



CENTENNIAL CARE 2.0 DEMONSTRATION

1115 Demonstration Quarterly Report
Demonstration Year: 9 (1/1/2022 – 12/31/2022)
Annual Report 2022

March 31, 2023

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INTRODUCTION

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

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

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

- Improving continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, increasing utilization of preventive services, and promoting administrative simplification and fiscal sustainability of the Medicaid program;
- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Continuing the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative;

- Building upon policies that seek to enhance members’ ability to become more active and involved participants in their own health care; and
- Further simplifying administrative complexities and implementing refinements in program and benefit design.

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

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

Status of Key Dates:

TOPIC	KEY DATE	STATUS
Quality Strategy	Final Quality Strategy posted to HSD website on September 1, 2022.	Final copy submitted to CMS on October 26, 2022.
Substance Use Disorder (SUD) Implementation Plan	Approved by CMS on May 21, 2019.	Approved by CMS on May 21, 2019.
Evaluation Design Plan	Submitted to CMS on June 27, 2019.	Approved by CMS on April 3, 2020.
SUD Monitoring Protocol	Submitted to CMS on July 31, 2019.	Approved by CMS on July 21, 2020.
1115 Demonstration Amendment #2	Submitted to CMS on March 1, 2021.	CMS Completeness Letter Received on March 25, 2021. Under CMS review.
1115 Demonstration Amendment #2 Letter Amendment	Submitted to CMS on December 30, 2021.	Under CMS review.
New Mexico Turquoise Care 1115 Waiver Renewal Application	Submitted to CMS on December 15, 2022.	CMS Completeness Letter received on December 29, 2022. Federal Comment Period occurred December 29, 2022 through January 28, 2023. Under CMS review.

ITEMS UNDER CMS REVIEW

Centennial Care 2.0 1115 Waiver Amendment #2 Requests

New Mexico continues its collaboration with CMS to obtain federal authority to implement the following changes under the Centennial Care 2.0 waiver:

- Seek a waiver of the Institution for Mental Disease (IMD) exclusion for all Medicaid beneficiaries, specifically those with Serious Mental Illness (SMI)/Serious Emotional Disorder (SED), to maintain and enhance beneficiary access to behavioral health services in appropriate settings and ensure that individuals receive care in the facility most appropriate for their needs.
- Establish a High-Fidelity Wraparound (HFW) as an intensive care coordination approach for children and youth who have high intensity needs.
- Create Graduate Medical Education (GME) expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.
- Expansion of Community Benefit Waiver Slots by 1,000 to enable more elderly and disabled New Mexicans to receive Community Benefits.
- Increase Transitional Service Limits from \$3,500 to \$4,000, per person, every 5 years to support members returning to the community from an institutional living arrangement and to improve system rebalancing efforts.
- Increase Environmental Modification Service Limits from \$5,000 to \$6,000, per person, every 5 years to promote aging-in-place for those who are at risk of institutionalization and help offset cost increases of construction resulting from the public health emergency.

New Mexico Turquoise Care 1115 Waiver Renewal

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

As New Mexico prepared its waiver renewal application, it held several stakeholder engagements to obtain valuable input on the current Centennial Care 2.0 Medicaid program

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

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

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

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

MISSION



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

GOALS



**We help
NEW MEXICANS**

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



**We communicate
EFFECTIVELY**

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



**We make access
EASIER**

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



**We support
EACH OTHER**

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

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

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

Turquoise Care has targeted initiatives focused on the following populations:

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

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

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

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

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

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

The Medicaid 1115 demonstration waiver in New Mexico is one key component of the overall vision for a person-centered Medicaid delivery system that strives to improve population health. New Mexico will utilize multiple authorities and modify Managed Care Organization (MCO) responsibilities through the MCO contracts to strengthen existing

successful programs while adding new initiatives that align with the State's goals for Turquoise Care. Additionally, as the state finalized its renewal application, several groundbreaking approvals in other states, notably Massachusetts, Oregon, Arkansas, and Arizona, were released. These approvals detail significant investments in health-related social needs and workforce solutions through financing mechanisms that would support the vision and goals of Turquoise Care. As CMS reviews New Mexico's Waiver Renewal Application, the State is working to develop additional proposals to leverage the new policies announced through these approvals and will submit either an Addendum or Amendment under the Turquoise Care Waiver Renewal to CMS in the near future.

CENTENNIAL CARE 2.0 POST AWARD FORUMS

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

During the November 21, 2022 MAC meeting the following topics were addressed in support of the Centennial Care 2.0 waiver and Medicaid 1115 demonstration waiver renewal:

- Public Health Emergency (PHE), which included updates on the following: PHE declaration; Medicaid's unwinding plan; anticipated disenrollment; CMS reporting requirements; communication plan, campaign, and tools; postcards, social media, and renewal forms; technical solutions and enhancements; staffing solutions in collaboration with our Income Support Division; and collaboration with BeWellNM (New Mexico's Health Insurance Exchange).
- Budget & Enrollment Projection Assumptions, which also addressed New Mexico's 12-month unwinding period.
- Medicaid Dashboards, which included a utilization and cost overview for the current 12-month timeframe of July 1, 2021 to June 30, 2022 and previous 12-month timeframe of July 1, 2020 to June 30, 2021.
- Provider Rate Review Phase II, which included updates on the following: comprehensive review across all non-pharmacy Medicaid services; benchmark analysis; stakeholder feedback; recommendations and operational strategy; rate recommendation; and report overview.
- Medicaid 1115 Demonstration Waiver Renewal and Managed Care Organization (MCO) Procurement, which included updates on the following: timeline and activities; and overview of detailed timeline for MCO procurement post award.
- Payment Error Rate Measurement (PERM) Audit, which provided an overview of the audit and improper payment rate estimates for Medicaid and CHIP.
- Legislative Session dates and MAC scheduling.

- Medicaid Management Information System Replacement (MMISR), which included updates on the timeline, module components, and statuses.

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

- April 15, 2019
- December 16, 2019
- January 27, 2020
- April 27, 2020
- August 3, 2020
- November 2, 2020
- January 19, 2021
- May 10, 2021
- August 9, 2021
- November 8, 2021
- January 24, 2022
- May 16, 2022
- August 8, 2022
- November 21, 2022

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

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ENROLLMENT AND BENEFITS INFORMATION

Table 1: QUARTER 4 MCO MONTHLY ENROLLMENT CHANGES

MANAGED CARE ORGANIZATION	9/30/2022 ENROLLMENT	12/31/2022 ENROLLMENT	PERCENT INCREASE / DECREASE Q4
BlueCross BlueShield of New Mexico (BCBS)	297,063	297,426	0.1%
Presbyterian Health Plan (PHP)	426,837	426,906	0.0%
Western Sky Community Care (WSCC)	89,095	91,466	2.7%

Source: Medicaid Eligibility Reports, September 2022 – December 2022

CENTENNIAL CARE 2.0 MANAGED CARE ENROLLMENT

Centennial Care 2.0 MCO enrollment and expenditure data by programs for October 2020 - September 2022 is available in Attachment A to this report.

MCO Enrollment

In aggregate, MCO enrollment increased by 5% from the previous to current period. This increase is comprised of the following:

- 7% increase in Physical Health enrollment.
- 2% increase in Long-Term Services and Supports enrollment.
- 2% increase in Other Adult Group enrollment.

Physical Health and Other Adult Group enrollment experienced continued growth due to the Maintenance of Effort (MOE) requirements during the Public Health Emergency (PHE). Enrollment numbers are expected to decline once the PHE ends. Enrollment graphs in Attachment A illustrate a decrease for the most recent month, which is mostly due to retroactivity not yet accounted for at the cutoff date of the enrollment data (i.e., September 30, 2022). Historically, this decrease in the last month changes to an increase in subsequent quarter due to additional runoff.

MCO Per Capita Medical Costs:

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

increase to pharmacy services. On a dollar basis, higher enrollment levels and the increase in per capita medical costs are driving the 9% year over year increase in total medical expenses.

CENTENNIAL CARE TO CENTENNIAL CARE 2.0

Molina Healthcare Plan Termination

Molina Healthcare (MHC) was required to comply with all duties and obligations incurred prior to the contract termination date of December 31, 2018, as well as continuing obligations following termination. During DY8, MHC provided monthly updates on the progress of its termination plan. HSD identified that MHC had \$1,926,347.83 in financial obligations. In DY8 Q4, MHC was notified of the payable amount due, and provided payment in the amount of \$1,926,347.00, which was accepted by the state. On August 15, 2022, HSD notified MHC by letter that it had fulfilled all its continuing obligations under the contract. MHC acknowledged receipt of the letter and had no questions. HSD considers this matter closed and will remove references to the MHC termination from future quarterly submissions.

CENTENNIAL REWARDS

The Centennial Rewards program provides incentives to members for engaging in and completing healthy activities and behaviors. Beginning in DY9, New Mexico modified its 2022 Rewards Program as illustrated below.

Reward Activity	Age Requirement	2022 Modification
Adult Primary Care Provider (PCP) Checkup – Complete annual PCP wellness checkup	Ages 22+	Age requirement changed from Ages 19+ to 22+
Asthma Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 5-17	Reward activity eliminated
Bipolar Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 18-64	Reward activity eliminated
COVID-19 Vaccine or Booster – Complete COVID-19 vaccine or booster	All ages, as advised by CDC	Added booster
Dental Checkup (Adult) – Complete annual dental checkup	Ages 18+	Reward activity eliminated
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20	Age requirement changed from 2-17 to 2-20

Diabetes HbA1C Test – Completion of HbA1C Test <ul style="list-style-type: none"> Bonus: Diabetes HbA1C Control – Attain HbA1c control (<8%) 	Ages 10-75	Added new bonus reward activity
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75	No change
Diabetes Nephropathy Exam – Completion of diabetic nephropathy exam	Ages 10-75	Reward activity eliminated
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
Schizophrenia Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	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 <ul style="list-style-type: none"> Bonus: Complete all eight well-child visits with a PCP between 0-30 months of life 	0-30 months	Combined Well-Baby Checkup activities and added new bonus reward activity
3-week Step-Up Challenge – Successfully complete 3-week Step-Up Challenge	Ages 10+	Reward activity eliminated
9-week Step-Up Challenge – Successfully complete 9-week Step-Up Challenge	Ages 10+	Reward activity eliminated
Antidepressant Medication Management - Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+	Added new reward activity
Child & Adolescent Well-Care Visit - Complete annual wellness checkup with a PCP or an OB/GYN <ul style="list-style-type: none"> Bonus: Adolescent Immunization Series – Complete adolescent immunization series by 13th birthday 	Ages 3-21	Added new reward activity
Follow-up After Emergency Dept. Visit for Mental Illness – Complete follow-up visit within 30 days of emergency department visit for mental illness or intentional self-harm diagnoses	Ages 6+	Added new reward activity
Follow-up After Hospitalization for Mental Illness - Complete follow-up visit within 30 days of hospitalization for mental illness or intentional self-harm diagnoses	Ages 6+	Added new reward activity

Centennial Rewards Participation

As of DY9 Q4 there are 825,601 Centennial Care members eligible and participating in the Centennial Rewards Program. Registering for the Centennial Rewards program is not

required to participate in the program, but is required for reward redemption. Quality improvement and participation trends are demonstrated in the table below.

Table 2: Centennial Rewards

CENTENNIAL REWARDS				
	January - March 2022	April - June 2022	July - September 2022	October - December 2022
Number of Medicaid Enrollees Receiving a Centennial Care Rewardable Service this Quarter*	161,053	186,917	159,246	120,552
Number of Members Newly Registered in the Rewards Program this Quarter	3,793	3,954	5,416	6,609
Number of Members Who Redeemed Rewards this Quarter**	22,540	27,751	30,754	49,202

*Only includes rewards earned THIS quarter.

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

Source: Finity Quarter 4 Report

Following is a summary of DY9 observations:

- Percentage of Medicaid Enrollees Participating in the Rewards Program this Quarter
 - Member participation has increased quarter over quarter throughout the life of the rewards program, reaching an all-time high in Q4 2022 of 75.2%.
- Number of Medicaid Enrollees Receiving a Centennial Care Reward Service this Quarter
 - The number of enrollees receiving a Centennial Care Reward Service in Q4 2022 was lowest compared to the previous quarters this year as gaps-in-care are lowest towards year-end. This trend is in line with previous years.
- Number of Members Newly Registered in the Rewards Program this Quarter
 - Newly registered members reached a high this quarter compared to previous quarters this year as members are required to register to redeem rewards and reward redemptions are always highest in Q4 2022. This is primarily a result of holiday shopping, and this trend is consistent with previous years.
- Number of Members Who Redeemed Rewards this Quarter
 - Q4 2022 always reflects the highest redemptions of the year and Q4 2022 is no exception. Of total dollars redeemed in 2022, almost 41% were from Q4 2022 redemptions. This is primarily a result of members saving up their reward points to spend on holiday shopping. Members are also sent point expiration communications in Q4 2022 to remind them that they need to redeem their points before they expire.

Centennial Care Rewards Multimedia Campaigns

In DY9 Q4, Finity conducted the below multimedia campaigns to support members. With the exception of the Child Dental Campaign and COVID Immunization Campaign, all campaigns previously reported were conducted in DY9 Q4. HSD also initiated 2 new campaigns in DY9 Q4 for point expiration and women's cancer screening.

Adolescent Immunization Campaign: Designed to encourage members ages 9 to 18 to complete their Adolescent Immunization vaccine series. Currently there isn't a reward associated with this campaign. Texts and emails were sent in November 2022.

- 24K texts sent in Q4 2022
- 24K emails sent in Q4 2022

Monthly Redemptions Campaign: Designed to notify members who have earned rewards that they have points to spend in the Centennial Rewards Catalog on essential items like oximeters, thermometers, cleaning supplies, Personal Protective Equipment (PPE), diapers, nursing supplies, toilet paper, and more. Texts and emails were sent October through December 2022. This is an ongoing campaign and Q4 2022 results are provided below:

- 207K texts sent in Q4 2022
- 157K emails sent in Q4 2022

Native American Program Engagement Campaign: Designed to encourage Native American members to self-attest to reward activities they've completed by either going on the Centennial Rewards Portal or calling the call center. Texts and emails were sent in December 2022.

- 14K texts sent in Q4 2022
- 7K emails sent in Q4 2022

Points Expiration Campaign: Designed to notify members who have earned rewards to spend their points before they expire. Texts and emails were sent October through December 2022. This is an annual Q4 campaign and results are provided below:

- 150K texts sent in Q4 2022

Well-Baby Immunization Campaign: Designed to encourage parents/guardians to complete immunizations for their babies ages 0-30 months. Campaign texts and emails were sent in October 2022. This is an ongoing campaign and DY9 Q4 results are provided below:

- 23K texts sent in Q4 2022
- 5K emails sent in Q4 2022

Women's Cancer Screening Campaign: Designed to encourage eligible members to complete breast and cervical cancer screenings. There were no rewards associated with these activities in 2022. Rewards have been added in 2023. Campaign tests and emails were sent in November 2022. This is an ongoing campaign and DY9 Q4 results are provided below:

- 123K texts sent in Q4 2022
- 81K emails sent in Q4 2022

Additional Key Statistics through DY9 Q4 2022:

- Member participation in Q4 2022 reached an all-time high of over 75.2%.
- In Q4 2022, members earned \$2.5M in rewards by completing healthy activities.
- In Q4 2022, members redeemed \$1.8M in rewards.
- 39% of total dollars redeemed in Q4 2022 can be attributed to December and holiday shopping.
- Of total dollars redeemed in 2022, almost 41% were from Q4 2022 redemptions.

Enhanced Customer Satisfaction Survey: Finity enhanced the Centennial Rewards member satisfaction survey in 2021 by adding new questions that were approved by HSD. For DY9, HSD has observed that the number of surveys completed have steadily increased in line with the increases in program participation. As survey responses have grown, member satisfaction for the rewards program has remained relatively steady quarter after quarter. All responses are consistently in the high eighties to high nineties. Members have been highly satisfied with the program since its inception. The results of the DY9 Q4 2022 survey are listed below.

Table 3: Centennial Rewards Customer Satisfaction Survey

Centennial Rewards Customer Satisfaction Survey												
	DY9 Q1			DY9 Q2			DY9 Q3			DY9 Q4		
	# OF RESPONDENTS 1,713			# OF RESPONDENTS 2,577			# OF RESPONDENTS 3,340			# OF RESPONDENTS 3,961		
	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER	YES	NO	OTHER
Are you satisfied with Centennial Care?	97%	3%	n/a	97%	3%	n/a	98%	2%	n/a	97%	3%	n/a
Are you satisfied with your doctor?	86%	3%	9% I don't have a doctor	88%	5%	7% I don't have a doctor	89%	4%	7% I don't have a doctor	88%	4%	8% I don't have a doctor
Are you satisfied with your health plan?	96%	4%	n/a	96%	4%	n/a	96%	4%	n/a	96%	4%	n/a
Are you satisfied with the help provided by your care coordinator?	97%	3%	n/a	97%	3%	n/a	85%	7%	9% I don't have a care coordinator	90%	8%	2% I don't have a care coordinator

Source: Finity Quarter 4 Report

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ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

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

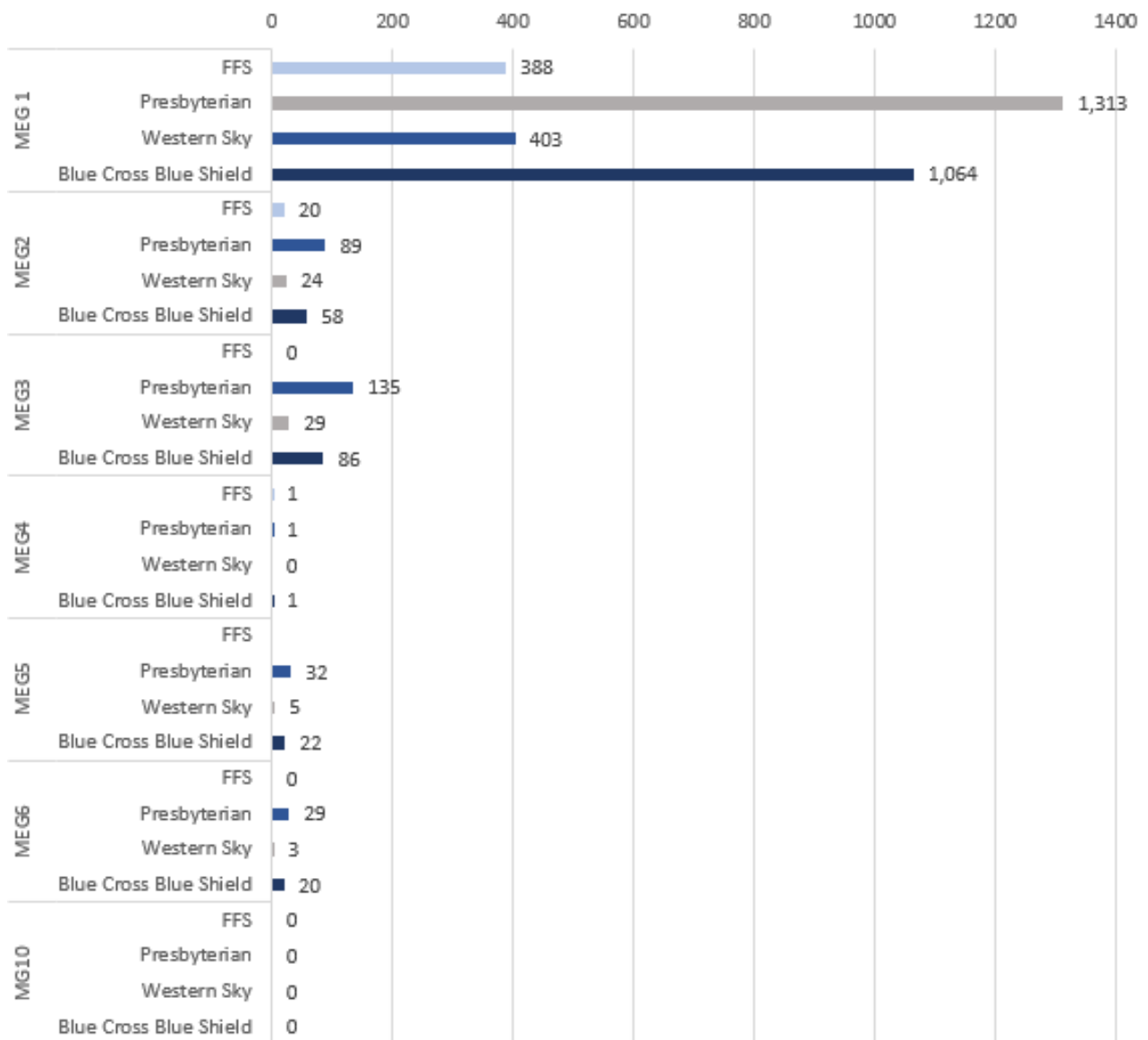
The enrollment counts are unique enrollee counts, not member months. Please note that these numbers reflect current enrollment and disenrollment in each Medicaid Eligibility Group (MEG). If members switched MEGs during the quarter, they were counted in the MEG that they were enrolled in at the end of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

The disenrollment for this quarter is attributed to incarceration, death, and members moving out of state.

Due to Public Health Emergency (PHE) regarding Coronavirus (COVID-19), HSD meets the Maintenance of Effort (MOE) statutory requirements to receive the 6.2% increased Federal Medical Assistance Percentage (FMAP) by ensuring individuals are not terminated from Medicaid if they were enrolled in the program as of March 18, 2020, or become enrolled during the emergency period, unless the individual voluntarily terminates eligibility.

Demonstration Population		Total Number Demonstration Participants DY9 Q4 Ending December 2022	Current Enrollees (Rolling 12-month Period)	Total Disenrollments During DY9 Q4
Population MEG1 - TANF and Related	0-FFS	36,527	37,886	388
	Presbyterian	227,608	223,163	1,313
	Western Sky	44,074	43,970	403
	Blue Cross Blue Shield	150,126	147,891	1,064
	Summary	458,335	452,910	3,168
Population MEG2 - SSI and Related - Medicaid Only	0-FFS	2,581	2,485	20
	Presbyterian	20,864	20,807	89
	Western Sky	3,915	3,905	24
	Blue Cross Blue Shield	12,630	12,509	58
	Summary	39,990	39,706	191
Population MEG3 - SSI and Related - Dual	0-FFS	0	0	0
	Presbyterian	22,627	23,880	135
	Western Sky	3,639	3,838	29
	Blue Cross Blue Shield	11,460	12,188	86
	Summary	37,726	39,906	250
Population MEG4 - 217- like Group - Medicaid Only	0-FFS	213	173	1
	Presbyterian	98	108	1
	Western Sky	14	17	0
	Blue Cross Blue Shield	76	81	1
	Summary	401	379	3
Population MEG5 - 217- like Group - Dual	0-FFS	0	0	0
	Presbyterian	3,043	3,346	29
	Western Sky	504	555	3
	Blue Cross Blue Shield	2,360	2,573	20
	Summary	5,907	6,474	52
Population MEG6 - VIII Group (expansion)	0-FFS	27,714	38,829	401
	Presbyterian	130,144	140,209	1,028
	Western Sky	34,779	37,436	381
	Blue Cross Blue Shield	105,061	113,170	941
	Summary	297,698	329,644	2,751
Population MG10 - IMDSUD Group	0-FFS	8	51	0
	Presbyterian	98	549	0
	Western Sky	18	81	0
	Blue Cross Blue Shield	73	319	0
	Summary	197	1,000	0
Population MGX8 - IMDSUD VIII Group	0-FFS	0	0	0
	Presbyterian	204	1,057	0
	Western Sky	52	253	0
	Blue Cross Blue Shield	172	890	0
	Summary	428	2,200	0
Summary		840,682	872,219	6,415

Total Disenrollments During DY9 Q4



Source: Enrollee Counts Report

4

OUTREACH/ INNOVATIVE ACTIVITIES TO ASSURE ACCESS

Outreach and Training	
DY9 Q4	<p>In DY9 Q4, HSD staff participated in the remaining statewide town hall events known as “Cabinet in Your Community.” The purpose of these events is to meet with constituents and community leaders to resolve issues and provide on-site assistance and support from HSD staff, Cabinet Secretary, and/or Deputy Secretary.</p> <p>HSD provided coaching, outreach and educational activities through webinars to Presumptive Eligibility Determiners (PEDs) in the Presumptive Eligibility and JUST Health Programs to help them better assist their clients in the completion of Medicaid eligibility applications, both on-line and telephonically. HSD also provided on-line certification and refresher training sessions for prospective and current PEDs.</p> <p>HSD is participating in the New Mexico Health Marketing Coalition Committee, now bi-weekly and led by the NM Department of Tourism (NMDT), to promote outreach for new COVID-19 Vaccine and Booster Campaigns developed by the NMDT and their contractor. The campaigns are designed to encourage New Mexicans to get the COVID-19 vaccine immunization series. The New Mexico Department of Health (DOH), HSD’s Managed Care Organizations, and other healthcare stakeholders comprise this coalition.</p> <p>Additionally, HSD staff are participating in an HSD COVID-19 Vaccination Workgroup and a DOH COVID Provider Update Workgroup. The purpose of these meetings is to communicate and discuss COVID-19 vaccine efforts, upcoming statewide events, review federal guidelines, and outline operational procedures during the PHE.</p>

5

COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

The MCOs submit encounters daily and/or weekly to stay current with encounter submissions, including encounters that are or not accepted by HSD. HSD meets regularly with the MCOs to address specific issues and to provide guidance. HSD regularly monitors encounters by comparing encounter submissions to financial reports to ensure completeness. HSD monitors encounters by extracting data monthly to identify the accuracy of encounter submissions and shares this information with MCOs. HSD extracts encounter data on a quarterly basis to validate and enforce compliance with accuracy. Based on the most recent quarterly data extracted, the MCOs are compliant with encounter submissions.

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

6

OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT/ISSUES

FISCAL ISSUES

The capitation payments through DY9 Q4 reflect the Centennial Care 2.0 rates effective on January 1, 2022 and rate updates effective July 1, 2022. The rates are developed with efficiency, utilization, trends, prospective program changes, and other factors as described in the rate certification reports. The rate updates for July 1, 2022 through December 31, 2022 reflected the post-partum extension, earned sick leave, gross receipts tax, temporary economy recovery payment under Section 9817 of the America Rescue Plan Act of 2021, directed payment for early and periodic screening, diagnostic, and treatment rate increase, revised market basket index to the nursing facility health care quality surcharge, and revised New Mexico Medical Insurance Pool cost. The rate certification reports for January 1, 2022 through December 31, 2022 were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 31, 2021; the rate updates were submitted on June 30, 2022.

During DY9 Q4, financial payments were made for the University of New Mexico Medical Group (UNMMG) directed payment, University of New Mexico Hospital (UNMH) directed payment and payment for quality, hospital access payment (HAP), COVID-19 vaccine non-risk payment, interim medical credit reconciliation, retroactive reconciliation, hepatitis C reconciliation, and Indian Health Service (IHS) reconciliation. The UNMMG directed payments, UNMH directed payment, HAP and IHS reconciliation partially contributed to the Per Member Per Month (PMPM) increase for MEG 1 of DY 9.

The payments related to the public health emergency due to the Coronavirus (COVID-19) pandemic was \$27.1 million during CY 2022. In addition, expenditures and member months for substance use disorder in an institution for mental diseases (SUD IMD) were reported for DY6 to DY9 for both fee-for-service and managed care.

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

On January 31, 2020 the Health and Human Services Secretary, Alex M. Azar II, declared a public health emergency for the United States to aid the nation's healthcare community in responding to the 2019 novel coronavirus also known as COVID-19. This declaration is retroactive to January 27, 2020. To help meet the needs of the nation during the ongoing

COVID-19 pandemic, U.S. Health and Human Services (HHS) Secretary Xavier Becerra renewed the COVID-19 PHE declaration for COVID-19 on February 9, 2023 and the Biden administration announced their intent to end the COVID-19 PHE effective May 11, 2023, providing states and territories with 60 days' advance notice of the PHE termination. Historically the Maintenance of Effort (MOE) for Medicaid enrollment has been tied to the PHE declaration; however, with the passing of the Consolidation Appropriations Act of 2023 in December 2022, the MOE and the PHE have been decoupled, and both have different end dates. The PHE will end on May 11, 2023 and the MOE continuous eligibility will end March 31, 2023. New Mexico will begin its unwinding activities in March 2023 and are projecting terminations to begin May 1, 2023. CMS has provided states with three different options to begin unwinding activities, and New Mexico has elected to begin activities in March 2023. New Mexico will use all 12 months of the unwinding period and will prioritize members that are expected to be financially ineligible based on existing system data and analyses. We are expecting 87,836 members to be ineligible for Medicaid. On February 15, 2023, New Mexico submitted its State Renewal Distribution Report (baseline report) and PHE Unwinding Configuration and Testing Plan to CMS. During New Mexico's 12-month unwinding period, it will submit a monthly report to CMS by the 8th of each month.

Following is a chronology of the renewals to date:

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

Separately, on May 9, 2022, HHS Secretary, Xavier Becerra, declared a public health emergency for the State of New Mexico to aid the State in regions impacted by wildfires and straight-line winds. Effective July 4, 2022, the declaration was renewed as a result of the continued consequences of wildfires and straight-line winds on the State of New Mexico, which had existed since April 5, 2022. Thereafter, no further renewals were required. New Mexico Medicaid did not request any CMS flexibilities, including waiver authorities as a result of this PHE declaration as business operations and service delivery were not impacted.

Renewing PHE declarations ensure health care providers and state and territorial health departments have continued flexibility to respond to the pandemic, helping save lives. These flexibilities support efforts such as rapid patient care during emergencies, including waivers from CMS for certain requirements under [section 1135](#) of the Social Security Act. Examples

of such requirements include pre-approval requirements and [temporarily reassignment](#) of state, territorial, tribal or local staff who are typically funded by federal grants in order to respond to the emergency. In response to the COVID-19 PHE, HSD requested and received approval for several federal waiver authorities as indicated below.

New Mexico Disaster Relief State Plan Amendments (SPAs)

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

- Expanding the list of qualified entities allowed to do Presumptive Eligibility.
- Increasing Diagnosis-related Group (DRG) rates for ICU inpatient hospital stays by 50% and all other inpatient hospital stays by 12.4% from April 1, 2020 – September 30, 2020.
- Establishing Category of Eligibility (COE) for the COVID-19 Testing Group for the uninsured population.
- Providing Targeted Access UPL Supplemental Payments.
- Applying a Nursing Facility Rate Increase when treating fee for service COVID-19 members from April 1, 2020 – June 30, 2020.
- Increasing reimbursement for hospital stay services from April 1, 2020 – June 30, 2020.
- Increasing reimbursement to non-hospital providers for E&M codes and non-E&M codes, as well as an increase to Medicaid only procedure codes from April 1, 2020 – June 30, 2020.
- Increasing rates for services provided under the Family Infant Toddler (FIT) Program for July 1, 2020 through July 31, 2020.
- Providing Targeted Access supplemental payments for Safety-Net Care Pool (SNCP) hospitals from April 1, 2020 through December 31, 2020.
- Implementing coverage and reimbursement for COVID-19 vaccine and vaccine administration in accordance with Medicare's billing and reimbursement guidance.
- Providing reimbursement for administration of COVID-19 vaccines to homebound eligible Medicaid beneficiaries from March 15, 2021 through the end of the PHE.
- Applying a rate increase to non-emergency transportation providers from January 1, 2022 through June 30, 2022 or the end of the PHE, whichever comes first.
- Applying a nursing facility rate increase for COVID-19 members from January 1, 2022 through June 30, 2022 or the end of the PHE, whichever comes first.
- Applying rate increases for ICU inpatient hospital services and for all other inpatient hospital services from January 1, 2022 through June 30, 2022 or the end of the PHE, whichever comes first.
- Implementing targeted access supplemental payments for Safety-Net Care Pool (SNCP) hospitals from January 1, 2021 through the end of the PHE.

- Implementing a temporary 15% reimbursement increase in accordance with Section 9817 of the American Rescue Plan (ARP) Act of 2021 and New Mexico’s approved Spend Plan for providers of Personal Care Services (PCS) and Private Duty Nursing (PDN) under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit from May 1, 2021 to June 30, 2022, or the end of the PHE, whichever comes first.
- Allowing hospital providers to bill and be paid for pasteurized donor human milk (PDHM) services separate from the Diagnosis-related group (DRG) and in addition to the inpatient hospital stay for infants through New Mexico Medicaid enrolled medical supply companies effective July 1, 2022.
- Implementing a rate increase for providers of Personal Care Services (PCS) and Private Duty Nursing (PDN) services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Effective July 1, 2022 through the end of the PHE, reimbursement for providers of PCS and PDN services under EPSDT will be set at the same rates as 1915(c) provider rates.

1135 Waiver

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

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

Appendix Ks

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

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

- Exceeding service limitations (i.e., allowing additional funds to purchase electronic devices for members, exceeding provider limits in a controlled community residence and suspending prior authorization requirements for waiver services, which are related to or resulting from this emergency).

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

1115 Demonstration Waiver for Home Community Benefit Services (HCBS)

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

1915c (Supports Waiver and Developmental Disabilities Waiver)

- Modifying provider qualifications to suspend fingerprint checks or modify training requirements.
- Modifying processes for level of care evaluations or re-evaluations.
- Temporarily modifying incident report requirements for deviations in staffing.

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

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

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

New Mexico is collaborating with CMS to end specific flexibility initiatives effective March 31, 2023 that were previously approved through Appendix K amendments in order to return to normal operations as approved in the base waivers.

PATIENT CENTERED MEDICAL HOMES (PCMH)

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

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

Table 4 below reports the total number of members paneled to a PCMH per MCO. DY9 Q3 reflects an overall aggregate increase in members receiving care through a PCMH compared to DY9 Q2. The DY9 Q4 data will be reported in the DY10 Q1 CMS Quarterly Monitoring Report.

Table 4: PCMH Assignment

PCMH ASSIGNMENT				
Total Members Paneled to a PCMH				
	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
BCBS	138,596	137,858	135,065	156,969
PHP	269,646	273,786	277,943	272,903
WSCC	38,421	38,772	37,344	36,433
Percent of Members Paneled to a PCMH				
	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
BCBS	47.20%	46.30%	45.30%	51.90%
PHP	63.90%	64.70%	65.30%	63.90%
WSCC	44.50%	44.40%	42.30%	40.20%

Source: MCO Report #48 DY9 Q3

MCO PCMH initiatives:

BCBS: Care coordinators interact with PCMH members to prevent Emergency Department (ED) visits and hospital readmissions. BCBS has also contracted with paramedicine organizations to provide in house care for members who are discharged from the hospital and flagged as high utilizers. In this process, paramedics focus on assessment, education, ensuring proper follow up care, and connecting members with needed resources to address social determinants of health. Additionally, BCBS offers remote monitoring by the paramedicine team for members with congestive heart failure and diabetes. This consists of 10 home visits over a 3-month timeframe including potential accompaniment to a clinician visit. The paramedicine program provides equipment for vital signs, which is transmitted to the cloud, monitored by paramedics, and communicated to the member’s clinician with the member’s consent. While this is not a new program for BCBS, they are in the process of expanding it and ensuring that all PCMH groups are aware of how their patients can be included.

PHP: During discussions with PCMH groups in DY9 Q3, the Value Based Purchasing (VBP) team and PHP Performance Improvement (PI) team discussed how to partner with PCMH groups to mitigate barriers. PI Program Managers provided education on screening event partnerships, interventionist teams, etc. PHP's VBP team continues to provide information and education on current and upcoming health equity training courses available during the year as well as Continuing Education Units (CEU)/Continuing Medical Education (CME) opportunities. PHP's VBP team also continues to have monthly meetings with PCMH groups to review quality measure tip sheets, member education opportunities, and utilization of telehealth. Member education opportunities include nurse advice line, in home screening options, extending walk-in hours, etc. Overall, these initiatives have assisted in increasing utilization for PCMHs.

WSCC: Continually monitors PCMH membership, percentage of members paneled to a PCMH, ED utilization, and hospital admissions. During DY9 Q3, WSCC continued to monitor outcomes using key performance indicators (KPIs) to evaluate members in disease management. WSCC's disease management teams track all referrals to ensure members are engaged and accessing available community resources. WSCC utilizes an interdisciplinary team of care coordinators and the Member Connections team, as well as other departments, to assist and identify member-centric goals for disease management program success and to address gaps in care. WSCC's provider engagement and quality improvement team approach allows for continuous monitoring and tracking of interventions and initiatives to identify opportunities for improvement that ensure optimal member and provider engagement, while utilizing data to track performance and assist with effective planning. The quality improvement team monitors an evaluation strategy for member and provider interventions to assess effectiveness of all populations including PCMHs.

CARE COORDINATION MONITORING ACTIVITIES

Care Coordination Monitoring Activities

DY9 Q4

HSD continued to monitor MCO enrollment and member engagement through the quarterly Care Coordination Report. This report includes data related to completion of required assessments and touchpoints within contract timeframes. The DY9 Q4 report contains data from DY9 Q3. DY9 Q4 data will be reported in DY10 Q1. The MCO aggregate results show performance benchmarks of 85% were met, or exceeded, for timely completion of Health Risk Assessments (HRAs) for 'new to Medicaid' members, members with a change in health condition, Comprehensive Needs Assessments (CNAs) and Comprehensive Care Plans (CCPs).

The aggregate completion rate for HRAs for 'new to Medicaid' members was 97% in DY9 Q3, which was consistent with the DY9 Q2 rate. The aggregate completion rate for HRAs for members with a 'change in health condition' decreased from 99% in DY9 Q2 to 98% in DY9 Q3.

Aggregate completion percentages for CNAs for CCL2 members were at 95% in DY9 Q2 and DY9 Q3. Aggregate completion percentages for CNAs for CCL3 members remained at 93% from DY9 Q2 to DY9 Q3.

Aggregate completion percentages of CCPs for CCL2 members increased from 95% in DY9 Q2 to 96% in DY9 Q3. Aggregate completion rates for CCPs for CCL3 members remained at 96% from DY9 Q2 to DY9 Q3.

The Care Coordination Report includes MCO strategies for engaging and retaining members. Consistent and timely assessment and touchpoint completion is vital to engendering member trust. In DY9 Q3, MCOs reported on multiple strategies to retain engagement with members, many who have never had face to face interactions with their care coordinators due to the Public Health Emergency (PHE). All MCOs reported conducting motivational interviewing training several times in DY9 Q3. BCBS care coordinators met with management to discuss their member engagement strategies, which include earlier outreach attempts and developing a trusting rapport with members on their first successful contact. PHP care coordinators worked to ensure that member care plans were individualized and focused on needs important to the member. WSCC utilized various systems to confirm valid contact information for their members: PRISM, Impact Pro, CVS Caremark, Collective Medical, TruCare, SYNCRONYS, etc. All MCOs organized and led, or participated in, community outreach events distributing Personal Protective Equipment (PPE), food boxes, baby car seats, and supplies for newborns as well as school backpacks and supplies in DY9 Q3.

HSD continues to monitor strategies and interventions for all MCOs to retain and increase compliance with performance benchmarks. The table below details aggregate and individual MCO performance for DY8 Q4 through DY9 Q3. DY9 Q4 data will be reported in DY10 Q1.

Table 5 – Care Coordination Monitoring

MCO Performance Standards	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
HRAs for new Members	99.7%	72%	97%	97%%
BCBSNM	99.9%	99.9%	98%	98%%
PHP	96%	45%	96%	97%%
WSCC	100%	100%	100%	100%%
HRAs for Members with a change in health condition	92%	98%	99%	98%%
BCBSNM	100%	100%	100%	100%%
PHP	90%	98%	99%	96%%
WSCC	100%	100%	100%	100%%
CNAs for CCL2 Members	96%	96%	95%	95%%
BCBSNM	90%	92%	90%	92%%
PHP	98%	98%	98%	97%%
WSCC	99.7%	100%	99%	99%%
CNAs for CCL3 Members	94%	95%	93%	93%%
BCBSNM	86%	88%	87%	88%%
PHP	97%	98%	96%	95%%
WSCC	100%	100%	100%	100%%
CCPs for CCL2 Members	97%	95%	95%	96%%
BCBSNM	91%	87%	87%	89%%
PHP	100%	99%	99%	99%%
WSCC	98%	99%	98%	99%%
CCPs for CCL3 Members	97%	96%	96%	96%%
BCBSNM	92%	90%	91%	88%%
PHP	99%	99%	99%	99%%
WSCC	97%	100%	97%	98%%

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

In DY9 Q3, HSD continued to monitor the ongoing impact of the Public Health Emergency (PHE) and engagement of members in Care Coordination through a bi-weekly ‘Telephonic In-Lieu of Face-to-Face Visits’ report. This report monitors compliance of the MCOs’ use of telephonic and video visits for Comprehensive Needs Assessments (CNAs) and required touchpoints. The report identifies if MCOs are able to continue to provide Care Coordination by completing assessments and

touchpoints for members telephonically.

The MCOs report CNAs and touchpoints that have been completed/not completed due to member-driven COVID-19 concerns. These member-driven concerns include the absence of privacy in the member’s home to discuss Protected Health Information (PHI) and a lack of sufficient minutes on a member’s cell phone. Aggregate MCO completion rates in DY9 Q3 were above 90% for all assessments and touchpoints conducted telephonically. In subsequent months, the MCOs attempt to conduct assessments and touchpoints that were not completed in prior months. The table below details the MCOs’ DY9 Q3 completion of bi-weekly ‘Telephonic In Lieu of Face-To-Face Visits.’ DY9 Q4 data will be reported in DY10 Q1.

Table 6 - Telephonic In Lieu of Face-To-Face Visits

TELEPHONIC IN LIEU OF FACE TO FACE VISITS	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
Initial CNAs completed	2,318	1,999	2,485	1,902
BCBSNM	995	887	959	743
PHP	1,116	946	1,339	1,019
WSCC	207	166	187	140
Initial CNAs not completed due to COVID-19	58	107	131	23
BCBSNM	51	50	38	0
PHP	7	57	93	23
WSCC	0	0	0	0
Annual CNAs completed	6,496	6,105	7,538	6,074
BCBSNM	2,439	2,317	2,750	2,349
PHP	3,627	3,329	4,239	3,281
WSCC	430	459	549	444
Annual CNAs not completed due to COVID-19	616	635	708	446
BCBSNM	239	212	163	0
PHP	377	423	545	446
WSCC	0	0	0	0
Semi-annual CNAs completed	577	436	595	585
BCBSNM	197	153	233	222
PHP	305	216	286	288
WSCC	75	67	76	75
Semi-annual CNAs not completed due to COVID-19	44	22	32	7
BCBSNM	39	19	22	0
PHP	5	3	10	7
WSCC	0	0	0	0

Quarterly in-person visits completed	1,734	1,314	1,974	1,450
BCBSNM	716	508	803	525
PHP	968	758	1,073	859
WSCC	50	48	98	67
Quarterly in-person visits not completed due to COVID-19	125	93	137	85
BCBSNM	6	1	4	0
PHP	119	92	133	85
WSCC	0	0	0	0
Semi-annual in-person visits completed	7,184	4,924	6,590	6,318
BCBSNM	1,113	847	1,201	1,044
PHP	5,536	3,670	4,961	4,835
WSCC	535	407	428	439
Semi-annual in-person visits not completed due to COVID-19	689	427	556	560
BCBSNM	4	3	3	0
PHP	685	424	553	560
WSCC	0	0	0	0

Source: HSD DY9 Q3 MCO Ad Hoc Report: Bi-Weekly Telephonic in Lieu of Face-To-Face Report
Percentages in bold are MCO aggregate of the total assessments completed or not completed.

Care Coordination Audits

In DY9 Q3, HSD monitored MCO compliance with contract and policy by conducting quarterly Care Coordination audits. These audits monitor:

- If members listed as Difficult to Engage (DTE), Unable to Reach (UTR) or Refused Care Coordination (RCC) have been correctly categorized: Care Coordination Categorization Audit.
- Verification that Transition of Care (TOC) plans for members transitioning from an In-Patient (IP) hospital stay or Nursing Facility (NF) to the community adequately address the members' needs, including the need for Community Benefits: Transition of Care Audit.
- Confirmation that members are being correctly referred for a Comprehensive Needs Assessment (CNA) if triggered by a completed Health Risk Assessment (HRA): Health Risk Assessment and Care Coordination Level Audit.
- Placement of members in the correct Care Coordination Level (CCL), based on information in the CNA and criteria outlined in contract: Health Risk Assessment and Care Coordination Level Audit.

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

care coordination staff.

HSD audits 15 member files per category, per MCO, quarterly for a total of 45 DTE, 45 UTR, 45 RCC, 30 HRA, 30 CCL, 30 TOC from IP to community, and 30 NF to community.

The table below details the Care Coordination Categorization Audit results for DY9 Q3. DY9 Q4 data will be reported in DY10 Q1.

Table 7 - Care Coordination Categorization Audit

Care Coordination Categorization	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
Difficult to Engage (DTE)	88%	100%	84%	90%
BCBS	97%	100%	93%	89%
PHP	73%	100%	72%	93%
WSSC	93%	100%	87%	87%
Unable to Reach (UTR)	89%	92%	98%	95%
BCBS	86%	X*	X*	X*
PHP	87%	X*	X*	X*
WSSC	93%	92%	98%	95%
Refused Care Coordination (RCC)	96%	92%	89%	97%
BCBS	87%	93%	83%	92%
PHP	100%	87%	85%	100%
WSSC	100%	95%	100%	100%

Source: HSD DY9 Q3 Care Coordination Categorization Audits

Percentages in bold are MCO averages

*See below for details regarding BCBS/PHP UTR IAPs

In DY9 Q1, HSD strongly encouraged BCBS and PHP to implement an internal corrective action plan due their failure to meet requirements for audited Unable to Reach (UTR) member files. BCBS and PHP updates HSD quarterly on the training, oversight, and follow-up activities that are occurring to ensure contract requirements are being met. BCBS and PHP complete quarterly internal audits of their UTR membership and report the audit results and the steps they are taking to ensure consistency and increase compliance to HSD. Based on the progress of BCBS' and PHP' internal corrective action plans, UTR audits have been suspended. Both BCBS and PHP achieved over 85% compliance in their DY9 Q3 reports.

In DY9 Q4, HSD conducted a confirmation audit of BCBS and PHP internal audit findings for their internal corrective action plans. HSD's audit results agreed with BCBS' and their internal corrective action plan was closed. BCBS will resume regular UTR audit procedures in DY10 Q1. While HSD agreed with the vast majority of PHP's findings, there was one disagreement. Therefore, PHP will remain on their internal corrective action plan for at least

one more quarter.

HSD noted that DY9 Q3 Care Coordination Categorization audit results showed an increase in compliance from DY9 Q2 to DY9 Q3 for Difficult to Engage (DTE) members from 84% to 90%, and members Refusing Care Coordination (RCC) from 89% to 97%, and a decrease in compliance for Unable to Reach (UTR) members from 98% to 95%.

In addition to HSD submitted audit findings to MCOs, a discussion of DY9 Q3 audit results occurred with all MCOs at the Quarterly Care Coordination Meeting, to clarify HSD expectations and requirements. Specific areas addressed were:

- Member files being incorrectly included in audit universes;
- Inconsistent documentation on timeliness of outreach; and
- Conflicting documentation on member Care Coordination Levels.

Based on HSD audit findings and recommendations, the MCOs conducted additional outreach to members, updated member file documentation, and increased training of care coordination staff. HSD requested and received follow-up on audit files that did not meet compliance.

HSD notes that all MCOs are conducting additional, targeted outreach to members who have been UTR or DTE for a significant amount of time. These projects have been successful in engaging additional members and categorizing them appropriately. HSD advised MCOs to increase the clarity of documentation to ensure member files include notation of the special outreach project.

The table below details the Transition of Care Audit results for DY9 Q3. DY9 Q4 data will be reported in DY10 Q1.

Table 8 - Transition of Care Audit

Transition of Care	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
In-Patient	98%	99%	99%	91%
BCBS	95%	98%	100%	98%
PHP	100%	98%	98%	91%
WSCC	100%	100%	100%	83%
Nursing Facility	98%	99.9%	99.0%	88.0%
BCBS	97%	99.7%	99.7%	100.0%
PHP	97%	100%	99%	90%
WSCC	100%	X*	97%	75%

Source: HSD DY9 Q3 Quarterly TOC Audits

Percentages in bold are MCO averages.

*WSCC had no NF transitions in DY9 Q1.

Areas that needed improvement were related to:

- Files for members outside of the audit scope being incorrectly included in the audit universe; and
- Post-discharge assessments being completed prior to discharge.

HSD provided detailed findings, reiterated contract requirements, and stressed the importance of comprehensive documentation to the MCOs. Additionally, HSD met with each MCO at monthly meetings and discussed the decreases in compliance. BCBS IP audit scores decreased from 100% in DY9 Q2 to 98% in DY9 Q3 due to documentation issues related to a member with multiple hospitalizations within the audit timeframe. HSD requested BCBS only include documentation germane to the specific discharge being audited. PHP's IP audit scores decreased from 96% in DY9 Q2 to 91% in DY9 Q3 and their NF scores decreased from 99% in DY9 Q2 to 90% in DY9 Q3 due to insufficient and confusing documentation, post-discharge assessments being conducted prior to discharge, and member files being incorrectly included in the audit universe. HSD requested PHP conduct additional oversight prior to submitting the quarterly audit universes, conduct targeted re-training on comprehensive member file documentation, and ensure that the 3-day post discharge assessment is completed with all members transitioning from an IP or NF back to the community who may be in need of Community Benefits. WSCC also saw a decrease in IP audit results from 100% in DY9 Q2 to 93% in DY9 Q3 and NF results from 97% in DY9 Q2 to 75% in DY9 Q3. HSD noted that the audited assessments did not contain all required elements. WSCC assured HSD that targeted re-training would occur and that additional oversight would be conducted by all supervisors. WSCC had just two NF to Community

transitions in DY9 Q3 and due to one file not including the required TOC Plan, their final audit score was affected. WSCC acknowledged the oversight and agreed to additional review of member files prior to audit submissions.

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

Table 9 - Health Risk Assessment and Care Coordination Level Audit

HRA/CCL Audit	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
Health Risk Assessment (HRA)	96%	95%	99%	99%
BCBS	99%	98%	100%	99%
PHP	90%	88%	99%	100%
WSCC	99%	100%	99%	98%
Care Coordination Level (CCL)	94%	94%	100%	96%
BCBS	93%	99%	100%	100%
PHP	93%	99%	100%	100%
WSCC	96%	83%	100%	88%

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

Results of the HRA Audit showed that the MCOs consistently met all contract requirements when completing HRAs. HSD noted that aggregate rates of compliance remained at 99% from DY9 Q2 to DY9 Q3. Points were deducted for incomplete documentation. HSD requested, and received, updates on specific audited members and ongoing training provided to care coordination staff.

Aggregate rates of compliance for the CCL Audit decreased from 100% in DY9 Q2 to 96% in DY9 Q3. Discrepancies identified in the Care Coordination (CCL) Audit were related to inconsistent documentation. HSD reiterated the need for robust documentation and MCOs conducted additional, targeted training with care coordinators to ensure the accuracy of documentation.

Care Coordination CNA Ride-Alongs

HSD conducted 4 virtual CNA ride-alongs with MCO care coordinators in DY9 Q3 to observe completion of member assessments. The MCOs began utilizing telephonic or virtual visits in lieu of in-home, in-person touchpoints in DY7 Q1 to reduce the risk of spreading COVID-19 through face-to-face contact.

HSD attended annual virtual CNAs conducted by all 3 MCOs.

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

HSD provided written feedback to the MCOs on the following:

- Care coordinators adhered to all contractual responsibilities in their assessments;
- Care coordinators were kind, thorough, and professional with the members;
- HSD noted care coordinators employing motivational interviewing with members;
and
- Care coordinators often went beyond contract requirements to assist members with locating and applying for additional resources and services.

Care Coordination HRA Ride-Alongs

HSD conducted 10 virtual HRA ride-alongs with MCO care coordinators in DY9 Q3 to observe completion of member assessments. All HRAs observed were conducted telephonically.

HSD provided written feedback to the MCOs on the following:

- The majority of care coordinators were friendly, thorough, and professional with the members;
- Care coordinators often explained to members that they could request care coordination in the future if they would like assistance;
- Care coordinators referred members to resources to address specific concerns;
and
- HSD noted opportunities for improvement that included:
 - Ensuring that care coordinators explain the purpose of the HRA;
 - Ensuring that care coordinators thoroughly explain the services available through care coordination; and
 - Ensuring all contract required topics are addressed in HRA.

Care Coordination All MCO Meetings

HSD conducts regular quarterly meetings with the MCOs to review data on member engagement, care coordination timeliness, performance analysis, and member outcomes.

HSD held the DY9 Q3 Quarterly Meeting on September 21, 2022 and reviewed:

- Aggregate data from the following reports related to enrollment and compliance with assessment and touchpoint timeliness:
 - Quarterly Care Coordination Report;

- Children in State Custody (CISC) Report;
- Comprehensive Addiction and Recovery Act (CARA) Report;
- JUST Health Transition of Care (TOC) Report;
- Traumatic Brain Injury/Acquired Brain Injury (TBI/ABI Report); and
- Staffing & Training Report.
- Aggregate data from the Care Coordination and Children in State Custody Performance Measures (CC and CISC PMs);
- Results of the DY9 Q2 audits of member categorization, HRAs, Care Coordination Levels (CCLs), and compliance with TOC requirements; and
- Results of the DY9 Q2 audits of CISC HRAs and CCLs.

BEHAVIORIAL HEALTH

The Behavioral Health Services Division (BHSD) continues to maintain and expand critical behavioral health services established during the COVID-19 public health emergency. As providers welcome their patients back to in-office visits, telehealth continues to expand and be one of the greatest resource improvements, expanding capacity by reaching those in the most rural and frontier areas of the state.

In DY9 Q3, a total of 35,297 Medicaid Members received behavioral health services through telehealth, with a total cumulative total of 51,487 persons served throughout the report period. This quarter's total did see a slight decrease of 7.2% compared to the DY9 Q2 total of 38,039 persons served through this medium. Of those served in DY9 Q3 through telehealth, 14,350 persons reside in rural or frontier counties. This accounts for 41% of those served and is reflective of client and provider preferences and the high value of telehealth in New Mexico's rural and frontier landscapes.

Service delivery over telephonic means continues to see growth. In DY9 Q3, 23,537 members received services through this modality compared to 27,433 in DY9 Q2 which is a decrease of 3,896 people or a decrease of 14%. As the timing of this report occurs soon after the end of the quarter, the results reported at this time are not final for telehealth nor telephonic services and will be refreshed next quarter when claim lag is no longer present, so the result of those served during DY9 Q3 will likely increase. BHSD continues to evaluate which behavioral health services are appropriate to continue delivery through telephone when the public health emergency is over. This option has undoubtedly been a critical link to services during the COVID-19 crisis.

All MCOs reported significant increases in telehealth services to all age groups, in urban, rural, and frontier counties, and to all populations of Serious Mental Illness (SMI), Severe Emotional Disturbance (SED), and Substance Use Disorder (SUD) clients. In addition to

increased utilization, behavioral health providers around the state are reporting qualitative improvements – a decline in no-shows and cancellations, clients less stressed because they have not had to leave their homes or children, and therapists more informed about their clients because they can see more of their lives. However, some providers are also reporting ‘zoom fatigue’ and greater difficulty keeping some clients engaged.

TREAT FIRST

As depression, anxiety and other behavioral health needs surge from the stresses related to COVID-19, Treat First engages clients quickly in services that address their immediate needs. Treat First agencies have seen 4,911 new clients during the twelve months of 2022. With support from the Treat First agencies, 30.1% of these individuals were able to resolve their issues with solution-focused interventions within 4 visits. The balance of those clients continued in services. The “No Show” for clients in this period was very low, only 8.2%. This is impressive particularly during the pandemic and significantly lower than before agencies started the Treat First Approach.

For this period, youth and 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 their sessions at 92.7% and Adults rated theirs at 88.%.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

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

In DY9 Q3, SBIRT utilization increased 6.9% to 1,697 persons served compared to 1,588 in the prior quarter. During the reporting period of DY9 Q1 through Q3, a total of 4,230 persons have been served with SBIRT.

On a monthly average, 551 persons received SBIRT in DY9 Q2 whereas in the prior quarter the average was 518 per month. In the midpoint of DY9, a total of 2,811 beneficiaries have received screening, brief intervention, and referral to treatment services. There is likely minimal claim lag represented in these results, so the performance may exceed the current increase; however, this will be noted in the refreshed totals in next quarter’s report.

EXPANDED SERVICES FOR SUBSTANCE USE DISORDER

The Centennial Care 2.0 program includes new and expanded services for Medicaid recipients with Substance Use Disorder (SUD). In DY9, the State continued efforts to implement Crisis Treatment Centers (CTC). Provider-specific cost-based rates are established for three CTC providers in the state and are now delivering in-patient and outpatient CTC services. Expansion of CTCs continues as the state expands the 988 Crisis Now initiatives.

In DY9, HSD continues to focus on expanding other services that are key to addressing SUD, such as Intensive Outpatient Services (IOP) and Comprehensive Community Support Services (CCSS).

As part of the SUD 1115 Waiver, services have been approved for specific substance abuse populations in an Institution for Mental Disease (IMD). An IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating SUD that is not part of a certified general acute care hospital. HSD has expanded coverage of recipients ages 22 through 64 to inpatient hospitalization in an IMD, for SUD diagnoses only, with criteria for medical necessity, and based on American Society of Addiction Medicine (ASAM) admission criteria. Covered services include withdrawal management (detoxification) and rehabilitation.

In DY9 Q3, the total number of persons served with a SUD in an IMD was 2,153, which is a decrease of 1,409 persons compared to DY9 Q2. On a month-to-month average during the first three quarters of DY9, 1,299 persons were served in an IMD with a substance use disorder, with the greatest utilization occurring between March and May of 2022 where 1,596 persons were served per month on average. The unduplicated total of persons served during the three quarters of DY9 is 7,393.

SUD Health IT

In DY9, HSD continued to actively develop and maintain the necessary SUD Health IT capabilities and infrastructure to support member health outcomes and address the SUD goals of the demonstration. New Mexico has developed a workgroup to review our Health IT plan to ensure the progress and support of each milestone.

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

The New Mexico Fee for Service (FFS) Drug Utilization Review (DUR) Board met quarterly in 2022 on January 19, April 13, July 20, and October 12, 2022. Attendees included board members and invited guests, including MCO representatives. Every meeting included

reporting of member enrollment data for MCO and FFS, board member updates, and COVID-19 updates. Clinical and data review topics included: Epidiolex utilization, Aduhelm, diabetes management indicators, tumor necrosis factor inhibitors, metabolic monitoring for second-generation antipsychotics, Attention Deficit Hyperactivity Disorder (ADHD) medications outcomes, ivermectin use, and diabetes management indicators. The follow-up from 2021 interventional mailings of Influenza vaccination and the Opioid, Benzodiazepine, and/or Antipsychotics Repeat Intervention were reported in the April meeting. Review of the 2021 intervention, *The Treatment with Non-Steroidal Anti-Inflammatory Drugs*, was reported in the October meeting. The DUR provider mailings for 2022 were Ivermectin Educational Newsletter and Diabetes Management Indicators Intervention.

Project ECHO continues to train providers on pain management; however, DY9 showed a 39% decrease in the number of providers attending from 459 to 282, but showed an increase of 54% in the number of session held from 33 to 72. Additionally, advertising for these sessions continues to expand to multiple websites and list-serves (recruitment listings). The next reporting period is March 2023.

Through the ECHO program, the New Mexico Bridge Project continues to expand its training on prescribing for opioid use disorder for hospital emergency departments, inpatient, and related clinics throughout the state. The Project completed training in 5 rural hospitals, including 2 that are Indian Health Services. The Project continues to work with 4 additional hospitals in rural settings to provide trainings. As part of this project, all prescribing practitioners have attained their waivers to prescribe buprenorphine. The trainings include buprenorphine initiation, responsible opioid prescribing, treatment in clinic settings, OUD in pregnancy, neurobiological basis of SUD, case reviews, toxicology updates, “blue” fentanyl updates, and more. Prescribing practitioners attain waivers to prescribe buprenorphine upon training completion. More information on the Project can be found here: <https://nmbridge.org/>.

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

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

HSD and vendors for the new MMIS continue to design and implement enhanced data analytics in 2022. Smart phone apps are part of the MMIS unified public interface (UPI). HSD and vendors for the new MMIS continue to design and implement smart phone capabilities (UPI) in 2022. This initiative will assist in retention or treatment for OUD and other SUDS. HSD and vendors for the new MMIS are also designing and implementing data services to provide analytics for public health and clinical support for providers, which is in progress.

ADULT ACCREDITED RESIDENTIAL TREATMENT CENTERS (AARTC) SERVICES

A total of 18 AARTCs applications have been approved since the onset of the AARTC application process (multiple providers have multiple locations). In DY8 Q4, one provider did not correct accreditation and was no longer approved to bill Medicaid. In DY9 Q2, another provider ceased operations and closed. During DY9, BHSD worked with 8 providers in completing the AARTC application. There are 3 providers in various stages of the application process and are submitting required documentation for review. There are 2 providers in the rate setting process.

Table 10 – AARTC Client Counts

MEDICAID CLIENT COUNTS				
PROVIDER #	DY9 Q1	DY9 Q2	DY9 Q3	DY9 Q4
716	0	0	0	0
090	51	60	69	61
037	376	339	351	309
081	12	7	12	11
589	18	10	13	9
332	0	27	48	31
049	31	29	19	28
825	3	4	5	1
896	0	4	13	3
302	1	45	105	90
60	NA	NA	NA	15
760	NA	NA	NA	11
Unduplicated Total	492	525	635	569

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

There are 14 AARTC’s in operation, approved to bill Medicaid. The data above identifies the total number of clients who received AARTC services during DY9 Q1, Q2, Q3, and Q4. Client counts are impacted by the claim lag of up to 120 days following the end of the recent quarter. The provider number is a unique identifier and is used to correlate the number of members seen by each provider for each quarter. Providers who were not approved to bill Medicaid for

previous quarters have NA in the data field to represent this. Although 12 provider sites are represented in the chart above, provider 037 has three sites that are being represented through their 037 data. All AARTC provider sites are actively in process to receive distinct identification numbers to ensure accuracy in client counts for each site.

The utilization of the Medicaid services shows an increase of clients served from DY9 Q1 through Q3. There is a decrease from DY9 Q3 to Q4, which may be attributed to the 90-day claim lag submitted for DY9 Q3 and Q4. It is expected that numbers will increase as actual counts are adjusted to account for claim lag. Further analysis is warranted to ensure counts are accurately reported and represented for those providers. The table reflects refreshed numbers in all quarters.

HSD continues discussing next steps to developing AARTC rates. Rates are being assessed by acquiring one full year of utilization by each provider with a review of expenditure data collected to determine the actual costs of operation. Two providers have completed the re-base process. Interim rates will then be adjusted to ensure AARTCs services are appropriately supported and funded.

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.

The 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 have guided 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.

CLNM Health Home Activities

DY9 Q4
Activities

New Mexico continues to focus many services within the health homes to coordinate OUD and SUD services through prevention by assuring our members with SUD have access to Naloxone and educational services, and through the ASAM assessment coordination of the right therapeutic programs. However, our state-wide deaths by overdose remain way above the national numbers, i.e., 6th among states. The national number for overdose deaths in 2021 was 32.4 per 100,000 deaths, and New Mexico's was 50.6 per 100,000 deaths. Our efforts at combating this do show statistical improvements, and our HEDIS metrics for both SUD and SMI/SED continue to exceed the National Committee for Quality Assurance (NCQA) regional targets (e.g., initiation and engagement of Alcohol and Other Drugs (AOD), anti-depressant meds both acute and continuation, and 7 and 30-day follow-up after mental health hospitalization).

A recent member survey elicited exceptional results including comments such as "Giving me the oomph to make the calls when I can't and checking in to make sure everything is good;" "Somebody to talk to and help with getting me connected to the right people;" and "If it weren't for my care coordinator, I would be dead."

Staff in the health homes have taken advantage of many state offered educational programs such as stigma training, motivational interviewing, and the nuts and bolts of medication assisted treatment among others.

Insufficient staffing levels remain of high concern; especially for those positions requiring independently licensed staff, such as the supervisors. There is a dearth of these clinicians across all of New Mexico. Requests from the health homes to change the requirement from independent licensure, to master level clinicians with experience has not yet resulted in a positive response. A policy change for acceptance of remote supervision is approved. Low staffing resulted in a 2.3% decrease in membership. The decrease is all attributed to lack of staff.

There is a large focus on substance use disorders. All new staff members take an ASAM course conducted by the University of New Mexico. The ASAM assessments are done by either the care coordinators or agency clinical staff and become part of the placement criteria for each member with a SUD.

As shown on Table 11 below, there is a slight decrease of 2.30% in member enrollment from 4,338 in DY9 Q3 to 4,222 in DY9 Q4.

Table 11: Number of Members Enrolled in Health Homes

Number of Members Enrolled in Health Homes			
DY9 Q1 JAN - MAR	DY9 Q2 APR - JUNE	DY9 Q3 JUL - SEPT	DY9 Q4 OCT - DEC
4,384	4,338	4,222	4,125
% CHANGE	% CHANGE	% CHANGE	% CHANGE
0.40%	0.48%	2.67%	2.30%

Source: NMStar, CLNM Opt-in Report.

SUPPORTIVE HOUSING

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

Linkages agencies have been able to bill Medicaid for comprehensive community support services (CCSS), but since the supportive housing services were included in the Centennial Care 2.0 waiver, BHSD has continued to strongly encourage Linkages providers to shift to billing the supportive housing benefit directly. The H0044 benefit reimburses at a higher rate than CCSS. The Centennial Care 2.0 waiver requires that the services be provided by a certified peer support worker (CPSW) to align with the state’s goals for building the peer support workforce. One Linkages provider has 9 CPSWs assigned to deliver Linkages supportive housing services; this provider actively and consistently utilizes the H0044 code for reimbursement. Another Linkages provider has 1 CPSW to render Linkages support services and another existing staff member who recently received their CPSW status to assist; this provider amended their existing contracts with MCOs to allow for H0044 reimbursement and began billing in January 2022. A third provider had identified 1 CPSW to render Linkages support services, amended their existing contracts with MCOs to allow for H0044 reimbursement, and began billing in December 2021. Since the CPSW of this third provider left the provider agency in December 2022, the provider created a Linkages CPSW position, which will focus on providing pre-tenancy and tenancy related to Linkages services;

the provider posted and is recruiting to fill the position. Besides the open position, this provider has 2 internal staff who are working towards securing their CPSW status, which will allow for the provider to resume billing against H0044. A fourth Linkages provider hired 1 CPSW in December 2021, amended their MCO contracts to allow for H0044 reimbursement, and began billing in July 2022. A fifth Linkages provider recruited for a CPSW to fill their second Supportive Housing position, but the individual selected to fill the position did not have CPSW status. Therefore, this provider is not currently able to bill H0044 due to the current provider eligibility guidelines.

The Linkages providers that have secured a CPSW to render supportive housing services relative to H0044 have also updated their agency's electronic health record (EHR) systems to allow for appropriate documentation and revised workflows to clarify the process for H0044 delivery and documentation for billing. The remaining Linkages providers (6) continue to consider hiring CPSW staff for Linkages programming and/or are actively seeking CPSWs to hire, while utilizing case managers, community support workers, and supportive housing coordinators to render these services. There are 11 Linkages support service providers, and the interest of all providers not yet utilizing H0044 has increased with the progress made by the providers who have established H0044 reimbursement. The BHSD Supportive Housing Coordinator-Supervisor has been working with the BHSD MCO Contract Managers and MCOs to ensure successful processing establishment and billing of H0044 for the providers and has required MCOs to 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 to recruit CPSW staff. OPRE has a list-serv of CPSWs available to providers to verify if a potential peer hire is certified. Also, OPRE has a Supportive Housing specialty endorsement, which is an additional training for CPSWs. The available list-serv indicates if CPSWs carry this specialty endorsement, which is not required for Medicaid billing, but helpful for those CPSWs involved with supportive housing services.

HSD continues to promote the use of CPSWs to render Linkages support services; however, Linkages providers and providers of other behavioral health services have experienced continued challenges with hiring and vacancies within their agencies during the COVID-19 pandemic. Providers continue to receive information, education, and training about the value of Medicaid reimbursement through H0044, 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 for State Fiscal Year 2022 and 2023 include an item specific to Medicaid and H0044.

Table 12: Medicaid Supportive Housing Utilization

MEDICAID SUPPORTIVE HOUSING UTILIZATION			
(January 1, 2022 – December 31, 2022)			
DY9 Q1	DY9 Q2	DY9 Q3	DY9 Q4
68	76	74	60
Unduplicated Total - 95			

* Due to claim lag, prior quarters’ data has been refreshed
 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 and 2023 was applied to Linkages programming. The funding increases allow HSD to expand Linkages services that are not covered by Medicaid. HSD also utilizes these funds to support rental assistance vouchers for eligible Linkages clients. In SFY20, funding allowed for 160 households to receive a rental assistance voucher and support services; in SFY21, the funding increased to support a capacity of 318 households. In SFY22, the funding remained equivalent to SFY21 and continued to support a capacity of 318 households. In SFY23, the capacity of households to be served with a voucher is 338. 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, an average of 309 vouchers were issued or filled; a filled voucher means housing has been secured.

In SFY21, Linkages expanded from six to eight sites with Curry and McKinley as new Linkages sites. In SFY22 and SFY23, the Linkages budget will maintain the SFY21 site expansion. The increased funding in FY23 has supported increased rent costs.

CENTENNIAL HOME VISITING (CHV) PROGRAM

In DY9 Q3, the Centennial Home Visiting (CHV) program served 351 families and in DY9 Q4 the CHV program served 379 families. The models are as follows:

Nurse Family Partnership (NFP) Model:

- University of New Mexico Center for Development and Disability (UNM CDD) NFP served a total of 82 unique families in DY9 Q3 and 86 families in DY9 Q4 in Bernalillo County and Valencia County.
- Youth Development Inc. (YDI) served 50 unique families in DY9 Q3 and 61 families in DY9 Q4 in Bernalillo, Rio Arriba, Torrance, and Sandoval counties.

Parents as Teachers (PAT) Model:

- UNM CDD PAT served 36 unique families in DY9 Q3 and 32 families DY9 Q4 in Bernalillo and Valencia County.
- ENMRSH still served 20 unique families both DY9 Q3 and DY9 Q4 in Curry County and Roosevelt County at their capacity.
- Taos Pueblo/Tiwa Babies served 12 unique families in Taos County.
- MECA Therapies served 139 unique families in DY9 Q3 and 131 families DY9 Q4 in Chaves, Curry, Dona Ana, and Lea Counties.
- Aprendamos started in DY9 Q4 and served 17 unique families in Doña Ana and Otero Counties.
- Community Action Agency of Southern New Mexico served 19 unique families in DY9 Q3 and 25 families DY9 Q4 in Doña Ana and Otero Counties.
- Presbyterian Medical Services served 5 unique families in DY9 Q3 and 7 families in DY9 Q4.

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

- Day One Home Visiting Tresco has completed enrollment in NM Medicaid. They are in the process of creating contracts with the 3 MCOs. They will serve Bernalillo and Santa Fe Counties.
- Guidance Center of Lea County is in the process of enrollment with NM Medicaid. They are approved for 20 families in Lea County.

Several strategies are currently being employed to streamline the process of enrollment, credentialing, billing, and referral management. HSD is meeting regularly with the Early Childhood Education and Care Department (ECECD) to create a provider manual and process map that will live on the HSD website. The MCOs are also contributing their procedures to the process map.

PRESUMPTIVE ELIGIBILITY PROGRAM

The New Mexico HSD Presumptive Eligibility (PE) program continues to be an important part of the State's efforts. Presumptive Eligibility Determiners (PEDs) are employees of qualified hospitals, clinics, FQHCs, IHS facilities, schools, primary care clinics, community organizations, County Jails and Detention Centers, and some New Mexico State Agencies including the New Mexico Department of Health (DOH), New Mexico Children Youth and Families Department (CYFD), and the New Mexico Corrections Department (NMCD). Currently, there are approximately 776 active certified PEDs state-wide. These PEDs provide PE screening, grant PE approvals, and assist with on-going Medicaid application submissions.

HSD staff conduct monthly PE certification trainings for employees of qualified entities that choose to participate in the PE program. PE certification requirements include active participation during the entire training session, completion of a post-training comprehension test, and submission of all required PED registration documents. For active PEDs, PE program staff conduct "Your Eligibility System for New Mexico-Presumptive Eligibility (YESNM-PE)" demo trainings. During demo trainings, the PEDs have the opportunity to take a refresher training on "How To" utilize the tools and resources available to them; specifically, the New Mexico Medicaid Portal and YESNM-PE to screen for PE, grant PE, and submit ongoing Medicaid applications. PE program staff conducted 12 PE certification trainings and 19 YESNM-PE demo refresher trainings in DY9.

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

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

Access to the Baby Bot is available through a link located on the PED's home page in YESNM-PE. The Baby Bot platform operates as a webservice and sends the information electronically to ASPEN, HSD's eligibility system. Once the mother's eligibility has been electronically verified in ASPEN, the system automatically adds the newborn to the case. This allows immediate access to benefits for the newborn. Currently 245 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 13 below:

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

Table 13: Medicaid-eligible newborns submitted through Baby Bot on YESNM-PE

AVA Baby Bot (January - December 2022)					
Quarter	Newborns Submitted through AVA	Newborns Successfully Enrolled	Newborns Unsuccessfully Enrolled - Tasks Created	% of Newborns Successfully Enrolled	% of Newborns Unsuccessfully Enrolled
Q1	2,037	651	1,386	32%	68%
Q2	2,100	1,117	983	53%	47%
Q3	2,434	1,495	939	61%	39%
Q4	2,113	1,091	1,022	52%	48%
Total	8,684	4,354	4,330	50%	50%

Source: Accenture Baby Bot dashboard RPA activity detail daily report

In DY9, 84 PEDs used the Baby Bot functionality. Although, there is steady use of PED participation throughout the year, we noticed an increase in the number of newborns added through the Baby Bot functionality. In this annual reporting period, staff observed a slight decrease of Newborns “Successfully Enrolled.” During the beginning of this reporting period, the department went through a server migration, which inadvertently caused the slight decrease in Newborns “Successfully Enrolled.” HSD program staff continue to work with PEDs and system developers to increase the number of newborn submissions as well as the number of successful submissions through the Baby Bot.

Table 14: PE Approvals

PE APPROVALS (January - December 2022)				
Quarter	PEs Granted	% PE Granted with Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
Q1	347	99.14%	1,891	1,535
Q2	380	99.74%	1,641	1,048
Q3	424	98.82%	1,612	1,200
Q4	413	99.27%	1,484	998
Total	1,564	99.24%	6,628	4,781

Source: Monthly PE001 Report from ASPEN and OmniCaid

Table 14 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. This is reflected by the increase of PE approvals that also had an ongoing application submitted in DY9. In DY9, 99.24% of all PE approvals had an ongoing application submitted.

JUST HEALTH PROGRAM

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

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

It is HSD's goal to reduce recidivism by ensuring that individuals have immediate access to services (i.e., prescriptions, transportation, Behavioral Health appointments, outpatient/inpatient residential treatment for SUD) upon release. To help facilitate access to

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

The following table outlines the number of PE approvals granted and the total number of ongoing applications submitted and approved. HSD did see a slight decrease in the amount of PE applications and ongoing Medicaid applications submitted from a jail or prison setting. The decrease may be due to COVID-19 protocols in jails and prisons. The department continues to work hard on the relationships between the jails and prisons, and with the justice involved population. In DY9, 87.92% of all JUST Health PE approvals had an ongoing application submitted.

Table 15: PE Approvals

PE APPROVALS – JUST HEATH				
(January - December 2022)				
Quarter	PEs Granted	% PE Granted w/ Ongoing Applications Submitted	Total Individuals Applied	Individuals Approved
Q1	12	92%	111	102
Q2	18	100%	126	112
Q3	5	60%	123	110
Q4	13	100%	140	124
Total	48	87.92%	500	448

Source: Monthly PE001 Report from ASPEN and OmniCaid

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HCBS REPORTING

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

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

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

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

Consumer Support Program

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

Year to Date (YTD) and quarterly reporting are provided by the Aging and Long-Term Services Department (ALTSD), Aging and Disability Resource Center (ADRC). The ADRC is the single point of entry for older adults, people with disabilities, their families, and the broader public to access a variety of services. The type and number of issues identified and resolved through the Consumer Support Program for DY9 are listed in the tables below.

Table 16: ADRC Hotline Call Profiler Report

ADRC HOTLINE CALL PROFILER REPORT January - December 2022	
TOPIC	NUMBER OF CALLS
Home/Community Based Care Waiver Programs	8,478
Long Term Care/Case Management	8
Medicaid Appeals/Complaints	16
Personal Care	488
State Medicaid Managed Care Enrollment Programs	62
Medicaid Information/Counseling	2,341

Source: SAMS Call Profiler Report; GSA I 7-630-8000-0001 CDA 93-778 State Fiscal Year 2022, Quarter 1-4 reports

Table 17: ADRC Care Transition Program Report

ADRC CARE TRANSITION PROGRAM REPORT January - December 2022			
COUNSELING SERVICES	NUMBER OF HOURS	NUMBER OF NURSING HOME RESIDENTS	NUMBER OF CONTACTS
Transition Advocacy Support Services			575
*Medicaid Education/Outreach	13,671		
Nursing Home Intakes		302	
**LTSS Short-Term Assistance			986

*Care Transition Specialist team educates residents, surrogate decision makers, and facility staff about Medicaid options available to the resident and assist with enrollment.

**Clients are provided short-term assistance in identifying and understanding their needs and to assist them in making informed

decisions about appropriate long-term services and supports choices in the context of their personal needs, preferences, values, and individual circumstances.

Source: Care Transition Bureau (CTB) GSA I 7-630-8000-0001 CFDA 93-778 State Fiscal Year 2022, Quarter 1-4 reports

Critical Incidents

Critical Incidents	
DY9 Q4	<p>HSD conducts a quarterly meeting with MCOs. The goal of the quarterly meeting is to provide guidance and discuss findings of the MCO's reporting of critical incidents.</p> <p>The quarterly meeting was held on November 16, 2022. The primary discussion was regarding Neglect Refusing Services and Neglect Insufficient Staffing COVID-19 critical incident reports. Each MCO reported that the primary issue contracted agencies continue to experience is insufficient staff. Agencies continue to report that the challenge in recruiting staff is attributed to low salary and stressful work environment. The MCOs provided details of various actions taken to support the agencies.</p> <p>HSD has initiated conducting monthly meetings with MCOs. The goal of the monthly meeting is to provide individual guidance addressing and clarifying questions concerning quarterly reports, concerns identified for critical incidents reported, and contract and policy requirements.</p> <p>Items of discussion during the DY9 Q3 MCO monthly meetings were:</p> <ul style="list-style-type: none"> • PHP- review of critical incident reports filed identified “No follow up activity documented: Members health and safety not addressed” was a continued area of concern. PHP stated they will implement internal trainings to include the detailed activity in Diary Entry documentation. • BCBS- review of critical incident reports filed identified “No follow up activity documented: Members health and safety not addressed” was a continued area of concern. BCBS stated the Critical Incident (CI) team scrubs the report for demographic accuracy and proper incident type and subcategory then alerts Care Coordination of the CI report and will document in the Diary Entries the report was referred to care coordination for follow-up. BCBS Care Coordination will document follow-up activities into the Diary Entries.

The tables below represent an MCO summary of the critical incident reporting for DY9 Q3. DY9 Q4 data will be received on January 30, 2023 and be reflected in DY10 Q1 report.

Table 18: Critical Incidents Reported

CRITICAL INCIDENTS REPORTED (DY9 Q1 - DY9 Q3)															
MCO	CENTENNIAL CARE (CC)				BEHAVIORAL HEALTH (BH)				SELF DIRECTED (SD)				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
BCBS	7,695	9,376	8,235		230	143	211		174	177	156		25,306	584	507
PHP	17,322	19,422	18,607		500	454	785		608	573	520		55,351	1,739	1,701
WSCC	1,580	1,800	1,309		52	59	55		40	42	44		4,689	166	126
Total	26,597	30,598	28,151		782	656	1,051		822	792	720		85,346	2,489	2,334

Source MCO quarterly report #36

BCBS (DY9 Q1 - DY9 Q3)															
Critical Incident Types	Centennial Care				Behavioral Health				Self-Directed				Year-to-date Totals		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	103	104	96		7	14	29		6	7	5		303	50	18
Death	293	230	215		9	4	6		7	7	10		738	19	24
Elopement / Missing	2	2	3		0	0	1		0	0	0		7	1	0
Emergency Services	1,289	1,413	1,476		98	81	114		90	102	96		4,178	293	288
Environmental Hazard	19	53	37		3	1	0		1	4	0		109	4	5
Exploitation	35	47	18		2	4	0		1	4	2		100	6	7
Law Enforcement	26	36	32		2	2	11		6	3	0		94	15	9
Neglect	5,928	7,491	6,358		109	37	50		63	50	40		19,777	196	153
All Incident Types	7,695	9,376	8,235		230	143	211		174	177	153		25,306	584	504

Source MCO quarterly report #36

PHP (DY9 Q1 - DY9 Q3)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	191	217	167		47	49	61		29	18	8		575	157	55
Death	520	411	328		19	10	7		26	20	23		1,259	36	69
Elopement/ Missing	17	15	11		2	1	1		1	1	1		43	4	3
Emergency Services	5,955	6,508	6,871		281	287	561		391	422	418		19,334	1,129	1,231
Environmental Hazard	62	117	76		2	6	10		3	3	6		255	18	12
Exploitation	60	47	59		6	2	3		5	4	8		166	11	17
Law Enforcement	57	37	58		17	3	15		5	2	1		152	35	8
Neglect	10,460	12,070	11,037		126	96	127		148	103	55		33,567	349	306
All Incident Types	17,322	19,422	18,607		500	454	785		608	573	520		55,351	1,739	1,701

Source MCO quarterly report #36

WSCC (DY9 Q1 - DY9 Q3)															
CRITICAL INCIDENT TYPES	CENTENNIAL CARE				BEHAVIORAL HEALTH				SELF DIRECTED				YEAR TO DATE TOTALS		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	CC	BH	SD
Abuse	27	16	20		10	4	4		2	2	0		63	18	4
Death	41	39	44		4	1	5		3	3	3		124	10	9
Elopement/ Missing	6	1	2		3	0	1		0	0	0		9	4	0
Emergency Services	245	254	255		13	23	33		28	23	36		754	69	87
Environmental Hazard	16	20	10		0	1	0		1	4	0		46	1	5
Exploitation	6	12	7		0	0	0		1	0	1		25	0	2
Law Enforcement	6	11	11		2	1	4		0	1	0		28	7	1
Neglect	1,233	1,447	960		20	29	8		5	9	4		3,640	57	18
All Incident Types	1,580	1,800	1,309		52	59	55		40	42	44		4,689	166	126

Source MCO quarterly report #36

Community Benefit

In DY9, Community Benefit (CB) related projects have included updating the Statewide Transition Plan as requested by CMS for final approval by March 17, 2023, developing a new tracking database for HSD approved Agency-Based Community Benefit (ABCB) providers, and the Self-Directed Community Benefit (SDCB) vendor transition. HSD continued to collaborate with providers, stakeholders, and state agencies to amend our proposed plan for the American Rescue Plan Act (ARPA) increased HCBS for submission to CMS. HSD requested and received approval for 200 additional CB slots through an Attachment K authority for the ability to serve more members who are not otherwise Medicaid eligible. We increased allocation efforts to fill the new slots as quickly as possible.

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

- Implementing rate increases for PCS and other CB services to coincide with state and local minimum wage increases, and the paid sick leave requirement for

NM employees per the Healthy Workforce Act. We are planning for another statewide minimum wage increase that will occur in January 2023.

- HSD continues to monitor MCO accountability to ensure minimum wage increases and paid sick leave requirements are met with weekly MCO report updates.
- Using ARPA funds for temporary economic relief payments to Community Benefit providers.
- 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. The final report on how the grant funds were used to recruit and retain workers will be available by July 2023.

Electronic Visit Verification

HSD, in partnership with the MCOs, continued to operate EVV for Agency-Based Community Benefit (ABCB), SDCB, and EPSDT Personal Care Services. HSD received CMS approval for our Good Faith Effort Exemption request to CMS for Home Health Services. We anticipate implementing EVV for Home Health in July of 2023.

For DY9, the average number of SDCB caregivers using EVV is 70%. HSD is continuing to offer training and technical assistance for SDCB agencies and individual employees to encourage more SDCB providers to use EVV.

ABCB EVV data for DY9 Q4 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.

Table 19: EVV DATA

EVV DATA (October 2022 - December 2022)		
MCO	AVERAGE NUMBER OF UNIQUE MEMBERS AUTHORIZED THIS PERIOD	NUMBER OF TOTAL CLAIMS THIS PERIOD
BCBS	7,453	453,023
PHP	14,555	891,300
WSCC	1,918	114,588
TOTAL	23,926	1,458,911

Source: MCO Report #35 DY9 Q4 October 2022 – December 2022

Statewide Transition Plan

In DY9, HSD met with CMS to obtain technical assistance and feedback on our Statewide Transition Plan (STP) to come into compliance with the HCBS Final Settings Rule. HSD attended numerous CMS webinars and training sessions. We worked closely with the CMS team to respond to all feedback in order to obtain full approval of our STP by the deadline of March 17, 2023. For the Community Benefit HCBS settings, the MCOs formed a workgroup and collaborated in planning and implementing ongoing monitoring activities including provider training and care coordination tools.

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

HSD requires the MCOs to provide a quarterly summary of their internal audits of NF LOC Determinations. Each MCO conducts internal random sample audits of both community-based and facility-based determinations completed by their staff based on HSD NF LOC criteria and guidelines. The audit includes accuracy, timeliness, consistency, and training of reviewers. The results and findings are reported quarterly to HSD along with any Quality Performance Improvement Plan.

Total audits for Q3 DY9:

1. BCBS conducted 106 total audits of NF LOC determinations, 18 facility-based and 88 community-based.
2. PHP conducted 212 total audits of NF LOC determinations, 57 facility-based and 175 community-based.
3. WSCC conducted 60 total audits of NF LOC determinations, 12 facility-based determinations and 48 community-based.

Audit results for NF LOC determinations for DY9 Q3:

1. BCBS reported 100% agreement with reviewer determination for High and Low Facility Based NF LOC, and 100% agreement for Community Based NF LOC.
2. PHP reported 100% agreement with reviewer determination for High and Low Facility Based NF LOCs, and 100% agreement for Community Based NF LOCs.
3. WSCC reported 100% agreement with reviewer determination for High and Low Facility Based NF LOCs, and 100% agreement for Community Based NF LOCs.

Audit results for timeliness of determinations for DY9 Q3:

1. BCBS reported 100% timeliness of determinations for Low Facility Based NF LOCs and Community Based NF LOCs, and 50% for High Facility Based NF LOCs.
2. PHP reported 100% timeliness of determinations for High and Low Facility Based and Community Based NF LOCs.
3. WSCC reported 100% timeliness of determinations for High and Low Facility Based and Community Based NF LOCs.

Aggregate results:

1. NF LOC determinations aggregate results are 100% for High and Low Facility Based and Community Based NF LOCs.
2. Timeliness of determinations aggregate results are 100% for Low Facility Based and Community Based, and 98% for High Facility Based NF LOCs.
3. Aggregate results are improved from DY9 Q2.

HSD will continue to monitor the MCOs' internal audits of NF LOC determinations and identify and address any concerns. The Nurse Auditor will provide technical assistance to the MCO internal auditors as needed. Additionally, the Nurse Auditor will report quarterly findings and recommendations in the CMS monitoring report commencing in DY9 Q4.

Table 20: MCO Internal NF LOC Audits– Facility-Based

Facility-Based Internal Audits	July	Aug	Sept	DY9 Q3
High NF Determinations				
Total number of High NF LOC files audited	14	13	14	41
BCBSNM	3	3	2	8
PHP	9	8	10	27
WSCC	2	2	2	6
Total number of files with correct NF LOC determination	14	13	14	41
BCBSNM	3	3	2	8
PHP	9	8	10	27
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%

Low NF Determinations	July	Aug	Sept	DY9 Q3
Total number of Low NF LOC files audited	15	16	15	46
BCBSNM	3	3	4	10
PHP	10	11	9	30
WSCC	2	2	2	6
Total number of files with correct NF LOC determination	15	16	15	46
BCBSNM	3	3	4	10
PHP	10	11	9	30
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	July	Aug	Sept	DY9 Q3
Total number of High NF LOC determinations completed within required timeframes	14	13	13	40
BCBSNM	3	3	1	7
PHP	9	8	10	27
WSCC	2	2	2	6
% of High NF LOC determinations completed within required timeframes	100%	100%	93%	98%
BCBSNM	100%	100%	50%	88%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Total number of Low NF LOC determinations completed within required timeframes	15	16	15	46
BCBSNM	3	3	4	10
PHP	10	11	9	30
WSCC	2	2	2	6
% of Low NF LOC determinations completed within required timeframes	100%	100%	100%	100%
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%

Source: DY9 Q3 MCO Internal Audit Results

Table 20: MCO Internal NF LOC Audit Report – Community-Based

Community-Based Internal Audits	July	Aug	Sept	DY9 Q3
Total number of Community-Based NF LOC files audited	105	105	101	311
BCBSNM	30	30	28	88
PHP	59	59	57	175
WSCC	16	16	16	48
Total number with correct NF LOC determination	105	105	101	311
BCBSNM	30	30	28	88
PHP	59	59	57	175
WSCC	16	16	16	48
% with correct NF LOC determination	100%	100%	100%	100%
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Timeliness of Determinations	July	Aug	Sept	DY9 Q3
Total number of Community-Based determinations completed within required timeframes	105	105	101	311
BCBSNM	30	30	28	88
PHP	59	59	57	175
WSCC	16	16	16	48
% of Community-Based determinations completed within required timeframes	100%	100%	100%	100%
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%

Source: DY9 Q3 MCO Internal Audit Results

MCO NF LOC Determinations

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

- The aggregated Facility Based High NF LOC determination/redetermination percentage for DY9 Q3 is 80%, a decrease from DY9 Q2 of 86%.
 - BCBS shows a significant decrease with 43% reported for DY9 Q3 from DY9 Q2 of 76%. BCBS had 0% that met high NF LOC criteria for DY9 Q3.
- The aggregated Facility Based Low NF LOC determination/redetermination percentage for DY9 Q3 is 97%, a slight increase from DY9 Q2 of 96%.

- WSCC has had 100% for DY9 Q3 and DY9 Q2.
- The aggregated Community Based determination/redetermination percentage for DY9 Q3 is 98%, an insignificant decrease from DY9 Q2 of 99%.
 - All MCOs achieved 98% for DY9 Q3.

HSD will continue to monitor the MCO NF LOC determinations and identify and address any trends and provide technical assistance as needed.

Table 21: MCO NF LOC Determinations – Facility-Based

Facility-Based Determinations				
High NF Determinations	July	Aug	Sept	DY9 Q3
Total number of determinations/redeterminations completed for High NF LOC requests	65	64	57	186
BCBSNM	21	15	6	42
PHP	41	42	41	124
WSCC	3	7	10	20
Total number of determinations/redeterminations that met High NF LOC criteria	52	50	46	148
BCBSNM	13	5	0	18
PHP	37	39	38	114
WSCC	2	6	8	16
% of determinations/redeterminations that met High NF LOC criteria	80%	78%	81%	80%
BCBSNM	62%	33%	0%	43%
PHP	90%	93%	93%	92%
WSCC	67%	86%	80%	80%
Low NF Determinations	July	Aug	Sept	DY9 Q3
Total number of determinations/redeterminations completed for Low NF LOC requests	371	422	428	1,221
BCBSNM	122	113	134	369
PHP	219	278	247	744
WSCC	30	31	47	108
Total number of determinations/redeterminations that met Low NF LOC criteria	358	411	411	1,180
BCBSNM	116	111	132	359
PHP	212	269	232	713
WSCC	30	31	47	108
% of determinations/redeterminations that met Low NF LOC criteria	96%	97%	96%	97%
BCBSNM	95%	98%	99%	97%
PHP	97%	97%	94%	96%
WSCC	100%	100%	100%	100%

Source: DY9 Q3 MCO NF LOC Determinations Report

Table 22: MCO NF LOC Determinations – Community-Based

Community Based Determinations	July	Aug	Sept	DY9 Q3
Total number of determinations/redeterminations completed	2,252	2,277	2,071	6,600
BCBSNM	582	610	576	1,768
PHP	1,531	1,497	1,324	4,352
WSCC	139	170	171	480
Total number of determinations/redeterminations that did not meet NF LOC criteria	2,213	2,227	2,027	6,467
BCBSNM	572	598	569	1,739
PHP	1,506	1,461	1,290	4,257
WSCC	135	168	168	471
% of determinations/redeterminations that did not meet NF LOC criteria	98%	98%	98%	98%
BCBSNM	98%	98%	99%	98%
PHP	98%	98%	97%	98%
WSCC	97%	99%	98%	98%

Source: DY9 Q3 MCO NF LOC Determinations Report.

External Quality Review Organization (EQRO) NF LOC

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

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

In DY9 Q3:

- Aggregated results for NF LOC determinations from EQRO were 100%.
 - HSD reviewed the determinations from the EQRO reviews. The EQRO agreed with the MCOs for NF LOC determinations for High Facility Based, Low Facility Based, and Community Based files for DY9 Q3.
- HSD will continue to monitor the EQRO audit of MCO NF LOC determinations and identify and address any trends and provide technical assistance as needed.

Table 23: EQRO NF LOC Review

Facility-Based High NF Determination	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
Number of Member files audited	19	16	18	17
BCBSNM	7	6	6	6
PHP	6	5	6	6
WSCC	6	5	6	5
Number of Member files the EQRO agreed with the determination	19	16	18	17
BCBSNM	7	6	6	6
PHP	6	5	6	6
WSCC	6	5	5	5
% of Member files the EQRO agreed with the determination	100%	100%	100%	100%
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%
Low NF Determination	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
Number of Member files audited	35	38	36	37
BCBSNM	11	12	12	12
PHP	12	13	12	12
WSCC	12	13	12	13
Number of Member files the EQRO agreed with the determination	35	38	35	37
BCBSNM	11	12	12	12
PHP	12	13	12	12
WSCC	11	13	11	13
% of Member files the EQRO agreed with the determination	100%	100%	97%	100%
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	92%	100%
Community-Based	DY8 Q4	DY9 Q1	DY9 Q2	DY9 Q3
Number of Member files audited	90	90	90	90
BCBSNM	30	30	30	30
PHP	30	30	30	30
WSCC	30	30	30	30
Number of Member files the EQRO agreed with the determination	90	90	90	90
BCBSNM	30	30	30	30
PHP	30	30	30	30
WSCC	30	30	30	30
% of Member files the EQRO agreed with the determination	100%	100%	100%	100%
BCBSNM	100%	100%	100%	100%
PHP	100%	100%	100%	100%
WSCC	100%	100%	100%	100%

Source: EQRO NF LOC Report for CMS.

Waiver Assurance Performance Measures

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

- Administrative Authority: In DY9 Q2, HSD developed 3 performance measures to monitor the HCBS Administrative Authority. Please find DY9 results below.
 - PM #1: Percentage of required HCBS reports submitted timely by the MCOs.
 - Report #4, *Community Benefit* - 100% compliance
 - Report #8, *Nursing Facility Level of Care* - 100% compliance
 - Report #35, *Electronic Visit Verification* - 100% compliance
 - PM #2: Percentage of required HCBS reports submitted accurately without an MCO Self-Identified Error.
 - Report #4, *Community Benefit* - 100% compliance
 - Report #8, *Nursing Facility Level of Care* - 82% compliance
 - Report #35, *Electronic Visit Verification* - 100% compliance
 - PM #3: Percentage of required HCBS reports submitted accurately without an HSD rejection.
 - Report #4, *Community Benefit* - 86% compliance
 - Report #8, *Nursing Facility Level of Care* - 88% compliance
 - Report #35, *Electronic Visit Verification* - 82% compliance
- Level of Care (LOC): MCOs submit quarterly LOC reports to HSD that identify the number of initial LOCs conducted in the quarter. The information to support that the initial LOC is conducted timely is reported above under the NF LOC reporting.
- Qualified Providers: In DY9 Q2, HSD began to work on developing measures to monitor the HCBS Qualified Provider requirements. In DY9, there were a total of 304 approved Community Benefit providers. HSD reviews and approves all Agency-Based Community Benefit (ABCB) providers to ensure that they meet all program requirements as outlined in Section 8 of the Managed Care Policy Manual. Providers must obtain this program approval from HSD prior to contracting with the MCOs and providing services to ABCB members. In the Self-Directed Community Benefit (SDCB), the MCOs contract with a single Fiscal Management Agency (FMA) to oversee provider enrollment. The FMA ensures that all providers meet program requirements as outlined in Section 9 of the managed Care Policy Manual. SDCB providers must meet all program requirements and be approved by the FMA prior to rendering services to SDCB members. 100% of providers meet the program requirements prior to providing

services to members. HSD will continue to update CMS on its progress to establish and implement performance measures.

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

On a quarterly basis, HSD's EQRO validates MCO compliance with federal requirements for HCBS service plans. These reviews are conducted virtually, in real time, and include MCO care coordination staff participation. For each record in the sample, the MCO staff display pertinent information in the MCO's care coordination systems to demonstrate compliance. Pertinent information includes, but is not limited to: the comprehensive needs assessment; HCBS service plan; back-up plan; disaster plan; progress notes; claims; and eligibility data. A total of 8 performance measures are reviewed for each record. MCO agreement/acceptance of the review determination (met or not met) for each performance measure is captured prior to the conclusion of the review. Following is a summary of DY9 monitoring results:

- Statewide, 94 records were reviewed each 3 quarters beginning January 1, 2022.
- DY9 Q1 indicates 100% compliance with all performance measures for PHP and WSCC. BCBS has 1 file lacking "disaster preparedness" documentation. Giving a statewide percentage of 98.9% for Disaster Preparedness.

- DY9 Q2 indicates 100% compliance for all performance measures for WSCC. BCBS and PHP both had 1 file lacking “#6, disaster preparedness” documentation, giving a statewide percentage in this area of 97.9%. PHP had 1 file lacking “#5, service plan revision” giving a statewide percentage in this area of 98.5%.
- DY9 Q3 indicates 100% compliance for all performance measures for the 3 MCOs, BCBS, PHP and WSCC.
- HSD will continue to monitor EQRO HCBS Service Plan Review for compliance of the 8 performance measures to identify and address any trends and provide technical assistance as needed.

The tables below include a summary of the quarterly HCBS Service Plan data for DY9 Q3. The DY9 Q4 data will be reported on the DY10 Q1 CMS Quarterly Monitoring Report.

Table 24: HCBS SERVICE PLAN REVIEW SUMMARY

Eligible Population and Sample Size, DY9 Q3			
MCO	Eligible Population for DY9 Q3	MCO % of Entire HCBS Population in DY9 Q3	Number of HCBS Files Reviewed for DY9 Q3
BCBS	5,230	29%	34
PHP	12,114	66%	54
WSCC	943	5%	6
Centennial Care	18,287	100%	94

Source: DY9 Q3 External Quality Review Organization (EQRO) Quarterly HCBS Service Plan Report

Service Plan Review Results DY9 Q3						
Performance Measure	MCO	Total Files Reviewed	# of Files Met	# of Files Not Met	# of Files Not Applicable	% of Files Met
Member's choice to receive HCBS services versus institutional care is documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Member's choice of HCBS services and providers are documented in a written comprehensive care plan	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Member's HCBS service plan adequately addressed his/her assessed needs	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Services authorized by the MCO were delivered in accordance with the HCBS service plan, including the type, scope, amount, duration, and frequency are specified in the HCBS service plan	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
The HCBS service plan was revised, as needed, to address changing needs	BCBS	34	21	0	13	100%
	PHP	54	18	0	36	100%
	WSCC	6	6	0	0	100%
	Statewide	94	45	0	49	100%
A disaster preparedness plan specific to the member was in the HCBS service plan and documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Member's eligibility start and end dates are documented	BCBS	34	34	0	0	100%
	PHP	54	54	0	0	100%
	WSCC	6	6	0	0	100%
	Statewide	94	94	0	0	100%
Linkages to protective services are documented	BCBS	34	32	0	2	100%
	PHP	54	1	0	53	100%
	WSCC	6	0	0	6	100%
	Statewide	94	33	0	61	100%

Source: DY9 Q3 External Quality Review Organization (EQRO) Quarterly HCBS Service Plan Report

- **Health and Welfare of Enrollees:** HSD has implemented a monitoring process for assuring the health and welfare of members enrolled in HCBS through quarterly MCO reporting on established performance measures. The critical incident performance measures listed below will identify, address, and seek to prevent instances of abuse, neglect, exploitation, and unexpected death. HSD staff will review and analyze the data to determine if the MCOs report any significant changes from previous reporting periods. HSD findings are communicated to each MCO through Monthly Quality Bureau Critical Incident calls and during the Quarterly Critical Incident Meeting.

In DY9 Q1 through Q3, initial MCO submissions were received. Additional guidance was provided so data was collected in the same way by each MCO. HSD has adjusted certain DY9 Q1 data to reflect the consistency in reporting.

HSD observed that Performance Measure #5 demonstrated an increase in DY9 Q3 from DY9 Q2 and a decline in DY9 Q2 from DY9 Q1 in percentages reported for Adult Protective Services (APS) and Children Protective Services (CPS). Performance Measure #6 demonstrated that that the percentage of providers and MCO staff trained on reporting critical incidents into the HSD Portal initially at the start or at hire, and at least annually thereafter, had increases in percentages reported each quarter. All other Performance Measures demonstrated consistency or slight differences in percentages reported.

The table below is a summary of the quarterly data reported by the MCOs for DY9 Q1-Q3.

Table 25: Critical Incidents Performance Measures

Critical Incident Performance Measures (CI PM)												
CI PM	BCBS			PHP			WSCC			Total by Quarter		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
The number of all substantiated critical incidents.	7,695	9,376	8,235	17,322	19,422	18,607	1,580	1,800	1,309	26,597	30,598	28,151
CI PM	BCBS			PHP			WSCC			Percentage by Quarter		
PM #1: The percentage of substantiated critical incidents reported by category of abuse, neglect, exploitation and unexpected death:												
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
1.a. Percentage of substantiated individual abuse incidents identified and reported.	1.34	1.11	1.17	1.1	1.12	0.9	1.71	0.89	1.53	1.38%	1.04%	1.20%
1.b. Percentage of substantiated individual neglect incidents identified and reported.	77.04	79.9	77.21	60.39	62.15	59.32	78.04	80.39	73.34	71.82%	74.15%	69.96%
1.c. Percentage of substantiated individual exploitation incidents identified and reported.	0.45	0.5	0.22	0.35	0.24	0.32	0.38	0.67	0.53	0.39%	0.47%	0.36%
1.d. Percentage of substantiated individual unexpected death incidents identified and reported.	0.56	0.36	0.51	0.5	0.26	0.24	0.25	0.022	1.22	0.44%	0.28%	0.66%
CI PM	BCBS			PHP			WSCC			Percentage by Quarter		
PM #2: The percentage of substantiated critical incidents being reported within the required timeframe.												
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Percentage of substantiated critical incidents being reported within 24 hours.	89.67	92.99	92.33	85.85	89.66	89.07	91.27	88.28	88.58	88.93%	90.31%	89.99%
CI PM	BCBS			PHP			WSCC			Percentage by Quarter		
PM #3: The percentage of substantiated individual critical incidents where follow up (safety plans, corrective action plans, etc.) was completed:												
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed.	100	88.4	92.68	94.86	97.35	97.55	84.49	83.78	65.47	93.12%	89.84%	85.23%

CI PM	BCBS			PHP			WSCC			Percentage by Quarter		
PM #4: The percentage of follow-up actions taken on the substantiated critical incidents on a systemic basis to prevent future incidents, such as investigation as well as educating individuals and families:												
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
4.a. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) was completed to prevent future incidents.	37.99	14.12	28.35	31.23	31.93	27.94	97.66	98.06	97.86	55.63%	48.04%	51.38%
4.b. Percentage of substantiated individual critical incidents where follow up actions (safety plans, corrective action plans, etc.) included investigation and educating individuals and families was completed.	57.17	68.83	68.43	3.5	3.04	2.26	82.15	83.94	78.38	47.61%	51.94%	49.69%
CI PM	BCBS			PHP			WSCC			Percentage by Quarter		
PM #5: The percentage of the substantiated critical incidents with a referral to Adult Protective Services (APS) or Child Protective Services (CPS):												
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
5.a. Percentage of substantiated individual critical incidents where referrals to APS were completed.	19.99	20.49	46.59	50.98	52.1	44.18	60.44	32.33	5.81	43.80%	34.97%	32.19%
5.b. Percentage of substantiated individual critical incidents where referrals to CPS were completed.	0.84	0.57	1.66	1.06	0.82	0.31	0.7	0.06	0.23	0.87%	0.48%	0.73%
CI PM	BCBS			PHP			WSCC			Percentage by Quarter		
PM #6: The percentage of providers and MCO staff trained on reporting critical incidents into the HSD Portal:												
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
6.a. The percentage of contracted providers, agencies and MCO educated about reporting critical incidents to the HSD Portal initially at the start or at hire during the reporting period.	74.47	60.71	85.71	2.98	6.15	11.41	50	66.67	66.67	42.48%	44.51%	54.59%
6.b. The percentage of contracted providers, agencies and MCO that attended the annual training and were educated about reporting critical incidents to the HSD Portal. NOTE: THIS WILL ONLY BE REPORTED ONCE A YEAR IN THE QUARTER THE ANNUAL TRAINING IS HELD.	0	0	0	0	0	0	0	0	0	0.00%	0.00%	0.00%
CI PM	BCBS			PHP			WSCC			Percentage by Quarter		
PM #7: The percentage of substantiated critical incidents for Members with Multiple critical incidents identified and reported:												
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
The percentage of substantiated Members with Multiple critical incidents identified and reported.	62.01	74.25	64.81	73.22	74.76	73.47	64.62	70.33	58.06	66.62%	73.11%	65.45%

- **Financial Accountability:** In late DY9, HSD began to work on developing measures to monitor HCBS Financial Accountability requirements. MCOs send encounters to HSD for all Community Benefits services. HSD is working with the EQRO to monitor HCBS claims and will provide additional reporting in DY10.

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AI/AN REPORTING

MCO	Date of Board Meeting	Issues/Recommendations
BCBS	November 17, 2022 Virtual meeting	<p>Issue: When BCBS members attend the Native American Advisory Board meetings, even if the meeting is virtual, they can receive a gift card for attendance. One member told BCBS they have not received any gift cards for the past two or three meetings. He asked that BCBS contact him.</p> <p>Response: One of the BCBS staff reached out to the member and resent the missing gift cards. Issue was closed.</p> <p>Issue: A lady that attended the meeting said she was working with her care coordinator for a diabetic meter, but never received it.</p> <p>Response: A staff person from BCBS reached out to the member and provided information about the process to get a diabetic meter.</p> <p>Issue: Another member said it was difficult to get glasses. She wanted to know if BCBS provided glasses and where to go with her BCBS card.</p> <p>Response: A staff member with BCBS checked her eligibility and told her the type of coverage she has does not include vision coverage. BCBS provided her with information on Lion’s Club International to try and get eyeglasses through that program.</p>

PHP	December 8, 2022 Virtual meeting	<p>Issue: A member said she experienced an issue when she applied for Traditional Medicine Assistance towards the end of year. When she inquired about applying for the following year, she was told that she would have to wait until the end of the year to apply. PHP stated that when the application is received, the signature date is marked as the date of service. The signature date will be used to apply to the appropriate year of application. Presbyterian also reiterated that the service is available once per member per calendar year.</p> <p>Response: Member understood.</p> <p>Issue: A member asked how to get the Tabtime Vibe pill case.</p> <p>Response: PHP stated that if the individual is involved in care coordination, they can request it from their care coordinator. Also, a Community Health Worker can request this for members. Member was provided the email of someone from BCBS to contact.</p> <p>Issue: A member asked if a post-concussion or traumatic brain injury would fall under mental health.</p> <p>Response: The Behavioral Health Liaison at PHP answered that due to this being an injury to the brain this would fall under mental health - both within physical health and mental health. PHP encouraged him to get connected with a care coordinator and provided him with contact information.</p>
WSCC	December 2, 2022 Virtual meeting	<p>Issue: A member expressed concern around the transportation vendor Secure. They stated they have been missing appointments due to Secure cancelling the ride without notice. The member asked what follow-up should be done.</p> <p>Response: WSCC staff responded they will do some research on resolving these types of issues and follow up with the member. Member was encouraged to get a care coordinator involved and contact the WSCC Ombudsman to resolve any issues.</p> <p>Issue: A member asked how many miles non-emergency medical transportation is allowed to go.</p>

		Response: WSCC responded that if a member is referred by IHS or a Tribal 638 program, the miles are unlimited. If a member obtains prior authorization from Member Services, care coordinator, or Utilization Management, miles are unlimited.
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MCO	Status of Contracting with MCOs
BCBS	BCBS efforts to contract with the Navajo Area and other I/T/U providers continued to be unsuccessful. Although BCBS had some success in engaging conversations with some I/T/U providers, none of those conversations led to the successful execution of a contract.
PHP	PHP has been speaking with several Tribal 638 health care providers about Value Based Purchasing (VBP) agreements and support for programs that address Native American health disparities. Follow-up discussions will be held in early 2023. Also, one of the Tribal communities wants to discuss with PHP the potential for non-emergency transportation reimbursements. PHP Provider Network Operations and Native American Affairs have provided an onboarding training to Navajo Nation Division of Behavioral Health, and they are now live in the PHP network. Native American Affairs will continue agreement discussions on the possibility of including a VBP or limited care coordination agreement.
WSCC	<p>WSCC staff met with the Navajo Nation Department of Corrections to continue to develop the ability of corrections staff to complete a physical health assessment of incoming members for referral to behavioral health services, detox, and mental health services that align with the State of NM's JUST Health program. WSCC and the Corrections department staff (Four Corners Detox and Behavioral health Center and E-TACT, and software developer) met to develop an online intake form and develop the referral process. WSCC will also provide several different training opportunities for corrections staff, such as motivational interviewing, Narcan, and stress busting. WSCC will continue to meet with all stakeholders on implementation and any contract amendments in the first quarter of 2023.</p> <p>WSCC Tribal Relations conducted outreach to the Pueblo of Santo Domingo programs seeking approval of a Letter of Agreement (LOA) regarding Kewa Family Health and Wellness program. The LOA includes developing and implementing a process for limited Care Coordination delegation, Non-Emergency Medical Transportation (NEMT), and other services outlined in the LOA.</p>

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ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

BLUE CROSS BLUE SHIELD	
ACTION PLAN	Noncompliance by Transportation Vendor
IMPLEMENTATION DATE:	3/26/21
COMPLETION DATE:	Open
ISSUES	ModivCare has been placed on a corrective action plan for not meeting the contractual timeliness measures for certain Customer Service Call Center metrics and other additional contractual requirements.
RESOLUTION	<p>Due to continued service level failures, the action plan remains open.</p> <p>Service Level (85% or more calls answered by a live person within 30 seconds), Nurse Advice Line (85% or more calls answered by a live person within 30 seconds), Provider Services line (85% of calls answered within 30 Seconds) were all in compliance as of February and March 2022. Closed</p> <p>DY9 Q4 updates: Plan of Action (POA) related to call center remains open. BCBS is continuing to monitor the call center stats that include A-Leg (On Time Performance), Provider No-Shows, and member satisfaction. For DY9 Q4, ModivCare has improved overall and has increased the number of customer service staff, drivers, vehicles, and changed the member satisfaction survey questions to be easier and focus on members overall trip satisfaction. Below are the most current stats:</p> <p>November 2022:</p> <ul style="list-style-type: none"> - ASA = 17 seconds (met) - Service Level = 81.1% (not met) - Member Satisfaction = 90.8% (met) - A Leg Pick Up = 89.13% (not met) - Provider No-Shows = 68 - Total # of completed trips = 41,322 <p>To reduce the number of provider no-shows, ModivCare continues to add other transportation providers to the network.</p> <p>BCBS is also working on adding UBER (rideshare) to ModivCare's options for transportation for those members that are ambulatory (can walk safely on their own to/from vehicle) and will start this service in specific counties.</p>

HSD receives bi-weekly updates and continues to carefully review the ModivCare remediation plan and progress.

BLUE CROSS BLUE SHIELD

ACTION PLAN	DentaQuest (Quality of Care Process Improvement)
IMPLEMENTATION DATE:	7/15/22
COMPLETION DATE:	Open
ISSUES	<p>A NM Medicaid member received in-office dental services that involved sedation. The member encountered respiratory difficulties, was transported to a higher level of care, and subsequently passed away. Initially, DentaQuest reviewed the medical records and determined that there were no quality-of-care concerns. BCBS' corporate office requested that DentaQuest conduct a second review on the case, due to an internal clinical review, and upon doing so, DentaQuest ultimately terminated the provider and will be reporting their findings to the National Practitioner Data Bank (NPDB) as well as the NM Dental Board. DentaQuest did not thoroughly review the medical records to identify quality-of-care concerns, and the original review of medical records and second review had markedly different outcomes. Additionally, DentaQuest did not appropriately and timely terminate the provider, resulting in potential quality-of-care concerns for NM Medicaid members.</p>
RESOLUTION	<p>On 7/15/2022 BCBS initiated a Plan of Action (POA) against DentaQuest's Quality of Care (QOC) Review process.</p> <p>On 11/22/2022, BCBS created an addendum to the POA against DentaQuest. The addendum included: DentaQuest will need to take the following actions to ensure quality-of-care processes are handled appropriately; and DentaQuest to continue collaborative efforts by providing all clinical QOC reviews by staff who serve in clinical QOC review roles going forward.</p> <p>On 12/02/2022, BCBS requested that DentaQuest provide additional documentation to demonstrate remediation of the POA, which should be provided to the business partners of the BCBS corporate office within 14 calendar days after the expected completion date. Known or potential delays to remediation activities should be communicated to BCBS' corporate business partners as soon as possible and prior to the expected completion date. BCBS and DentaQuest continue to monitor the POA and have scheduled a future meeting that would include the BCBS Medical Director on the call.</p> <p>HSD will continue to receive updates from BCBS and will continue to monitor the progress.</p>

PRESBYTERIAN HEALTH PLAN

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

09/15/22 - VP of Finance reviewing final budget, approval pending.

12/31/2022 – Status remains unchanged.

PRESBYTERIAN HEALTH PLAN

ACTION PLAN	Secure Transportation
IMPLEMENTATION DATE:	03/04/21
COMPLETION DATE:	In Process
ISSUES	Improvement Plan – Network Adequacy
RESOLUTION	<p>Secure Transportation (ST) was placed on an improvement plan for the network issues. Monthly meetings will be held between ST and PHP leadership to review issues/concerns.</p> <p>09/13/21 Update: Network concerns remained an issue for ST. PHP placed ST on a corrective action plan (CAP) as the issues are not resolved timely. ST will provide monthly updates on efforts to improve the network, the next update was due in October 2021.</p> <p>02/15/22: ST added new providers to its network of drivers. PHP is working on increasing mileage reimbursement. Mileage reimbursement is offered at the front end of the scheduling process through care coordination to free up drivers for members who do not have supports for this option. ST is offering hiring bonuses and retention bonuses to help maintain the current network.</p> <p>04/01/22: Areas that are remaining a focus of the CAP for ST. This CAP is to remain open until network adequacy is improved.</p> <p>Action Plan Items:</p> <ul style="list-style-type: none">• Risk Stratification – policy to identify and prioritize high risk members (dialysis, chemotherapy, radiation, pre or post operative care, surgery, high risk pregnancy related appointments and urgent care); and members at risk of being dropped by their provider for missed appointments• Network Adequacy Plan - include specifics to ensure statewide coverage including 100 miles from the NM state borders (excluding Mexico)• Recruiting Plan – include number of vehicles, candidates, and area serviced• Network Monitoring processes<ul style="list-style-type: none">○ Retention Plan○ Incentive Plans - including incentive plans for resolving issue regarding short distance trips• Provider Issues – action plan to address providers regarding no-shows and those with excessive late pick-ups.

12/15/2022: ST remains on a CAP. PHP and ST developed a policy and process to improve access for critical care appointment scheduling and transportation completion that was approved by HSD. PHP is monitoring and seeing improved results.

PRESBYTERIAN HEALTH PLAN

ACTION PLAN	Home and Community Based Services (HCBS) Settings
IMPLEMENTATION DATE:	09/01/22
COMPLETION DATE:	In Process
ISSUES	Not conducting onsite inspections of Personal Care Service Agency offices.
RESOLUTION	<p>09/01/22: PHP Provider Network Operations (PNO) is working on getting in-person visits conducted by October 2022.</p> <p>12/14/22: PNO continues to work on setting up a schedule for in person visits for 2023.</p>

PRESBYTERIAN HEALTH PLAN

ACTION PLAN	Personal Care Service (PCS) Agency Employee File Auditing
IMPLEMENTATION DATE:	09/01/22
COMPLETION DATE:	In Process
ISSUES	Not reviewing PCS Agency policies and employee records for accuracy and all requirements.
RESOLUTION	<p>09/01/22 - An internal audit is being conducted to pilot the process for reviewing PCS agencies for their contractual and regulatory requirements. The plan is to send out a request for information from 20 randomly chosen PCS agencies representing all 5 regions of NM, and sample five randomly chosen employee records to review from each agency. Audit start date is tentatively scheduled for 10/17/2022.</p> <p>12/14/22 – The audit is underway with tentative completion date of mid-February 2023. Closed</p>

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Provider Satisfaction Survey
IMPLEMENTATION DATE:	8/26/22
COMPLETION DATE:	Open Item
ISSUES	2021/2022 Provider Satisfaction Survey
RESOLUTION	WSCC did not send the approved Provider Satisfaction Survey from HSD to providers for the calendar years 2021 and 2022. WSCC also misnamed the survey as “physician satisfaction” and not the “provider satisfaction” survey. WSCC sent a new survey for review and HSD approved the new survey in DY9 Q3. WSCC re-fielded the 2022 survey. WSCC submitted weekly reports to HSD pertaining to the re-fielding of the 2022 survey. WSCC is submitting the results of the survey in DY10 Q1. Closure is anticipated in DY10 Q2.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Payment Error- Reprocessing and Recoupment of Payments
IMPLEMENTATION DATE:	9/20/22
COMPLETION DATE:	Open item
ISSUES	Payment Error- Reprocessing and Recoupment of Payments, Temporary Economic Recovery Payments increase for Home and Community Based Services (HCBS)
RESOLUTION	During a routine audit of payments issued through WSCC’s accounts payable platform, a discrepancy was identified related to payments described in a Letter of Direction (LOD) that HSD sent to the MCOs. This LOD directed the MCOs to provide a temporary economic recovery payment increase for Home and Community Based Services. A misalignment occurred between the payable supplier ID and the amount due to the provider, creating over and under payments. WSCC is providing outreach to those providers impacted to ensure payments are issued for those providers who were underpaid, as well as working on repayment options for the providers who were issued overpayments. HSD is closely monitoring this through weekly detailed reports from WSCC. WSCC is at a 99% completion rate for underpaid providers and at a 84.3% completion rate for overpaid providers There is a payment plan for all but 7 of the 70 providers who were overpaid. The remaining 7 providers are actively working with WSCC on a payment plan. Closure is anticipated in DY10 Q2.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Secure Transportation No Show Remediation Plan
IMPLEMENTATION DATE:	11/17/22

COMPLETION DATE:	Open item
ISSUES	Secure Transportation (Secure) has not met performance measures for driver no shows for critical care appointments for the period beginning in July 2022.
RESOLUTION	The expectation is that driver no shows are reduced to 1% of total monthly critical care trips. Secure provided a remediation plan to WSCC. The plan includes Secure, WSCC, and Uber Health working to gain approval for Uber Health (and other rideshare providers) to be able to operate in the state. This plan also includes initiatives with Secure senior leadership team to analyze the network and provide feedback on matching capacity to demand, discussion around reimbursement rates, and reducing the number of driver no-shows. HSD approved WSCC plans and is closely monitoring this. Closure is anticipated in DY10 Q3.

WESTERN SKY COMMUNITY CARE	
ACTION PLAN	Provider Directory
IMPLEMENTATION DATE:	December 2022
COMPLETION DATE:	Closed
ISSUES	2020 Provider Directory Audit
RESOLUTION	There were 8 findings from an external audit related to the completeness, accuracy, and consistency of information included in the provider directory when compared to the requirements in Sections 4.14.5.1 and 4.14.5.4 of the Managed Care Agreement. In DY8 Q3, WSCC provided a detailed action plan with timelines for resolution of each finding. WSCC provided additional information related to the tracking of provider issues and how they are resolved to HSD. HSD closed this concern DY9 Q4 as the above issues have been resolved.

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FINANCIAL/ BUDGET NEUTRALITY DEVELOPMENT/ISSUES

DY9 Q4 reflects the capitation rates for Centennial 2.0 that were submitted to the Centers for Medicare and Medicaid Services (CMS) on December 31, 2021 and the rate updates on June 30, 2022. On average, the CY 2022 rate was higher than that of CY 2021; however, fee-for-service claim payments during CY 2022 were still lagging, and they affected the PMPMs. In addition, data run out for CY 2022 will continue and the Per Member per Months (PMPMs) will continue to change as expenditures come in (see Attachment A – Budget Neutrality Monitoring, Table 3 - PMPM Summary by Demonstration Year and MEG). On Attachment A – Budget Neutrality Monitoring Spreadsheet – Budget Neutrality Limit Analysis indicates that DY 7 is 12.0% below the budget neutrality limit (Table 7.5) through 12 quarters of payments. For DY 8, Table 8.5 shows a 10.3% below the budget neutrality limit with data through 8 quarters. Table 9.5 shows a 14.3% below the budget neutrality limit for DY 9 with preliminary data with 4 quarters of payments.

In calendar year (CY) 2022, HSD monitored MCO contractual compliance for insolvency and performance bond coverage. All 3 MCOs remained in good standing by maintaining an account balance equal to no less than 90% of the average monthly capitation paid to the MCO in the most recent quarter. Also, MCOs remained compliant with Fidelity bond requirements. To limit the MCOs' risk of catastrophic losses and exposure to large claims by individuals with chronic or high-cost conditions, the MCOs maintained a minimum of \$1,000,000 per member in reinsurance protection. The reinsurance pays a percentage of losses in excess of the deductible; 23 members met the reinsurance deductible in CY 2022.

HSD has provisions in the Centennial Care contract that allows for recoupment of capitation payments made for members who were incorrectly enrolled with more than one MCO, members who die prior to the enrollment month for which a capitation payment was made, and members whom HSD later determines were ineligible for Medicaid during the enrollment month for which a capitation payment was made. HSD also processes mass adjustments for capitation payments issued at a non-dual rate cohort and then reissued at a dual rate cohort for members who are retroactively determined to have Medicare coverage and do not exceed the time period that the MCO can retroactively adjust claims payment to providers for those services for which Medicare would be the primary payer.

The recoupments and adjustments are processed monthly. In CY2018, HSD added the recoupment of capitation payments for individuals who are Medicaid enrolled and have their benefits suspended after 30 days of incarceration. At the end of CY22, 74% of total capitation payments were recouped from the MCOs because of the issues mentioned above.

The final payment or recoupment for the CY2020 Retroactive Period, Medical Care Credit, and Hepatitis C Risk Corridor reconciliations were finalized during CY2022. The initial payment or recoupment for the CY2021 reconciliations was completed with final evaluations scheduled to be completed mid-year 2023. Indian Health Service (IHS) payments are paid based on the Date of Payment (DOP) and are paid quarterly. CY2022 IHS payments have been paid based on DOP criteria. After completing the reconciliations, the evaluation of the underwriting gain earned by each MCO for the contract period was performed.

In CY2019, none of the 3 MCOs exceeded the permitted 3% underwriting gain limitation. In the final interim for CY2020, 2 of the 3 MCOs exceeded the permitted 3% underwriting gain limitation. The MCOs share 50% of the underwriting gain in excess of 3.0% with HSD.

In CY2019, HSD implemented the Medical Loss Ratio (MLR) report, with MCOs required to submit annually. The CY2022 MLR report is due on July 31, 2023. In addition, HSD has received finalized CY2019 MLR examination reports conducted by external auditors, Myers and Stauffer, LC.

All MCOs are required to submit their CY2022 Q4 financial reports on February 15, 2023. Reviews will be completed with observations and questions being sent to the MCOs for response and review of the categorization of service logic within their reporting. HSD continues to focus attention on the categorization of expenditures by program, cohort, and category of service and the comparison of submitted encounter data to financial reports. Final CY2022 annual supplement financial reports are due on May 15, 2023. HSD continues to evaluate the MCO's financial and operational performance at both the individual MCO level and an aggregate level.

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MEMBER MONTH REPORTING

Member Months		2022
		4
MEG1	0-FFS	106,622
	Presbyterian	684,092
	Western Sky	131,661
	Blue Cross Blue Shield	449,504
	Total	1,371,879
MEG2	0-FFS	7,656
	Presbyterian	62,573
	Western Sky	11,713
	Blue Cross Blue Shield	37,816
	Total	119,758
MEG3	0-FFS	0
	Presbyterian	67,246
	Western Sky	10,667
	Blue Cross Blue Shield	33,887
	Total	111,800
MEG4	0-FFS	608
	Presbyterian	289
	Western Sky	43
	Blue Cross Blue Shield	221
	Total	1,161
MEG5	0-FFS	0
	Presbyterian	8,970
	Western Sky	1,499
	Blue Cross Blue Shield	6,968
	Total	17,437
MEG6	0-FFS	79,806
	Presbyterian	385,897
	Western Sky	102,446
	Blue Cross Blue Shield	310,234
	Total	878,383
MEG10	0-FFS	9
	Presbyterian	104
	Western Sky	21
	Blue Cross Blue Shield	77
	Total	211
MGX8	0-FFS	0
	Presbyterian	229
	Western Sky	54
	Blue Cross Blue Shield	200
	Total	483
Total		2,501,112

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CONSUMER ISSUES

GRIEVANCES

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

In DY9 Q4, the reports submitted by MCOs for October through December 2022 were reviewed and analyzed to determine compliance with contractual requirements. HSD observed in DY9 Q4 the second top primary member grievance code reported was Dental. This remains the same as in DY9 Q3 and was a change from Provider Specialist in DY9 Q2 and MCO Operational Issues in DY9 Q1. Overall, for DY9, the Year to Date Total for Dental was the second top primary member grievance per aggregate data. The table below is a summary of the quarterly data reported by the MCOs for DY9 Q4.

Table 26: Grievances Reported

Grievances reported (January - December 2022)																
Grievances	BCBS				PHP				WSCC				TOTAL BY QUARTER			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Member Grievances	485	431	283	276	434	458	437	326	39	44	47	44	958	933	767	646
Top Two Primary Member Grievance Codes																
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER			
													Q1	Q2	Q3	Q4
Transportation Ground Non-Emergency	346	312	168	182	180	175	226	141	15	13	18	21	541	500	412	344
Dental	15	11	11	14	0	14	25	8	2	2	2	3	17	27	38	25
Variable Grievances	124	108	104	80	254	269	186	177	22	29	27	20	403	406	317	277

Source: MCO Report #37

APPEALS

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

In DY9 Q4, the reports submitted by MCOs for October through December 2022 were reviewed and analyzed to determine compliance with contractual requirements. The table below is a summary of the quarterly data reported by the MCOs for DY9 Q4.

Table 27: Appeals Reported

Appeals Reported (January - December 2022)																
APPEALS	BCBS				PHP				WSCC				TOTAL BY QUARTER			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Standard Member Appeals	369	363	354	355	484	484	566	487	23	30	43	43	876	877	963	885
Number of Expedited Member Appeals	35	46	49	33	28	25	36	44	6	3	5	14	69	74	90	91
Top Two Primary Member Appeal Codes																
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	TOTAL BY QUARTER			
													Q1	Q2	Q3	Q4
Denial or limited authorization of a requested service	327	412	360	325	497	494	572	512	29	25	42	56	853	931	974	893
Denial in whole of a payment for a service	70	19	36	54	7	15	29	16	0	0	0		77	34	65	70
Variable Appeals	7	-22	7	9	8	0	1	3	0	8	6	1	15	-14	14	13

Source: MCO Report #37

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QUALITY ASSURANCE/ MONITORING ACTIVITY

ADVISORY BOARD ACTIVITIES

Under the terms of HSD’s Centennial Care 2.0 Managed Care Services Agreements and the Managed Care Policy Manual, the MCOs are required to convene and facilitate a Native American Advisory Board and a Member Advisory Board to advise on service delivery, the quality of covered services, and member needs, rights, and responsibilities. HSD specifies the frequency of board meetings. The MCOs report semi-annually on the activities of the Advisory Boards. Please reference the table below for 2022 MCO Advisory Board Meeting Schedules.

Table 28: 2022 MCO Advisory Board Meeting Schedules

BCBS 2022			
MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	03/03/2022	12:00-1:30 PM	Virtual - Albuquerque - Central
BCBS	04/07/2022	3:30-5:00 PM	Virtual - Valencia and Socorro Counties - Central
BCBS	06/16/2022	12:00-1:30 PM	Virtual – Albuquerque - Central
BCBS	07/21/2022	12:00-1:30 PM	Virtual – Albuquerque - Central
STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	09/29/2022	12:00-1:30 PM	Virtual - Las Cruces (Dona Ana County) - Regional
BCBS	10/20/2022	12:00-1:30 PM	Virtual - Santa Fe (Santa Fe County) - Regional
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
BCBS	02/10/2022	12:00-1:30 PM	Virtual - Sandoval and Bernalillo Counties
BCBS	05/05/2022	3:30-5:00 PM	Virtual - McKinley (Crownpoint)
BCBS	08/25/2022	12:00-1:30 PM	Virtual - Eight Northern Pueblos
BCBS	11/17/2022	12:00-1:30 PM	Virtual - McKinley (Zuni, Ramah and Pine Hill)

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 2022			
Meetings will be held virtually until state restrictions are lifted for in-person meetings. SDCB Subcommittee Member Advisory Board Meetings are currently on hold.			
MEMBER ADVISORY BOARD MEETING SCHEDULE (CENTRAL AREA)			
MCO	DATE	TIME	LOCATION
PHP	03/04/2022	1:30-3:30 PM	Virtual Meeting
PHP	06/03/2022	1:30-3:30 PM	Virtual Meeting
PHP	09/09/2022	1:30-3:30 PM	Virtual Meeting
PHP	12/02/2022	1:30-3:30 PM	Virtual Meeting
RURAL AREA MEETINGS			
MCO	DATE	TIME	LOCATION
PHP	09/16/2022	10:00-12:00 PM	Virtual Meeting (Deming)
PHP	10/19/2022	12:30 – 2:30 PM	Virtual Meeting (Alamogordo)
NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
PHP	03/24/2022	3:00-5:00 PM	Virtual Meeting
PHP	06/09/2022	3:00-5:00 PM	Virtual Meeting
PHP	09/08/2022	3:00-5:00 PM	Virtual Meeting
PHP	12/08/2022	3:00-5:00 PM	Virtual Meeting
SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE			
MCO	DATE	TIME	LOCATION
PHP	TBD	TBD	Meetings on Hold <ul style="list-style-type: none"> Due to the low volume of self-directed members, PHP opted to fold these meetings into its broader Centennial Care 2.0 Member Advisory Board. Updates are provided at every meeting, presented by PHP's LTC Care Coordination Manager.

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
PHP	03/08/2022	1:00-2:30 PM	Virtual Meeting
PHP	06/07/2022	1:00–2:30 PM	Virtual Meeting
PHP	09/13/2022	1:00–2:30 PM	Virtual Meeting
PHP	12/13/2022	1:00–2:30 PM	Virtual Meeting

WSCC 2022

MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	02/11/2022	2:00-4:00 PM	Virtual Meeting
WSCC	05/14/2022	10:00 AM-12:00 PM	Virtual Meeting
WSCC	08/18/2022	11:00 AM- 1:00 PM	Virtual Meeting
WSCC	12/08/2022	2:00-4:00 PM	Virtual Meeting

STATEWIDE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	04/14/2022	4:00-6:00 PM	Virtual Meeting
WSCC	10/12/2022	3:00-5:00 PM	Virtual Meeting

NATIVE AMERICAN ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	03/03/2022	11:00 AM- 1:00 PM	Virtual Meeting
WSCC	06/02/2022	4:00-6:00 PM	Virtual Meeting
WSCC	09/02/2022	11:00 AM-1:00 PM	Virtual Meeting
WSCC	12/02/2022	4:00-6:00 PM	Virtual Meeting

SDCB SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	08/18/2022	11:00 AM-1:00 PM	Virtual Meeting (Included in the MAB Presentation)

BH SUBCOMMITTEE MEMBER ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	10/12/2022	3:00-5:00 PM	Virtual Meeting (Included in Statewide)

COMMUNITY ADVISORY BOARD MEETING SCHEDULE

MCO	DATE	TIME	LOCATION
WSCC	06/15/2022	3:00-5:00 PM	Virtual Meeting

Quality Assurance

DY9 Q4

Quarterly Quality Meeting

HSD holds Quarterly Quality Meetings (QQMs) with the MCOs to provide HSD updates and guidance on required quality monitoring activities as well as relay HSD findings from the monthly, quarterly, and annual reports submitted by the MCOs.

HSD's Quality Bureau, Performance Measures Unit, held the QQM for DY9 Q4 on December 20, 2022.

HSD presented a focus on three specific MCO Tracking Measures (TMs), Consumer Assessment of Healthcare Providers and Systems (CAHPS) results, and Hospital Directed Payment updates.

The MCO TMs presented by HSD this quarter were, TM#2, *Diabetes Short-Term Complication Admissions*, TM#9, *Annual Dental Visits*, and TM#12, *Child and Adolescent Well-Child Visits*. HSD presented the CY22 Q3 aggregate rate compared to the CY21 Q4 aggregate rate for each measure to show how the data is trending. Each MCO provided their barriers experienced with avoiding high admission rates, and their initiatives to avoid short term complications admissions for members with diabetes. MCOs also explained how they use the quarterly TM report to monitor progress and outcomes internally, and goals are set to meet internal monthly targets.

BCBS stated that they promote telehealth outreach, send member newsletters, conduct upcoming dental event reminder calls, and use internal monthly reports to monitor and gauge progress on quarterly measures.

PHP reported they have an internal monthly monitoring process to gauge performance and use quality measures as part of value-based purchasing to drive and incentivize provider performance, such as incentivizing dentists and/or pediatric groups for an annual dental visit.

WSCC utilizes NCQA requirements to set internal goals and their Transition of Care (TOC) team and disease management programs monitor data to ensure goals are met. One barrier

WSSC experienced is providers are not accepting new patients, so WSSC allows members to be seen by any provider.

HSD also presented aggregate CAHPS results focused on Health Plan questions in the Adult, Child and Children with Chronic Conditions survey, comparing the Measurement Year 2021 (MY2021) survey results to the MY2020 survey results.

HSD advised that MCOs were collectively 1 percentage point below the MY2021 Quality Compass National Average for the following Adult survey question, “In the last six months, how often did your health plan’s customer service give you the information or help you needed?”

For the same question in the Child survey, “In the last 6 months, how often did customer service at your child’s health plan give you the information or help you needed?” the MCOs collectively achieved the National Average of 83%, which is a 3 percentage point improvement from MY2020.

The MCOs collectively remained steady from MY2019 to MY2020 with only a 1 percentage point drop in MY2021 for the same question in the Child with Chronic Conditions survey, “In the last 6 months, how often did customer service at your child’s health plan give you the information or help you needed?”

HSD ended the meeting with the DY9 evaluation results for 3 hospital directed payment preprints reflecting metric results for Plan All Cause Readmissions, Hemoglobin A1c testing, and 30 Day Follow Up After Hospitalization for Mental Illness rates for Community Tribal Hospitals, NM for Profit Hospitals and NM Not for Profit Hospitals. Lastly, HSD presented DY9 evaluation results for the Trauma Facilities hospital directed payment, providing each participating Trauma Hospital’s HCAHPS score for Communication with Doctors and Discharge Information categories. HSD acknowledged the MCOs for providing the data used to evaluate performance for 30 facilities included in the preprints.

Monthly Performance Measure Monitoring Plan

In DY7, the HSD Quality Bureau initiated a Monthly Monitoring Plan to address the decline in Healthcare Effectiveness Data and

Information Set (HEDIS) rates from DY4 to DY5 for *Follow-Up After Hospitalization for Mental Illness (FUH)* and *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* performance measures. Due to ongoing efforts to improve member outcomes and noticeable improvement for all 3 MCOs as a result of the Monthly Monitoring Plan, HSD ceased monthly submissions of the FUH and FUM measures effective with completion of their DY9 M3 submissions.

In DY9 Q3, HSD introduced 3 new measures to the Monthly Monitoring Plan for MCOs due to the decline in rates for PM #1 (W30), PM #3 (PPC-Prenatal) and PM #5 (CIS – Combination 3). HSD provided the MCOs with directions and a monitoring tool to provide a monthly account of the ongoing interventions, strategies, and barriers associated with improving performance outcomes to ensure progress is being monitored and PM targets are met by the end of DY9 and DY10. The first report of DY9 Q3 data is reported below. The DY9 Q4 data will be reported on the DY10 Q1 CMS Quarterly Monitoring Report.

The State of New Mexico and HSD established an annual target rate for CY 2022 for PM #1 – Well Child Visits in the First Fifteen (15) Months of Life (W30) of 64.82%. Through DY9 Month 9 (M9), the MCOs had the following average rates: BCBS 56.77%, PHP 47.98%, and WSCC 51.18%.

The CY 2022 HSD annual target rate for PM #3 – Prenatal & Postpartum Care (PPC) is 82.73%. Through DY9 M9, the MCOs had the following average rates for Timeliness of Prenatal Care: BCBS 58.27%, PHP 60.63%, and WSCC 55.02%.

The CY 2022 HSD annual target rate for PM #5 – Childhood Immunization Status (CIS) is 70.53%. Through DY9 M9, the MCOs had the following average rates for Combination 3 Immunizations: BCBS 59.02%, PHP 62.30%, and WSCC 54.01%.

HSD expects to see these rates increase quarter over quarter, and the final determination of whether the MCOs have met the established targets is reliant on the CY 2022 annual audited HEDIS report, which will be received in June 2023.

BCBS:

W30: M7 54.16%; M8 57.06%; and M9 59.08%. Increase of 4.92 percentage points from M7 to M9.

Strategies and Interventions:

In DY9 Q3, BCBS implemented activities in a three-pronged intervention approach to increase measure compliance as it relates to who turned 15 months old and had 6 or more well-child visits in the measurement year. BCBS also continues to target members who have gaps in well-child visits and performs member outreach through multiple initiatives, which includes an SMS texting campaign, currently in the production phase, to deliver timely reminders to parents/guardians encouraging well-child visits. This campaign was created to bring awareness to parents/guardians to schedule an appointment with their healthcare provider or contact BCBS if member needs assistance with scheduling an appointment. BCBS continues to engage provider groups through value-based contracts and dashboards are reviewed and discussed, and trendlines among attributed members are also reviewed. BCBS data analysts provide Quality Measure (QM) staff with gap lists for members 0-15 months of age who may need 1 or more well child visit during the rest of the measurement year. QM staff provide outreach to members by conducting a telephone call to offer assistance in scheduling an appointment. Member outreach calls are made based on gaps identified through data analytics with a focused approach for addressing gaps in care for well child visits. BCBS Quality and Operations staff meet with each value-based provider during a monthly joint operations meeting where Value Based Contract (VBC) dashboards are reviewed with the expectation to identify and mitigate barriers, and to close gaps in care.

PPC: M7 58.47%; M8 58.10%; M9 58.23%. Decrease of 0.24 percentage points from M7 to M9.

Strategies and Interventions:

BCBS reports that measure compliance and activities are monitored monthly and are shared with all value-based providers with the expectation to mitigate member facing barriers and close respective gaps in care. During monthly joint operating meetings, BCBS reviews provider performance against the assigned target

and provides a prenatal specific gap list so the provider group can assist in gap closure. BCBS began utilizing gap lists to direct both texts and emails, promoting timeliness of prenatal care, to newly identified pregnant members while offering assistance with scheduling an appointment with an OBGYN and/or PCP. Joint operating meetings continue with provider groups incentivized through VBC with the goal to improve Timeliness of Prenatal Care (PPC-TOPC) measure compliance among their attributed BCBS Centennial members. Provider groups are offered gap in care lists, identifying new pregnancies on a monthly basis and encouraged to close gaps within first trimester of pregnancy. BCBS collaborates with Tricore Labs to monitor members who are accessing laboratory services through their payor portal. Members identified by the payor portal create a member touch point for intervention. BCBS actively analyzes prenatal measure compliance trends, deploys strategies for improvement, and takes actionable steps to mitigate barriers as well as sustain improvements. Member level interventions include, 'The Special Beginnings' Care Coordination program specifically tailored for high-risk pregnant members and the Centennial Home Visiting program focusing on the mother child unit. BCBS' Community Outreach team is holding community baby shower events this year in Roswell, New Mexico.

CIS: M7 57.79%; M8 59.27%; M9 59.99%. Increase of 2.2 percentage points from M7 to M9.

Strategies and Interventions:

BCBS conducts member outreach targeting childhood immunizations Combo 3 gaps through multiple initiatives including the development of an SMS texting campaign, which is currently in the production phase, created to deliver timely reminders to encourage parents/guardians to complete immunizations. The BCBS QM Specialist conducts telephonic outreach to members to encourage parent/guardian to schedule and complete well child visits in the first 15 months of life including those members with respective immunization gaps. BCBS data analysts provide QM staff with gap lists of members 0-15 months of age with gaps in Combo 3 immunizations, as well as those members who may have missed or need to catch up on Combo 3 immunizations. Member outreach calls are made based on gaps identified through data analytics with a focused

approach for addressing gaps in care and offer assistance with scheduling an appointment. The calls also serve as reminder if the member chooses to schedule an appointment on their own. Member outreach calls are made year-round and aligns data analytics with a focused approach for addressing gaps in care for Immunizations. BCBS engages provider groups through value-based contracts with a goal to improve the CIS-Combo 3 measure compliance among their attributed BCBS members. Monitoring activities are held directly with the value-based providers. During monthly joint operating meetings, dashboards are reviewed against measure performance and target goals for CIS-Combo 3. The expectation for each provider group is to work with BCBS's Quality and Operations staff to mitigate barriers and close gaps. Providers are encouraged to overlay the first 6 provider visits in the first 15 months of life with the CDC immunization schedule for CIS-Combo 3.

PHP:

W30: M7 45.14%; M8 47.90%; M9 50.90%. Increase of 5.76 percentage points from M7 to M9.

Strategies and Interventions:

PHP conducts referrals to their internal Centennial Care Baby Bonuses incentive program for eligible members. This program provides a small monetary reward to members who complete eligible well-child visits. PHP routinely contacts members who had a live birth and provides them with information about the importance of well-child visits and immunizations and assists with enrollment and scheduling follow-up visits if members are interested in the program. Throughout the quarter, presentations were given to statewide early intervention workers, community health workers, and care coordinators offering information on PHP's child centered reward program. Continuous enrollment for eligible members is done weekly based on program referrals and enrollment from live phone calls with eligible members. PHP plans to increase collaboration through internal PHP CHW training and member phone call campaigns to remind families to schedule and complete well-child visits. Data monitoring is also conducted through Presbyterian Health Services (PHS) Provider Quality Incentive Program to reimburse providers when they complete targeted W30 and other children's HEDIS measures. PHP is conducting clinic-based member outreach by providing

Gap in Care reports for members seen at the clinic and provider groups. PHP is also incorporating a member mailing reminder to complete well child visits, in addition to, sending daily mailings of standard Early and Periodic Screening, Diagnostic and Treatment (EPSDT) letters. PHP continues to participate in the statewide “Got Shots” campaign with University of New Mexico Health Sciences Office of Community Health, as well as conducts community outreach at health fairs, farmers markets, and back to school events in order to provide health education on the importance of well-child visits.

PPC: M7 60.73%; M8 60.50%; M9 60.67%. Decrease of .06 percentage points from M7 to M9.

Strategies and Interventions:

PHP began working on a new report pulled from Presbyterian Medical Group’s Electronic Medical Records (EMR) system, EPIC, which will identify members who have had a positive pregnancy test. This report will help PHP identify members who are pregnant and accessing services within the Presbyterian Medical Group (PMG) network. PHP’s program manager completes telephonic outreach to members participating in the Baby Benefits prenatal reward program and encourages members to register and engage in the program. HEDIS rates and associated members on Gap in Care (GIC) reports are reviewed monthly to look at opportunities for outreach members and encourage prenatal and postpartum visits. PHP reviews statistics around their internal Baby Benefits program monthly. The data reviewed includes, but is not limited to: newly enrolled members, completion rates, member concerns, and call volume. PHP also conducts monthly reviews of pregnancy reports to ensure members have access to a provider and needed referrals are made. PHP is developing a new program aimed to identify and refer members in need of expanded support and/or at high risk to develop complications connected to home visiting to assist with navigating the health care system. PHP conducts a year-round medical record abstraction to assist with improving the timeliness of prenatal care by the end of the calendar year, along with a monthly review of prospective rates, which will track changes and focus on expected year-end results. PHP continues to participate in community events that focus on women’s health to educate members on prenatal and postpartum care. In

addition, PHP educates clinics on member and provider rewards programs that focus on prenatal and post-partum care. PHP is also expanding health education information on social media platforms to engage members in prenatal care and the reward program.

CIS: M7 61.69%; M8 62.44%; M9 62.77%. Increase of 1.08 percentage points from M7 to M9.

Strategies and Interventions:

PHP promotes the importance of childhood immunizations statewide with member outreach at community events, as well as attends such events in order to engage community members in obtaining childhood immunizations. PHP attended 3 community events in DY9 Q3 where they provided giveaway items for children while sharing health, wellness, and immunization information to event participants. Outreach is typically done by Performance Improvement (PI) Program Managers and PI Interventionists annually each calendar year, generally at community events scheduled from April through October. PHP also conducts active phone call outreach by PI staff to members who graduated from the Baby Benefit Reward Program to educate and engage, where appropriate, in PHP's internal Baby Bonuses incentive program. The Baby Bonuses program promotes completion of infant wellness visits thru 30 months of age. At well child visits, PHP addresses immunizations with parents and guardians, as this is a Value-Added Benefit and incentive program for Centennial Care members. Ongoing EPSDT letters with age-appropriate immunization information continue to be mailed out from PHP daily. In DY9 M9, PHP increased communication with PMG Clinics regarding the total number of members eligible for CIS Combo 3 with gaps in care as well as coordinated outreach efforts to close the current gaps. PHP will continue collaboration with Presbyterian Health Services VBP and Provider Quality Incentive Programs (PQUIP) to encourage PHS/PMG providers to engage members to complete needed immunizations in this measure.

W30:

W30: M7 47.66%; M8 51.90%; M9 53.99%. Increase of 6.33 percentage points from M7 to M9.

Strategies and Interventions:

The mPulse Member Outreach Campaign sends text reminders to member’s parents/guardians to schedule a well child visit. WSCC’s Quality Department is reviewing various data sets to determine the effectiveness of this intervention. WSCC is also teaming up with FarmBox to provide a box of healthy snacks, recipes, and reading material to members identified as having a gap in care. FarmBox will be conducted as a pilot project, which is launching in DY9 Q4 and will focus on members that have yet to receive their immunizations, well care visit, and annual dental exam. The timeline allotted for this initiative will provide 45 days for a member to get the well care visit completed to receive a box. WSCC is anticipating that members will enjoy the initial FarmBox and would want to continue to receive them, which should pursue the member’s parents/guardians to schedule the appropriate appointments. WSCC is also preparing for a Quality Provider Summit, which will include trainings and overview on initiatives focused on well child visits. During the overview, providers can ask questions and request to participate in WSCC utilization efforts to close gaps for members. Additionally, WSCC Quality Reporting Specialists (QRS) work with providers to meet their targets in completing well child visits and provide support on alleviating barriers to care. WSCC has provided a Quick Reference Guide (QRG) for all HEDIS measures that is sent to providers during provider engagement meetings, Provider Roadshows, and upon request. The QRGs include tips on how to close code to ensure gap closure, overview of the measures, and any exclusions. Quality Improvement (QI) nurses conduct targeted member outreach for any member that hasn’t completed their well child visit, and assists members in overcoming barriers, scheduling appointments, education on the importance of the visits, and advising members of any WSCC events or incentives they are eligible to receive or attend.

PPC: M7 54.63%; M8 53.31%; M9 57.11%. Increase of 2.48 percentage points from M7 to M9.

Strategies and Interventions:

WSCC receives a Notification of Pregnancy (NOP) for pregnant members through claims data, state eligibility data, and member and provider referrals to help identify risk factors in the earliest stages of pregnancy, improve healthy birth outcomes, and offer

available maternity programs. As an incentive for members to complete a NOP, WSCC rewards eligible members with a \$25.00 VISA gift card to use at their discretion. In addition to the gift card, eligible members receive a free digital thermometer, WSCC branded baby bottles, pacifiers and bibs, as well as educational material based on the stages of their pregnancy, including post-delivery. Once a NOP is completed, members are enrolled in WSCC's main maternal health program called Start Smart for Baby (SSFB) program, a pregnancy management program that incorporates care management, care coordination, and health education. SSFB monitors the NOP process to ensure that all outreach efforts are conducted timely. For members that are medium to high risk, the SSFB Care Coordinator engages with the member on a weekly basis. WSCC offers Virtual Baby Showers for expecting members and uses the opportunity to educate members on prenatal and postpartum care, Safe Sleep practices, smoking cessation through our Puff Free Pregnancy program, and provides \$250 Holistic Care Grants (when available) to put toward the purchase of a crib or any equipment needed for baby. WSCC also partners with Families First/Early Childhood Education and Care Development (ECECD), to train their staff on the Pacify application, Timeliness of Prenatal Care materials, and completing NOPs for WSCC members that are unable to reach and/or underage pregnant members for additional support. WSCC monitors ECECD engagement and member referrals to the Centennial Home Visiting program (CHV) by having quarterly meetings with Families First to track trends, concerns, and share successes. Interventions are monitored by WSCC during a weekly interdepartmental meeting to safeguard the effectiveness of the PPC measure.

CIS: M7 52.83%; M8 54.28%; M9 54.92%. Increase of 2.09 percentage points from M7 to M9.

Strategies and Interventions:

WSCC teamed up with Pfizer to send reminders to members about making an appointment to complete immunizations in a timely manner through a Vaccine Adherence in Kids (VAKS) program. WSCC's Value Based Providers (VBP) team and Quality Reporting Specialist (QRS) collaborate in monthly, bimonthly, or quarterly meetings with Value Based providers to review scorecards, provide gap lists, and address barriers, giving

the providers an opportunity to conduct member outreach and schedule members for appointments. During these meetings, providers are given quality training on correct CPT coding to ensure that gaps are closed correctly. A team of quality nurses provide daily member outreach to help schedule appointments for members that have not completed their immunizations. During this outreach, nurses inform parents and members of the importance of immunizations to calm their hesitancy as well as answer any questions they may have, including transportation or finding a physician. Lastly, WSCC will be sending out a box of healthy snacks through FarmBox when a member receives their needed immunizations for the year. On a weekly basis during the interdepartmental collaborative meeting hosted by the Quality Department, WSCC reviews each initiative for CIS, which helps them analyze the status and outcomes on member data. WSCC has put an emphasis on the CIS measure and is currently adding additional efforts to meet the state target before the end of the year, which includes working with providers to work together to get members in for their immunizations.

Performance Measures (PMs)

HSD Performance Measures (PMs) and targets are based on HEDIS technical specifications. Each MCO is required to meet the established performance targets. Each DY target is a result of the DY6 MCO aggregated Audited HEDIS data, calculating an average increase for each DY until reaching the DY6 Quality Compass Regional Average plus 1 percentage point. Failure to meet the HSD-designated target for individual performance measures during the DY will result in a monetary penalty based on 2% of the total capitation paid to the MCO for the agreement year.

HSD requires the MCOs to submit quarterly reports that are used to monitor the performance of each PM to determine if MCOs are on track for meeting the established target. MCOs report any significant changes as well as interventions, strategies, and barriers that impact improved performance. HSD staff will review and analyze the data to determine if the MCOs are trending towards meeting the established targets. HSD findings are communicated to the MCOs through MCO-specific technical

assistance (TA) calls and during the Quarterly Quality Meeting (QQM). HSD expects to see rates increase quarter over quarter and the final determination of whether the MCOs have met the targets is reliant on the DY9 annual audited HEDIS report, which will be received in DY10 Q2.

Below are the MCO quarterly rates and interventions for each Performance Measure (PM) and their established target for DY9.

The following PMs show results for DY9 Q3 reporting:

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

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

DY9 target is 64.82%.

BCBS Q1 36.81%; Q2 50.94%; Q3 59.08%: Increase of 8.14 percentage points from Q2 to Q3 and is 5.74 percentage points below the DY9 target.

PHP Q1 52.11%; Q2 52.75%; Q3 52.20%: Decrease of 0.55 percentage points from Q2 to Q3 and is 12.62 percentage points below the DY9 target.

WSCC Q1 30.31%; Q2 39.45%; Q3 51.90%: Increase of 12.45 percentage points from Q2 to Q3 and is 12.92 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 38.54%; Q2 Total 49.61%; Q3 Total 55.07%: Increase of 5.46 percentage points from Q2 to Q3 and is 9.75 percentage points below the DY9 target.

MCO Strategies and Interventions:

BCBS's SMS texting campaign is in the production phase to deliver timely reminders to parents/guardians to encourage well child visits. This campaign was created to bring awareness to parents/guardians to schedule an appointment with their healthcare provider or contact BCBS if a member needs assistance with scheduling an appointment. During one-on-one phone calls with parents/guardians, members were encouraged to schedule and complete a well child visit in the first 15 months

of life. Newly enrolled members were provided with the Member Handbook, which is also available on the BCBS member website. Special Beginnings Care Coordinators utilized a script when speaking with members about what happens after delivery. The script discusses the importance of well child visits and childhood immunizations. Additionally, health education on well child visits was presented to BlueCross Community Centennial members. Through value-based contracts, BCBS is engaging provider groups incentivizing W30 rates with their attributed membership. Other interventions include providing member gap lists to providers and promoting effective solutions that overlay the CDC immunization schedule with well child visits in the first 15 months of life.

PHP is focusing on targeted member outreach through telephone calls from PHP's Performance Improvement (PI) department where information on the Baby Bonus incentives program is given to the member or caregiver. PHP has increased communication to Presbyterian Health Services (PHS)/Presbyterian Medical Group (PMG) Providers to contact members with gaps in care for this measure.

WSCC is currently assessing efforts to reach members and initiatives are being re-evaluated to determine the most effective way members prefer to be reached, leveraging technology or vendors being used. WSCC's Quality Improvement (QI) team continues to target member outreach by holding provider engagement meetings, provider road show events, and continuing the mPulse texting campaign. WSCC implemented a gift card incentive for new members in September.

PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

The percentage of members ages 3 through 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.

For this measure the National Committee for Quality Assurance (NCQA) offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in June 2023.

DY9 target is 58.14%.

BCBS Q1 10.56%; Q2 15.73%; Q3 22.73%: Increase of 7 percentage points from Q2 to Q3 and is 35.41 percentage points below the DY9 target.

PHP Q1 11.02%; Q2 14.63%; Q3 20.86%: Increase of 6.23 percentage points from Q2 to Q3 and is 37.28 percentage points below the DY9 target.

WSCC Q1 8.92%; Q2 10.32%; Q3 15.27%: Increase of 4.95 percentage points from Q2 to Q3 and is 42.87 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 10.60%; Q2 Total 14.65%; Q3 Total 21.03%: Increase of 6.38 from Q2 to Q3 and is 37.11 percentage points below the DY9 target.

MCO Strategies and Interventions:

BCBS developed value-based contracts with multiple provider groups. During monthly joint operational meetings, scorecards on WCC performance rates for provider's attributed membership are shared and gap-in-care lists are also provided. The importance of weight assessment and counseling taking place during a provider visit is conveyed along with related coding requirements. Healthcare Common Procedure Coding (HCPC) Code G0447 was further incentivized and unbundled so it may be included in any claim where applicable.

PHP continued to educate members in the community at local health fairs, member mailings, and telephone outreach to members with gaps in this measure were emphasized. PHP increased communication to providers to complete outreach for members who have attended the clinic previously. PHP incentivizes providers participating in the Provider Quality Incentive Program (PQIP) that complete qualifying HEDIS visits

in this measure. Statewide efforts to get members immunized were advertised in a “Got Shots?” campaign, which encouraged member caregivers to return to clinics for well child visits and to complete missing or required immunizations.

WSCC set up supplemental data feeds from large pediatric provider groups in DY9 Q3 to close gaps in care as members become compliant. WSCC is launching a new project called FarmBox, which provides healthy snack boxes to members who complete this measure. WSCC is hopeful that this new incentive will increase member compliance with the measure. The Quality Improvement and VBP teams continue to work together to gather data from providers' electronic medical record systems, in-person medical chart reviews, and supplemental data feeds to allow for gap closure throughout the year. WSCC implemented an incentive in DY9 Q4 for members who complete the three required sub-measures of WCC, nutrition counseling, physical activity counseling, and Body Mass Index documentation.

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.

DY9 target is 82.73%.

BCBS Q1 59.50%; Q2 58.47%; Q3 58.23%: Decrease of 0.24 percentage points from Q2 to Q3 and is 24.50 percentage points below the DY9 target.

PHP Q1 61.98%; Q2 61.02%; Q3 60.67%: Decrease of 0.35 percentage points from Q2 to Q3 and is 22.06 percentage points below the DY9 target.

WSCC Q1 52.23%; Q2 52.92%; Q3 57.11%: Increase of 4.19 percentage points from Q2 to Q3 and is 25.62 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 54.21%; Q2 Total 59.25%; Q3 Total 59.37%: Increase of 0.12 percentage points from Q2 to Q3 and is 23.36 percentage points below the DY9 target.

MCO Strategies and Interventions:

In DY9 Q3, BCBS participated in a community baby shower in Hobbs, NM with the Community Outreach Team and Carevan. The Special Beginnings Maternity Care Coordination program continues to assist members to better engage, understand, and manage their pregnancy. The program offers prenatal and postnatal health education and guidance. The Special Beginnings Program also promotes the Centennial Rewards program and its benefits to members. Special Beginnings utilizes Tricare Labs payor portal which provides information about members accessing laboratory services, creating touch points for interventions such as offering additional health plan resources like Special Beginnings Care Coordination, and/or disease management material. TriCore Labs also provides a monthly report and collaborates with BCBS for certain conditions such as prenatal, postpartum and diabetes working to identify the pregnant population earlier in hopes of engaging members sooner to meet timeliness of prenatal care measure goals. In DY9 Q4, BCBS will outreach newly identified moms with texts and emails containing educational messaging and offering to schedule with an existing OBGYN or PCP within their first trimester. Emails contained educational media messaging and resources. BCBS's Clinical Value Consultants and Clinical Practice Consultant team meets with contracted provider groups to educate them about the PPC measure and share performance scorecards. Joint operating meetings continue with provider groups incentivized through Value Based Contracts (VBC). The goal of VBC contracts is to improve PPC-Timeliness of Prenatal Care measure compliance among their attributed BCBS Centennial Care members. Provider groups are offered gap in care lists identifying new pregnancies monthly and are encouraged to close gaps within the first trimester of pregnancy.

PHP continues to find new strategies to identify pregnant members working with community resources and new partnerships to provide additional services to pregnant members and engage them in prenatal rewards programs and home visiting programs. PHP continues to outreach to members with

Social Determinants of Health effects due to lack of transportation, financial concerns, and access to OBGYN providers.

WSSC's mPulse continues to provide members with text message reminders around prenatal care as well as biweekly texting campaigns that provide reminders to members to schedule and maintain important prenatal follow up visits. WSSC will continue to communicate with members through Start Smart for Your Baby Care Coordination interventions. This program encourages pregnant members to be more engaged in their health and the health of their new baby, while providing the support to member through their pregnancy to improve birth outcomes.

PM #4 (1 point) – Prenatal and Postpartum Care (PPC)

The percentage of member deliveries that had a postpartum visit on or between 7 and 84 Calendar Days after delivery.

For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in June 2023.

DY9 target is 65.95%.

BCBS Q1 42.11%; Q2 49.60%; Q3 50.92%: Increase of 1.32 percentage points from Q2 to Q3 and is 15.03 percentage points below the DY9 target.

PHP Q1 50.98%; Q2 55.56%; Q3 57.66%: Increase of 2.10 percentage points from Q2 to Q3 and is 8.29 percentage points below the DY9 target.

WSSC Q1 40.11%; Q2 44.80%; Q3 47.09%: Increase of 2.29 percentage points from Q2 to Q3 and is 18.86 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 52.37%; Q2 Total 52.25%; Q3 Total 53.98%: Increase of 1.73 percentage points from Q2 to Q3 and is 11.97 percentage points below the DY9 target.

MCO Strategies and Interventions:
BCBS Quality Management Specialists performed member calls to postpartum members educating on the importance of attending postpartum appointments. If the member is not reached, an unable to reach letter is sent via regular mail as a follow-up to the attempted outreach. In DY9 Q3, BCBS participated in a community baby shower in Hobbs, NM with the Community Outreach Team and Carevan. Resource information was posted on social media, Connect Community Blue Cross Blue Shield, titled "Postpartum Health." The Special Beginnings Maternity Care Coordination program continues to assist members to better engage, understand and manage their pregnancy. The program offers prenatal and postnatal health education and guidance, as well as promotes the Centennial Rewards program and its benefits to members. Special Beginnings utilizes Tricare Labs payor portal, which provides information about members accessing laboratory services, creating touch points for interventions such as offering additional health plan resources like Special Beginnings Care Coordination, and/or disease management material. In DY9 Q4, BCBS will outreach newly identified moms with texts and emails containing educational messaging and offering to schedule with an existing OBGYN or PCP within their first trimester. Emails will contain educational media messaging and resources. BCBS's Clinical Value Consultants and Clinical Practice Consultant team meets with contracted provider groups to educate them about the PPC measure and share performance scorecards. Joint operating meetings continue with provider groups incentivized through Value Based Contracts (VBC). Provider groups are offered gap lists identifying members with recent deliveries so they may outreach and schedule post-partum visits with those members.

PHP continues to find new strategies to identify pregnant women working with community resources and new partnerships to provide additional services to pregnant women and engage members in prenatal rewards programs and home visiting programs. PHP continues to outreach to members with Social Determinants of Health effects due to lack of transportation, financial concerns, and access to OBGYN providers.

WSSC's Quality Registered Nurses continue to conduct member outreach to work with bringing members into compliance with this measure. The team continues to assist members with scheduling an appointment (if needed), educate members on the importance of postpartum visits, and provide resources or benefits Western Sky offers. Western Sky's Quality team works with Provider Quality Liaisons to conduct and educate providers on their quality scorecards for this measure and has created Quick Reference Guides (QRGs) for providers to reference. The WSSC Provider Quality Liaisons continue to conduct provider meetings, to encourage provider outreach to assigned or attributed members. Western Sky continued its member texting campaign (MPulse) in DY9 Q3. Start Smart for Baby (SSFB) and the Pacify App continue to be available for all new mothers.

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

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

For this measure the NCQA offers the option to utilize a hybrid review method which consists of administrative claims data and medical record review. The quarterly MCO data provided for this measure consists of strictly administrative data. The actual rate will be available in June 2023.

DY9 target is 70.53%.

BCBS Q1 40.41%; Q2 55.52%; Q3 59.93%: Increase of 4.41 percentage points from Q2 to Q3 and is 10.60 percentage points below the DY9 target.

PHP Q1 62.63%; Q2 62.97%; Q3 63.24%: Increase of 0.27 percentage points from Q2 to Q3 and is 7.29 percentage points below the DY9 target.

WSSC Q1 41.83%; Q2 48.60%; Q3 54.28%: Increase of 6.77 percentage points from Q2 to Q3 and is 16.25 percentage points

below the DY9 target.
MCO Aggregate: Q1 Total 45.26%; Q2 Total 56.96%; Q3 Total 60.65%: Increase of 3.69 percentage points from Q2 to Q3 and is 9.88 percentage points below the DY9 target.

MCO Strategies and Interventions:

BCBS's SMS texting campaign is in the production phase to deliver timely reminders to encourage parents/guardians to complete immunizations. This campaign was created to bring awareness to parents/guardians to schedule an appointment with their healthcare provider or contact BCBS if member needs assistance with scheduling an appointment. Special Beginnings Care Coordinators utilize a script that discusses well child visits and childhood immunizations. Community Health Workers (CHWs) continue to utilize the CHW tool: Wellness Guidelines and Information, which provides talking points encouraging parent/guardians of children 2 years of age to complete Combo 3 Immunizations. In DY9 Q3, Members were contacted telephonically to encourage parents/guardians to complete immunizations as needed and were offered assistance in scheduling an appointment. Health Education on Childhood Immunizations was presented to Blue Cross Community Centennial members. Monitoring activities are held directly with value-based providers and dashboards are reviewed against measure performance and target goal for CIS-3 during monthly joint operating meetings. The expectation for each provider group is to work with BCBS Quality and Operations staff to mitigate barriers and close gaps. Providers are encouraged to overlay the first 6 provider visits in the first 15 months of life with the CDC immunization schedule for CIS-3.

PHP continues to increase member education on the incentive program, Baby Bonuses, to engage members to return to clinics for wellness and any missed or required immunizations. Increased efforts to work with Presbyterian Medical Group clinics for outreach to members in rural areas with any gaps. PHP increased phone outreach to members who appear are missing immunizations. PHP PI internal staff attended community health events to provide education and information to members in the

community.

The WSCC team is working with providers to pull supplemental data from electronic health record to increase compliance. WSCC is also implementing a new program called FarmBox as an incentive for members when they receive their immunization. The member will receive a box of health snacks, a brochure that has fun games, healthy recipes, and information for the parent to complete all needed appointments. WSCC continues the Vaccine Adherence in Kids (VAKs) Campaign which is a campaign that sends out postcards to members. The postcard is also a birthday card for the member, informing them that certain immunizations are due. Targeted member outreach by the QI team of nurses and member gift card incentive continues. WSCC continues to meet with providers to share member gap lists to Value Based Payment providers to get these providers to contact members and schedule visits.

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.

DY9 target is 35.19%.

BCBS Q1 32.36%; Q2 37.30%; Q3 41.44%: Increase of 4.14 percentage points from Q2 to Q3 and is 6.25 percentage points above the DY9 target.

PHP Q1 46.17%; Q2 44.55%; Q3 44.30%: Decrease of 0.25 percentage points from Q2 to Q3 and is 9.11 percentage points above the DY9 target.

WSCC Q1 33.18%; Q2 35.03%; Q3 41.38%: Increase of 6.35 percentage points from Q2 to Q3 and is 6.19 percentage points above the DY9 target.

MCO Aggregate: Q1 Total 36.57%; Q2 Total 39.99%; Q3 Total 42.77%: Increase of 2.78 percentage points from Q2 to Q3 and is 7.58 percentage points above the DY9 target.

MCO Strategies and Interventions:

BCBS launched a member education video on the importance of medication compliance on social media. Additional outlets for distributing the video were explored and will be utilized in DY9 Q4. A member incentive for AMM was planned in and is expected to be implemented in DY9 Q4. Outreach calls to members continued to remind members to refill their antidepressant medication. Planning continued for a provider educational webinar titled, "Suicide Prevention in the Military Community", that will take place in DY9 Q4 and will include the AMM measure.

PHP's educational brochure regarding depression and diabetes was mailed to members with diabetes. Members who express depression symptoms during the Health Risk Assessment are now mailed an educational brochure about depression, symptoms, and treatment options. During the DY9 Q3 Provider Education Conference (PEC), physical and behavioral health providers were reminded of the importance of assessing and screening for depression and of the increased risk of depression in individuals with diabetes and/or cardiovascular disease. In Q3, BCBS created a member newsletter article on AMM. Text messages to members in the AMM measure are still being explored with hopeful implementation in DY9 Q4. Incentivization of AMM and depression screening codes continued through the Value Based Purchasing Provider Quality Incentive Program (VBP PQIP). VBP programs were promoted as planned during the DY9 Q3 PEC and eligible providers were encouraged to enroll in PQIP AMM or Depression Screening metrics. Member rewards continued for members who filled their antidepressant medication within AMM measure timeframes.

WSSC members identified for outreach continue to receive a call from a pharmacist who counsels members and addresses antidepressant medication adherence and barriers. WSSC Pharmacy Coordinators continue to help with refills and inform of the option for 90-Day supply prescriptions through calls and faxes to providers and pharmacies. Continued work with Walgreens to provide a weekly list of members for outreach by Walgreens' clinical staff to provide counseling on member's antidepressant medication and address any barriers or concerns. WSSC members are educated about and referred to the Behavioral Health Disease Management Program as appropriate to receive

support, education, and resources from WSCC's BH Disease Management Registered Nurse. The program helps to increase members understanding of medication usage and compliance, promotes healthy lifestyle activities, empowers members to take charge of their health, and monitors for any signs of decompensating mental health through regular PHQ-9 assessments. WSCC members are encouraged to utilize the MyStrength program, which is available to members online and as an app they can download onto their phone or tablet. The program utilizes evidence-based paradigms such as Cognitive Behavioral Therapy, Behavioral Activation, and Acceptance and Commitment Therapy to help members develop individualized strategies for addressing core focus areas including, but not limited to, depression, anxiety, stress, trauma, and mindfulness. Provider Quality Liaisons (PQLs) continue to collaborate with providers regarding care gap closure and performance. Monthly and quarterly meetings are held with small practices, individual providers, and Value Based Purchasing (VBP) program behavioral health providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care. Provider Roadshows continue to take place throughout the state to offer opportunities for providers to engage with WSCC and receive education and support. The "At-a-Glance" BH Provider Toolkit, updated with 2022 specs, and the BH Clinical Training Series have been made available to providers and contain BH HEDIS measure details, tips, and best practice strategies as well as education on gap closure and quality patient care.

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.

DY9 target is 46.14%.

BCBS Q1 41.26%; Q2 43.73%; Q3 44.45%: Increase of 0.72 percentage points from Q2 to Q3 and is 1.69 percentage points below the DY9 target.

PHP Q1 47.16%; Q2 49.75%; Q3 51.99%: Increase of 2.24 percentage points from Q2 to Q3 and is 5.85 percentage points

above the DY9 target.
WSSC Q1 45.30%; Q2 46.44%; Q3 46.84%: Increase of 0.40 percentage points from Q2 to Q3 and is 0.70 percentage points above the DY9 target.
MCO Aggregate: Q1 Total 44.74%; Q2 Total 47.14%; Q3 Total 48.62%: Increase of 1.48 percentage points from Q2 to Q3 and is 2.48 percentage point above the DY9 target.

MCO Strategies and Interventions:
BCBS interventions included member outreach through Recovery Support Assistants (RSAs) with aftercare, an IET enhanced payment initiative, as well as value-based contracting. Providers have access to provider education webinar recordings to earn continuing education credit, including a webinar on the importance of substance abuse follow-up and coordinating care. In DY9 Q3, planning for the distribution of a member video on the importance of seeking professional substance abuse treatment took place for distribution in DY9 Q4. BCBS also focused on a social media launch strategy and developed promotional flyers in Q3. Additionally, a member incentive related to this measure was approved and is expected to be implemented in DY9 Q4.

PHP's VBP programs were promoted during the DY9 Q3 Provider Education Conference (PEC) and the Q3 BH Provider Town Hall. Eligible providers were encouraged to enroll in the PQIP or BH Quality Incentive Programs (BQIP). Data research and discussions were held with local vendors around members with AOD and pregnancy. The Care Coordination team received weekly updates in the clinical operations bulletin on BH HEDIS measures, including IET. Members who receive services from the peer support or community health worker teams receive regular education on the importance of engaging in AOD/SUD treatment and recovery services. Ongoing discussions with inpatient facilities explore the complexities and identify opportunities of improvement related to serving members with AOD/SUD diagnoses in an inpatient setting.

WSSC reinstated daily reports from Collective Medical Technologies (CMT), a real-time care notification and

collaboration platform, for early identification of members with substance use diagnoses. This system allows outreach to members within 24 to 48 hours of an Emergency Department (ED) encounter. Members identified from CMT, and internal reports are referred to NM Family Services (NMFS) for outreach and engagement in treatment if they are not already engaged with an outpatient provider. NMFS staff collaborate with members' assigned care coordinators and refers members to the WSCC Member Connections Team for additional peer support and other assistance when requested by the member. In Q3, outreach was conducted by the WSCC Member Connections Team to adolescent members identified as having a substance use diagnosis within the previous six months. The outreach was aimed at supporting members in engaging in treatment and connecting the families with community resources. Care Coordinators continue to work with members enrolled in care coordination services to address gaps in care, provide member education, connect members with providers, and assist with transportation or other barriers. WSCC continues to utilize the mPulse texting program when members with a high ED utilization are seen in the ED. Members receive a text message to check in about follow-up care and allows members to respond with any needs. Members who respond receive telephonic outreach from either their assigned care coordinator, or from the member connections team. WSCC implemented the Health Assistance, Linkage, & Outreach (HALO) TM program. HALO focuses on prevention of the abuse of alcohol, amphetamines, opioids, and other substances through early identification of members at risk of developing a substance use disorder. The program aims to engage those already abusing substances in treatment to avoid worsening of symptoms by connecting members to necessary care. Transportation services through Secure Transportation are available and encouraged for members having difficulties getting to their appointments.

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.

DY9 target is 52.02%.

BCBS Q1 48.30%; Q2 53.12%; Q3 54.08%: Increase of 0.96 percentage points from Q2 to Q3 and is 2.06 percentage points above the DY9 target.

PHP Q1 49.22%; Q2 52.59%; Q3 52.94%: Increase of 0.35 percentage points from Q2 to Q3 and is 0.92 percentage points above the DY9 target.

WSCC Q1 50.23%; Q2 54.57%; Q3 55.10%: Increase of 0.53 percentage points from Q2 to Q3 and is 3.08 percentage points above the DY9 target.

MCO Aggregate: Q1 Total 49.03%; Q2 Total 53.03%; Q3 Total 53.65%: Increase of 0.62 percentage points from Q2 to Q3 and is 1.63 percentage points above the DY9 target.

MCO Strategies and Interventions:

BCBS interventions included planning for the distribution of a member video on the importance of follow-up care after a mental health hospitalization. The video will be widely distributed to members and providers through social media and provider sites in DY9 Q4. BCBS is also developing a provider education webinar titled, "Suicide Prevention in the Military Community." The webinar will take place in DY9 Q4 and will include education on the importance of follow-up care for mental health. The Facility Incentive Program was expanded, and 2 additional facilities were added.

PHP's VBP programs continued, including the Model Facility Incentive Program (MFIP) for inpatient acute psychiatric facilities/units, the BH Quality Incentive Program (BQIP) for outpatient behavioral health providers, and the Provider Quality Incentive Program (PQIP) for physical health providers. VBP programs were promoted during the DY9 Q3 Provider Education Conference (PEC) and the Q3 BH Provider Town Hall. Recruitment efforts continued to recruit more providers into both the BQIP and PQIP FUH measures. The VBP team met with 11 out of 13 enrolled MFIP facilities during quarterly engagement meetings, which are used to problem-solve any barriers to performance and includes input from different departments across the health plan and inpatient organization to help address

strengths and specific gaps identified. Routine inpatient Care Coordination (IPCC) activities include contacting members who were hospitalized and offering Care Coordination services, including discharge planning assistance. PHP's IP Task Team continued meeting to discuss and coordinate care related to several individual members with high utilization rates to reduce rehospitalization rates for those members. The IP Task Team actively addresses members' barriers to stabilization in the community to decrease their overall hospitalization rates.

WSSC's Behavioral Health Liaisons (BH Liaison), Behavioral Health Utilization Management (BH UM) teams, and inpatient and residential facilities continue to work collaboratively to ensure engagement in aftercare is accessible for members. The BH Liaison Team connects with members during and after their inpatient stay to help with scheduling appointments and meeting community resource needs. In addition to receiving assistance from the BH Liaisons, members are offered support from WSSC team of Certified Peer Support Workers and Certified Community Health Workers. The WSSC Member Connections Team continues to reach out to members who are at high risk for suicide as part of the Choose Tomorrow: A Zero Suicide Prevention Program. The program focuses on early identification, screening, and specialized ongoing support for at-risk individuals. WSSC continues to partner with TeamBuilders Behavioral Health (TBBH) to complete an initial telehealth visit with members within 7 days of being discharged. WSSC members are encouraged to utilize the MyStrength program, which is available to members online and as an app they can download onto their phone or tablet. The program utilizes evidence-based paradigms such as Cognitive Behavioral Therapy, Behavioral Activation, and Acceptance and Commitment Therapy to help members develop individualized strategies for addressing core focus areas including, depression, anxiety, stress, trauma, and mindfulness. WSSC continues to provide telehealth options such as Teladoc to address barriers such as transportation. Member facing staff continue to educate members and encourage utilization of Secure Transportation for members who are having difficulties getting to their appointments. Provider Quality Liaisons (PQLs) continue to collaborate with providers regarding care gap closure and performance. Monthly and quarterly meetings are held with small practices, individual providers, and Value Based Purchasing (VBP) program

behavioral health (BH) providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care. Provider Roadshows continue to take place throughout the state to offer opportunities for providers to engage with WSCC and receive education and support.

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.

DY9 target is 46.50%.

BCBS Q1 46.85%; Q2 51.18%; Q3 50.98%: Decrease of 0.20 percentage points from Q2 to Q3 and is 4.48 percentage points above the DY9 target.

PHP Q1 60.71%; Q2 59.18%; Q3 58.86%: Decrease of 0.32 percentage points from Q2 to Q3 and is 12.36 percentage points above the DY9 target.

WSCC Q1 48.78%; Q2 54.60%; Q3 51.79%: Decrease of 2.81 percentage points from Q2 to Q3 and is 5.29 percentage points above the DY9 target.

MCO Aggregate: Q1 Total 53.31%; Q2 Total 55.47%; Q3 Total 54.93%: Decrease of 0.54 percentage points from Q2 to Q3 and is 8.43 percentage points above the DY9 target.

MCO Strategies and Interventions:

BCBS's Transition of Care (TOC) staff and Recovery Support Assistant (RSA) staff continued member outreach by using the EDIE© system to identify gaps in care. In DY9 Q3, BCBS continued to develop a member video on the importance of follow-up care, which will be distributed in DY9 Q4 via social media and provider sites. BCBS also continued to develop a provider education webinar titled, "Suicide Prevention in the Military Community", which will be available in Q4. The webinar will educate providers on the importance of follow-up care for mental health conditions.

PHP's VBP programs were promoted during the DY9 Q3 Provider

Education Conference (PEC) and the Q3 BH Provider Town Hall, where eligible providers were encouraged to enroll in either PQIP or BQIP FUM metrics. PHP's Care Coordination team receives weekly updates on BH HEDIS measures, including FUM through a Clinical Operations bulletin. PHP's Care Coordination teams also perform follow-up activities for members seen in the ED for a mental health reason.

WSSC utilizes notifications received from Collective Medical Technologies (CMT), a real-time care notification and collaboration platform, for early identification of members seen in the ED due to possible mental health reasons. This system allows for outreach to members as soon as 24 to 48 hours of an Emergency Department (ED) encounter where mental health diagnoses are noted. Members identified from CMT, and internal reports are referred to TeamBuilders Behavioral Health (TBBH) for outreach and completion of an initial telehealth assessment. TeamBuilders staff collaborates with members' assigned care coordinators as needed and refers members to the WSSC Member Connections Team for additional Peer Support and other assistance when requested by the member. The Member Connections Team continues to reach out to members who are at high risk for suicide as part of the Choose Tomorrow: A Zero Suicide Prevention Program. The program focuses on early identification, screening, and specialized ongoing support for at-risk individuals. WSSC members are encouraged to utilize the MyStrength program, which is available to members online and as an app they can download onto their phone or tablet. The program utilizes evidence-based paradigms such as Cognitive Behavioral Therapy, Behavioral Activation, and Acceptance and Commitment Therapy to help members develop individualized strategies for addressing core focus areas including, but not limited to, depression, anxiety, stress, trauma, and mindfulness. Members are educated about and encouraged to engage in Care Coordination services, Behavioral Health Disease Management programs, and to utilize Teladoc and Secure Transportation to address transportation and safety barriers and concerns. The FUM incentive gift card program was retired as of July as members are now eligible to receive incentives through Centennial Rewards for completion of their 7-Day or 30-Day follow-up appointments after ED visits related to mental health. Performance rates will continue to be monitored and discussed

monthly during a Priority Measures meeting to ensure adjustments are made should any significant negative impact to the performance rating be noted.

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

The percentage of members 18-64 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.

DY9 target is 82.07%.

BCBS Q1 40.76%; Q2 61.41%; Q3 71.03%: Increase of 9.62 percentage points from Q2 to Q3 and is 11.04 percentage points below the DY9 target.

PHP Q1 41.50%; Q2 61.08%; Q3 72.76%: Increase of 11.68 percentage points from Q2 to Q3 and is 9.31 percentage points below the DY9 target.

WSCC Q1 40.10%; Q2 54.19%; Q3 65.98%: Increase of 11.79 percentage points from Q2 to Q3 and is 16.09 percentage points below the DY9 target.

MCO Aggregate: Q1 Total 41.07%; Q2 Total 60.57%; Q3 Total 71.39%: Increase of 10.82 percentage points from Q2 to Q3 and is 10.68 percentage points below the DY9 target.

MCO Strategies and Interventions:

BCBS reports that in-home A1c test kits were mailed to members identified through telephonic outreach by Care Coordination. BCBS's Pharmacy Department continues to fax letters to providers to remind them to schedule a diabetes test for members in the SSD measure. BCBS is developing a member video on SSD and the importance of diabetes screening, if prescribed antipsychotic medications. A provider article on the SSD measure will be distributed to providers in DY9 Q4. BCBS is also developing an intervention to place A1c test kits in selected provider offices. Care Coordination continued to outreach members to educate them on the importance of following up with their provider for a diabetes screening and to offer the in-home test kit.

PHP's VBP programs were promoted during the Provider Education Conference (PEC) and the BH Provider Town Hall, where eligible providers were encouraged to enroll in PQIP or

BQIP SSD metrics. A Provider Newsletter article regarding diabetes screening for members with schizophrenia and on antipsychotic medication was created and will be distributed in DY9 Q4. PHP's Care Coordination teams attended an educational webinar regarding working with members diagnosed with schizophrenia and the importance of metabolic monitoring. A call campaign for members in care coordination was launched. Members will be contacted and encouraged to complete metabolic monitoring before the end of the calendar year. The QI team continued SSD abstraction and uploaded records for abstraction. The abstraction process involves cross referencing gap-in-care lists with inpatient hospitalization records to secure lab results that likely took place during inpatient hospitalization. Direct peer to peer outreach between PHP's behavioral health medical director and prescribers within the SSD measure occurred. PHP's BH medical director conducted meetings with SSD prescribers, informing them of the SSD measure requirements and offering educational assistance. The SSD measure was discussed at all VBP hospital engagement meetings and hospitals were asked to provide A1C or glucose values in discharge paperwork. PHP continued implementing lab testing kits at prescriber's office within the SSD measure, where providers who are contracted with a local lab vendor will be given lab kits to use in office when a member presents for normal follow-up appointments.

WSCC has begun sending in-home test kits to members through Harmony Cares (formerly Lab2U). Members enrolled in Care Coordination services and have not returned their test kits received outreach from their assigned Care Coordinators in DY9 Q3. Outreach to members not enrolled in Care Coordination services was conducted by the Quality Improvement Nurse Team. Additional member outreach by Care Coordinators and the Quality Improvement Nurse Team is scheduled to provide education and encourage members to complete and return the kits for testing or to complete testing through their PCP. In DY9 Q3, WSCC implemented the SSD Incentive Gift Card program. Members in the SSD measure who complete their A1c testing are eligible to receive a \$30 gift card. In Q3, faxes were sent to prescribers to remind them of the importance of A1c monitoring for patients taking antipsychotic medications. WSCC partnered with TriCore Reference Laboratories to receive lab test results for members who had an A1c screening. Provider Quality Liaisons (PQLs) continue to collaborate with providers regarding care gap closure and performance. Monthly and quarterly meetings are held with small practices, individual providers, and Value Based Purchasing

(VBP) program behavioral health (BH) providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care. Provider Roadshows continue to take place throughout the state to offer opportunities for providers to engage with WSCC and receive education and support. A live Quality Improvement Provider Summit is planned to occur in DY9 Q4 to provide an overview of topics including, CAHPS Survey and results, Cultural Competency and Language Services, Provider Relations, Community Outreach/Value Added Services, Care Coordination Overview, P4P Program, Quality Initiatives, and other topics. The “At-a-Glance” BH Provider Toolkit, updated with 2022 specs, and the BH Clinical Training Series have been made available to providers and contain BH HEDIS measure details, tips, and best practice strategies as well as education on gap closure and quality patient care.

Tracking Measures (TMs)

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

The following TMs show results for DY9 Q3 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 0.01%; Q2 0.04%; Q3 0.05%: Increase of 0.01 percentage point from Q2 to Q3.

PHP Q1 3.49%; Q2 3.64%; Q3 3.03%: Decrease of 0.61 percentage points from Q2 to Q3.

WSSC Q1 0.52%; Q2 0.50%; Q3 0.37%: Decrease of 0.13 percentage points from Q2 to Q3.

MCO Aggregate: Q1 0.91%; Q2 0.93%; Q3 0.76%: Decrease of 0.17 percentage points from Q2 to Q3.

MCO Strategies and Interventions:

BCBS: BCBS continues to engage and educate clinicians to appropriately evaluate fall risk at the index visit and to correctly code the fall risk assessment on the day of the index visit.

PHP: PHP conducts outreach to members at risk of falls to evaluate for care coordination needs and when needs are identified, a plan of care is developed to address the needs.

WSSC: WSSC offers referrals to the Department of Health's "Path to Health" Fall Prevention Program and offers transportation services for members to attend this program.

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 eighteen (18) and older. Reported as a rate per 100,000 member months. A lower rate indicates improvement for this measure.

BCBS Q1 19.17; Q2 23.00; Q3 24.18: Decline in performance of 1.18 per 100,000 member months from Q2 to Q3.

PHP Q1 14.90; Q2 15.17; Q3 15.73: Decline in performance of 0.56 per 100,000 member months from Q2 to Q3.

WSSC Q1 1.22; Q2 7.56; Q3 8.10: Decline in performance of .54 per 100,000 member months from Q2 to Q3.

MCO Aggregate: Q1 Total 14.87; Q2 Total 17.10; Q3 Total 17.53: Decline in performance of 0.43 per 100,000 member months from Q2 to Q3.

MCO Interventions:

BCBS: BCBS distributed its annual diabetes Unique Member Letter with Personal Care Record wallet cards during late September to 15,334 members, age 18 and above with a diagnosis of diabetes and having 1 or more diabetes HEDIS testing gaps and provides information on needed testing gap closure.

PHP: In DY9 Q3, the entire diabetes population was included in a depression and diabetes mailing and the A1c care gaps mailing also occurred.

WSCC: WSCC's Disease Management program has a diabetic focus where members can get assistance with medication management and adherence review so they can get the resources to manage their diabetes more effectively. Members are assigned a health coach to assist with navigating through their needs.

TM #3 – Screening for Clinical Depression

Percentage of Medicaid enrollees ages eighteen (18) and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. An increase in percentage indicates improvement for this measure.

BCBS Q1 0.80%; Q2 1.33%; Q3 1.59%: Increase of 0.26 percentage points from Q2 to Q3.

PHP Q1 1.02%; Q2 1.76%; Q3 1.98%: Increase of 0.22 percentage points from Q2 to Q3.

WSCC Q1 0.96%; Q2 1.28%; Q3 1.70%: Increase of 0.42 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 0.94%; Q2 Total 1.57%; Q3 Total 1.82%: Increase of 0.25 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: Planning began in DY9 Q3 to produce a provider video on appropriately billing for the depression screening. Planning also continued in DY9 Q3 for another series of provider education webinars that will include the depression screening.

PHP: A presentation regarding the importance of depression screening was delivered during the Provider Education Conference in DY9 Q3. This presentation encourages providers to screen members for depression and offers tips/resources on how to code appropriately.

WSCC: Beginning in September of DY9, WSCC increased

reimbursement for Non-Behavioral Health practitioners for member depression screenings. A provider alert was sent out on 9/1/2022 to notify providers of the increase and provided information about the use of appropriate billing codes.

TM #4 – Follow-up after Hospitalization for Mental Illness

The percent of seven-day follow-up visits into community-based Behavioral Health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days. An increase in rate indicates improvement for this measure.

BCBS Q1 32.99%; Q2 33.53%; Q3 35.02%: Increase of 1.49 percentage points from Q2 to Q3.

PHP Q1 36.33%; Q2 36.63%; Q3 38.26%: Increase of 1.63 percentage points from Q2 to Q3.

WSCC Q1 15.38%; Q2 45.55%; Q3 41.18%: Decrease of 4.37 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 32.22%; Q2 36.39%; Q3 Total 37.38%: Increase of 0.99 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: The Facility Incentive Program was expanded in DY9 Q3, and 1 additional facility was added. The Reserved Appointment Initiative and Outpatient Incentive Programs were also continued in DY9 Q3.

PHP: In DY9 Q3, the Value Based Purchasing team met with 11 out of 13 enrolled Model Facility Incentive Program (MFIP) facilities during quarterly engagement meetings. MFIP meetings are used to problem-solve any barriers to performance and includes input from different departments across the health plan and inpatient organization to help address strengths and specific gaps identified. Collaboration will continue between utilization management, hospital discharge planning staff, and Care Coordination teams.

WSCC: The BH Liaison Team connects with members during and after their inpatient stay to help with scheduling appointments and meeting community resource needs. On average, there is a 70% successful contact rate for reaching and engaging with these

members.

TM #5 – Immunizations for Adolescents (IMA)

The percentage of adolescents thirteen (13) years of age who had one (1) dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. An increase in percentage indicates improvement for this measure.

BCBS Q1 71.25%; Q2 76.89%; Q3 81.80%: Increase of 4.91 percentage points from Q2 to Q3.

PHP Q1 73.61%; Q2 76.23%; Q3 82.34%: Increase of 6.11 percentage points from Q2 to Q3.

WSCC Q1 20.92%; Q2 69.61%; Q3 74.97%: Increase of 5.36 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 67.43%; Q2 75.77%; Q3 Total 81.41%: Increase of 5.64 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: In DY9 Q3, BCBS initiated new value based contracting arrangements with provider groups promoting pediatric measures including immunization for adolescents. Gap lists are shared to help provider groups identify parents or guardians of attributed members.

PHP: Interventions include increased community outreach at health fairs, NM Expo Flea Market, and participation in University of New Mexico Health Sciences Center “Got Shots” campaign to encourage members missing immunizations to complete required immunizations and get caught up on needed vaccinations.

WSCC: The new Vaccine Adherence in Kids (VAKs) campaign reminds members via texts and automated calls to schedule an appointment for immunizations.

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 168; Q2 368; Q3 567.

PHP Q1 299; Q2 615; Q3 909.

WSCC Q1 42; Q2 103; Q3 158.

MCO Aggregate: Q1 Total 509; Q2 Total 1,086; Q3 Total 1,634.

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 919; Q2 1,783; Q3 2,614: Increase of 831 members from Q2 to Q3.

PHP Q1 1,547; Q2 2,915; Q3 4,202: Increase of 1,287 members from Q2 to Q3.

WSCC Q1 251; Q2 534; Q3 787: Increase of 253 members from Q2 to Q3.

MCO Aggregate: Q1 Total 2,717; Q2 Total 5,232; Q3 Total 7,603: Increase of 2,371 members from Q2 to Q3.

MCO Interventions:

BCBS: Pharmaceutical Service Reimbursement continues since its implementation in June of DY9, which BCBS believes will increase smoking cessation counseling and efforts by pharmacies to be reimbursed for the services along with the products.

PHP: PHP is working to positively impact trends by increasing visibility of the Tobacco Cessation Programs to our members and providers by providing education to our clinic-based delegated care coordination teams about the availability of the newly released nurse-led Tobacco Cessation Program.

WSCC: Pyx is member engagement app that addresses loneliness and healthcare needs for members. Push notifications are utilized in Pyx to encourage members to begin tobacco cessation and educates members on first steps.

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 73.54; Q2 160.47; Q3 246.69: Increase of 86.22 per

1,000 member months from Q2 to Q3.
PHP Q1 65.72; Q2 142.30; Q3 221.56: Increase of 79.26 per 1,000 member months from Q2 to Q3.
WSCC Q1 33.32; Q2 105.31; Q3 183.12: Increase of 77.81 per 1,000 member months from Q2 to Q3.
MCO Aggregate: Q1 Total 64.93; Q2 144.68; Q3 Total 226.25: Increase of 81.57 per 1,000 member months from Q2 to Q3.

MCO Interventions:

BCBS: The Transition of Care (TOC) team hosted all staff trainings in DY9 Q3, where the TOC process is reviewed with staff to ensure best practices. The TOC team continues to provide education to patients about the importance of primary care, assisting with appointment scheduling, and following up with patients to monitor and address additional barriers patients might have.

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

WSCC: Provider Quality Liaisons (PQLs) continue to collaborate with providers regarding care gap closure and performance. Monthly and quarterly meetings are held with small practices, individual providers, and Value Based Purchasing (VBP) program providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care.

TM #8 – Ambulatory Care Emergency Department Visits

Utilization of emergency department (ED) visits reported as a rate per 1,000 member months. A lower rate indicates improvement for this measure.

BCBS Q1 9.15; Q2 20.29; Q3 31.77: Decline in performance of 11.48 per 1,000 member months from Q2 to Q3.

PHP Q1 8.31; Q2 18.92; Q3 30.10: Decline in performance of 11.18 per 1,000 member months from Q2 to Q3.

WSCC Q1 5.31; Q2 15.75; Q3 27.96: Decline in performance of 12.21 per 1,000 member months from Q2 to Q3.

MCO Aggregate: Q1 Total 8.28; Q2 Total 19.06; Q3 Total 30.46:

Decline in performance of 11.40 per 1,000 member months from Q2 to Q3.

MCO Interventions:

BCBS: The BCBS team of medical directors and utilization management continue to partner with Care Coordination to best identify appropriate discharge disposition and reduce re-admissions.

PHP: PHP is strengthening cross area outreach activities to improve messaging and decrease duplication, which will ensure that all members needing outreach are contacted.

WSCC: Members seen in the ED for mental health reasons continue to be referred to TeamBuilders Behavioral Health (TBBH) for outreach, engagement in outpatient services, and connection with community resources. TBBH successfully engaged an average of 34% of the members referred to them during DY9 Q3 with 37 initial assessments being completed. On average since the beginning of the year, TBBH has successfully engaged 49% of the members referred to them.

TM #9 – Annual Dental Visit (ADV)

The percentage of enrolled Members ages two (2) to twenty (20) years who had at least one (1) dental visit during the measurement year. An increase in percentage indicates improvement for this measure.

BCBS Q1 19.66%; Q2 31.75%; Q3 32.14%: Increase of 0.39 percentage points from Q2 to Q3.

PHP Q1 22.46%; Q2 42.11%; Q3 52.05%: Increase of 9.94 percentage points from Q2 to Q3.

WSCC Q1 8.88%; Q2 32.88%; Q3 45.93%: Increase of 13.05 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 20.09%; Q2 Total 37.63%; Q3 Total 44.70%: Increase of 7.07 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: A Preventive Health handout is a component of the Quality Provider Toolkit. This handout serves as a reminder to the

provider to encourage dental visits.

PHP: PHP is also strengthening cross area outreach activities to improve messaging and decrease duplication, which will ensure that all members needing outreach are contacted.

WSCC: In DY9 Q3, WSCC expanded the dental initiatives with providers from 1 day of visits to a full week of visits. This has given members additional time to get in and receive their annual dental visit and receive the WSCC gift card incentive. This has been a motivational factor in getting members to complete this visit in a timely manner.

TM #10 – Controlling High Blood Pressure (CBP)

The percentage of Members ages eighteen (18) to eighty-five (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 8.37%; Q2 12.59%; Q3 15.68%: Increase of 3.09 percentage points from Q2 to Q3.

PHP Q1 19.35%; Q2 29.12%; Q3 33.48%: Increase of 4.36 percentage points from Q2 to Q3.

WSCC Q1 3.16%; Q2 6.94%; Q3 12.52%: Increase of 5.58 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 13.52%; Q2 Total 20.46%; Q3 Total 23.99%: Increase of 3.53 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: To improve this measure in DY9 Q3, the BCBS Provider website offered an online article titled “Help Close Diabetes Disparity Gaps” which included a link for blood pressure control. The link takes the viewer to a provider and member friendly article, “Your Blood Pressure Has a Big Impact on Your Health”.

PHP: PHP mailed letters to members who were not in compliance in July of DY9. There were 12,900 members who were mailed a letter about controlling blood pressure and seeing a provider.

WSCC: In DY9 Q3, WSCC interventions include constant

communication and efforts from Care Coordination staff for members in Care Coordination, WSCC's Disease Management program which includes health education for members with chronic health conditions/comorbid complication, and provider engagement meetings.

TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Initiation Phase: The percentage of members ages six (6) to twelve (12) newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had one 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 46.09%, Q2 46.46%; Q3 46.58%; Increase of 0.12 percentage points from Q2 to Q3.

PHP Q1 26.77%, Q2 27.65%; Q3 27.90%; Increase of 0.25 percentage points from Q2 to Q3.

WSCC Q1 45.62%, Q2 50.23%; Q3 50.68%; Increase of 0.45 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 35.95%, Q2 Total 37.04%; Q3 Total 37.25%; Increase of 0.21 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: Planning continued in DY9 Q3 for another series of provider education webinars that will include the ADD measure.

PHP: The ADD measure is included in the Value Based Purchasing Provider Quality Incentive Program (VBP PQIP). In DY9 Q3, VBP programs were promoted during the quarterly Provider Education Conference (PEC).

WSCC: Psychiatric Medication Utilization Reviews facilitate timely identification of members prescribed 2 or more concomitant stimulants or alpha agonists. These members are presented, as appropriate, during Integrated Inpatient/Outpatient Rounds (IIOR) for further review.

TM #11 – Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Continuation and Maintenance Phase: The percentage of

members ages six (6) to twelve (12) newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at least two follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure.

BCBS Q1 60.29%; Q2 60.83%; Q3 55.69%: Decrease of 5.14 percentage points from Q2 to Q3.

PHP Q1 37.97%; Q2 38.10%; Q3 38.92%: Increase of 0.82 percentage points from Q2 to Q3.

WSCC Q1 58.33%; Q2 65.52%; Q3 65.00%: Decrease of 0.52 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 48.30%; Q2 Total 48.31%; Q3 Total 46.88%: Decrease of 1.43 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: A member education video on the importance of medication compliance was released on social media in DY9 Q3.

PHP: Eligible providers were encouraged to enroll in the Provider Quality Incentive Program (PQIP) ADD metric. Most recent data reflects there were 21 providers enrolled in the PQIP ADD measure.

WSCC: Provider Quality Liaisons (PQLs) continue to collaborate with providers regarding care gap closure and performance. Monthly and quarterly meetings are held with small practices, individual providers, and Value Based Purchasing (VBP) program behavioral health (BH) providers across the state to address issues such as member access to appointments, Pay for Performance metrics, and best practices for providing the highest quality care.

TM #12 – Child and Adolescent Well-Care Visits (WCV)

The percentage of members three (3) to twenty-one (21) years of age who had at least one (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 8.83%; Q2 19.22%; Q3 32.87%: Increase of 13.65 percentage points from Q2 to Q3.

PHP Q1 7.46%; Q2 15.84%; Q3 26.92%: Increase of 11.08 percentage points from Q2 to Q3.

WSCC Q1 4.53%; Q2 13.02%; Q3 24.43%: Increase of 11.41 percentage points from Q2 to Q3.

MCO Aggregate: Q1 Total 7.62%; Q2 Total 16.68%; Q3 Total 28.66%: Increase of 11.98 percentage points from Q2 to Q3.

MCO Interventions:

BCBS: In DY9 Q3, BCBS initiated new value based contracting arrangements with provider groups promoting pediatric measures including Well Child Care Visits. Monthly joint operating committee meetings are held with participating provider groups where trending measure performance is discussed via scorecards. Gap lists are shared to help provider groups identify and reach out to parents or guardians of attributed members.

PHP: PHP continued member outreach via telephone and member mailings to encourage members in the 18 to 21 age group to complete wellness visits.

WSCC: WSCC has hosted and collaborated on back-to-school events throughout the State to encourage members to attend to complete their well-care visit and quality nurses conduct targeted member outreach to address the well-child visit and to assist members in scheduling their visit.

External Quality Review

HSD conducts bi-weekly meetings with the External Quality Review Organization (EQRO) to review monthly projects, provide consistent feedback and communication, provide assistance and support, and to assess issues.

EQRO Reviews and Validations in DY9 Q4 consisted of the below.

DY6 EQR Reviews and Validations:

DY6 New Mexico Centennial Care Validation of Performance Improvement Projects posted to the HSD website.

	<p>DY7 EQR Reviews and Validations: DY7 New Mexico Centennial Care Compliance Review posted to the HSD website. DY7 New Mexico Centennial Care Validation of Performance Improvement Projects posted to the HSD website.</p> <p>DY8 EQR Reviews and Validations: DY8 Validation of Network Adequacy received by HSD from the EQRO. DY8 Performance Measure Validation Report received by HSD from the EQRO.</p>
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UTILIZATION

- Centennial Care 2.0 key utilization data and cost per unit data by programs is provided for October 2020 – September 2022. Please see Attachment C: Key Utilization/Cost per Unit Statistics by Major Population Group.
- The underlying utilization and unit cost data is based on paid claims with no additional estimation for claims incurred but not reported. As such, a certain level of underreporting exists due to claims runout, especially in the most recent months of the October 2021 – September 2022 time period.
- Year over year changes in costs per unit for inpatient services are primarily due to elevated levels of high-cost utilization related to the PHE during the previous 12-month data period.

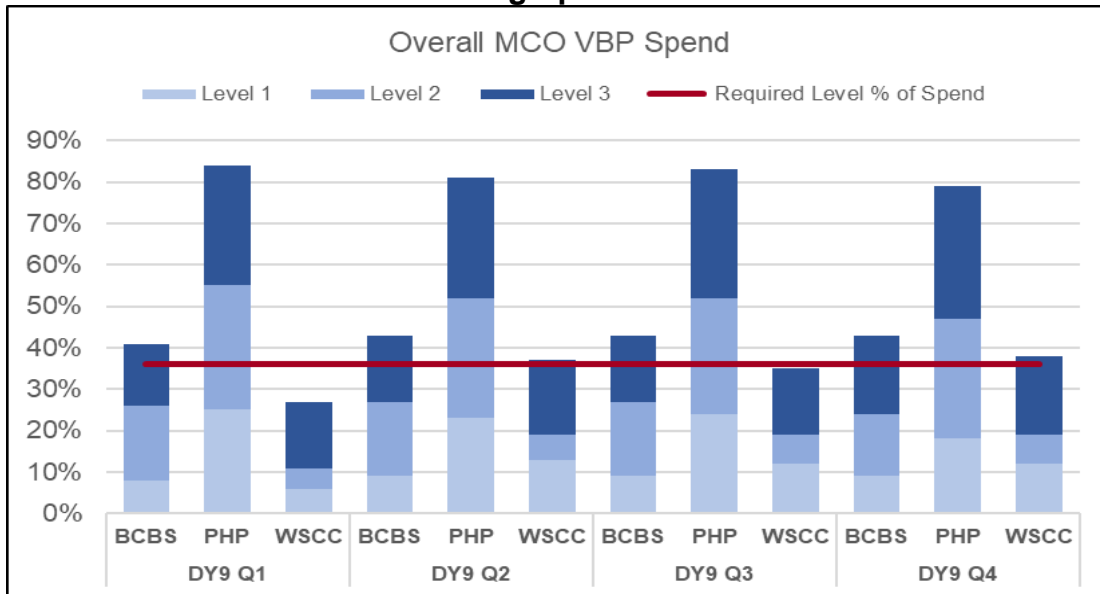
VALUE BASED PURCHASING

To support Centennial Care 2.0’s value-based purchasing goals, HSD requires the MCOs to implement a Value Based Purchasing program that is based upon improved quality and/or member healthcare outcomes. To accomplish this, the MCO must meet minimum targets for 3 levels of VBP arrangements. Minimum targets are set to both a required spend as a percentage of paid claims and required contracts with certain provider types. DY9 requirements are as follows:

VBP Level	Level 1	Level 2	Level 3
Required Spend	12%	15%	9%
Required Provider Types	<ul style="list-style-type: none"> • Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. 	<ul style="list-style-type: none"> • Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. 	<ul style="list-style-type: none"> • 8% with traditional PH Providers. • 1% with Providers who are primarily BH (whose primary services are BH). • Actively build Long-Term Care Providers including nursing facilities full-risk.

For DY9 Q4, BCBS, PHP, and WSCC exceeded the required VBP spend target of 36%.

Table 29: Value Based Purchasing Spend



Source: MCO Calendar Year (CY) 2022 Quarter 1-4 VBP Financial Reports.

LOW ACUITY NON-EMERGENT CARE (LANE)

As part of HSD's strategic goal to improve the value and range of services to members, HSD collaborates with the MCOs to reduce avoidable Emergency Room (ER) visits. HSD implemented rule changes in DY7 resulting in a provider rate increase for outpatient settings, including Evaluation & Management codes, dispensing fees to community-based pharmacies, Long-Term Services and Supports providers, and supportive housing benefits for people with Serious Mental Illness. There also were increases in payment rates to governmental and investor-owned hospitals, as well as hospitals serving a high share of members who identify as Native American.

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

The Community Paramedicine Program is an additional outreach project supporting this effort. The program helps direct members to the right care, at the right time, and in the right setting for better health outcomes. The program is intended to reduce non-emergency medical calls, improve patient care and relieve rescue units for more life-threatening calls. The program targets members with chronic medical conditions such as diabetes and congestive heart failure who also may face social barriers to better health, including unstable housing or unreliable transportation. In rural communities where transportation may be difficult to obtain or distance is a barrier, especially for people who are elderly or homebound, community paramedics play an important role on a patient's care team because they can also deliver basic primary care services in the patient's home without requiring them to travel to a clinic. Community paramedicine services can ensure prompt care and identify health issues that need to be escalated to another provider. Community paramedics can also facilitate communication between the patient and their primary care provider.

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

BCBS began an evidence-based program to ensure members are established with a Primary Care Provider (PCP). BCBS pulls weekly reports which identify members who have had 6 or more ED visits in 6 months. The BCBS Community Health Worker (CHW) team calls members to provide education about the importance of seeing their doctor rather than returning to the ER. The CHW team also helps the member become established with

a PCP. Additionally, BCBS's digital teams sends non-PHI texts to members using Collective Medical real-time data, while the member is in the emergency room, suggesting options such as urgent care or primary care. The goal of digital outreach is so there is immediate response and follow-up action or encouragement for the member.

PHP interventions for preventing non-emergent ER utilization include monitoring Collective Medical real-time data for high utilizer or chronic utilizers in order to notify a CHW or peer support specialist when a member has arrived in the ED and prompts a live outreach option. Interventions include issuing educational materials, partnerships within the PHS delivery system and their partnership with Albuquerque Ambulance for Paramedicine. PHP has 2 unique programs, first is statewide outreach for the difficult-to-engage population and second is a high-risk task force reviewing claims and calling entities who have rapport with members to intervene. PHP VBP groups discuss barriers to improve access to care and high ED utilization while Long Term Services and Support (LTSS) programs collaborate with TOC teams for hospitalization discharge to prevent readmissions and completing in-home nurse practitioner visits. PHP also helps sponsor rural providers to gain access to pre-manage real-time systems and offers provider incentives when they provide after-hours care.

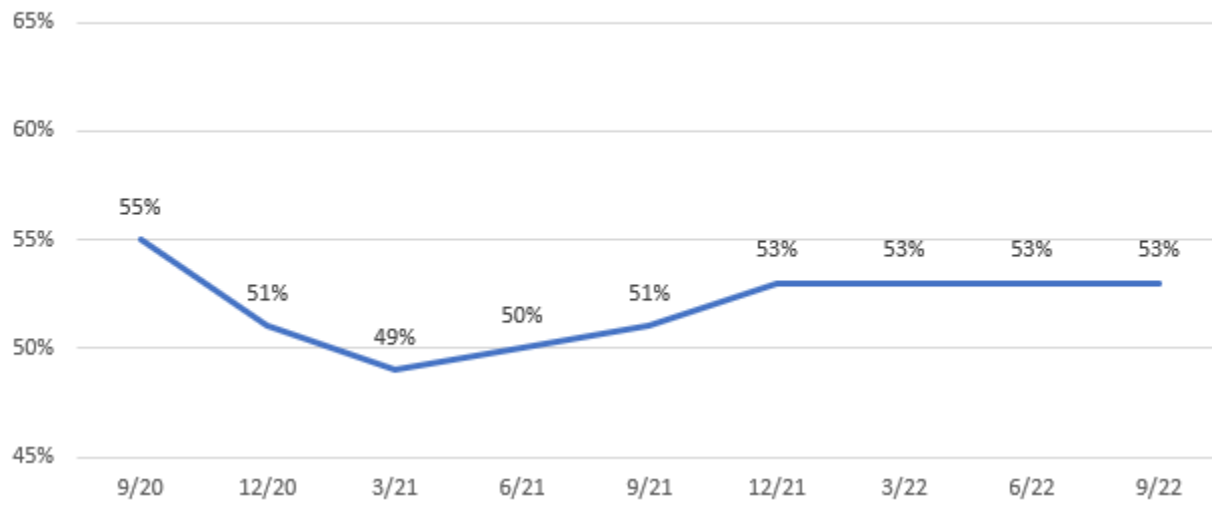
WSCC has a texting campaign utilizing Collective Medical real-time data providing follow up or connecting members to WSCC Member Connections (MC) teams that consist of peer support specialists and CHWs with the outcome of connecting to PCPs, urgent care, or nurse advice line. WSCC Care Coordinators use Collective Medical real-time data and are trained to receive alerts on emergency usage and provide support following the ER visit, provide educational flyers, and distribute magnets with contact information. WSCC providers also call members to follow-up after an ED mental health visit.

As a result of the MCO strategies and interventions in DY8, which focused on reducing ED visits for non-emergent care, the percentage of emergency utilization that are considered low acuity increased from DY8 Q3 to DY9 Q3. In comparing low acuity ED visits from September of 2021 (51%) to September of 2022 (53%), the percentage of visits to the emergency department for non-emergent care increased by 2 percentage points. A lower rate indicates improvement for this measure. The trend for this measure indicates a steady increase in the number of low acuity ED visits.

The graph below reflects the percentage of members using the ER for non-emergent care between DY7 Q3 and DY9 Q3. Data is reported quarterly based upon a rolling 12-month measurement period and excludes retro membership. The data for DY9 Q4 will be reported in the DY10 Q1 CMS Quarterly Monitoring Report.

Table 30: Non-Emergent ER Use

Percent of Non Emergent ER Use



Source: Mercer- Non-Emergent Emergency Room Utilization Report

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MANAGED CARE REPORTING REQUIREMENTS

GEOGRAPHIC ACCESS

Geographic access performance standards remain the same in DY9 with the requirement that at least 90% of members having access to certain provider types in urban, rural, and frontier geographic areas within a defined distance. Geographical Access is collected and validated on a quarterly basis.

Physical Health and Hospitals

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

- MCOs performance in access to general hospitals, PCPs, pharmacies, and most specialties in urban, rural, and frontier areas were met.
- Provider shortages have impacted geographic access; however, access has been maintained. MCOs closely monitor the following services and employ ongoing efforts to ensure member access such as targeted recruitments, referral training, provider enrollment training, telehealth options and value-based contract arrangements.
 - Rural areas did not meet standards for certified midwives.
 - Rural and Frontier areas did not meet standards for the following: dermatology; endocrinology; Ear, Nose, and Throat (ENT); and urology services.
 - Some MCOs reported below standard performance for neurosurgeons and rheumatology in all geographical areas.

Table 31: Physical Health Geographical Access

Geo Access PH DY9 Q3 (July - September 2022)									
	Urban			Rural			Frontier		
PH - Standard 1	BCBS	PHP	WSCC	BCBS	PHP	WSCC	BCBS	PHP	WSCC
PCP including Internal Medicine, General Practice, Family Practice	100.00%	100.0%	100.0%	99.50%	100.0%	100.0%	100.0%	99.9%	100.0%
Pharmacies	100.00%	100.0%	100.0%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%
FQHC - PCP Only	100.00%	100.0%	100.0%	90.60%	90.7%	99.4%	96.9%	89.4%	98.8%
PH - Standard 2									
Cardiology	99.30%	98.9%	99.0%	99.8%	100.0%	100.0%	99.8%	99.9%	99.8%
Certified Nurse Practitioner	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%
Certified Midwives	99.20%	98.9%	94.1%	87.0%	88.4%	99.2%	99.8%	98.6%	99.8%
Dermatology	99.20%	98.9%	98.9%	70.7%	73.8%	90.4%	85.4%	89.7%	98.3%
Dental	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinology	99.20%	98.9%	98.9%	74.1%	65.5%	87.0%	84.3%	89.0%	92.6%
ENT	99.10%	98.8%	98.9%	86.2%	88.0%	100.0%	95.3%	88.5%	97.1%
FQHC	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hematology/Oncology	99.20%	98.9%	98.9%	99.6%	94.4%	99.4%	99.4%	99.9%	93.4%
Neurology	99.20%	98.9%	99.0%	98.8%	96.2%	92.1%	93.9%	93.0%	95.4%
Neurosurgeons	99.10%	83.0%	98.9%	39.7%	75.7%	41.0%	68.0%	87.8%	81.3%
OB/Gyn	99.30%	98.9%	99.0%	99.7%	99.8%	100.0%	99.8%	99.8%	99.8%
Orthopedics	99.20%	98.9%	98.9%	99.7%	94.0%	100.0%	96.4%	98.3%	99.7%
Pediatrics	100.00%	98.9%	99.0%	99.8%	100.0%	99.9%	99.8%	98.7%	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%	98.9%	99.1%	99.7%	99.7%	99.9%	96.6%	98.7%	100.0%
Rheumatology	99.20%	98.9%	83.1%	77.8%	83.6%	70.4%	82.4%	85.3%	74.4%
Surgeons	99.30%	98.9%	99.1%	100.0%	100.0%	100.0%	99.8%	99.9%	99.8%
Urology	99.10%	98.8%	98.9%	91.1%	93.4%	91.4%	89.4%	93.1%	90.3%
LTC - Standard 2									
Personal Care Service Agencies	100.00%	100.0%	100.0%	100.00%	99.8%	99.7%	100.0%	100.0%	100.0%
Nursing Facilities	99.30%	92.9%	99.4%	99.7%	97.7%	99.8%	99.8%	100.0%	99.8%
General Hospitals	99.20%	98.9%	98.9%	99.7%	99.4%	100.0%	100.0%	99.9%	99.8%
Transportation	100.00%	100.0%	100.0%	87.4%	99.9%	100.0%	100.0%	100.0%	100.0%

Source: MCO Report #55 GeoAccess Q3CY22

Transportation

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

- **Grievances:** Consistent with previous reporting, Non-Emergency Medical Transportation (NEMT) grievances is the leading category of grievances in the reporting period. The MCOs along with HSD are monitoring accessible transportation options as a barrier to member access with transportation vendors and exploring new options. HSD continues to work with MCOs on the concerns and inquiries surrounding the NEMT program, unreliable transports, and shortage in drivers and vehicles.
- **Initiatives:**
HSD has received approval from CMS through a Disaster State Plan Amendment (SPA # 22-0001) to temporarily increase provider reimbursement to NEMT providers by 6.81% for all transportations made between January 1, 2022, through June 30, 2022. HSD will establish a post payment adjustment process that will identify these transports so that the provider will be reimbursed the additional 6.81%.

HSD is enhancing its oversight of the MCOs' provision of NEMT to its members. The initial focus is on trips for Critical Care Appointments: dialysis, radiation, chemotherapy, dialysis, pre/post-surgery, urgent care, and high-risk pregnancy. To date, the MCOs have been directed to: 1) work with their transportation vendors to ensure that all requested rides are provided for these appointments; 2) develop and submit for approval detailed operational plans for providing NEMT for Critical Care service appointments when the transportation vendors are unable to provide the service; 3) submit an NEMT monthly report that provides data on NEMT trips; 4) In DY9 Q4, HSD provided performance targets to the MCOs for the number of trips that could not be scheduled, and for the number of scheduled trips that did not occur due to transportation provider actions, such as canceled or missed trips. The MCOs were informed that failure to meet the target level of performance would result in significant monetary penalties.

Customer Service Reporting

BCBS met all call center metrics for the reporting period, DY9 Q4.

PHP met all call center metrics for the reporting period, DY9 Q4.

WSSC met all call center metrics for the reporting period, DY9 Q4.

Telemedicine Delivery System Improvement Performance Target (DSIPT)

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

The MCOs shall use the end of CY21 as the baseline for CY22 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.

All three MCOs met the Telemedicine Delivery System Improvement Performance Targets for DY9.

Table 32: Unduplicated Members Served with Telemedicine

Total Unduplicated Members Served with Telemedicine	DY9 Q1	DY9 Q2	DY9 Q3	DY9 Q4
New Behavioral Health Members	45,049	12,208	9,832	6,669
BCBSNM	17,489	4,647	3,717	2,470
PHP	23,109	6,111	4,896	3,296
WSCC	4,451	1,450	1,219	903
New Physical Health Members	67,116	28,340	23,879	17,694
BCBSNM	24,390	10,134	8,941	6,910
PHP	38,345	15,910	12,752	9,235
WSCC	4,381	2,296	2,186	1,549
Total New Unduplicated Members	102,650	34,312	27,958	19,923
BCBSNM	37,909	12,234	10,331	7,531
PHP	56,471	18,848	14,749	10,343
WSCC	8,270	3,230	2,878	2,049
YTD* Unduplicated Members	102,650	136,962	164,920	184,843
BCBSNM	37,909	50,143	60,474	68,005
PHP	56,471	75,319	90,068	100,411
WSCC	8,270	11,500	14,378	16,427

Source: Telemedicine Delivery System Improvement Performance Target (DSIPT) * January – December 2022

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DEMONSTRATION EVALUATION

Evaluation Findings and Design Plan

DY9 Q4

The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) continued to work together to collect and finalize data validation and gap analysis on various data extracts for use in the interim report analysis including, Medicaid Management Information Systems (MMIS), Value-based purchasing (VBP) reports, Health Home, Low-birth weight, Financial and Managed Care Organization (MCO) report data.

The team also collaborated to define key terms used in measure specifications to ensure accurate and complete results, finalize the outline for the interim evaluation report based on the Centers for Medicare & Medicaid Services (CMS) guidance, and develop, review, and finalize the interim evaluation report in preparation for submission to CMS. Additionally, the team worked to revise select AIM 4 (Improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder (SUD) measures for the summative evaluation report.

HSAG finalized the SAS® programming code, calculations, statistical modeling, and analyses for 54 performance measure calculations for inclusion in the interim evaluation report.

HSAG finalized the cost-effectiveness analysis for the interim evaluation report (the cost effectiveness analyses completed for the interim evaluation report are not the same as the formal budget neutrality tests required under the Section 1115 Waiver Demonstration program).

During this reporting period of calendar year (CY) 2022, HSD and HSAG have not encountered any evaluation or technical challenges.

HSAG will continue to collaborate with HSD to revise the interim evaluation report upon receipt of CMS feedback. HSAG and HSD will continue discussions on evaluation activities, including refining SUD measures for the summative evaluation report.

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ENCLOSURES/ATTACHMENTS

Attachment A: October 2020 – September 2022 Statewide Dashboards

Attachment B: Budget Neutrality Monitoring Spreadsheet

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

Attachment D: Customer Service

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STATE CONTACTS

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

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ADDITIONAL COMMENTS

MCO INITIATIVES

BCBS:

Full Delegation of Care Coordination

BCBS has signed a full delegation of care coordination contract with a community behavioral health provider. Agreement includes care coordination services required for Level 2 and Level 3 care coordination, as well as enhanced services for members with Severe Emotional Disturbance (SED) that require ongoing intensive services often with weekly touchpoints. Providing care coordination at the provider level is expected to increase member and family engagement, improve health outcomes, and help facilitate effective and efficient use of medical and community resources.

Behavior Health Providers

BCBS' contracting team executed 64 new provider contracts, 39 of the contracts are with behavioral health providers.

Provider Reporting Tool (Lightbeam)

BCBS has implemented a new reporting tool for providers participating in BCBS shared savings/risk value-based purchasing plan (VBP). Lightbeam is an interactive reporting tool that providers can directly access online to view actionable cost and utilization data. Providers can evaluate healthcare spend and performance through cost and utilization metrics; identify cost drivers; and drill down to the practice, clinic, practitioner, and member level details. Lightbeam includes financial information to help providers see how they are performing against their VBP target.

PHP:

Enhancements:

Medicaid Performance Improvement

Presbyterian Health Plan (PHP) supported Centennial Care members with type 1 and type 2 diabetes through the Diabetes Management Performance Improvement Project. PHP provided enhanced follow up on members with high risk for complications. Additionally, PHP explored and selected a partner for a food resource program in the NW part of the state and is developing implementation processes. PHP has prioritized the following activities of focus to enhance the PIP:

- Continue to select targeted high-risk members in the Native American community to ensure outreach is completed.
- Develop a care coordination program with these members to facilitate food box pick up.

Baby Bonuses

PHP continued to develop the PHS Baby Bonuses enrollment portal to support Centennial Care members to attend well-baby doctor visits from birth to 30 months of age. PHP continued to train and educate internal and external stakeholders on the incentive program for eligible babies. Additionally, PHP explored social media options and increased outreach to both providers and members. PHP has successfully completed the following activities to enhance participation in the reward program and increase the well-baby health outcomes:

- Streamline Baby Bonuses Tracker to accurately reflect 15 month and 30-month dates for enrolled babies.
- Began telephone outreach to eligible members who have completed their post-partum visit and members previously enrolled but not engage in Baby Bonuses rewards program.
- Finalized the PHS Centennial Care Baby Bonuses Portal and began entering member information.
- Started an ROI investigation in collaboration with AO to determine value and HEDIS rate increase of program.

Innovations:

Colon Cancer At-home Screenings

In 2022 PHP supported the population of Medicaid members who had not received a colon cancer screening according to our data. For the first time ever, PHP mailed at home testing kits to 4,542 Centennial Care members in November 2022. As of the most recent data in late December the lab had received and processed 222 kits for Centennial Care members, or almost 5%, with more expected as data is received.

WSCC:

Pyx Health Program

Pyx Health is a free program for WSCC members to address loneliness, social isolation and social determinants of health needs. Through the combination of an engaging mobile app, as well as live staff at the Compassionate Support Center, Pyx Health supports WSCC members 24/7. The program went live for WSCC members in July 2022.

As of DY9 Q4, 406 WSCC members have enrolled in the program and actively benefited from the phone app or the live support to access health plan resources, community

services, to address general health care questions, urgent support, caregiver support, mental health, and substance abuse support, LGBTQIA services, and pregnancy support.

Provider Outreach and Education

In DY9 Q4, Provider Outreach and Education offered education to our providers, caregivers, and community stakeholders. Below are some highlights:

Highlights:

- By the end of DY9 Q4, WSCC Clinical Provider Trainers will have offered at least 75 trainings on long-term care, foster care, behavioral health, and/or integrated health care related topics. At the time of this report, trainings offered during DY9 Q4 had an average Net Promoter Score (NPS) of 99 and had at least 187 participants.
- At least 57 trainings offered were eligible for continuing education in DY9 Q4.
- Among the trainings WSCC offered was the Stress-Busting Program for Family Caregivers of Persons with Chronic Illness™ (SBP). SBP is an evidence-based 9-week wellness training program that supports unpaid and partially paid family caregivers of adults living with chronic illness. WSCC had three caregivers participate in the program and of these 3 caregivers, 2 completed the program. The program was well-received with an average NPS of 89 for the DY9 Q4 SBP Group.
- WSCC offered one Virtual Youth Mental Health First Aid and three Virtual Adult Mental Health First Aid courses as part of the quarter's training offerings.
- In DY9 Q4, WSCC had two new training topics offered to both of their WSCC Behavioral Health (BH) and Long-Term Care (LTC) Webinar Series, these include Strategies to Improve Care Coordination Outcomes and Customer Experience: Optimizing the Impact of Behavioral Health HEDIS® Measures and An Overview of Trauma-Informed Care When Working with Older Adults.
- All provider training can be accessed on WSCCs' Training and Education Page located at: Provider Training & Toolkits (westernskycommunitycare.com) and provides a centralized location for educational opportunities for providers.
- Caregiver Training for unpaid and partially paid caregivers of vulnerable and/or older adults can be accessed at: Caregiver Resources (westernskycommunitycare.com).

All provider training can be accessed on WSCCs' Training and Education Page.

MEMBER SUCCESS STORIES

BCBS:

After a nearly 3.5 year stay in out-of-state residential treatment center level of care, a now 16-year-old female has been discharged back to the State of New Mexico and to treatment foster care. This member struggles with developmental delays, depression and has a history of trauma and behavioral issues. This member's case has had barriers related to her discharge, including a family guardian who refused to take member back home, numerous CYFD reports that were investigated and ultimately closed out, and step-down placements that would deny member repeatedly, as packets were submitted and re-submitted through the years. Behavioral health supervisors and the Care Coordination Liaison worked tirelessly with Children, Youth and Families Department representatives and residential treatment center facility staff, eventually meeting weekly, in a collaborative effort for guardianship/CYFD custody and to ultimately locate appropriate placement. Less than a week before Christmas, member was transported to an out-of-state airport by residential treatment center staff. The member's Children, Youth and Families Department Permanency Plan worker escorted the member back to New Mexico and to the care of her treatment foster family. This young lady will be spending her first Christmas, since 2019, outside of an institution. The member says the things she is most excited about is getting to play with the treatment foster family pets/dogs. The member looks forward to when she can start volunteering at the local animal shelter.

PHP:

A 23-year-old PHP female member, who lives in the Albuquerque metro area, was assigned a Community Health Worker (CHW) due to pregnancy. The referral for the CHW was to engage member, verify pregnancy, and follow her through the pregnancy and postpartum care, along with offering member a referral for home visiting. CHW followed member throughout pregnancy with monthly follow-up check-in calls. CHW ended up engaging with member over a 9-month period. Member attended all scheduled prenatal appointments. CHW assisted with enrolling member in the Presbyterian Baby Benefits program, provided educational information about the Baby Bonuses program, and ensured the member was engaged with Women Infant Children (WIC) services. Member initiated prenatal care with a local midwife but had to be transferred to a medical doctor due to non-reassuring fetal status which resulted in a Cesarean-section delivery. The CHW was a consistent support for this member through many months and ensured that member attended the 6-week postpartum visit, which the member had no further needs or concerns at that time. Member was thrilled with her baby and appreciated all assistance that she received from PHP's CHW.

WSSC:

A member struggled with schizophrenia and had trouble sleeping. He was afraid to go to sleep and feared someone would enter through his bedroom window. The member's care coordinator (CC) advocated on his behalf and was able to get safety bars installed on his bedroom window. This was completed through an EMOD (environmental modification). This is not common because EMODs usually address physical limitations. However, based on member's significant behavioral health needs, this was approved and completed. The member and his parents report that the company did a great job and member is sleeping better through the night. The member and his parents are very grateful for the assistance they received from the CC.

MCO COVID-19 RELIEF EFFORTS

BCBS:

Grants

- There were no COVID-19 related grants received or issued in DY9 Q4.

Donations

- There were no donations issued in DY9 Q4.

Events

- APS Employee Group Event, October 6th
- Highland Senior Center Event, October 7th
- Premier Medical Group COVID-19 Vaccine Clinic, October 17th
- Premier Medical Group COVID-19 Vaccine Clinic, October 18th
- Los Volcanes Senior Center Event, October 28th
- Brentwood Senior Apartments Clinic, November 4th
- Solar Villa Apartments Clinic, November 4th
- Indigenous Life Celebration Event, November 5th
- Pecos Senior Center Event, November 10th
- Route 66 Employee Group Clinic, November 16th
- Premier Medical Group COVID-19 Vaccine Clinic, November 21st
- Premier Medical Group COVID-19 Vaccine Clinic, November 22nd
- Premier Medical Group COVID-19 Vaccine Clinic, December 10th
- Premier Medical Group COVID-19 Vaccine Clinic, December 13th
- Premier Medical Group COVID-19 Vaccine Clinic, December 19th
- Premier Medical Group COVID-19 Vaccine Clinic, December 20th

- Supported the following COVID-19 Vaccination Events across the state and in tribal communities:
 - Vacuna por Pavo, November 19th
BCBS joined El Mezquite Market, Walgreens, and other local partners at this annual event where turkeys were distributed to community members that received a flu or COVID-19 vaccine and resource information was provided.

PHP:

Supporting Members

- PHP continued to promote the vaccine through member communications (newsletter, web, social media) and interactions (care coordination, member calls).
- Community Health Workers have coordinated with food pantries to provide emergency food boxes to members who are in immediate need of food and who are COVID-19 positive. PHP established a new partnership with Roadrunner Food Bank for emergency food boxes. The CHW is able pickup food boxes from their administrative location and deliver them to the member's homes eliminating the need for the member and their family to attend a food distribution event while recovering from COVID-19.

Peer Support COVID-19 Efforts

- PHP continues to offer the Meals on Wheels (MOW) delivery program for COVID-19 positive members with food insecurity. PHP has coordinated a total of 12,238 meals thus far for members with food insecurity who required support following a COVID-19 diagnosis.

In 2022 PHP provided the following number of COVID-19 meals:

- 131 members were outreached to by CHW team
- 20 members accepted the MOW benefit
- Total meals = 456 (on 1/4 one member and care giver received 56 meals and benefit changed to max 20 meals on 1/10). The report identifying members who were COVID-19 positive was also paused for the 3rd quarter due to a system conversion.

The CHW team is still offering COVID-19 meals to its members.

Supporting Native Americans

- Provided guidance for COVID-19 testing and resources during the Q1 Native American Consumer Advisory Board.
- Participated in the National Indian Health Board discussion on "Disparities of

COVID-19 Transmission Among American Indian/Alaskan Native Populations”.

- Provided ongoing guidance and support for tribal leaders for on-site COVID-19 testing.
- Offered on-line opportunities to educate members of available services and benefits.
- Facilitated communications for specific complex cases. Engaged with pueblo and Indian Health Services resources on guidance in returning critical care member to a community that is experiencing large COVID-19 surge and lack of medical providers.
- Updated the tribal liaison team on the Presbyterian Mobile Testing Unit locations. Schedule allowed for referrals when mobile unit is in tribal communities.

Supporting Providers

- Continue to send monthly lists to primary care providers (PCP) of their paneled members who have not received the COVID-19 vaccine.
- Created reports that identified PCP's with no or low volume of COVID-19 vaccination claims and outreached to them to identify barriers in delivering the vaccine to their patients or in submitting claims to PHP. Assisted with billing inquiries.

WSCC:

- WSCC has been collaborating with the other MCOs and community partners to make COVID-19 vaccination a part of immunization events and community outreach.
- WSCC partnered with Mesa Verde Community Center to provide a Thanksgiving grocery giveaway. WSCC provided 300 grocery bags for a full Thanksgiving feast to those who received a flu and or COVID-19 vaccination. WSCC hosted a similar event in Santa Fe at the Genoveva Chavez Center where 360 COVID-19 and flu shots were administered and over 300 grocery bags filled were provided. The last Thanksgiving event was hosted at the Dennis Chavez Community Center. Ten COVID-19 boosters and 5 flu shots were administered at this event. Grocery bags filled with food items for Thanksgiving meals were provided to those 15 individuals who received these COVID-19 booster and flu shots.