,680,285	18%
Generic	$ 5,181,701	$ 6,123,558	18%
Other Rx	$ 423,120	$ 367,108	-13%
Total	**$ 29,012,632**	**$ 34,170,951**	**18%**

% of Rx Spend **% of Scripts**

Current

1% 18% 81%
2% 8% 90%

Previous

1% 18% 81%
2% 10% 88%

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

4. Notes

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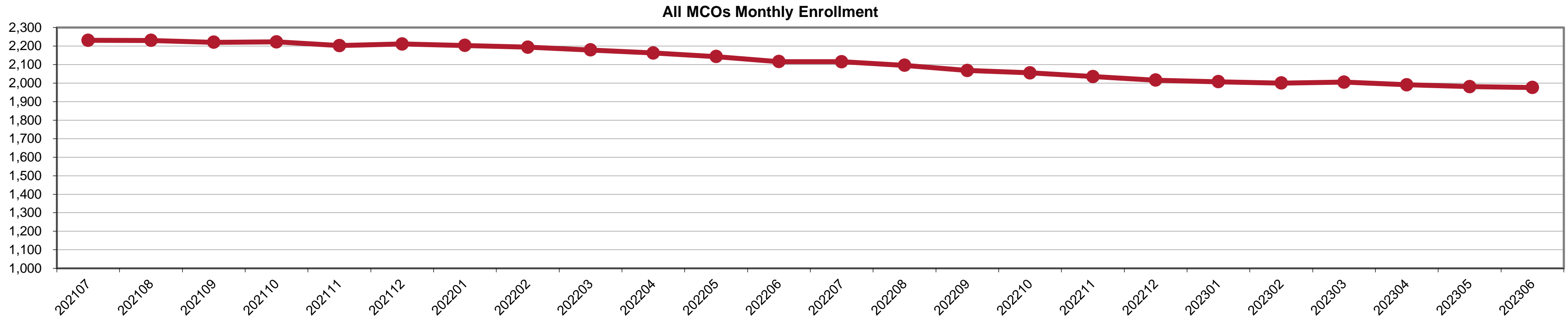
State of New Mexico - All MCOs
LTSS - Self Directed Population
Utilization and Cost Review

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

1. Total Population Monthly Enrollment



2. Total Population Medical/Pharmacy Dollars

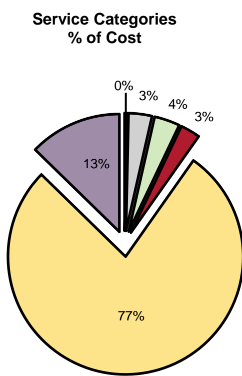
Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 112,663,306	$ 104,022,007	-8%
Pharmacy	$ 3,030,147	$ 2,892,016	-5%
Total	**$ 115,693,453**	**$ 106,914,022**	**-8%**

Aggregate Costs by Service Categories

Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Nursing Facility (NF)	$ 361,106	$ 366,392	1%
Inpatient (IP)	$ 3,392,733	$ 3,436,488	1%
Outpatient (OP)	$ 3,525,048	$ 3,759,304	7%
Pharmacy (RX)	$ 3,030,147	$ 2,892,016	-5%
HCBS	$ 80,745,029	$ 82,869,507	3%
Other (OTH)	$ 24,639,390	$ 13,590,316	-45%
Total Population Costs	**$ 115,693,453**	**$ 106,914,022**	**-8%**
Per Capita Cost (PMPM)	**$ 4,396.82**	**$ 4,391.62**	**0%**
Total Member Months	**26,313**	**24,345**	**-7%**

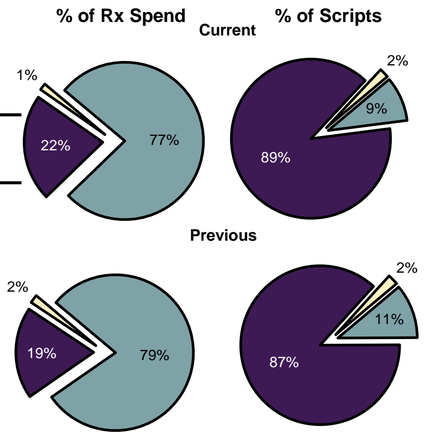
Service Categories % of Cost



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 2,400,807	$ 2,216,767	-8%
Generic	$ 576,460	$ 634,704	10%
Other Rx	$ 52,880	$ 40,544	-23%
Total	**$ 3,030,147**	**$ 2,892,016**	**-5%**



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

4. Notes

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

State of New Mexico - All MCOs

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

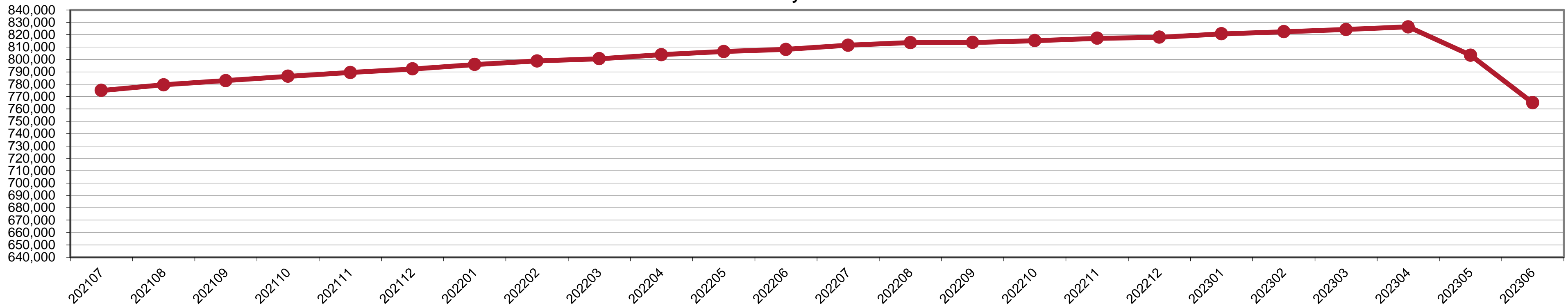
Behavioral Health Utilization and Cost Review

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

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

Current Period: July 1, 2022 to June 30, 2023

1. Total Population Monthly Enrollment



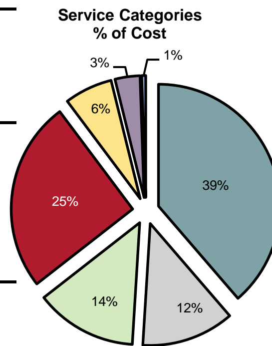
2. Total Population Medical/Pharmacy Dollars

Aggregate Annual Costs

	Previous (12 mon)	Current (12 mon)	% Change
Medical	$ 499,612,540	$ 561,206,628	12%
Pharmacy	$ 76,301,913	$ 78,864,100	3%
Total	**$ 575,914,453**	**$ 640,070,729**	**11%**

Aggregate Costs by Service Categories

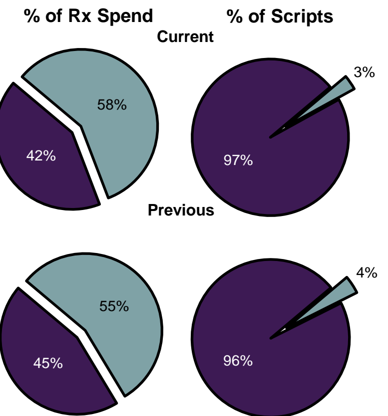
Service Categories	Previous (12 mon)	Current (12 mon)	% Change
Outpatient/Clinic (OP/CL)	$ 218,595,336	$ 247,402,478	13%
Pharmacy (RX)	$ 76,301,913	$ 78,864,100	3%
Res. Treatment Ctr. (RTC)	$ 101,776,808	$ 86,419,583	-15%
Behavioral Health Prov (BHP)	$ 125,900,026	$ 161,802,882	29%
Core Service Agencies (CSA)	$ 32,039,112	$ 40,890,636	28%
Inpatient (IP)	$ 19,372,959	$ 21,269,480	10%
Other (OTH)	$ 1,928,299	$ 3,421,569	77%
Total Population Costs	**$ 575,914,453**	**$ 640,070,729**	**11%**
Per Capita Cost (PMPM)	**$ 60.50**	**$ 65.64**	**8%**
Total Member Months	**9,519,291**	**9,751,477**	**2%**



3. Retail Pharmacy Usage (Definitions in Glossary)

Total Generic / Brand Rx

	Previous Costs (12 mon)	Current Costs Current (12 mon)	% Change
Brand	$ 42,158,451	$ 45,793,992	9%
Generic	$ 34,143,462	$ 33,070,109	-3%
Total	**$ 76,301,913**	**$ 78,864,100**	**3%**



4. Notes

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

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

Quarter 3
Start Date:7/1/2023
End Date: 9/30/2023

Table 3 - PMPM Summary by Demonstration Year and MEG

MEG01 TANF & Related	DY 01 Cost Estimates	DY 01 YTD - Actuals [2]	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	4,727,584	4,517,149	4,861,847	4,454,290	5,020,343	4,621,656	5,092,636	4,623,475	5,132,359	4,422,938	4,974,487	4,313,641
PMPM	$ 385.80	$ 329.14	$ 400.77	$ 344.32	$ 416.32	$ 334.75	$ 432.47	$ 341.04	$ 449.25	$ 353.31	$ 460.00	$ 397.15
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	$ 1,562,670,294	$ 2,288,249,485	$ 1,713,145,073

MEG02 SSI & Related - Medicaid Only	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	508,700	497,958	513,736	494,529	518,976	493,577	524,737	487,798	530,824	459,830	499,659	448,460
PMPM	$ 1,763.90	$ 1,656.75	$ 1,842.83	$ 1,785.41	$ 1,925.21	$ 1,756.52	$ 2,008.00	$ 1,734.28	$ 2,094.34	$ 1,729.95	$ 2,158.77	$ 1,930.36
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	$ 795,483,090	$ 1,078,650,304	$ 865,688,657

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

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

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

MEG06 VIII Group - Medicaid Expansion	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals [2]	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MMs [1]	1,632,968	1,887,728	1,788,895	2,748,632	1,800,808	3,078,074	1,763,748	3,143,890	1,773,299	3,019,164	3,299,404	3,070,895
PMPM	$ 577.87	$ 453.48	$ 607.34	$ 476.42	$ 638.31	$ 442.85	$ 670.87	$ 450.19	$ 705.08	$ 484.90	$ 738.22	$ 524.65
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	$ 1,463,980,846	$ 2,435,685,299	$ 1,611,156,552

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

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

Centennial Care 2.0 Medicaid SUD/IMD	DY 01 Cost Estimates	DY 01 YTD - Actuals	DY 02 Cost Estimates	DY 02 YTD - Actuals	DY 03 Cost Estimates	DY 03 YTD - Actuals [2]	DY 04 Cost Estimates	DY 04 YTD - Actuals [2]	DY 05 Cost Estimates	DY 05 YTD - Actuals [2]	DY 06 Cost Estimates	DY 06 YTD - Actuals [2]
MM											595	595
PMPM											$ 808.21	$ 5,795.10
Dollars											$ 480,885	$ 3,448,086

Notes:
1.) Actual member months for Demonstration Year 9 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, FFY2023 Quarter 4. Report pulled on 11/06/2023.

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 2023 Quarter 4 submission.
3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

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%	$ 1,471,328,144	$ 1,562,670,294	$ 1,180,620,316
MEG02 - SSI & Related - Medicaid Only	$ 2,094.34	459,830	$ 963,039,856	74.05%	$ 713,100,513	$ 795,483,090	$ 576,985,579
MEG03 - SSI & Related - Dual Eligible	$ 2,107.39	432,715	$ 911,899,885	74.05%	$ 675,232,983	$ 558,418,717	$ 403,163,956
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.05%	$ 51,010,362	$ 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**		**$ 2,919,566,399**	**$ 2,997,473,277**	**$ 2,219,534,027**

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%	$ 2,005,116,995	$ 1,463,980,846	$ 1,378,952,952
Grand Total			**$ 2,128,754,916**		**$ 2,005,116,995**	**$ 1,463,980,846**	**$ 1,378,952,952**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,919,566,399**
Federal Share (Title XIX) Actual Reported	$ 2,219,534,027
Excess Spending - Test 1	$ 20,637,930
Excess Spending - Test 2	$ -
Total Actuals	$ 2,240,171,957
Difference (Actuals - Limit)	$ (679,394,442)
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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

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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%	$ 1,483,081,806	$ 1,713,145,073	$ 1,307,627,178
MEG02 - SSI & Related - Medicaid Only	$ 2,158.77	448,460	$ 968,123,620	74.74%	$ 723,597,131	$ 865,688,657	$ 633,237,747
MEG03 - SSI & Related - Dual Eligible	$ 2,057.62	433,415	$ 891,801,274	74.74%	$ 666,552,112	$ 557,052,123	$ 403,427,596
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	74.74%	$ 51,489,413	$ 68,889,316	$ 50,869,441
MEG09 HQII	NA	NA	$ 12,000,000	74.74%	$ 8,969,067	$ 12,000,002	$ 9,127,363
Grand Total			**$ 3,925,076,543**		**$ 2,933,689,527**	**$ 3,216,775,171**	**$ 2,404,289,325**

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%	$ 2,110,918,241	$ 1,611,156,552	$ 1,500,232,419
Grand Total			**$ 2,266,995,241**		**$ 2,110,918,241**	**$ 1,611,156,552**	**$ 1,500,232,419**

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	$ 3,448,086	$ 3,183,671
Grand Total			**$ 480,885**		**$ 444,008**	**$ 3,448,086**	**$ 3,183,671**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 2,933,689,527**
Federal Share (Title XIX) Actual Reported	$ 2,404,289,325
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,739,663
Total Actuals	$ 2,404,289,325
Difference (Actuals - Limit)	$ (529,400,202)
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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

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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%	$ 1,760,365,168	$ 1,952,892,725	$ 1,584,280,835
MEG02 - SSI & Related - Medicaid Only	$ 2,247.28	450,397	$ 1,012,169,676	80.26%	$ 812,386,267	$ 1,007,302,350	$ 798,943,177
MEG03 - SSI & Related - Dual Eligible	$ 2,141.98	433,319	$ 928,159,496	80.26%	$ 744,958,129	$ 625,582,634	$ 494,860,305
MEG08 Uncompensated Care Pool	NA	NA	$ -	80.26%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	80.26%	$ 9,631,424	$ 11,999,993	$ 9,559,194
Grand Total			**$ 4,145,606,329**		**$ 3,327,340,988**	**$ 3,597,777,702**	**$ 2,887,643,511**

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%	$ 2,286,976,072	$ 1,976,337,271	$ 1,784,502,787
Grand Total			**$ 2,532,826,556**		**$ 2,286,976,072**	**$ 1,976,337,271**	**$ 1,784,502,787**

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	**$ 3,327,340,988**
Federal Share (Title XIX) Actual Reported	$ 2,887,643,511
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,115,778
Total Actuals	$ 2,887,643,511
Difference (Actuals - Limit)	$ (439,697,477)
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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 8

Start Date: 01/01/2021

End Date: 12/31/2021

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

MEG	DY 8 - PMPM	DY 8 - Actual Reported Member Months [1]	Total Expenditure Budget Neutrality Limit [DY 8 - PMPM X Actual Member Months]	Composite FFP [2]	Federal Share (Title XIX) Budget Neutrality Limit	Actual Reported Expenditures	Federal Share (Title XIX) Actual Reported
MEG01 - TANF & Related	$ 495.62	5,134,916	$ 2,544,972,764	82.59%	$ 2,101,875,691	$ 2,357,660,998	$ 1,949,247,464
MEG02 - SSI & Related - Medicaid Only	$ 2,339.42	462,038	$ 1,080,901,844	82.59%	$ 892,709,479	$ 1,070,455,548	$ 874,895,677
MEG03 - SSI & Related - Dual Eligible	$ 2,229.80	436,655	$ 973,652,643	82.59%	$ 804,133,093	$ 670,781,533	$ 561,460,419
MEG08 Uncompensated Care Pool	NA	NA	$ -	82.59%	$ -	$ -	$ -
MEG09 HQII	NA	NA	$ 12,000,000	82.59%	$ 9,910,718	$ 12,000,000	$ 9,559,194
Grand Total			**$ 4,611,527,251**		**$ 3,808,628,981**	**$ 4,110,898,079**	**$ 3,395,162,754**

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%	$ 15,440,707	$ 11,711,889	$ 9,766,272
MEG 05 - "217 Like" Dual Eligible	$ 3,967.56	68,653	$ 272,384,656	84.29%	$ 229,590,020	$ 246,178,530	$ 207,606,716
Grand Total			**$ 290,703,447**		**$ 245,030,727**	**$ 257,890,419**	**$ 217,372,988**

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	90.68%	$ 2,571,750,431	$ 2,174,796,256	$ 1,972,057,853
Grand Total			**$ 2,836,140,532**		**$ 2,571,750,431**	**$ 2,174,796,256**	**$ 1,972,057,853**

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%	$ 3,726,463	$ 6,523,668	$ 5,805,507
Grand Total			**$ 4,187,439**		**$ 3,726,463**	**$ 6,523,668**	**$ 5,805,507**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,808,628,981**
Federal Share (Title XIX) Actual Reported	$ 3,395,162,754
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 2,079,044
Total Actuals	$ 3,395,162,754
Difference (Actuals - Limit)	$ (413,466,227)
Percentage Difference	-10.9%

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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

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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	71.91%	$ 2,016,540,838	$ 2,813,162,495	$ 1,949,247,464
MEG02 - SSI & Related - Medicaid Only	$ 2,435.34	474,778	$ 1,156,245,855	71.91%	$ 831,436,971	$ 1,182,781,316	$ 874,895,677
MEG03 - SSI & Related - Dual Eligible	$ 2,321.22	448,958	$ 1,042,130,289	71.91%	$ 749,378,384	$ 725,572,069	$ 561,460,419
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	71.91%	$ 49,537,155	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	71.91%	$ 8,637,522	$ -	$ 9,559,194
Grand Total			**$ 5,083,599,315**		**$ 3,655,530,870**	**$ 4,721,515,880**	**$ 3,395,162,754**

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	77.14%	$ 15,128,672	$ 11,165,493	$ 9,766,272
MEG 05 - "217 Like" Dual Eligible	$ 4,130.23	70,970	$ 293,122,423	77.14%	$ 226,102,137	$ 270,640,322	$ 207,606,716
Grand Total			**$ 312,735,475**		**$ 241,230,809**	**$ 281,805,815**	**$ 217,372,988**

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	83.16%	$ 2,488,132,134	$ 2,371,520,280	$ 1,972,057,853
Grand Total			**$ 2,992,131,192**		**$ 2,488,132,134**	**$ 2,371,520,280**	**$ 1,972,057,853**

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	79.57%	$ 4,345,678	$ 7,296,086	$ 5,805,507
Grand Total			**$ 5,461,442**		**$ 4,345,678**	**$ 7,296,086**	**$ 5,805,507**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,655,530,870**
Federal Share (Title XIX) Actual Reported	$ 3,395,162,754
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 1,459,829
Total Actuals	$ 3,395,162,754
Difference (Actuals - Limit)	$ (260,368,116)
Percentage Difference	-7.1%

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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

ATTACHMENT B

New Mexico Budget Neutrality Monitoring Spreadsheet

- Budget Neutrality Limit Analysis

DY 10

Start Date: 01/01/2023

End Date: 12/31/2023

Table 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	3,923,755	$ 2,095,285,170	79.11%	$ 1,657,551,740	$ 1,777,707,112	$ 1,423,120,053
MEG02 - SSI & Related - Medicaid Only	$ 2,535.19	359,928	$ 912,485,866	79.11%	$ 721,855,219	$ 863,660,239	$ 673,521,704
MEG03 - SSI & Related - Dual Eligible	$ 2,416.39	338,307	$ 817,481,652	79.11%	$ 646,698,671	$ 545,626,908	$ 424,546,268
MEG08 Uncompensated Care Pool	NA	NA	$ 68,889,323	79.11%	$ 54,497,411	$ -	$ -
MEG09 HQII	NA	NA	$ 12,011,853	79.11%	$ 9,502,414	$ -	$ -
Grand Total			**$ 3,906,153,864**		**$ 3,090,105,455**	**$ 3,186,994,259**	**$ 2,521,188,025**

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	2,790	$ 18,124,705	77.80%	$ 14,100,354	$ 8,925,515	$ 6,938,668
MEG 05 - "217 Like" Dual Eligible	$ 4,299.57	54,837	$ 235,775,520	77.80%	$ 183,424,680	$ 208,015,899	$ 161,833,770
Grand Total			**$ 253,900,225**		**$ 197,525,033**	**$ 216,941,414**	**$ 168,772,438**

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	2,607,832	$ 2,313,407,767	90.49%	$ 2,093,334,768	$ 1,672,381,438	$ 1,513,288,863
Grand Total			**$ 2,313,407,767**		**$ 2,093,334,768**	**$ 1,672,381,438**	**$ 1,513,288,863**

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	3,958	$ 3,756,696	87.24%	$ 3,277,230	$ 4,864,463	$ 4,243,613
Grand Total			**$ 3,756,696**		**$ 3,277,230**	**$ 4,864,463**	**$ 4,243,613**

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

Federal Share (Title XIX) Budget Neutrality Limit	**$ 3,090,105,455**
Federal Share (Title XIX) Actual Reported	$ 2,521,188,025
Excess Spending - Test 1	$ -
Excess Spending - Test 2	$ -
Excess Spending - Test 3	$ 966,383
Total Actuals	$ 2,521,188,025
Difference (Actuals - Limit)	$ (568,917,430)
Percentage Difference	-18.4%

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 2023 Quarter 4 submission.

3.) Expenditures as reported on the CMS-64 Schedule C, FFY 2023 Quarter 4. Report pulled on 11/06/2023.

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 4/2023

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	1,562,670,294	1,713,145,073	1,952,892,725	2,357,660,998	2,813,162,495	1,777,707,112	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18,321,594,160	18,321,594,160
MEG2- SSI Medicaid Only	0	824,991,985	882,936,445	866,977,418	845,978,765	795,483,090	865,688,657	1,007,302,350	1,070,455,548	1,182,781,316	863,660,239	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9,206,255,813	9,206,255,813
MEG3- SSI DUAL	0	570,643,867	584,265,571	609,500,283	564,265,856	558,418,717	557,052,123	625,582,634	670,781,533	725,572,069	545,626,908	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,011,709,561	6,011,709,561
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	11,165,493	8,925,515	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	99,740,461	99,740,461
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	246,178,530	270,640,322	208,015,899	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,571,777,606	1,571,777,606
MEG6-VIII GROUP	0	856,045,974	1,309,500,952	1,363,113,600	1,415,361,896	1,463,980,846	1,611,156,552	1,976,337,271	2,174,796,256	2,371,520,280	1,672,381,438	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,214,195,065	16,214,195,065
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	3,448,086	4,652,395	6,523,668	7,296,086	4,864,463																26,784,698	26,784,698
Total	**0**	**3,900,806,141**	**4,471,181,314**	**4,562,413,298**	**4,605,361,789**	**4,608,248,276**	**4,986,650,384**	**5,782,730,614**	**6,550,108,422**	**7,382,138,061**	**5,081,181,574**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**51,930,819,873**	**51,930,819,873**
Check		*3,900,806,141*	*4,471,181,314*	*4,562,413,298*	*4,605,361,789*	*4,608,248,276*	*4,986,650,384*	*5,782,730,614*	*6,550,108,422*	*7,382,138,061*	*5,081,181,574*																	
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	1,180,620,316	1,307,627,178	1,584,280,835	1,949,247,464	2,322,146,694	1,423,120,053		0	0	0	0	0	0	0	0	0	0	0	0	0	0	14,265,526,850	14,265,526,850
MEG2- SSI Medicaid Only	0	574,950,391	619,379,415	614,385,717	606,610,371	576,985,579	633,237,747	798,943,177	874,895,677	953,068,454	673,521,704		0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,925,978,232	6,925,978,232
MEG3- SSI DUAL	0	395,585,750	408,061,166	430,111,909	402,851,084	403,163,956	403,427,596	494,860,305	561,460,419	588,475,590	424,546,268		0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,512,544,043	4,512,544,043
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	9,055,970	6,938,668		0	0	0	0	0	0	0	0	0	0	0	0	0	0	75,140,180	75,140,180
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	207,606,716	219,955,221	161,833,770		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,207,571,965	1,207,571,965
MEG6-VIII GROUP	0	856,020,190	1,309,439,632	1,362,203,902	1,346,722,655	1,378,952,952	1,500,232,419	1,784,502,787	1,972,057,853	2,147,512,474	1,513,288,863		0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,170,933,727	15,170,933,727
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	3,183,671	4,177,407	5,805,507	6,422,141	4,243,613																23,832,339	23,832,339
Total	**0**	**3,009,422,953**	**3,565,370,178**	**3,668,052,017**	**3,675,763,985**	**3,704,463,315**	**4,020,152,230**	**4,837,691,458**	**5,590,429,108**	**6,246,636,544**	**4,207,492,939**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42,501,642,388**	**42,501,642,388**
Check		*3,009,422,953*	*3,565,370,178*	*3,668,052,017*	*3,675,763,985*	*3,704,463,315*	*4,020,152,230*	*4,837,691,458*	*5,590,429,108*	*6,246,636,544*	*4,207,492,939*																	
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	127.139.804	140.154.570	101.732.412	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.124.143.264	1.124.143.264
Total	**0**	**84,356,751**	**123,819,527**	**118,473,862**	**106,619,834**	**97,506,744**	**105,963,616**	**118,376,144**	**127,139,804**	**140,154,570**	**101,732,412**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,124,143,264**	**1,124,143,264**

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	108,148,565	119,134,008	85,758,331	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,021,521,842	1,021,521,842
Total	**0**	**66,272,555**	**105,308,829**	**118,473,862**	**106,619,822**	**97,505,399**	**103,493,469**	**110,807,002**	**108,148,565**	**119,134,008**	**85,758,331**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,021,521,842**	**1,021,521,842**

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	265.134.052	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1.265.606.683	1.265.606.683
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 Onlv	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**	**265,134,052**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,901,686,225**	**1,901,686,225**
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*	*265,134,052*																	
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	173.962.464	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	837.343.664	837.343.664
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 Onlv	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**	*173,962,464*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,239,455,010**	**1,239,455,010**
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*	*173,962,464*																	
Difference		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*																	

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MEMBER MONTHS

CENTENNIAL CARE MEG REPORTING

Eligibility Group	CY 2016 Quarter 1	2	3	4	Total	CY 2017 Quarter 1	2	3	4	Total
Population 1 – TANF and Related	########	########	########	1,170,974	**4,621,656**	########	1,170,146	1,145,575	########	**########**
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**
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**
Population 4 – 217-like Group – Medicaid Only	566	1064	564	793	**2,987**	1,133	1,006	857	801	**3,797**
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**
Population 6 – VIII Group (expansion)	753,995	761,293	778,625	784,161	**3,078,074**	806,114	802,658	773,108	762,010	**########**
Population 7 - CHIP Group	151,824	140,006	134,983	132,292	**559,105**	133,031	130,727	123,340	117,212	**504,310**
Population 10 - SUD IMD										
Total	**#######**	**#######**	**#######**	**2,333,446**	**9,235,066**	**#######**	**2,351,579**	**2,286,361**	**#######**	**#######**

Eligibility Group	CY 2018 Quarter 1	2	3	4	Total	CY 2019 Quarter 1	2	3	4	Total
Population 1 – TANF and Related	########	########	########	########	**4,422,938**	########	########	1,079,500	########	**########**
Population 2 – SSI and Related – Medicaid Only	116,043	115,944	114,284	113,559	**459,830**	112,782	112,246	111,860	111,572	**448,460**
Population 3 – SSI and Related - Dual	108,032	108,101	108,318	108,264	**432,715**	108,143	108,378	108,509	108,385	**433,415**
Population 4 – 217-like Group – Medicaid Only	830	835	853	789	**3,307**	754	751	746	739	**2,990**
Population 5 – 217-like Group - Dual	11,050	11,820	12,257	12,311	**47,438**	12,167	12,422	12,828	13,350	**50,767**
Population 6 – VIII Group (expansion)	762,410	756,109	747,006	753,639	**3,019,164**	759,129	765,866	767,811	778,089	**########**
Population 7 - CHIP Group	117,719	113,236	109,585	111,810	**452,350**	113,954	111,660	112,480	115,511	**453,605**
Population 10 - SUD IMD						93	324	92	86	**595**
Total	**#######**	**#######**	**#######**	**#######**	**8,837,742**	**#######**	**#######**	**2,193,826**	**#######**	**#######**

Eligibility Group	CY 2020 Quarter 1	2	3	4	Total	CY 2021 Quarter 1	2	3	4	Total
Population 1 – TANF and Related	########	########	########	########	**4,593,472**	1,242,048	1,264,108	########	########	**5,134,916**
Population 2 – SSI and Related – Medicaid Only	112,231	111,666	112,949	113,551	**450,397**	114,465	115,066	115,626	116,881	**462,038**
Population 3 – SSI and Related - Dual	108,324	108,074	108,273	108,648	**433,319**	107,956	108,420	109,664	110,615	**436,655**
Population 4 – 217-like Group – Medicaid Only	724	762	775	746	**3,007**	779	779	727	713	**2,998**
Population 5 – 217-like Group - Dual	14,040	14,723	15,545	16,256	**60,564**	16,706	17,025	17,347	17,575	**68,653**
Population 6 – VIII Group (expansion)	784,171	814,819	827,549	850,436	**3,276,975**	866,005	871,996	879,825	886,857	**3,504,683**
Population 7 - CHIP Group	118,810	114,070	118,310	119,859	**471,049**	124,273	128,782	118,258	121,190	**492,503**
Population 10 - SUD IMD	609	621	651	848	**2,729**	1,192	1,305	1,101	1,183	**4,781**
Total	**#######**	**#######**	**#######**	**#######**	**9,291,512**	**2,473,424**	**2,507,481**	**#######**	**#######**	**########**

Eligibility Group	CY 2022 Quarter 1	2	3	4	Total	CY 2023 Quarter 1	2	3	4	Total
Population 1 – TANF and Related	########	########	########	########	**5,451,107**	########	########	########		**########**
Population 2 – SSI and Related – Medicaid Only	117,425	118,920	118,793	119,640	**474,778**	120,182	120,339	119,407		**359,928**
Population 3 – SSI and Related - Dual	110,905	111,978	112,624	113,451	**448,958**	113,955	113,543	110,809		**338,307**
Population 4 – 217-like Group – Medicaid Only	764	762	788	799	**3,113**	878	953	959		**2,790**
Population 5 – 217-like Group - Dual	17,493	17,749	17,701	18,027	**70,970**	18,305	18,465	18,067		**54,837**
Population 6 – VIII Group (expansion)	887,606	880,616	881,366	881,867	**3,531,455**	885,014	896,840	825,978		**########**
Population 7 - CHIP Group	124,276	129,115	131,429	135,045	**519,865**	140,516	124,640	112,706		**377,862**
Population 10 - SUD IMD	1,330	1,460	1,672	1,528	**5,990**	1,660	1,549	749		**3,958**
Total	**#######**	**#######**	**#######**	**#######**	**########**	**#######**	**#######**	**#######**	**0**	**#######**

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Table #9 - Waiver Year 9 Expenditures

Medicaid Eligibility Group (MEG)	Program Expenditures	Administrative Expenditures
Admin		**233,949,809**
MEG01 - TANF & Related	$ 2,813,162,495	$ -
MEG02 - SSI & Related - Medicaid Only	$ 1,182,781,316	$ -
MEG03 - SSI & Related - Dual Eligible	$ 725,572,069	$ -
MEG04 - "217 Like" Medicaid Only	$ 11,165,493	$ -
MEG05 - "217 Like" Dual Eligible	$ 270,640,322	$ -
MEG06 - VIII Group - Medicaid Expansion	$ 2,371,520,280	$ -
MEG07 - CHIP	$ 140,154,570	$ -
Uncompensated Care "UC" Pool	$ -	N/A
Hospital Quality Improvement Incentive "HQII" Pool	$ -	N/A
Centennial Care 2.0 Medicaid SUD/IMD	$ 7,296,086	N/A
Grand Total	**$ 7,522,292,631**	**$ 233,949,809**

Source: New Mexico CMS 64 Submission, FFY 2023 Quarer 4, 2023.

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) July 2021 - June 2022	Utilization (per 1,000 Members) July 2022 - June 2023	Cost per Unit July 2021 - June 2022	Cost per Unit July 2022 - June 2023
Inpatient (Admissions)	82.3	72.5	$ 11,091	$ 9,349
Inpatient (Days)	382.4	327.0	$ 2,386	$ 2,072
Practitioner / Physician (Services)	7,348.5	6,872.9	$ 83	$ 83
Emergency Department (Visits)	513.3	533.9	$ 502	$ 517
Outpatient (Visits)	1,781.8	1,500.6	$ 273	$ 288
Pharmacy (Scripts)	4,400.3	4,363.8	$ 79	$ 84
Other (Services)1	8,929.0	8,290.5	$ 62	$ 65

Pharmacy Classification	Script Utilization July 2021 - June 2022	Script Utilization July 2022 - June 2023	Script Cost per Unit July 2021 - June 2022	Script Cost per Unit July 2022 - June 2023
Brand	12.0%	7.4%	$ 496	$ 839
Generic	86.8%	91.5%	$ 22	$ 23
Other Rx2	1.3%	1.1%	$ 72	$ 70

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 June 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) July 2021 - June 2022	Utilization (per 1,000 Members) July 2022 - June 2023	Cost per Unit July 2021 - June 2022	Cost per Unit July 2022 - June 2023
Inpatient (Admissions)	74.1	66.7	$ 17,583	$ 17,466
Inpatient (Days)	619.2	870.3	$ 2,105	$ 1,338
Practitioner / Physician (Services)	7,998.6	7,162.5	$ 94	$ 97
Emergency Department (Visits)	585.7	539.9	$ 662	$ 687
Outpatient (Visits)	2,285.8	1,920.3	$ 329	$ 350
Pharmacy (Scripts)	7,828.3	7,360.0	$ 107	$ 124
Other (Services)1	9,513.5	8,332.5	$ 75	$ 80

Pharmacy Classification	Script Utilization July 2021 - June 2022	Script Utilization July 2022 - June 2023	Script Cost per Unit July 2021 - June 2022	Script Cost per Unit July 2022 - June 2023
Brand	12.1%	9.4%	$ 723	$ 1,083
Generic	86.4%	89.3%	$ 21	$ 24
Other Rx2	1.5%	1.4%	$ 93	$ 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 June 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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Inpatient (Admissions)	220.0	217.9	$ 2,858	$ 1,943
Inpatient (Days)	1,510.6	1,469.3	$ 416	$ 288
Nursing Home (Days)	243,317.2	194,509.8	$ 50	$ 57
Personal Care (Services / hr.)	783,380.6	768,240.5	$ 20	$ 20
Outpatient (Visits)	5,860.0	4,969.9	$ 147	$ 126
Pharmacy (Scripts)	814.1	741.9	$ 22	$ 14
HCBS (Services)	7,022.7	9,796.4	$ 179	$ 122
Other (Services)1	45,003.8	35,201.2	$ 41	$ 46

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Brand	13.2%	12.4%	$ 104	$ 48
Generic	83.2%	83.7%	$ 7	$ 6
Other Rx2	3.5%	3.9%	$ 59	$ 64

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 June 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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Inpatient (Admissions)	327.6	314.7	$ 18,481	$ 18,092
Inpatient (Days)	2,792.8	2,378.8	$ 2,168	$ 2,393
Nursing Home (Days)	16,899.5	18,205.6	$ 203	$ 196
Personal Care (Services / hr.)	671,717.6	652,665.3	$ 20	$ 21
Outpatient (Visits)	8,199.1	7,455.4	$ 499	$ 543
Pharmacy (Scripts)	30,495.5	29,257.0	$ 124	$ 143
HCBS (Services)	26,083.0	25,905.3	$ 91	$ 91
Other (Services)1	61,544.1	57,286.2	$ 101	$ 103

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Brand	10.0%	8.5%	$ 992	$ 1,355
Generic	87.9%	89.7%	$ 25	$ 29
Other Rx2	2.1%	1.8%	$ 88	$ 87

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 June 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: Self-Directed Population (Dual and Medicaid Only)

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Inpatient (Admissions)	190.6	196.7	$ 8,601	$ 7,397
Inpatient (Days)	1,390.5	1,340.7	$ 1,179	$ 1,085
Nursing Home (Days)	4,913.0	4,916.3	$ 30	$ 43
Personal Care (Services / hr.)	-	-	$ -	$ -
Outpatient (Visits)	7,214.7	5,931.7	$ 235	$ 250
Pharmacy (Scripts)	11,310.0	10,503.5	$ 129	$ 134
HCBS (Services)	283,012.7	249,883.4	$ 94	$ 94
Other (Services)1	51,422.2	42,838.7	$ 55	$ 63

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Brand	11.0%	9.1%	$ 923	$ 1,133
Generic	86.8%	89.0%	$ 28	$ 33
Other Rx2	2.2%	1.9%	$ 104	$ 97

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 June 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

	Utilization (per 1,000 Members)		Cost per Unit	
Service Grouping	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Inpatient (Admissions)	76.9	49.7	$ 4,280	$ 6,091
Inpatient (Days)	538.7	381.9	$ 611	$ 792
Practitioner / Physician (Services)	8,342.1	6,696.4	$ 29	$ 29
Emergency Department (Visits)	597.6	496.2	$ 172	$ 167
Outpatient (Visits)	3,036.1	2,471.3	$ 165	$ 137
Pharmacy (Scripts)	1,350.1	1,201.2	$ 32	$ 27
Other (Services)1	7,296.2	6,299.8	$ 91	$ 138

	Script Utilization		Script Cost per Unit	
Pharmacy Classification	July 2021 - June 2022	July 2022 - June 2023	July 2021 - June 2022	July 2022 - June 2023
Brand	17.7%	15.6%	$ 124	$ 110
Generic	80.4%	82.2%	$ 10	$ 9
Other Rx2	1.9%	2.1%	$ 77	$ 78

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 June 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) July 2021 - June 2022	Utilization (per 1,000 Members) July 2022 - June 2023	Cost per Unit July 2021 - June 2022	Cost per Unit July 2022 - June 2023
Inpatient (Admissions)	39.3	34.7	$ 589	$ 539
Inpatient (Days)	90.1	75.6	$ 257	$ 248
BH Practitioner (services)	675.0	616.1	$ 157	$ 166
Core Service Agency (Services)	313.8	298.8	$ 180	$ 189
BH outpatient / clinic (Services)	3,404.0	3,039.0	$ 77	$ 82
Pharmacy (Scripts)	1,568.0	1,511.7	$ 63	$ 67
Residential Treatment Center (days)	37.3	37.6	$ 3,297	$ 2,708
Other (Services)1	12.8	10.6	$ 115	$ 136

Pharmacy Classification	Script Utilization July 2021 - June 2022	Script Utilization July 2022 - June 2023	Script Cost per Unit July 2021 - June 2022	Script Cost per Unit July 2022 - June 2023
Brand	3.7%	3.1%	$ 938	$ 1,258
Generic	96.3%	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 June 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 Q3 Attachment D: Customer Service Summary (Jan 1 - Sep 30, 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			
	Number of Calls Answered - All Queues		13,474	11,476	12,276	10,180	10,900	9,804	9,604	11,006	9,430			
	Percent of Calls Abandoned	**< 5%**	0.5%	0.8%	0.9%	0.6%	0.4%	0.8%	0.4%	0.3%	1.1%			
	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%			
	Average Wait Time	**< 2 minutes**	0.1	0.2	0.3	0.2	0.1	0.2	0.1	0.1	0.1			
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%			
Nurse Advice Line	Number of Calls Received - All Queues		624	601	637	560	591	491	526	567	569			
	Number of Calls Answered - All Queues		612	593	627	555	589	488	523	562	567			
	Percent of Calls Abandoned	**< 5%**	1.9%	1.3%	1.6%	0.9%	0.3%	0.6%	0.6%	0.9%	0.4%			
	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%			
	Average Wait Time	**< 2 minutes**	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.1			
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			
	Number of Calls Answered - All Queues		6,322	5,762	6,345	5,725	6,213	6,329	5,332	6,477	5,977			
	Percent of Calls Abandoned	**< 5%**	0.5%	0.9%	0.7%	0.4%	0.4%	0.5%	0.3%	0.3%	0.4%			
	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%			
	Average Wait Time	**< 2 minutes**	0.2	0.3	0.3	0.2	0.1	0.2	0.1	0.1	0.2			
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100.0%	100.0%	100.0%	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			
	Number of Calls Answered - All Queues		4,937	4,791	5,037	4,395	5,159	4,831	4,410	5,123	4,197			
	Percent of Calls Abandoned	**< 5%**	0.4%	0.4%	0.7%	0.4%	0.2%	0.4%	0.3%	0.2%	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%			
	Average Wait Time	**< 2 minutes**	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.0	0.4			

Source: WSCC Report 2, M1-M9 CY23

DY10 Q3 Attachment D: Customer Service Summary (Jan 1 - Sep 30, 2023)

PHP CALL CENTER STANDARDS AND PERFORMANCE MEASURES

Legend: Meets Standard (green) | Does Not Meet (red)

			PHP											
		CONTRACT STANDARD	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			
	Number of Calls Answered - All Queues		23,036	18,605	18,786	16,266	17,185	17,597	16,880	19,005	15,883			
	Percent of Calls Abandoned	**< 5%**	1.7%	0.8%	1.4%	1.0%	1.4%	1.8%	1.5%	1.9%	1.6%			
	Percent of Calls Answered within 30 Seconds	**85%**	90%	95%	90%	93.0%	91.0%	88.2%	88%	88%	88%			
	Average Wait Time	**< 2 minutes**	0.3	0.2	0.3	0.2	0.3	0.4	0.3	0.4	0.4			
	Percent of Voicemails Returned by Next Business Day	**100%**	100%	100%	100%	100.0%	100.0%	100.0%	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			
	Number of Calls Answered - All Queues		2,284	2,052	2,553	2,054	2,139	1,957	1,958	1,979	1,896			
	Percent of Calls Abandoned	**< 5%**	1.5%	2.8%	2.2%	2.2%	1.3%	0.9%	1.0%	1.2%	1.4%			
	Percent of Calls Answered within 30 Seconds	**85%**	97%	93%	94%	92%	97%	98%	98%	97%	98%			
	Average Wait Time	**< 2 minutes**	0.1	0.2	0.2	0.3	0.1	0.1	0.1	0.1	0.1			
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			
	Number of Calls Answered - All Queues		3,897	3,686	6,196	5,417	5,187	4,955	4,580	5,275	4,135			
	Percent of Calls Abandoned	**< 5%**	0.8%	0.4%	0.5%	0.8%	0.3%	0.4%	0.4%	0.3%	0.4%			
	Percent of Calls Answered within 30 Seconds	**85%**	93%	96%	90%	89.3%	90.7%	90.4%	93%	92%	89%			
	Average Wait Time	**< 2 minutes**	0.2	0.1	0.2	0.2	0.2	0.2	0.1	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%			
UM Line	Number of Calls Received - All Queues		971	844	1,283	1,061	851	937	786	936	714			
	Number of Calls Answered - All Queues		966	836	1,277	1,056	847	933	782	924	710			
	Percent of Calls Abandoned	**< 5%**	0.5%	0.9%	0.5%	0.5%	0.5%	0.4%	0.5%	1.3%	0.6%			
	Percent of Calls Answered within 30 Seconds	**85%**	90%	92%	96%	94%	91%	91%	94%	91%	92%			
	Average Wait Time	**< 2 minutes**	0.2	0.2	0.1	0.1	0.2	0.2	0.1	0.2	0.1			

Source: PHP Report 2, M1-M9 CY23

DY10 Q3 Attachment D: Customer Service Summary (Jan 1 - Sep 30, 2023)

WSCC 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		5,740	4,868	5,509	4,585	5,154	5,305	4,951	5,741	5,205			
	Number of Calls Answered - All Queues		5,604	4,735	5,405	4,547	5,111	5,277	4,894	5,683	5,085			
	Percent of Calls Abandoned	< 5%	2.4%	2.7%	1.9%	0.8%	0.8%	0.5%	1.2%	1.0%	2.3%			
	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%			
	Average Wait Time	< 2 minutes	0.5	0.4	0.3	0.1	0.1	0.1	0.5	0.2	0.5			
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%	100%			
Nurse Advice Line	Number of Calls Received - All Queues		162	134	159	138	153	158	126	151	145			
	Number of Calls Answered - All Queues		158	132	158	135	151	156	124	150	139			
	Percent of Calls Abandoned	< 5%	2.5%	1.5%	0.6%	2.2%	1.3%	1.3%	1.6%	0.7%	4.1%			
	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%			
	Average Wait Time	< 2 minutes	0.7	0.1	0.2	0.2	0.1	0.2	0.1	0.1	0.1			
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			
	Number of Calls Answered - All Queues		4,044	4,052	4,204	3,887	4,505	4,294	4,157	5,189	4,270			
	Percent of Calls Abandoned	< 5%	1.9%	2.7%	1.8%	1.8%	2.2%	1.9%	1.1%	1.6%	2.2%			
	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%			
	Average Wait Time	< 2 minutes	0.3	0.6	0.4	0.4	0.3	0.5	0.3	0.6	0.5			
	Percent of Voicemails Returned by Next Business Day	100%	100%	100%	100%	100.0%	100.0%	100.0%	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			
	Number of Calls Answered - All Queues		1,524	1,408	1,657	1,465	1,601	1,492	1,402	1,765	1,386			
	Percent of Calls Abandoned	< 5%	1.8%	1.9%	2.0%	3.4%	3.0%	3.8%	5.3%	1.0%	1.4%			
	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%			
	Average Wait Time	< 2 minutes	0.3	0.4	0.4	0.3	0.3	0.3	0.4	0.1	0.2			

Source: WSCC Report 2, M1-M9 CY23