

TURQUOISE CARE DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 12 (7/1/2024 – 9/30/2024)
Quarter 1 of the Demonstration Year

March 31, 2025

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INTRODUCTION

On July 1, 2024, the State of New Mexico launched the New Mexico Health Care Authority, a new agency. The agency merged the New Mexico Human Services Department, the State Employee Benefits team from the General Services Department, and the Developmental Disabilities Supports Division and Division of Health Improvement from the New Mexico Department of Health, and the Health Care Affordability Fund from the Office of the Superintendent of Insurance. The New Mexico Health Care Authority will leverage purchasing power, partnerships and data analytics to create innovative policies and models of comprehensive coverage for New Mexicans.

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). The demonstration authorizes the comprehensive managed care delivery system, the Home and Community-Based Services (HCBS) Community Benefit (CB) program and several transformative initiatives that serve most of the State's Medicaid beneficiaries. Following is the evolution of New Mexico's 1115 Demonstration Waiver:

- On July 12, 2013, CMS approved New Mexico's 1115 Demonstration Waiver under the name Centennial Care, January 1, 2014, through December 31, 2018, which created a comprehensive managed care delivery system offering the full array of Medicaid services, including acute care, pharmacy, behavioral health services, institutional services, and community-based long term services and supports. Other features included expanded care coordination for all beneficiaries and a member rewards program to provide incentives for members to pursue healthy behaviors.
- On December 14, 2018, CMS approved New Mexico's 1115 Demonstration Waiver extension under the name 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 February 7, 2020, CMS approved New Mexico's 1115 Demonstration Waiver Amendment, effective February 7, 2020, through December 31, 2023. The amendment removed three authorities: co-payments for non-emergency use of the emergency room and non-preferred prescription drugs, monthly premiums for the

Adult Expansion Group, and limitations on retroactive eligibility beginning on February 8, 2020. Additionally, the amendment authorized the state to increase the number of CB slots and expand the Centennial Home Visiting pilot program by removing restrictions.

- On March 28, 2023, CMS approved New Mexico's 1115 Demonstration Waiver amendment, effective March 28, 2023, through December 31, 2023. The amendment provided expenditure authority for two initiatives: short-term stays in applicable Institutions for Mental Diseases (IMDs) for diagnoses of serious mental illness (SMI) and/or serious emotional disturbance (SED); and implementation of a High-Fidelity Wraparound (HFW) intensive care coordination benefit. The amendment also approved HCBS improvements, including increases to CB slots and specific benefit limits.
- 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, to allow New Mexico and CMS to continue negotiations over New Mexico's demonstration application submitted on December 15, 2022.
- On September 7, 2023, CMS approved a time-limited amendment to New Mexico's 1115 Demonstration Waiver, Centennial Care 2.0, effective May 11, 2023, to November 11, 2023, to provide expenditure authority for payments to Legally Responsible Individuals (LRIs) rendering personal care services (PCS).
- 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. The amendment included approval for the following: LRIs providing PCS to members receiving benefits under the CB and Early and Periodic Screening, Diagnostic and Treatment programs; increased enrollment limit for CB program from 6,789 to 7,789 slots; increased enrollment limit for supportive housing program from 180 to 450 members with SMI; continuous eligibility for children up to age six; and expansion of the Home Visiting program to incorporate additional evidence based models.
- On July 25, 2024, CMS approved New Mexico's 1115 Demonstration Waiver extension under the name Turquoise Care, July 25, 2024, through December 31, 2029. The extension approval time period incorporated a 6-month temporary extension period and New Mexico's request to align the demonstration years with the calendar year to reflect New Mexico's managed care contract schedule. The demonstration extension includes approval of longstanding authorities as well as new initiatives including the Reentry Demonstration initiative and the Health-Related Social Needs (HRSN) Services program, which includes Medical Respite and meals

for pregnant members. The extension also approved expansions to Supportive Housing and CB Home-Delivered Meals and phased out the Family Planning waiver authority and a Self-Directed CB healer benefit.

Turquoise Care's goals and initiatives center on improving core health outcomes and attending to the social and economic determinants of health, and in particular addressing the needs of the State's historically underserved populations. New Mexico's vision is that every Medicaid member has high-quality, well-coordinated, person-cente red care to achieve their personally defined health and wellness goals. To advance on these opportunities and move closer to this vision, the New Mexico Health Care Authority (HCA) will operate a data-driven Medicaid program that measures quality based on population health outcomes.

With the launch of Turquoise Care, New Mexico contracted with different MCOs. HCA's quarterly and annual monitoring reports for Calendar Year (CY) 2024 will reflect data and information for the MCOs as specified below.

Demonstration Year (DY) 11 Quarter 1 (January – March) and 2 (April – June) reports include data and information for the following Centennial Care 2.0 MCOs:

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

DY12 Quarter 1 (July – September) and 2 (October – December) reports, and DY13 (CY2025) future reports will include data and information for the following Turquoise Care MCOs:

- BlueCross BlueShield of New Mexico (BCBS),
- Presbyterian Health Plan (PHP),
- Molina Health Care (MHC), and
- United Health Care (UHC).

HCA is refining its monitoring report structure to comply with the current Special Terms and Conditions (STCs) executed between New Mexico and CMS. Report refinements will continue to be made with a target completion date of DY13 (CY2025) reporting.

TURQUOISE CARE POST AWARD FORUMS

On August 20, 2024, HCA provided an update on the implementation of Turquoise Care to the Medicaid Advisory Committee (MAC), which serves as the post award forum meeting. HCA presented progress reports on the Turquoise Care waiver at all subsequent MAC

meetings. All MAC meetings have a public comment opportunity. The following includes a summary of all MAC meetings held in 2024.

During the May 6, 2024, MAC meeting the following topics were addressed in support of the Turquoise Care 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-erm 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, and
- 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 20, 2024 (date correction for the DY11 Q2 report). 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.

During the August 5, 2024, MAC meeting the following topics were addressed in support of the Medicaid 1115 demonstration waiver renewal and implementation of Turquoise Care:

- Budget and 1115 Demonstration updates,
- Review of new benefit implementation progress including Community Health Worker (CHW) services, step therapy pharmacy, delivery of necessary diabetic resources, and mobile crisis intervention and mobile response and stabilization services.

- Progress on the development of the Behavioral Health continuum of care and the increases of Medicaid BH provider enrollment,
- Presentation of the justice-related program: Reach, Intervene, Support and Engage (RISE), which in collaboration with managed care organizations (MCOs), assists justice-involved Medicaid members with warm hand-offs to care coordination in the community,
- Medicaid Management Information System Replacement (MMISR) – Announcement that the Benefit Management Services (Provider Enrollment) module will be going live on October 30, 2024, and the Unified Portal will be going live for Medicaid applicants on August 22, 2024.

An opportunity to provide public comment on the progress of the demonstration was provided and no comments were received. To date, HCA has not received public comments related to the progress of the Turquoise Care Demonstration. All stakeholder feedback gathered at the Medicaid Advisory Committee (MAC) as well as other public forums have been used to monitor and inform the development of the Turquoise Care waiver. The following is a listing of MAC meeting dates that occurred in CY2024:

- March 4, 2024
- May 6, 2024
- June 20, 2024
- August 5, 2024

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

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: DY12 QUARTER 1 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	6/30/2024 ENROLLMENT	9/30/2024 ENROLLMENT	PERCENT INCREASE / DECREASE Q3
BlueCross BlueShield of New Mexico (BCBS)	259,803	267,073	2.8%
Presbyterian Health Plan (PHP)	366,994	364,496	-0.7%
Western Sky Community Care (WSCC)	85,854	0	-100.0%
United Health Care	0	39,759	100.0%
Molina Health Care	0	41,222	100.0%

Source: Medicaid Eligibility Reports, June 2024 and September 2024

CENTENNIAL CARE 2.0 TRANSITION TO TURQUOISE CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment and expenditure data by programs for July 2022 – June 2024 is available in Attachment A to this report.

MCO Enrollment

In aggregate, MCO enrollment decreased by 10% from the previous-to-current period. This decrease is comprised of the following:

- 14% decrease in Physical Health enrollment,
- 4% decrease in Long-Term Services and Supports enrollment,
- 3% decrease in Other Adult Group enrollment.

Enrollment levels have continued 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., June 30, 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 15% from the previous-to-current period. This consists of a 9% increase to pharmacy services and 16% for non-pharmacy services.

On a dollar basis, the lower enrollment levels (-10%) have been offset by the increase in per capita medical costs (15%), driving the 4% increase in total medical expenses.

CENTENNIAL CARE 2.0 AND TURQUOISE CARE REWARDS

The Centennial Rewards program was renamed to Turquoise Rewards beginning DY12 Q1 and provides incentives to members for engaging in and completing healthy activities and behaviors. Beginning in DY12 Q1, New Mexico modified its 2024 Turquoise Rewards Program as illustrated below.

Reward Activity	Age Requirement	2024 Modification
Address Update	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 Medicaid Home Visit (MHV)	All ages	Added new reward activity
MHV Video Completion	All ages	Added new reward activity

First MHV after baby is born	All ages	Added new reward activity
Ongoing MHV Visits	All ages	Added new reward activity
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	No change
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

Turquoise Rewards Participation

In DY12 Q1, 747,921 Turquoise Care members are participating in the Member Rewards program. Registering for the Turquoise Rewards program is not required to participate in the program but is required for reward redemption. Quality improvement and participation trends are demonstrated in the table below.

Table 2: Turquoise Rewards

TURQUOISE REWARDS				
	October - December 2023	January - March 2024	April - June 2024	July - September 2024
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	125,575	200,288	182,207	193,232†
Number of Members Newly Registered in the Rewards Program this Quarter**	6,497	3,332	5,003	6,911
Number of Members Who Redeemed Rewards this Quarter***	50,159	17,180	29,960	26,902

Source: Finity Quarter 3 2024 Report

† In July 2024, member rewards were redistributed from past quarters to facilitate the mid-year MCO changes.

*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 early in 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 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.

Turquoise Rewards Multimedia Campaigns

In DY12 Q1, Finity, the Turquoise 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, HEDIS measures. All multimedia communications align with HCA'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 is not a reward associated with this campaign. Texts and emails were sent in July 2024.

- 31K texts sent in DY12 Q1
- 29K emails sent in DY12 Q1

Monthly Redemptions Campaign: Designed to notify members who have earned rewards that they have points to spend in the Turquoise 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 in DY12 Q1 results are provided below:

- 423K texts sent in DY12 Q1
- 242K emails sent in DY12 Q1

Points Expiration Campaign: Designed to notify members who have earned rewards to spend their points before they expire. Texts and emails were sent in September. This is an annual calendar year (CY) Q3 campaign and results are provided below:

- 11K texts sent in DY12 Q1
- 15K emails sent in DY12 Q1

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 July. This is an ongoing campaign and DY12 Q1 results are provided below:

- 33K texts sent in DY12 Q1
- 8K emails sent in DY12 Q1

Additional Key Stats through DY12 Q1:

- Member participation in DY12 Q1 reached an all-time high of 77.26%,
- In DY12 Q1, the number of newly registered members increased by 38% over DY11 Q2,
- With 26K members redeeming nearly $1M in DY12 Q1, redemptions have remained consistent year-over-year during the same time period and are expected to rise in DY12 Q2 due to points expiration and holiday shopping.

Table 3: Turquoise Rewards Customer Satisfaction Survey

Turquoise Rewards Customer Satisfaction Survey												
	DY10 Q4			DY11 Q1			DY11 Q2			DY12 Q1		
	# OF RESPONDENTS 3,954			# OF RESPONDENTS 867			# OF RESPONDENTS 1,407			# OF RESPONDENTS 1,339		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Turquoise Care?	96%	4%	n/a	98%	2%	n/a	96%	4%	n/a	98%	2%%	n/a
Are you satisfied with your 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	87%	3%	10% I don't have a doctor
Are you satisfied with your health plan?	96%	4%	n/a	97%	3%	n/a	96%	4%	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	93%	7%	<1% I don't have a care coordinator	92%	7%	<1% I don't have a care coordinator	92%	8%	<1% I don't have a care coordinator

Source: Finity DY12 Quarter 1 Report

TURQUOISE CARE

The New Mexico Turquoise Care program began 7/1/2024. Prior to Go Live, MCOs had been meeting regularly to ensure warm handoffs for high-risk members transitioning between MCOs. These activities, ensuring that members had Care Coordinator introductions and service access, continued until all members were reached. MCOs offered extended call center hours for all members and had additional staff ready to meet any unanticipated needs. Additional call volume did not occur, and MCOs return to normal staffing and hours by week two. HCA staff and leadership monitored key performance indicators weekly for any early indications of transition challenges or concerns. Overall, data reflected few operational concerns.

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 documented 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. HCA and WSCC met weekly to discuss transition activities, and WSCC submitted progress reports every 30 days. New Mexico closely monitored 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.

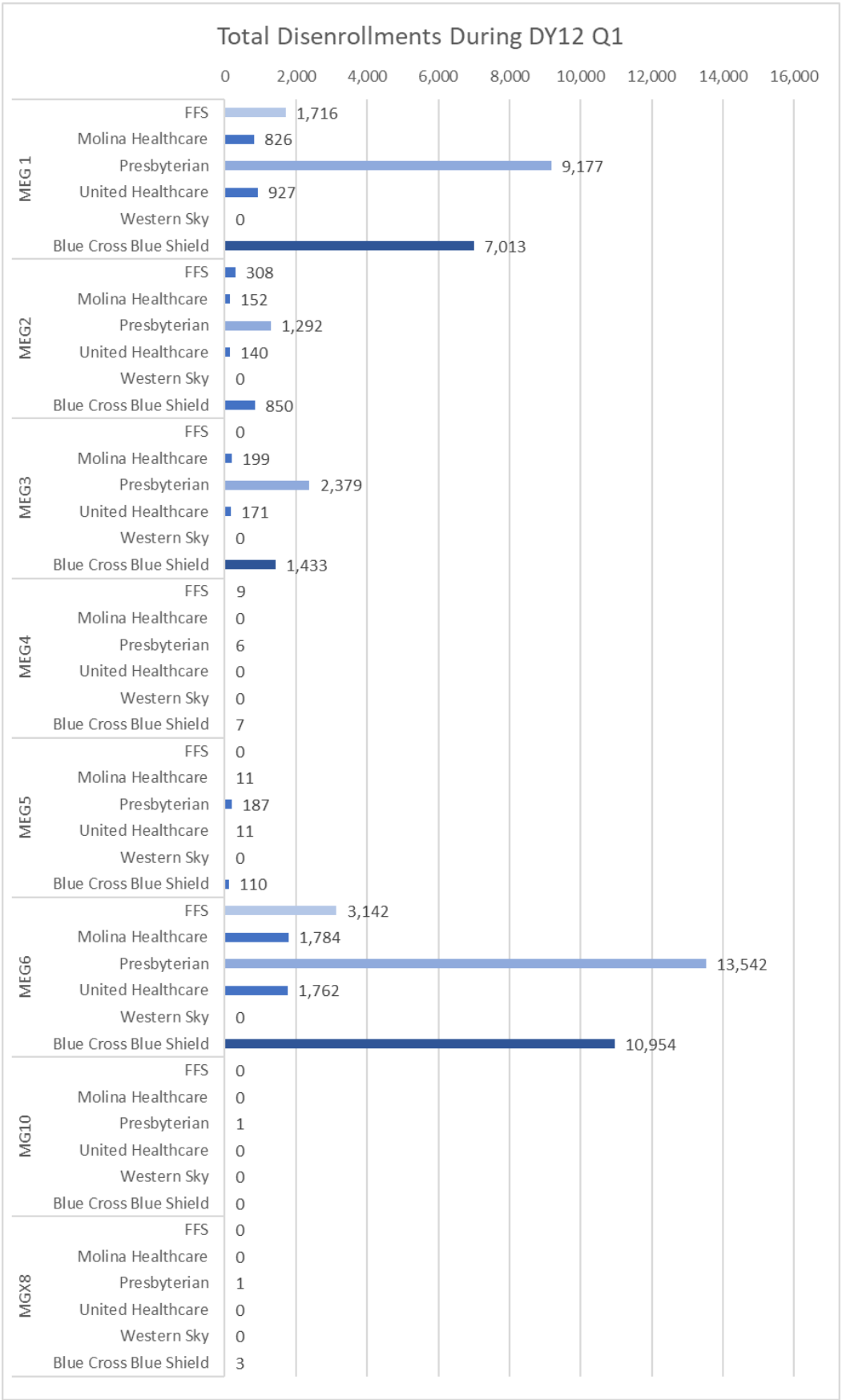
As the public health emergency (PHE) ended on May 11, 2023, and the MOE continuous eligibility ended March 31, 2023. New Mexico began its unwinding activities in March 2023 and terminations began May 1, 2023. As a result of unwinding activities, New Mexico had observed increases in disenrollments across all MEGs. Most disenrollments for this quarter are attributed to loss of eligibility, members moving out of state, and incarcerated individuals.

During DY12 Q1, there had been a reinstatement of 19,655 children ages 0 up to age 19, which occurred on July 26, 2024. The reinstatements were for procedurally closed children during the PHE. The reinstated coverage was retroactive back to the termination date for each impacted child and prospectively based on their date of termination so that each child could go through the regular 90-day renewal process. Reinstated months prior to July 1, 2024, were added into fee-for-service. As of July 1, 2024, these members' ongoing coverage was transitioned to managed care, unless Native American exempt.

DY12 Q1 Data

Demonstration Population		Total Number Demonstration Participants DY12 Q1 Ending Sept. 2024	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY12 Q1 (July-Sept. 2024)
Population MEG1 - TANF and Related	0-FFS	27,892	319,089	1,716
	Molina Healthcare	18,378	750	826
	Presbyterian	178,587	21,351	9,177
	United Healthcare	18,868	825	927
	Western Sky	0	3,785	0
	Blue Cross Blue Shield	129,154	16,242	7,013
	Summary	**372,879**	**362,042**	**19,659**
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,298	32,887	308
	Molina Healthcare	1,596	186	152
	Presbyterian	20,013	3,070	1,292
	United Healthcare	1,538	164	140
	Western Sky	0	384	0
	Blue Cross Blue Shield	12,917	1,923	850
	Summary	**38,362**	**38,614**	**2,742**
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Molina Healthcare	1,581	1,621	199
	Presbyterian	21,083	23,368	2,379
	United Healthcare	1,818	1,731	171
	Western Sky	0	653	0
	Blue Cross Blue Shield	11,284	12,711	1,433
	Summary	**35,766**	**40,084**	**4,182**
Population MEG4 - 217-like Group - Medicaid Only	0-FFS	188	360	9
	Molina Healthcare	6	1	0
	Presbyterian	124	16	6
	United Healthcare	6	1	0
	Western Sky	0	1	0
	Blue Cross Blue Shield	74	17	7
	Summary	**398**	**396**	**22**
Population MEG5 - 217-like Group - Dual	0-FFS	0	0	0
	Molina Healthcare	137	145	11
	Presbyterian	3,370	3,781	187
	United Healthcare	184	177	11
	Western Sky	0	74	0
	Blue Cross Blue Shield	2,385	2,684	110
	Summary	**6,076**	**6,861**	**319**
Population MEG6 - VIII Group (expansion)	0-FFS	26,711	275,198	3,142
	Molina Healthcare	15,151	2,022	1,784
	Presbyterian	133,719	52,271	13,542
	United Healthcare	15,880	1,972	1,762
	Western Sky	0	11,037	0
	Blue Cross Blue Shield	108,896	41,438	10,954
	Summary	**300,357**	**383,938**	**31,184**
Population MEG10 - IMDSUD Group	0-FFS	8	34	0
	Molina Healthcare	1	1	0
	Presbyterian	71	389	1
	United Healthcare	0	0	0
	Western Sky	0	69	0
	Blue Cross Blue Shield	69	302	0
	Summary	**149**	**795**	**1**
Population MEGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Molina Healthcare	2	3	0
	Presbyterian	285	1,167	1
	United Healthcare	2	1	0
	Western Sky	0	296	0
	Blue Cross Blue Shield	258	1,206	3
	Summary	**547**	**2,673**	**4**
Summary		**754,534**	**835,403**	**58,113**

Source: Enrollee Counts Report


Total Disenrollments During DY12 Q1
0
2,000
4,000
6,000
8,000
10,000
12,000
14,000
16,000
MEG 1
FFS 1,716
Molina Healthcare 826
Presbyterian 9,177
United Healthcare 927
Western Sky 0
Blue Cross Blue Shield 7,013
MEG2
FFS 308
Molina Healthcare 152
Presbyterian 1,292
United Healthcare 140
Western Sky 0
Blue Cross Blue Shield 850
MEG3
FFS 0
Molina Healthcare 199
Presbyterian 2,379
United Healthcare 171
Western Sky 0
Blue Cross Blue Shield 1,433
MEG4
FFS 9
Molina Healthcare 0
Presbyterian 6
United Healthcare 0
Western Sky 0
Blue Cross Blue Shield 7
MEG5
FFS 0
Molina Healthcare 11
Presbyterian 187
United Healthcare 11
Western Sky 0
Blue Cross Blue Shield 110
MEG6
FFS 3,142
Molina Healthcare 1,784
Presbyterian 13,542
United Healthcare 1,762
Western Sky 0
Blue Cross Blue Shield 10,954
MG10
FFS 0
Molina Healthcare 0
Presbyterian 1
United Healthcare 0
Western Sky 0
Blue Cross Blue Shield 0
MGX8
FFS 0
Molina Healthcare 0
Presbyterian 1
United Healthcare 0
Western Sky 0
Blue Cross Blue Shield 3

4

OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY12 Q1	In DY12 Q1, the New Mexico Health Care Authority (HCA), 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 HCA to active PEDs. The newsletter provides updates on HCA 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. HCA also continues to provide online PED certification and refresher demo training sessions for prospective and current PEDs. HCA continues to provide Turquoise Care members information about Turquoise Care benefits, open enrollment and value-added benefits through each of the 4 new MCOs. During the quarter, Medical Assistance Division (MAD) staff traveled throughout the state visiting 26 different cities including Native American pueblos and presented the new Turquoise Care benefits and services. MCOs joined the MAD team, each promoting their value-added benefits and contact information. MAD also provided the same presentation virtually through Zoom meetings for members who were not able to join personally. In DY12 Q1, MAD staff provided 4 additional virtual presentations through Zoom to the Children, Youth, and Families Department (CYFD). MAD continues to socialize Turquoise Care through commercials and radio spots.

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 are not accepted by HCA. HCA meets regularly with the MCOs to address specific issues and to provide guidance. HCA regularly monitors encounters by comparing encounter submissions to financial reports to ensure completeness. HCA monitors encounters by extracting data monthly to identify the accuracy of encounter submissions and shares this information with MCOs. HCA 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. Molina and UHC required testing prior to submitting production encounters.

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

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OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments through DY12 Q1 reflect the Turquoise Care rates effective for the period from July 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, and the update rates for July 1 through December 31, 2024, were submitted on June 28, 2024.

During DY12 Q1, no financial payments were made. However, 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, non-risk COVID-19 vaccine payment, and health care quality surcharge reconciliation for DY 10 and DY 11.

SYSTEM ISSUES

There were no system issues for this quarter.

PATIENT CENTERED MEDICAL HOMES (PCMH)

HCA's PCMH initiative continues to support HCA's commitment to improving health outcomes, improving service delivery, and reducing administrative burdens. MCOs work with contract providers to implement PCMH programs to build better relationships between members and their care teams.

HCA 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. PCMH report was discontinued after DY11 Q2.

Table 4 below reports the total number of members paneled to a PCMH per MCO. DY11 Q2 reflects a decrease in members receiving care through a PCMH for two MCOs while one MCO showed an increase in DY11 Q2 compared to DY11 Q1. This overall reduction in

membership and subsequent paneling to PCMH can be attributed to the redetermination efforts made by the Department. Medicaid members were required to renew their Medicaid financial eligibility. Members have been issued correspondence related to the redetermination efforts and several different options on how to renew their Medicaid were provided.

Table 4: PCMH Assignment

PCMH ASSIGNMENT Total Members Paneled to a PCMH				
	DY10 Q3	**DY10 Q4**	**DY11 Q1**	**DY11 Q2**
BCBS	151,385	140,280	135,896	132,683
PHP	225,734	226,527	188,833	189,926
WSCC	47,826	44,770	45,815	43,514
Percent of Members Paneled to a PCMH				
	DY10 Q3	**DY10 Q4**	**DY11 Q1**	**DY11 Q2**
BCBS	53.60%	51.00%	50.60%	49.20%
PHP	61.00%	60.90%	50.90%	51.70%
WSCC	51.40%	48.00%	48.40%	48.10%

Source: MCO Report #48 DY11 Q2

MCO PCMH initiatives:

BCBS: BCBS employs a variety of programs as part of their initiatives to deliver interventions that positively impact hospital readmission rates and works to toward reducing high ED utilization. These include: The Transition of Care Support Program, Community-Based Workers Support who educate patients, Disease Management Program, Paramedicine Program, and Recovery Support. In addition to programs that support reducing ED utilization and hospital admissions, BCBS has regular reviews by medical directors to ensure quality care as well as interdisciplinary and complex care rounds. BCBS aims to enhance communications with members on a routine basis to review all care options, such as telehealth, to decrease ED utilization. BCBS collaborates with practitioners and state authorities to create Value-Based Care Models, emphasizing PCMH and primary care payment reforms.

PHP: PHP strives to provide education on preventive care programs, disease management programs, member reward programs, and incentives for completing health screenings in attempts to improve PCMH outcomes. PHP monitors disease management, risk outcomes based on chronic conditions, and the impact of disease management on utilization and

medication adherence. Additionally, the Presbyterian Community Health team offers numerous health programs, such as nutritional counseling and cooking classes, fitness classes like strength training and flexibility, and wellness classes that include mindfulness and gardening. PHP continues to provide data, such as, social determinants for transportation and food insecurity, as well as addressing non-binary and transgender patients more appropriately. By providing this information and helping PCMH groups identify potential health disparities, they can identify members who would benefit from telehealth visits or appointment transportation. Earlier this year, the PHP VBP team launched the VBP Hub, a website that enables provider groups to access upcoming trainings, register, and review past materials in one place. The team continues to build on this platform and update resources as needed.

WSCC: WSCC worked to address high ED utilization and hospital admissions/readmission with several programs, and has actively leveraged telehealth capabilities, identified, and addressed Social Detriments of Health (SDOH), provided quality analytic tools, and offered value-based contracts to their PCMH providers. Telemedicine has been a key strategy for increasing patient access to PCMH by enhancing member access to care via Telemedicine. WSCC recognizes that preventative care and value-based programs with PCMH providers can reduce emergency room utilization and hospital readmissions. WSCC incentivizes providers to deliver exceptional care, improve health outcomes, and enhance patient experience. WSCC and TeamBuilders (TB) collaborated with contracted behavioral health providers. TB clinicians completed an initial telehealth assessment and assisted members in connecting to ongoing outpatient BH services, community resources, peer support, and care coordination services. Over 3,000 referrals were sent to TeamBuilders Behavioral Health throughout the course of this partnership with an average of 35% successful member engagements.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities	
DY12 Q1	HCA 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 DY12 Q1 report contains data from DY11 Q2. DY12 Q1 data will be reported in DY12 Q2. The MCO aggregate results show performance benchmarks of 85% were met, or exceeded, for timely completion of Health Risk Assessments (HRAs) for 'new to Medicaid' members, members with a change in health condition, Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs). The aggregate completion rate for HRAs for 'new to Medicaid' members decreased from 95% in DY11 Q1 to 93% in DY11 Q2. The aggregate completion rate for HRAs for members with a 'change in health condition' decreased from 99% in DY11 Q1 to 98% in DY11 Q2. Aggregate completion percentages for CNAs for CCL2 members increased from 90% in DY11 Q1 to 91% in DY11 Q2. Aggregate completion percentages for CNAs for CCL3 members increased from 89% in DY11 Q1 to 90% in DY11 Q2. 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 decreased from 95% in DY11 Q1 to 94% in DY11 Q2. CCPs for CCL3 members decreased from 96% in DY11 Q1 to 95% in DY11 Q2. MCOs have consistently met performance benchmarks for CCPs for CCL2 and CCL3 members. Aggregate completion rates for CCPs for CCL2 members were 93% in DY6, increased to 96% in DY8 and decreased to 94% in DY10. Aggregate completion rates for CCPs for CCL3 members showed a larger increase from 88% in DY6 to 96% in DY10 Q2.

	The Care Coordination Report includes MCO strategies for engaging and retaining members. In DY11 Q2, MCOs reported on multiple strategies to retain engagement with members. BCBS focused on targeted training for all Care Coordination staff to prepare for the rollout of Turquoise Care. With new standardized assessments and a renewed focus on Health-Related Social Needs, BCBS emphasized the importance of assisting members in all physical, behavioral, and social areas of need. PHP continued to increase collaboration between care coordinators, Community Health Workers, and Peer Support Workers in order to locate and engage more members who may have been identified, through referrals or claims mining reports, to have a need for additional assistance. WSCC continued to see increased participation from their members accessing services through their Compassionate Support Center which supports member access to health plan resources, community services, urgent care, general health questions, caregiver needs and more. WSCC notes that participants using their mobile application, which leads them to live assistance, showed a 45% reduction in loneliness based on UCLA-3 scores and a 43% decrease in depression and anxiety based on PHQ-4 scores. All MCOs participated in community and statewide events providing educational material, food boxes, school items, and health related services. All MCOs report that the connection made with members, face-to-face, provides the MCO staff with the opportunity to engage with more members, connect them to the communities they serve, and better understand the needs and priorities of their members. HCA 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 Q3 through DY11 Q2.

Table 5: Care Coordination Monitoring

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

Source: HCA DY10 Q3 to DY11 Q2 Report #6 –Care Coordination Report
Percentages in bold are MCO aggregate of the total assessments due and completed.

Care Coordination Audits

HCA suspended the quarterly Health Risk Assessment, Comprehensive Needs Assessment, and Transition of Care Assessment audits in DY11 Q2 for several reasons. HCA had been auditing HRAs to ensure timely completion and correct referrals for a CNA since DY6 Q1 with consistent audit results above 98%. Similarly, HCA had been auditing CNAs since DY6 Q1 to ensure assessments were timely, members were leveled correctly, and service needs

addressed. HCA audit results were consistently above 95% throughout the audit timeframe. Lastly, HCA had been auditing MCO Transition of Care compliance for members transitioning from an Inpatient or Nursing facility stay back into the community since DY6 Q1. HCA had several concerns with MCO compliance in DY6 and DY7; however, with continued auditing and regular meetings with MCOs concerning transitions, audit results were at or above 94% from DY8 through DY11 Q1. With the transition from Centennial Care to Turquoise Care being a focus for HCA and MCOs in DY11 Q2, HCA worked with both current and incoming MCOs to prepare for the significant changes ahead.

Standardized Assessment Workgroup

In DY11 Q1 and DY11 Q2, HCA met with the four Turquoise Care MCOs; BCBS, MHC, PHP, and UHC, to create standardized assessments to align with Turquoise Care (TC) contract and policy requirements. During Centennial Care 2.0, each MCO used their own Comprehensive Needs Assessment (CNA), Comprehensive Care Plan (CCP), and Transition of Care Assessment and Plan (TOC) which aligned with contract and policy requirements. However, HCA and the MCOs found that having multiple assessments created difficulty for members transitioning between MCOs. Additionally, with new contract and policy requirements, having standardized assessments used across all MCOs would ensure all members were being assessed consistently and provided the same opportunities for services.

Over eleven meetings, HCA and the MCOs created:

- Standardized Health Risk Assessment (HRA)
- Standardized Comprehensive Needs Assessment (CNA)
- Standardized Comprehensive Care Plan (CCP)
- Standardized Transition of Care Plan (TOC)
- Standardized Assessment Plan Health Risk Assessment (APHRA) for members transitioning from incarceration back into the community
- Standardized Care Coordination Declination Document
- Standardized Signature Page

HCA and the TC MCOs participating in the workgroup felt the process was successful, provided an opportunity to collaborate with colleagues, and clarify questions about contract requirements.

Care Coordination CNA Ride-Alongs

HCA conducted 2 CNA ride-alongs with MCO care coordinators in DY11 Q2, to observe completion of member assessments.

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

HCA 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.

HCA 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.
- HCA 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.
- HCA noted that care coordinators were well-versed in Medicare dual eligible members.

Care Coordination HRA Ride-Alongs

HCA conducted 15 virtual HRA ride-alongs with MCO care coordinators in DY11 Q2, to observe completion of member assessments. All HRAs observed were conducted telephonically.

HCA 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.
- HCA 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.
- HCA requested MCOs continue ongoing training and internal review of HRA Assessors to ensure any issues are resolved quickly.

Care Coordination MCO Meetings

HCA conducts regular quarterly meetings with all MCOs to review data on member engagement, Care Coordination timeliness, performance analysis, and member outcomes. HCA conducted the DY11 Q2 meeting on June 5, 2024, with the Centennial Care MCOs. This meeting focused on the work done from DY6 Q1 through DY10 Q4 in providing physical healthcare, behavioral healthcare and social resources to our members. HCA reviewed the steady rise in overall Medicaid membership which increased by 25% from DY6 Q1 (664,375) to DY10 Q1 (823,915) and then decreased 12% during the unwinding by DY11 Q1 (720,426). During Centennial Care 2.0, HCA saw an overall increase of 8% in total membership. Throughout Centennial Care 2.0, the number of members engaged in Care Coordination Level 2 or Level 3 increased along with the total population; however, the percentage of members engaged remained consistent at 5.5%.

HCA reviewed the focus the MCOs placed on locating, assessing, and engaging members who were Unable to be Reached (UTR), Difficult to Engage (DTE), or qualified for Care Coordination but chose to Refuse Care Coordination (RCC). In DY6 Q1, 15% of all members were categorized as UTR, DTE, or RCC. That number increased to 24% in DY8Q1. HCA convened a workgroup to address the growing number of unengaged members and work on ways to locate, assess, and assist these members. MCOs immediately placed an increased focus on these members and utilized Community Health Workers, Peer Support Workers, providers, community resources, and care coordinators to engage this population. The increased efforts resulted in a 76% decrease in the number of members not reached and assessed, resulting in a decrease to 5.8% of the total population in these categories by DY11 Q1. The decrease in members refusing Care Coordination was even more pronounced, decreasing by 81% from DY8Q1 to DY11 Q1.

HCA reviewed MCO compliance with HRA, CNA, CCP requirements and telephonic and in-person touchpoints throughout Turquoise Care. As previously stated, compliance for HRAs was at or above 98% compliance throughout Turquoise Care, and CNA compliance was at or above 95%. HCA reviewed HRA, CCL, and TOC audit results as well as audits specific to UTR, DTE, and RCC members. HCA initiated audits for Children in State Custody (CISC) members in DY9 Q1 and reviewed the high compliance findings. CISC HRAs were at or above 99%, and CNAs were at or above 94% compliance from DY8 Q2 through DY10 Q4.

HCA implemented Care Coordination Performance Measures in DY9 Q1 which provided data on five measures comparing members engaged in Care Coordination (treatment group) with members who had indicators qualifying them for Care Coordination but refused (control group). HCA reviewed the annual data for DY9 and DY10 with MCOs showing some

significant differences in adherence. HCA noted a positive 9 percent point difference for Annual Dental Visits (ADV), a positive 3 percent point difference in Antidepressant Medication Management (AMM) and a positive 9 percent point difference for Statin Therapy (SPC) for members engaged in Care Coordination. These Performance Measures will continue to be reviewed during Turquoise Care.

The June 5, 2024, All Turquoise Care MCO Meeting focused on the progress made during Centennial Care 2.0 with BCBS, PHP, and WSCC. On June 13, 2024, HCA met with Care Coordination staff from Molina Health Care (MHC) and United Health Care (UHC) to prepare them for the requirements of Turquoise Care. HCA covered the requirements for requesting a CNA exception and provided the required form. HCA explained recurring reports due from TC MCOs, audits that will be conducted, ride-alongs attended, and meetings scheduled. HCA provided detailed timeframes for submissions, answered questions on methodology for reports, and started the process of building a collaborative relationship with the incoming MCOs.

BEHAVORIAL HEALTH

The Behavioral Health Services Division (BHSD) continues to maintain and expand critical behavioral health services. Telehealth service expansion continues, and is a valuable resource for building capacity, reaching individuals in the most rural and frontier areas of the state.

In DY11 Q2, a total of 35,508 Medicaid members accessed behavioral health services via telehealth, a 15.9% increase compared to DY10 Q2 and a total of 30,629 individuals receiving telehealth services. Of those receiving services in DY11 Q2, 15,421 individuals reside in rural or frontier counties, representing 43.43% of the total population receiving telehealth services. This reflects both member and provider preferences, and the crucial role telehealth plays in addressing the unique needs of New Mexico's rural and frontier communities.

Telephonic service delivery increased 13% when comparing DY11 Q1 and DY11 Q2; 37,400 members to 42,261. However, when comparing DY11 Q2 to DY10 Q2, a slight decrease was observed. The number of people receiving services via phone dropped by 1,575, or 3.6%, 43,836 to 42,261 in total. The Behavioral Health Services Division (BHSD) continues to assess which behavioral health services remain appropriate for telephonic delivery now that the public health emergency has ended.

While the end of the Public Health Emergency led to an overall decrease in the number of Medicaid members utilizing telehealth and telephonic services, the demand for these services remains steady in rural and frontier regions, helping to reduce barriers to care. Although in-person treatment continues to be the preferred choice for many, telehealth and telephonic service remain an important resource for enhancing capacity and access.

TREAT FIRST

As depression, anxiety and other behavioral health needs surge, Treat First engages clients quickly in services that address their immediate needs. The 40 certified Treat First agencies have seen over 2,822 new clients during the first nine months of 2024. With support from the Treat First agencies, 40.2% 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” rate for clients in this period was low, representing only 10.4% of scheduled appointments. This is significantly lower than before agencies started the Treat First approach.

Youth or adults were asked how they felt their Treat First visits were going, and on average, both groups felt that the sessions were working very well to address their immediate needs. Youth rated sessions at 92.8% and adults at 87.2%.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an important evidence-based tool that can be used by all primary care providers to identify problematic alcohol or substance use/misuse, depression or trauma, and refer an individual for additional treatment as appropriate. SBIRT was added to the state’s Medicaid program in 2019, and since then, BHSD expanded outreach and training for primary care providers and hospitals statewide. In DY11 Q2, SBIRT utilization decreased by 29%, with 1,331 individuals served compared to 1,875 individuals served in DY11 Q1. A similar decrease was observed when comparing the DY11 Q2 totals in the same quarter from the previous year. The number of individuals served in DY11 Q2 dropped by 34.1% compared to 2,020 individuals served in DY10 Q2.

In DY11 Q2, the monthly average of SBIRT services received was 500, with the highest utilization in April yielding 543 individuals screened. The current monthly average for SBIRT in DY11 Q2 is 26% lower than in DY11 Q1 (676 individuals screened) and 34.1% lower than in DY10 Q2 (717 individuals screened).

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

The Turquoise Care program includes new and expanded services for Medicaid recipients

with Substance Use Disorder (SUD). In State Fiscal Year (SFY) 2024, the state finalized the contract to deliver SBIRT training for primary care and hospitals statewide and will continue training through SFY 2025. Expansion of 988 Crisis Now initiatives continue with support for crisis triage centers, mobile crisis teams and alternative crisis triage center sites with space set up to be utilized when needed such as a hotel room, firehouse, or outpatient clinic. HCA continues to focus on expanding other services that are key to addressing SUD, such as Intensive Outpatient Services (IOP) and Comprehensive Community Support Services (CCSS).

As part of the SUD 1115 Waiver, services have been approved for specific substance abuse populations in an Institution for Mental Disease (IMD). An IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating SUD that is not part of a certified general acute care hospital. HCA 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 Q2, the total number of people served with a SUD in an IMD was 3,818, which is an increase of 8% compared to the 3,509 reported in DY11 Q1. When comparing DY11 Q2 results to DY11 Q1, the utilization remained stable at 1,709 people served on a monthly average. The total number served in an IMD with SUD through the first six months of DY11 was 6,543. The latest quarter’s results show a stable rate of utilization through the start of DY12.

SUD HEALTH IT

In DY12, HCA developed and maintained the necessary SUD Health IT capabilities and infrastructure to support member health outcomes and address the SUD goals of the demonstration. This is demonstrated through progress reports.

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%. HCA 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 August 28, 2024. Attendees included board members (a quorum was met electronically for voting purposes) and invited guests,

including managed care organization representatives. Client counts for both FFS and Managed Care were reported, and a continued trend of small decreases in total members enrolled was noted. Utilization of Prospective DUR edits targeted for prevention of fraud, waste and abuse and to meet Support Act requirements were presented and reviewed for the period of April 1, 2024, to June 30, 2024. The data demonstrate the effectiveness of the Prospective DUR edits for preventing overutilization and deterring abuse and waste. No new changes were recommended for the reported edits. The Prospective DUR reporting will continue as a quarterly report at the DUR meetings. For DY12 Q1, the intervention that was decided on was the underutilization of sodium-glucose co-transporter 2 (SGLT-2). The purpose of this intervention is to identify patients who have heart failure, but who are not being treated with the sodium glucose co-transporter inhibitor. There were 397 providers, concerning 276 patients, identified. The intervention was mailed on 9/19/2024.

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 or concerns noted. While the reporting for metabolic monitoring of SGAs is currently mandatory in youth, the DUR board agreed to continue to report on both youth and adults. New reports for each month of DY11 Q2 were presented with an analysis of the top 25 drugs utilized. The reports were broken out by the top 25 drugs by the number of claims, the top 10 brand name drugs by claims, the top 10 generic drugs by claims, and the top 10 therapeutic classes by claims. The board agreed that for DY12 Q2, the retrospective intervention will be an educational letter sent to providers regarding SMART (Single Maintenance and Reliever Therapy) and will include new treatment recommendations from the Global Initiative for Asthma (GINA) guidelines and the National Asthma Education and Prevention Program.

In 2024, Project ECHO introduced 39 new clinics, bringing the total to 65. 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. HCA 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 2025.

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, Lovelace Women's Hospital, and Sierra Vista Hospital. These seven 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 and Sierra Vista Hospital is currently being gathered). Five hospitals participated in aspects of engagement and/or training, including 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. Sierra Vista Hospital completed the program during this time period but continues to stay in contact with team for support during the final stages. 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 additional on-site provider and nursing trainings to Holy Cross Medical Center in September 2024, conducted on-site nursing trainings to Sierra Vista Hospital in September 2024, and conducted remote provider trainings to University of New Mexico in September 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. In addition to the new Bridge team member that was added to provide peer support worker and supervisor education, another new Bridge team member was added to support and enhance engagement efforts for new hospital partners. More information on the program can be found at www.nmbridge.com.

HCA 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). HCA 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. HCA 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

			DY10Q4	DY11Q1	DY11Q2
			2023	2024	
Provider_ID	Last 3 Characters	Provider_Name	Q4	Q1	Q2
15453081	081	SHADOW MOUNTAIN RECOVERY RIO RANCHO	25	27	
20887825	825	TURNING POINT DETOX LLC	14	12	18
23501090	090	HOY RECOVERY PROGRAM INC	64	66	52
32279302	302	CARLSBAD LIFEHOUSE INC	117	105	122
32736258	258	NEW MEXICO WELLNESS LLC	1	18	37
35605081	081	ZIA RECOVERY CENTER		1	
42155037	037	SANTA FE RECOVERY CENTER	395	399	349
51679060	060	ICARUS BEHAVIORAL HEALTH	35	19	52
55074049	049	TURQUOISE LODGE HOSPITAL	20	25	21
58186760	760	MAKING AN IMPACT LLC	63	69	70
72030569	569	VANGUARD BEHAVIORAL HEALTH			1
82536716	716	FOUR CORNERS DETOX RECOVERY CENTER	3	5	12
95158332	332	CENIKOR FOUNDATION	69	86	94
00250589	589	SHADOW MOUNTAIN RECOVERY TAOS	19	22	1
04327896	896	TURNING POINT DETOX LLC	5	7	9
Unduplicated Count			**794**	**819**	**808**

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

There are 22 AARTCs approved to bill Medicaid. The data above identifies the total number of clients who received AARTC services during DY11 Q2. These numbers are a refresh of DY11 Q1 and Q2 data as stated in the DY11 Q2 report. This is to account for claims lag which can take up to 120 days. DY12 Q1 data will be reported in DY12 Q2. 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 15 provider sites are represented in the chart above, Santa Fe Recovery Center has 4 sites represented in their data. All AARTC provider sites are actively in the process of receiving distinct identification

numbers to ensure accuracy in client counts for each site.
Medicaid utilization has remained relatively stable from 819 individuals in DY11 Q1 to 808 individuals in DY11 Q2. 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 have been 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. As of February 2025, a per diem rate has been established for Tier 1, 2 and 3, and will go into effect on January 1, 2026.

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	
DY12 Q1 Activities	In DY12 Q1, the CLNM Health Homes made some progress in the recruitment of new staff, which has been an ongoing problem because of the scarcity of behavioral health clinicians in our rural and frontier areas. This has helped with the programming for these behavioral health chronic conditions and other physical co-morbidities. All Directors and Supervisors attended a re-education on the CMS and State requirements for a health home as there has been much turnover of staff. Together, they will be developing a growth strategy for the upcoming year. All CLNM HHs

	underwent an on-site quality review with excellent outcomes. All six agencies (10 sites) received their continuing 3-year certification of membership. One of the HHs left as they are now a CCBHC. Updates to the State Plan Amendment will allow for the continued enrollment of new health homes when ready and will not be constrained to certain counties.

Table 9: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY10 Q4 OCT - DEC	DY11 Q1 JAN - MAR	DY11 Q2 APR - JUNE	DY12 Q1 JUL - SEPT
3,692	3,488	3,348	3,248
% CHANGE	% CHANGE	% CHANGE	% CHANGE
4.55%	5.15%	4.01%	2.99%
Decrease	Decrease	Decrease	Decrease

Source: NMStar, CLNM Opt-in Report.

HIGH FIDELITY WRAPAROUND

The High-Fidelity Wraparound (HFW) benefit in Turquoise Care 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 a part of the New Mexico Section 1115 Medicaid Waiver effective March 28, 2023. Since that time the NM HFW Steering Committee, including representatives from HCA 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 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, HCA and CYFD are in process of developing claims data, provider level, and MCO reports to monitor program requirements including eligibility criteria as well as provider employee requirements. Additionally, HFW treatment plans will receive clinical review through CYFD.

HCA and CYFD continue to collaborate on the development of HFW performance measures as well as data report development. The measures will be reported as soon as they are available.

SUPPORTIVE HOUSING

The supportive housing benefit in Turquoise Care 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 Section 1115 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 Turquoise Care 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 assisting 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 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.

HCA 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**	**DY12 Q1**	**DY12 Q2**
127	141	102	
Unduplicated Total - 163			

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 HCA to expand Linkages services that are not covered by Medicaid. HCA 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 SFY2025, an average of 356 vouchers were issued or filled; the previous quarter had an average of 360. A filled voucher means housing has been secured. Therefore, 356 individuals and their households benefited from a voucher with housing stability. The decrease may be attributed to transition within a provider agency.

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. On May 4, 2024, CMS extended the deadline to March 2025. New Mexico will prepare its SMI/SED Monitoring Protocol following issuance of new templates and guidance from CMS.

MEDICAID HOME VISITING (MHV) PROGRAM

In DY12 Q1, the Medicaid Home Visiting (MHV) program served 746 families. Following is DY12 Q1 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 66 unique families in DY12 Q1 in Bernalillo County and Valencia Counties.
- Youth Development Inc. (YDI) served 101 families in DY12 Q1 in Bernalillo, Rio Arriba, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 15 unique families in DY12 Q1 in Bernalillo County.
- ENMRSH served 39 unique families in DY12 Q1 in Curry and Roosevelt Counties.
- Taos Pueblo served 18 unique families in DY12 Q1 in Taos County.
- MECA Therapies served 157 unique families in DY12 Q1 in Chaves, Curry, Doña Ana, Roosevelt, and Lea Counties.
- Aprendamos served 243 unique families in DY12 Q1 in Doña Ana, Sierra, and Otero Counties.

- Community Action Agency of Southern New Mexico served 25 unique families in DY12 Q1 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 35 unique families in DY12 Q1 in San Juan County.
- Tresco served 22 unique families in DY12 Q1 in Bernalillo and Santa Fe Counties.
- Guidance Center of Lea County served 25 unique families in DY12 Q1 in Lea County.

The Medicaid Home Visiting Program (MHV) 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.

The Medicaid Home Visiting Program (MHV) 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. HCA has been approved to add 4 MHV models to include Child First, Family Connect, Healthy Families America, and SafeCare Augmented.

Several strategies are currently being employed to streamline the process of enrollment, credentialing, billing, and referral management. The Provider Billing Manual has been revised to provide updated MCO information and is currently out for Public Comment. HCA and the Early Childhood Education and Care Department (ECECD) meet monthly with providers to ensure support for providers with any questions and concerns that may hinder member access to MHV services. ECECD has established a provider concerns email for providers to submit issues and concerns which will allow a timely resolution.

PRESUMPTIVE ELIGIBILITY PROGRAM

The New Mexico HCA 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). During this reporting period, there are approximately 985 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assist with on-going Medicaid application submissions.

HCA staff conduct monthly PED certification trainings for employees of qualified entities that choose to participate in the PE program. PED certification requirements include active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct "Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE)" demo trainings. During demo trainings, the PEDs have the opportunity to take a refresher training on "How To" utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit ongoing Medicaid applications. PE program staff conducted 3 PE certification trainings and 5 YESNM-PE demo refresher trainings in DY12 Q1.

HCA 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, HCA'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 301 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 Percent of Newborns Successfully Enrolled)**
    - Number (and Percent) of newborns automatically added to an existing Medicaid case at time of submission.

- **Newborns Unsuccessfully Enrolled (and Percent Newborns Unsuccessfully Enrolled)**
    - Number (and Percent) of submissions not completed automatically; newborn added to the case via worker manual intervention.

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

AVA Baby Bot (July - Sept 2024)					
Month	**Newborns Submitted through AVA**	**Newborns Successfully Enrolled**	**Newborns Unsuccessfully Enrolled - Tasks Created**	**% of Newborns Successfully Enrolled**	**% of Newborns Unsuccessfully Enrolled**
July	887	645	242	73%	27%
August	789	558	231	71%	29%
September	847	623	224	74%	26%
Total	**2,523**	**1,826**	**697**	**72%**	**28%**

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY12 Q1, 78 PEDs used the Baby Bot functionality. Program staff noticed an 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 an increase in the percentage of Newborns “Successfully Enrolled.” HCA 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 (July - Sept 2024)				
Month	**PEs Granted**	**% PE Granted with Ongoing Applications Submitted**	**Total Individuals Applied**	**Individuals Approved**
July	272	98%	679	518
August	292	98%	772	543
September	252	99%	807	586
Total	**816**	**99%**	**2,258**	**1,647**

Source: Monthly PE001 Report from YESNM, 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, HCA saw an increase in the number of PEs granted and PEs that also had an ongoing application submitted. In DY12 Q1, 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 HCA'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, HCA has established the Turquoise 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. HCA 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 DY12 Q1. Now that the PHE has ended

and COVID-19 protocols in jails and prisons are lifted, HCA does 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. Following the State's approval of the 1115 Re-entry demonstration waiver the department has started meeting with justice involved stakeholders to develop the framework and implementation plan for the enhanced JUST Health program. In DY12 Q1, 100% of all JUST Health PE approvals had an ongoing application submitted.

Table 13: PE Approvals

PE APPROVALS – JUST HEATH (July-Sept 2024)				
Quarter	**PEs Granted**	**% PE Granted w/ Ongoing Applications Submitted**	**Total Individuals Applied**	**Individuals Approved**
July	8	100%	106	84
August	12	100%	115	100
September	10	100%	123	98
Total	**30**	**100%**	**344**	**282**

Source: Monthly PE001 Report from YESNM, ASPEN and OmniCaid

7
HCBS REPORTING

Community Benefit

In DY12 Q1, Community Benefit (CB) related projects have included:

- continued monitoring of MCO readiness and implementation of the CB program,
- reporting for the new tracking database for HCA approved Agency-Based Community Benefit (ABCB) providers,
- CB rate study activities, and
- increasing CB allocations to fill approved slots.

HCA 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.
    - HCA 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 was issued in 2024. HCA 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 continued in 2024.
- Another MCO convened an LTSS provider stakeholder group to obtain feedback and develop solutions to address workforce shortages.
- HCA, in collaboration with the NM Aging and Long-Term Services Department

has been awarded a direct care workforce (DCW) TA opportunity through the ACL DCW Strategies Center. HCA has regular meetings with this workgroup to strategize for statewide improvements.

- HCA conducted a rate study for CB services. Rates may be increased in CY 2025 if sufficient funding is awarded by the legislature.

Under the TC waiver, CMS approved 6,789 CB slots for those who are not otherwise Medicaid eligible. The state may expand the number of slots by an additional 800 slots, bringing the total number of slots to 7,589, if the state finds it has sufficient funding. At the end of DY12 Q1, 5,675 of the 6,789 available slots were filled, leaving 1,114 available slots. HCA will report the total number of expanded slots that should be counted for ARPA to CMS as required.

Electronic Visit Verification

HCA, 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 HCA continues to collaborate with the MCOs, providers, and CMS to ensure requirements are met.

Electronic Visit Verification - HCBS

For DY12 Q1, the average number of SDCB caregivers using EVV is 73%. HCA is continuing to offer training and technical assistance for SDCB agencies and individual employees to encourage more SDCB providers to use EVV. In DY11 Q2, HCA 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 continued in DY12 Q1.

ABCB EVV data for DY12 Q1 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: For From July 1 to September 30, 2024, MCOs reported that 98% of EPSDT PCS captured with EVV used either Fiserv Authenticare application (30%) or Interactive Voice Response (IVR) phone system (68%).

Home Healthcare Services: From July to September 30, 2024, MCOs reported 62% of Home Health services captured with EVV used either Fiserv Authenticare application (58%) or Interactive Voice Response (IVR) phone system (4%). HCA has been able to capture issues in reporting the recently implemented EVV. HCA accessing ways to improve data collection and monitoring MCOs actions to assist home health agencies in their transition to EVV utilization. It is noted that this is the first quarter for 2 MCOs. HCA anticipates continued improvement as new MCOs align systems and process.

Table 14: ABCB EVV DATA

EVV DATA (July-Sept 2024)		
MCO	**AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD**	**NUMBER OF TOTAL CLAIMS THIS PERIOD**
BCBS	7,973	26,263
PHP	17,165	872,409
UHC	2,047	1,810
MHC	786	38,286
TOTAL	**27,971**	**938,768**

Source: MCO Report #35 DY12 Q1, July-September 2024

Statewide Transition Plan

HCA 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. HCA completed an on-site review from CMS and New Editions in September 2024. CMS and New Editions conducted an on-site visit in NM during the week of September 15th. HCA staff were in attendance during the site visits. For the 1115 CB program, two assisted living facilities and one adult day health facility were visited.

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

HCA 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 HCA's NF LOC criteria and guidelines. The audit includes accuracy, timeliness,

consistency, and training of reviewers. The results and findings are reported quarterly to HCA along with any Quality Performance Improvement Plan. HCA is reporting DY11 Q2 audit results this quarter and audit findings for DY12 Q1 will be reported in DY12 Q2.

Total audits for DY11 Q2:

- BCBS conducted 107 total audits of NF LOC determinations, 18 facility-based and 89 community-based.
- PHP conducted 239 total audits of NF LOC determinations, 65 facility-based and 174 community-based.
- WSCC conducted 16 total audits of NF LOC determinations, 6 facility-based determinations and 10 community-based.

Audit results for NF LOC determinations for DY11 Q2:

- BCBS reported 100% agreement with reviewer determination for High and Low Facility Based NF LOC, and 100% agreement for Community Based NF LOC.
- PHP reported 100% agreement with reviewer determination for High and Low Facility Based NF LOCs, and 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 Q2:

- 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 33% timeliness of determinations for Low Facility Based as there were no determination for Hight Facility based and 70% 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 94% for Low - Facility Based and 98.5% for Community Based.

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

Table 15: MCO Internal NF LOC Audits – Facility-Based

Facility-Based Internal Audits				
High NF Determinations	**April**	**May**	**June**	**DY11 Q2**
Total number of High NF LOC files audited	**7**	**7**	**10**	**24**
BCBSNM	4	3	3	**10**
PHP	3	4	7	**14**
WSCC	0	0	0	**0**
Total number of files with correct NF LOC determination	**7**	**7**	**10**	**24**
BCBSNM	4	3	3	**10**
PHP	3	4	7	**14**
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	**April**	**May**	**June**	**DY11 Q2**
Total number of Low NF LOC files audited	**26**	**21**	**18**	**65**
BCBSNM	2	3	3	**8**
PHP	22	16	13	**51**
WSCC	2	2	2	**6**
Total number of files with correct NF LOC determination	**26**	**21**	**18**	**65**
BCBSNM	2	3	3	**8**
PHP	22	16	13	**51**
WSCC	2	2	2	**6**
% of files with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Timeliness of Determinations	**April**	**May**	**June**	**DY11 Q2**
Total number of High NF LOC determinations completed within required timeframes	**7**	**7**	**10**	**24**
BCBSNM	4	3	3	**10**
PHP	3	4	7	**14**
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	**26**	**19**	**16**	**61**
BCBSNM	2	3	3	**8**
PHP	22	16	13	**51**
WSCC	2	0	0	**2**
% of Low NF LOC determinations completed within required timeframes	**100%**	**90%**	**89%**	**94%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	0%	0%	**33%**

Source: DY11 Q2 MCO Internal Audit Results

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

Community-Based Internal Audits	April	May	June	DY11 Q2
Total number of Community-Based NF LOC files audited	**93**	**89**	**91**	**273**
BCBSNM	30	29	30	**89**
PHP	57	58	59	**174**
WSCC	6	2	2	**10**
Total number with correct NF LOC determination	**93**	**89**	**91**	**273**
BCBSNM	30	29	30	**89**
PHP	57	58	59	**174**
WSCC	6	2	2	**10**
% with correct NF LOC determination	**100%**	**100%**	**100%**	**100%**
BCBSNM	100%	100%	100%	**100%**
PHP	100%	100%	100%	**100%**
WSCC	100%	100%	100%	**100%**
Timeliness of Determinations	**April**	**May**	**June**	**DY11 Q2**
Total number of Community-Based determinations completed within required timeframes	**92**	**87**	**90**	**269**
BCBSNM	29	29	30	**88**
PHP	57	58	59	**174**
WSCC	6	0	1	**7**
% of Community-Based determinations completed within required timeframes	**99%**	**98%**	**99%**	**98.5%**
BCBSNM	97%	100%	100%	**99%**
PHP	100%	100%	100%	**100%**
WSCC	100%	0%	50%	**70%**

Source: DY11 Q2 MCO Internal Audit Results

MCO NF LOC Determinations

HCA 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 HCA NF LOC criteria.

- The aggregated Facility Based High NF LOC determination/redetermination percentage for DY11 Q2 was 79%, an increase from DY11 Q1 of 77%.
- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY11 Q2 was 95%, an increase from DY11 Q1 of 82%.
- The aggregated Community Based determination/redetermination percentage for DY11 Q2 was 98%, remained the same as the 98% reported for DY11 Q1.

HCA 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 DY12 Q1 will be reported in the DY12 Q2 report.

Table 17: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	**April**	**May**	**June**	**DY11 Q2**
Total number of determinations/redeterminations completed for High NF LOC requests	**85**	**66**	**62**	**213**
BCBSNM	51	43	43	**137**
PHP	30	18	16	**64**
WSCC	4	5	3	**12**
Total number of determinations/redeterminations that met High NF LOC criteria	**65**	**51**	**52**	**168**
BCBSNM	43	32	34	**109**
PHP	19	14	15	**48**
WSCC	3	5	3	**11**
% of determinations/redeterminations that met High NF LOC criteria	**76%**	**77%**	**84%**	**79%**
BCBSNM	84%	74%	79%	**80%**
PHP	63%	78%	94%	**75%**
WSCC	75%	100%	100%	**92%**
Low NF Determinations	**April**	**May**	**June**	**DY11 Q2**
Total number of determinations/redeterminations completed for Low NF LOC requests	**401**	**339**	**317**	**1057**
BCBSNM	123	122	132	**377**
PHP	273	200	176	**649**
WSCC	5	17	9	**31**
Total number of determinations/redeterminations that met Low NF LOC criteria	**365**	**325**	**309**	**999**
BCBSNM	119	119	129	**367**
PHP	241	189	171	**601**
WSCC	5	17	9	**31**
% of determinations/redeterminations that met Low NF LOC criteria	**91%**	**96%**	**97%**	**95%**
BCBSNM	97%	98%	98%	**97%**
PHP	88%	95%	97%	**93%**
WSCC	100%	100%	100%	**100%**

Source: DY11 Q2 MCO NF LOC Determinations Report

Table 18: MCO NF LOC Determinations – Community-Based

Community Based Determinations	April	May	June	DY11 Q2
Total number of determinations/redeterminations completed	**2448**	**2197**	**1984**	**6629**
BCBSNM	718	643	596	**1957**
PHP	1432	1494	1357	**4283**
WSCC	298	60	31	**389**
Total number of determinations/redeterminations that meet NF LOC criteria	**2399**	**2157**	**1961**	**6517**
BCBSNM	704	630	584	**1918**
PHP	1401	1467	1346	**4214**
WSCC	294	60	31	**385**
% of determinations/redeterminations that meet NF LOC criteria	**98%**	**98%**	**99%**	**98%**
BCBSNM	98%	98%	98%	**98%**
PHP	98%	98%	99%	**98%**
WSCC	99%	100%	100%	**99%**

Source: DY11 Q2 MCO NF LOC Determinations Report.

External Quality Review Organization (EQRO) NF LOC

HCA'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 HCA's NF LOC criteria consistently. The EQRO provides a summary of their review to HCA monthly. Additionally, HCA 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 Q2:

Based on the EQRO's evaluation of NF LOC determinations, aggregated results reflect 100% compliance for High NF LOC determinations, and 89% compliance for Low NF LOC determinations. Areas of noncompliance were addressed with the applicable MCOs, who were later found compliant with the provision of supporting materials originally absent from audit packets. HCA collaborated with the applicable MCOs to improve processes for providing complete audit materials. . Separately, the EQRO determined 99% compliance for Community Based NF LOC determinations. One MCO was found non-compliant but remediation was not required due to the MCO transition.

HCA 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 DY12 Q1 will be reported in the DY12 Q2 report.

Table 19: EQRO NF LOC Review

Facility-Based				
High NF Determination	**DY11 Q1**	**DY11 Q2**	**DY12 Q1**	**DY12 Q2**
Number of Member files audited	**18**	**18**		
BCBSNM	6	6		
PHP	6	6		
WSCC	6	6		
Number of Member files the EQRO agreed with the determination	**18**	**18**		
BCBSNM	6	6		
PHP	6	6		
WSCC	6	6		
% of Member files the EQRO agreed with the determination	**100%**	**100%**		
BCBSNM	100%	100%		
PHP	100%	100%		
WSCC	100%	100%		
Low NF Determination	**DY11 Q1**	**DY11 Q2**	**DY12 Q1**	**DY12 Q2**
Number of Member files audited	**36**	**36**		
BCBSNM	12	12		
PHP	12	12		
WSCC	12	12		
Number of Member files the EQRO agreed with the determination	**32**	**32**		
BCBSNM	10	11		
PHP	12	12		
WSCC	10	11		
% of Member files the EQRO agreed with the determination	**89%**	**89%**		
BCBSNM	83%	92%		
PHP	100%	100%		
WSCC	83%	92%		
Community-Based	**DY11 Q1**	**DY11 Q2**	**DY12 Q1**	**DY12 Q2**
Number of Member files audited	**90**	**90**		
BCBSNM	30	30		
PHP	30	30		
WSCC	30	30		
Number of Member files the EQRO agreed with the determination	**90**	**89**		
BCBSNM	30	30		
PHP	30	30		
WSCC	30	29		
% of Member files the EQRO agreed with the determination	**100%**	**99%**		
BCBSNM	100%	100%		
PHP	100%	100%		
WSCC	100%	97%		

Source: DY11 Q2 EQRO NF LOC Report.

Waiver Assurance Performance Measures

In accordance with New Mexico's 1115 Demonstration Waiver STCs and clarification received from CMS, HCA has removed the 1915(c)-like waiver assurance performance measures from this quarterly monitoring report. With guidance from CMS, HCA has addressed the waiver assurances by including performance measures in its Quality Improvement Strategy (QIS) that was submitted to CMS on February 25, 2025, and HCBS Performance Measure Reports that were submitted to CMS on February 28, 2025. These deliverables remain under CMS review.

8

AI/AN REPORTING

Access to Care

According to MCO Report #55, *Geographical Access Report* for DY12 Q1:

- BCBSNM reported 96.2% access to behavioral health services in rural areas and 95.2% access in frontier areas. For physical health, BCBSNM reported 96.2% in rural areas and 96.8% in frontier areas.
- MHP reported 96.8% access for behavioral health services in rural areas and 100% access in frontier areas. For physical health, MHC reported 100% access in rural areas and 100% access in frontier areas.
- PHP reported 98.5% access to behavioral health services in rural areas and 98.8% access in frontier areas. For physical health, PHP reported 98.5% in rural areas and 98.8% in frontier areas.
- UHC reported 9.7% access to behavioral health services in rural areas and 12.3% access in frontier areas. For physical health, UHC reported 93.6% in rural areas and 97.2% in frontier areas.

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

The following are DY12 Q1 updates on contracting between MCOs and I/T/U providers.

MCO	Status of Contracting with MCOs
BCBSNM	BCBS reports they reached out to San Ildefonso Pueblo, Navajo Regional Behavioral Health, Pine Hill and the Southern Ute Tribe. BCBS is waiting for signature from San Ildefonso Pueblo; BCBS was unable to schedule a meeting with Navajo Regional Behavioral Health; BCBS received what they needed from Pine Hill to write up the contract and requested information for the Southern Ute Tribe.
MHC	Molina reports that their Office of Native American Affairs has been actively engaging with I/T/Us to advance contracting efforts. These efforts aim to improve access to quality healthcare for Native Americans by streamlining coordination between the MCO and I/T/U provider. Molina reports that 4 providers are interested in contracting. All providers are reviewing the contract with Molina.
PHP	PHP continues to work on agreement outreach efforts to their Native American partners statewide. PHP Native American Affairs is working with the

	Contracting Department to update the Mutual Partnership Agreement templates. PHP reports they have active agreements with San Ildefonso Behavioral Health, Kewa Pueblo Health Corporation, First Nations in Albuquerque and Tewa Roots in Nambe Pueblo.
UHC	UHC entered the market on July 1, 2024, and is working to build relationships with Tribes/Pueblos/Nations and IHS, Tribal 638s and Urban Indian Health Centers. Currently UHC has not been able to enter into any agreements with Tribes/Pueblos/Nations and Tribal 638s and I/T/Us.

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

According to MCO Report #47, *Claims Activity Report* for DY12 Q1:

- BCBSNM processed 99.6% clean claims within 15 days and 99.8% clean claims within 30 days.
- MHC processed 90.5% clean claims within 15 days and 99.1% within 30 days.
- PHP processed 98.5% clean claims within 15 days and 100.0% clean claims within 30 days.
- UHC processed 100.0% clean claims within 15 days and 100.0% 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 DY12 Q1 NATAC meeting held on September 16, 2024 –

- New Mexico was selected for a demonstration waiver by CMS for Traditional Health Care Practices reimbursement. NATAC had a discussion on how this would be implemented through I/T/Us in New Mexico.
- The Community Health Representative (CHR) billing SPA was approved by CMS and NATAC discussed having CHRs get together for trainings, updates, billing, documentation, credentialing etc. on an ongoing basis in Tribal communities.
- 4 walls discussion - the current grace period to provide services outside the 4 walls of the clinic is set to expire 2/2025. CMS is proposing to update the rule to allow Medicaid clinic services to be done outside the four walls of the clinic under three exceptions. Discussion followed on how this will impact IHS and tribal facilities.
- Innovative Health Programs/Justice Involved Pre-Release Services – CMS

approved the Justice Re-Entry Waiver Program in NM. Incarcerated individuals will receive care coordination, Medication Assisted Treatment (MAT) and prescriptions prior to release from jail/incarceration beginning July 2025.

The DY12 Native American Technical Advisory Committee (NATAC) Schedule

Date		Time	Location
September 16, 2024	1:00 p.m. - 4:00 p.m.	virtual	
December 16, 2024	1:00 p.m. - 4:00 p.m.	virtual	
March 17, 2025		1:00 p.m. - 4:00 p.m.	virtual
June 16, 2025		1:00 p.m. - 4:00 p.m.	virtual

Native American Advisory Board (NAAB) Issues and Recommendations

The following issues were raised at the DY12 Q1 NAAB meetings:

MCO	DATE	Issues/Recommendations
BCBSNM	N/A	There is no meeting scheduled until October.
PHP	September 26, 2024 Dulce, NM	Members had questions about whether they could use IHS and Presbyterian simultaneously (which is allowed), how to tell if your Traditional Healing Benefit is approved, and if you can receive the benefit if you are listed as Caucasian. PHP responded that you have to be listed as Native American in the Medicaid web portal to receive this benefit. The stipend is to be used for traditional or ceremonial services only. Some questions from the Albuquerque meeting were: **Question: "**If a member is further along in their pregnancy, can they get the Pregnancy Passport program?" **Answer:** "Yes". **Question**: "With the switch from Centennial Care to Turquoise Care, will the same providers and VAS be available?" **Answer:** "The way it is structured, there should be very little member disruptions with member benefits and VAS. The member can call the customer service number on the back of their membership card if they have any questions." **Question**: "If I haven't communicated with my care coordinator for a while, will I still have the same one?" **Answer:** "Have the member call the Care Coordination hotline to see if their case is closed. If it is, they can start over again."
MHC	N/A	There is no meeting scheduled until October.

UHC	September 25, 2024 (virtual meeting)	There were no questions from the 4 attendees at the meeting. However, they had the following comments: • "Make sure there are language interpreters for crisis calls and interpreters for doctor appointments for patients who need that." • "Explore additional services in rural areas such as work therapy, massage/acupuncture therapy, children's services, justice involved services, and long-term care services."

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ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	Noncompliance by Transportation Subcontractor
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. **DY12 Q1 update:** The Plan of Action (POA) related to the non-emergency medical transportation (NEMT) call center remains open. For DY12 Q1, ModivCare did not meet all call metrics. BCBS continues to meet with ModivCare daily to discuss issues and/or concerns. BCBSNM meets with ModivCare weekly to monitor the on-time performance measures. ModivCare reports there were several challenges that impacted ModivCare's Service Level results. • ModivCare experienced technology issues with their call center software • ModivCare had a higher-than-expected call volume • ModivCare staffing ModivCare reports that their technology issues have been fixed with no new issues reported. ModivCare reported higher than expected call volume, and they were understaffed for the quarter. ModivCare reports they hired individuals to fill the staffing gaps that affected the service levels. HCA meets with BCBS regularly to review the progress of this POA.

PRESBYTERIAN	
ACTION PLAN	None in effect during DY12 Q1
IMPLEMENTATION DATE	
COMPLETION DATE	
ISSUES	
RESOLUTION	

MOLINA HEALTH CARE	
ACTION PLAN	Internal Action Plan
IMPLEMENTATION DATE	7/1/2024
COMPLETION DATE	Open
ISSUES	During the New Mexico Medicaid implementation, the established processes for submitting provider data were not consistently followed. Specifically, provider data loads were not fully submitted to Provider Data Management (PDM) in accordance with procedural guidelines. This non-adherence included a failure to submit the required provider contracts along with the provider data, which is a critical step in the data validation process.
RESOLUTION	The root cause analysis identified the issue of data loads and contracts not being consistently submitted to Provider Data Management (PDM), highlighting the need for stricter adherence to internal policies. The introduction of Key Performance Indicators (KPIs) now relies on Provider Data Load record and iServe ticket submission. To ensure stricter adherence to internal policies and procedures, the following steps were taken: 1. Policy Reinforcement: o Updated Documentation: Redistributed policies and procedures related to the submission of provider data and contracts to all relevant teams. o Mandatory Training: Conducted mandatory training and retraining sessions for all staff involved in the provider data submission process. Training focused on the importance of policy adherence, the correct submission procedures, and the consequences of non-compliance. 2. Process Ownership: Assigned specific process owners in the contracting and data management teams responsible for ensuring all submissions are complete and compliant with the internal policies.

	3. Tracking and Monitoring: o Key Performance Indicators (KPIs): Introduced KPIs to monitor submission completeness and Turn-Around-Time (TAT), with regular monitoring to identify any areas of non-compliance.

UNITEDHEATHCARE	
ACTION PLAN	None in effect during DY12 Q1
IMPLEMENTATION DATE	
COMPLETION DATE	
ISSUES	
RESOLUTION	

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FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ ISSUES

DY12 Q1 reflects the capitation rates for Turquoise Care that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 28, 2023. On weighted average, the CY 2024 rate is 4.69% higher than that of CY 2023; the fee-for-service claim payments for July 1 to September 2024 are still lagging. In addition, data run outs for CY2023 and CY2024 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 10, Table 10.5, is 9.9% below the budget neutrality limit with data through seven (7) quarters. Table 11.5 shows a 4.6% below the budget neutrality limit for DY 11 with data of three (3) quarters. Table 12.5 shows preliminary data for DY12 of 11.6% below the budget neutrality limit with single quarters of data.

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MEMBER MONTH REPORTING

Member Months		2024
		3
MEG1	0-FFS	80,528
	Molina Healthcare	58,176
	Presbyterian	541,485
	United Healthcare	55,783
	Western Sky	0
	Blue Cross Blue Shield	385,420
	Total	**1,121,392**
MEG2	0-FFS	6,775
	Molina Healthcare	5,005
	Presbyterian	60,046
	United Healthcare	4,493
	Western Sky	0
	Blue Cross Blue Shield	38,351
	Total	**114,670**
MEG3	0-FFS	0
	Molina Healthcare	4,818
	Presbyterian	62,049
	United Healthcare	5,187
	Western Sky	0
	Blue Cross Blue Shield	32,706
	Total	**104,760**
MEG4	0-FFS	569
	Molina Healthcare	13
	Presbyterian	358
	United Healthcare	13
	Western Sky	0
	Blue Cross Blue Shield	228
	Total	**1,181**
MEG5	0-FFS	0
	Molina Healthcare	427
	Presbyterian	9,786
	United Healthcare	515
	Western Sky	0
	Blue Cross Blue Shield	6,896
	Total	**17,624**
MEG6	0-FFS	71,003
	Molina Healthcare	43,459
	Presbyterian	375,752
	United Healthcare	43,817
	Western Sky	0
	Blue Cross Blue Shield	302,208
	Total	**836,239**
MG10	0-FFS	10
	Molina Healthcare	1
	Presbyterian	85
	United Healthcare	0
	Western Sky	0
	Blue Cross Blue Shield	74
	Total	**170**
MGX8	0-FFS	0
	Molina Healthcare	3
	Presbyterian	354
	United Healthcare	1
	Western Sky	0
	Blue Cross Blue Shield	283
	Total	**641**
	Total	**2,196,677**

Source: Enrollee Counts Report.

The new MEG for SMI/SUD has not been developed. The new MMIS system will go live July 31, 2025. The change for the new SMI/SUD MEG will need to be developed in the new MMIS system. The current Omnicaid system is in a code freeze.

12
CONSUMER ISSUES

GRIEVANCES

HCA 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. This report will be submitted quarterly with data broken down into monthly reporting periods in Turquoise Care.

In DY11 Q2, it was determined the MCO reports complied with contractual requirements. HCA observed in DY11 Q2 that the top overall member grievance reporting code continues to be "Transportation Ground Non-Emergency." The number of these grievances filed in DY11 Q2 decreased 9% from DY11 Q1.

"Provider Specialist" was the second most frequently reported member grievance code. There was an 8% increase in the number of grievances filed in this category.

The table below is a summary of the data reported by the MCOs for DY10 Q3 – DY11 Q2. DY12 Q1 data will be reported in DY12 Q2.

Table 20: Grievances Reported

Grievances Reported (DY10 Q3 – DY11 Q2) (Q3 CY23 – Q2 CY24)																
Grievances	**BCBS**				**PHP**				**WSCC**				**AGGREGATE**			
	Q3 CY23	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**	**Q3 CY23**	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**	**Q3 CY23**	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**	**Q3 CY23**	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**
Number of Member Grievances	462	409	333	336	295	230	241	267	59	46	59	31	816	685	633	634
Top Two Overall Primary Member Grievance Codes																
	BCBS				**PHP**				**WSCC**				**AGGREGATE**			
	Q3 CY23	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**	**Q3 CY23**	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**	**Q3 CY23**	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**	**Q3 CY23**	**Q4 CY23**	**Q1 CY24**	**Q2 CY24**
Transportation Ground Non-Emergency	326	273	190	163	68	63	56	65	7	15	10	6	401	351	256	234
Provider Specialist	33	14	21	26	0	0	0	0	5	2	5	2	38	16	26	28
Variable Grievances	103	122	122	147	227	167	185	202	47	29	44	23	377	318	351	372

Source: MCO Report #37

APPEALS

Report 37 appeals section provides monitoring to guarantee that member appeals are handled promptly and suitably. The report also provides data related to the summary of member appeals reason codes.

In DY11 Q2, it was determined that all reports complied with contractual requirements. HCA observed in DY11 Q2 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 Q2 demonstrated a 5% increase from DY11 Q1.

"Denial in whole of a payment for a service" was the second most frequently reported member appeal code. The number of these appeals filed in DY11 Q2 showed an 8% decrease from DY11 Q1. The table below is a summary of the quarterly data reported by the MCOs for DY10 Q3 – DY11 Q2. DY12 Q1 data will be reported in DY12 Q2.

Table 21: Appeals Reported

Appeals Reported (DY10 Q3 – DY11 Q2) (Q3 CY23 – Q2 CY24)																
APPEALS	BCBS				PHP				WSCC				AGGREGATE			
	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24
Number of Standard Member Appeals	409	333	361	265	581	489	408	482	71	38	49	52	1,061	860	818	799
Number of Expedited Member Appeals	32	31	27	58	17	30	29	43	9	10	17	10	58	71	73	111
Top Two Primary Member Appeal Codes																
	BCBS				PHP				WSCC				AGGREGATE			
	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24	Q3 CY23	Q4 CY23	Q1 CY24	Q2 CY24
Denial or limited authorization of a requested service	366	327	356	298	568	502	401	502	71	45	56	56	1,005	874	813	856
Denial in whole of a payment for a service	63	32	19	20	12	10	17	13	0	0	0	0	75	42	36	33
Variable Appeals	12	5	13	5	18	7	19	10	9	3	10	6	39	15	42	21

Source: MCO Report #37

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QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HCA's Turquoise Care 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. HCA specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please refer to the table below for 2024 MCO Advisory Board Meeting Schedules.

Table 22: 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	07/11/2024	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	09/26/2024	Noon-2:00 PM	Jicarilla Apache Health Care Facility
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)

MHC 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
MHC	9/26/24	12:00 PM – 1:30 PM	Virtual
MHC	12/4/24	5:30 PM – 6:35 PM	Las Cruces - Hybrid

STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
N/A	N/A	N/A	N/A
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
MHC	10/16/24	10:00 AM – 1:00 PM	Las Cruces - Hybrid
MHC	12/18/24	10:00 AM – 11:30 AM	Virtual

UHC 2024			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
UHC	9/25/24	5:30 PM – 6:30 PM	Virtual
UHC	12/4/24	5:30 PM – 6:30 PM	Virtual
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
N/A	N/A	N/A	N/A
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	**DATE**	**TIME**	**LOCATION**
UHC	9/25/24	12:00 PM – 1:00 PM	Virtual
UHC	12/4/24	12:00 PM – 1:00 PM	Virtual

Quality Assurance	
DY12 Q1	**Quarterly Quality Meeting** HCA holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HCA updates and guidance on required quality monitoring activities as well as relay HCA findings from the monthly, quarterly, and annual reports submitted by the MCOs. The DY12 Q1 meeting was held on September 26, 2024. HCA agenda items included a review of CY23 Centennial Care 2.0 MCO Performance Measures (PMs) aggregate HEDIS results. BCBS met 6 out of 10 PM targets for CY23, PHP met 9 out of 10 PM targets for CY23 and WSCC

	met 3 out of 10 PM targets for CY23. All 3 MCOs met or exceeded the PM target in CY23 for PM #4 Postpartum Care (PPC), PM #6 Antidepressant Medication Management (AMM) Continuation Phase and PM #8 30 Day Follow Up After Hospitalization for Mental Illness. 2 out of 3 MCOs met or exceeded the PM target in CY23 for PM #2 Weight Assessment for Physical Activity for Children and Adolescents (WCC) and PM #9 30 Day Follow Up After Emergency Department for Mental Illness (FUM). HCA presented the MCO PMs carried over from Centennial Care 2.0 to Turquoise Care including the targets assigned for those PMs for CY25 through CY27. A review of the SFY24 Q4 Legislative Finance Committee (LFC) PM state aggregate rates were also presented to MCOs in comparison to the LFC-assigned state fiscal year target for SFY24. HCA then presented the state's LFC-assigned PMs and targets for SFY25, effective July 1, 2025, for MCO awareness of stakeholder-focused populations and the expectation for MCOs to initiate strategies and interventions that improve health outcomes for targeted populations. MCOs are directed to focus on developing innovative strategies and interventions for the upcoming SFY25 LFC performance measures. Next, HCA reviewed CY24 Q2 MCO Tracking Measure (TM) rates as compared to previous quarters and presented observed trends and discussed planned interventions and strategies for improvement. MCO shared their smoking cessation and vaping prevention strategies which included a "Live Vape Free" Program, working closely with School Based Health Centers to develop interventions for youth, and online accessible resources. MCOs were advised to continue tracking the number of members who call into the MCO quit line and sharing smoking cessation and vaping prevention initiatives targeting youth and adolescents in upcoming HCA-MCO one-on-one quarterly meetings and upcoming quarterly quality meetings. HCA expects the MCOs to closely monitor tracking measures to ensure continuous improvement. Last, HCA included a brief overview of MCO reporting requirements and expectations, which included guidance on providing thorough and meaningful written analysis in a narrative format, ensuring a peer review is completed prior to report submission, and strategies and interventions,

	trend comparisons, barriers, and additional supporting information is included to assist the reviewer evaluate and support performance. **Monthly Performance Measure Monitoring Plan** In DY9 Q3, HCA 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. HCA provides the MCOs with reporting instructions and a monitoring template which is submitted monthly to HCA. 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 HCA to monitor the progress towards improving outcomes and meeting the established PM targets. The closing of DY11 Q2 included the phasing out of the monthly performance measure monitoring program for Centennial Care 2.0. HCA will monitor and assess MCO performance in Turquoise Care to re-implement monthly monitoring if declines in performance measure outcome rates are observed. Through DY11 Month 6 (M6), the MCOs reported the following average rates for Well Child Visits in the First 15 Months of Life (W30): BCBS 46.43%, PHP 41.14%, and WSCC 52.02%. Through DY11 M6, the MCOs reported the following average rates for Timeliness of Prenatal Care (PPC): BCBS 59.34%, PHP 64.79%, and WSCC 53.75%. HCA expects to see these rates increase quarter over quarter as quarterly monitoring of these PMs will continue in Turquoise Care. **BCBS:** **W30**: M4 41.48%; M5 46.54%; M6 51.27%. Increase of 9.79 percentage

	points from M4 to M6. **Strategies and Interventions:** BCBS Wellness Education Specialists continued to contact parents/guardians of members to assist with scheduling W30 appointments. Targeted text messages and emails encouraging well-child visits and immunizations were sent to parents/guardians. Members are also eligible for 50 reward points for completing up to six well-baby visits through the Finity rewards program. BCBSNM continues to assist provider groups by promoting innovative solutions that target members who are identified as having a gap in care. BCBS incentivizes providers who offer reserved wellness appointments after hours and on weekends. **PPC**: M4 59.34%; M5 59.18%; M6 59.49%. Increase of 0.15 percentage points from M4 to M6. **Strategies and Interventions**: During DY11 Q2, BCBS initiated a targeted email campaign sent to expecting members. The emails included information regarding prenatal and postpartum care education and visits. BCBS also offered reward points for attending the initial prenatal visit in the first trimester as well as other select healthy activities. BCBS supports members with high-risk pregnancies through the Special Beginnings program. First time mothers are also offered support through the Medicaid Home Visiting Program up to 5 years post-delivery. **PHP:** **W30**: M4 39.48%; M5 41.08%; M6 42.87%. Increase of 3.39 percentage points from M4 to M6. **Strategies and Interventions**: PHP performance improvement interventionist team continues to call parents/guardians to encourage w30 compliance and assist with scheduling appointments. PHP continued its collaboration with the Presbyterian Medical Group (PMG) Las Estancias to decrease its high pediatric no-show rate. PMG has sponsored social media posts to educate members on the importance of well-child visits. PHP engages members with the Baby Bonus program. Members are encouraged to join the program through member outreach efforts. PHP also promotes the Baby Bonus program

	through the New Baby Welcome letter. **PPC**: M4 64.51%; M5 64.87%; M6 64.98%. Increase of 0.47 percentage points from M4 to M6. **Strategies and Interventions**: PHP continued to engage members with high-risk pregnancies through outreach phone calls to assist with scheduling appointments. The Pregnancy Passport Program rewards members for attending prenatal and postpartum visits. Members receive a $150 gift card after completing a prenatal visit within the first trimester of pregnancy or within 42 days of joining Presbyterian Health Plan. This program is designed to encourage timely appointments by rewarding members who attend their required prenatal and postpartum care visits. The PHP Performance Improvement team has ongoing provider and clinic staff presentations to explain the importance of the PPC measure timeline when scheduling member visits to ensure the member receives perinatal and postpartum care during the appropriate timelines. **WSCC:** **W30**: M4 37.80%; M5 58.77%; M6 59.48%. Increase of 21.68 percentage points from M4 to M6. **Strategies and Interventions:** WSCC continued to send reminder cards to members' parents/guardians through its partnership with Pfizer. Members received information regarding the incentive programs My Health Pays and Centennial Rewards programs through member outreach efforts. Members are eligible for 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 Quality provider engagement team meets with providers to increase provider performance. The team also shares non-compliant member lists and discusses barriers. **PPC:** M4 53.55%; M5 54.00%; M6 53.70%. Increase of 0.15 percentage points from M4 to M6. **Strategies and Interventions:** WSCC sent mPulse text messages to pregnant members to inform them of

	NOP completion, prenatal appointments, and prenatal care tips. Members and providers were incentivized to submit Notification of Pregnancy forms. Members received a $25 gift card for completing the notification of pregnancy forms. WSCC continued to encourage members to enroll in the Start Smart for your Baby program. The program addressed areas like disease management, care coordination, care management, and health education. WSCC offered first-time mothers located in Bernalillo, Sandoval, Valencia, Rio Arriba, and Torrance Counties an opportunity to participate in the Nurse-Family Partnership (NFP). This service provides pregnant moms with a personal nurse who provides support, advice, and information needed during their pregnancy. **Performance Measures (PMs)** HCA 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 HCA-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. HCA 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. HCA staff will review and analyze the data to determine if the MCOs are trending towards meeting the established targets. HCA findings are communicated to the MCOs through MCO-specific technical assistance (TA) calls and during the Quarterly Quality Meeting (QQM). HCA expects to see rates improve quarter over quarter. The introduction of Turquoise Care will include the quarterly monitoring of 13 Performance Measures effective DY12 Q1. Quarterly monitoring of the following Centennial Care 2.0 PMs will continue in Turquoise Care: Well Child Visits in the First 30 Months of Life (W30), Prenatal and Postpartum

	Care (PPC), and & Day Follow-Up After Hospitalization for Mental Illness (FUH). New Turquoise Care PMs will include, Child and Adolescent Well-Care Visits (WCV), Oral Evaluation Dental Services (OED), Breast Cancer Screening (BCS-E), Follow-up Care for Children Prescribed ADHD Medication – Initiation (ADD-E), Immunizations for Adolescents (IMA), Pharmacotherapy for Opioid Use Disorder (POD), Glycemic Status Assessment for Patients With Diabetes (GSD), Eye Exam for Patients With Diabetes (EED), Kidney Health Evaluation for Patients With Diabetes (KED), Lead Screening in Children (LSC). The data for DY12 Q1 will be reported in the DY12 Q2 CMS Quarterly Monitoring Report. Below are the final MCO quarterly rates and interventions for each Centennial Care 2.0 PM for DY11 Q2 reporting. ***PM #1 (1 point) – Well-Child Visits in the First 15 Months of Life (W30)*** The percentage of members who turned 15 months old during the measurement year and had 6 or more well-child visits. • BCBS Q1 36.90%; Q2 51.27% • PHP Q1 34.73%; Q2 42.87% • WSCC Q1 33.54%; Q2 59.48% • MCO Aggregate: Q1 35.31%; Q2 47.37% **MCO Strategies and Interventions:** • BCBS continued several member outreach efforts. BCBS' Wellness Education Specialists placed outreach calls to remind parents/guardians of W30 measure appointments. BCBS Community Health Workers provided wellness guidelines and information to encourage parents/guardians to schedule a well-child visit. Parents/guardians were sent targeted emails and text messages. BCBS continued several provider-focused initiatives. Providers were incentivized to reserve appointments for BCBS Centennial Members. Providers were incentivized to offer after-hours and weekend appointments to BCBS Centennial Members. The provider initiatives were promoted during joint operating committee meetings with Value-Based Contracted (VBC) providers who are committed to improving their W30 rates.

- PHP's efforts to improve W30 measure performance included targeted member outreach. The Performance Improvement (PI) Interventionist team contacted Members to educate them on the importance of well-baby visits and assist with scheduling appointments when possible. PHP sent Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters to parents/guardians to remind them to complete well-baby visits. PHP utilized social media posts to increase awareness of W30 visits. PHP engaged Members with the Baby Bonuses rewards program to encourage participation in well-baby visits for this measure. Members received a $50 reward for completing the first six well-child visits from birth to 15 months.

- WSCC continued to collaborate with Pfizer to mail well-child reminder cards to parents/guardians of Members. WSCC continued to educate Members and their parents/guardians about the importance of well-child visits. To address barriers to care, WSCC continued to encourage Members experiencing difficulties getting to their appointments to use transportation services through its vendor Secure Transportation. WSCC engaged Members with My Health Pay Rewards. The Quality Provider Engagement team hosted bimonthly meetings with providers to share non-compliant member lists and discuss any barriers.

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.

- BCBS Q1 15.65%; Q2 21.45%
- PHP Q1 15.46%; Q2 20.27%
- WSCC Q1 13.78%; Q2 40.00%

- MCO Aggregate: Q1 15.33%; Q2 20.85%

MCO Strategies and Interventions:

- BCBS partnered with the New Mexico Department of Health to provide free annual sports physicals at Hatch Valley High School. The health and wellness ambassador for community engagement “Blue Bear” participated in the Aztec Library summer reading program kick-off. The Blue Bear presented options for nutritious meals and snacks during the presentation. BCBS added a Value-Added Service to assist Members with paying for after-school youth activities. Targeted text messages and emails were sent to parents/guardians of Members ages 3 – 20 encouraging them to schedule a comprehensive exam. BCBS will provide a maximum of $50 per member for each state fiscal year for registration fees, uniforms, equipment purchases, etc. Providers received a higher payout for code GO447 to support the counseling and nutrition for physical activity measure.

- PHP Collaborated with the Presbyterian Medical Group (PMG) pediatric clinics to implement strategies to decrease the rate of no-show patients. The strategies implemented were social media outreach to people of all genders ages 20-60 within a 15-mile radius of the Las Estancias Presbyterian Clinic. The posts educate parents/guardians on the importance of maintaining and completing appointments. PHP’s Performance Improvement (PI) team launched a pilot program to encourage parents/guardians to schedule well-child visits at participating PMG clinics for their recommended vaccines. Scheduling well-child visits in advance allows providers to address nutritional and activity counseling during well-child appointments.

- WSCC outreach teams contacted Members via telephone to encourage compliance with well-child appointments. Pfizer mailed reminder cards to complete various well-child visits for the WCC HEDIS measure. The Quality provider engagement team continued to meet with providers to provide education on the importance of weight assessment and counseling. The Quality provider engagement team shared non-compliant member lists and discussed barriers. WSCC provided education materials and tip sheets to

providers for the WCC measure to ensure the providers are coding correctly to close the gap 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.

- BCBS Q1 59.83%; Q2 59.49%
- PHP Q1 65.12%; Q2 64.98%
- WSCC Q1 52.98%; Q2 52.90%
- MCO Aggregate: Q1 61.53%; Q2 61.52%

MCO Strategies and Interventions:

- BCBS contacted pregnant Members to offer care coordination to help manage their pregnancies. BCBS sent targeted text messages and emails to remind Members to schedule prenatal care visits. Blood pressure monitors were offered to the high-risk pregnancy Native American population. Members were required to respond by expressing interest in receiving the blood pressure monitor. BCBS engaged value-based contracted providers with monthly joint operating meetings. The meetings are an opportunity to discuss provider scorecards and Member gap lists.

- PHP's Performance Improvement (PI) team focused on identifying Members who are within their first trimester or within 42 calendar days of enrollment to complete their first prenatal appointment. Pregnant Members were identified through the Early Identification of Pregnancy report. This report was also used by CHWs, Care Coordination, and the interventionist teams to provide outreach to Members. PHP continued to engage Members with the Pregnancy Passport program. Members received a prenatal reward of $150 for attending an early prenatal visit within the first trimester or within 42 days of enrollment.

- WSCC collaborated with providers to complete Notification of

Pregnancy (NOP) forms. WSCC conducted Member outreach to the identified pregnant Members to introduce them to maternity programs. Members also received a $25.00 gift card for completing the NOP form. WSCC engaged Members with its Start Smart for your Baby (SSFB) obstetric care coordination program. SSFB Care Coordinators assisted Members with organizing their prenatal checkups and addressing barriers to care. WSCC connected Members to a dedicated clinical team through its Pacify Lactation Consulting and Virtual Doula app. The Pacify app allowed Members virtual access to nurses, nutritionists, doulas, and lactation consultants.

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.

- BCBS Q1 44.46%; Q2 49.90%
- PHP Q1 54.39%; Q2 60.94%
- WSCC Q1 44.93%; Q2 53.70%
- MCO Aggregate: Q1 49.53%; Q2 56.13%

MCO Strategies and Interventions:

- BCBS performed Member outreach calls to offer Members assistance with scheduling postpartum appointments. Members were offered care coordination when necessary. BCBS identified Members with high-risk pregnancy conditions like hypertension, depression, diabetes, etc. and offered them free blood pressure monitors. BCBS produced a Blue Review provider article titled “Supporting Maternal Quality Care” in the online provider newsletter. BCBS continued to collaborate with the Rhodes Group to generate a list of postpartum Members. This collaboration enabled timely Member outreach.

- PHP continued to contact Members who recently delivered a baby to educate them on the importance of postpartum care and offered assistance with appointment scheduling. The Performance Improvement (PI) interventionist team mailed letters with information and resources on postpartum care to Members with confirmed pregnancies. PHP engaged Members with postpartum rewards through the Pregnancy Passport Rewards Program. Members were given $100 for completing a postpartum visit within 7-84 days after delivery. PHP also used social media posts to encourage Members to attend postpartum appointments.

- WSCC Start Smart for your Baby (SSFB) Care Coordinators performed outreach to assist Members in organizing their postpartum appointments and address barriers to care. SSFB Care Coordinators are all registered nurses with prior NICU and OB experience. WSCC also used mPulse to send biweekly text messages to remind Members to schedule postpartum appointments. WSCC encouraged Members who were experiencing difficulties with transportation to appointments to use transportation service benefits through its vendor Secure Transportation.

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.

- BCBS Q1 33.96%; Q2 37.62%
- PHP Q1 36.94%; Q2 38.43%
- WSCC Q1 18.69%; Q2 36.44%
- MCO Aggregate: Q1 33.31%; Q2 37.98%

MCO Strategies and Interventions:

- BCBS mailed “Happy Birthday” postcards to Members who turned 1, 2, and 3 years old. The postcard informed the parents/guardian that their child may be due for a well-child visit, dental and/or immunizations. BCBS also placed outreach calls to schedule or notify parents/guardians of the “Got Shots” campaign. This campaign is aimed at Members aged 1 month to 21 years with the intent to ensure school children receive immunizations before the beginning of the school year. BCBS also engaged providers with incentivized payments for reserving wellness appointments for BCBS Centennial Members. Providers were also incentivized for after-hour and weekend appointments. BCBS issued a provider newsletter in April that gave guidance regarding Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appointments. The EPSDT well-child visit guidance included information regarding the maintenance of the child/adolescent immunization schedule, as well as the EPSDT services available for families.

- The PHP Performance Improvement (PI) Interventionist team contacted Members’ parents/guardians to educate them on the importance of immunizations and assist with scheduling appointments. PHP mailed Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters to remind parents/guardians to complete well-baby visits. PHP also engaged Members with the Baby Bonus rewards program. Members received a $25 reward for completing two well-child visits from 16-30 months of age. PHP also used social media posts to remind Members of the importance of well-child visits and immunizations.

- WSCC continued to educate parents/guardians about the safety and importance of childhood immunizations. WSCC and Pfizer mailed immunization reminder cards to parents/guardians. To increase member outreach efforts, WSCC continued to search multiple systems for updated contact information and attempted outreach to all available phone numbers. Members received My Health Pays Rewards for completion of CIS measure appointments. WSCC provided education materials and tip sheets to providers for the CIS

Combo 3 measure to ensure all immunizations are administered to close the gap in care.

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.

- BCBS Q1 33.43%; Q2 37.02%
- PHP Q1 45.98%; Q2 50.17%
- WSCC Q1 34.83%; Q2 46.60%
- MCO Aggregate: Q1 39.96%; Q2 44.89%

MCO Strategies and Interventions:

- BCBS distributed a video educating members about substance use through flyers and facility partnerships. The video provided information on recognizing signs of substance abuse, finding substance use treatment, and emphasizing the importance of post-diagnosis treatment. Recovery Support Assistants identified members who had an Emergency Department visit related to substance use through the PointClickCare (formerly EDIE) System. The identified members were contacted and connected with the appropriate level of follow-up treatment and offered continuous support. The Recovery Support Assistants made multiple attempts to contact members when immediate outreach was not possible. BCBS incentivized providers to ensure members received appropriate follow-up care. The incentive was delivered through value-based contracting with provider groups and enhanced payments initiatives for facilities.

- PHP continued to educate members on medication adherence through targeted member outreach. PHP continued its member call campaign in counties with low AMM rates to educate members on the value of antidepressant adherence. PHP utilized the Health Risk Assessment (HRA) to send members who indicated they experience

depression educational materials on depression, including medication adherence. PHP also mailed Drug Benefit Flyers to qualifying members. PHP assessed race, age, and gender data of members within the AMM measure to identify potential opportunities to improve medication adherence. Provider education was delivered via Provider Education Conference, the Provider Newsletter, and a Behavioral Health (BH) Townhall.

- WSCC continued to encourage members to use Teladoc Health to reduce barriers to care. Teladoc mental health experts assisted members with a variety of services, including medication management via virtual appointments seven days a week. WSCC continued to partner with Outcomes™ Clinical Pharmacists to educate members on the value of taking their prescribed medications and effectively managing their medical and behavioral health needs. WSCC's BH Disease Management Registered Nurse continued to encourage members to adhere to their medication regimens. The BH Disease Management Nurse regularly contacted AMM members to provide education and assistance in addressing barriers that cause challenges with medication adherence. WSCC Pharmacy Coordinators continued to contact physicians and pharmacies to assist with refills and 90-day supply prescriptions. WSCC's vendor, Outcomes™, continued to notify pharmacists through their Targeted Intervention Program when members required additional medication adherence guidance.

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.

- BCBS Q1 45.47%; Q2 47.26%
- PHP Q1 54.75%; Q2 46.83%
- WSCC Q1 47.34%; Q2 49.79%
- MCO Aggregate: Q1 50.29%; Q2 47.33%

MCO Strategies and Interventions:

	• BCBS's member outreach efforts were heavily focused on contacting Members who were recently discharged from EDs for substance use visits. These Members were identified via the PointClickCare (formerly Emergency Department Information Exchange) System. Recovery Support Assistants made multiple attempts to contact Members to connect them with the appropriate level of follow-up treatment and offer continuous support. Recovery Support Assistants scheduled a total of 113 appointments for Members during SFY24 Q4. Provider interventions included value-based contracting with participating provider groups as well as the IET enhanced payment initiative for facilities. • PHP supported state efforts to implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program in rural hospitals and EDs. Certified peer support workers are stationed in the ED within the Presbyterian Health Services (PHS) delivery system. The peer's primary focus is to engage individuals with opioid overdoses or opioid-related episodes in recovery and treatment; however, they will also assist Members with alcohol-related episodes. The peer support team continued to work with Members to provide peer support services. PHP identified geographic areas with higher rates of lack of service to increase provider capacity in these areas. CHWs were notified of Members who were in ED for alcohol and other drug (AOD) use. The CHW staff then engaged the Members while in the ED, which led to a greater probability of engagement. When engagement with the Member was successful, the CHW completed the Healthy Lifestyles Questionnaire to assess the member's needs and refer the member to the appropriate level of care. • WSCC continued targeted Member outreach following a new episode of alcohol or drug use to improve access to and initiation of treatment. WSCC utilized claims-based care gap reports to identify and contact Members to connect them with resources and substance abuse treatment if they had not already done so within 14 days of an ED visit or outpatient diagnosis. WSCC continued to partner with UNM Hospital's CHW program to engage Members while they are in the ED for substance use. This partnership facilitated the completion of

Social Determinants of Health (SDOH) screenings to identify Members' needs and connect them with support. WSCC also collaborated with Affect Therapeutics to offer alcohol and drug addiction treatment through telehealth and digital treatment programs. WSCC's Value Added Services included a sober living benefit which was available to Members who needed a safe place to stay while actively engaging in intensive outpatient substance abuse services.

PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness (FUH): 30 Day

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

- BCBS Q1 43.47%; Q2 51.06%
- PHP Q1 48.24%; Q2 53.00%
- WSCC Q1 46.37%; Q2 49.31%
- MCO Aggregate: Q1 46.24%; Q2 51.71%

MCO Strategies and Interventions:

- BCBS developed a Blue Door Neighborhood Center. The Center will partner with community organizations and health care providers to offer a variety of resources and programming to impact community health, including targeting maternal health, diabetes, behavioral health, and heart disease. There will also be no-cost wellness classes, connections to social services, and customer engagement. BCBS collaborated with behavioral health providers to schedule outpatient appointments to ensure timely follow-up for Members. BCBS held a provider training webinar on adolescent mental health. Providers were offered Continuing Educational Units to attend.

- PHP provided onsite peer consultation liaison services at the ED to support Members in attending after-care behavioral health appointments. PHP worked to increase access to behavioral health services by offering providers training in behavioral telehealth certification. PHP continued to educate behavioral health providers

on the FUM metric and encouraged behavioral health providers to partner with EDs to offer follow-up appointments. PHP uses monthly reporting data to identify high-volume, low score facilities that are not part of the Model Facility Incentive Program (MFIP). The Behavioral Health Medical Director contacted these facilities.

- WSCC continued to conduct targeted outreach to Members following an ED visit for mental health or intentional self-harm. Members received outreach from a licensed mental health clinician within 24 to 48 hours of visiting the ED through the PointClickCare (formerly EDIE) notification system. WSCC's Care Coordinators contacted Members after emergency department visits to address gaps in care, provide education, connect them with providers, and assist them with transportation or other barriers. The CPSW's and CHWs help Members navigate systems, make follow-up appointments, and connect with community resources. WSCC's Member Connections Team and Care Coordinators connected Members who called the 24-hour mental health crisis line with outpatient behavioral health providers. WSCC continued to offer no-cost training to mental health and integrated care practitioners. The WSCC Quality Improvement Program HEDIS webpage included topics related to optimizing the FUM HEDIS measure and enhancing member experience with behavioral health care services.

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.

- BCBS Q1 49.16%; Q2 52.52%
- PHP Q1 39.55%; Q2 44.65%
- WSCC Q1 41.18%; Q2 42.42%
- MCO Aggregate: Q1 43.60%; Q2 47.34%

MCO Strategies and Interventions:

- BCBS Case Managers contact Members to encourage a diabetes screening for those who are prescribed an anti-psychotic medication

	and offer them A1C at-home test kits or assistance with scheduling an appointment. The Case managers also provide reminders and education regarding the importance of screening. Outpatient providers are incentivized to distribute test kits to Members during visits. The providers use their monetary rewards to support patients with essential needs, such as transportation, gift cards, or assistance in obtaining necessary documents. A total of 620 bulk kits were sent to providers. • PHP continued Member outreach calls to Members who were included in the denominator of the SSD measure. PHP continued to give providers point of service A1c test kits. The value-based purchasing team identified geographic areas with a high volume of Members with a gap in care. The value-based purchasing team contacted providers within these areas to attempt to recruit them into the Behavioral Health Quality Incentive Program (BQIP). PHP and the Behavioral Health Medical Director continued to educate providers on the SSD measure and best practices in prescribing antipsychotics during the Provider Education Conference (PEC) meeting. • WSCC continued to prioritize monthly outreach to Members in the SSD measure to ensure Members were educated about the importance of annual blood glucose screening when taking antipsychotic medications. WSCC continued to collaborate with HarmonyCares to provide Members with easy to complete at-home A1c test kits. WSCC partnered with NM Community Care (NMCC), a community paramedicine service, to perform telephonic and face-to-face outreach to SSD measure Members to complete A1c test kits with Members in their homes. WSCC supplied A1c test kits to NMCC, NM Solutions, TeamBuilders Behavioral Health, and Border Area Mental Health and offered a provider incentive for every test kit completed with a WSCC Member. WSCC Provider Quality Liaisons (PQLs) continued to engage providers with information about behavioral health measures, gaps in care lists, and examined ways to help practitioners overcome obstacles. ***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. • BCBS Q1 43.66%; Q2 63.26% • PHP Q1 47.61%; Q2 65.16% • WSCC Q1 43.15%; Q2 66.67% • MCO Aggregate: Q1 45.29%; Q2 64.35% **MCO Strategies and Interventions:** • BCBS incentivized providers to ensure Members receive appropriate follow-up care. The incentive was delivered through value-based contracting with provider groups and enhanced payments initiatives for facilities. Additional interventions used by BCBS to improve this measure included provider webinars. Provider webinars were held to provide education on this measure, while also providing Continuing Education Credits (CEU) to providers for attending. • PHP continued to educate Members on medication adherence through targeted Member outreach. PHP continued its Member call campaign in counties with low AMM rates to educate Members on the value of antidepressant adherence. PHP utilized the Health Risk Assessment (HRA) to send Members who indicated they experience depression educational materials on depression, including medication adherence. PHP also mailed Drug Benefit Flyers to qualifying Members. PHP assessed race, age, and gender data of Members within the AMM measure to identify potential opportunities to improve medication adherence. Provider education was delivered via Provider Education Conference, the Provider Newsletter, and the Behavioral Health (BH) Townhall. • WSCC continued to encourage Members to use Teladoc Health to reduce barriers to care. Teladoc mental health experts assisted Members with a variety of services, including medication

management via virtual appointment seven days a week. WSCC continued to partner with Outcomes™ Clinical Pharmacists to educate Members on the value of taking their prescribed medications and effectively managing their medical and behavioral health needs. WSCC's BH Disease Management Registered Nurse continued to encourage Members to adhere to their medication regimens. The BH Disease Management Nurse regularly contacted AMM Members to provide education and assistance in addressing barriers that cause challenges with medication adherence. WSCC Pharmacy Coordinators continued to contact physicians and pharmacies to assist with refills and 90-day supply prescriptions. WSCC's vendor, Outcomes™, continued to notify pharmacists through their Targeted Intervention Program when Members required additional medication adherence guidance.

Tracking Measures (TMs)

HCA requires the MCOs to submit quarterly reports for the Tracking Measures listed in the MCO contract. HCA 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. HCA'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 introduction of Turquoise Care will include the quarterly monitoring of 11 Tracking Measures effective DY12 Q1. Quarterly monitoring of the following Centennial Care 2.0 TMs will continue in Turquoise Care: Diabetes Short Term Complications Admission Rate and Smoking Cessation. New Turquoise Care TMs will include, Childhood Immunization Status (CIS) - Combination 3, 7 Day Follow-Up After ED Visit for Mental Illness (FUM), Depression Screening and Follow-Up for Adolescents and Adults (DSF-E), Cervical Cancer Screening (CCS), Statin Therapy for Patients with Diabetes (SPD) and Cardiovascular Disease (SPC), Contraceptive Care for Women, Initiation and Engagement of Substance Use Disorder (IET), Prenatal Depression Screening and Follow-Up (PND-

E) and Postpartum Depression Screening and Follow-up (PDS-E).

The TM data for DY12 Q1 will be reported in the DY12 Q2 CMS Quarterly Monitoring Report.

Below are the final MCO quarterly rates and interventions for each Centennial Care 2.0 TM for DY11 Q2 reporting.

TM #1 – Fall Risk Management

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

- BCBS Q1 0.02%; Q2 0.02%
- PHP Q1 1.07%; Q2 0.86%
- WSCC Q1 0.15%; Q2 0.26%
- MCO Aggregate: Q1 Total 0.30%; Q2 Total 0.27%

MCO Strategies and Interventions:

- BCBS: Effective July 2024, shower chairs were added as a member benefit under Value Added Services.

- PHP: Care Coordinators assessed the members for issues that could increase fall risk, such as mobility issues, inability to complete activities of daily living, or environmental risks in the home. Care Coordinators then developed a comprehensive plan of care to address the identified concerns with interventions including: referrals to providers, physical or occupational therapy, home health services, personal care services, and environmental modifications.

- WSCC: During DY11 Q2, Western Sky Community Care continued to provide members who were recently discharged from a hospitalization the opportunity to participate in the Transition of Care program where the Transition of Care Coaches educate members on fall prevention and address falls with clinicians.

	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; Q2 25.80 • PHP Q1 15.65; Q2 20.01 • WSCC Q1 9.27; Q2 0.00 (WSCC reported denominator of zero in Q2.) • MCO Aggregate: Q1 Total 16.09; Q2 Total 22.29 MCO Strategies and Interventions: • BCBS: BCBS Health Education and Health Literacy (HEHL) traveled to Crownpoint, Farmington, and Rio Rancho, New Mexico during DY11 Q2 to discuss health education with BCBS and community members. Working closely with BCBS Community Outreach, BCBS HEHL educates adult members on how to lower the risk of type 2 diabetes through dietary changes, exercise, and following up with diabetes health care providers. • PHP: Any member identified as having a possible change in condition is contacted to complete a Health Risk Assessment (HRA). If appropriate, a Comprehensive Needs Assessment (CNA) is completed, and the member is engaged in the level of care coordination indicated by the CNA. Members work with their care coordinator and providers to optimize their health and reduce utilization of avoidable medical services, including diabetes short-term complication admissions. • WSCC: During DY11 Q2, WSCC continued to offer members with diabetes the opportunity to participate in the Diabetes Health Coaching program which provides members with education and guidance on managing their diabetes and preventing complications. *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%; Q2 1.33% • PHP Q1 1.56%; Q2 1.91% • WSCC Q1 1.36%; Q2 1.63% • MCO Aggregate: Q1 Total 1.41%; Q2 Total 1.70% MCO Strategies and Interventions: • BCBS: In DY11 Q2, the member newsletter included an article on depression screening with a QR code linked to an educational video. • PHP: Education for physical health providers included a recorded webinar titled "Treating Depression in the Primary Care Provider Environment" that was placed on the provider portal. • WSCC: Healthcare providers have access WSCC's website on behavioral health-related provider toolkits related to anxiety, bipolar disorder, depression, health equity, integrated care, substance use disorders, and social determinants of health. *TM #4 – Follow-up after Hospitalization for Mental Illness* The percent of 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%; Q2 53.84% • PHP Q1 41.20%; Q2 35.65% • WSCC Q1 29.69%; Q2 32.45% • MCO Aggregate: Q1 Total 42.47%; Q2 Total 41.85% MCO Strategies and Interventions: • BCBS: The Facility Incentive program rewarded participating facilities for ensuring appropriate follow-up after hospitalization. • PHP: Continuous provider education on the FUH HEDIS measure

	and best practices for follow-up care through trainings were provided by the quality team at the behavioral health Provider Education Conference (PEC). • WSCC: The Holistic Care Grant was provided to 600 members for $250 per household in 2024, which supported members' whole body health including body, mind, spirit, and emotion. *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%; Q2 79.96% • PHP Q1 75.31%; Q2 78.38% • WSCC Q1 59.94%; Q2 71.34 % • MCO Aggregate: Q1 Total 73.94%; Q2 Total 78.51% MCO Strategies and Interventions: • BCBS: In DY11 Q2, BCBS sent 6,011 targeted e-mails and 243 text messages to parents encouraging well-care visits and immunizations. • PHP: The summer vaccine campaign, "Hero Days", was launched in June 2024. The Performance Improvement (PI) Interventionist team made 549 calls to parents and guardians of members on the gap in care list for participating clinics. Of these calls, 179 led to scheduled vaccine appointments for the "Hero Days" campaign. • WSCC: The My Health Pays member incentive program encourages members to receive important immunizations. Members are primarily using earned incentives for purchases at Walmart and to help pay rent and utilities. *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; Q2 310.
- PHP Q1 233; Q2 504.
- WSCC Q1 57; Q2 104.
- MCO Aggregate: Q1 Total 440; Q2 Total 918.

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; Q2 1,904
- PHP Q1 1,362; Q2 2,713
- WSCC Q1 338; Q2 683
- MCO Aggregate: Q1 Total 2,722; Q2 Total 5,300

MCO Strategies and Interventions:

- BCBS: The BCBS Care Coordination team has aligned the Tobacco Cessation program with the Transition of Care program to provide timely referrals to the BCBS Quit Line from providers, Care Coordinators, and the Special Beginnings program to members identified as using tobacco products during an acute care stay.

- PHP: The nurse-led Tobacco Cessation Disease Management program is promoted for members ages 14 and older. The program is presented annually during the Care Coordination team webinar to promote the program to members and staff. The PHP tobacco cessation flyer is distributed to providers, members, and during community events to expand program enrollment.

- WSCC: Care Coordinators educated members on strategies for smoking and tobacco cessation, assisted with overcoming barriers, and referred members to WSCC's health coaching programs.

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; Q2 154.76 • PHP Q1 58.99; Q2 141.68 • WSCC Q1 62.33; Q2 0.00 (WSCC reported denominator of zero in Q2.) • MCO Aggregate: Q1 Total 64.33; Q2 Total 146.78 MCO Strategies and Interventions: • BCBS: The peer support team uses the Emergency Department Information Exchange (EDIE) to engage members prior to discharge and assist in identifying barriers and encourage care coordination to ensure appropriate care. • 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 continued to work with providers on improving access to care to address gaps in care and improve 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; Q2 22.47 • PHP Q1 8.36; Q2 19.17 • WSCC Q1 10.67; Q2 0.00 (WSCC reported denominator of zero in Q2.) • MCO Aggregate: Q1 Total 9.58; Q2 Total 20.45 MCO Strategies and Interventions: • BCBS: The EDIE continued to be used by the Community Health Workers (CHWs) to monitor and contact members who are utilizing the emergency room to promote connection with outpatient care.

	• PHP: The expansion of the Tyto Care at-home primary care provider (PCP) and urgent care offerings through PHP's largest network provider, Presbyterian Medical Group (PMG), offers members and patients the option for at home and remote visits to meet an expanding need for virtual care. The option for improved urgent care at home may decrease the need for escalated emergency department (ED) visits due to delayed care. • WSCC: After an ED visit for mental health, Care Coordinators continued to reach out to members in DY11 Q2 to address gaps in care, provide education, connect them with primary care providers, and assist them with transportation or other barriers. *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%; Q2 42.45%. • PHP Q1 21.78%; Q2 46.47% • WSCC Q1 14.95%; Q2 8.11% • MCO Aggregate: Q1 19.60%; Q2 Total 44.97% MCO Strategies and Interventions: • BCBS: In DY11 Q2, approximately 1,287 members received a text message encouraging them to schedule a dental exam, informing them that their plan includes preventative dental care, and educating them on how dental health can affect their overall health. • PHP: In DY11 Q2, there were 40,500 Early and Periodic Screening Diagnostic and Treatment (EPSDT) letters mailed to members ages 2 to 20 years old. • WSCC: The Centennial Rewards member-incentive program rewards members when they complete an 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%; Q2 30.02% • PHP Q1 27.02%; Q2 36.67% • WSCC Q1 18.30%; Q2 20.00% • MCO Aggregate: Q1 Total 24.02%; Q2 Total 33.81% MCO Strategies and Interventions: • BCBS: In DY11 Q2 an email message titled “Know Your Numbers” was successfully delivered to 1,845 members ages 35-64, recommending they see their health care provider to have their blood pressure checked, weight and BMI assessed, and screening for prediabetes or Type 2 diabetes. • PHP: Calls to members include blood pressure check reminders in conjunction with other gap-in-care calls. • WSCC: WSCC’s Cardiac Health Coaching program provides members with the opportunity to work with a registered nurse (RN) for guidance and education on the management of cardiac conditions, including as hypertension. The RN Health Coach promotes adherence to cardiac health guidelines including heart-healthy nutrition habits and maintaining a healthy weight. Members are also educated about risks associated with hypertension and non-adherence with prescribed medications. *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%; Q2 48.52% • PHP Q1 32.84%; Q2 34.67% • WSCC Q1 45.00%; Q2 47.71%

	• MCO Aggregate: Q1 Total 39.71%; Q2 Total 41.25% MCO Strategies and Interventions: • BCBS: Developed a provider video regarding ADD medication treatment and follow up. • PHP: Survey attestations were sent to providers to complete so they can receive their members currently on the gap and care list in order to follow-up with them. • WSCC: Transportation services through Secure Transportation continued to be available and encouraged for members experiencing difficulties with getting to their appointments and to the pharmacy to pick up their prescription medications. There were 1,970 unique members who utilized transportation services in the months of April and May 2024. *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%; Q2 56.02% • PHP Q1 36.08%; Q2 41.05% • WSCC Q1 42.31%; Q2 50.00% • MCO Aggregate: Q1 Total 44.56%; Q2 Total 47.56% MCO Strategies and Interventions: • BCBS: Outreach calls to members were made regarding ADD medication refills. • PHP: During DY11 Q2, PHP mailed educational letters to prescribers of ADHD medication within the ADD measure. These letters contained member-specific information that informed providers of the measure and encouraged providers to complete follow-up

appointments within the measure timeline.

- WSCC: Care Coordinators continued to maintain contact in DY11 Q2 with members, their families, and caregivers to address gaps in care, provide education, help members contact providers, and assist with transportation needs.

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%; Q2 21.81%
- PHP Q1 8.42%; Q2 14.08%
- WSCC Q1 8.88%; Q2 16.59%
- MCO Aggregate: Q1 Total 9.10%; Q2 Total 16.93%

MCO Strategies and Interventions:

- BCBS: BCBS used gap lists to perform targeted member outreach calls promoting well-care visits.

- PHP: In DY11 Q2, there were 38,978 automated EPSDT letters mailed to members in this measure.

- WSCC: WSCC educated members about the importance of preventative care and annual wellness visits for children and encouraged members and their parents or guardians to take an active role in their healthcare.

External Quality Review

HCA 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. HCA's collaboration with

	the EQRO fosters a culture of continuous improvement. EQR Reviews and Validations in DY12 Q1 consisted of the below. <u>DY9 CY22 EQR statuses of reviews and validations:</u> Validation of Performance Improvement Projects Report, posted to the HCA website

UTILIZATION

HCA is missing encounters for both MHC and UHC data in DY12 Q1. HCA will provide utilization data as soon as the encounter data is complete.

VALUE BASED PURCHASING

To support Turquoise Care value-based purchasing goals, HCA 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 Minimum Requirements for **Legacy Contractors** (BCBS and PHP)

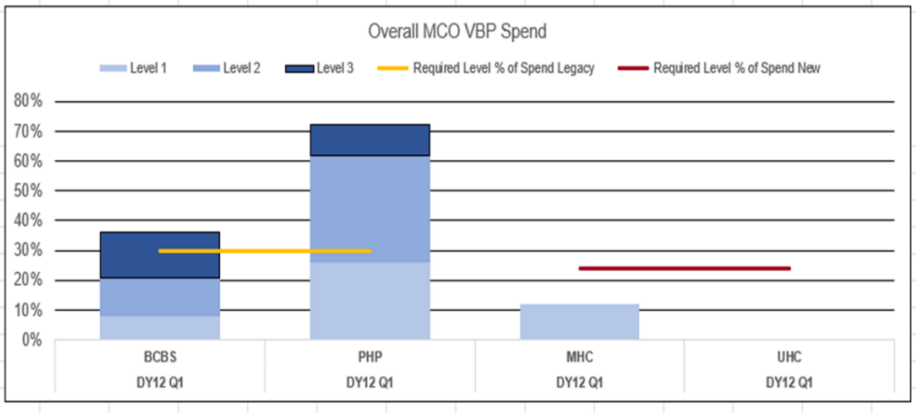
VBP Level	Level 1	Level 2	Level 3
Required Spend	10%	13%	7%
Required Provider Types	• Traditional Physical Health (PH) providers with at least 2 small Providers. • Behavioral Health (BH) Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty BH services. • Long-Term Care (LTC) providers including nursing facilities.	• Traditional Physical Health (PH) providers with at least 2 small Providers. • Behavioral Health (BH) Providers (whose primary services are BH and/or integrated providers who offer a continuum of specialty BH services. • Actively build readiness for Long Term (LTC) providers including nursing facilities.	• Traditional Physical Health (PH) providers. • Develop Level 3 Behavioral Health (BH) provider agreement model that includes providers who are primarily BH and/or integrated provider systems who offer a continuum of specialty BH services. • Implement a contractor led Long-Term Care (LTC) provider (including nursing facilities) level workgroup to design full-risk model.

VBP Level Minimum Requirements for **New Contractors** (MHC and UHC)

VBP Level	Level 1	Level 2	Level 3
Required Spend	8%	11%	5%
Required Provider Types	• Traditional Physical Health (PH) providers with at least 2 small Providers. • Behavioral Health (BH) providers whose primary services are BH and/or integrated Providers • Long-Term Care (LTC) providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • Behavioral Health (BH) providers whose primary services are BH and/or integrated providers who offer a continuum of specialty BH services. • Actively build readiness for Long-Term Care (LTC) Providers including nursing facilities.	• Traditional Physical Health (PH) providers. • Implement a contractor led Behavioral Health (BH) provider level workgroup that works with BH Providers to design full risk model.

For DY12 Q1, BCBS, PHP (Legacy MCOs) met the required VBP spend target of 30%. MHC and UHC (New MCOs) did not meet the required VBP spend target of 24%. The new MCOs continue to develop their VBP programs. This is the first quarter of reporting for the new MCOs.

Table 22: MCO VBP Spend



Source: MCO Calendar Year 2024 Q3 Quarterly Financial Reports.

LOW ACUITY NON-EMERGENT CARE (LANE)

As part of HCA's strategic goal to improve the value and range of services to members, HCA collaborates with the MCOs to reduce avoidable emergency room (ER) visits. HCA includes requirements in its Turquoise Care 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, HCA 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 HCA in January 2020 estimates that 46 new primary care residents will graduate in New Mexico each year, beginning in 2025; and, the number of primary care GME programs will grow by more than 60% within the next 5 years.

BCBS's ED Reduction Program targets Members who have visited the Emergency Room (ER) more than six times in the last six months. These Members are contacted by a CHW with a goal of ensuring the member is established with a PCP. Member Education is provided on the importance of having an out-patient-care provider. BCBS's digital texting campaign was sent to Members who have visited the ED at a minimum of two times in the past 60 days. Links are sent within the text that offer help with finding a PCP, location of the nearest Urgent Care Centers and a telephone number for the Nurse Advise Line. Furthermore, critical incident reports that show a pattern of frequent ED visits and are not listed as having a care coordinator assigned, will then be referred to care coordination.

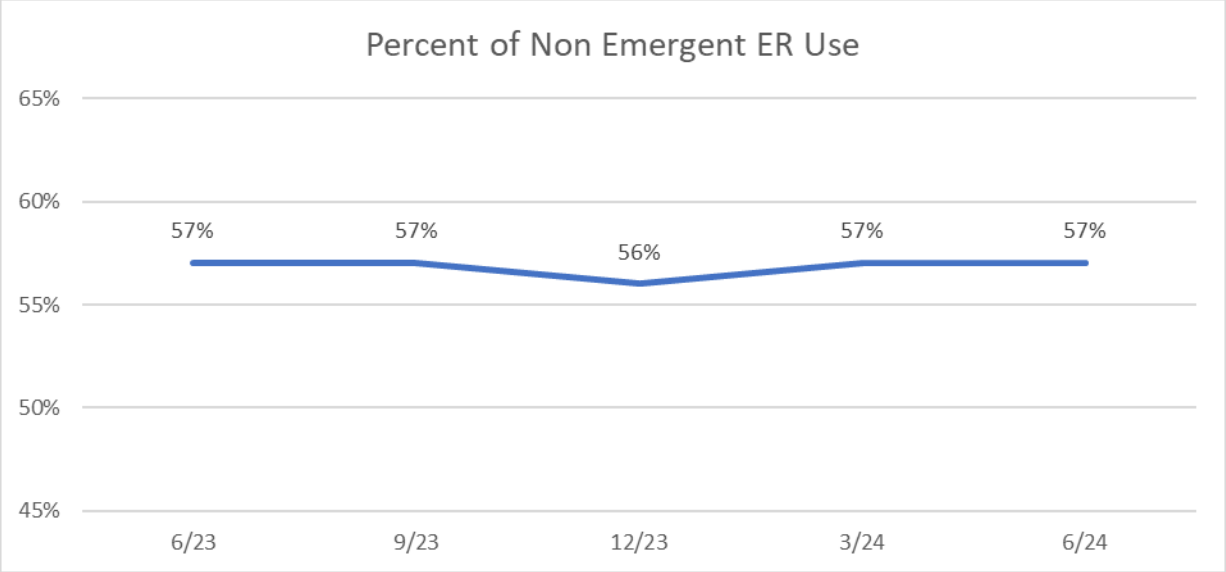
PHP's interventions in place to reduce LANE utilization in DY11 Q2 consisted of the following: Members in care coordination receive follow up from care coordinators following an ED visit to assess for a possible change in condition. PHP provides Member education on alternatives to utilizing the ED. CHWs also work to evaluate unmet social determinants of health (SDOH) needs. In addition, PHP peer support workers provide support to 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. PHP promotes the use of the PresNow urgent care facilities and telehealth options to reduce unnecessary ER utilization.

WSCC's interventions utilized to reduce avoidable ED visits included the use of Mpulse Mobile to text Members who were recently discharged from the ED. The purpose is to engage Members and find out if the Member had a follow up visit with a PCP. The text message also provides information on how to access urgent care services in the area, phone number for the WSCC Nurse Advice Line, and information on WSCC's telehealth program, Teladoc. Care Coordinators utilize Krames, an online resource used to access educational member materials including handouts on when it is appropriate to go to urgent care/ED. Additionally, WSCC offers Pyx Health which is a free program to address loneliness, social isolation, and SDOH needs. Pyx Health supports WSCC Members 24/7. As of DY11 Q2, WSCC has enrolled 2,319 WSCC Members in the program that offered access to health plan resources.

The percentage of emergency utilization considered low acuity remained consistent from DY11 Q1 (57%) to DY11 Q2 (57%). In comparing low acuity ED visits from DY10 Q2 (57%) to DY11 Q2 (57%), the percentage of visits to the emergency department for non-emergent care indicates a steady trend. HCA expects to see this rate decrease quarter-over-quarter as a lower rate indicates improvement for this measure. The graph below reflects the percentage of members using the ER for non-emergent care between DY10 Q2 and DY11

Q2. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership. The data for DY12 Q1 will be reported in the DY12 Q3 CMS Quarterly Monitoring Report.

Table 23: Non-Emergent ER Use



Source: Mercer- Non-Emergent Emergency Room Utilization Report

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MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access is being reported for DY11 Q2. DY12 Q1 will be reported in DY12 Q2 quarterly/annual report.

Physical Health and Hospitals

All 4 MCOs demonstrated steady access with slight fluctuations during this quarter. Small changes (+/-) in access, ranging from 0.1% to 0.4%, reflect shifts in the distribution of enrolled populations and/or the geolocation of addresses in software tool.

- MCOs performance in access to general hospitals, PCPs, pharmacies, and most specialties in urban, rural, and frontier areas were met.
- Provider shortages have impacted geographic access; however, access has been maintained. MCOs closely monitor the following services and employ ongoing efforts to ensure member access such as targeted recruitments, referral training, provider enrollment training, telehealth options and value-based contract arrangements.
    - WSCC did not meet pharmacy standards for Frontier areas
    - BCBS did not meet standards for certified midwives in Rural areas.
    - For FQHC – PCP Only, PHP did not meet the standards for Rural or Frontier areas.
    - For dermatology, none of the MCOs met standards in Rural areas and only WSCC met standards in Frontier areas.
    - Only WSCC met standards for endocrinology in Rural and Frontier areas this quarter.
    - For Ear, Nose, and Throat (ENT), neither BCBS nor PHP met standards for Rural and Frontier areas.
    - Each MCO met standards for urology, except for BCBS in both Rural and Frontier areas.
    - All MCOs met standards for all geographic areas for neurology.
    - All MCOs met standards for rheumatology in Urban areas. Only PHP met standards for Rural areas, and none met standards for Frontier areas.

Table 24: Physical Health Geographical Access

Geo Access PH DY11 Q2 (April 2024 - June 2024 Data)									
	Urban			Rural			Frontier		
PH - Standard 1	**BCBS**	**PHP**	**WSCC**	**BCBS**	**PHP**	**WSCC**	**BCBS**	**PHP**	**WSCC**
PCP including Internal Medicine, General Practice, Family Practice	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	99.9%	100.0%
Pharmacies	100.0%	100.0%	98.8%	100.0%	100.0%	99.2%	100.0%	100.0%	77.9%
FQHC - PCP Only	100.0%	100.0%	100.0%	90.3%	79.3%	99.5%	97.0%	89.5%	99.0%
PH - Standard 2									
Cardiology	99.2%	98.9%	98.9%	99.8%	100.0%	100.0%	99.9%	99.9%	100.0%
Certified Nurse Practitioner	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Certified Midwives	99.2%	98.9%	98.9%	81.3%	93.6%	99.8%	99.6%	98.5%	99.8%
Dermatology	99.2%	98.8%	98.8%	79.9%	71.5%	89.5%	84.8%	87.6%	97.6%
Dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	99.1%	98.8%	98.8%	61.5%	65.2%	90.8%	84.0%	84.2%	92.2%
ENT	99.1%	98.8%	98.8%	83.8%	87.5%	100.0%	89.1%	85.2%	99.6%
FQHC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/ Oncology	99.20%	98.9%	98.8%	98.7%	98.7%	89.7%	97.3%	91.0%	99.9%
Neurology	99.20%	98.9%	98.9%	99.4%	96.7%	99.5%	98.6%	96.4%	93.5%
Neurosurgeons	99.10%	82.50%	98.80%	38.80%	66.80%	43.80%	67.60%	85.80%	83.50%
OB/Gyn	99.20%	98.8%	98.8%	99.7%	99.8%	100.0%	99.8%	99.8%	99.9%
Orthopedics	99.20%	98.8%	98.8%	95.2%	100.0%	100.0%	96.3%	98.3%	100.0%
Pediatrics	100.00%	98.9%	99.0%	100.0%	100.0%	99.9%	99.9%	98.5%	100.0%
Physician Assistant	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Podiatry	99.20%	98.8%	99.0%	99.8%	99.9%	99.8%	96.5%	100.0%	100.0%
Rheumatology	99.20%	98.8%	98.6%	86.8%	90.5%	74.9%	82.0%	88.5%	78.9%
Surgeons	99.30%	98.9%	99.0%	100.0%	100.0%	100.0%	99.9%	99.9%	99.9%
Urology	99.10%	98.7%	98.8%	78.4%	93.4%	91.2%	89.6%	93.3%	90.6%
LTC - Standard 2									
Personal Care Service Agencies	100.0%	100.0%	100.0%	100.00%	99.7%	99.7%	100.0%	100.0%	100.0%
Nursing Facilities	99.5%	93.0%	99.3%	99.8%	97.6%	99.7%	99.9%	99.9%	99.9%
General Hospitals	99.2%	98.9%	98.8%	99.7%	99.4%	99.6%	100.0%	99.9%	99.9%
Transportation	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: MCO Report #55 GeoAccess CY2024 Q2

Transportation
Non-emergency medical transportation is a means for MCOs to ensure members have timely access to medically necessary services particularly for specialty services in provider shortage areas.

The HCA is continuing to assess NEMT needs with the launch of Turquoise Care across all four MCOs and will respond to needs with initiatives in the months following the program launch.

Customer Service Reporting
With the inception of Turquoise Care, a call center metric, Percent of Calls Resolved in the First Call" was added for both the Member and Provider Services lines. Additionally, the Percent of Calls Answered by a Live Voice within 30 Seconds increased from 85% to 90%.

BCBS met all call center metrics for the reporting period, DY12 Q1.

PHP met all call center metrics for the reporting period, DY12 Q1.

MHC did not meet the call center metric for the Percent of Calls Answered by a Live Voice within 30 seconds, reporting 84.9% rather than the minimum of 90%. MHC met all other call center metrics for the reporting period, DY12 Q1.

UHC did not meet the call center metric for the percentage of calls answered within 30 seconds. UHC reported for the month of August 88.9% for the Nurse Advice Line. Subsequent months met standards. UHC reported for the month of September 87.4% for Provider Services. UHC met all other call center metrics for the reporting period, DY12 Q1.

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 7% threshold supersedes the 20% baseline target. The MCOs provide quarterly reports to HCA 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 7% threshold is not met. This is Molina Health Care (MHC) and United Health Care (UHC) baseline report

All three MCOs met the 7% of total membership with telemedicine visits for the Telemedicine Delivery System Improvement Performance Targets for DY12 Q1 with the exception of the MHC and UHC as this served as their baseline report.

Table 31: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Serviced with Telemedicine	DY10 Q4	DY11 Q1	DY11 Q2	DY12 Q1
New Behavioral Health Members	**7,846**	**37,578**	**10,664**	**11,937**
BCBSNM	3,395	15,909	4,671	5,111
PHP	3,531	17,794	4,785	5,102
WSCC	920	3,875	1,208	
MHC				1,021
UHC				703
New Physical Health Members	**12,377**	**25,893**	**15,553**	**14,579**
BCBSNM	3,793	7,690	3,835	3,756
PHP	7,346	16,026	10,511	9,932
WSCC	1,238	2,177	1,207	
MHC				542
UHC				349
Total New Unduplicated Members	**16,800**	**59,652**	**22,970**	**22,459**
BCBSNM	5,940	22,330	7,535	7,713
PHP	9,027	31,557	13,276	12,189
WSCC	1,833	5,765	2,159	
MHC				1,505
UHC				1,052
YTD* Unduplicated Members	**147,548**	**59,652**	**82,622**	**104,669**
BCBSNM	54,249	22,330	29,865	39,995
PHP	78,861	31,557	44,833	62,117
WSCC	14,438	5,765	7,924	
MHC				1,505
UHC				1,052

Source: Telemedicine Delivery System Improvement Performance Target (DSIPT) data is refreshed quarterly* July-October 2024.

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan	
DY12 Q1	The New Mexico Health Care Authority (HCA) and Health Services Advisory Group, Inc. (HSAG) worked together in DY12 Q1 (July 1, 2024, to September 30, 2024) to evaluate New Mexico's Section 1115 Demonstration Waiver, Centennial Care 2.0. In DY12 Q1, HSAG and HCA performed the following accomplishments: **Centennial Care 2.0** HSAG began preparing for the upcoming summative evaluation, which included developing the Summative Evaluation Report template. The template will provide an outline of each section of the Summative Evaluation Report with a brief description of the content of each section. HSAG began preparing the summative evaluation data request, including reviewing each evaluation measure to compile a complete list of the required data sources. The data request will encompass any data that HSAG does not receive in its regular quarterly extracts that are required to complete the summative evaluation. **Turquoise Care** In DY12 Q1, HCA received CMS approval of New Mexico's Turquoise Care 1115 Waiver and Special Terms and Conditions (STCS) on July 25, 2024. HCA completed the initial phase of the Request for Quotes (RFQ) process to secure an Independent Evaluator for the Turquoise Care Evaluation Design Plan. As of September 12, 2024, HCA is still in the process of obtaining the necessary approvals to move forward with contract execution. The next phase of the Evaluation Design Plan will include the development of driver models, hypotheses and research questions that align with section 15.6 of the Turquoise Care Special Terms and Conditions (STCs).

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ENCLOSURES/ATTACHMENTS

Attachment A: April 1, 2022 – March 31, 2024, Statewide Dashboards
Attachment B: Budget Neutrality Monitoring Spreadsheet
Attachment C: Utilization Statistics – July 2022 – June 2024
Attachment D: Call Center Stats July – September 2024

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ADDITIONAL COMMENTS

MCO INITIATIVES

BCBS:

BCBSNM contracted with eight provider groups for maternity delegation of care coordination, offering care coordination services to all pregnant and post-partum members during DY12 Q1. Provider groups include OB/GYNs, community-based organizations, and existing delegated care coordination providers expanding services to include the maternity population. BCBSNM provides the maternity groups with a list of members eligible for prenatal or post-partum care. The provider groups agreed to outreach to these members to offer care coordination services and are eligible for services throughout their pregnancy and 12-months post-partum. This initiative helps support improved maternal health outcomes for BCBS members.

PHP:

Interactive Support Programs

PHP continued to support Turquoise Care Members with identified risks for developing type 2 diabetes through the Diabetes Prevention Program (DPP). PHP also supported at-risk populations through a Healthy Weight (HW) program, which addresses the importance of maintaining a healthy weight and healthy lifestyle modifications. Both programs offer Members continued access to registered dieticians and health coaches. In DY12 Q1, associated program activities included, but were not limited to:

- Continued a Member and Provider communication campaign to promote health and wellness programs; as well as information about how Members can participate.
- Reviewed and updated a comprehensive multimodal communication and outreach plan.
- Updated Member and Provider outreach materials to promote program awareness and uptake.
- Provided an overview of Population Health tools and resources via webinar, including DPP and Healthy Weight programs to PHP's Provider education Conference.

MHC:

Molina partnered with a vendor to provide telehealth services for Perinatal and Postpartum telehealth. This vendor also offers behavioral health support, lactation support, and social work services to address Social Determinants of Health (SDOH) needs.

Additionally, the vendor conducts prenatal and postpartum screenings and is actively working on launching Medication-Assisted Treatment (MAT) to support members with Substance Use Disorder (SUD). The vendor's team includes midwives, nurse practitioners, doctors, and remote fetal specialists to ensure comprehensive maternal and prenatal care. Interprofessional consults and preconception care.

In crisis situations, the vendor facilitates a warm handoff to 988 for immediate support.

UHC:

Transforming Member Support with Social Determinants of Health (SDoH) Community Connector Enhancements

Community Connector (FindHelp) introduced two key enhancements to improve member support and resource discovery. First, benefit check integration allows advocates to confirm member benefits and provide appropriate SDoH referrals. Second, Community Connector's AI-Powered Search enables members to easily find resources for their social determinants of health (SDOH) needs.

Previously, navigating through various categories was challenging, especially with typing errors. This enhancement ensures members quickly find the support they need, improving overall satisfaction and reducing reliance on customer service calls.

MEMBER SUCCESS STORIES

BCBS:

A Blue Cross Blue Shield (BCBS) member living in a rural New Mexican area was in need of an additional caregiver due to an increase in physical and behavioral health needs, The Member worked with BCBS to coordinate additional support. The Member now has an additional caregiver assigned to her and reports decreased anxiety and an improved sense of well-being. Additionally, the member reports that they have been able to keep and track appointments consistently.

PHP:

A Presbyterian Health Plan (PHP) member was assigned to a community Care Coordinator after receiving full Medicaid. Member's health issues are significant, including

bladder cancer and dementia. Member and his family were excited when he became eligible for community benefits and requested PCS. However, Member resides in a rural community and there are challenges identifying an agency with available caregivers. Member did not have a caregiver to provide services. The Care Coordinator made outreach to all agencies who service the area, in efforts to assist Member in identifying an agency with available caregivers. An agency was not identified, and the Care Coordinator had to deliver the news to Member. Member and family were concerned due to plans to go out of town for a required work trip, thereby leaving Member without supports to manage his Activities of Daily Living. The Care Coordinator reached out to another agency as part of her ongoing attempts to assist Member in meeting his needs. The last agency stated they had one caregiver who was available in the Member's home area. Member's family expressed their gratitude to the Care Coordinator in a letter submitted to Presbyterian Health Plan. Member's family thanked the Care Coordinator for her work and diligence and stated when faced with the challenge and their despair, "(Care Coordinator) did not turn away; rather she doubled down and literally saved the situation." With the help of PHP's Leadership and Utilization Management team, the request was sent for urgent review and this Member's needs will now be met in time for the natural supports to go on their trip.

MHC:

Molina Health Care successfully and consistently provided support to a member with a range of complex health needs that require consistent and ongoing support. To support necessary out-of-state visits for specialized care and treatments, the Molina team has provided assistance in coordinating visits, including securing reliable transportation, ensuring access to suitable lodging, and managing meal reimbursements during travel.

In addition to travel-related needs, the member follows a medical diet, which requires careful management of food choices and preparation. As part of their travel arrangements, the member requires financial assistance for grocery reimbursements to ensure the member can maintain the diet. The Molina team has successfully coordinated and ensured both dietary and ADA needs during travel allowing the member to focus on their health care needs without any additional travel and coordination strains.

UHC:

In July 2024, a member was referred to the United Health Care (UHC) housing navigator for a community transition from long-term nursing facility care to their own apartment. She found an affordable apartment and negotiated the deposit, and first month's rent based on a pro-rated move-in date. However, she lacked the $250 payment to secure the

apartment. The UHC Social Determinants of Health Flex Fund was used to secure the unit. The member then used the Community Transition Services benefit to purchase furniture and other household goods. Once she transitioned back into the community, she contacted the Social Security Office to secure social security to continue paying her rent. UHC Care coordination continues to support this member.

PHE Unwinding Outreach Actions

Unwinding activities have concluded. Outreach Actions will no longer be reported.