CENTENNIAL CARE 2.0 DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 11 (1/1/2024 – 12/31/2024)
Quarter 2 of 2024

October 30, 2024

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INTRODUCTION

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

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

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

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

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

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

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

Status of Key Dates:

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

New Mexico Turquoise Care 1115 Waiver Renewal Application	Submitted to CMS on December 15, 2022.	CMS Completeness Letter received on December 29, 2022. Federal Comment Period occurred December 29, 2022, through January 28, 2023. CMS' Temporary Extension Approval received on September 5, 2023. CMS Amendment Approval received on December 15, 2023, for some waiver renewal initiatives. CMS and New Mexico continue negotiations.
SMI/SED Implementation Plan	Due to CMS June 26, 2023 Resubmission due January 31, 2024 (extensions approved by CMS). Resubmission due date April 12, 2024	Submitted to CMS 6/26/2023. CMS feedback received July 17, 2023, and New Mexico resubmitted September 29, 2023. New Mexico resubmitted plan on 10/18/2023 and CMS provided additional feedback on 10/31/2023. New Mexico resubmitted plan on February 20, 2024, and CMS provided feedback on March 14, 2024. New Mexico resubmitted plan to CMS on April 11, 2024. Under CMS review.
SMI/SED Monitoring Protocol	Due to CMS August 25, 2023	On August 18, 2023, CMS extended the deadline to September 29, 2023. On September 1, 2023, CMS extended the deadline to January 31, 2024. On December 22, 2023, CMS extended the deadline to May 31, 2024. Deadlines will continue to be extended until CMS develops and issues new monitoring templates and guidance.
Centennial Care 2.0 -	Due to CMS September 4, 2023	On September 18, 2023, CMS granted

COVID-19 Vaccine Final Report		New Mexico an extension to submit by October 31, 2023. On November 16, 2023, CMS granted New Mexico an extension to submit by February 29, 2024. New Mexico submitted the COVID-19 Report to CMS on February 28, 2024. Under CMS review.
Centennial Care 2.0 Amended Evaluation Design	Due to CMS September 25, 2023 Resubmission due March 1, 2024	New Mexico submitted September 25, 2023, to include Serious Mental Illness (SMI)/serious emotional disturbance (SED), High Fidelity Wraparound (HFW), Home and Community Based Services (HCBS) Enhancements, and Legally Responsible Individual (LRI) components. On December 13, 2023, CMS provided feedback. On March 1, 2024, New Mexico resubmitted its Evaluation Design to CMS. On April 23, 2024, CMS approved New Mexico's Evaluation Design.
Centennial Care 2.0 Public Health Emergency Amendment for Legally Responsible Individuals under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit Final Report	Due to CMS November 11, 2024. Reporting Period: May 11, 2023 – November 11, 2023	In progress.
NM COVID Authorities Temporary Extension for Legally Responsible Individuals under EPSDT and Community Benefit Final Report	Due to CMS February 28, 2025 Reporting Period: November 12, 2023 – February 29, 2024	In progress.

NEW MEXICO AND CMS WAIVER ACTIVITIES

New Mexico Centennial Care 2.0 Waiver Amendment #2

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

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

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

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

Updates for Q2 CY2023

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

Updates for Q3 CY2023

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

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

Updates for Q1 CY2024
New Mexico resubmitted its SMI/SED Implementation Plan to CMS on February 20, 2024 and CMS provided feedback on March 14, 2024. New Mexico is preparing the resubmission. Separately, New Mexico submitted its Centennial Care 2.0 COVID-19 Vaccine Final Report to CMS on February 29, 2024, which remains under CMS review. Lastly, New Mexico resubmitted its revised Evaluation Design to CMS on March 1, 2024, which remains under CMS review.

Updates for Q2 CY2024
New Mexico and CMS continue their collaboration on required deliverables. The following are deliverable updates this quarter:

- New Mexico resubmitted its SMI/SED Implementation Plan to CMS on April 11, 2024, which remains under CMS review.
- New Mexico's Centennial Care 2.0 COVID-19 Vaccine Final Report remains under CMS review.
- New Mexico's revised Evaluation Design was approved by CMS on April 23, 2024.

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

As New Mexico prepared its waiver renewal application, it held several stakeholder engagements to obtain valuable input on the current Centennial Care 2.0 Medicaid program and innovations that could be explored as part of the 1115 demonstration renewal. A formal public comment period was held from September 6, 2022 through October 31, 2022 providing opportunities to health care and social service providers, Tribal leadership, Indian Health Services, Tribal Nations, Tribal health providers, Urban Indian healthcare

providers, Managed Care Organizations, hospitals and health systems, medical associations, community-based organizations, members of the public, and others to provide feedback on HSD's draft Medicaid 1115 Waiver Renewal Application. Public comments were welcomed by mail, email, public hearing, and Tribal Consultation. Two public hearings and one Tribal Consultation was held to obtain verbal feedback. The following table lists stakeholder engagements that occurred throughout the process:

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

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

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

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

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

Turquoise Care has targeted initiatives focused on the following populations:

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

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

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

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

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

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

- Additional support for rural hospitals.

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

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

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

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

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

During the COVID-19 public health emergency (PHE), the traditional provider workforce

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

Updates for Q4 CY2023

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

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

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

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

Updates for Q2 CY2024
CMS and New Mexico continue negotiations on the state's 1115 Waiver Renewal request. The target date for approval is July 2024.

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

During the May 6, 2024 MAC meeting, the following topics were addressed in support of the Centennial Care 2.0 waiver and Medicaid 1115 demonstration waiver renewal:

- Leadership update – Provided budget update;
- Updates on approved State Plan Amendments;
- 1115 Demonstration Updates – Included information on approved services, ongoing waivers, and updates to the 1902 Eligibility Waiver to include approval from CMS to extend eligibility for seniors received long-term care and individuals with disabilities;
- Maternal Health Strategy and the impact of Maternal Mortality Review Committee on policy including key findings, proposed interventions, and recommendations;
- Update on Health Care Authority (HCA) including a transition timeline and operational changes being completed by June 2024;
- Turquoise Care overview – Including transitions and goals to include enhancing healthcare delivery, implementing payment reforms, addressing health disparities, and supporting Children in State Custody through; Presbyterian Healthcare;
- Medicaid Management Information System Replacement (MMISR) - Included updates on MMISR project overview, go live dates, and module updates.

A Special Session of the Medicaid Advisory Committee meeting was held during DY11 Q2 on June 6, 2026. The following topics were discussed:

- Medicaid Forward Plan per HB400 (2023) – Discussion included partnering with Mercer Government Human Services Consulting to conduct a study mandated by the bill, and assess impacts on enrollment, premiums, provider reimbursement, costs, waivers, and budgets, including effects on other insurance markets;

- Update provided on CMS Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) changes and new requirements. Provided an overview of the timeline and highlighted bills impacting Medicaid.

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

- April 15, 2019;
- December 16, 2019;
- January 27, 2020;
- April 27, 2020;
- August 3, 2020;
- November 2, 2020;
- January 19, 2021;
- May 10, 2021;
- August 9, 2021;
- November 8, 2021;
- January 24, 2022;
- May 16, 2022;
- August 8, 2022;
- November 21, 2022;
- February 13, 2023;
- May 8, 2023;
- August 21, 2023;
- November 13, 2023;
- March 4, 2024;
- May 6, 2024;
- June 20, 2024.

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

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: QUARTER 2 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	3/31/2024 ENROLLMENT	6/30/2024 ENROLLMENT	PERCENT INCREASE / DECREASE Q2
BlueCross BlueShield of New Mexico (BCBS)	259,620	259,803	0.1%
Presbyterian Health Plan (PHP)	368,761	366,994	-0.5%
Western Sky Community Care (WSCC)	90,234	85,854	-4.9%

Source: Medicaid Eligibility Reports, March 2024 and June 2024

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment and expenditure data by programs for April 2022 – March 2024 is available in Attachment A.

MCO Enrollment

In aggregate, MCO enrollment decreased by 7% from the previous to current period. This decrease is comprised of the following:

- 10% decrease in Physical Health enrollment;
- 2% decrease in Long-Term Services and Supports enrollment;
- 2% decrease in Other Adult Group enrollment.

Enrollment levels have started to decline in recent months as a result of member disenrollments that began May 1, 2023. Enrollment graphs in Attachment A illustrate a decrease for the most recent month which is mostly due to retroactivity not yet accounted for at the cutoff date of the enrollment data (i.e., March 31, 2024). Historically, this decrease in the last month changes to an increase in subsequent quarter due to additional runout.

MCO Per Capita Medical Costs:
In aggregate, total MCO per capita medical costs increased by 8% from the previous to current period. This consists of an 8% increase to pharmacy services and non-pharmacy services.

On a dollar basis, the lower enrollment levels (-7%) have been offset by the increase in per capita medical costs (8%), driving the negligible increase in total medical expenses.

CENTENNIAL CARE 2.0 AND TURQUOISE CARE

CENTENNIAL REWARDS

The Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors. Beginning in DY11, New Mexico modified its 2024 Rewards Program as illustrated below.

Reward Activity	Age Requirement	2024 Modification
Address Update (supports PHE unwinding efforts)	Any	Added new reward activity
Adult Primary Care Provider (PCB) Checkup – Complete annual PCP wellness checkup	Ages 20+	Age requirement changed from Ages 22+ to 20+
Antidepressant Medication Management - Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	No Change
Breast Cancer Screening (BCS) – Complete mammogram	Ages 50-74	Added new reward activity
Cervical Cancer Screening (CCS) – Ages 21-64: Cervical cytology (pap test) Ages 30-64 high-risk women: HPV test and/or pap test	Ages 21-64	Added new reward activity
Childhood immunizations (CIS) – Complete immunization series	Age 2	Added new reward activity
Child & Adolescent Well-Care Visit - Complete annual wellness checkup with a PCP or an OB/GYN • Bonus: Adolescent Immunization Series – Complete adolescent immunization series by 13th birthday	Ages 3-21	No Change
Schedule and Complete First Centennial Home Visit (CHV)	All ages	Added new reward activity

CHV Video Completion	All ages	Added new reward activity
First CHV after baby is born	All ages	Added new reward activity
Ongoing CHV Visits	All ages	Added new reward activity
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	No change
Diabetes HbA1C Test – Completion of HbA1C Test • Bonus: Diabetes HbA1C Control – Attain HbA1c control (<8%)	Ages 10-75	Reward activity eliminated
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75	No change
Flu Shot - Receive flu vaccine	Ages 6 months+	No change
1st Prenatal Care Visit – Complete prenatal care visit in the first trimester or within 42 days of enrollment	All ages	No change
Postpartum Visit – Complete postpartum care visit between 7 and 84 days after delivery	All ages	No change
Postpartum Depression Screening – Complete postpartum depression screening	All ages	Added new reward activity
Smoking/Vaping Prevention – Complete vaping/smoking prevention learning module	Age under 18	No change
Step-Up Challenge (FCHAL-SU-3)– Successfully complete 3-week Step-Up Challenge	Ages 10+	No change
Well-Baby Checkups – Complete up to six well-child visits with a PCP during the first 15 months of life and up to two well-child visits with a PCP between 16-30 months of life • Bonus: Complete all eight well-child visits with a PCP between 0-30 months of life	0-30 months	No change

Centennial Rewards Participation

In DY11 Q2, 734,671 Centennial Care members participated in the Centennial Rewards Program. Participating members must take action to register for the Centennial Rewards program in order to receive reward redemptions. (In DY11 Q1 and DY10 Q4, participation data was erroneously reported as registrations.) Quality improvement and participation trends are demonstrated in the table below.

Table 2: Centennial Rewards

CENTENNIAL REWARDS				
	July - September 2023	October - December 2023	January - March 2024	April - June 2024
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	209,316	125,575	200,288	182,207
Number of Members Newly Registered in the Rewards Program this Quarter**	4,612	6,497	3,332	5,003
Number of Members Who Redeemed Rewards this Quarter***	30,542	50,159	17,180	29,960

Source: Finity Quarter 2 Report
*Only includes rewards earned in relevant quarter. This measure is typically highest early in the year as the majority of members have gaps-in-care at that time.
**Members only need to register to redeem rewards. Registration is typically lowest in the first half of the year as members save their reward points to spend when they have more buying power or during the holidays.
***In line with registration trends, reward redemptions are typically lowest in the early in the year as members save their reward points to spend when they have more buying power or during the holidays. Earned rewards expire December 31st of the following year (e.g., rewards earned in 2023 expire on December 31st, 2024). Rewards can be redeemed anytime during that period.

The following is a summary of DY11 Q2 observations of Table 2 above:

- Number of Medicaid Enrollees Receiving a Centennial Care Reward Service this Quarter
  - This measure is typically highest early in 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 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 early in the year as members save their reward points to spend when they have more buying power or during the holidays. Earned rewards expire December 31st of the following year (e.g., rewards earned in 2023 expire on December 31, 2024). Rewards can be redeemed anytime during that period.

Centennial Care Rewards Multimedia Campaigns

In DY11 Q2, Finity, the Centennial Care Rewards vendor, conducted the following multimedia campaigns to encourage members to keep their preventive appointments, receive vaccinations, and complete targeted condition management activities that align with state performance 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.

- 23K texts sent in Q2 2024;
- 24K emails sent in Q2 2024.

Child Dental Campaign: Designed to encourage members between the ages of 2 and 20 to go in for their dental visits. Members earn $30 (300 points) for completing their visit. Texts and emails were sent in May.

- 54K texts sent in Q2 2024;
- 49K emails sent in Q2 2024.

Monthly Redemptions Campaign: Designed to notify members who have earned rewards that they have points to spend in the Centennial Rewards Catalog on essential items like oximeters, thermometers, cleaning supplies, diapers, nursing supplies, kitchen items, and more. Texts and emails were sent April through June. This is an ongoing campaign and Q2 results are provided below:

- 477K texts sent in Q2 2024;
- 376K emails sent in Q2 2024.

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 June. This is an ongoing campaign and Q2 results are provided below:

- 23K texts sent in Q2 2024;
- 5K emails sent in Q2 2024.

Women's Cancer Screening Campaign: Designed to encourage eligible members to complete breast and cervical cancer screenings. Campaign texts and emails were sent in June. This is an ongoing campaign and Q2 results are provided below:

- 332K texts sent in Q2 2024;
- 240K emails sent in Q2 2024.

Additional Key Stats through Q2 2024:

- Member participation in Q2 2024 reached an all-time high of 77.23%;
- In Q2 2024, the number of newly registered members increased by 50% over Q1;
- With 30k members redeeming nearly $1M in Q2 2024, redemptions have remained consistent year over year during the same time period, even as eligibility has decreased following PHE unwinding;
- In Q2, members redeeming rose 74% from Q1.

Table 3: Centennial Rewards Customer Satisfaction Survey

Centennial Rewards Customer Satisfaction Survey												
	DY10 Q3			DY10 Q4			DY11 Q1			DY11 Q2		
	# OF RESPONDENTS 2,686			# OF RESPONDENTS 3,954			# OF RESPONDENTS 867			# OF RESPONDENTS 1,407		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Centennial Care?	97%	3%	n/a	96%	4%	n/a	98%	2%	n/a	96%	4%	n/a
Are you satisfied with your doctor?	88%	5%	7% I don't have a doctor	88%	5%	8% I don't have a doctor	86%	4%	10% I don't have a doctor%	87%	5%	8% I don't have a doctor
Are you satisfied with your health plan?	95%	5%	n/a	96%	4%	n/a	97%	3%	n/a	96%	4%	n/a
Are you satisfied with the help provided by your care coordinator?	92%	8%	<1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator	93%	7%	<1% I don't have a care coordinator	92%	7%	<1% I don't have a care coordinator

Source: Finity Quarter 2 Report

TURQUOISE CARE

The New Mexico Turquoise Care begins 7/1/2024, with four Turquoise Care MCOs: Blue Cross Blue Shield of New Mexico, Presbyterian Health Plan, Molina Healthcare of New Mexico, and United Healthcare Insurance Company. In DY11 Q2, each Turquoise Care MCO received a Readiness Review Report that provided a summary of the on-site review process for each focus area identified below, with particular emphasis on items that required additional follow-up.

Following is the Readiness Focus Areas:

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

During Q2, the Turquoise Care MCOs submitted additional information to address areas needing follow up. All the Turquoise Care MCOs have been determined ready to implement Turquoise Care on 7/1/2024.

CENTENNIAL CARE

Western Sky Community Care (WSCC) was not selected as a Turquoise Care MCO, and its Managed Care Agreement terminated 6/30/2024. WSCC developed, and New Mexico approved, a Termination Plan. The Plan will document WSCC's compliance with all duties and obligations, including financial requirements, incurred prior to the termination date, and the WSCC actions necessary to ensure the safe and efficient transition of its members to the Turquoise Care MCOs. WSCC will submit updates on its progress every 30 days. New Mexico will closely monitor WSCC's adherence to the approved termination plan and will notify WSCC in writing when all obligations have been fulfilled.

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ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

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

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

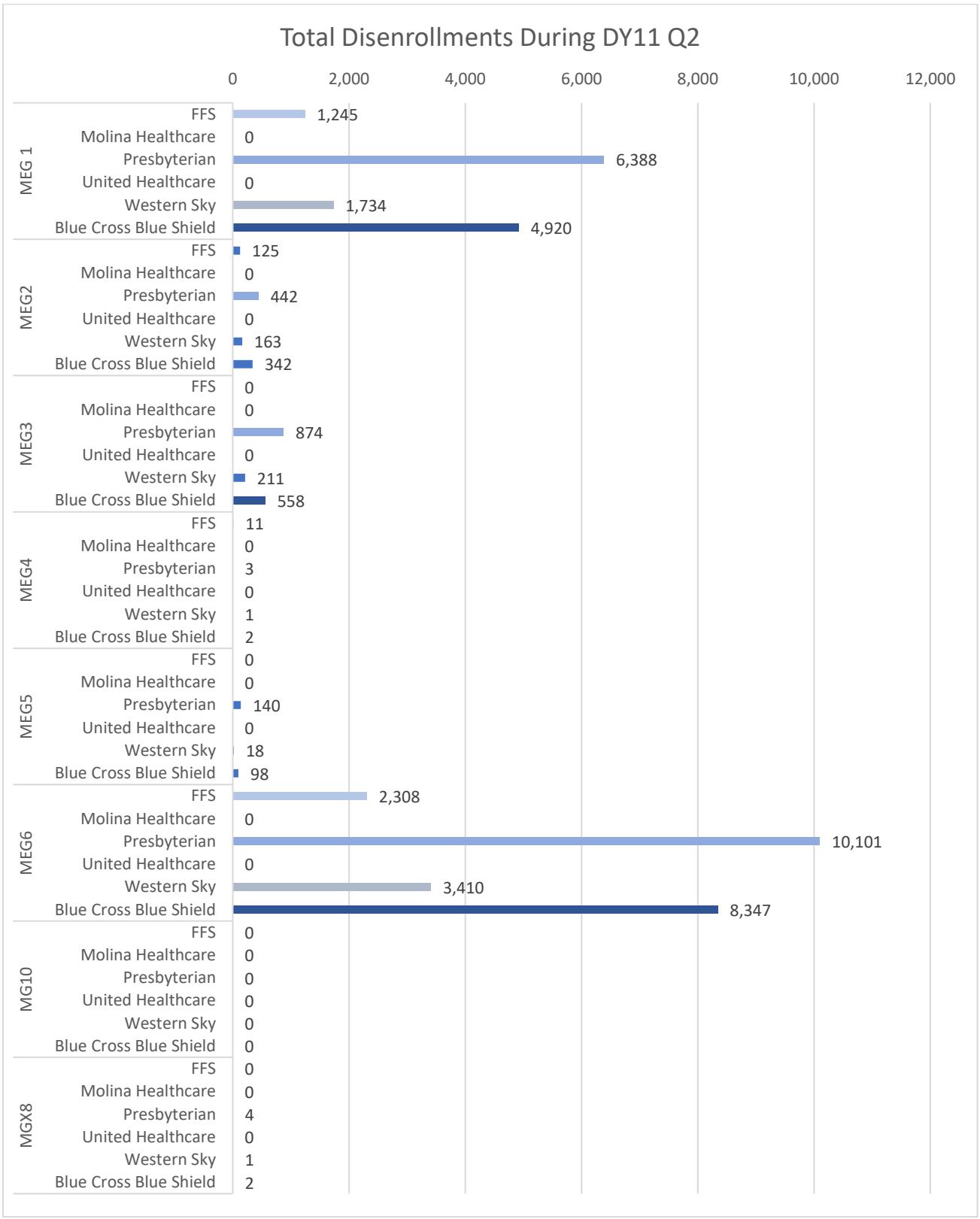
Most disenrollments for this quarter are attributed to loss of eligibility, members moving out of state, and administrative closure.

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

DY11 Q2 Data

Demonstration Population		Total Number Demonstration Participants DY11 Q2 Ending June 2024	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY11 Q2 (March-June 2024)
Population MEG1 - TANF and Related	0-FFS	24,857	27,927	1,245
	Presbyterian	177,198	181,359	6,388
	Western Sky	38,676	6,159	1,734
	Blue Cross Blue Shield	122,591	129,448	4,920
	Summary	**363,322**	**368,948**	**14,287**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,066	2,333	125
	Presbyterian	19,909	20,335	442
	Western Sky	4,009	516	163
	Blue Cross Blue Shield	12,439	12,809	342
	Summary	**38,423**	**38,935**	**1,072**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Presbyterian	21,104	23,834	874
	Western Sky	4,078	919	211
	Blue Cross Blue Shield	10,911	12,841	558
	Summary	**36,093**	**40,866**	**1,643**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	68	70	11
	Presbyterian	116	112	3
	Western Sky	13	3	1
	Blue Cross Blue Shield	74	83	2
	Summary	**271**	**276**	**17**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Presbyterian	3,138	3,712	140
	Western Sky	512	111	18
	Blue Cross Blue Shield	2,263	2,731	98
	Summary	**5,913**	**6,875**	**256**
Population MEG6 - VIII Group (expansion)	0-FFS	23,709	35,315	2,308
	Presbyterian	135,723	175,108	10,101
	Western Sky	38,925	15,295	3,410
	Blue Cross Blue Shield	106,266	139,288	8,347
	Summary	**304,623**	**393,099**	**24,166**
Population MEG10 - IMDSUD Group	0-FFS	7	40	0
	Presbyterian	91	420	0
	Western Sky	29	92	0
	Blue Cross Blue Shield	72	310	0
	Summary	**199**	**862**	**0**
Population MEGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Presbyterian	285	1,147	4
	Western Sky	86	377	1
	Blue Cross Blue Shield	294	1,137	2
	Summary	**665**	**2,661**	**7**
Summary		**749,509**	**852,522**	**41,448**

DY11 Q2 Complete Data



4

OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY11 Q2	In DY11 Q2, the Human Service Department (HSD), Medical Assistance Division (MAD) continued to provide coaching, outreach, and educational activities through webinars to Presumptive Eligibility Determiners (PEDs) in the Presumptive Eligibility (PE) and Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) programs to help PEDs better assist their clients in the completion of Medicaid eligibility applications, both online and telephonically. A monthly “PED Medicaid Monthly” newsletter is sent by HSD to active PEDs. The newsletter provides updates on HSD programs, policy changes, YESNM-PE system updates, tips and audit reminders for PEDs. The newsletter features a PED Hero section to allow active PEDs to nominate and feature one of their own. HSD also continues to provide online PE certification and refresher demo training sessions for prospective and current PEDs. In preparation for the transition from Centennial Care to Turquoise Care 7/1/2024, the Human Services Department (HSD), Medical Assistance Division (MAD) traveled throughout New Mexico to provide information on the upcoming changes and improvements to the Managed Care system. The in-person and virtual presentations were open to any interested stakeholders.

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

6

OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments through DY11 Q2 with the extension reflect the Centennial Care 2.0 rates effective for the period from January 1, 2024, through December 31, 2024. The rates were developed with efficiency, utilization, trends, prospective program changes, and other factors as described in the rate certification reports; the rate certification reports for January 1 through December 31, 2024, were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 28, 2023.

During DY11 Q2, financial payments were made for University of New Mexico Medical Group (UNMMG) directed payment, University of New Mexico Hospital (UNMH) directed payment, hospital value-based payments, retroactive reconciliation, health care quality surcharge reconciliation, medical care credit reconciliation.

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

SYSTEM ISSUES

There are no system issues to report for this quarter.

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

On January 31, 2020, the Health and Human Services Secretary, Alex M. Azar II, declared a public health emergency for the United States to aid the nation’s healthcare community in responding to the 2019 novel coronavirus also known as COVID-19. This declaration is retroactive to January 27, 2020. To help meet the needs of the nation during the ongoing COVID-19 pandemic, U.S. Health and Human Services (HHS) Secretary Xavier Becerra renewed the COVID-19 PHE declaration for COVID-19 on February 9, 2023, and the Biden administration announced their intent to end the COVID-19 PHE effective May 11, 2023, providing states and territories with 60 days’ advance notice of the PHE termination.

Following is a chronology of the renewals to date:

Historically the Maintenance of Effort (MOE) for Medicaid enrollment has been tied to the PHE declaration; however, with the passing of the Consolidation Appropriations Act of 2023 in December 2022, the MOE and the PHE were decoupled, and both had different end dates. The PHE ended on May 11, 2023, and the MOE continuous eligibility ended March 31, 2023. New Mexico began its unwinding activities in March 2023 and terminations began May 1, 2023. CMS provided states with three different options to begin unwinding activities, and New Mexico elected to begin activities in March 2023. New Mexico will use all 12 months of the unwinding period and will prioritize members who 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 June 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 apply this strategy to individuals who have procedurally closed since April 1, 2023.
            - Approved by CMS September 29, 2023, effective April 1, 2023, and will remain effective for renewals initiated through the end of the state's 12-month unwinding period, as defined in the March 3, 2022, CMS SHO letter #22-001.
- Permit Managed Care Plans to provide assistance to enrollees to complete and submit Medicaid renewal forms;
    - Approved by CMS September 5, 2023, effective September 1, 2023, and will remain effective for renewals initiated through the end of the state's 12-month unwinding period, as defined in the March 3, 2022, CMS SHO letter #22-001.
- Permit the designation of an authorized representative for the purposes of signing and application of renewal form by the telephone without a signed designation from the applicant or beneficiary;
    - Approved by CMS September 7, 2023, effective September 1, 2023, and will remain effective until 14 months after the end of the continuous enrollment condition (i.e. May 31, 2024).
- Waive the recording of the telephone signature from the applicant or beneficiary;
    - Approved by CMS September 7, 2023, effective September 1, 2023, and will remain effective until 14 months after the end of the continuous enrollment condition (i.e. May 31, 2024).
- Reinstate eligibility effective on the individuals' s prior termination date for individuals disenrolled based on a procedural reason who are subsequently redetermined eligible for Medicaid during a 90-day reconsideration period;
    - Approved by CMS September 7, 2023, effective September 1, 2023, and will remain effective until 17 months after the end of the continuous enrollment condition (i.e., August 31, 2024).
- Extend automatic reenrollment into a Medicaid Managed Care Plan up to 120 days after a loss of Medicaid coverage;

    - Approved by CMS September 29, 2023, effective September 1, 2023 and will remain effective until 17 months after the end of the continuous enrollment conditions (i.e., August 31, 2024)

- Delay procedural terminations for beneficiaries for 1 month while the state conducts targeted renewal outreach;
    - On August 30, 2023, CMS permitted the state to begin implementing this strategy, but a formal concurrence would follow.
        - On November 3, 2023, CMS concurred with New Mexico's request to use the exception in the regulations (42 CFR 435.912(e)) in meeting timeliness requirements to support states processing of Medicaid eligibility and enrollment actions conditioned that the state documents the reason for delay in each beneficiary's case record. The exception is effective for renewals due in the month of September 2023 and will remain effective for renewals due in each subsequent month of the state's unwinding period.

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

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

New Mexico Disaster Relief State Plan Amendments (SPAs)

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

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

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

In May 2023, New Mexico submitted NM SPA 23-0007 requesting CMS' approval effective April 30, 2023, to end coverage for the COVID-19 testing group at 1902(a)(10)(A)(ii)(XXIII) of the Act as previously authorized in New Mexico Disaster SPA 20-0007. On August 11, 2023, CMS approved New Mexico's request effective April 30, 2023.

1135 Waiver

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

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

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

Appendix Ks

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

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

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

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

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

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

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

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

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

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

1915c (Supports Waiver and Developmental Disabilities Waiver)

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

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

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

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

PATIENT CENTERED MEDICAL HOMES (PCMH)

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

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

Table 4 below reports the total number of members paneled to a PCMH per MCO. DY11 Q1 reflects a decrease in members receiving care through a PCMH for two MCOs while one MCO

showed an increase in DY11 Q1 compared to DY10 Q4. This overall reduction in membership and subsequent paneling to PCMH can be attributed to the ending of the Public Health Emergency (PHE). As a result, members were required to renew their Medicaid financial eligibility. During the PHE, members eligibility was continuously renewed as approved by federal waiver. Members have been issued correspondence related to the ending of the PHE and several different options on how to renew their Medicaid. The DY11 Q2 data will be reported in the DY11 Q3 CMS Quarterly Monitoring Report.

Table 4: PCMH Assignment

PCMH ASSIGNMENT Total Members Paneled to a PCMH				
	DY10 Q2	**DY10 Q3**	**DY10 Q4**	**DY11 Q1**
BCBS	161,328	151,385	140,280	135,896
PHP	267,851	225,734	226,527	188,833
WSCC	52,767	47,826	44,770	45,815
Percent of Members Paneled to a PCMH				
	DY10 Q2	**DY10 Q3**	**DY10 Q4**	**DY11 Q1**
BCBS	52.70%	53.60%	51.00%	50.60%
PHP	66.10%	61.00%	60.90%	50.90%
WSCC	59.80%	51.40%	48.00%	48.40%

Source: MCO Report #48 DY11 Q1

MCO PCMH initiatives:

BCBS: To positively impact hospital readmissions and high ER room utilization, BCBS utilizes a variety of Transition of Care (TOC) programs. BCBS made attempts to be proactive with early engagement in care coordination during hospitalization. BCBS initiated an ED report that goes to care coordinators when members go to the ER which allows them to follow up with members and engage high ER utilizers. If members can't be reached by phone, CHW's will attempt a home visit. Additionally, the Recovery Support team attempts to meet members in the ER to assist linking members to SUD or mental health services and avoid future ER visits, admission/readmission. In addition, BCBS tracks members with a chronic medical history who are likely to have increased emergency room visits. BCBS program/care managers identify appropriate members for outreach and involve them in disease management. BCBS uses predictive modeling programs to identify PCMH members at risk who are likely to be high utilizers for hospital admission and emergency room visits. BCBS continues to work with practitioners and the state in creating Value-Based Care Models with a PCMH and primary care payment reforms.

MCO PCMH initiatives:

PHP: PHP attributes progress in reducing ED visits to PCMH's following up with members after ER discharge. PHP provides education to PCMH care teams on timely care post-discharge while attempting to identify barriers to care. PHP reviews patient resources with providers, offering services such as care coordination, transportation, member incentives, and provider education on quality measure details. PHP flags members that meet disease state criteria, such as Diabetes, within JIVA. PHP monitors disease management, potential risk outcomes based on chronic conditions, and the impact of disease management on utilization and medication. In addition, PHP offers health programs, such as nutritional counseling and cooking classes, fitness/wellness classes. Monthly scorecards were also reviewed for ED utilization and inpatient admission rates. PHP PCMH groups identify potential health disparities for their population, they can address the SDOH needs and quickly identify Members who would benefit from telehealth visits or appointment transportation.

WSCC: WSCC's value-based programs incentivize providers to deliver exceptional care, improve health outcomes, and enhance patient experience in attempts to reduce healthcare costs and increase access for PCMH members. WSCC offers analytics in real-time quality dashboards, gaps-in-care member lists, member-level readmission rates, and financial performance reporting, all presented in ongoing monthly or quarterly PCMH Provider Engagement meetings, and available in WSCC's Provider Portal. WSCC meets monthly to review the performance of these measures, set goals, discuss barriers to meet targets, and best practices for member engagement. Additionally, providers can access self-evaluation reporting around cost, utilization, hospital/ED admissions, claims, and assigned membership statistics via WSCC's provider portal. WSCC internal monitoring for disease management includes assessing population risk scores. Key performance indicators (KPIs) are used to evaluate members in disease management programs.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities	
DY11 Q2	HSD continued to monitor MCO enrollment and member engagement through the quarterly Care Coordination Report. This report includes data related to completion of required assessments and touchpoints within contract timeframes. The DY11 Q2 report contains data from DY11 Q1. DY11 Q2 data will be reported in DY11 Q3. 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 remained at 95% in DY10 Q4 and DY11 Q1. The aggregate completion rate for HRAs for members with a 'change in health condition' increased from 98% in DY10 Q4 to 99% in DY11 Q1. Aggregate completion percentages for CNAs for CCL2 members increased from 89% in DY10 Q4 to 90% in DY11 Q1. Aggregate completion percentages for CNAs for CCL3 members increased from 85% in DY10 Q4 to 89% in DY11 Q1. MCOs will continue to monitor by utilizing daily operational oversight reports and tracking mechanisms to increase timely completion. Aggregate completion percentages of CCPs for CCL2 members remained at 95% in DY10 Q4 and DY11 Q1. CCPs for CCL3 members remained at 96% in DY10 Q4 and DY11 Q1. In DY10 Q1, BCBS initiated a process improvement project to streamline CCP completion, decrease the completion time, allow for more detail, and be more member centric. HSD notes that BCBS increased their CCP timely completion percentage for CCL2 Members from 85% in DY10 Q1 to 89% in DY11 Q1. For CCL3 Members, their CCP timely completion percentage increased from 86% in DY10 Q1 to 91% in DY11 Q1. The Care Coordination Report includes MCO strategies for engaging and retaining members. In DY11 Q1, MCOs reported on multiple strategies to retain engagement with members.

	BCBS has been utilizing interventions that were put on hold during the Public Health Emergency, such as driving by member homes and leaving door hangers as well as an increase in collaborating with CHWs and their paramedicine team to assist with engagement. PHP has placed a focus on increasing awareness of Care Coordination with providers and community-based organizations. PHP has also held additional internal meetings with supervisors and managers regarding engagement rates, reviewing the impact of member delays and rescheduling assessments, and brainstorming key talking points for continued training with staff. WSCC participates in numerous community events across the state, from school-based activities to cultural celebrations with the goal of increasing engagement in Care Coordination and increasing their members' quality of life. WSCC continues to partner with New Mexico Community Care (NMCC), a statewide paramedicine program, to expand efforts to complete HRAs for unable to reach members, outreach to members with a Notification of Pregnancy, provide education, and to complete A1C test administration for members who are non-compliant with their annul screening. NMCC is able to outreach to 5,000 member referrals each month statewide. HSD continues to monitor strategies and interventions for all MCOs to increase member engagement and compliance with performance benchmarks. The table below details aggregate and individual MCO performance from DY10 Q2 through DY11 Q1. DY11 Q2 data will be reported in DY11 Q3.

Table 5: Care Coordination Monitoring

MCO Performance Standards	DY10 Q2	DY10 Q3	DY10 Q4	DY11 Q1
HRAs for new Members	**96%**	**96%**	**95%**	**95%**
BCBSNM	95%	96%	97%	97%
PHP	95%	94%	90%	90%
WSCC	100%	100%	100%	100%
HRAs for Members with a change in health condition	**99%**	**99%**	**98%**	**99%**
BCBSNM	100%	100%	100%	99%
PHP	98%	96%	95%	97%
WSCC	100%	100%	100%	100%
CNAs for CCL2 Members	**91%**	**90%**	**89%**	**90%**
BCBSNM	88%	87%	86%	86%
PHP	92%	90%	90%	93%
WSCC	100%	100%	100%	94.00%
CNAs for CCL3 Members	**90%**	**86%**	**85%**	**89%**
BCBSNM	86%	83%	82%	85%
PHP	91%	85%	85%	90%
WSCC	100%	100%	97%	98%
CCPs for CCL2 Members	**94%**	**94%**	**95%**	**95%**
BCBSNM	85%	84%	87%	89%
PHP	99%	99%	99%	99%
WSCC	93%	97%	95%	96%
CCPs for CCL3 Members	**95%**	**96%**	**96%**	**96%**
BCBSNM	87%	90%	91%	91%
PHP	98%	99%	99%	99%
WSCC	94%	96%	94%	100%

Source: HSD DY10 Q2 to DY11 Q1 Report #6 –Care Coordination Report
Percentages in bold are MCO aggregate of the total assessments due and completed.

Care Coordination Audits

In DY11 Q1, HSD monitored MCO compliance with contract and policy by continuing to conduct Care Coordination audits. These audits monitor:

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

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

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

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

The table below details the Transition of Care (TOC) Audit results from DY10 Q2 through DY11 Q1. DY11 Q2 data will be reported in DY11 Q3.

Table 6: Transition of Care Audit

Transition of Care	DY10 Q2	DY10 Q3	DY10 Q4	DY11 Q1
In-Patient	**91%**	**88%**	**97%**	**98%**
BCBS	97%	85%	94%	100%
PHP	99%	85%	99%	95%
WSCC	77%	93%	x*	x*
Nursing Facility	**90%**	**99%**	**97%**	**100%**
BCBS	93%	100%	97%	100%
PHP	100%	100%	100%	100%
WSCC	77%	96%	95%	100%

Source: HSD DY10 Q2 to DY11 Q1 Quarterly TOC Audits
Percentages in bold are MCO averages.
*WSCC had no IP to Community Transitions in DY11 Q1

The aggregate compliance rate for IP to Community TOC files increased from 97% in DY10 Q4 to 98% in DY11 Q1. The aggregate compliance for NF to Community TOC audited files increased from 97% in DY10 Q4 to 100% in DY11 Q1.

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

Areas noted for discussions with MCOs:

- BCBS's compliance percentage for IP to community increased from 94% in DY10 Q4 to 100% in DY11 Q1. BCBS had excellent documentation and ensured all 3-day post discharge assessments were conducted in the member's home, were timely, and followed up with all needed Community Benefits.
- PHP's compliance percentage for IP to community decreased from 99% in DY10 Q4 to 95% in DY11 Q1, primarily due to untimely 3-day post discharge assessments.
- WSCC had no members transitioning from IP to the Community in need of Community Benefits in DY11 Q1.
- BCBS's compliance percentage for NF to community increased from 97% in DY10 Q4 to 100% in DY11 Q1. WSCC also reported an increase for their NF to community member compliance from 95% in DY10 Q4 to 100% in DY11 Q1. All MCOs had stellar documentation, robust coordination with discharge planning teams, and ensured successful transitions back to the community for all members audited.
- PHP's compliance percentage for NF to community was at 100% for DY10 Q4 and DY11 Q1.

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; however, audit results remain above 85% and aggregate results above 95% in the last two quarters. 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. MCOs conduct quarterly documentation training for all staff, as well as targeted training for staff who need additional assistance.

The table below details the Health Risk Assessment and Care Coordination Level Audit results from DY10 Q2 through DY11 Q1. DY11 Q2 data will be reported in DY11 Q3.

Table 7: Health Risk Assessment and Care Coordination Level Audit

HRA/CCL Audit	DY10 Q2	DY10 Q3	DY10 Q4	DY11 Q1
Health Risk Assessment (HRA)	**98%**	**98%**	**98%**	**100%**
BCBS	99%	99%	99%	100%
PHP	99%	96%	96%	100%
WSCC	96%	99%	99%	100%
Care Coordination Level (CCL)	**95%**	**98%**	**99.70%**	**98%**
BCBS	90%	99%	99%	95.00%
PHP	100%	99%	100%	100.00%
WSCC	96%	97%	100%	99%

Source: HSD DY10 Q2 to DY11 Q1 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 98% in DY10 Q4 to 100% in DY11 Q1. All MCOs increased from DY10 Q4 to a 100% compliance in DY11 Q1.

Aggregate rates of compliance for the CCL Audit decreased from 99.7% in DY10 Q4 to 98% in DY10 Q4. BCBS decreased from 99% in DY10 Q4 to 95% DY11 Q1. PHP remained at 100% from DY10 Q4 to DY11 Q1. WSCC decreased from 100% in DY10 Q4 to 99% in DY11 Q1. All MCOs provided excellent file documentation, covered all required elements for their transitioning members, and ensured that members were receiving their needed services once back in the community. Any points deducted were for issues related to bookmarking and discrepancies between Care Coordination levels listed in member files and those identified in MCO platforms.

Care Coordination CNA Ride-Alongs

HSD conducted 2 CNA ride-alongs with MCO care coordinators in DY11 Q1, to observe completion of member assessments.

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

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

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

- Care coordinators adhered to all contractual responsibilities in their assessments.
- Care coordinators were kind, thorough, and professional with the members.
- HSD noted care coordinators employing motivational interviewing with members.
- Care coordinators often went beyond contract requirements to assist members with locating and applying for additional resources and services.
- Care coordinators were fluent in the language preferred by their member.
- HSD noted that care coordinators had received targeted training on Medicare for dual eligible members.

Care Coordination HRA Ride-Alongs

HSD conducted 15 virtual HRA ride-alongs with MCO care coordinators in DY11 Q1, to observe completion of member assessments. All HRAs observed were conducted telephonically.

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

- The majority of Assessors were friendly, thorough, non-judgmental, and professional with the members.
- Assessors often explained to members that they could request Care Coordination in the future if they would like assistance.
- Assessors provided additional information such as offering Transition of Care services if the member had recently been released from incarceration.
- Assessors referred members to resources to address specific concerns.
- Assessors provided warm handoffs to customer service staff for needs such as additional insurance cards or to Care Coordination staff to schedule their Comprehensive Needs Assessment.
- HSD revised the HRA to ensure all prenatal members are referred to, and encouraged to engage with, Home Visiting programs. Assessors were consistent in following this new directive.
- HSD requested MCOs continue ongoing training and internal review of HRA Assessors to ensure any issues are resolved quickly.

Care Coordination MCO Meetings

HSD conducts regular quarterly meetings with all MCOs to review data on member engagement, Care Coordination timeliness, performance analysis, and member outcomes. However, HSD did not hold an all MCO Care Coordination meeting in DY11 Q1. The Care Coordination Unit participated in reviewing all policies and procedures related to Care

Coordination for Turquoise Care (TC) Readiness including onsite visits with the four TC MCOs. A final DY11 Q2 meeting with the Centennial Care MCOs has been scheduled for June 2024 and will be reported on in the DY11 Q3 report.

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 DY11 Q1, a total of 35,114 Medicaid members received behavioral health services through telehealth. This quarter's total did see a decrease of 8.1% compared to the DY10 Q1 total of 38,199 persons served through this medium. Of those served in DY11 Q1 through telehealth, 14,731 persons reside in rural or frontier counties. This accounts for 42% of those served. This accounts for 42% of those served and is reflective of client and provider preferences and the high value of telehealth in New Mexico's rural and frontier landscapes.

Service delivery over telephonic means continues to see a decrease. In DY11 Q1, 37,400 members received services through this modality compared to 37,959 in DY10 Q1 which is a decrease of 559 people or 1.5%. BHSD continues to evaluate which behavioral health services are appropriate to continue delivery through telephone now that the public health emergency is over. This option was undoubtably a critical link to services during the COVID-19 crisis and remains vital to increasing access in rural and frontier areas of the state.

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

TREAT FIRST

As depression, anxiety and other behavioral health needs surge from the stresses related to COVID-19, Treat First engages clients quickly in services that address their immediate needs. The 40 certified Treat First agencies have seen over 1,812 new clients during the first six months of 2024. With support from the Treat First agencies, 39.6% of these individuals were able to resolve their issues with solution focused interventions within four

visits. The balance of those clients continued in services. The “No Show” for clients in this period was very low, only 10.2%. This is impressive now and it is 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 92.6% and adults at 87.0%.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

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

In DY11 Q1, SBIRT utilization decreased 10% to 1,875 persons served during the quarter compared to 2,083 persons served during DY10 Q4. However, SBIRT utilization increased 17.5% when compared to DY10 Q1, the same quarter of the prior year, where 1,596 persons were served. The increase in persons receiving SBIRT in DY11 Q1 compared to DY10 Q1 can be linked to additional funding and efforts to offer more SBIRT training to hospital, emergency department and primary care staff.

On a monthly average, 676 persons received SBIRT in DY11 Q1, with the greatest utilization occurring in January with 831 persons screened. The current monthly average utilization trend for SBIRT in DY11 Q1 is averaging 10.1% less than the DY10 Q4 quarterly monthly average.

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

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

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 DY11 Q1, the total number of persons served with a SUD in an IMD was 3,509, which is an increase of 260 persons (or 8%) compared to DY10 Q4. When comparing DY11 Q1 results to DY10 Q4, the utilization increased from 1,447 persons served on a monthly average to 1,555. The upward trend in utilization of persons served in an IMD with a substance use disorder started in January 2024 and continued into March. As this quarter's results show a reversal of the prior quarter's downward trend, the noted increase is similar to prior years with greatest utilization occurring in the beginning of the report period with declines occurring in later quarters. The trend will continue to be analyzed quarter-to-quarter as future reporting occurs.

SUD HEALTH IT

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

Utilization of the New Mexico Prescription Monitoring Program (NM PMP) continues to be utilized by prescribers with the number of providers utilizing the NM PMP providers checking the PMP at 88%. This is a 1% increase over the previous year at 87%. HSD continues to monitor with data as updated from the New Mexico Board of Pharmacy.

The New Mexico Fee for Service (FFS) Drug Utilization Review (DUR) Board conducted the Fee for Service Drug Utilization Review meeting on April 24, 2024. Attendees included board members (a quorum was met for voting purposes) and invited guests, including managed care organization representatives. Client counts for both FFS and Managed Care were reported with continued trend small decreases in total members enrolled. Utilization of Prospective DUR edits targeted for fraud waste and abuse prevention and the SUPPORT Act were presented and reviewed for the time period of January 1, 2024, to March 31, 2024. The edits show effectiveness of the Prospective DUR edits for preventing overutilization and deterring potential for abuse and waste. No new edits or changes were recommended for

the reported edits. The Prospective DUR reporting will now continue as a quarterly report at the DUR meeting. On February 22, the GLP-1 Receptor Agonist intervention was mailed out to 11 providers concerning 11 patients for the first quarter 2024 intervention. A summary report for the fourth quarter 2023 intervention for patients diagnosed with hepatitis C and no record of medication treatment was presented with 6 response forms returned as of April 9th giving a 2.1% response rate. The results reported are 2 patients were negative or non-detectable, 3 were noted as not the provider's patient and 1 had not been seen since 2022.

Support act reports for Metabolic Monitoring of Second-Generation Antipsychotics (SGAs) in youth and adults, opioid usage with benzodiazepines, antipsychotics, smooth muscle relaxants, Gabapentinoids, stimulants, and non-benzodiazepine sedative hypnotics were presented with no trends of concerns reported. While the reporting for metabolic monitoring of SGAs is currently mandatory in youth, the DUR board agreed to continue to report on youth and adults. New reports for the DUR meeting presented were analysis of the top 25 medications for each month of the first quarter 2024. These utilization reports were broken down monthly by top 25 drugs by number of claims, top 10 brand name drugs by claims, top 10 generic drugs by claims, top 10 therapeutic classes by claims. The intervention for the second quarter will be on the combined use of opioids and central nervous system (CNS) depressants in patients with respiratory impairment, and the use of opioids and CNS depressants with no record of naloxone on file. This intervention is aimed at improving patient safety with interventions as needed. The Board approved the intervention for the second quarter mailing. The board agreed for the FY24 Q3 intervention to be on the underutilization of SGLT2 in patients with heart failure. This intervention aligns with the data presented in claims utilization consistent with a high number of diabetic patients in the population served. The final version of the intervention will be voted on for the third quarter DUR meeting. The board discussed and agreed for a fourth quarter intervention to focus on albuterol use with asthma, which was also consistent with the data presented in the claims utilization reports.

In 2023, Project ECHO trained over 3,100 New Mexico healthcare providers. Thirty-six unique clinical, mental, and public health topic areas were addressed, including but not limited to: Diabetes Management in Primary Care, Improving Perinatal Health Opioid Use Disorders for Prescribers, Adverse Childhood Events, and Alcohol Use and Mental Health. HSD released a supplement to providers outlining opportunities to participate in ECHO case reviews. Additionally, recruitment for participation continues to expand, with particular emphasis on engaging rural, underserved, and tribal communities. Project Echo will continue these programs in 2024.

The New Mexico Bridge Program continues to expand its training on prescribing for Opioid Use Disorder (OUD) for hospital emergency departments, inpatient, and related clinics throughout the state. The New Mexico Bridge team conducts live trainings at hospitals and provides a virtual training series for hospitals and community members. The project has engaged with 12 hospitals since its inception in 2021. These hospitals have completed various stages of engagement and implementation. These include Holy Cross Medical Center, Gallup Indian Medical Center, Socorro General Hospital, Memorial Medical Center, University of New Mexico Hospital, and Lovelace Women's Health Center. These six hospitals have started prescribing buprenorphine and the program has tracked 744 patients that have received this treatment to date from Taos, Memorial, Gallup, Socorro, and UNM Hospital (data collection from Lovelace is currently being gathered). Six hospitals participated in aspects of engagement and/or training, including Sierra Vista Hospital, Christus St. Vincent Regional Medical Center, San Juan Regional Medical Center, Plains Region Medical Center, Northern Navajo Medical Center, and Gerald Champion Medical Center. NM Bridge is in discussion with other hospitals to plan engagement in the future, including Mesilla Valley Hospital and Lincoln County Medical Center. All hospitals serve patients in/from both rural and urban settings. During this time period, NM Bridge helped Lovelace Women's Hospital L&D and UNM Hospital ED complete their programs. The NM Bridge team started working on extending the programs to Lovelace Women's Hospital ED and UNM Hospital Pediatric ED. NM Bridge made good progress with Sierra Vista Hospital and is on track to complete the program. NM Bridge remains in beginning stages with Christus St. Vincent Regional Medical Center and San Juan Regional Medical Center. NM Bridge continues to work with Socorro General Hospital and Taos Holy Cross Medical Center's Women's Health Institute. NM Bridge conducted on-site provider and nursing trainings to Lovelace Women's Hospital L&D in March 2024, conducted on-site provider and nursing trainings to Taos Holy Cross Medical Center L&D in May 2024, and conducted remote provider trainings to Sierra Vista Hospital ED in April 2024 and June 2024. NM Bridge continues providing monthly trainings remotely to hospitals. The NM Bridge trainings include buprenorphine initiation, responsible opioid prescribing, treatment in clinic settings, SUD and pregnancy, neurobiological basis of SUD, case reviews, toxicology updates, fentanyl updates, and more. NM Bridge continues to reach out statewide to encourage engagement. The new NM Bridge team member, who was added to provide peer support worker and supervisor education, conducted on-site education on stigma and peer support for Socorro General Hospital and University of New Mexico Hospital in May 2024. More information on the program can be found at www.nmbridge.com.

To further support all prescribing practitioners working with individuals with opioid use disorders and other substance use disorders, the University of New Mexico's poison center

continues to provide a 24/7/365 call-in center for prescribing practitioners to assist with complex cases.

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

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

ADULT ACCREDITED RESIDENTIAL TREATMENT CENTERS (AARTC) SERVICES

During DY11 Q2, 2 AARTC applications were in the review process and 3 applications were approved. A total of 27 AARTCs provider applications have been approved since the onset of the application process in December of 2019 (multiple providers have multiple locations).

Table 8: AARTC Client Counts

MEDICAID CLIENT COUNTS				
PROVIDER #	**DY10 Q3**	**DY10 Q4**	**DY11 Q1**	**DY11 Q2**
716	0	0	0	0
090	67	44	60	64
037	331	90	275	377
081	14	22	26	25
589	8	4	10	11
332	26	18	29	21
049	54	12	21	20
825	30	8	11	14
896	0	2	6	5
302	105	33	50	81
60	27	5	16	35
258	0	0	9	1
760	17	41	65	63
Unduplicated Total	**679**	**279**	**578**	**717**

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

There are 18 AARTCs in operation, approved to bill Medicaid. The data above identifies the total number of clients who received AARTC services during DY11 Q2. 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 13 provider sites are represented in the chart above, provider 037 has 4 sites represented in their data. All AARTC provider sites are actively in the process of receiving distinct identification numbers to ensure accuracy in client counts for each site. This impacts the 0 reporting for provider #716 which will be updated in future reports.

Medicaid utilization increased from 578 individuals in DY11 Q1 to 717 individuals in DY11 Q2. The increase may be attributable to the 90-day claim lag for services provided during the period. It is expected that numbers will fluctuate as actual counts are adjusted to account for claims lag. Further analysis is warranted to ensure counts are accurately reported and represented for those providers. The table reflects refreshed numbers in all quarters. Rates are assessed by acquiring 1 full year of utilization by each provider with a review of expenditure data collected to determine the actual costs of operation. There are 6 providers in the rebasing phase. Only one provider has completed the rebasing process in DY11 Q2. Two providers have asked for an extension until October 2024 to submit their survey data to complete the recalculation of their rates. The rate development process continues to be refined as the progression of the data collection expands.

HEALTH HOMES (HHs)

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

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

CareLink Health Homes (CLNM) Activities	
DY11 Q2 Activities	In Q2, CLNM providers prepared for the transition of two new MCOs, United Health Care and Molina Health Care on July 1, 2024. The HH program manager collaborated with the new MCOs and requested that they be part of the steering committee and join the quarterly meetings. The PRISM system usage from which the HHs can retrieve diagnostic information, has continued to increase with training held during the months of April – June. Quality Service Reviews were tentatively scheduled for the months ranging from September – November in FY 25. The CLNM site visit letter and certification letter were updated/modified to meet current standards. The CLNM Member Satisfaction Survey was edited during this quarter with CLNM providers to ensure the language was up to date. The HH program manager attended the Mathematica two-day meeting to vote for measures for the 2026 HH core set. There were no measures added to the core set for 2026.

Table 9: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY10 Q3 JUL - SEPT	DY10 Q4 OCT - DEC	DY11 Q1 JAN - MAR	DY11 Q2 APR - JUNE
3,868	3,692	3,488	3,348
% CHANGE	% CHANGE	% CHANGE	% CHANGE
5.70%	4.55%	5.15%	4.01%
Decrease	Decrease	Decrease	Decrease

Source: NMStar, CLNM Opt-in Report.

HIGH FIDELITY WRAPAROUND

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

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

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

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

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

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

SUPPORTIVE HOUSING

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

each county of every state annually.

Linkages agencies have been able to bill Medicaid for comprehensive community support services (CCSS), but since the H0044 supportive housing services inclusion in the Centennial Care 2.0 waiver, BHSD continues to strongly encourage Linkages providers to shift to billing the supportive housing benefit directly. The H0044 benefit reimburses at a higher rate than CCSS. The Centennial Care 2.0 waiver requires that the services be provided by a certified peer support worker (CPSW) to align with the state's goals for building the peer support workforce. One Linkages provider has 5 CPSWs assigned to deliver Linkages supportive housing services. The 5 CPSWs of this provider carry a Linkages program specific caseload. This provider previously had 9 CPSWs assigned to clients participating in Linkages and various other programs; however, utilizing less CPSWs with a specialized case load has optimized Linkages service provision and outcomes. CPSWs assigned to deliver Linkages supportive housing services currently include a CPSW Supervisor, a CPSW Lead, and 3 field CPSWs. This provider has consistently utilized the H0044 code for reimbursement since October 2019 and is contracted with all 3 MCOs for reimbursement. A second Linkages provider has 3 CPSW positions, 2 full time CPSW field staff and 1 part-time CPSW supervisor/manager. A CPSW is the primary provider for Linkages, and a second CPSW serves as Linkages back up and to assist clients in need of SSI/SSDI Outreach, Access to Recovery (SOAR). This second provider has been utilizing the H0044 code for reimbursement since January 2022 and is contracted with all 3 MCOs for reimbursement. A third Linkages provider had 4 CPSWs rendering Linkages supportive housing services with 2 CPSWs who were billing H0044 last quarter. This quarter, this provider had 3 CPSWs assigned to render Linkages supportive housing services. 2 CPSWs resigned from the provider agency at the end of the quarter, and the provider has 1 dedicated CPSW who renders Linkages and billing of 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 the remaining 6 Linkages providers continue to consider hiring CPSW staff for Linkages programming and/or are actively seeking CPSWs to hire. In the meantime, these providers are utilizing case managers, community support workers, and/or supportive housing coordinators to render the supportive housing services. The interest of all providers not yet utilizing H0044 remains high and increases with the progress made by the providers who have established H0044 reimbursement. The BHSD Supportive Housing Coordinator and Supportive Housing Coordinator-Supervisor continue to support providers and work with the BHSD MCO Contract Managers and MCOs to ensure successful processing establishment and billing of H0044. MCOs submit quarterly Ad Hoc reports with H0044 encounters data.

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

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

Table 10: Medicaid Supportive Housing Utilization

MEDICAID SUPPORTIVE HOUSING UTILIZATION (January 1, 2024 – December 31, 2024)			
DY11 Q1	**DY11 Q2**	**DY11 Q3**	**DY11 Q4**
127	141		
Unduplicated Total - 159			

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 360 vouchers were issued or filled; the previous quarter had an average of 353. A filled voucher means housing has been secured. Therefore, 360 individuals and their households benefited from a voucher and housing stability.

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

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

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

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

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

New Mexico's SMI/SED Implementation plan was submitted on June 25, 2023. CMS provided feedback to New Mexico on July 17, 2023, and New Mexico resubmitted its implementation plan on October 18, 2023. CMS provided feedback to New Mexico on October 31, 2023. New Mexico resubmitted its implementation plan on February 20, 2024. CMS provided feedback to New Mexico on March 14, 2024. New Mexico resubmitted its implementation plan on April 11, 2024, and is pending CMS feedback. New Mexico also provides assurance that Federal Financial Participation (FFP) will not be claimed until CMS approves the State's SMI/SED Implementation Plan.

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

CENTENNIAL HOME VISITING (CHV) PROGRAM

In DY11 Q2, the Centennial Home Visiting (CHV) program served 420 families. Following is DY11 Q2 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 71 unique families in DY11 Q2 in Bernalillo County and Valencia Counties.
- Youth Development Inc. (YDI) served 0 families in DY11 Q2 in Bernalillo, Rio Arriba, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 0 unique families in DY11 Q2 in Bernalillo County.
- ENMRSH served 37 unique families in DY11 Q2 in Curry and Roosevelt Counties.
- Taos Pueblo served 17 unique families in DY11 Q2 in Taos County.
- MECA Therapies served 136 unique families in DY11 Q2 in Chaves, Curry, Doña Ana, Roosevelt, and Lea Counties.
- Aprendamos served 87 unique families in DY11 Q2 in Doña Ana, Sierra, and Otero Counties.
- Community Action Agency of Southern New Mexico served 23 unique families in DY11 Q2 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 30 unique families in DY11 Q2 in San Juan County.
- Tresco served 7 unique families in DY11 Q2 in Bernalillo and Santa Fe Counties.
- Guidance Center of Lea County served 12 unique families in DY11 Q2 in Lea County.

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

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

PRESUMPTIVE ELIGIBILITY PROGRAM

The New Mexico HSD Presumptive Eligibility (PE) program continues to be an important part of the State's efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some New Mexico State Agencies including the New Mexico Department of Health (DOH), New Mexico Children Youth and Families Department (CYFD), and the New Mexico Corrections Department (NMCD). Currently, there are approximately 904 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assist with on-going Medicaid application submissions.

HSD staff conduct monthly PE certification trainings for employees of qualified entities that choose to participate in the PE program. PE certification requirements include active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct "Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE)" demo trainings. During demo trainings, the PEDs have the opportunity to take a refresher training on "How To" utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit ongoing Medicaid applications. PE program staff conducted 4 PE certification trainings and 6 YESNM-PE demo refresher trainings in DY11 Q2.

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

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

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

certified to use the Baby Bot functionality with more trainings scheduled to increase participation.

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

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

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

AVA Baby Bot (April - June 2024)					
Month	**Newborns Submitted through AVA**	**Newborns Successfully Enrolled**	**Newborns Unsuccessfully Enrolled - Tasks Created**	**% of Newborns Successfully Enrolled**	**% of Newborns Unsuccessfully Enrolled**
April	782	435	347	56%	44%
May	754	502	252	67%	33%
June	770	533	237	69%	31%
Total	**2,306**	**1,470**	**836**	**64%**	**36%**

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY11 Q2, 72 PEDs used the Baby Bot functionality. Program staff noticed a slight increase in the amount of PED participation during this reporting period and in the number of newborns added through the Baby Bot functionality. In this reporting period, staff observed a slight increase in the percentage of Newborns “Successfully Enrolled”. HSD program staff continue to work with system developers and PEDs to continue the increase of the number of newborn submissions as well as the number of successful submissions through the Baby Bot functionality.

Table 12: PE Approvals

PE APPROVALS (April - June 2024)				
Month	**PEs Granted**	**% PE Granted with Ongoing Applications Submitted**	**Total Individuals Applied**	**Individuals Approved**
April	299	99%	720	512
May	283	99%	733	328
June	216	99%	578	441
Total	**798**	**99%**	**2,031**	**1,281**

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, HSD saw a decrease in the number of PEs granted and PEs that also had an ongoing application submitted. In DY11 Q2, 99% of all PE approvals had an ongoing application submitted.

JUST HEALTH PROGRAM

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

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

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

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

The following table outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. HSD observed a slight decrease in the amount of PE applications granted, and a slight increase in the number of Medicaid applications submitted from jail or prison settings in DY11 Q2. 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, and anticipates increased engagement with these facilities if the State's 1115 Waiver demonstration Justice Re-entry project is approved. In DY11 Q2, 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 13: PE Approvals

PE APPROVALS – JUST HEATH (April-June 2024)				
Quarter	**PEs Granted**	**% PE Granted w/ Ongoing Applications Submitted**	**Total Individuals Applied**	**Individuals Approved**
April	13	100%	92	79
May	4	100%	82	53
June	14	100%	82	75
Total	**31**	**100%**	**256**	**207**

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 DY11 Q2 are listed in the tables below.

Table 14: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT (April-June 2024)	
TOPIC	**NUMBER OF CALLS**
Home/Community Based Care Waiver Programs	2,748
Long Term Care/Case Management	1
Medicaid Appeals/Complaints	3
Personal Care	2
State Medicaid Managed Care Enrollment Programs	3
Medicaid Information/Counseling	847

Source: SAMS Call Profiler Report; GSA I 7-630-8000-0001 CDA 93-778 State Fiscal Year 2024, Quarter 4 report

Table 15: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT (April-June 2024)			
COUNSELING SERVICES	**NUMBER OF HOURS**	**NUMBER OF NURSING HOME RESIDENTS**	**NUMBER OF CONTACTS**
Transition Advocacy Support Services		118	
*Medicaid Education/Outreach	3,033		
Nursing Home Intakes		38	
**LTSS Short-Team Assistance			217

*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 4 report

Critical Incidents

Critical Incidents	
DY11 Q1	HSD conducts a quarterly meeting with all MCOs to provide guidance and discuss findings related to the MCOs' critical incident reporting. The quarterly meeting was held on February 21, 2024. The primary discussion was regarding the dramatic decrease in Physical Health CIRs filed. This was due to the updated CIR reporting process at the end of Q4 CY23. The filing process was updated for reporting staffing issues; instead of filing a CIR every time a visit is missed, only one CIR is filed, and follow-up actions are documented multiple times within the same CIR. HSD conducted daily reviews of critical incidents submitted by the MCOs and providers for the purpose of ensuring compliance with reporting requirements, identifying areas of concern, and monitoring members' health and safety. HSD provided daily assistance to MCOs and providers to obtain access to the CIR portal by establishing and/or resetting login credentials, correcting MCO entries and deleting duplicate reports. During DY11 Q1, 15,299 CIRs were filed in the Centennial Care category, which includes Physical Health (13,847), Behavioral Health (781), and Self-Directed members (671). In DY11 Q1, the total number of Physical Health CIRs filed decreased 66% from DY10 Q4 (41,027 to 13,847), Behavioral Health reports increased 10% from DY10 Q4 (709 to 781), and SDCB reports increased 7% from DY10 Q4 (628 to 671). The tables below represent a summary of the critical incident reporting from DY10 Q2 – DY11 Q1. DY11 Q2 data will be reported in the DY11 Q3 report.

Table 16: Critical Incidents Reported

CRITICAL INCIDENTS REPORTED (DY11 Q1 - DY11 Q4)															
MCO	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				TOTALS		
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	PH	BH	SD
BCBS	11,040	12,929	12,598	3,975	134	141	117	107	267	221	211	211	40,542	499	910
PHP	35,687	26,305	25,278	9,138	623	535	554	631	508	418	394	437	96,408	2,343	1,757
WSCC	2,282	3,443	3,151	734	52	56	38	43	25	37	23	23	9,610	189	108
Total	49,009	42,677	41,027	13,847	809	732	709	781	800	676	628	671	146,560	3,031	2,775

Source MCO quarterly report #36

BCBS (DY11 Q1 - DY11 Q4)															
Critical Incident Types	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				TOTALS		
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	PH	BH	SD
Abuse	108	83	83	72	17	13	17	13	8	6	5	4	346	60	23
Death	202	204	194	225	11	8	7	9	8	8	10	10	825	35	36
Elopement / Missing	5	3	9	5	1	0	1	2	1	0	1	0	22	4	2
Emergency Services	2,210	1,988	1,838	1,889	81	84	70	66	162	137	127	129	7,925	301	555
Environmental Hazard	37	25	32	23	2	2	1	2	4	2	1	1	117	7	8
Exploitation	83	22	24	31	1	0	0	1	0	1	2	0	160	2	3
Law Enforcement	36	29	19	39	6	8	2	3	5	8	1	6	123	19	20
Neglect	8,359	10,575	10,399	1,691	15	26	19	11	79	59	64	61	31,024	71	263
All Incident Types	11,040	12,929	12,598	3,975	134	141	117	107	267	221	211	211	40,542	499	910

Source MCO quarterly report #36

PHP (DY11 Q1 - DY11 Q4)															
CRITICAL INCIDENT TYPES	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	168	188	185	156	55	62	54	52	10	8	4	5	697	223	27
Death	398	316	336	374	16	11	8	12	13	13	11	12	1,424	47	49
Elopement/ Missing	20	15	13	11	2	0	1	3	1	1	0	0	59	6	2
Emergency Services	6,787	6,063	5,755	5,993	435	333	332	371	377	324	306	378	24,598	1,471	1,385
Environmental Hazard	109	100	82	78	6	5	4	7	6	6	6	8	369	22	26
Exploitation	65	46	73	52	3	2	3	2	12	3	17	1	236	10	33
Law Enforcement	63	63	44	54	10	18	11	9	11	5	3	6	224	48	25
Neglect	28,077	19,514	18,790	2,420	96	104	141	175	78	58	47	27	68,801	516	210
All Incident Types	35,687	26,305	25,278	9,138	623	535	554	631	508	418	394	437	96,408	2,343	1,757

Source MCO quarterly report #36

WSCC (DY11 Q1 - DY11 Q4)															
CRITICAL INCIDENT TYPES	PHYSICAL HEALTH (PH)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	PH	BH	SD
Abuse	29	29	31	36	9	9	5	5	1	3	1	1	125	28	6
Death	27	29	37	34	2	2	2	2	1	1	1	0	127	8	3
Elopement/ Missing	4	3	2	2	2	0	0	1	0	0	0	0	11	3	0
Emergency Services	285	265	239	242	32	28	25	29	21	28	19	20	1,031	114	88
Environmental Hazard	12	56	3	10	0	0	2	0	0	0	2	0	81	2	2
Exploitation	8	5	12	7	1	1	1	0	0	1	0	0	32	3	1
Law Enforcement	8	11	7	11	1	6	1	3	2	2	0	0	37	11	4
Neglect	1,909	3,045	2,820	392	5	10	2	3	0	2	0	2	8,166	20	4
All Incident Types	2,282	3,443	3,151	734	52	56	38	43	25	37	23	23	9,610	189	108

Source MCO quarterly report #36

Community Benefit

In DY11 Q2, Community Benefit (CB) related projects have included:

- conducting MCO trainings on Turquoise Care LTSS, and other readiness activities;
- reporting for the new tracking database for HSD approved Agency-Based Community Benefit (ABCB) providers;
- CB rate study activities; and
- increasing CB allocations to fill approved slots.

HSD also continued to collaborate with providers, stakeholders, and state agencies to implement initiatives approved under its American Rescue Plan Act (ARPA) HCBS Spending Plan and Narrative.

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

- Implementing rate increases for PCS and other CB services to coincide with state and local minimum wage increases, and the paid sick leave requirement for NM employees per the Healthy Workforce Act.
    - HSD continues to monitor MCO accountability to ensure minimum wage increases and paid sick leave requirements are met with regular MCO report updates. There were several local minimum wage increases effective in early 2024.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers. A quarterly 5% payment is being issued in 2024. HSD requires that providers attest that they are using the funding in accordance with the CMS approved ARPA spending plan before any payments are made.
- Approving higher rates for certain caregivers in rural areas on a case-by-case basis.
- One MCO issued grants to PCS agencies through the NM Association for Home Health and Hospice Care. These grants are continuing in 2024.
- Another MCO is convening an LTSS provider stakeholder group to obtain feedback and develop solutions to address workforce shortages.
- HSD, in collaboration with the NM Aging and Long-Term Services Department has applied for a direct care workforce (DCW) TA opportunity through the ACL DCW Strategies Center and we will report on any progress in DY11 Q2.
- HSD is conducting a rate study for CB services. Rates may be increased in CY 2025 if sufficient funding is awarded by the legislature.

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

Electronic Visit Verification

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

Electronic Visit Verification - HCBS

For DY11 Q2, the average number of SDCB caregivers using EVV is 73%. HSD is continuing to offer training and technical assistance for SDCB agencies and individual employees to encourage more SDCB providers to use EVV. In DY11 Q1, HSD began working with the SDCB Fiscal Management Agency (FMA) and the EVV vendor to explore ways to streamline file feeds and improve EVV user experience. This work is continuing in DY11 Q2.

ABCB EVV data for DY11 Q2 is outlined in the table below. The MCOs reported that 76.7% of the total ABCB PCS claims were created by the Interactive Voice Response (IVR) phone system. The remainder of claims were created through the Fiserv Authenticare application.

Electronic Visit Verification - Physical Health

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

Home Healthcare Services: January to March 2024, MCOs reported 26% of Home Health services captured with EVV used either Fiserv Authenticare application (65%) or Interactive Voice Response (IVR) phone system (2%). HSD has been able to capture issues in reporting the newly implemented EVV. HCA is accessing ways to improve data collection and monitoring MCOs actions to assist home health agencies in their transition to EVV utilization.

Table 17: ABCB EVV DATA

EVV DATA (April-June 2024)		
MCO	**AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD**	**NUMBER OF TOTAL CLAIMS THIS PERIOD**
BCBS	6,963	451,077
PHP	13,075	843,443
WSCC	ND	ND
TOTAL	**20,038**	**1,294,520**

Source: MCO Report #35 DY11 Q2, April-June 2024

Statewide Transition Plan

HSD received approval of its Statewide Transition Plan (STP) on March 10, 2023. The 508 compliant version of the statewide transition plan has been posted online. The MCOs formed a workgroup and continue to collaborate on ongoing monitoring activities including provider training, attestations and care coordination tools. The MCOs audited all Community Benefit settings in DY10 Q4 and no concerns were identified. HSD will receive an on-site review from CMS and New Editions in September 2024. HSD has had several preparation calls with CMS and New Editions and has received the itinerary. HCA will work with providers and CMS/NE to prepare for the visit and provide any requested information. HSD LTSS staff will be on-site with CMS/NE.

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 DY11 Q1 audit results this quarter and audit findings for DY11 Q2 will be reported in DY11 Q3.

Total audits for DY11 Q1:

- BCBS conducted 108 total audits of NF LOC determinations, 18 facility-based and 90 community-based.
- PHP conducted 260 total audits of NF LOC determinations, 75 facility-based and 185 community-based.
- WSCC conducted 30 total audits of NF LOC determinations, 6 facility-based determinations and 24 community-based.

Audit results for NF LOC determinations for DY11 Q1:

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

Audit results for timeliness of determinations for DY11 Q1:

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

Aggregate results:

- NF LOC determinations aggregate results are 100% for High and Low Facility Based and 100% for Community Based NF LOCs.
- Timeliness of determinations aggregate results are 100% for High and Low - Facility Based and 99.7% 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	**Jan**	**Feb**	**March**	**DY11 Q1**
Total number of High NF LOC files audited	**5**	**6**	**13**	**24**
BCBSNM	3	3	3	**9**
PHP	2	3	10	**15**
WSCC	0	0	0	**0**
Total number of files with correct NF LOC determination	**5**	**6**	**13**	**24**
BCBSNM	3	3	3	**9**
PHP	2	3	10	**15**
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	N/A	N/A	N/A	**N/A**
Low NF Determinations	**Jan**	**Feb**	**March**	**DY11 Q1**
Total number of Low NF LOC files audited	**28**	**27**	**20**	**75**
BCBSNM	3	3	3	**9**
PHP	23	22	15	**60**
WSCC	2	2	2	**6**
Total number of files with correct NF LOC determination	**28**	**27**	**20**	**75**
BCBSNM	3	3	3	**9**
PHP	23	22	15	**60**
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	**Jan**	**Feb**	**March**	**DY11 Q1**
Total number of High NF LOC determinations completed within required timeframes	**5**	**6**	**13**	**24**
BCBSNM	3	3	3	**9**
PHP	2	3	10	**15**
WSCC	0	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	N/A	N/A	N/A	**N/A**
Total number of Low NF LOC determinations completed within required timeframes	**28**	**27**	**20**	**75**
BCBSNM	3	3	3	**9**
PHP	23	22	15	**60**
WSCC	2	2	2	**6**
% of Low NF LOC determinations completed within required timeframes	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**

Source: DY11 Q1 MCO Internal Audit Results

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

Community-Based Internal Audits	Jan	Feb	March	DY11 Q1
Total number of Community-Based NF LOC files audited	**98**	**102**	**99**	**299**
BCBSNM	30	30	30	**90**
PHP	60	64	61	**185**
WSCC	8	8	8	**24**
Total number with correct NF LOC determination	**98**	**102**	**99**	**299**
BCBSNM	30	30	30	**90**
PHP	60	64	61	**185**
WSCC	8	8	8	**24**
% with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Timeliness of Determinations	**Jan**	**Feb**	**March**	**DY11 Q1**
Total number of Community-Based determinations completed within required timeframes	**98**	**101**	**99**	**298**
BCBSNM	30	29	30	**89**
PHP	60	64	61	**185**
WSCC	8	8	8	**24**
% of Community-Based determinations completed within required timeframes	**100%**	**99%**	**100%**	**99.7%**
BCBSNM	100%	97%	100%	**99%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**

Source: DY11 Q1 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 DY11 Q1 was 77%, an increase from DY10 Q4 of 73%.
- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY11 Q1 was 82%, an increase from DY10 Q4 of 80%.
- The aggregated Community Based determination/redetermination percentage for DY11 Q1 was 98%, a slight increase from the 97% reported for DY10 Q4.

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

any trends and provide technical assistance as needed. MCO NF LOC determinations for DY1 Q2 will be reported in the DY11 Q3 report.

Table 20: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	**Jan**	**Feb**	**March**	**DY11 Q1**
Total number of determinations/redeterminations completed for High NF LOC requests	**69**	**69**	**85**	**223**
BCBSNM	36	42	54	**132**
PHP	27	19	24	**70**
WSCC	6	8	7	**21**
Total number of determinations/redeterminations that met High NF LOC criteria	**52**	**54**	**66**	**172**
BCBSNM	29	36	43	**108**
PHP	17	10	16	**43**
WSCC	6	8	7	**21**
% of determinations/redeterminations that met High NF LOC criteria	**75%**	**78%**	**78%**	**77%**
BCBSNM	81%	86%	80%	**82%**
PHP	63%	53%	67%	**61%**
WSCC	100%	100%	100%	**100%**
Low NF Determinations	**Jan**	**Feb**	**March**	**DY11 Q1**
Total number of determinations/redeterminations completed for Low NF LOC requests	**474**	**363**	**399**	**1236**
BCBSNM	152	101	114	**367**
PHP	313	254	280	**847**
WSCC	9	8	5	**22**
Total number of determinations/redeterminations that met Low NF LOC criteria	**402**	**275**	**333**	**1010**
BCBSNM	141	81	109	**331**
PHP	252	186	219	**657**
WSCC	9	8	5	**22**
% of determinations/redeterminations that met Low NF LOC criteria	**85%**	**76%**	**83%**	**82%**
BCBSNM	93%	80%	96%	**90%**
PHP	81%	73%	78%	**78%**
WSCC	100%	100%	100%	**100%**

Source: DY11 Q1 MCO NF LOC Determinations Report

Table 21: MCO NF LOC Determinations – Community-Based

Community Based Determinations	Jan	Feb	March	DY11 Q1
Total number of determinations/redeterminations completed	**2258**	**2249**	**2338**	**6845**
BCBSNM	721	650	721	**2092**
PHP	1387	1435	1458	**4280**
WSCC	150	164	159	**473**
Total number of determinations/redeterminations that meet NF LOC criteria	**2208**	**2196**	**2288**	**6692**
BCBSNM	707	636	709	**2052**
PHP	1354	1399	1422	**4175**
WSCC	147	161	157	**465**
% of determinations/redeterminations that meet NF LOC criteria	**98%**	**98%**	**98%**	**98%**
BCBSNM	98%	98%	98%	**98%**
PHP	98%	97%	98%	**98%**
WSCC	98%	98%	99%	**98%**

Source: DY11 Q1 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 DY11 Q1:
Aggregated results for NF LOC determinations from the EQRO were 100% in agreement with High NF, and 89 agreement with Low NF. There were two disagreements with WSCC during the quarter and as a result, a deliverable was sent with request for the MCO to investigate the situation and verify that missing documents were available but not sent with audit packet and report back to the HSD Nurse Auditor. There were also two disagreements with BCBS during the quarter and as a result a deliverable was sent with request for MCO to investigate the situation and verify that missing documents were available but not sent with audit packet and report back to the HSD Nurse Auditor. The EQRO is 100% in agreement for Community Based NF LOC determinations.

HSD will continue to monitor the EQRO audit of MCO NF LOC determinations to identify and address any trends and provide technical assistance as needed. NF LOC determinations for DY11 Q2 will be reported in the DY11 Q3 report.

Table 22: EQRO NF LOC Review

Facility-Based				
High NF Determination	**DY11 Q1**	**DY11 Q2**	**DY11 Q3**	**DY11 Q4**
Number of Member files audited	**18**			
BCBSNM	6			
PHP	6			
WSCC	6			
Number of Member files the EQRO agreed with the determination	**18**			
BCBSNM	6			
PHP	6			
WSCC	6			
% of Member files the EQRO agreed with the determination	**100%**			
BCBSNM	100%			
PHP	100%			
WSCC	100%			
Low NF Determination	**DY11 Q1**	**DY11 Q2**	**DY11 Q3**	**DY11 Q4**
Number of Member files audited	**36**			
BCBSNM	12			
PHP	12			
WSCC	12			
Number of Member files the EQRO agreed with the determination	**32**			
BCBSNM	10			
PHP	12			
WSCC	10			
% of Member files the EQRO agreed with the determination	**89%**			
BCBSNM	83%			
PHP	100%			
WSCC	83%			
Community-Based	**DY11 Q1**	**DY11 Q2**	**DY11 Q3**	**DY11 Q4**
Number of Member files audited	**90**			
BCBSNM	30			
PHP	30			
WSCC	30			
Number of Member files the EQRO agreed with the determination	**90**			
BCBSNM	30			
PHP	30			
WSCC	30			
% of Member files the EQRO agreed with the determination	**100%**			
BCBSNM	100%			
PHP	100%			
WSCC	100%			

Source: DY11 Q1 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. Please note that some data for DY11 Q2 is not yet available.
    - PM #1: Percentage of required HCBS reports submitted timely by the MCOs. DY11 Q2 results are reported below.
        - Report #4, *Community Benefit* – 100% compliance
        - Report #8, *Nursing Facility Level of Care* – 100% compliance
        - Report #35, *Electronic Visit Verification* – 100% compliance
    - PM #2: Percentage of required HCBS reports submitted accurately without an MCO Self-Identified Error. DY11 Q2 results are not yet available and will be reported next quarter.
    - PM #3: Percentage of required HCBS reports submitted accurately without an HSD rejection. DY11 Q2 results are not yet available and will be reported next quarter.

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

- Qualified Providers: In DY11 Q2, HSD continued to receive and review applications for incoming CB providers. HSD reviews and approves all Agency-Based Community Benefit (ABCB) providers to ensure that they meet all program requirements as outlined in Section 8 of the Managed Care Policy Manual. Providers must obtain this program approval from HSD prior to enrolling with the state as a Medicaid provider, contracting with the MCOs and providing services to ABCB members. In the Self-Directed Community Benefit (SDCB), the MCOs contract with a single Fiscal Management Agency (FMA) to oversee provider enrollment. The FMA ensures that all providers meet program requirements as outlined in Section 9 of the managed Care Policy Manual. SDCB providers must meet all program requirements and be approved by the FMA prior to rendering services to SDCB members. 100% of providers meet the program requirements

prior to providing services to members. HSD has directed the MCOs to audit all ABCB providers and the SDCB Fiscal Management Agency (FMA) on an annual basis, starting in DY10. The MCOs completed their annual 2023 audit of all CB providers and the SDCB FMA. No audits resulted in provider terminations; however, several providers were placed on corrective action plans until audit concerns were resolved. The MCOs will complete another ABCB provider and SDCB FMA audit in late CY 2024.

- 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 DY11 Q1 monitoring results:

- Statewide, 94 records are reviewed each quarter, which began January 1, 2024.
- DY11 Q1 indicates 100% compliance across all performance measures for BCBS. PHP indicates 98% compliance on PM #3. WSCC indicates a 67% on PM #3 and a 67% on PM#4.

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 DY11 Q1. The DY11 Q2 data will be reported on the DY11 Q3 CMS Quarterly Monitoring Report.

Table 23: HCBS Service Plan Review Summary

Eligible Population and Sample Size, DY11 Q1			
MCO	**Eligible Population for DY11 Q1**	**MCO % of Entire HCBS Population in DY11 Q1**	**Number of HCBS Files Reviewed for DY11 Q1**
BCBS	4,455	24%	34
PHP	12,501	67%	54
WSCC	1,583	9%	6
Centennial Care	**18,539**	**100%**	**94**

Service Plan Review Results DY11 Q1						
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			100%
	PHP	54	54			100%
	WSCC	6	6			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			100%
	PHP	54	54			100%
	WSCC	6	6			100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's HCBS service plan adequately addressed his/her assessed needs	BCBS	34	34			100%
	PHP	54	53	1		98%
	WSCC	6	4	2		67%
	Statewide	**94**	**91**	**3**	**0**	**97%**
Services authorized by the MCO were delivered in accordance with the HCBS service plan, including the type, scope, amount, duration, and frequency are specified in the HCBS service plan	BCBS	34	34			100%
	PHP	54	54			100%
	WSCC	6	4	2		67%
	Statewide	**94**	**92**	**2**	**0**	**98%**
The HCBS service plan was revised, as needed, to address changing needs	BCBS	34	3		31	100%
	PHP	54	1		53	100%
	WSCC	6	2		4	100%
	Statewide	**94**	**6**	**0**	**88**	**100%**
A disaster preparedness plan specific to the member was in the HCBS service plan and documented	BCBS	34	34			100%
	PHP	54	54			100%
	WSCC	6	6			100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Member's eligibility start and end dates are documented	BCBS	34	34			100%
	PHP	54	54			100%
	WSCC	6	6			100%
	Statewide	**94**	**94**	**0**	**0**	**100%**
Linkages to protective services are documented	BCBS	34	1		33	100%
	PHP	54	0		54	100%
	WSCC	6	0		6	100%
	Statewide	**94**	**1**	**0**	**93**	**100%**

Source: DY11 Q1 External Quality Review Organization (EQRO) Quarterly HCBS Service Plan Report

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

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

In the DY11 Q1 Performance Measures (PMs), HSD observed the following notable fluctuations between DY10 Q3 and DY10 Q4:

- The number of all substantiated critical incidents decreased by 66%. The dramatic decrease in incidents filed was due to the updated CIR reporting process at the end of DY10 Q4. The filing process was updated for reporting staffing issues; instead of filing a CIR every time a visit is missed, only one CIR is filed, and follow-up actions are documented multiple times within the same CIR.
- PM #1b: The percentage of substantiated individual neglect incidents identified and reported decreased by 41 percentage points.
- PM #4a: The percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents increased by 30 percentage points.
- PM #7: The percentage of substantiated Members with Multiple critical incidents identified and reported decreased by 30 percentage points.

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

The table below details the quarterly data reported by the MCOs from DY10 Q2 through DY11 Q1. DY11 Q2 data will be reported in DY11 Q3.

Table 24: Critical Incidents Performance Measures

Critical Incident Performance Measures (CI PM)				
CI PM	BCBS	PHP	WSCC	Aggregate
	Q1	Q1	Q1	Q1
The number of all substantiated critical incidents.	3,975	9,138	734	13,847
CI PM	**BCBS**	**PHP**	**WSCC**	**All MCO Average**
PM #1: The percentage of substantiated critical incidents reported by category of abuse, neglect, exploitation and unexpected death:				
	Q1	Q1	Q1	Q1
1.a. Percentage of substantiated individual abuse incidents identified and reported.	1.81%	1.71%	4.90%	2.81%
1.b. Percentage of substantiated individual neglect incidents identified and reported.	42.54%	26.48%	53.41%	40.81%
1.c. Percentage of substantiated individual exploitation incidents identified and reported.	0.78%	0.57%	0.95%	0.77%
1.d. Percentage of substantiated individual unexpected death incidents identified and reported.	0.78%	0.57%	1.91%	1.09%
CI PM	**BCBS**	**PHP**	**WSCC**	**All MCO Average**
PM #2: The percentage of substantiated critical incidents being reported within the required timeframe.				
	Q1	Q1	Q1	Q1
Percentage of substantiated critical incidents being reported within 24 hours.	92.93%	93.65%	96.05%	94.21%
CI PM	**BCBS**	**PHP**	**WSCC**	**All MCO Average**
PM #3: The percentage of substantiated individual critical incidents where follow up (safety plans, corrective action plans, etc.) was completed:				
	Q1	Q1	Q1	Q1
Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed.	81.46%	95.70%	37.06%	71.41%
CI PM	**BCBS**	**PHP**	**WSCC**	**All MCO Average**
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:				
	Q1	Q1	Q1	Q1
4.a. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents.	75.87%	58.79%	37.06%	57.24%
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.	29.81%	5.01%	32.43%	22.42%

CI PM	BCBS	PHP	WSCC	All MCO Average
PM #5: The percentage of the substantiated critical incidents with a referral to Adult Protective Services (APS) or Child Protective Services (CPS):				
	Q1	Q1	Q1	Q1
5.a. Percentage of substantiated individual critical incidents where referrals to APS were completed.	0.93%	1.09%	3.41%	1.81%
5.b. Percentage of substantiated individual critical incidents where referrals to CPS were completed.	0.00	0.05%	0.68%	0.25%
CI PM	**BCBS**	**PHP**	**WSCC**	**All MCO Average**
PM #6: The percentage of providers and MCO staff trained on reporting critical incidents into the HSD Portal:				
	Q1	Q1	Q1	Q1
6.a The percentage of 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.	86.36%	2.53%	2.86%	30.58%
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**	**All MCO Average**
PM #7: The percentage of substantiated critical incidents for Members with Multiple critical incidents identified and reported:				
	Q1	Q1	Q1	Q1
The percentage of substantiated Members with Multiple critical incidents identified and reported.	54.82%	37.73%	49.18%	47.24%

Source: MCO CI PM quarterly report.

- **Financial Accountability:** In DY10 Q1, the EQRO began reviewing MCO claims for financial accountability to ensure that Community Benefit claims were not overpaid. New Mexico has received data from all MCOs for DY10 Q1 through DY10 Q4. There have been no concerns with financial accountability. All MCOs are paying claims accurately.

8

AI/AN REPORTING

Access to Care

According to MCO Report #55, *Geographical Access Report* for Q2 2024:

- BCBSNM reported 96.3% access to behavioral health services in rural areas and 95.0% access in frontier areas. For physical health, BCBSNM reported 96.3% in rural areas and 96.6% in frontier areas.
- PHP reported 98.4% access to behavioral health services in rural areas and 98.8% access in frontier areas. For physical health, PHP reported 98.4% in rural areas and 98.7% in frontier areas.
- WSCC reported 96.9% access to behavioral health services in rural areas and 100.0% access in frontier areas. For physical health, WSCC reported 96.9% in rural areas and 100.0% in frontier areas.

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

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

MCO	Status of Contracting with MCOs
BCBSNM	Below are the latest updates with Indian Health Service and Tribal 638 providers: • **Canoncito Band of Navajos Health Center** - BCBSNM reports their contract is signed and loaded in BCBSNM system with an effective date of 08/01/2024. • **Navajo Regional Behavioral Health** – BCBSNM is currently awaiting a response to previous emails that were sent regarding contracting since several meetings have been rescheduled. BCBSNM latest email was sent on 07/29/2024. • **Pine Hill** - BCBSNM is currently awaiting a response to previous emails that were sent regarding contracting and if the group is still interested in all lines of business. Last email sent by BCBSNM 7/29/2024. • **Southern Ute Indian Tribe dba: Southern Ute Health Center** - BCBSNM is finalizing contracts to send out to the group for review. • **San Ildefonso Behavioral Health** – BCBSNM sent contracts to provider on 7/24/2024. BCBSNM is waiting for the signature. Provider stated contracts are with the Governor for review.

PHP	PHP utilizes Mutual Partnership Agreements (MPA) or Letters of Direction (LOD) to support contracting efforts. Each agreement is tailored to meet the specific goals, needs and services of Tribal communities, with a goal of improving access to health care for Native American members. Below is an update of current contracting efforts: • **Changing Woman Initiative** – PHP reached out to organization to explore options to establish a VBP arrangement. No response. PHP provided a small monetary contribution to support their doula training. • **San Ildefonso Pueblo Behavioral Health** – Agreement is signed and now live in the network. • **Kewa Pueblo Health Corp./Kewa Family Wellness Center** – PHP recently updated this agreement to add the FQHC rates. Other discussions continue to be on hold pending personnel and 2024 leadership changes. PHP also included VBP in these discussions. • **Picuris Pueblo** – PHP Native American Affairs is in discussions with Picuris Pueblo non emergency medical transportation. This has been identified as a pilot and is pending the MPA template updates. • **Jicarilla Apache Behavioral Health** – PHP continues to reach out to this organization, but they are undergoing a lot of staff changes. PHP will continue to work with this program once the Legislative Council identifies a contact person.
WSCC	• **Santa Clara Pueblo Adult Day Care –** WSCC met with the adult day care program to assist with non emergency medical transportation development in April and May 2024. • **San Felipe Pueblo** – WSCC met with Pueblo for technical assistance on CHR reimbursement. • **Ramah Pine Hill Health Center –** WSCC met with health center to go over all services in Medicaid and the Marketplace.They also resolved claim denials. • **Pueblo of Santo Domingo –** WSCC met with Pueblo and provided an update regarding contracting for CHR reimbursement. • **Picuris Pueblo** – WSCC provided technical assistance to Pueblo with a grant proposal April, May and June. • **Navajo Nation –** WSCC met with Crownpoint on their JUST health program contract still in effect April 2024 and also met with Tribal delegate to discuss Tribal initiatives.

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

According to MCO Report #47, *Claims Activity Report* for Q2 2024:

- BCBSNM processed 99.5% clean claims within 15 days and 99.9% clean claims within 30 days.
- PHP processed 99.2% clean claims within 15 days and 100.0% clean claims within 30 days.
- WSCC processed 98.7% clean claims within 15 days and 99.8% clean claims within 30 days.

There were complaints that PHP was not paying the correct rate for pharmacy claims. This issue was resolved to IHS satisfaction.

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

At the DY11 Q2 NATAC meeting held on June 17, 2024 –

- There was a discussion about Community Health Representative (CHR) billing by MAD's Medical Director and clarification that the reimbursement did not include transportation.
- The NATAC was given an update on CMS initiative to seek guidance and comment on traditional healing reimbursement. A listening session is being scheduled to have more time to discuss the details of how CMS proposes to reimburse for traditional healing.
- The Medicaid Director shared recently approved State Plan Amendments (SPAs) and billable services for Tribes which includes continuous coverage for children up to the age of six; several new behavioral health modalities, and Medicaid coverage for a year post-partum rather than three months. There were also updates on the Turquoise Care roadshow and the Health Care Authority (HCA) which will be the new name for HSD effective 7/01/2024.
- Per the request of NATAC, there was a discussion on mental health parity laws as well as new behavioral health programs being provided through the Behavioral Health Services Division.

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

The DY11 Native American Technical Advisory Committee (NATAC) Schedule

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

Native American Advisory Board (NAAB) Issues and Recommendations

The following issues were raised at the DY11 Q2 NAAB meetings:

MCO	DATE	Issues/Recommendations
BCBSNM	May 9, 2024 Crownpoint Chapter House	The first quarter Native American Advisory Board (NAAB) meeting for BCBSNM was held on May 9, 2024. It was a hybrid meeting focused on Native American Members in Cibola and McKinley Counties. Meeting invitations were shared statewide. A total of 66 attendees attended the meeting including 29 members, three guests, 11 providers/community partners, two state representatives and 21 BCBSNM staff members. **Question – "**Is there a time limit for the Traditional Medicine Benefit?" **Response –** "Yes**.** The benefit is available once per year per Native American member." **Question -** "Is care coordination available for anybody even if they are healthy or is it only for those with a pre-existing condition?" **Response –** "Most times yes, you can request a care coordinator. You will complete an HRA, and based on the HRA, it will determine your level of care. While working with the care coordinator, you will develop a care plan to address your needs." **Question –** "Do you provide services to families that are going through trauma?" **Response –** "Yes, we help families who suffer with situations and educate them regarding the transition. We can also get a behavioral health care coordinator involved."
PHP	June 20, 2024 (virtual meeting)	PHP was unable to confirm a physical location so the meeting was hosted virtually. This meeting focused on Santa Ana and Zia Pueblos. Two hundred invitation letters were sent out prior to the meeting date. No attendees joined the call. At 3:20 pm the meeting was adjourned.
WSCC	May 1, 2024 (cancelled)	The May 1, 2024 meeting was cancelled by WSCC.

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ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE	3/26/21
COMPLETION DATE	Open
ISSUES	ModivCare has been placed on a corrective action plan for not meeting the contractual timeliness measures for certain Customer Service Call Center metrics and other additional contractual requirements.
RESOLUTION	Due to continued service level failures, the action plan remains open. **DY11 Q2 update:** Plan of Action (POA) related to call center remains open. For Q2 2024, ModivCare did not meet all metrics. BCBS continues to meet with ModivCare daily to discuss issues and/or concerns. HCSC/BCBSNM meets with ModivCare weekly to monitor the on-time performance measures. Below are the most current statistics: **April 2024 – June 2024(average):** ASA = 00:18 seconds (Met) Abandonment Rate = 0.22% (Met) Service Level = 82.4% **(NOT** Met) Member Satisfaction = 92% (Met) A-Leg Pick-up = 91% (Met) Provider No-Shows = 10 For quarter 2 reporting, ModivCare stated they received the heaviest flow of volume during the beginning of the month for April and May. During April and May of Q2, ModivCare had system issues which led to the service level not being met for both months. ModivCare reports they have addressed all issues and monitoring the service level to ensure the target is met. June 2024 metrics have not been received yet. BCBSNM continues to meet with ModivCare daily. BCBSNM and HCSC continue to monitor the service level to ensure the metrics are met.

PRESBYTERIAN	
ACTION PLAN	None in effect in DY11 Q2.
IMPLEMENTATION DATE	
COMPLETION DATE	
ISSUES	
RESOLUTION	

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	None in effect in DY11 Q2.
IMPLEMENTATION DATE	
COMPLETION DATE	
ISSUES	
RESOLUTION	

10

FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY11 Q2 reflects the capitation rates for Centennial Care 2.0 that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 28, 2023. On weighted average, the CY 2024 rate is 4.07% higher than that of CY 2023; the fee-for-service claim payments for CY 2024 are still lagging. In addition, data runs out for CYs 2023 and 2024 will continue and the PMPMs will continue to change as expenditures come in (see Attachment 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 DY 9, Table 9.5, is 9.1% below the budget neutrality limit with data through ten (10) quarters. Table 10.5 shows a 9.5% below the budget neutrality limit for DY 10 with data of six (6) quarters. And Table 11.5 shows preliminary data for DY 11 of 8.6% below the budget neutrality limit with two (2) quarters of data.

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MEMBER MONTH REPORTING

Member Months		2024 2
MEG1	0-FFS	75,834
	Presbyterian	538,885
	Western Sky	117,898
	Blue Cross Blue Shield	369,956
	Total	**1,102,573**
MEG2	0-FFS	6,248
	Presbyterian	59,677
	Western Sky	12,008
	Blue Cross Blue Shield	37,216
	Total	**115,149**
MEG3	0-FFS	0
	Presbyterian	62,155
	Western Sky	11,899
	Blue Cross Blue Shield	31,919
	Total	**105,973**
MEG4	0-FFS	214
	Presbyterian	348
	Western Sky	43
	Blue Cross Blue Shield	236
	Total	**841**
MEG5	0-FFS	0
	Presbyterian	9,204
	Western Sky	1,496
	Blue Cross Blue Shield	6,641
	Total	**17,341**
MEG6	0-FFS	67,344
	Presbyterian	381,665
	Western Sky	111,669
	Blue Cross Blue Shield	297,717
	Total	**858,395**
MG10	0-FFS	8
	Presbyterian	114
	Western Sky	35
	Blue Cross Blue Shield	85
	Total	**242**
MGX8	0-FFS	0
	Presbyterian	347
	Western Sky	107
	Blue Cross Blue Shield	359
	Total	**813**
	Total	**2,201,327**

Source: Enrollee Counts Report.

The new MEG for SMI/SUD requires criteria prior to development. HSD will work with its fiscal agent to add the new MEG to the Enrollee Counts report by Q2 2025.

12
CONSUMER ISSUES

GRIEVANCES

HSD receives MCO Report #37 Grievances and Appeals monthly. 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 DY11 Q1, it was determined the MCO reports complied with contractual requirements. HSD observed in DY11 Q1 that the top overall member grievance reporting code continues to be "Transportation Ground Non-Emergency". The number of these grievances filed in DY11 Q1 demonstrated a 27% decrease from DY10 Q4.

"Provider Specialist" was the overall second most frequently reported member grievance code. There was a 63% increase in the number of grievances filed in this category. However, the change was less significant when looking at the size of the cohorts for this metric, and there was a significant increase in DY10 Q3. HSD will continue to monitor. The table below is a summary of the quarterly data reported by the MCOs for DY10 Q2 – DY11 Q1. DY11 Q2 data will be reported in DY11 Q3.

Table 25: Grievances Reported

Grievances Reported (DY10 Q2 – DY11 Q1)																
Grievances	**BCBS**				**PHP**				**WSCC**				**AGGREGATE**			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Number of Member Grievances	483	462	409	333	243	295	230	241	52	59	46	59	778	816	685	633
Top Two Overall Primary Member Grievance Codes																
	BCBS				**PHP**				**WSCC**				**AGGREGATE**			
	Q2	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
Transportation Ground Non-Emergency	361	326	273	190	48	68	63	56	8	7	15	10	417	401	351	256
Provider Specialist	27	33	14	21	0	0	0	0	2	5	2	5	29	38	16	26
Variable Grievances	95	103	122	122	195	227	167	185	42	47	29	44	332	377	318	351

Source: MCO Report #37

APPEALS

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

In DY11 Q1, it was determined that all reports complied with contractual requirements. HSD observed in DY11 Q1 that the top overall primary member appeals code continued to be "Denial or limited authorization of a requested service". The number of these appeals filed in DY11 Q1 demonstrated a 7% decrease from DY10 Q4.

"Denial in whole of a payment for a service" was the overall second most frequently reported member appeal code. The number of these appeals filed in DY11 Q1 showed a 14% decrease from DY10 Q4. The table below is a summary of the quarterly data reported by the MCOs for DY10 Q2 – DY11 Q1. DY11 Q2 data will be reported in DY11 Q3

Table 26: Appeals Reported

Appeals Reported (DY10 Q2 – DY11 Q1)																
APPEALS	BCBS				PHP				WSCC				AGGREGATE			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Number of Standard Member Appeals	588	409	333	361	582	581	489	408	56	71	38	49	1,226	1,061	860	818
Number of Expedited Member Appeals	29	32	31	27	28	17	30	29	11	9	10	17	68	58	71	73
Top Two Primary Member Appeal Codes																
	BCBS				PHP				WSCC				AGGREGATE			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Denial or limited authorization of a requested service	410	366	327	356	583	568	502	401	60	71	45	56	1,053	1,005	874	813
Denial in whole of a payment for a service	199	63	32	19	12	12	10	17	0	0	0	0	211	75	42	36
Variable Appeals	8	12	5	13	15	18	7	19	7	9	3	10	30	39	15	42

Source: MCO Report #37

13
QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

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

Table 27: 2024 MCO Advisory Board Meeting Schedules

BCBS 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	03/21/2024	12:00-2:00 PM	Hybrid - Albuquerque - Metro
BCBS	04/13/2024	12:00-2:00 PM	Hybrid - Sandoval County - Central
BCBS	09/12/2024	12:00-2:00 PM	Hybrid - Albuquerque - Metro
BCBS	11/07/2024	12:00-2:00 PM	Hybrid - Albuquerque - Metro
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	04/11/2024	12:00-2:00 PM	Hybrid – Farmington (San Juan County) - Regional
BCBS	10/26/2024	12:00-2:00 PM	Hybrid - Las Cruces (Dona Ana County) - Regional
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	02/29/2024	12:00-2:00 PM	Virtual – Otero County (Mescalero) TBD
BCBS	05/09/2024	12:00-2:00 PM	Hybrid – McKinley County (Crownpoint) TBD
BCBS	08/15/2024	12:00-2:00 PM	Hybrid – Rio Arriba County (Dulce) TBD
BCBS	10/10/2024	12:00-2:00 PM	Hybrid – Albuquerque Blue Door Neighborhood Center
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
BCBS	See above	See above	All above locations (SDCB included in each meeting)

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

PHP 2024			
SDCB Subcommittee Member Advisory Board Meetings are currently on hold.			
MEMBER ADVISORY BOARD MEETING SCHEDULE (CENTRAL AREA)			
MCO	DATE	TIME	LOCATION
PHP	03/08/2024	11:30 AM-1:00 PM	Presbyterian Rev. Cooper Center
PHP	06/07/2024	11:30 AM-1:00 PM	Presbyterian Rev. Cooper Center
PHP	09/05/2024	3:30 PM-5:00 PM	Presbyterian Rev. Cooper Center
PHP	12/05/2024	3:30 PM-5:00 PM	Presbyterian Rev. Cooper Center
STATEWIDE MEETINGS			
MCO	DATE	TIME	LOCATION
PHP	05/09/2024	5:00 PM – 6:30 PM	Presbyterian Store Front, Las Cruces
PHP	11/07/2024	11:30 AM – 1:00 PM	Virtual Meeting via Teams
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
PHP	03/07/2024	Noon-1:00 PM	Virtual Meeting
PHP	06/04/2024	Noon-1:00 PM	TBD
PHP	08/29/2024	Noon-1:00 PM	TBD
PHP	11/21/2024	Noon-1:00 PM	Presbyterian Cooper Administrative Center
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
PHP	03/11/2024	1:00 PM-2:30 PM	Virtual Meeting (Zoom)
PHP	06/06/2024	1:00 PM–2:30 PM	Virtual Meeting (Zoom)
PHP	09/10/2024	1:00 PM–2:30 PM	Virtual Meeting (Zoom)
PHP	12/10/2024	1:00 PM–2:30 PM	Virtual Meeting (Zoom)

WSCC 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	2/16/2024	12:00PM -1:00PM	Virtual Meeting
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	04/24/2024	3:00PM-4:00PM	Virtual Meeting
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	03/20/2024	11:00 AM-1:00 PM	Virtual Meeting
WSCC	05/01/2024	4:00 PM-5:30PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	02/16/2024	12:00PM-1:00 PM	Virtual Meeting (Included in the MAB Presentation)
BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
WSCC	4/23/2024	3:00 PM-4:00 PM	Virtual Meeting (Included in Statewide)

Quality Assurance	
DY11 Q2	**<u>Quarterly Quality Meeting</u>** HSD holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HSD updates and guidance on required quality monitoring activities as well as relay HSD findings from the monthly, quarterly, and annual reports submitted by the MCOs. The DY11 Q2 meeting was held on June 20, 2024. HSD agenda items included Performance Measure (PM) rates, Introduction of Turquoise Care Performance Measures, Report Analysis Expectations, Tracking Measures, Tobacco Cessation Outcomes, CY23 State Quality Directed Payment Summary, and SFY25 LFC Performance Measures.

	Additionally, HSD presented the MCOs with their individual performance rate, and the aggregate state rate as of DY11 Q1 for each PM, compared to the respective DY10 annual and CY23 HSD established targets based on their reported administrative data. As of DY11 Q1, the MCOs aggregate performance exceeded the DY10 or CY23 HSD established targets for 2 of 10 performance measures: Antidepressant Medication Management Continuous Phase; and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Initiation Phase. As of DY11 Q1, the MCOs aggregate performance is at risk in meeting the DY10 HSD established targets for 8 of 10 performance measures: Well-Child Visits in the First 15 Months of Life, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Timeliness of Prenatal Care, Postpartum Care, Childhood Immunization Status-Combination 3, 30 Day Follow-Up After Hospitalization for Mental Illness, 30 Day Follow-Up After Emergency Department Visit for Mental Illness, and Diabetes Screening for People with Schizophrenia for Bipolar Disorder Who Are Using Antipsychotic Medications. HSD introduced Turquoise Care Performance Measures (13 in total), and report analysis expectations including responses with comprehensive details, MCO strategies, interventions, barriers encounter, and detailed information that may be vital to assess performance. HSD presented the following Tracking Measures (5 in total) that had an overall decline in performance from Calendar Year 2022 to Calendar 2023: Fall Risk Management; Diabetes Short-term Complication Admission Ages 18 and Older; Screening for Clinical Depression and Follow-Up Plan; Immunization for Adolescents; Follow-up Care Children Prescribed ADHD Medication – Continuation Phase. HSD expects the MCOs to closely monitor these tracking

	measures to ensure improvement. HSD also presented the total number of members receiving tobacco cessation products and services remained steady from CY23 Q1 to CY24 Q1. Additionally, the total dollar amount spent for tobacco cessation products and services declined from CY23 Q1 to CY24 Q1. MCOs were advised to share vaping prevention initiatives targeting youth and adolescents in a forthcoming deliverable and to continue tracking the number of members who call into the MCO quit line. CY23 State Quality Directed Payment Summaries were presented for 6 directed payments displaying quality measures with assigned targets and status of met and not met. University of New Mexico Hospital met 7 out of 10 performance measures; American Rescue Plan Act (ARPA) Home and Community-Based Services met 2 out of 3 quality measures; Early and Periodic Screening, Diagnostic and Treatment (EPSDT) did not meet its only 1 quality measure; Community Tribal Hospitals (6 participating hospitals) met 1 out of 3 assigned targets; For Profit Hospitals (31 participating hospitals) met 1 out of 3 assigned targets; and Not for Profit Hospitals (14 participating hospitals) met 1 out of 3 assigned targets. HSD introduced and presented SFY25 Legislative Finance Committee Performance Measures. The NM Legislative Finance Committee (LFC) in collaboration with State of New Mexico and HSD Leadership compiles a list of performance measurements for the upcoming measurement year SFY25, effective 7/1/2024. SFY25 LFC performance measures (21 in total) include Health Effective Data and Information Set (HEDIS) measures (11 in total) and non-HEDIS measures (10 in total). MCOs are directed to focus on developing innovative strategies and interventions for the SFY25 LFC performance measures. **<u>Monthly Performance Measure Monitoring Plan</u>** 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. Due to reasonable improvement over a 13-month monitoring period, Childhood Immunization Status – Combination 3 was removed from monthly monitoring with final submission in DY10 Q4. 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 DY11 for PM #1 – Well Child Visits in the First 15 Months of Life (W30) of 65.91%. Through DY11 Month 3 (M3), the MCOs reported the following average rates: BCBS 31.82%, PHP 29.32%, and WSCC 28.92%. The DY11 HSD annual target rate for PM #3 – Prenatal Care (PPC) is 84.75%. Through DY11 M3, the MCOs reported the following average rates for Timeliness of Prenatal Care: BCBS 59.68%, PHP 65.14%, and WSCC 53.11%. 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**: M1 26.60%; M2 31.97%; M3 36.90%. Increase of 10.30 percentage points from M1 to M3. **Strategies and Interventions:** BCBS engages members with reward points for completing well-child visits. During DY11 Q1, BCBS mailed a total of 1307 “Happy Birthday” immunization reminder postcards to members who turned 1 – 3 years old. BCBS Wellness

	Education Specialists continue to conduct member outreach calls daily to remind parents/ guardians that their child is due for a well-child visit and immunizations. The reserved wellness appointment program to incentivize providers who offer after-hour and weekend appointments is ongoing. The participating provider groups contact their members to offer them a reserved slot for a Well Child Visit (W30) or Well Care Visit (WCV). Provider groups are also engaged with value-based contract incentives to promote improvement in the W30 compliance rate. **PPC**: M1 59.15%; M2 60.05%; M3 59.83%. Increase of .68 percentage points from M1 to M3. **Strategies and Interventions**: BCBS continues to support members with high-risk pregnancies through the Special Beginnings program. BCBS continues to collaborate with Finity Baby Smart and Families First to engage members with low-risk pregnancies. Finity rewards members with 250 points ($25) for completing a postpartum visit within their first trimester. The Centennial Home Visiting program supports first-time mothers up to 5 years post-delivery. The Value-based providers are engaged during joint operating committee meetings. Value-based providers are also incentivized to improve their Timeliness of Prenatal Care rates. **PHP:** **W30**: M1 23.85%; M2 29.38%; M3 34.73%. Increase of 10.88 percentage points from M1 to M3. **Strategies and Interventions**: PHP's Performance Improvement department continues to meet with Presbyterian Medical Group Las Estancias location to improve their pediatric no-show rate. PHP's new hire training for Community Health Workers and Care Coordinators includes information regarding W30 and how they can affect compliance with this measure. The Performance Improvement Interventionists continue to make member outreach calls to offer assistance with scheduling

	appointments. Members are also engaged with rewards through the Baby Bonuses Program for W30 compliance. **PPC**: M1 65.29%; M2 65.01%; M3 65.12%. Decrease of .17 percentage points from M1 to M3. **Strategies and Interventions**: PHP changed the name of its prenatal and postpartum reward program from Baby Benefits to Pregnancy Passport. This program encourages pregnant members to complete prenatal and postpartum visits. The Community Health Workers continue to perform member outreach calls to members with high-risk pregnancies. The Community Health Workers assist with scheduling appointments. PHP has included PPC information in the new hire training for Community Health Workers and Care Coordinators. The Performance Improvement staff will all present information regarding PPC during monthly staff meetings. **WSCC:** **W30**: M1 24.12%; M2 29.10%; M3 33.54%. Increase of 9.42 percentage points from M1 to M3. **Strategies and Interventions:** WSCC continues to engage members with My Health Pays and Centennial rewards for completing six well-child visits within the first 15 months of life. Members can use My Health Pays rewards for utilities, transportation, rent, etc. The provider engagement team meets with providers on a bimonthly or monthly basis to discuss performance and non-compliant member lists. WSCC monitors the effectiveness of these interventions on a bi-weekly basis. **PPC:** M1 53.08%; M2 53.27%; M3 52.98%. Decrease of .10 percentage points from M1 to M3. **Strategies and Interventions:** WSCC continues to encourage members to enroll in the Start Smart for your Baby program. On 2/21/24, WSCC hosted a virtual maternal health meeting to educate expecting

	members on the available benefits and educational programs. Attending members were given an infant car seat or “pack n’ play”. The Maternal Home Visiting program supports expecting families with information on child development and parenting skills. WSCC continues to send mPulse SMS messages to educate members on prenatal care tips. WSCC continues to offer lactation consulting and access to virtual doulas via the Pacify app. **Performance Measures (PMs)** HSD Performance Measures (PMs) and targets are based on HEDIS technical specifications. Each MCO is required to meet the DY6 through DY10 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. Although MCO penalties are not associated to final DY11 rates, MCOs are expected to maintain or improve final DY10 rates. 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. Below are the MCO quarterly rates and interventions for each PM and the established target for DY11.

The following PMs show results for DY11 Q1 reporting.

PM #1 (1 point) – Well-Child Visits in the First 15 Months of Life (W30)

The percentage of members who turned 15 months old during the measurement year and had 6 or more well-child visits.

DY11 target is 65.91%.

- BCBS Q1 36.90% and is 29.01 percentage points below the DY11 target.
- PHP Q1 34.73% and is 31.18 percentage points below the DY11 target.
- WSCC Q1 33.54% and is 32.37 percentage points below the DY11 target.
- MCO Aggregate: Q1 35.31% and is 30.60 percentage points below the DY11 target.

MCO Strategies and Interventions:

- BCBS continued to present health education information on the importance of Well Child Visits at the Member Advisory Board (MAB) meeting in March and the Native American Advisory Board (NAAB) meeting in February. The Quality Management specialist conducted outreach calls to encourage parents/guardians to schedule and complete well-child visits in the first 15 months of life. BCBS also continued to send “Happy Birthday” postcards to members who have turned 1-3 years old. These postcards inform the parents/guardians that their child may be due for a well-child visit, immunizations, or dental appointments. The BCBS Wellness Education Specialists also assist provider groups with member outreach to schedule appointments. BCBS also engaged providers with the reserved wellness appointment initiative that incentivizes providers that offer after-hour and weekend appointments for Well Child visits and Combo 3 immunizations. BCBS will

	monitor the effectiveness of the reserved wellness appointment initiative by tracking the CPT code modifier claims quarterly. • PHP Performance Improvement Interventionist team continues to perform monthly member outreach calls to parents/guardians. During these calls, the parents/guardians are educated on the importance of well-child visits and offered assistance with scheduling appointments. PHP continues to mail Early and Periodic Screening Diagnostic and Treatment letters to remind parents/guardians to complete well child visits. PHP continues to promote the Baby Bonuses rewards program. PHP used social media posts to promote compliance with this measure. • WSCC continues to offer members incentives for completing well-child visits via My Health Pays and Centennial Rewards. WSCC also engages providers with bi-weekly or monthly meetings to discuss interventions, best practices, and to discuss providers scorecards. Pfizer continues to send reminder cards to parents/guardians to remind them of well-child visits. Various departments at WSCC meet biweekly to review performance data to drive these interventions. The quality team also meets biweekly to review performance measure data to determine the effectiveness of these interventions. ***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 DY12 M6. **DY11 target is 62.93%.** • BCBS Q1 15.65% and is 47.28 percentage points below the DY11 target. • PHP Q1 15.46% and is 47.47 percentage points below the DY11 target. • WSCC Q1 13.78% and is 49.15 percentage points below the DY11 target. • MCO Aggregate: Q1 15.33% and is 47.60 percentage points below the DY11 target. **MCO Strategies and Interventions:** • BCBS hosted a community event in February in Aztec, NM, where 18 children attended and were provided with age-appropriate education on the importance of physical activity. The Wellness Education Specialist continues performing member outreach calls to remind parents/guardians to schedule annual physicals or immunizations. BCBS continues the Centennial Rewards program which includes 200 reward points ($20 value) per year for completing at least one child or adolescent well-care visit. The BCBS Centennial Rewards website offers learning links that educate parents on weight and height discussions at well-child visits with providers. The accuracy of WCC billing and coding is promoted and encouraged during monthly joint operating committee meetings. The increased payout rate for CPT code G0447 encourages providers to have discussions regarding healthy height and weight with member parents/guardians. • PHP continues to educate providers and members on the importance of the WCC measure. PHP continues

	to mail Early and Periodic Screening Diagnostic and Treatment letters to remind parents/ guardians to complete well-child visits. There were 37,175 letters sent during Q1. PHP also engages providers with informative presentations regarding annual well-child visits and appropriate documentation. PHP is using social media to promote compliance with this measure and educate members on the importance of these visits. • WSCC continues to provide member incentives via My Health Pays. Pfizer continues to send parents/guardians well-child visit reminder cards. WSCC offers transportation services via secure transportation to members who are having difficulty getting to appointments. WSCC hosts biweekly or monthly provider meetings to discuss interventions and best practices. WSCC also gives providers education materials and tip sheets regarding the WCC measure. The tip sheets educate providers on proper coding of WCC appointments to close gaps in care. ***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. **DY11 target is 84.75%.** • BCBS Q1 59.83% and is 24.92 percentage points below the DY11 target. • PHP Q1 65.12% and is 19.63 percentage points below the DY11 target. • WSCC Q1 52.98% and is 31.77 percentage points

	below the DY11 target. • MCO Aggregate: Q1 61.53% and is 23.22 percentage points below the DY11 target. **MCO Strategies and Interventions:** • BCBS continues its member outreach efforts through collaboration with the Special Beginnings maternity program. BCBS encourages healthy activity through the Centennial Rewards Program. Members are given reward points for completing their first prenatal care appointment. The “Blue for Your Health” member newsletter featured a pregnancy-related article titled “Pregnancy Complication Warning Signs”. BCBS continues to provide performance scorecards and gap-in-care lists to Value-Based Contracted providers during monthly joint operating committee meetings. These provider groups are incentivized to improve the TOPC rates for their membership. BCBS continues to partner with the Rhodes group to identify pregnant members early in their pregnancy. • PHP’s Performance Improvement (PI) team is focused on identifying pregnant members to encourage them to complete their first prenatal visit within their first 14 weeks of pregnancy. The Early Identification of Pregnancy report assists with this effort. Community Health Workers also use this report to perform targeted member outreach. PHP continues the Pregnancy Passport program to offer member rewards to pregnancy members for early prenatal care visits during the first trimester of their pregnancy. PHP promotes this program during the quarterly Native American Consumer Advisory Board. PHP also uses social media posts to remind members of the importance of prenatal care. • WSCC Start Smart for your Baby (SSFB) care coordinators continue to conduct member outreach to

	identify if a member's pregnancy is high, medium, or low risk to ensure the member is provided with the appropriate care. The Start Smart for your Baby (SSFB) Care Coordinators also assist members with scheduling their prenatal visits and address any barriers that the member may have. WSCC continues to use Notification of Pregnancy forms that provide WSCC with valuable information about the members pregnancy. Providers and members are offered incentives for completing the NOP. ***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 DY12 M6. **DY11 target is 67.26%.** • BCBS Q1 44.46% and is 22.80 percentage points below the DY11 target. • PHP Q1 54.39% and is 12.87 percentage points below the DY11 target. • WSCC Q1 44.93% and is 22.33 percentage points below the DY11 target. • MCO Aggregate: Q1 49.53% and is 17.73 percentage points below the DY11 target. **MCO Strategies and Interventions:** • BCBS continues to engage pregnant members with Special Beginnings maternity care coordination programs. The pregnant members are provided care throughout their pregnancy and are transitioned to women's wellness and early childhood phase post-delivery. The BCBS Quality Management staff

	continues to perform member outreach calls to offer assistance with scheduling postpartum visits. Members who are in need of food or housing are referred to the care coordination team for additional follow-up. BCBS continues to engage Value Based Contracted providers with incentives for improving their postpartum rates. The value-based providers are also given gap-in-care lists and offered assistance with member outreach during monthly joint operating committee meetings. The Special Beginnings program continues to partner with the Rhodes Group to use claims to identify postpartum members. • PHP continues to conduct member outreach to members who have recently delivered to educate them on the importance of postpartum care and offer assistance with scheduling appointments. PHP's Community Health Workers and Performance Improvement interventionist teams are invested in this effort. PHP continues to issue member rewards for completing postpartum care visits through the Pregnancy Passport rewards program. The Pregnancy Passport program is promoted at the quarterly Native American Consumer Advisory Board. PHP is using social media posts to remind members of the importance of postpartum care. • WSCC continues to use mPulse SMS text messages to remind members of appointments and inform members of various programs. The Start Smart for Your Baby (SSFB) Care Coordinators contact members after birth to assist members with scheduling appointments and address any barriers. WSCC continues to use the mobile application Pacify to provide members with 24/7 access to lactation consultants and Doulas. WSCC refers pregnant members to the Medicaid Home Visiting (MHV) program to promote maternal and infant health. Parent educators within the MHV program focus on educating

	members on prenatal care, postpartum care, and early childhood development. ***PM #5 (1 point) – Childhood Immunization Status (CIS): Combination 3*** The percentage of children 2 years of age who had 4 diphtheria, tetanus and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps and rubella (MMR); 3 haemophilus influenza type B (HiB); 3 hepatitis B (HepB); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their 2nd birthday. For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in DY12 M6. **DY11 target is 71.78%.** • BCBS Q1 33.96% and is 37.82 percentage points below the DY11 target. • PHP Q1 36.94% and is 34.84 percentage points below the DY11 target. • WSCC Q1 18.69% and is 53.09 percentage points below the DY11 target. • MCO Aggregate: Q1 33.31% and is 38.47 percentage points below the DY11 target. **MCO Strategies and Interventions:** • BCBS Quality Management Specialists conducted member outreach calls to offer assistance with scheduling well child visits in the first 15 months of life. BCBS hosted a hybrid Member Advisory Board Meeting in Albuquerque, NM on March 21st and Native American Advisory Board (NAAB) meeting in Mescalero, NM. The Community Health Workers are provided with talking points to encourage parents/guardians to regularly schedule and complete

well-child visits. BCBS incentivizes providers who participate in the reserved wellness appointment program. These providers see members for well-child visits (W30) and Well Care Visits (WCV) after hours and on weekends. The BCBS Wellness Education Specialists offer member outreach assistance to Value Based contracted provider groups to help them meet their CIS-3 and W30 HEDIS performance targets.

- PHP conducts member outreach to provide education regarding the benefits of childhood immunizations. PHP continues to mail Early and Periodic Screening Diagnostic and Treatment letters to remind parents/guardians to complete well child visits. PHP is using social media posts to educate members on the importance of childhood immunizations. PHP sent e-blast to providers to encourage them to participate in the annual Got Shots Vaccine initiative. The Performance Improvement and Analytics Organization are working to find new ideas to improve the performance rate.

- WSCC continues to engage members who complete CIS immunizations with incentives via My Health Pays and Centennial Rewards. Parents/guardians are also mailed immunization reminder cards by Pfizer. WSCC continues to host Provider engagement meetings to review provider scorecards, identify members with open care gaps, and discuss barriers. Providers are given education materials and tip sheets to encourage proper coding of CIS Combo 3 appointments. Various teams at WSCC meet bi-weekly to review performance measure data and the effectiveness of these strategies and interventions.

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. **DY11 target is 35.61%.** • BCBS Q1 33.43% and is 2.18 percentage points below the DY11 target. • PHP Q1 45.98% and is 10.37 percentage points above the DY11 target. • WSCC Q1 34.83% and is .78 percentage points below the DY11 target. • MCO Aggregate: Q1 39.96% and is 4.35 percentage points above the DY11 target. **MCO Strategies and Interventions:** • BCBS Case Managers continue member outreach calls to remind members to refill and maintain consistency with antidepressant medications. Case Managers also assist with follow-up appointments when needed. BCBS hosted a webinar for providers regarding child and adolescent mental health including antidepressant medications. Providers were offered continuing education units for attendance. BCBS hosted another provider webinar regarding Social Determinants of Health. The webinars are available online for providers who were unable to attend. • PHP continues to educate members on medication adherence through various methods of member outreach. PHP continues its call campaign to members located in counties with low AMM rates. Members are mailed educational materials on depression and medication adherence when behavioral health issues are identified during a Health Risk Assessment. PHP evaluates the denominator and numerator data by race, age, and gender to identify potential opportunities to improve medication adherence. PHP continues to engage providers during

	the Provider Education Conference, Provider newsletters, and the behavioral health town hall. • WSCC Behavioral Health Disease Management Nurses conduct member outreach to AMM members to provide education on medication adherence and address any barriers the member may have. WSCC provides members access to therapy through the MyStrength program. This program helps participants create personalized strategies for addressing trauma, depression, anxiety, and stress. WSCC encourages members to use Teledoc Health for virtual mental health appointments. WSCC continues to offer transportation services to members who have difficulty getting to appointments via Secure Transportation. WSCC engages providers with in-person and online training opportunities. Providers are eligible for continuing education credits for attending trainings. ***PM #7 (1 point) – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation*** The total percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment. **DY11 target is 47.54%.** • BCBS Q1 45.47% and is 2.07 percentage points below the DY11 target. • PHP Q1 54.75% and is 7.21 percentage points above the DY11 target. • WSCC Q1 47.34% and is .20 percentage points below the DY11 target. • MCO Aggregate: Q1 50.29% and is 2.75 percentage points above the DY11 target. **MCO Strategies and Interventions:** • BCBS continues member outreach phone calls when the Point Click Care system (formerly Emergency

	Department Information Exchange) alerts Recovery Support Assistants of an Emergency Department visit for substance use. The goal is to connect members with the appropriate follow-up care and ongoing support. BCBS continues to distribute a member education video on substance use via flyers with a QR code through facility partnerships. The video instructs members on how to find substance use treatment. Value-based contracting with provider groups and enhanced payment initiatives are ongoing. • PHP supports state efforts to implement Screening, Brief Intervention and Referral to Treatment program (SBIRT) in rural hospitals and emergency room departments. Certified peer support workers are also stationed in the emergency departments of Presbyterian Health Services delivery system. The peer support workers engage individuals with opioid overdoses or alcohol-related episodes. PHP engages providers with the IET incentive. Providers are educated on the IET measure at the provider education conference, and through eblasts. PHP identified geographic areas that have the highest rates for lack of services to increase provider capacity in these areas. • WSCC continues to collaborate with providers to receive notification when members visit the Emergency Department for substance abuse-related reasons. The notification enables WSCC to connect members to licensed mental health clinicians within 24 to 48 hours of the Emergency Department visit. WSCC Care Coordinators also contact their assigned members when they are alerted to episodes of substance misuse. WSCC value added services include a sober living benefit, which provides members with a safe place to stay while actively engaging in intensive outpatient substance abuse services. WSSC Provider Quality Liaisons

	communicate with providers regarding behavioral health measures, member gap lists, and ways to overcome obstacles. ***<u>PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness</u> <u>(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. **DY11 target is 53.80%.** • BCBS Q1 43.47% and is 10.33 percentage points below the DY11 target. • PHP Q1 48.24% and is 5.56 percentage points below the DY11 target. • WSCC Q1 46.37% and is 7.43 percentage points below the DY11 target. • MCO Aggregate: Q1 46.24% and is 7.56 percentage points below the DY11 target. **MCO Strategies and Interventions:** • BCBS has begun construction on a Blue Door Neighborhood Center, which is scheduled for completion during DY11 Q3. The centers are often used as meeting places for Case Managers and members. The facility incentive program to pay facilities that meet this measure at a higher rate is being expanded to more facilities. Outpatient providers are also incentivized through an Outpatient Facility Incentive Program. BCBS continues to reserve appointments at outpatient facilities for discharging members. Members are provided with an appointment for medication management and one for therapy when appropriate. • PHP continues its clinical behavioral health follow-up appointment inpatient pilot program. The inpatient pilot

	targeted Behavioral Health members who were discharged to nursing facilities to provide clinical follow-up appointments at the nursing facility. The Behavioral Health network continues to recruit more telepsychiatry groups into the network. PHP continues to assist inpatient facilities conduct post-discharge clinical calls within 7 days of discharge. PHP continues its discharge planning program to improve the coordination of care for members after they are discharged from an acute care facility. • WSCC provides members who are hospitalized for mental illness with transitional care coordination services. The Behavioral Health Utilization and Liaison teams collaborate with facility discharge planners to ensure members receive prompt care upon discharge. WSCC member connections team outreach efforts target high-risk members who are difficult to contact with the use of their community and provider connections. WSCC Assertive Care Treatment program aims to address members who have a severe mental illness with community-based services. The goal of this program is to reduce emergency department and inpatient psychiatric utilization by promoting assertive care treatment services. WSCC offers providers in-person and online training options to improve the delivery of high-quality care to members. ***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. **DY11 target is 48.00%.** • BCBS Q1 49.16% and is 1.16 percentage points above the DY11 target.

	• PHP Q1 39.55% and is 8.45 percentage points below the DY11 target. • WSCC Q1 41.18% and is 6.82 percentage points below the DY11 target. • MCO Aggregate: Q1 43.60% and is 4.40 percentage points below the DY11 target. **MCO Strategies and Interventions:** • BCBS continues to reserve outpatient appointments with behavioral health providers for members who need a timely follow-up. BCBS hosted a provider training regarding adolescent mental health on 2/5/24 and 2/7/24. A total of 309 providers attended. Providers were offered continuing education units for attendance. The webinar is available online for providers who cannot attend. A Blue Door Neighborhood Center is scheduled to open during DY11 Q3. The center will offer access to mental health resources. • PHP behavioral health network team is working to recruit more telehealth psychiatric providers to improve access to care. PHP is also offering providers training to secure a behavioral telehealth certification as another effort to increase access to behavioral health services. PHP continues to educate providers on the FUM metric and encourages providers to partner with Emergency room departments to offer behavioral health follow-up appointments. Presbyterian Health Services provides onsite peer consultation liaison services at the emergency department to support members in attending aftercare appointments. • WSCC continues member outreach to increase participation in follow-up care after discharge from emergency department visits for mental health issues or intentional self-harm. WSCC also uses claims-

based care gap reports to identify and contact members who received follow-up care within 30 days of an emergency department visit. WSCC value-added services include electroconvulsive Therapy for members who meet medical necessity, reimbursement for ceremonial or spiritual healing for Native American members, and a holistic care grant of up to $250 per household. WSCC encourages members to use Teladoc Health for mental health virtual appointments to reduce barriers to care. WSCC also offers transportation services through contracted vendor, Secure Transportation to members who are having difficulty getting to their appointments.

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.

DY11 target is 82.78%.

- BCBS Q1 43.66% and is 39.12 percentage points below the DY11 target.
- PHP Q1 47.61% and is 35.17 percentage points below the DY11 target.
- WSCC Q1 43.15% and is 39.63 percentage points below the DY11 target.
- MCO Aggregate: Q1 45.29% and is 37.49 percentage points below the DY11 target.

MCO Strategies and Interventions:

- The BCBS Care Coordinators continue to offer members at-home A1C test kits during member outreach calls. Case Managers also offer reminders

	and education on the importance of screening. BCBS engages outpatient providers by sending bulk A1C test kits to distribute to members. Providers are incentivized to distribute the test kits to members during appointments. The incentivized providers have used the funds to assist patients with transportation etc. BCBS is seeking more facilities to participate in this intervention. • PHP continues its member outreach efforts to contact members who were in the SSD denominator. PHP gives providers point-of-service A1c test kits to distribute to members. PHP's Value-Based Purchasing team recruits providers located in geographic areas with a high volume of members with a gap in care into the Behavioral Health Quality Incentive program (BQIP). Providers are provided training on the SSD measure at the Behavioral Health Provider Education Conference. During the training, the medical director provides information on the best practices for prescribing antipsychotics. • WSCC continues to partner with HarmonyCares to provide members at home A1c test kits. Care Coordinators conduct monthly member outreach to their assigned members who have not yet completed their A1c screening. WSCC Program Coordinators contact members with mental health challenges to educate them on the importance the importance of A1c screenings when taking antipsychotic medications. WSCC utilizes state reinvestment funds to encourage contracted behavioral health providers to assist members who are taking antipsychotic medications with A1c screening. WSCC continues to partner with TriCore Reference Laboratories to receive lab results for members who had blood glucose testing completed through their lab. WSCC continues to provide A1c test kits to NM Family Services to complete screenings for members who are receiving services in their clinics located in the Las Cruces area.

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 DY11 Q1 reporting:

TM #1 – Fall Risk Management

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

- BCBS Q1 0.02%
- PHP Q1 1.07%
- WSCC Q1 0.15%
- MCO Aggregate: Q1 Total 0.30%

MCO Strategies and Interventions:

- BCBS: In DY11 Q1, the BCBS member care fund provided shower chairs when needed to help manage risk of falls.

- PHP: PHP monitors members for fall risk and change in condition through data mining. Members identified with a change in condition are assessed for new needs that are addressed quickly to avoid the risk of falls.

	• WSCC: Care Coordinators assess members' needs, identify fall risks, and provide strategies and interventions for fall prevention. *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 19.53 • PHP Q1 15.65 • WSCC Q1 9.27 • MCO Aggregate: Q1 Total 16.09. MCO Strategies and Interventions: • BCBS: BCBS established goals for state-directed tracking measures. For this measure, a 2% decrease in MY 2024 from the CY23 Q4 final rate is the goal. To help achieve this goal, multiple condition states and health care gaps were reported to Care Coordination in DY11 Q1 for diabetic members ages 18 and older so Care Coordinators could educate and assist with members' health care needs. • PHP: Monitored members for hospital admissions utilizing the Collective Medical Technologies (CMT) platform that connects patients' electronic health records among hospitals. All members who were admitted for inpatient care were assessed for a change in condition and had a transition of care plan implemented to facilitate a successful transition to a lower level of care. • WSCC: Care Coordinators helped to prevent member diabetic complications by educating members on the importance of completing A1c testing and taking

diabetic medication as prescribed.

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 1.11%
- PHP Q1 1.56%
- WSCC Q1 1.36%
- MCO Aggregate: Q1 Total 1.41%

MCO Strategies and Interventions:

- BCBS: Continued monthly calls to members to educate them on the importance of follow up after a positive depression screening and to offer resources.

- PHP: Physical health providers were educated on depression during the Provider Education Conference, in newsletter articles, and with a recorded webinar placed on the provider portal titled "Treating depression in the Primary Care Provider".

- WSCC: A $25 provider incentive is available up to 4 times per year for non-behavioral health care providers who complete the PHQ-9 depression screening tool (or a comparable screening tool) with WSCC members.

TM #4 – Follow-up after Hospitalization for Mental Illness
The percent of 7-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days. An increase in rate indicates improvement for this measure.

- BCBS Q1 50.94%

	• PHP Q1 41.20% • WSCC Q1 29.69% • MCO Aggregate: Q1 Total 42.47% MCO Strategies and Interventions: • BCBS: Members being discharged may reserve an appointment at an outpatient facility for medication management and therapy. • PHP: Inpatient Care Coordination (IPCC) activities returned to in-person in DY11 Q1. IPCC activities include contacting members who were hospitalized to offer care coordination services and discharge planning assistance. • WSCC: The MyStrength program is available online or via the mobile app to WSCC members 24/7. The program uses evidence-based techniques like behavioral activation, acceptance and commitment therapy, and cognitive behavioral therapy to help members create personalized strategies for addressing a range of concerns, including trauma, depression, anxiety, and stress. The program also includes basic tools, weekly exercises, mood trackers, and inspirational messages and videos. *TM #5 – Immunizations for Adolescents (IMA)* The percentage of adolescents 13 years of age who had 1 dose of meningococcal vaccine, 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. An increase in percentage indicates improvement for this measure. • BCBS Q1 76.19% • PHP Q1 75.31% • WSCC Q1 59.94% • MCO Aggregate: Q1 Total 73.94%

	MCO Strategies and Interventions: • BCBS: In DY11 Q1, BCBS hosted a Member Advisory Board Meeting (MAB) and a Native American Advisory Board (NAAB) meeting where health education information on the importance of well-care visits and immunizations was presented. • PHP: Mailed monthly Early Periodic Screening Diagnostic and Treatment (EPSDT) letters in DY11 Q1 to 2,110 members in this age group. • WSCC: The Vaccine Adherence in Kids (VAKS) program reminds parents/guardians of immunizations for their children that are due or overdue. *TM #6 – Long-Acting Reversible Contraceptive (LARC)* Utilization of Long-Acting Reversible Contraceptives. The contractor shall report LARC insertion/utilization data for this measure. • BCBS Q1 150 • PHP Q1 233 • WSCC Q1 57 • MCO Aggregate: Q1 Total 440 *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 1,022 • PHP Q1 1,362 • WSCC Q1 338 • MCO Aggregate: Q1 Total 2,722 MCO Strategies and Interventions:

	• BCBS: To promote engagement in the Tobacco Cessation program, steps have been taken in 2024 to increase the visibility of the tobacco cessation program to providers and to members by referring members to the BCBS quit line, educating member and providers about the Tobacco Cessation program at the MAB and NAAB meetings, and sending magnets with the quit line phone number to members. • PHP: When members' newborns are positive for nicotine and are identified as meeting the criteria for the Comprehensive Addiction and Recovery Act (CARA) program, PHP provides the members with a tobacco cessation flyer and encourages members who are smokers to participate in the Tobacco Cessation program. • WSCC: Tobacco Cessation program information and materials are provided to members through outreach so they have the information when they are ready to begin tobacco cessation. *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 73.83 • PHP Q1 58.99 • WSCC Q1 62.33 • MCO Aggregate: Q1 Total 64.33 MCO Strategies and Interventions: • BCBS: Targeted members are contacted by a Community Health Worker (CHW) to provide education on the importance of being connected to out-patient care and to ensure the member is established with a Primary Care Provider (PCP).

	• PHP: PHP has aligned multi-department communication outreach activities to improve messaging to members and decrease duplication, which will ensure that all members needing outreach are contacted via the appropriate channel with fitting resources to receive services at the appropriate level of care. • WSCC: WSCC's Value Based team and Provider Quality Liaisons work with providers on improving access to care, addressing gaps in care, and improving health care outcomes. *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 11.11 • PHP Q1 8.36 • WSCC Q1 10.67 • MCO Aggregate: Q1 Total 9.58 MCO Strategies and Interventions: • BCBS: Texting campaign targets members who have visited the ED a minimum of 2 times in the past 60 days. These members are sent a text with the telephone number for the Nurse Advise Line and links to help find a PCP and locate the nearest Urgent Care Centers. • PHP: Care Coordinators monitor ED utilization and follow up with members who may need assistance due to acute medical changes or a decline in functional status. • WSCC: When members who have high ED utilization are seen in the ED, the MPulse texting program sends a text message to these members to check in about

	follow-up care. Members can respond with their needs which triggers a telephonic outreach from either their assigned Care Coordinator or from the Member Connections team. *TM #9 – Annual Dental Visit (ADV)* The percentage of enrolled members ages 2 to 20 years who had at least 1 dental visit during the measurement year. An increase in percentage indicates improvement for this measure. • BCBS Q1 17.58% • PHP Q1 21.78% • WSCC Q1 14.95% • MCO Aggregate: Q1 19.60% MCO Strategies and Interventions: • BCBS: BCBS's "Winter 2024 Member Newsletter" provided education on the importance of having a yearly dental exam for optimal health outcomes. • PHP: In DY11 Q1, there were 38,933 EPSDT letters mailed to members ages 2 to 20 years old. • WSCC: WSCC's dental vendor, Evolve, sends quarterly dental newsletters and annual postcards to remind members of due or overdue for and annual dental visit. *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 22.03% • PHP Q1 27.02% • WSCC Q1 18.30%

	• MCO Aggregate: Q1 Total 24.02% MCO Strategies and Interventions: • BCBS: After opting in to receive a blood pressure monitor for in-home monitoring, 517 adult members ages 18 and older who were identified as overweight or were diagnosed with obesity and hypertension received the blood pressure monitor from 6 provider groups. These members were sent a tracker to record their blood pressure readings and were encouraged to follow up with their health care providers. • PHP: Meetings took place during DY11 Q1 between PHP's Performance Improvement, Disease Management, Wellness, Community Health, and Population Health to collaborate on improving the accessibility of blood pressure screenings, capturing blood pressure data, and managing chronic conditions. • WSCC: Pharmacy staff monitors members' data for medication compliance, then member outreach is completed to assist with compliance and to encourage 90-day medication fills to promote medication adherence. *TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)* Initiation Phase: The percentage of members ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had 1 follow-up visit with a practitioner with prescribing authority within 30 days of when the first ADHD medication was dispensed. An increase in rate indicates improvement for this measure. • BCBS Q1 47.68% • PHP Q1 32.84% • WSCC Q1 45.00% • MCO Aggregate: Q1 Total 39.71%

	MCO Strategies and Interventions: • BCBS: Held a provider webinar in DY11 Q1 on the topic of child and adolescent mental health, including the ADD measure standards. • PHP: Continued the outreach campaign to members in DY11 Q1 to remind them to schedule follow-up visits related to ADHD medications. • WSCC: Healthcare providers have access to a variety of behavioral health-related provider toolkits on WSCC's website that include topics such as anxiety, bipolar disorder, depression, health equity, integrated care, substance use disorders, and social determinants of health. *TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)* Continuation and Maintenance Phase: The percentage of members ages 6 to 12 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at least 2 follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure. • BCBS Q1 55.12% • PHP Q1 36.08% • WSCC Q1 42.31% • MCO Aggregate: Q1 Total 44.56% MCO Strategies and Interventions: • BCBS: Continued calls to members identified as having their first filled ADHD prescription with reminders about consistency and follow-up appointments. • PHP: Continued provider education and trainings by the quality team at the behavioral health Provider

Education Conference (PEC) on the ADD HEDIS measure and best practices for follow-up care.

- WSCC: Teladoc Health, a contracted telemedicine vendor, provides virtual appointments for mental and physical health 7 days a week. Teladoc mental health experts assist members with medication management and mental health-related telemedicine visits, including those with a psychiatrist.

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 10.34%
- PHP Q1 8.42%
- WSCC Q1 8.88%
- MCO Aggregate: Q1 Total 9.10%

MCO Strategies and Interventions:

- BCBS: Multiple participating providers are working with BCBS to offer reserved appointment slots for BCBS Centennial Care 2.0 members to ensure availability when members call to schedule an appointment.

- PHP: Outreach strategies and interventions for DY11 Q1 included outreach with Presbyterian Medical Group (PMG) Pediatric Clinics to identify potential interventions for 2024 and a workgroup with PMG Las Estancias to address no-show patients.

- WSCC: WSCC meets with providers on a bi-weekly or monthly basis to discuss well-child visit performance and non-compliant members requiring a well-child visit.

External Quality Review

	HSD holds bi-weekly meetings with the External Quality Review Organization (EQRO) to review monthly projects, provide feedback, offer support, and assess issues. This process ensures that deliverables are met and that desired outcomes are achieved within the established timeframe. The meetings facilitate identifying potential areas for improvement, reviewing, and revising existing processes, and developing new strategies for optimal project performance. HSD's collaboration with the EQRO fosters a culture of continuous improvement. EQR Reviews and Validations in DY11 Q2 consisted of the below. <u>DY9 EQR Reviews and Validations</u> • Validation of Performance Improvement Projects, in review with HSD. • Validation of Network Adequacy, posted to the HSD website. • Compliance Review, posted to the HSD website. • Annual Technical Report, posted to the HSD website.

UTILIZATION

- Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for April 2023 – March 2024. 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 April 2023 – March 2024 time period.

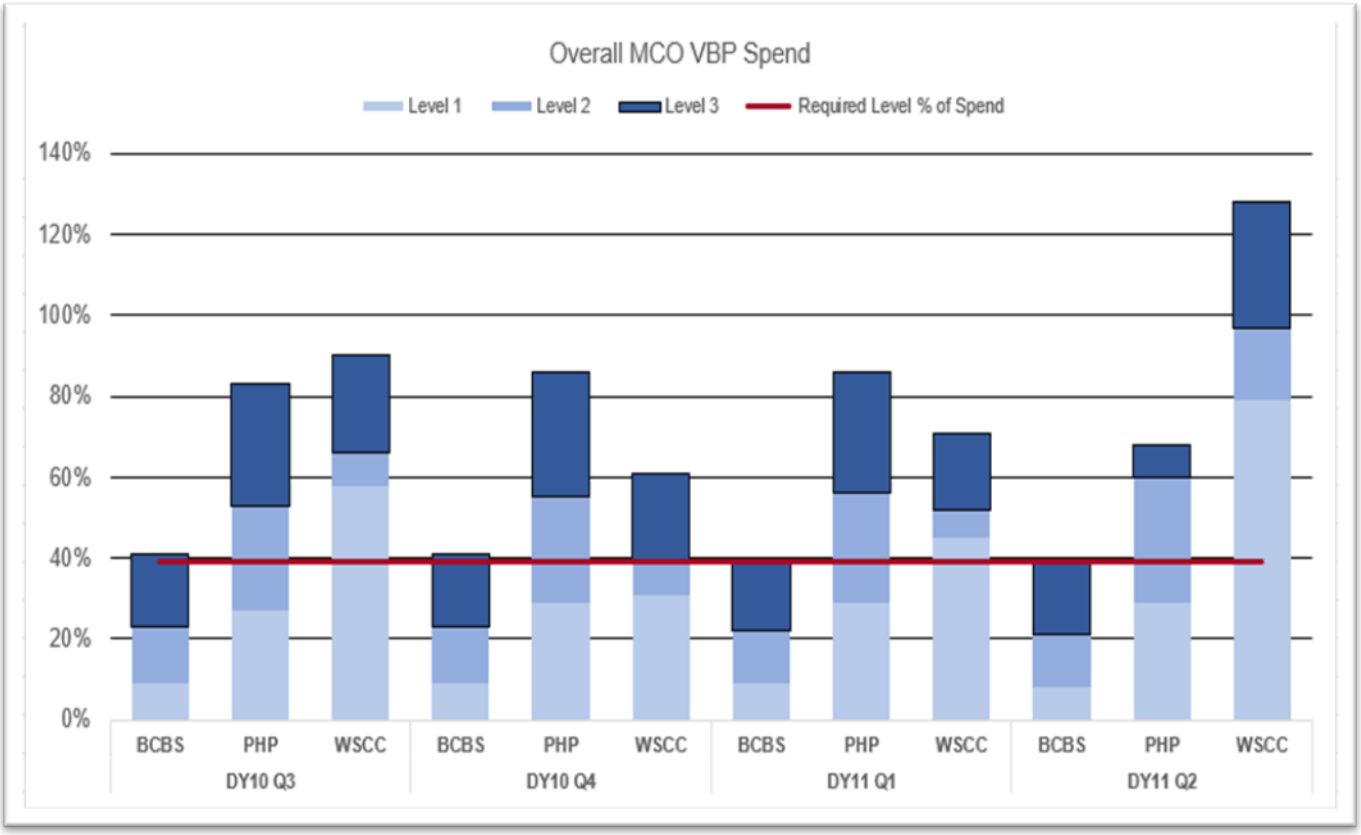
VALUE BASED PURCHASING

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

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

For DY11 Q2, BCBS, PHP, and WSCC met the required VBP spend target of 39%.

Table 28: MCO VBP Spend



Source: MCO Calendar Year (CY) 2023 Q3, Q3, Q4, and Calendar Year (CY 2024 Q1 Quarterly Financial Reports_ DY11 Q2 CY2024 Q1 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 interventions and strategies consisted of a digital text campaign that targets members visiting the ED with plans to continue through 2024. BCBS members who have

visited the ED a minimum of two times within 60 days are sent a text with links offering assistance in finding a PCP, Urgent Care locations and the Nurse Advise Line phone number. BCBS's goal is to provide early intervention with an opportunity to promote the importance of being established with a Primary Care Provider.

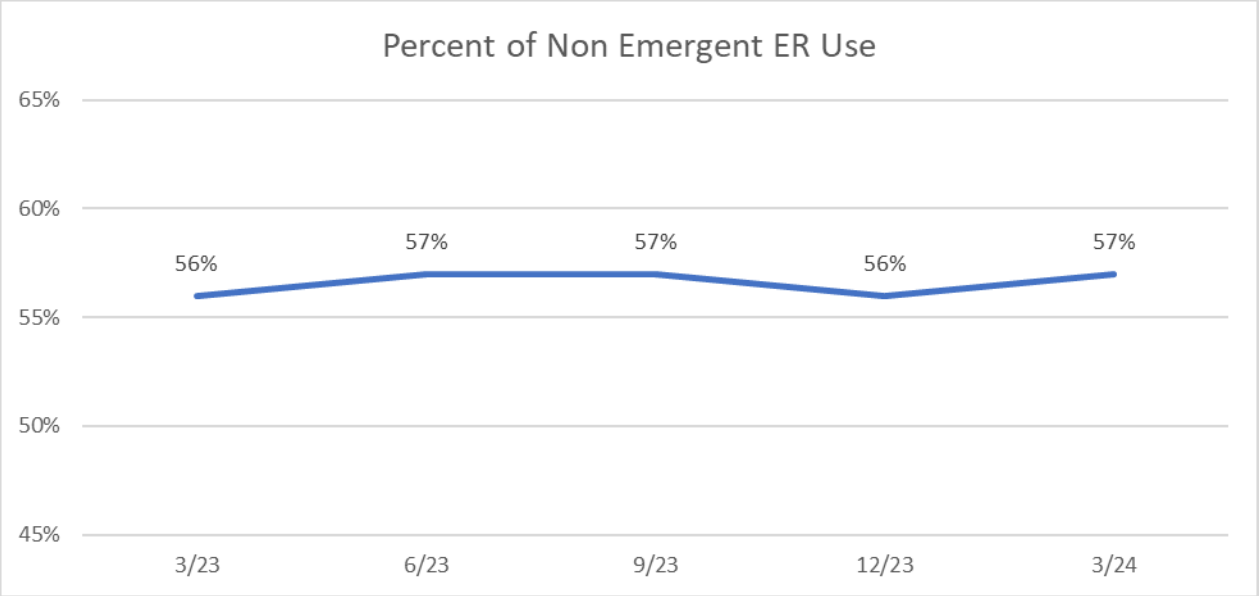
In order to reduce Low Acuity Non-Emergent (LANE) utilization, PHP members received a follow-up from care coordinators following an emergency room visit. Members receive alternatives to ER utilization. In addition, PHP support workers assist members who utilize the ER due to substance use disorder (SUD) or for members who are unhoused. Peer support workers engage members to provide education and resources to reduce LANE utilization. Presbyterian promotes the use of the PresNow facilities, that provide 24/7 access to urgent care services to reduce unnecessary ER use. Telehealth options are also available to members to provide alternatives to ER care.

WSCC continued initiatives to reduce ER visits that includes the use of mPulse Mobile reminding those discharged to follow up with a PCP. PHP utilizes Collective Medical to run customized reports based on member utilization. The system provides access to live member care information, and integration of care management systems. Care Coordinators utilize this system to research members who have been difficult to engage or unreachable and do not have updated contact information. In addition, WSCC utilizes Pyx Health to address loneliness and social isolation. Pyx Health is a free program for WSCC members. Pyx Health supports WSCC members 24/7. As of this quarter, 2,220 WSCC members have enrolled in the program and actively benefited from the Phone App or the live support to access health plan resources, community services, address general health care questions, urgent support, mental health, and substance abuse support.

The percentage of emergency utilization that are considered low acuity increased by 1 percentage point from DY10 Q4 to DY11 Q1. In comparing low acuity ED visits from DY10 Q1 (56%) to DY11 Q1 (57%), the percentage of visits to the emergency department for non-emergent care decreased by 1 percentage point. A lower rate indicates improvement for this measure. The trend for this measure indicates a steady rate. However, the goal is to see this rate decrease quarter over quarter a lower rate is a positive direction.

The graph below reflects the percentage of members using the ER for non-emergent care between DY10 Q1 and DY11 Q1. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership. The data for DY11 Q2 will be reported in the DY11 Q3 CMS Quarterly Monitoring Report.

Table 29: Non-Emergent ER Use



Source: Mercer- Non-Emergent Emergency Room Utilization Report

14
MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

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

Physical Health and Hospitals

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

Transportation

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

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

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

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

ensure that all requested rides are provided for these appointments; 2) develop and submit for approval detailed operational plans for providing NEMT for Critical Care service appointments when the transportation vendors are unable to provide the service; and 3) submit a NEMT monthly report that provides data on NEMT trips. In DY11 Q2, appointment arrival and pick up time standards were implemented for the MCOs and vendors. Arrival time must be no sooner than 1 hour before the appointment. Pick-up shall occur with 15 minutes of the scheduled time.

Customer Service Reporting

BCBS met all call center metrics for the reporting period, DY11 Q2.

PHP met all call center metrics for the reporting period, DY11 Q2.

WSCC met all call center metrics for the reporting period, DY11 Q2.

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 7% 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 CY23 as the baseline for CY24 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 DY11 Q2.

Table 30 Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine	DY10 Q3	DY10 Q4	DY11 Q1	DY11 Q2
New Behavioral Health Members	**10,757**	**7,846**	**37,578**	**10,664**
BCBSNM	4,989	3,395	15,909	4,671
PHP	4,572	3,531	17,794	4,785
WSCC	1,196	920	3,875	1,208
New Physical Health Members	**14,883**	**12,377**	**25,893**	**15,553**
BCBSNM	4,419	3,793	7,690	3,835
PHP	9,202	7,346	16,026	10,511
WSCC	1,262	1,238	2,177	1,207
Total New Unduplicated Members	**21,562**	**16,800**	**59,652**	**22,970**
BCBSNM	7,930	5,940	22,330	7,535
PHP	11,522	9,027	31,557	13,276
WSCC	2,110	1,833	5,765	2,159
YTD* Unduplicated Members	**130,748**	**147,548**	**59,652**	**82,622**
BCBSNM	48,309	54,249	22,330	29,865
PHP	69,834	78,861	31,557	44,833
WSCC	12,605	14,438	5,765	7,924

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

15
DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
DY11 Q2	The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) worked together in DY11 Q2 to perform evaluation work on New Mexico's Section 1115 Waiver Demonstration, Centennial Care 2.0. In DY11 Q2, HSAG and HSD performed the following accomplishments: HSD received the Centers for Medicare & Medicaid (CMS) approval on the revised Evaluation Design. The revisions to the Evaluation Design included adding components to evaluate the serious mental illness (SMI), high-fidelity wraparound (HFW), and home- and community-based services (HCBS). The amendment was approved to refine the existing Aim 4(Improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder [SUD]) and Centennial Rewards measures. Furthermore, components were added to evaluate personal care services. HSD obtained information on how to go about conducting the qualitative interview and analysis to evaluate the HFW program with our current Independent Evaluator. HSD obtained an "Anticipated Qualitative Interview and Analysis Schedule" from Health Services Advisory Group, Inc. (HSAG) on initiating the subject-matter expert (SME) interviews. The SME interviews are needed for the final Centennial Care 2.0 Medicaid 1115 Summative Evaluation Report. The following are the updates for the New Mexico's transition into Turquoise Care Medicaid 1115 Waiver: HSD has conducted cost analyses for cost associations related to activities that will be provided by selected independent evaluator for Turquoise Care. HSD is in the process of obtaining Requests for Quotes (RFQs) from potential Offerors for the contract. HSD anticipates the release of new CMS approvals and Special Terms and Conditions (STCs) needed to proceed with the procurement of an evaluator. HSD has conducted an internal comparative analysis of current evaluation design measures to determine effectiveness of metrics and data sources. The findings of this analysis will be taken into consideration in the development of the Turquoise Care Medicaid 1115 Waiver Evaluation Design.

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ENCLOSURES/ATTACHMENTS

Attachment A: April 1, 2022 – March 31, 2024 Statewide Dashboards
Attachment B: Budget Neutrality Monitoring Spreadsheet
Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group
Attachment D: Customer Service

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STATE CONTACTS

HSD State Name and Title	Phone	Email Address
Dana Flannery Medicaid Director HSD/Medical Assistance	480-375-0567	Dana.Flannery@hsd.nm.gov
Heidi Capriotti Deputy Director of Communication and Innovation HSD/Medical Assistance	(505) 629-2938	Heidi.Capriotti@hsd.nm.gov
Elisa Walker-Moran Deputy Director of Finance HSD/Medical Assistance	505-470-9330	Elisa.Walker-Moran@hsd.nm.gov
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

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ADDITIONAL COMMENTS

MCO INITIATIVES

BCBS:

Achievements

NM Medicaid Encounters is in the process of creating a NM Medicaid Encounters Manual to compile Standard Operating Processes into one single point of reference. The team has collaborated on the topics for the manual which has also involved workgroups for specific processes that require focused attention to create the content.
This will allow for more efficient reference of encounter processes, with positive impact to productivity. The intention is to make this a living document, much like the HSD systems manual, but complement it with information that is BCBSNM specific for all responsibilities within the NM Medicaid Encounters department.

The Member Care Fund for Q2 helped 60 members address their Social Determinants of Health. Out of these 60 members 28 were female and 32 were male. Out of those 60 members 31 were Latino, 12 white, 7 black, 1 Native American and 9 other races. The fund provided items such as clothing, household items, beds, bikes, wellness items, hygiene items, baby items and safety equipment as well as cleaning services and auto repair.

PHP:

Achievements

Diabetes Prevention and Healthy Weight Programs

In Q2 2024, the Diabetes Prevention Program (DPP) and Healthy Weight (HW) Program enrolled 94 new participants; 11 for DPP and 83 for HW; committing to a 12-month structured curriculum and coaching schedule. Since implementation, PHP had 581 Centennial Care Members enrolled and a total of 254 participants with logged individual sessions related to physical activity, healthy food choices, eating patterns, and daily weight management. The 12-month programs are offered to eligible Members and are evidence-based programs with oversight by the Centers for Disease Control and Prevention.

NCQA Health Equity Accreditation

In Q2 2024, PHP has made significant improvements the in NCQA Health Equity Accreditation requirements, including the following:

- In-depth collaboration from workstreams covering the six main areas of accreditation, including:
    - Diversity, equity, and inclusion in the workforce
    - Health equity data systems and collection
    - Language services
    - Provider network adequacy
    - Health Disparities (including HEDIS, quality improvement, and Culturally and Linguistically Appropriate Services program development)
    - Delegation
- While the workstreams were launched in Q1, in Q2 the workstreams met weekly to review each specific NCQA requirement, provided documentation of processes that currently met standards, and created solutions for requirements which were not yet met.
- The implementation project team provided weekly updates to our senior leadership, including the percentage of project completion, elevation of risks, and detailed updates on each requirement status.

Learning Collaboratives

Presbyterian's VBP team launched its new site 'Presbyterian Value-Based Care Hub'. The site can be reached here: Lunch and Learn: Value-Based Care Hub (swoogo.com)
This site is all-encompassing, allowing groups to see upcoming training, register, and review materials. It is also linked to the provider newsletter for easy access quarterly to remind providers to see what is new.

PHP continued its themed learning collaboratives for 2024. In Q2 2024, PHP covered Behavioral Health, Pediatric and Perinatal Measures and Introduction to Turquoise Care. Each month, PHP hosts various learning collaboratives for all contracted providers. The goal is to provide education and resources to provider groups around many topics. An introductory digital video was created providing an overview of value-based care. Currently PHP is working on computer-based trainings (CBTs) for existing trainings to deploy later in 2024. Additionally, they have expanded trainings with information on new topics such as managing a patient panel, risk adjustment, and an introduction to value-based care. 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.

Value-Based Care Digital Tools

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

Provider readiness assessment tool was completed late Q2 2024 and is currently pending approval of the Value-Based Care Steering Committee for deployment in early Q3 2024.

WSCC:

Pyx Health Program

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

Doula Services

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

MEMBER SUCCESS STORIES

BCBS:

Member is a 64-year-old man from Uganda. His primary language is Kinyarwanda. Member is quadriplegic and struggles with all Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IDL). Member was provided an electric wheelchair less than two years ago. He recently had brain bleeds which resulted in his losing cognitive function and subsequently was unable to utilize the electric wheelchair. Member reports he was unable to leave his bedroom and he could no longer attend medical appointments, access community resources, or attend social events including church. Care Coordinator (CC) spoke with Member's Primary Care Provider (PCP) to adjust his appointments to virtual until he could receive a manual wheelchair. Member had a catheter appointment at UNM Hospital that he needed to attend in person because of the risk of hospitalization.

CC continued collaboration with Member's PCP through his clinic, medical supply company, his guardian, his son, and his Blue Cross Blue Shields Community Health Worker (CHW). PCP sent in all required documents to medical supply company for member's manual wheelchair. On a regular basis CC has worked with both medical supply company and PCP to ensure documentation has been provided for member to receive the wheelchair.

CC continued to advocate on member's behalf for his overall well-being and safety. CC is happy to report member has received his manual wheelchair, which allows him to attend all medical appointments in person now and can now attend church and other cultural and social events in person. Member's family is extremely grateful for the manual wheelchair. Members guardian stated, "People take for granted being able to be mobile every day". CC and CHW witnessed the determination, resilience, and strength of the member's family while facing a barrier that effected their father's overall health.

CC will continue to collaborate with member and his family. She will take the knowledge and gained experience into future interactions with PHP members in need.

PHP

Member is an individual who has been engaged with a Care Coordinator for almost 5 years. This Member and Care Coordinator have worked together to complete quarterly touchpoints and annual assessments. The Care Coordinator has offered praise and positive encouragement to this Member over the years regarding his successes and efforts to make positive changes in his life. Member has thanked Care Coordinator for listening to him and being non-judgmental during setbacks related to their sobriety. Member is established with a primary care provider and sees a specialist every 3 months. Member reports he has become more stable in his health both mentally and physically,

due to his sobriety and is not wanting to continue with caregiver services any longer. Member reports sobriety for 2 years now and in the last 10 years has had long periods of sobriety and only a few instances of relapses, Member was able to move forward and continue with his sobriety despite setbacks. Member continues with his outpatient treatment program; he participates in both individual and group therapy on a weekly basis. Member attends AA meetings during the week and has been asked to become a peer support for his outpatient program. Member started a part time job and enjoys keeping busy and connecting with others. Member enjoys painting and hopes to sell some of his paintings in the future. Member wants to become a support to others that are pursuing sobriety. Member is looking into a peer support program at his local community college to become certified. Member continues to utilize his traditional healing benefits on an annual basis; he has shared that this has been beneficial to him and his cultural beliefs as part of his journey to sobriety. Member has created a support system within his outpatient program and feels confident about his future.

WSCC:

WSCC's Managed Care Services Agreement expired 6/30/2024, at the end of DY11Q2. No member success stories were provided during this quarter. WSCC did report it has worked diligently to ensure a smooth transition of its members to the Turquoise Care MCOs.

BCBS:

PHE Unwinding Outreach Actions, April 2024

Member Calls

Direct member (non-prerecorded) outbound calls: April 2024	BCBS
Members scheduled for direct calls	324
Number of calls made	361
Answered	331
No answer	30
Voicemail	N/A
Hung up	N/A
Contact completed (member reached; information conveyed)	311
Average call duration	N/A
Member inbound calls related to recertification	1193

Outreach Completed

Outreach Efforts Completed: April 2024	BCBS
Members targeted	3699
Special COEs/Groups targeted	N/A
Member letters/direct mail	259
Email 1	N/A
Email 2	N/A

Postcards	3440
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 April 2024 Termination file from HSD, urging members to not go uninsured but explore alternative Blue Cross and Blue Shield of New Mexico plan options at BeWellNM.com.

Notes
N/A

PHP:

PHE Unwinding Outreach Actions, April 2024

Member Calls

Direct member (non-prerecorded) outbound calls: April 2024	PHP
Members scheduled for direct calls	1749
Number of calls made	2170
Answered	558
No answer	1032
Voicemail	428
Hung up	15
Contact completed (member reached; information conveyed)	130
Average call duration	2m 49s
Member inbound calls related to recertification	622

Outreach Completed

Outreach Efforts Completed: April 2024	PHP
Members targeted	4617
Special COEs/Groups targeted	N/A
Member letters/direct mail	4444
Email 1	458
Email 2	N/A
Postcards	N/A
Text message 1	4617
Text message 2	N/A
Text message 3	N/A
Text message 4	N/A
Robocalls	N/A

Efforts targeting the closed population

Notes
• The State required MCO unwinding activities reporting through April 30, 2024. • 4,444 letters were sent to members on 4/8. Emails were sent to all members for which we had a valid email address in April (458 total) that mirrored the information relayed in the letter. Texts were sent out to 4,617 members in April. The discrepancies between the number of texts sent and the amount of letters is due to householding the mailing and some invalid mailing address • PHP care coordination completed outreach out to 421 members. • PHP Medicaid Outreach and Retention conducted and attended thirty-two outreach events with 3 Recertifications/Renewals for April 2024.

WSCC

PHE Unwinding Outreach Actions, April 2024

Member calls

Direct member (non-prerecorded) outbound calls April 2024	Western Sky
Members scheduled for direct calls	0
Number of calls made	0
Answered	0
No answer	0
Voicemail	0
Hung up	0
Contact completed (member reached, information conveyed)	0
Average call duration	0
Member inbound calls related to recertification	1

Notes
WSCC started the transition of members to other TC MCO on April 1, 2024. WSCC had no reporting metrics for outreach for April due to the transition of members.

Outreach Completed

Outreach Efforts Completed April 2024	Western Sky
Members targeted	0
Special COEs/Groups targeted	0
Member letters/direct mail	0
Email 1	0
Email 2	0

Postcards	0
Text message 1	0
Text message 2	0
Text message 3	0
Text message 4	0
Robocalls	

Efforts targeting the closed population

WSCC started the transition of members to other TC MCO on April 1, 2024. WSCC had no reporting metrics for outreach for April due to the transition of members.

Notes

N/A