HUMAN SERVICES DEPARTMENT

LEGISLATIVE FINANCE COMMITTEE
SEPTEMBER 21, 2022

INVESTING FOR TOMORROW, DELIVERING TODAY.

BEFORE WE START…

On behalf of all colleagues at the Human Services Department, we humbly acknowledge we are on the unceded ancestral lands of the original peoples of the Apache, Diné and Pueblo past, present, and future.

With gratitude we pay our respects to the land, the people and the communities that contribute to what today is known as the State of New Mexico.

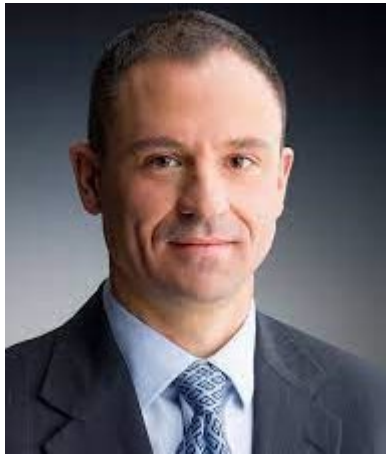
Evening drive through Corrales, NM in October 2021.
By HSD Employee, Marisa Vigil

AGENDA & PRESENTERS

- Human Services Department (HSD)
  - Medicaid Request and Forecast Update
  - Enrollment Outlook
  - Provider Rates
  - Controlling Hospital and Nursing Home Costs
  - Update on RFP and Waiver and Cost Overruns
- Medicaid Managed Care Organizations (MCO) Partners
  - Ensuring Access to Care
  - Utilization and Use of Services
  - Provider Rates

David R. Scrase, M.D.
Secretary (HSD); Acting Secretary (DOH)

Nicole Comeaux
State Medicaid Director



Brandon Frayer
President, Presbyterian Health Services

Jean Wilms
President and CEO, Western Sky Community Care

Sharon Huerta
Centennial Care CEO, VP, Medicaid Operations · Blue Cross Blue Shield of New Mexico

HUMAN SERVICES DEPARTMENT

MISSION

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

GOALS

We help NEW MEXICANS

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

We communicate EFFECTIVELY

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

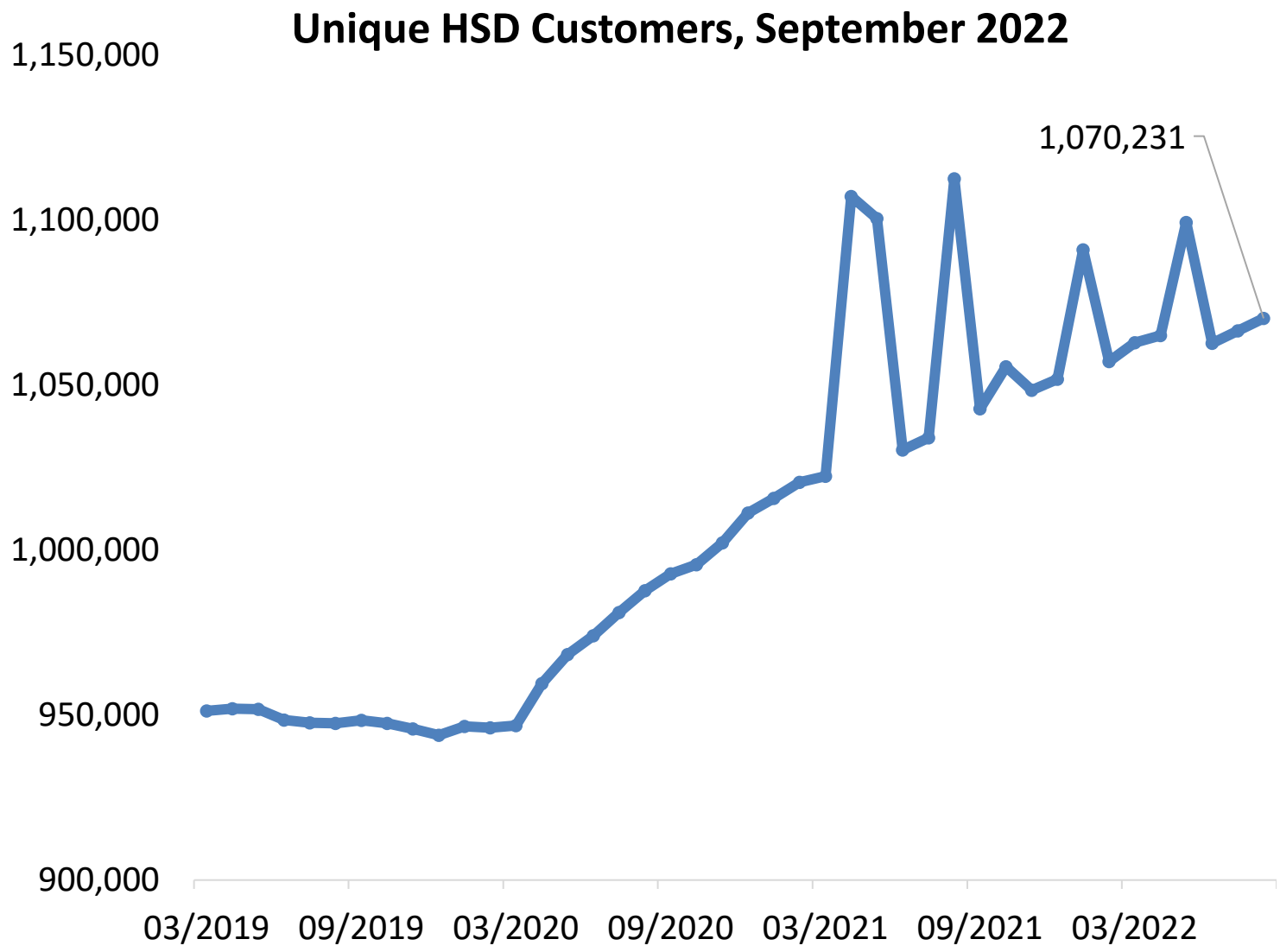
We make access EASIER

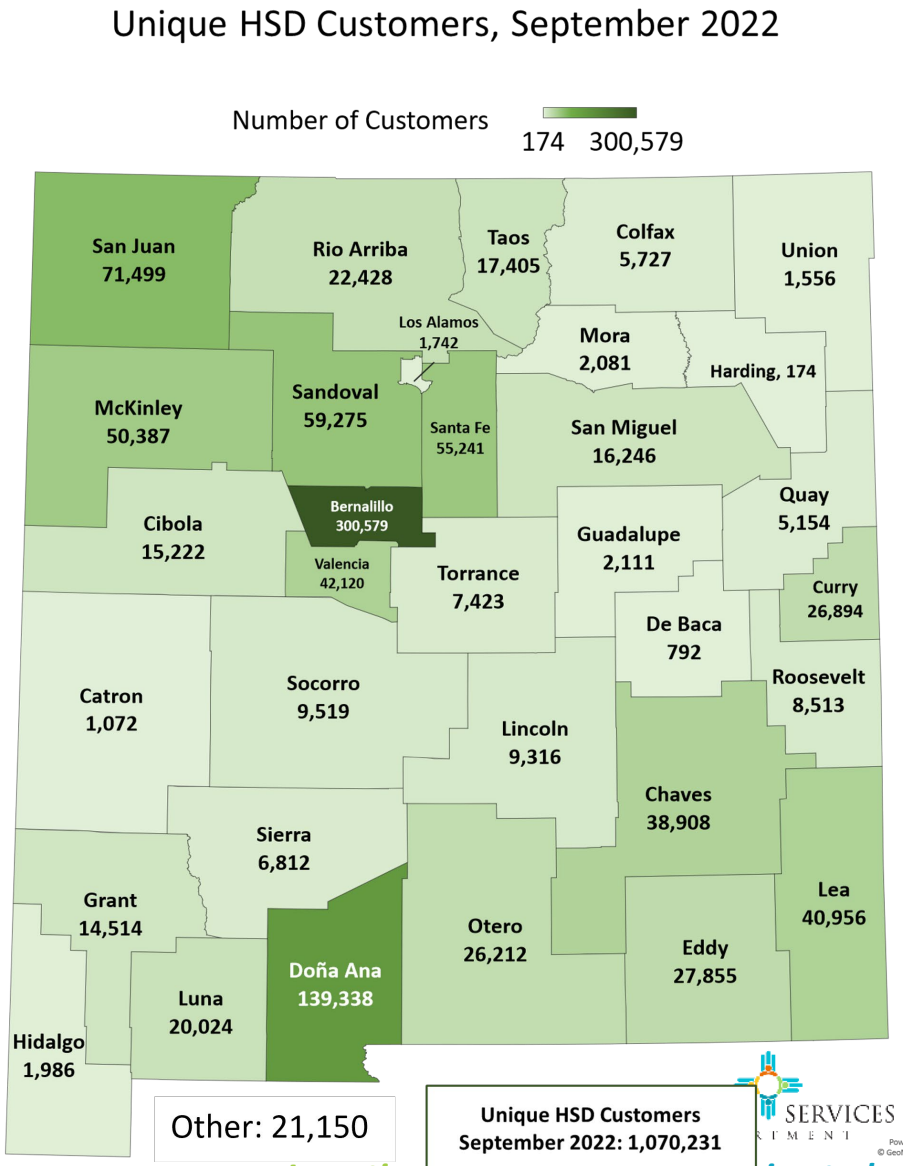
3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We support EACH OTHER

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

HSD SERVES 50% OF NEW MEXICANS





HSD'S SOCIAL IMPACT: NM BENEFITS FROM MODERN AND RESPONSIVE SOCIAL SAFETY NET

HSD's Programs have had the following social impact:

538,642,002 meals provided to New Mexicans through Supplemental Nutrition Assistance Program (SNAP) **over the last 12 months**

977,688 individuals provided the ability to visit a doctor, afford medication and immunizations through Medicaid **in August 2022**

54,856 homes heated and cooled for New Mexico families through Low Income Energy Assistance Program (LIHEAP) **in Federal Fiscal Year 2022**

10,986 families provided shelter and necessities through Temporary Assistance for Needy Families (TANF) **in August 2022**

$125.46* per month on average through child support to help kids be happy and healthy **over the last 12 months**

214,951 New Mexico adults supported by Behavioral Health programs and services** from **April 2021-March 2022**

last updated: 9/15/2022

*collections include current support and arrears debt to the custodial parent and/or the state.

**BH services include those covered through Medicaid and other sources (federal and general funds). The total is affected by a 3 month claim lag and therefore this measure is updated quarterly.

Source: https://sites.google.com/view/nmhsdscorecard

MEET THE VALDEZ FAMILY*

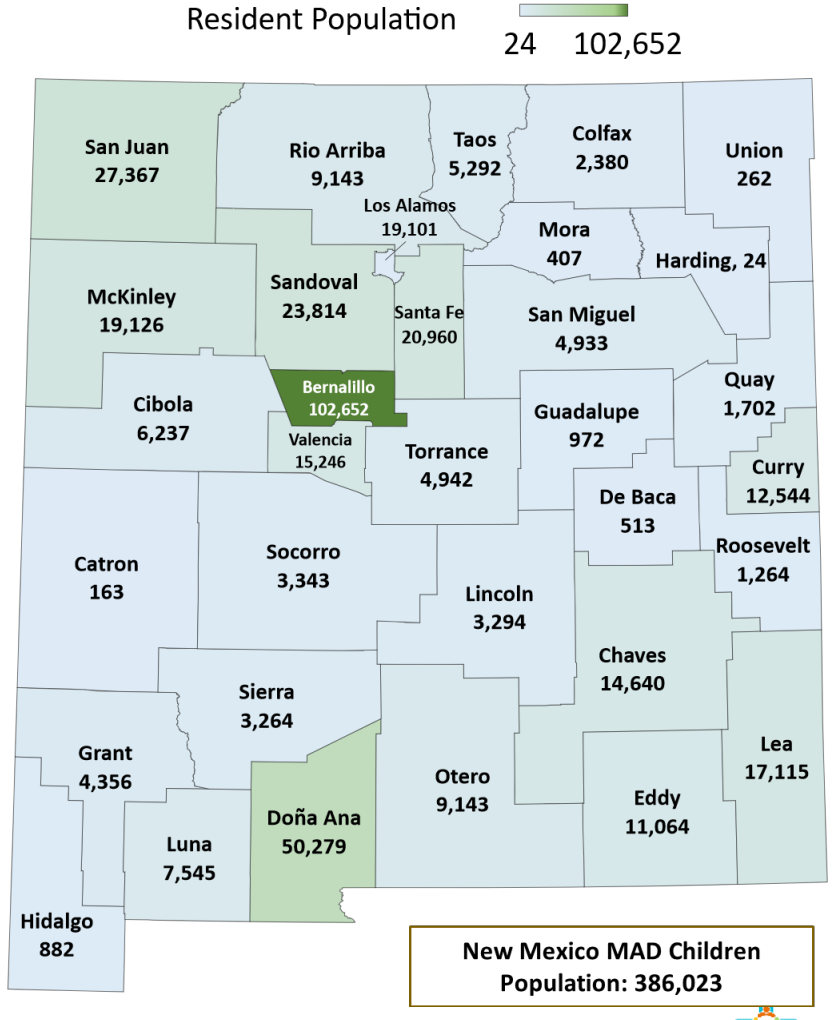
- Amanda Valdez is 16 and lives in Grants. During her junior year in high school, she becomes pregnant and receives food supports (SNAP) and Medicaid.
- Amanda's mother, Linda, was incarcerated during Amanda's pregnancy, leaving Amanda to attend medical appointments by herself.
- Amanda travels 80 miles to give birth to her son, Daniel, at UNM and during the birth she experiences cardiac arrest and seizures. After a stay in pediatric ICU, she stays in ABQ for several months for rehab.
- NM Corrections Dept. releases Linda from jail early to allow her to care for her daughter and grandchild.

**HSD has changed the name and photo of this HSD customer to protect privacy.*

NEW MEXICO MEDICAID UPDATES

- Published 5-year waiver renewal 9/6.
- Designed new Medicaid Contract and Request for Proposals to be released 9/30.
- Completed and published comprehensive provider rate study.
- Drafted complete Medicaid billing manual - complete 12/2022.
- Received Federal approval for reimbursement for services for all Medicaid children in schools (benefitting 386,023 school-age children).
- Distributed COVID-19 rate adjustments from FY22 $174 M appropriation ($26 M SGF).
- Completed $130 M in economic recovery payments to Home and Community-based Service providers.
- Continued elimination of Developmentally Disabled Waiver Waitlist in partnership with DOH.

Medicaid Customers < 21 Years Old By County, August 2022



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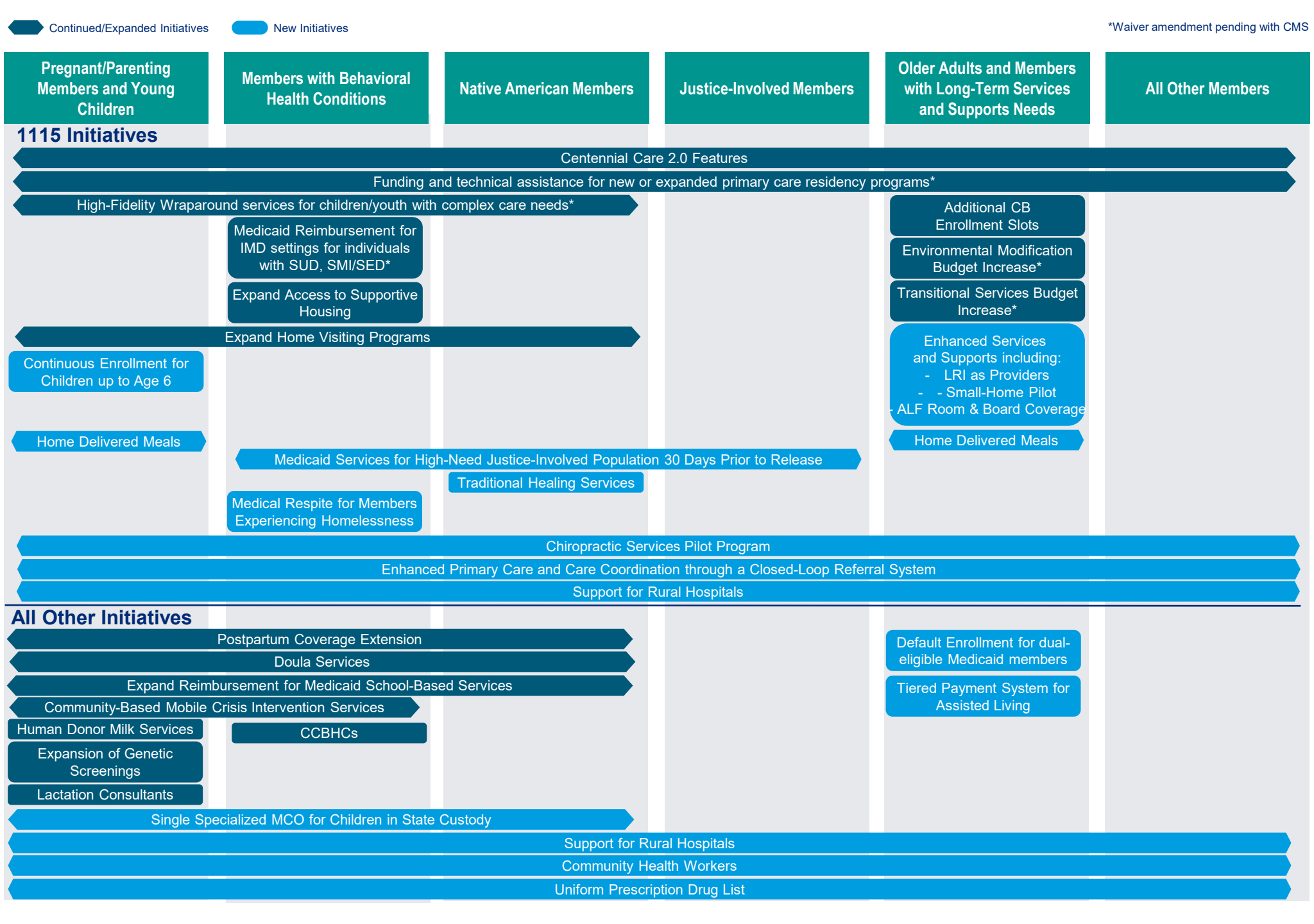
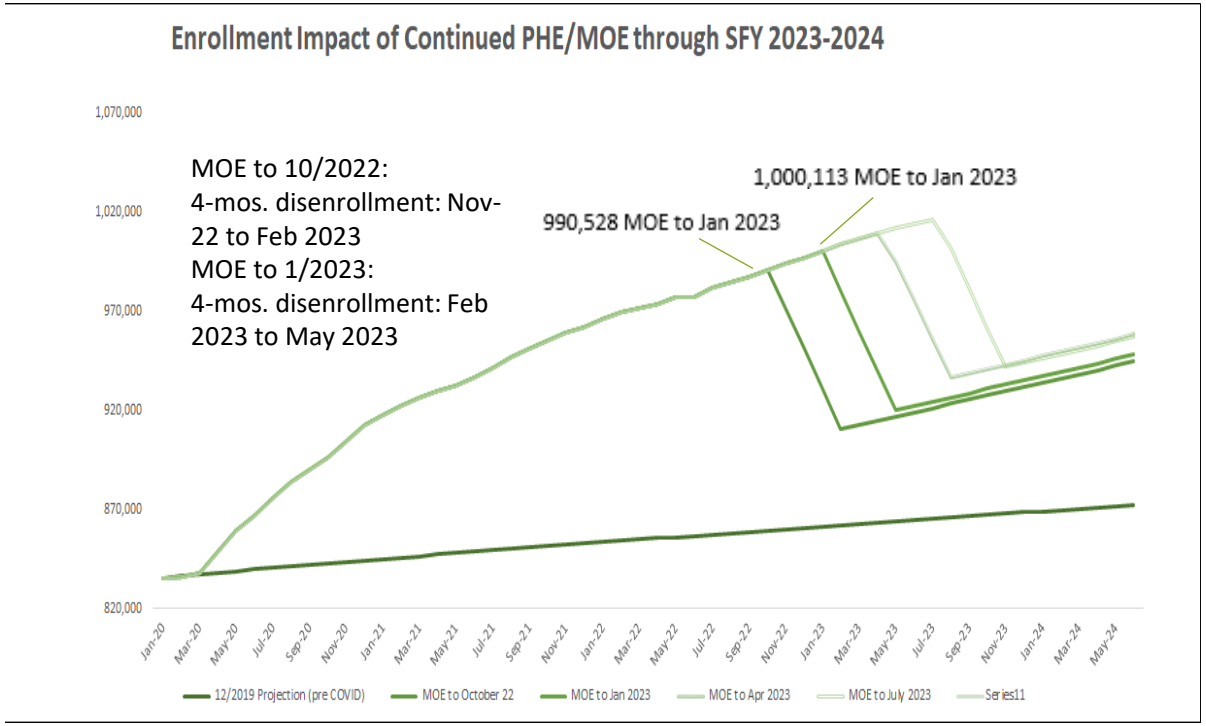
HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.


Continued/Expanded Initiatives
New Initiatives
*Waiver amendment pending with CMS
Pregnant/Parenting Members and Young Children
Members with Behavioral Health Conditions
Native American Members
Justice-Involved Members
Older Adults and Members with Long-Term Services and Supports Needs
All Other Members
1115 Initiatives
Centennial Care 2.0 Features
Funding and technical assistance for new or expanded primary care residency programs*
High-Fidelity Wraparound services for children/youth with complex care needs*
Medicaid Reimbursement for IMD settings for individuals with SUD, SMI/SED*
Expand Access to Supportive Housing
Additional CB Enrollment Slots
Environmental Modification Budget Increase*
Transitional Services Budget Increase*
Expand Home Visiting Programs
Continuous Enrollment for Children up to Age 6
Enhanced Services and Supports including:
- LRI as Providers
- - Small-Home Pilot
- ALF Room & Board Coverage
Home Delivered Meals
Home Delivered Meals
Medicaid Services for High-Need Justice-Involved Population 30 Days Prior to Release
Traditional Healing Services
Medical Respite for Members Experiencing Homelessness
Chiropractic Services Pilot Program
Enhanced Primary Care and Care Coordination through a Closed-Loop Referral System
Support for Rural Hospitals
All Other Initiatives
Postpartum Coverage Extension
Doula Services
Expand Reimbursement for Medicaid School-Based Services
Community-Based Mobile Crisis Intervention Services
Human Donor Milk Services
CCBHCs
Expansion of Genetic Screenings
Lactation Consultants
Default Enrollment for dual-eligible Medicaid members
Tiered Payment System for Assisted Living
Single Specialized MCO for Children in State Custody
Support for Rural Hospitals
Community Health Workers
Uniform Prescription Drug List

MEDICAID ENROLLMENT CHANGES OVER THE NEXT 14 MONTHS

COVID-19 pandemic, Maintenance of Effort (MOE) requirements, economic outlook, and stimulus policies influential factors in FY20 to FY23 enrollment and budget projections.



State Revenue $000s	PHE S.0 6.2% thru 12/31/22	PHE S.1 6.2% thru 3/31/23	PHE S.2 6.2% thru 6/30/23	PHE S.3 6.2% thru 9/30/23
FY23 Surplus / (Shortfall)	(57,336)	(960)	58,300	55,192
Change from Current PHE S.0	-	56,376	115,636	112,528
FY24 Surplus / (Shortfall)	(155,733)	(159,682)	(162,719)	(106,301)
Change from Current PHE S.0	-	(3,949)	(6,986)	49,432
Peak Enrollment	990,528	1,000,113	1,008,860	1,015,865

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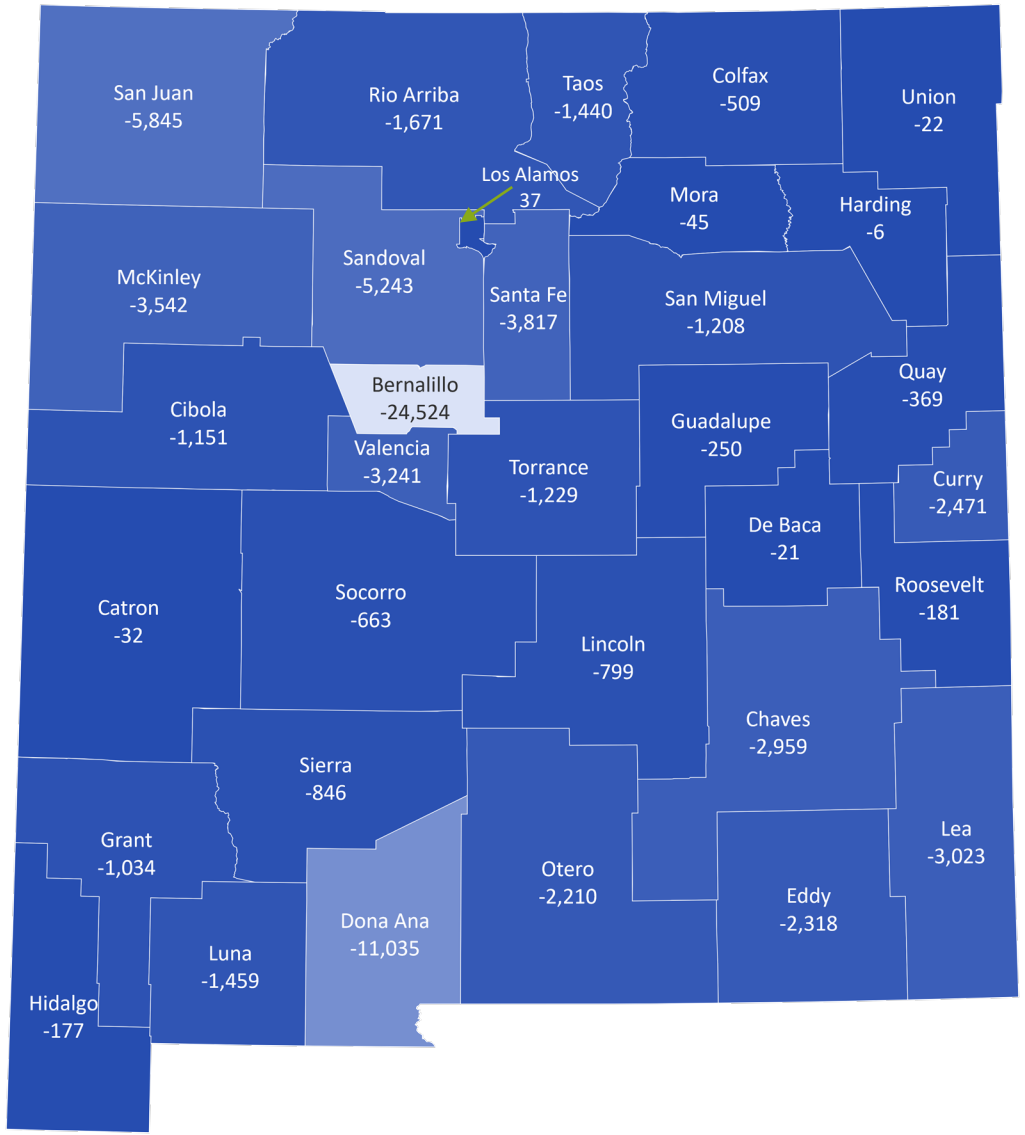
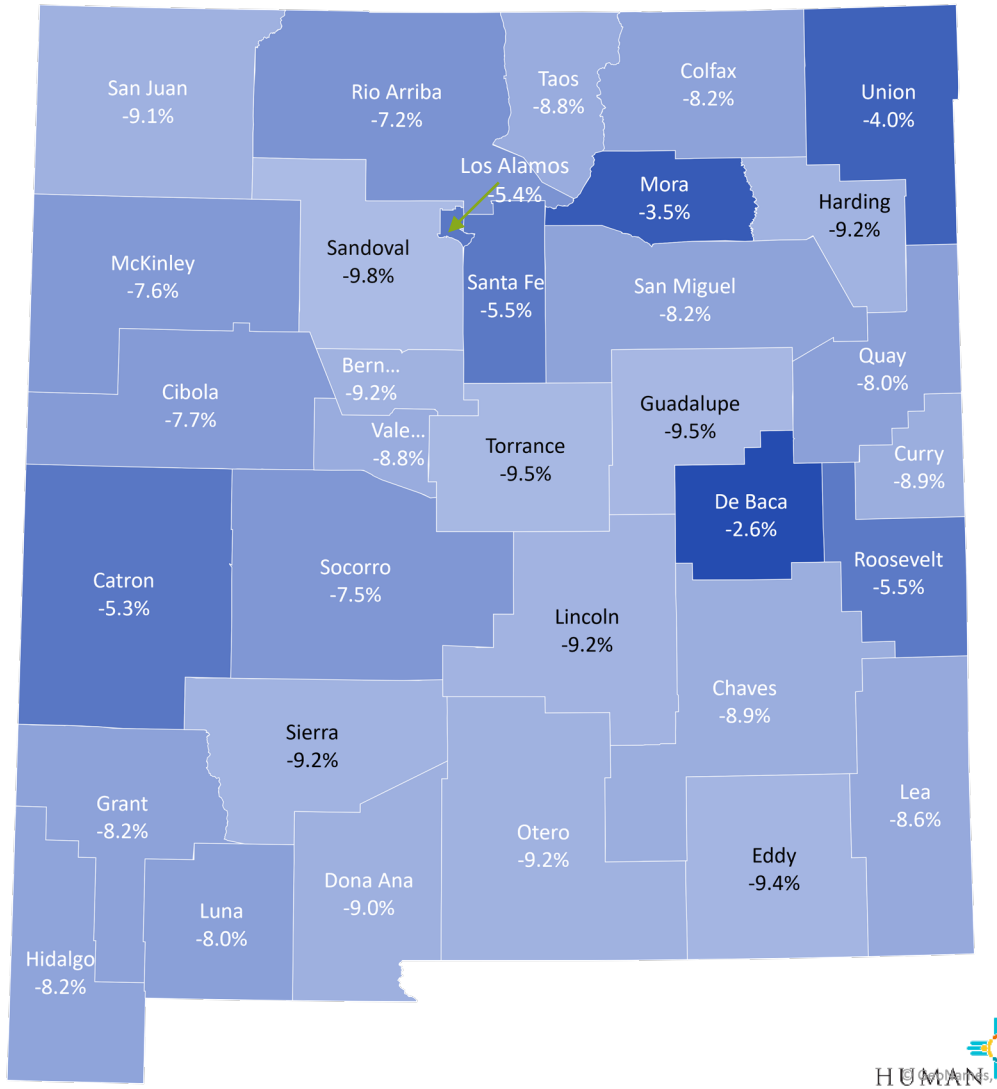
Estimated New Mexicans Financially Ineligible for Medicaid after Federal Public Health Emergency (PHE) Ends (June 2022 estimate)



Percent Decrease in Medicaid Enrollment by County after Federal Public Health Emergency (PHE) ends (June 2022 estimate)



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MEDICAID FMAP AND 6.2% INCREASE IMPACT

Federal Fiscal Year FMAP Changes

	FFY 2022 Policy Adjusted Federal and State FFP			FFY 2023 Policy Adjusted Federal and State FFP			FFY 2024 Federal and State FFP		
	Federal Match %	State Match %	Ratio (Federal to State)	Federal Match %	State Match %	Ratio (Federal to State)	Federal Match %	State Match %	Ratio (Federal to State)
Traditional (PH & LTSS)	79.91%	20.09%	3.98	79.46%	20.54%	3.87	72.92%	27.08%	2.69
Chip EFMAP	85.00%	15.00%	5.67	85.00%	15.00%	5.67	81.04%	18.96%	4.27
Other Adult Group (CY21)	90.00%	10.00%	9.00	90.00%	10.00%	9.00	90.00%	10.00%	9.00
State FY Blended FFP	83.43%	16.57%	**5.04**	80.23%	19.77%	**4.07**	77.87%	22.13%	**3.52**
Annual Change in Ratio			**0.16**			**-0.98**			**-0.55**

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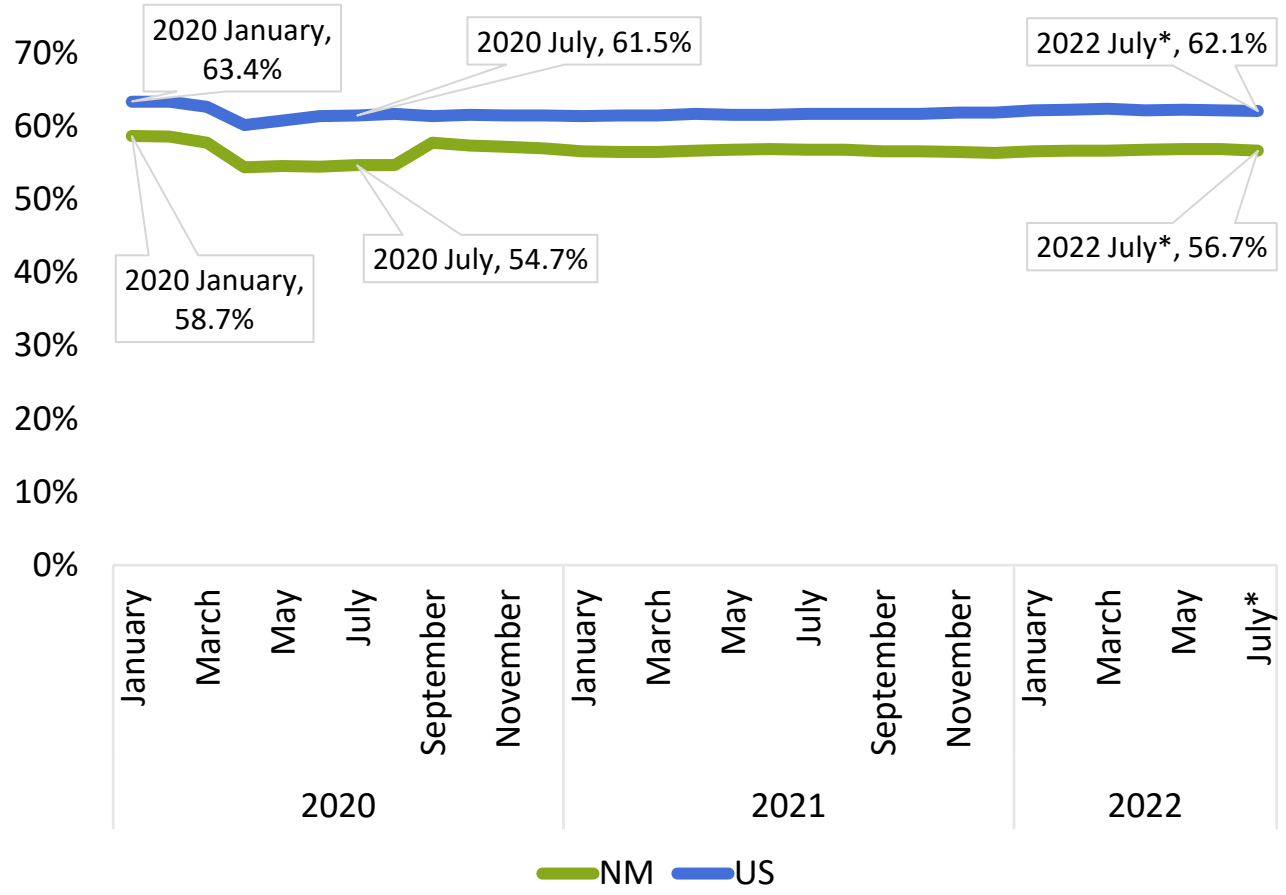
WHAT'S DRIVING MEDICAID ENROLLMENT?

- Growth in Medicaid/CHIP enrollment through July 2022 reflects:
  - effects of PHE.
  - stagnant workforce participation of lower-income parents (full-time vs. part-time status).
  - incentives for job search activity associated with stimulus/relief policies.
- Growth in Medicaid/CHIP enrollment over SFY 2023 affected most Maintenance of Effort unwinding, reflecting:
  - Processing eligibility redeterminations.
  - Procedural/financial closures.
  - Category of Eligibility transitions/churn.

U.S. & N.M. Labor Force Participation Rates: 1/2020 to 7/2022



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CHECKING IN ON THE VALDEZ FAMILY*

- After her pregnancy, Amanda becomes severely depressed because she could no longer do the things she enjoyed.
  - She begins to self-harm and experiences suicidal ideations. (She has a history of inpatient behavioral health admissions).
- Her healthcare providers diagnose her with Post Traumatic Stress Disorder, a brain injury, and cardiac issues.
- Amanda was proud to walk again with the help of a walker when she left rehab. But, back at home, she could not get her needed medical equipment or attend follow-up appointments.
  - Her mobility declined, and she developed ulcers.
- Linda did not allow family members or providers to intervene; and Amanda's aunt and uncle called protective services so Amanda and Daniel can get the care and support they need.

**HSD has changed the name and photo of this HSD customer to protect privacy.*

FY24 MEDICAID BUDGET OVERVIEW

MEDICAID BUDGET UPDATE: FY24 EXPENDITURES

Budget Projection – Expenditures	FY2024 ($000s)	FY2023 ($000s)	Change from FY2023 ($000s)	% Change from FY2023
Fee-For-Service	900,875	892,233	8,642	0.97%
DD & MF Traditional, and Mi Via Waivers	746,442	621,364	125,078	20.13%
Centennial Care MCO	6,826,839	6,733,560	93,279	1.39%
Medicare	281,199	262,741	18,458	7.03%
Other	77,253	28,207	49,046	173.88%
Total Projection (06/30/22)	**8,832,608**	**8,538,106**	**294,502**	**3.45%**

*The current quarterly budget projection is updated with data through June 30, 2022.

Increase due to DOH increase in need.

Increase due to Expansion Items

3.45% growth in expenditures

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MEDICAID BUDGET UPDATE: REVENUES

Budget Projection - Revenues	FY2024 ($000s)	FY2023 ($000s)	Change from FY2023 ($000s)
Federal Revenues	6,877,853	6,850,069	27,784
All State Revenues	1,886,218	1,624,507	261,711
Operating Transfers In	365,198	284,442	80,756
Other Revenues	65,072	65,072	0
General Fund Need	1,421,636	1,243,238	178,397
Appropriation	1,265,902	1,185,902	80,000
General Fund to Support Health Insurance Premium Surtax	34,313	31,755	2,558
State Revenue Surplus/(Shortfall)	**(155,733)**	**(57,336)**	**(98,397)**

Increase due to DOH increase in need.

Sweep due to contingency language of PHE extension

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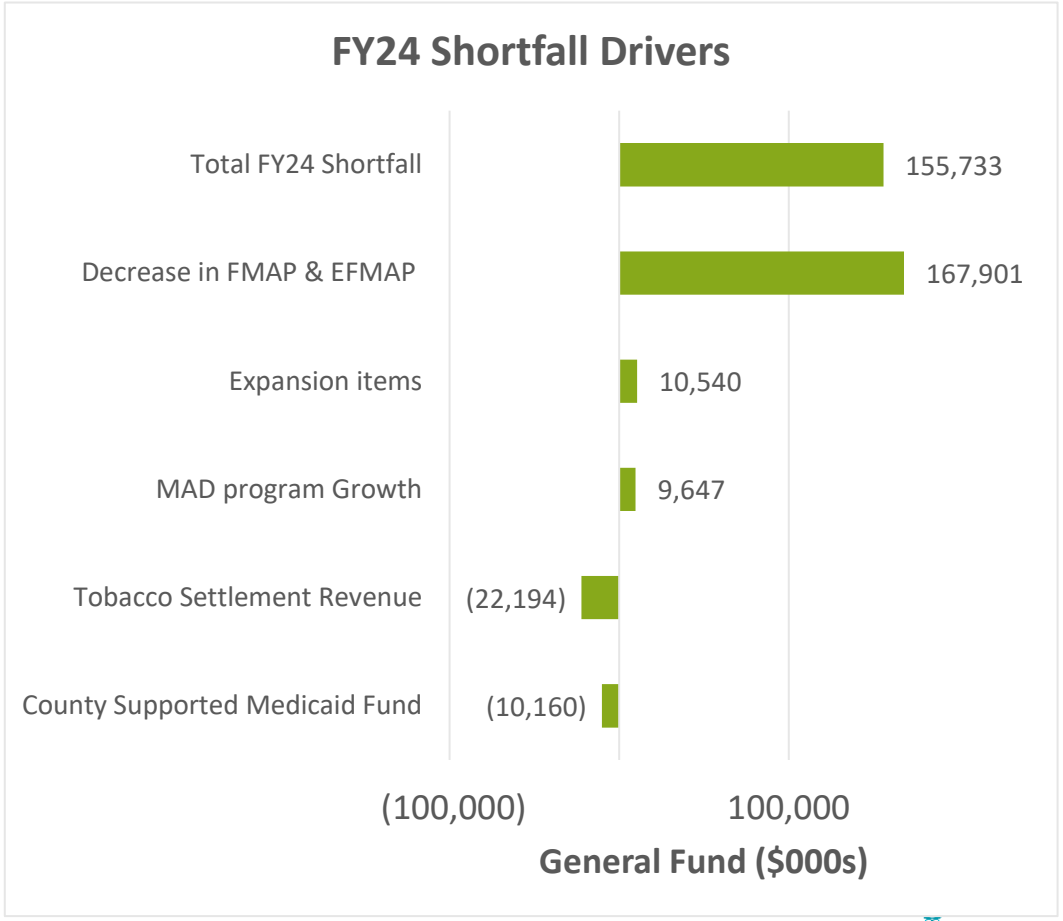
FY2024 MEDICAID PROGRAM SHORTFALL DRIVERS

What is built into the FY2024 Shortfall:	General Fund ($000s)	% Total
Change due to decrease in FMAP & EFMAP	(167,901)	109.0%
Expansion items	(10,540)	5.7%
MAD Program Growth	(9,647)	6.3%
Tobacco Settlement Revenue	22,194	-14.4%
County Supported Medicaid Fund	10,160	-6.6%
Total Shortfall	**(155,733)**	**100.0%**

Note: FY23 budget request included 8.9 million MCO Member Months (MMs). (FY23 MCO MM has grown to 9.4 million based on June 2022 projection.) FY24 budget request includes 9.2 million MCO MMs, which increases FY24 GF need by $41 M.



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NATIONAL CONTEXT

- New Mexico ranks 48th out of 54 states and territories in per recipient total Medicaid expenditures at $6,712 per person on average across all programs (min. $2,142; med. $8,436; high $13,811).
- NM per capita spending by category:
  - Children: 22nd out of 54.
  - Adult non-expansion: 47th out of 54.
  - Adult expansion: 10th out of 36 (not all states have expanded Medicaid).
  - Aged: 46th out of 54.
  - People with disabilities: 24th out of 54.

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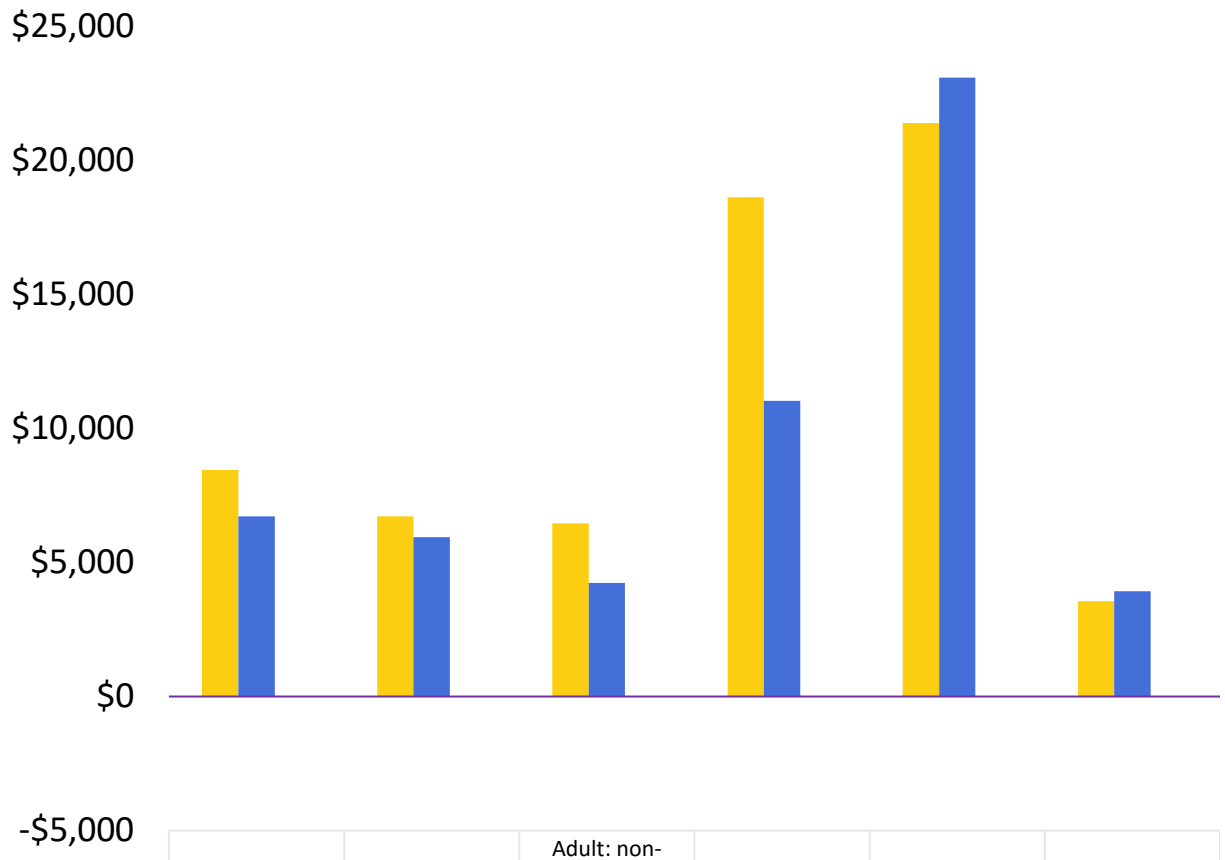
Annual Per Capita Medicaid Expenditures: NM Relative to US Median and Minimum



	Total	Adult: ACA Medicaid expansion	Adult: non-expansion, non-disabled, under age 65	Aged	People with disabilities	Children
US Median	$8,436	$6,709	$6,451	$18,610	$21,372	$3,556
New Mexico	$6,712	$5,931	$4,227	$11,021	$23,066	$3,921
NM % Above/Below Median	-20.4%	-11.6%	-34.5%	-40.8%	7.9%	10.3%

FACTORS CONTRIBUTING TO INCREASED MEDICAID MANAGED CARE SPENDING 2019 TO 2022

Factor	Cost Increase $(000s)	Cost Share	Comment
Legislative changes and special appropriations		63%	$127 estimated PMPM change. Over the period 2019 to 2022
Legislative Provider Network Investment: enhanced rates and reimbursements	$287,408	13%	$37.63 estimated PMPM change for HCQS (NF, ICF/IID); permanent hospital (201-205) rate increases (for profit, gov't, not for profit, trauma hospital, Native American), minimum wage increases, E&M to 90% of Medicare, dental, behavioral health and benefit changes, temporary COVID-19 provider rates (hospitals, NFs, NEMT, FQHC)
Legislative member related investment: population health care cost increase (demographic trending)	$344,844	16%	$45.15 estimated PMPM change for demographic trend adjustments.
Legislative directed payments	$353,661	16%	9% growth; Includes Directed Payments to providers & hospitals, IHS, other.
Legislative investment: Health Insurance Premium Surtax	$149,241	7%	$19.54 estimated PMPM change, from SB317.
Other non-medical expenses	$188,499	9%	$24.68 estimated PMPM change for all other non-medical expenses.
Membership growth in managed care	$893,841	39%	18% growth; 130,200 new members since 2019.
Total Changes	**$2,217,497**	**100%**	

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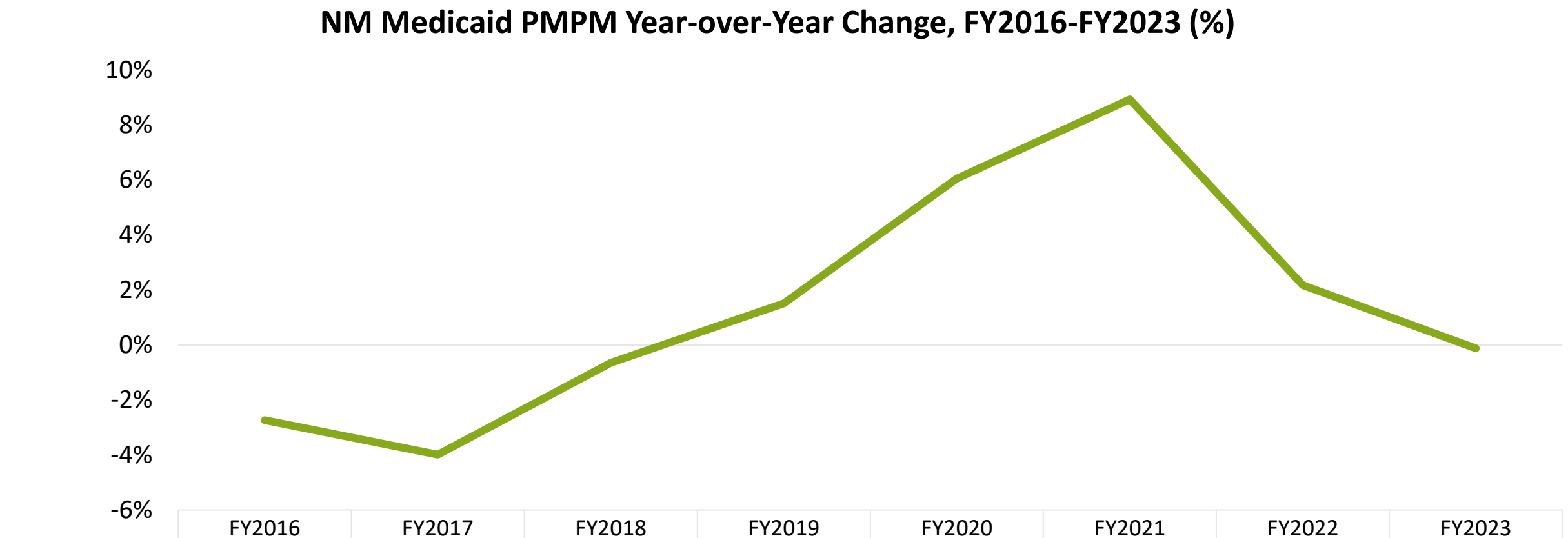
MEDICAID PMPM TRENDS AND DRIVERS: 19.7% INCREASE IN PER-MEMBER PER-MONTH (PMPM) COSTS



	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
PMPM % Change	-2.7%	-4.0%	-0.6%	1.5%	6.0%	8.9%	2.2%	-0.1%

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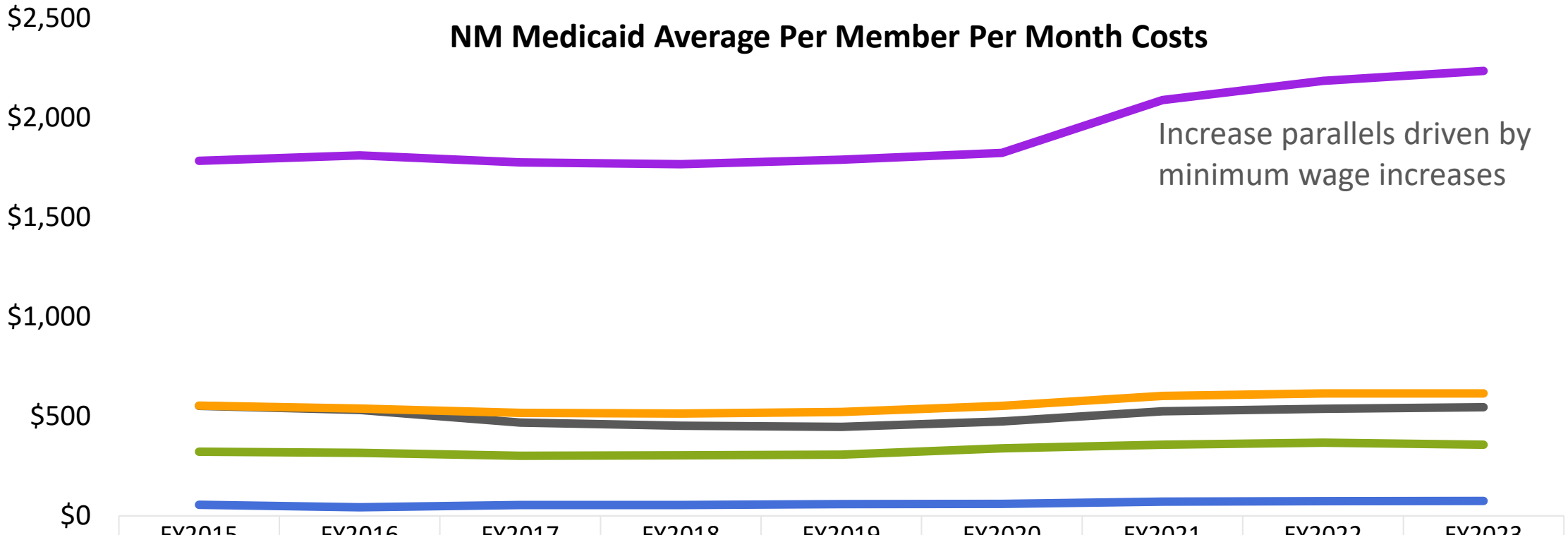
MEDICAID PER-MEMBER PER-MONTH (PMPM) BY LARGE COHORTS



	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
Behavioral Health	$55	$43	$54	$54	$58	$59	$71	$73	$75
Physical Health	$322	$317	$301	$304	$307	$339	$357	$367	$357
Expansion	$553	$532	$468	$453	$447	$474	$526	$538	$545
LTSS	$1,784	$1,812	$1,776	$1,767	$1,789	$1,824	$2,089	$2,186	$2,235
Average PMPM	$553	$538	$517	$514	$521	$553	$602	$615	$615

LTSS: Long-term services and supports

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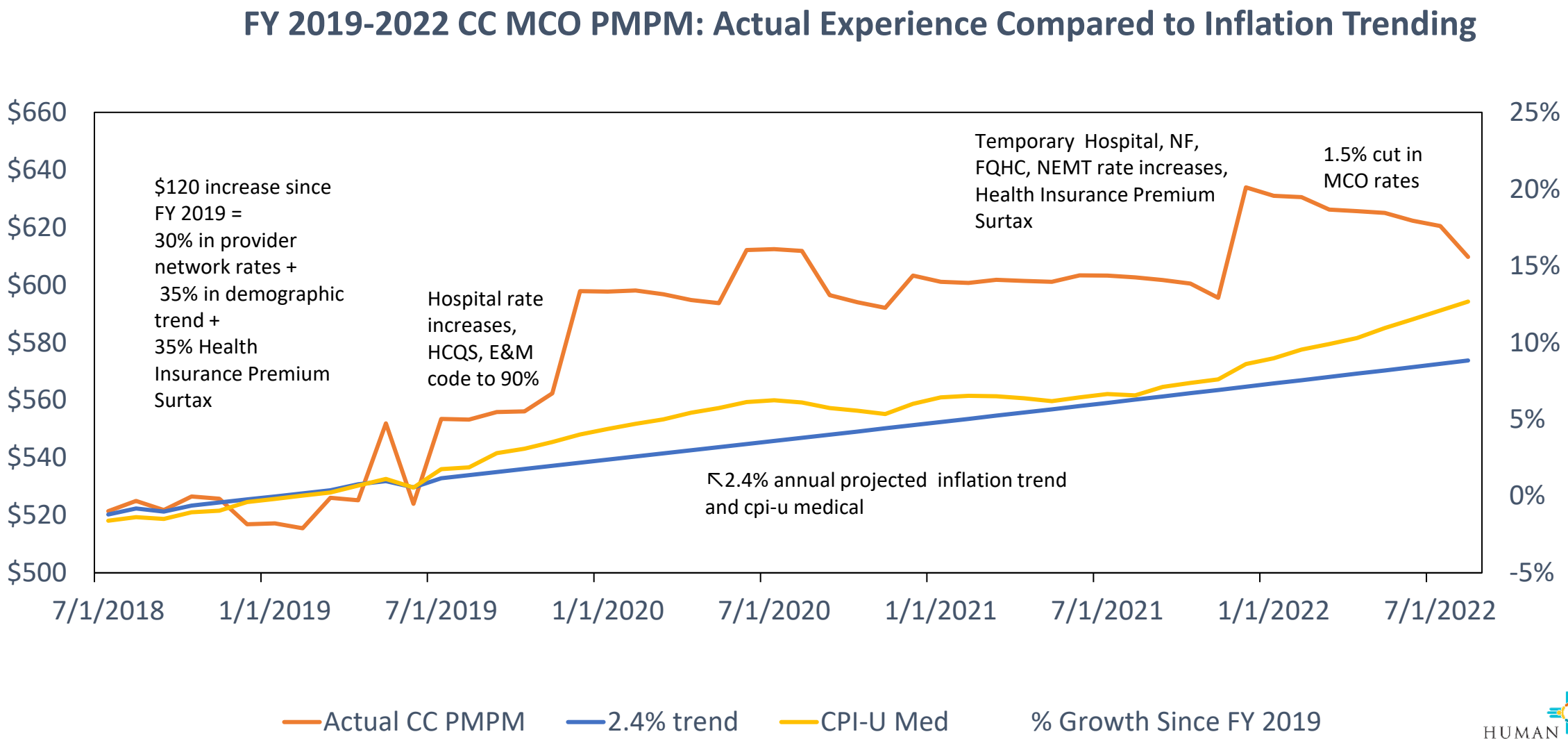
MEDICAID PMPM TRENDS AND DRIVERS



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HSD MCO COST CONTROL EFFORTS

Cost Control Tool	Mechanism	Dollar/percent impact
1. Risk Arrangement	• Single sided risk arrangement with profit capped at 3% (50% share after that)	• $180M cap
2. Medical Loss Ratio (MLR)	• 2019 – set at 86% of dollars expended must go to medical costs; no more than 14% to administrative expenditures • 2021 – amended contract to require 88% must go to medical costs; no more than 12% to admin	• 2019 - $5.16B to medical expense • 2021 - $5.28B to medical expense
3. Performance Measures & Delivery System Improvement Targets	• More capitation dollars at risk (3.5%) than they can gain in profit (3%)	• $210M at risk
4. Rate Adjustments	• "2020 MCO windfall" – required MCOs to cover cost of temporary COVID rate increases without adjusting their rates • 2021/22 – added .5% downward adjustment to rates due to MOE population decreases utilization and acuity • 2022 – exercised 1.5% rate reduction regulatory option considering continued PHE population and utilization trends	• 2020 - $123M MCO payment reduction • 2021/22 – $60M reduction over two years • 2022 - $93M payment reduction
5. Value-Based Purchasing Requirements	• Contract requires MCOs to have progressive number of provider contracts in VBP arrangements with risk structures that drive quality and outcomes, not volume	• All MCOs met target and have 36% of contracts in VBP arrangements
6. Risk Adjustment Methodology	• Changed the risk adjustment methodology (to CDPS+Rx) in 2021 to ensure more accurate payment by member type • Added a high-risk member pool to reduce potential for adverse member selection	• Realigned $23 million between MCOs • Realigned $4 million between MCOs

MCO PERFORMANCE

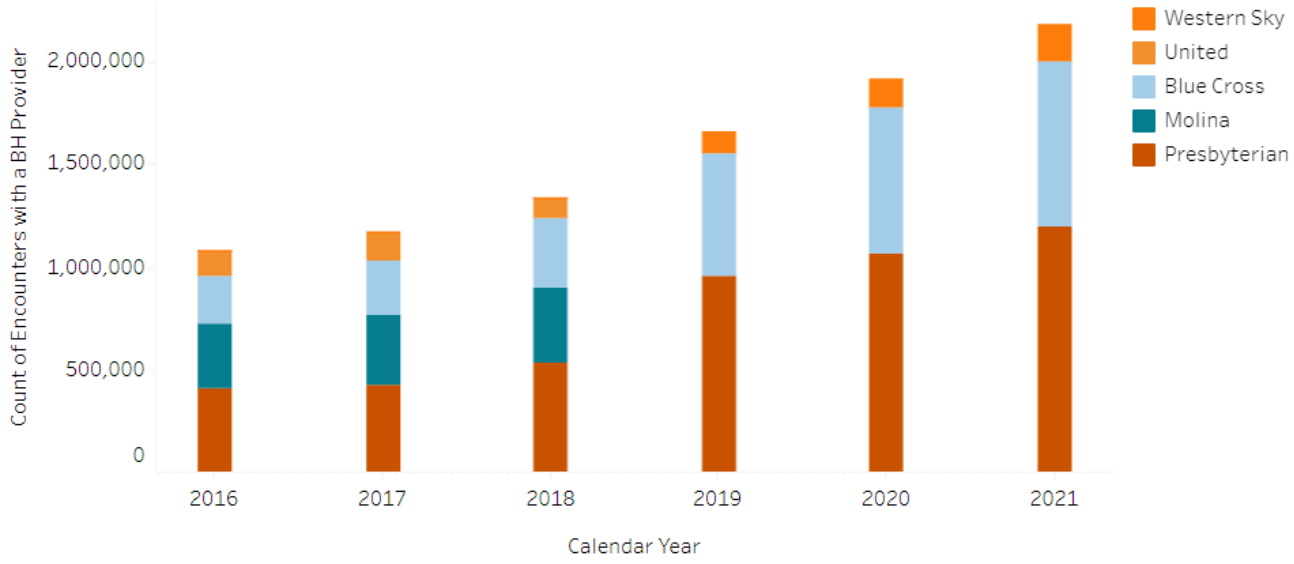
Underwriting Gain			
	MCO A	MCO B	MCO C
Final 2019	-10.8%	0.7%	-2.7%
Prelim. 2020	3.8%	7.1%	0.9%

Medical Cost Ratio			
	MCO A	MCO B	MCO C
2019	97.2%	91.5%	92.9%
2020	87.8%	91.1%	90.7%

Administrative Expense			
	MCO A	MCO B	MCO C
Final 2019	11.9%	6.9%	14.9%
Prelim. 2020	8.0%	5.5%	11.2%

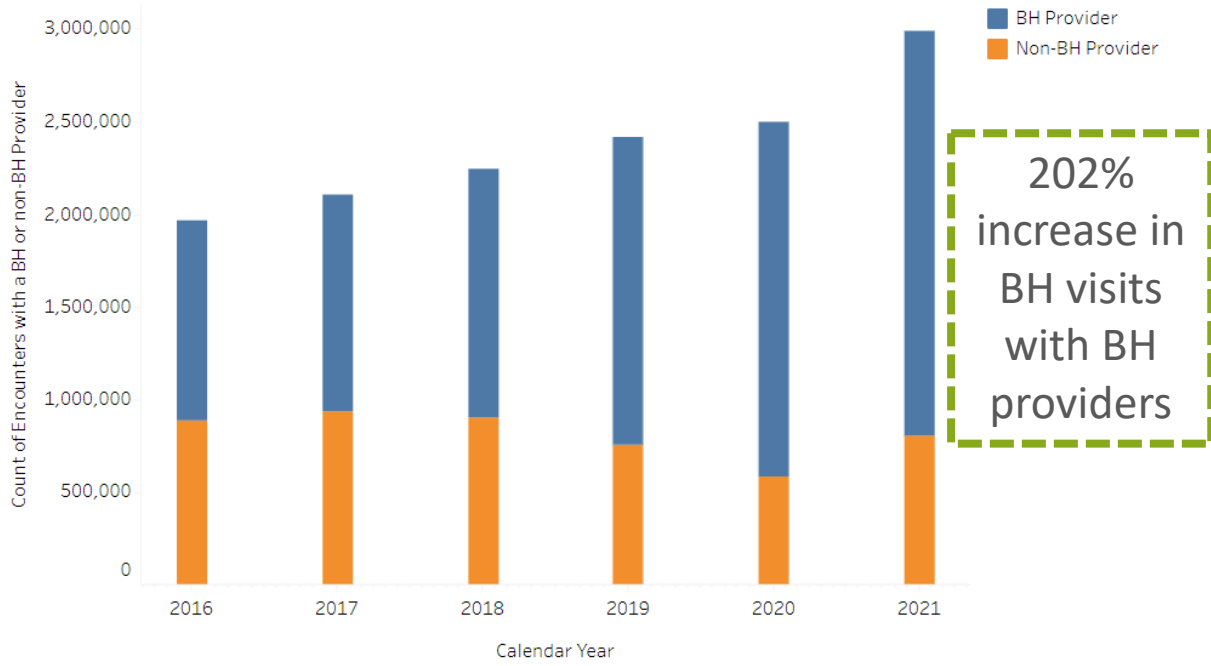
MCO PERFORMANCE

How good is my Managed Care Organization (MCO) at working with providers to ensure I have a behavioral health (BH) visit with a BH provider?



Last updated: 4/17/2022

How good is my Managed Care Organization (MCO) at working with providers to ensure I have a behavioral health (BH) visit with a BH or non-BH provider?



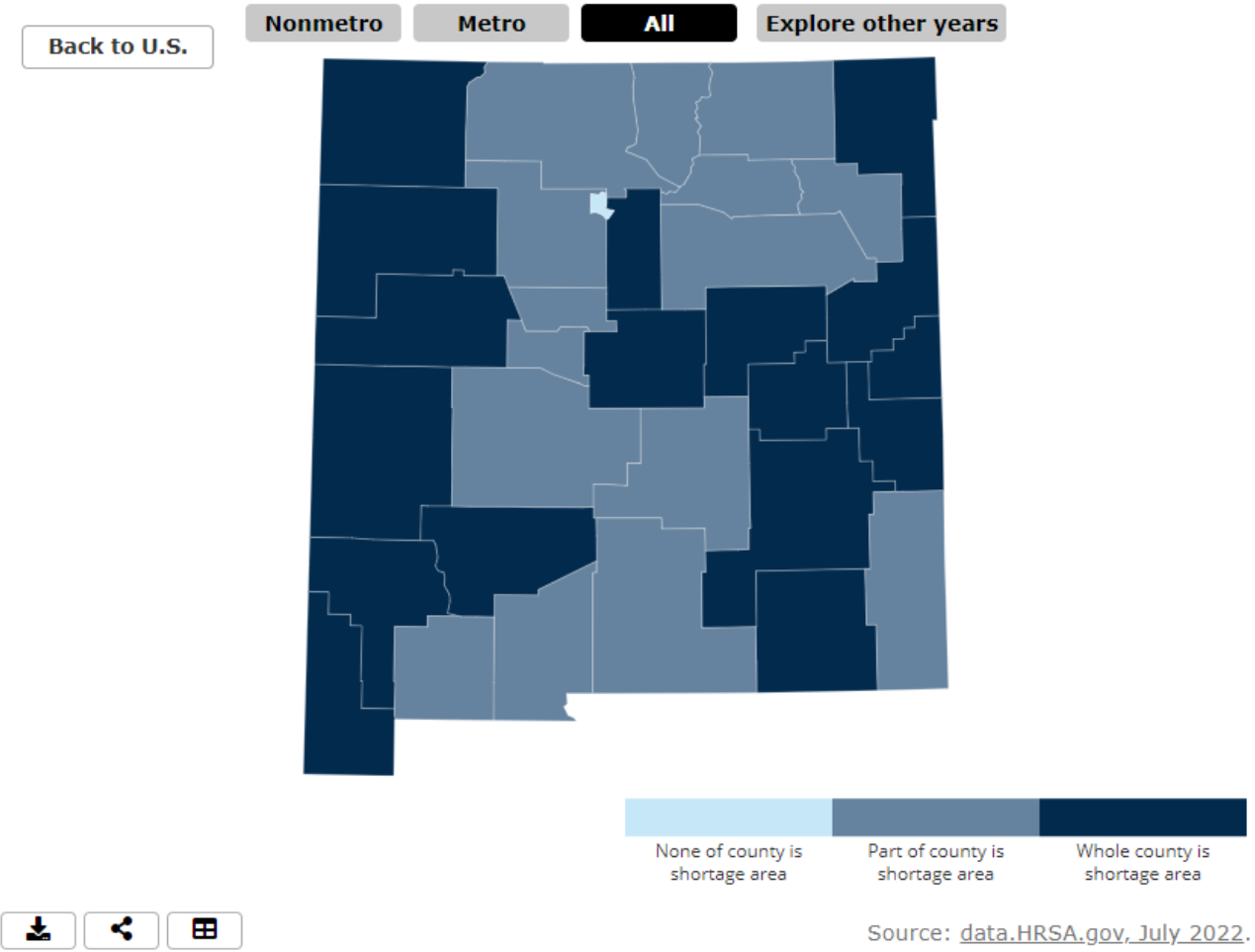
202% increase in BH visits with BH providers

Last updated: 4/17/2022

Source: https://sites.google.com/view/nmhsdscorecard/goal-1/mco-behavioral-health

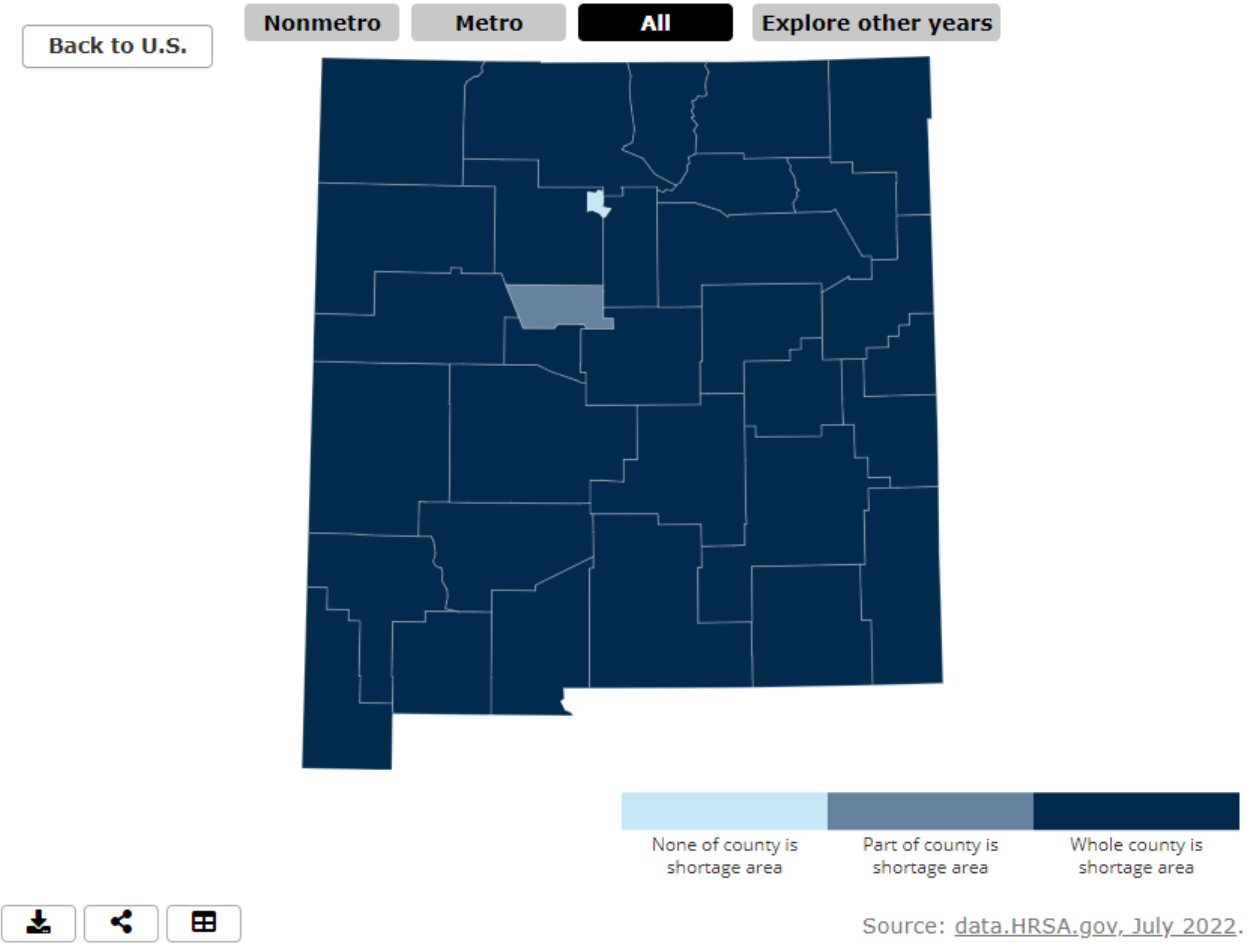
PROVIDER SHORTAGES: PRIMARY CARE & BEHAVIORAL HEALTH

Health Professional Shortage Areas: Primary Care, by County, 2022 - New Mexico



Source: data.HRSA.gov, July 2022.

Health Professional Shortage Areas: Mental Health, by County, 2022 - New Mexico



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RATE REVIEW BENCHMARK RESULTS

Table 1. Overview of New Mexico Benchmarking Results by Service Area ($ in Millions)

		CY2019			CY2021	
Phase 1 Service Area	Service Subgroups	Total Medicaid Expenditures[2]	Count of Members[3]	Managed Care Percent of FFSE[4]	NM FFS Percent of Medicare	NM FFS Percent of State Benchmarks[5]
ALL	**ALL**	**$2,107.6**	**673,684**	**103%**	**88%**	**91% to 124%**
HCBS	1115 Waiver Community Benefit	$432.6	67,331	124%	88%	90% to 145%
	State Plan Case Management	$13.0	30,756	169%	89%	85% to 158%
	1915(c) Waiver Services[6]	$403.1	5,036	N/A[6]	N/A[3]	N/A[6]
Physician & Other Practitioners	Evaluation & Management	$213.4	476,601	101%	82%	106% to 149%
	Surgery	$80.5	159,582	107%	89%	85% to 149%
	Radiology/Laboratory/Pathology	$69.7	351,403	100%	94%	88% to 120%
	Medicine	$64.0	287,118	100%	86%	79% to 139%
	Anesthesia	$14.0	46,641	30%[5]	86%	57% to 114%
HCPCS Level II	Other HCPCS Level II	$105.5	142,007	97%	82%	73% to 113%
	Non-Emergent Medical Transportation (NEMT)	$49.8	33,685	226%	N/A	46% to 159%
	Emergent Medical Transportation (EMT)	$42.7	39,116	106%	70%	77% to 172%
	Physician Administered Drugs	$41.8	47,533	101%	100%	97% to 103%
	Durable Medical Equipment	$22.8	29,993	117%	96%	72% to 114%
Maternal & Child Health	Maternity-Related	$46.6	25,157	87%	93%	80% to 139%
	Child Health & Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	$37.3	166,497	99%	112%	109% to 154%
	Newborn-Related Care	$18.5	15,741	104%	95%	101% to 140%
	Family Planning	$12.5	33,473	95%	104%	113% to 134%
Behavioral Health	General Behavioral Health	$138.0	100,380	100%	97%	101% to 152%
	Opioid Treatment Program	$25.5	7,628	99%	N/A	105% to 392%
	Applied Behavioral Analysis	$19.6	1,140	98%	N/A	73% to 172%
Dental	Diagnostic/Preventive/Other	$116.3	302,982	96%	N/A	79% to 109%
	Orthodontics	$13.3	11,787	94%	N/A	90% to 166%
FQHC/RHC	Federally Qualified Health Centers	$116.2	136,975	99%	N/A[6]	N/A[6]
	Rural Health Clinics	$11.0	20,286	107%	N/A[6]	N/A[6]

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RATE RECOMMENDATION

Service Area	Service Subgroup	Rate Increase to 70% of Medicare		Rate Increase to 80% of Medicare		Rate Increase to 90% of Medicare		Rate Increase to 100% of Medicare		Rate Increase to 100% (120% targeted) of Medicare	
		Total Estimated Impact of Rate Increases	Estimated % Impact of Rate Increases	Total Estimated Impact of Rate Increases	Estimated % Impact of Rate Increases	Total Estimated Impact of Rate Increases	Estimated % Impact of Rate Increases	Total Estimated Impact of Rate Increases	Estimated % Impact of Rate Increases	Total Estimated Impact of Rate Increases	Estimated % Impact of Rate Increases
Home & Community Based Servic	1115 Waiver Community Benefit	$ 32,848,517	8%	$ 33,062,111	8%	$ 33,827,502	8%	$ 35,969,973	8%	$ 35,969,973	8%
	State Plan Case Management	$ -	0%	$ 2,568	0%	$ 27,309	0%	$ 156,768	1%	$ 156,768	1%
	All Home & Community Based Ser	**$ 32,848,517**	**7%**	**$ 33,064,679**	**7%**	**$ 33,854,811**	**8%**	**$ 36,126,741**	**8%**	**$ 36,126,741**	**8%**
Physician & Other Practitioners	Evaluation & Management	$ -	0%	$ 5,927,653	3%	$ 20,412,476	11%	$ 42,267,287	23%	$ 88,254,485	47%
	Surgery	$ -	0%	$ 11,494	0%	$ 331,490	2%	$ 1,191,238	7%	$ 4,089,415	23%
	Radiology/Laboratory/Pathology	$ -	0%	$ 72,906	0%	$ 339,187	1%	$ 1,733,551	7%	$ 6,996,358	28%
	Medicine	$ 727,256	3%	$ 1,689,558	6%	$ 3,371,682	13%	$ 5,913,189	23%	$ 11,863,217	45%
	Anesthesia	$ -	0%	$ -	0%	$ 356,296	5%	$ 1,269,455	16%	$ 3,095,844	39%
	All Physician & Other Practitioner	**$ 727,256**	**0%**	**$ 7,701,611**	**3%**	**$ 24,811,131**	**9%**	**$ 52,374,719**	**20%**	**$ 114,299,319**	**43%**
HCPCS Level II	Other HCPCS	$ 3,506,890	12%	$ 4,182,202	14%	$ 4,857,514	16%	$ 6,547,833	22%	$ 6,547,833	22%
	Non-Emergency Medical Transportation	$ 8,058,976	18%	$ 8,058,976	18%	$ 8,058,976	18%	$ 8,058,976	18%	$ 8,058,976	18%
	Physician Administered Drugs	$ -	0%	$ -	0%	$ -	0%	$ 825	0%	$ 825	0%
	Emergency Medical Transportation	$ 2,297,957	6%	$ 5,577,283	15%	$ 10,206,495	28%	$ 15,411,342	42%	$ 15,411,342	42%
	Durable Medical Equipment	$ -	0%	$ -	0%	$ -	0%	$ 868,895	5%	$ 868,895	5%
	All HCPCS Level II	**$ 13,863,823**	**9%**	**$ 17,818,462**	**12%**	**$ 23,122,986**	**15%**	**$ 30,887,872**	**20%**	**$ 30,887,872**	**20%**
Maternal & Child Health	Maternity-Related	$ 65,762	0%	$ 280,416	1%	$ 2,192,892	7%	$ 4,295,840	14%	$ 9,171,793	31%
	Child Health and EPSDT	$ -	0%	$ 1,709,148	5%	$ 4,958,223	15%	$ 7,025,473	22%	$ 13,376,507	41%
	Newborn-Related Care	$ -	0%	$ 41,713	0%	$ 171,804	1%	$ 750,435	6%	$ 3,329,377	26%
	Family Planning	$ 77,322	1%	$ 545,845	5%	$ 1,383,467	13%	$ 2,461,154	23%	$ 3,927,440	37%
	All Maternal & Child Health	**$ 143,084**	**0%**	**$ 2,577,122**	**3%**	**$ 8,706,386**	**10%**	**$ 14,532,902**	**17%**	**$ 29,805,117**	**35%**
Behavioral Health	General Behavioral Health	$ 4,763,855	4%	$ 5,834,060	5%	$ 10,627,942	9%	$ 10,262,268	9%	$ 29,691,743	25%
	Opioid Treatment Program	$ 16,468	0%	$ 16,468	0%	$ 16,468	0%	$ 16,468	0%	$ 16,468	0%
	Applied Behavioral Analysis	$ 2,234,984	11%	$ 2,234,984	11%	$ 2,234,984	11%	$ 2,234,984	11%	$ 2,234,984	11%
	All Behavioral Health	**$ 7,015,307**	**4%**	**$ 8,085,512**	**5%**	**$ 12,879,393**	**8%**	**$ 12,513,720**	**8%**	**$ 31,943,195**	**20%**
Dental	Diagnostic/Preventive/Other	$ 11,053,847	16%	$ 11,053,847	16%	$ 11,053,847	16%	$ 11,053,847	16%	$ 11,053,847	16%
	Orthodontics	$ 554,061	5%	$ 554,061	5%	$ 554,061	5%	$ 554,061	5%	$ 554,061	5%
	All Dental	**$ 11,607,907**	**14%**	**$ 11,607,907**	**14%**	**$ 11,607,907**	**14%**	**$ 11,607,907**	**14%**	**$ 11,607,907**	**14%**
All Professional Services	**All Service Subgroups**	**$ 66,205,894**	**6%**	**$ 80,855,294**	**7%**	**$ 114,982,615**	**10%**	**$ 158,043,861**	**13%**	**$ 254,670,151**	**21%**
Services Not in Top 20 Codes	All Service Subgroups	$ 13,883,460	6%	$ 16,955,458	7%	$ 24,112,001	10%	$ 33,141,999	13%	$ 53,404,655	21%
Medicare Crossover Claims	All Service Subgroups	$ -	0%	$ -	0%	$ 7,570,995	48%	$ 10,406,349	66%	$ 10,406,349	66%
Total Medical Expenses	**All Service Subgroups**	**$ 80,089,354**		**$ 97,810,752**		**$ 146,665,610**		**$ 201,592,209**		**$ 318,481,155**	
Non-Medical Expenses	**All Service Subgroups**	**$ 14,390,716**		**$ 17,574,955**		**$ 26,353,355**		**$ 36,222,745**		**$ 57,225,732**	
Total Computable Cost		**$ 94,480,071**		**$ 115,385,707**		**$ 173,018,965**		**$ 237,814,954**		**$ 375,706,888**	
FFP		77.87%		77.87%		77.87%		77.87%		77.87%	
Total State General Fund		**$ 20,908,440**		**$ 25,534,857**		**$ 38,289,097**		**$ 52,628,449**		**$ 83,143,934**	

CHECKING IN ON THE VALDEZ FAMILY*

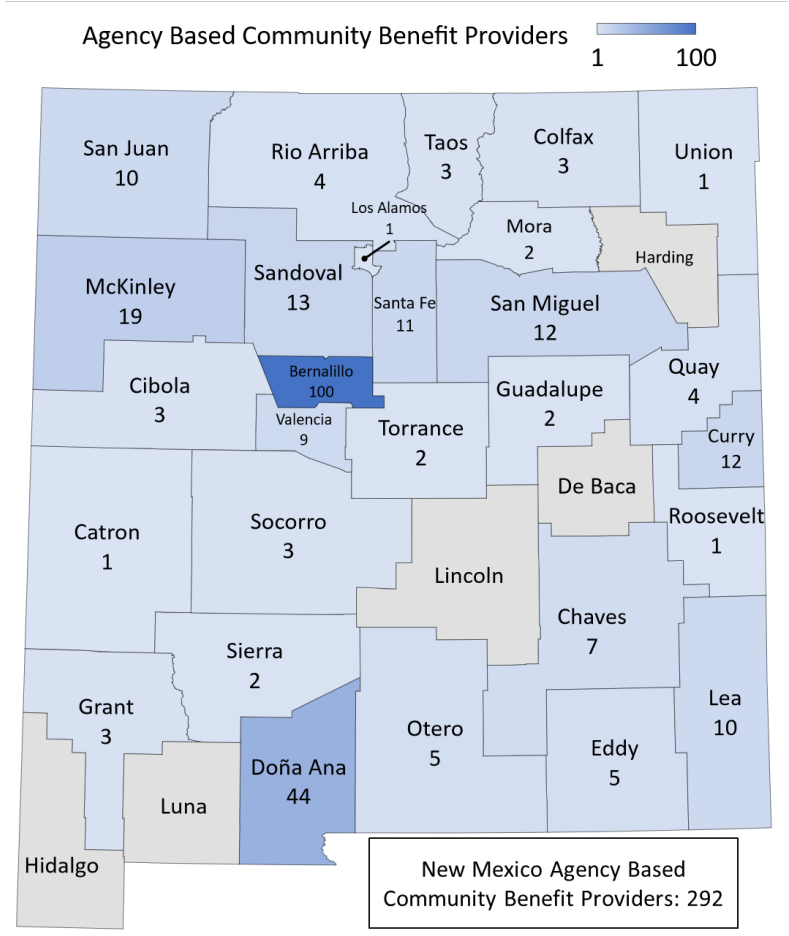
- After her referral to child protective services, Amanda's care coordinator completed comprehensive needs assessments and identified multiple unmet needs and risks.
- Her care coordinator also connected Amanda with a Certified Peer Support Worker (CPSW) to guide Amanda in her behavioral health and social needs.
- Amanda's Care Coordinator and Certified Peer Support Worker are part of Amanda's broader interprofessional care team, which also includes physicians and other providers.
  - Amanda's Primary Care Physician completed a home physical, ordered labs and physical, occupational and speech therapy so Amanda could walk again and care for Daniel successfully.
- Her care team (and Daniel's) provided the family with needed transportation, a cell phone, diapers, bedding, and medical supplies within a few days.

**HSD has changed the name and photo of this HSD customer to protect privacy.*

CONTROLLING NURSING FACILITY COST: COMMUNITY BENEFIT PROGRAM INVESTMENT

- Community Benefit Program serves individuals living in their homes and communities who need additional support to live independently.
  - It is more expensive for individuals to live in a nursing facility (average 2022 cost per-member per-month of $9,038.76 for nursing facility compared to $3,582.48 for Community Benefit).
- NM leads the nations in home and community-based long-term services and supports (LTSS), 88% of Medicaid LTSS members receive home and community services from a statewide network of providers.
  - 32,309 individuals receive home and community-based LTSS (8.6% increase since 2019).
- Between SFY 2017 and SFY 2022 Medicaid/CHIP per capita expenditures increased 37%, from $6,209/year to $8,527/year.
  - Between 2017 and 2020, HSD increased provider reimbursements statewide to follow Medicare reimbursement trends, primarily using adjustments in Medicaid fee schedules.

NM Medicaid Agency Based Community Benefit Providers by County, October 2021



HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

HEALTHCARE QUALITY SURCHARGE (HCQS) QUALITY PAYMENTS: PAY-FOR-PERFORMANCE

- Supplemental quality payments are made based on each facility's **performance on four measures**.
- Facilities are placed into "tiers" based on their performance points for each measure.
- Quality payments are distributed by tier, with **facilities in the highest performing tier receiving the greatest share of the quality payments**.
  - Program is currently in Year 3 (FY22).
  - Year 4 - no quality funds will be distributed to bottom performing facilities

HCQS Quality Measures
1. Falls with Major Injury
2. Depression
3. Flu Shot
4. Pneumonia Vaccine

Tier Cut Points	
Tier 1	320 points or more
Tier 2	319 to 260 points
Tier 3	259 to 200 points
Tier 4	199 to 140 points
Tier 5	139 points or less

Tier Percentages					
Tier %	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**
1st year	100%	100%	100%	100%	100%
2nd year	100%	95%	90%	85%	75%
3rd year	100%	85%	75%	65%	50%
4th year*	100%	75%	50%	25%	0%

*Proposed

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ALTERNATIVE PAYMENT MODELS: RURAL HOSPITAL VALUE-BASED PURCHASING (VBP)

- MCOs and rural hospitals workgroup convened with goal of transitioning Hospital Access Payment and Hospital Quality Improvement Initiative to new VBP design
  - Total pool = $69M ($57M HAP + $12M HQII)
  - Transition to value-based program over 5 years (starting with CY22)
    - Hospitals paid for reporting quality data in CY22
    - Transition to VBP payments based on quality outcomes starts CY23
- **Model supports rural hospitals and facilities with high Medicaid share; makes sure dollars are not shifted from rural to urban facilities**
- Metrics aligned with HSD, MCO and hospital priorities

Measure/Description	Measure Steward
1. All-Cause Readmissions	NCQA
2. Deaths Among Patients with Serious Treatable Complications after Surgery	AHRQ
3. Serious Complications that Patients Experienced During a Hospital Stay After Having Certain Inpatient Procedures	CMS
4. Follow-Up After Hospitalization Visit for Mental Illness – 30 Day	NCQA
5. Follow-Up After Hospitalization Visit for Mental Illness – 7 Day	NCQA
6. Severe Sepsis and Shock	CMS
7. Patient Care Survey (HCAHPs) – Communication with Doctor	CMS
8. Patient Care Survey (HCAHPs) - Communication with Nurse	CMS
9. Median Time from ED Arrival to ED Departure for Discharged ED Patients	CMS
10. Influenza Immunization	CMS

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THE VALDEZ FAMILY TODAY*

- Amanda was admitted to a rehab facility where she learned to walk again.
- She and Daniel live with her aunt and uncle, who will help her finish high school when she's ready.
- Amanda is learning how to help Daniel sleep and eat safely and care for him as part of their enrollment in a certified home visiting program.
- She and Daniel continue to receive SNAP and Medicaid, and her depression has subsided with treatment.
- Amanda recently achieved one of her rehab goals of going to her favorite makeup store at the mall and is excited about her life ahead!

**HSD has changed the name and photo of this HSD customer to protect privacy.*

HUMAN SERVICES DEPARTMENT

QUESTIONS & COMMENTS

INVESTING FOR TOMORROW, DELIVERING TODAY.

Western Sky Community Care Update

Jean Wilms, President & CEO

Confidential and Proprietary Information

Transform the Health of the Community, One Person at a Time

western sky community care

252
WSCC Employees

87,438
Medicaid Members
Began in 2019

8,034
Medicare Members
Began in 2020

704
BeWellNM Members
Began in 2021

- WSCC leverages Centene national expertise & innovation with local leadership & focus to meet the needs of New Mexico members.
- *Cultura* is the belief that quality healthcare is best delivered locally in New Mexico through culturally attuned, fully-integrated, high-quality, innovative, and cost-effective services to New Mexico residents and communities.
- Focused on long-term community investment and the development of people, systems, innovation & capabilities to find solutions & better serve our members, providers, local communities, and government partners.
  - New Mexico's Trusted Managed Care Partner — Experience, Expertise & Empathy
  - Building Access at Every Level to Expand Equity and Deliver Care When, Where, and How People Need It
  - Quality and Innovation at Every Stage of Life
  - Investing in Communities — Working Hand-in-Hand with Local Partners

Ensuring Access to Care – WSCC Performance

Adequate Network – support inclusive Medicaid network & continue to build contracted providers throughout New Mexico

	2019	2020	2021	2Q 2022	Change Since '19	% Change
PCP	2,132	2,894	3,047	3,507	1,375	64.49%
Physical Health	6,483	8,610	9,084	10,867	4,384	67.62%
Behavioral Health	3,042	3,430	3,587	4,233	1,191	39.15%
LTC	202	205	207	219	17	8.42%
PCMH Sites	646	654	N/A*	N/A*	8	1.24%

Access to Health Care

- Improvement in urgent primary care appointment availability (82.7% vs. 59%)
- Secret Shopper to assess "real" availability
- Care Coordinators live and work in the communities they serve for local knowledge of resources
- Membership PCMH assignment improvement from 33% to 37.9%

Ensuring Access to Care – Continued Challenges & Solutions

Adequate Network

- Continue to build network and contract providers throughout New Mexico
- Workforce Development
- Make it easy to work with us
- Reward providers \ VBP

Geographic Utilization For Unduplicated Members Behavioral Health Telemedicine Visit				
	2019	2020	2021	YTD 2022
Urban Total	241	4,150	5,093	3,387
Rural Total	438	2,717	3,096	1,976
Frontier Total	74	440	518	322
TOTAL	753	7,307	8,707	5,685

Physical Health Telemedicine Visit				
	2019	2020	2021	YTD 2022
Urban Total	103	5,857	5,541	3,477
Rural Total	86	4,461	5,354	2,603
Frontier Total	12	665	632	354
TOTAL	201	10,983	10,527	6,434

Access to Health Care

Creative solutions to bring care to members, build capacity in rural areas, and allow practitioners to practice to the fullest extent of their license

- A successful, multi-pronged approach to telehealth and technology solutions
- Utilize dental and vision vans to provide routine and preventive care
- Partnership with Family connects - support births with home visits
- Promotion of Community Health Workers and Peer Supports

Utilization & Use of Services – WSCC Performance

Top Inpatient DX Q1 & Q2
Uncomplicated Delivery
General Symptoms & Signs
Maj Depress Recur Sev w/o Pysch
Pneumonia Unspecified
UNS Dement w/o Behavioral Dist
Sepsis Unspecified
Type 2 DM w/o Complications
Encounter for CD w/ Indication
Acute Respiratory Failure with Hypoxia
Major Depress d/o Single Epis Uns

Top Outpatient DXs Q1 & Q2
Obstructive Sleep Apnea
COPD Unspecified
Transportation
LTSS (NFLOC HH Waiver Respite Services
Type 2 DM w/ Complications
Heart Disease Unspecified
Obesity Unspecified
Dental Caries Smooth Surf Pen Pulp
Unspecified Osteoarthritis Uns Site

WSCC experienced a shift of services during Covid

- Office visits to telehealth
- Outpatient to more acute inpatient
- Acute care to sub-acute and long-term care
- Preventive to urgently needed services

Care Coordinators assist members in finding the right care and safe transitions of care

WSCC works to effectively manage utilization and use of services to maximize health outcomes

- Review of high cost, high risk services
- Monitor underutilization of services
- CADA Tool – review and approve requests for authorizations automatically via web portal
- Annual review of services that require prior authorization to revise and remove those that are routinely approved

Utilization and Use of Services – Continued Challenges & Solutions

High Risk Pregnancy \ Maternal \ Child	
Start Smart for your Baby Program	Virtual Doula, Lactation Support - Pacify
Puff Free Pregnancy Program	Mom's Meals
Centennial Home Visiting Program	Baby Showers with Educational Programs
Social Determinants of Health	
Housing Specialists	Meals for Members discharged and New Moms
Social Isolation – Pyx Program	Health Equity Zones
Diabetes	
Diabetes Disease Management Program	Diabetes kits & education for newly diagnosed
Behavioral Health \ Substance Use Disorders	
Assessments (including telehealth) to engage members in treatment and connect them with community resources	Member incentives (gift cards) to do follow-up and engage in treatment
mPulse texting program – member engagement & care coordination	HALO (Health Assistance, Linkage & Outreach)TM – predictive modeling to identify engage at risk members
Choose Tomorrow™ Suicide Prevention Program	Provider education & tool kits

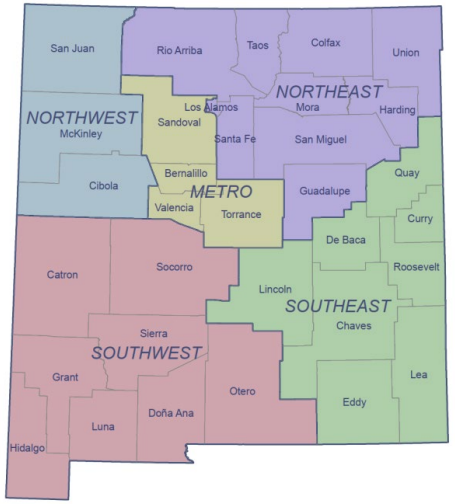
Provider Rates – WSCC Performance

western sky community care

WSCC has passed on all rate increases applicable to program changes to the provider network

Provider Reimbursement to Reward Value > Volume

- WSCC supports HSD Rate Reimbursement Study & Calibration & CMS actuarial guidance adherence
- WSCC supports Value Based Programs & reimbursement aligned with quality and health outcomes
- WSCC supports making it easier to do business with us and provider administrative simplification



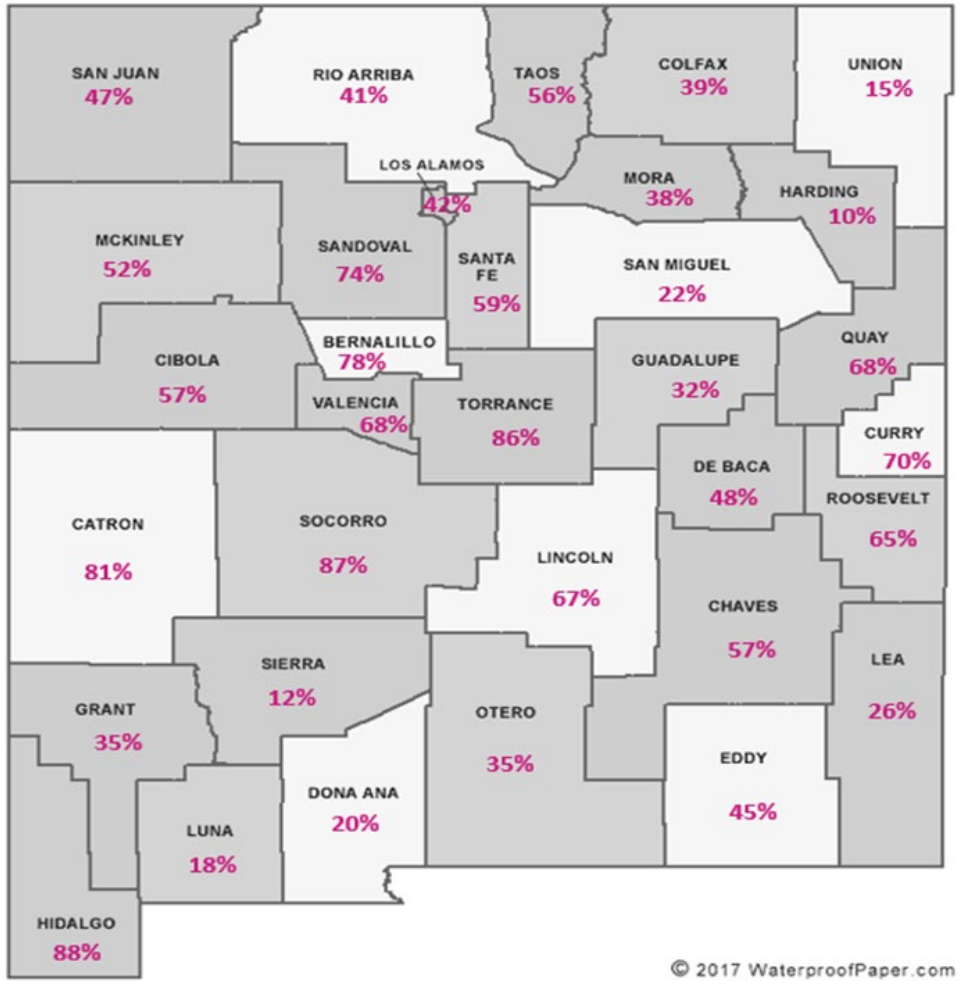
Program Changes included in 2021 included items such as:

- Community Hospital - Native Americans Rate Increase
- For-Profit & Government-Owned Hospital Rate Increase
- LARC increase effective January 1, 2020
- Adult Residential Treatment Center
- HCQS and NF MBI Adjustments
- PCS Minimum Wage effective 1/1/2021
- COVID-19 Testing, Treatment, and Delayed Costs
- COVID-19 BH Service Utilization Acuity Adjustment

Program Changes included in 2022 included items such as:

- Paid Sick Leave
- Minimum Wage
- Community Hospital - Native Americans Rate Increase
- Health Care Quality Surcharge (HCQS) Per Diem
- Nursing Facility Market Basket Index (NF MBI)
- Proposal W.2 Temporary Economic Recovery Payment
- COVID-19 Temporary Fee Increase - FQHC
- COVID-19 Temporary Fee Increase - Nursing Facility
- COVID-19 Temporary Fee Increase - NEMT

Provider Rates – Value Based Programs



58%

Western Sky Members in VBP

Year 5 Goal is 80%

Upside 65.4%

Downside 37.6%

Shared Risk Bonus Potential

$5.3M FY21

$4.9M FY22 (YTD)

Level I - Bonus or Incentive Program

All Primary Care and Selected Specialties

- P4P Quality Measures
- By Population - Ped, BH, LTSS
- Bundle – Pari, Strep, Mom Baby, Hep C

Level II & III - Upside & Downside Risk

Larger Health Systems

HCSC

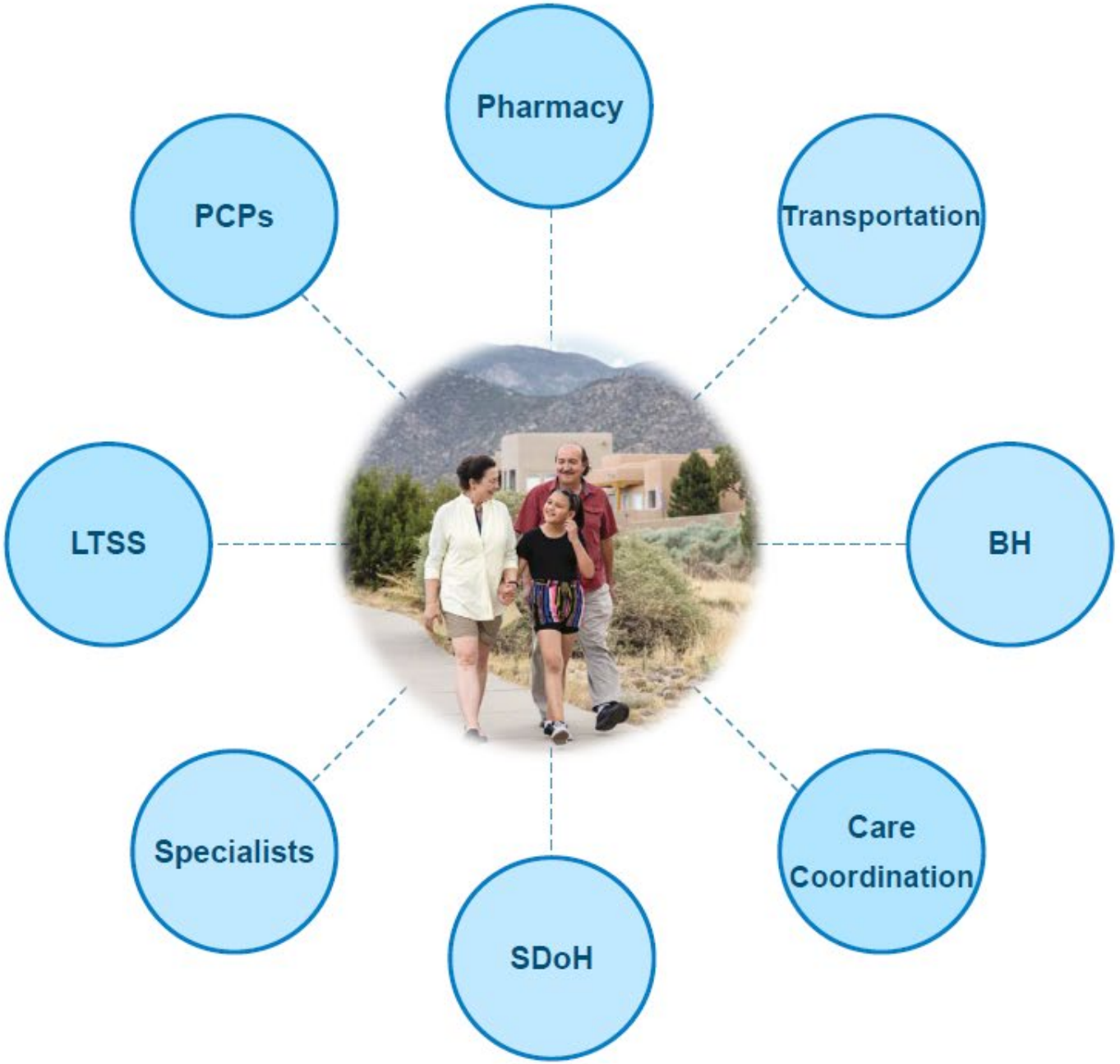
Legislative Finance Committee Hearing

September 21, 2022

Confidential and Proprietary

BCBSNM Member Value Story

- *85 year-old*
- *Hispanic Female*
- *Dual Eligible (D-SNP)*
- *Recently Widowed*
- *Home Bound*
- *Rural New Mexico*
- *Vascular Dementia*
- *Hypertension*
- *Ruptured Disc*
- *Inconsistent support system due to family proximity*



Access to Care

BCBSNM is dedicated to increasing access to care for our Medicaid members, especially throughout and following the PHE.

BCBSNM has implemented multiple interventions to increase access to care for our Medicaid members:

- ✓ Care coordination assistance
- ✓ Carevans
- ✓ LTSS partnerships
- ✓ Paramedicine Program
- ✓ Increased Telehealth utilization
- ✓ Reserved appointment times for Medicaid members with certain providers
- ✓ Telemedicine grants for PCPs and BH providers
- ✓ NMSU workforce expansion
- ✓ Peer Support Specialists
- ✓ Community investments in SDoH
- ✓ ModivCare Innovations (Uber, Lyft)
- ✓ Value-based reimbursement arrangements

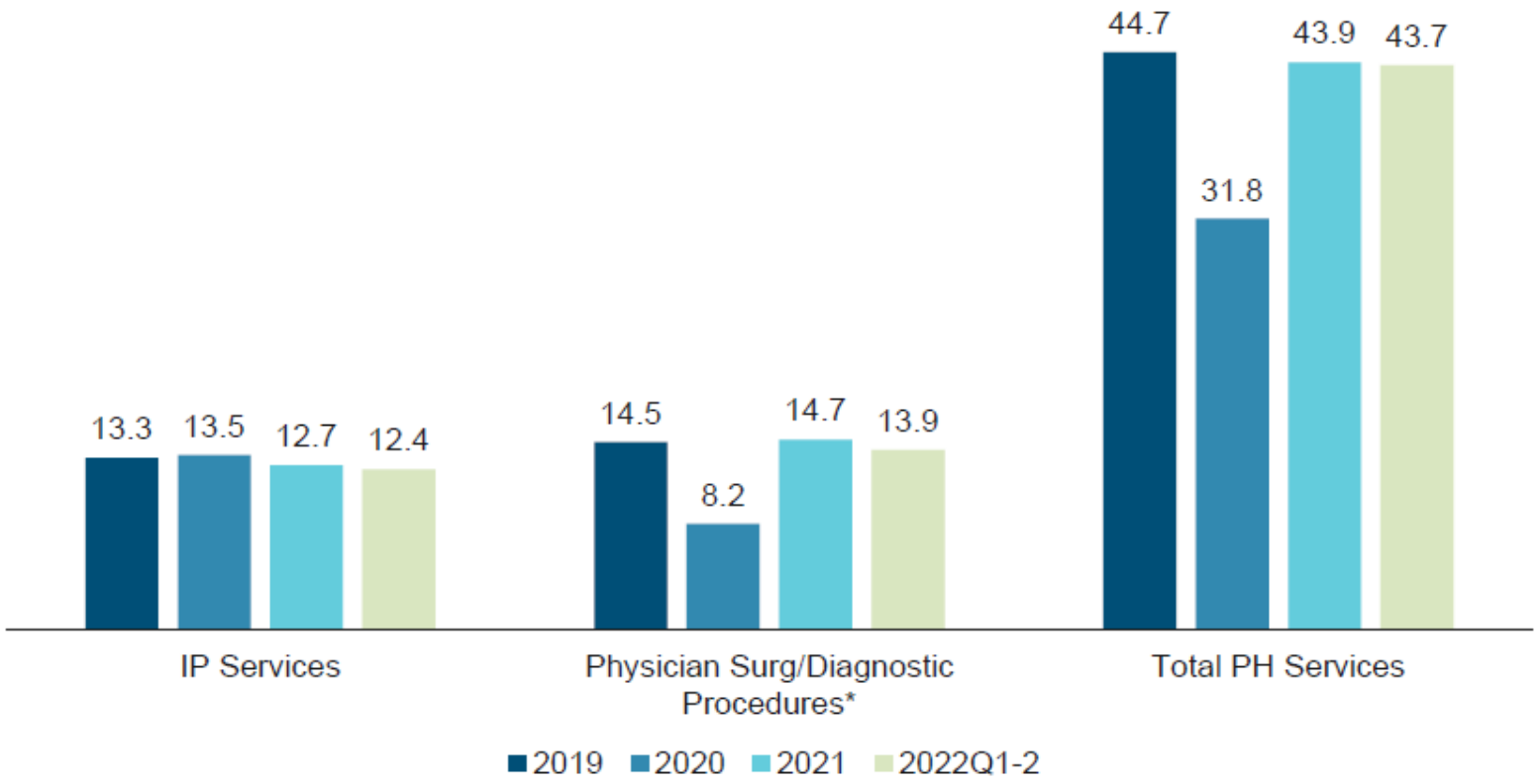
***Note**: List above is not exhaustive*

- *Since the implementation of NMCC2.0 in 2018, **BCBSNM has invested $7.7M in community-based programming ($5.3M between 2020 and 2022)***
- *We have been named one of the **top 50 community-minded organizations in the country***

Utilization and Use of Services

Based on services that require a prior authorization, physical health services have mostly rebounded to pre-PHE levels.

Requests/1,000 Members (2019, 2020, 2021, Q1/Q2 2022)



Steps to Address Utilization:

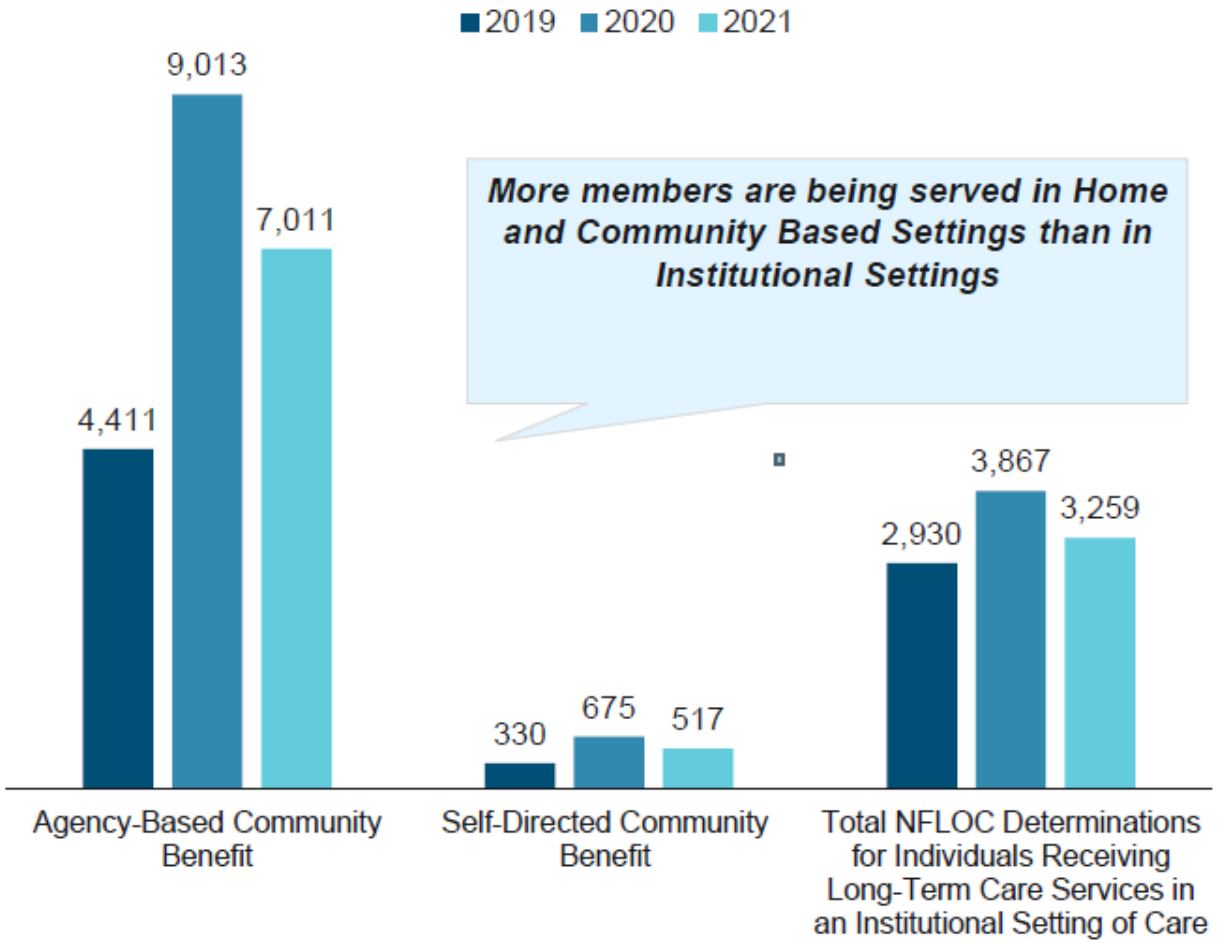
- ✓ Clinical rounds conducted with UM / CM staff and Medical Directors to identify member needs and develop individualized plans with members to engage in services
- ✓ No limitations on out-of-state / out-of-network during PHE
- ✓ Ongoing care coordination efforts for members utilizing ER services to engage proactively in preventive services
- ✓ Waiver of prior auth requirements to transfer from acute to post-acute services during PHE
- ✓ During PHE, service authorizations were automatically extended to prevent delays in service delivery

**Excludes Transplants*

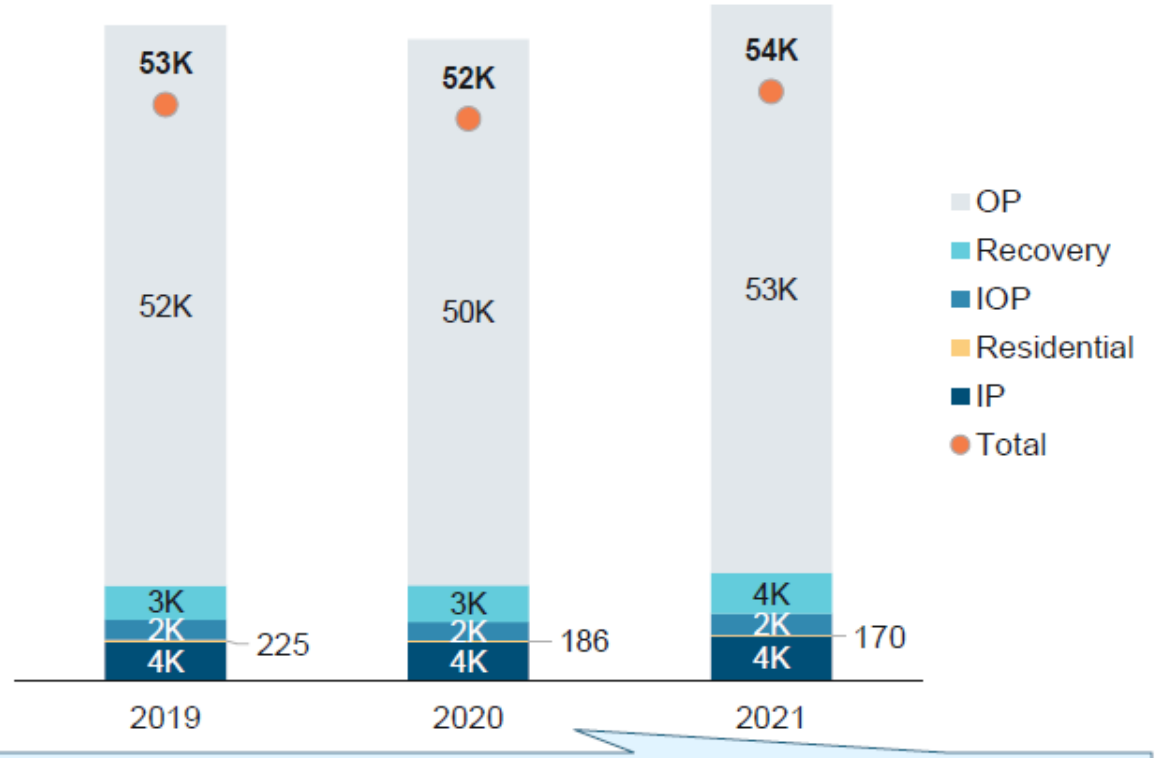
Note: Data above reflects services in which authorizations are requested. Many preventative and routine services across PH/BH do not require authorization.

Nursing Facility and Behavioral Health Services

NFLOC Determinations 2019-2021



YTD Unduplicated Member BH Service Utilization



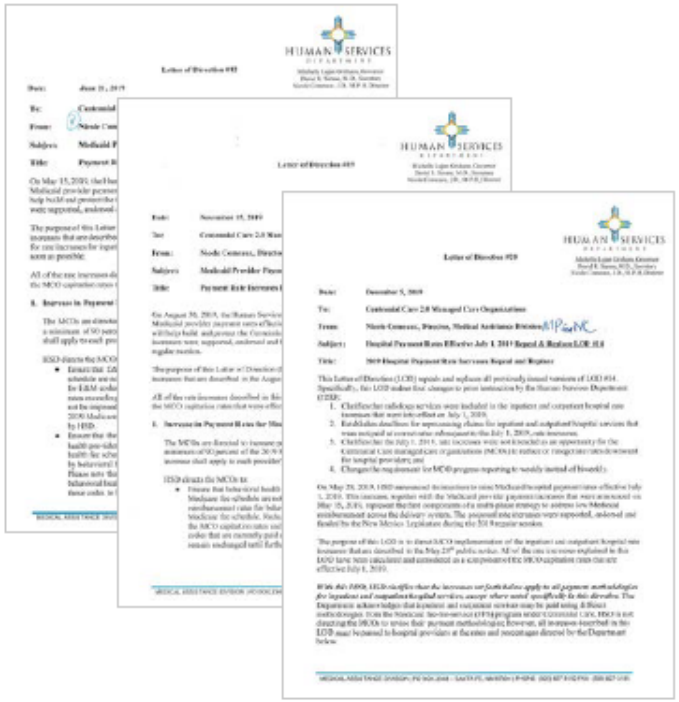
Reductions in utilization of certain BH services are often the result of concerted efforts / interventions which aim to support members receiving appropriate services in the ***least restrictive environment while helping them maintain their highest level of independent functioning within their community***

Sources: NFLOC: Annual Program Evaluations for BCBSNM 2019-2021 / BH: Internal Claims-Based Utilization Reporting 2019-2021

Provider Rates

In addition to provider payment oversight by HSD, BCBSNM must comply with contractual provisions that establish a minimum MLR standard and profit limitations (3%), which we only recently surpassed during the PHE and has resulted in a rebate back to the State.

HSD Oversight of Rates & Payments



*BCBSNM has closely followed each **Letter of Direction and increased our reimbursement rates for various provider types**; we adhere to the Medicaid Fee Schedule and contract with providers at or above 100% if needed to ensure an adequate network.*

Provider Rate Details: Letter of Direction Overview

- ✓ Since 2019, **HSD has issued 134 LODs** *(34 COVID-related; 19 related to provider rate increases)*
- ✓ From 2020-2021, **BCBSNM adjusted 778K claims based on LODs** (270K in 2020, 508K in 2021)
- ✓ *Since the beginning of 2020, BCBSNM has paid out **$385M in directed payments***
  - ➢ ***$85M related to COVID-specific LODs***
  - ➢ ***$300M related to directed payment LODs that existed prior to COVID**, including UNM, Hospital Access Payment, and Health Care Quality Surcharge*
- ✓ In addition to LOD-based claims adjustments, we are **adjusting payments to providers pursuant to House Bill 20 (Healthy Workplaces Act)** implementing requirements for earned sick leave, fully recognizing they are part of the communities we serve

HCSC

Questions?

PRESBYTERIAN
Health Plan, Inc.

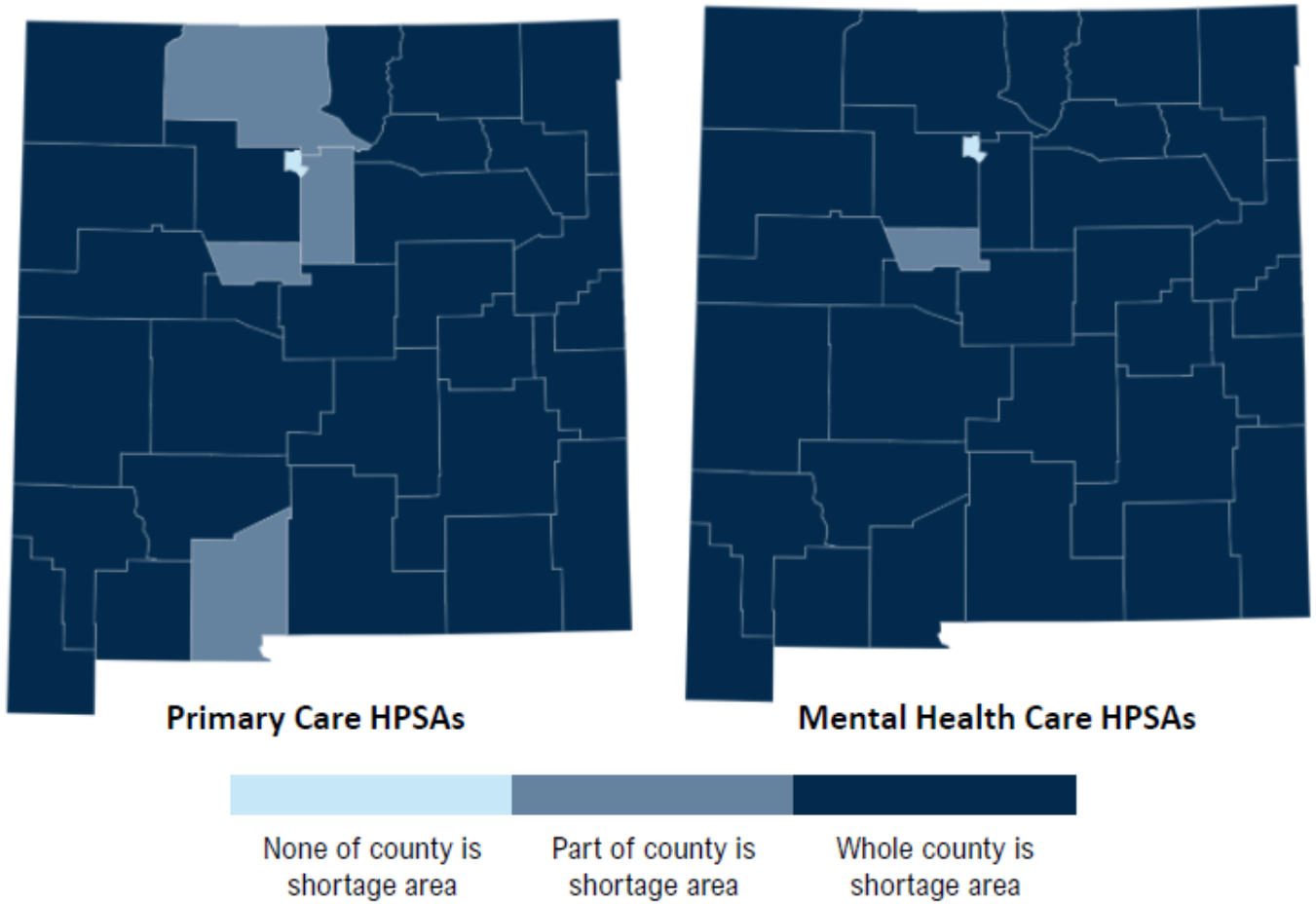
Legislative Finance Committee

Brandon Fryar, PHP President

SEPTEMBER 21, 2022

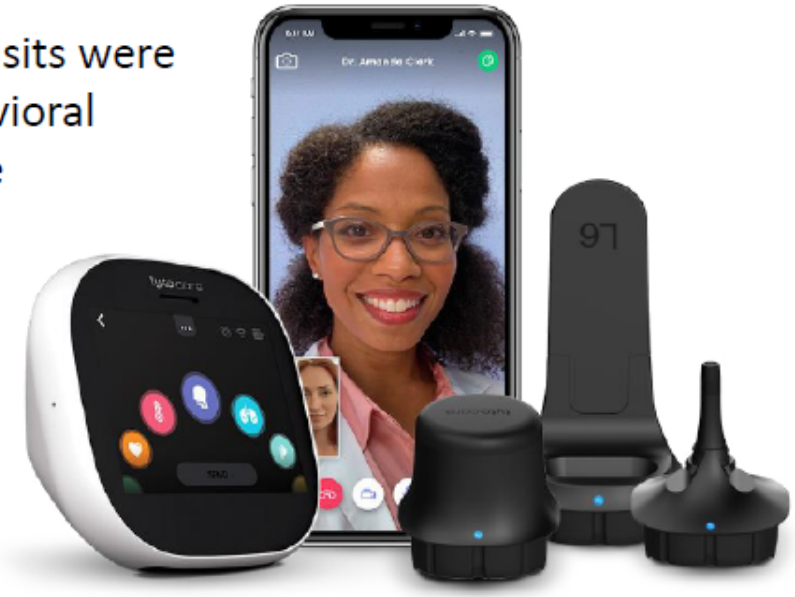
New Mexico's Workforce and Access Challenge

- The **delayed-care demand** coming out of the pandemic coupled with workforce shortage pressures healthcare providers across the U.S.
- **Aging population**: Among New Mexico's population (~2.1 million) approx. 377K (18%) are 65+
- HSD estimates that by 2030, 25%+ of population in every NM county will be 65+.
- U.S. Health Services & Resource Administration (HRSA) designates **primary and mental health professional shortage areas** (HPSAs) in NM.



How PHP and PHS Work Together to Address Access Challenges

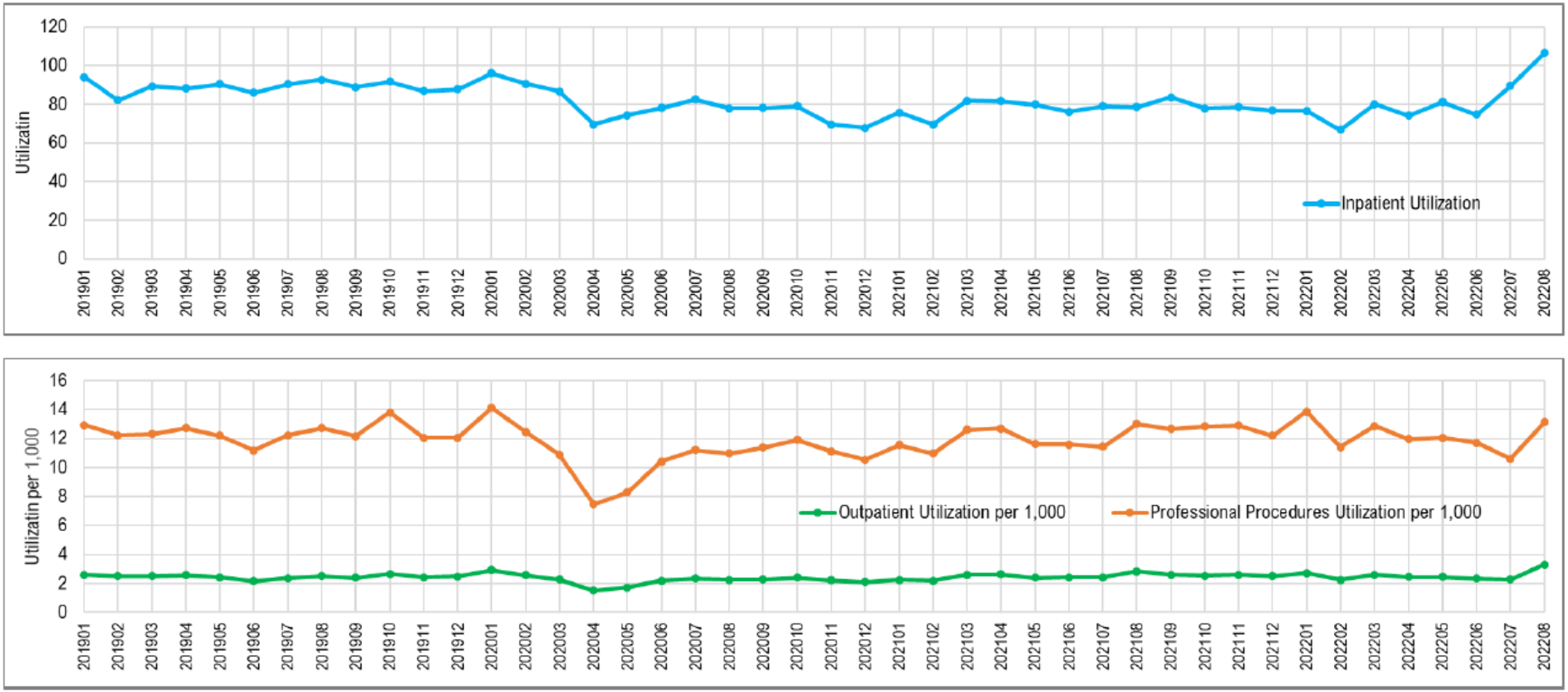
- July 2022 Research & Polling, Inc. mystery shopper survey compared access for PHP Medicaid and commercial members. Result: **Access for Medicaid members is equal to or better than for commercial members.**
- **PHP maintains a broad Medicaid network** that includes Presbyterian's system and providers, the University of New Mexico Hospital and Medical Group, Lovelace Health Systems, all federally qualified health centers (FQHCs), and almost all independent practices.
- Prior to pandemic, <18% of members were accessing behavioral health specialty services, but **in 2021 that number rose to 41.3%.** Many of these visits were delivered via telehealth modalities, which expanded across the entire behavioral health network due to the pandemic itself as well as corresponding practice changes that occurred.
- **PHP leverages telemedicine to ensure access to all our members.**
  We have expanded telehealth capability across Presbyterian Medical Group and across care provisions including: primary, specialty, and behavioral health. This enables members to receive these services from their homes and also enables primary care to specialty care consultations.



Recruitment, Retention, Training, and Partnerships

- In past year, **Presbyterian has recruited a total of 237 physicians and APCs**, including 46 PCPs, 13 behavioral health providers, and 50 adult medical specialty providers.
- **Academic partnership with CNM for nursing** as well as many of their allied health programs.
- Presbyterian is **second largest provider of clinical rotations in NM** (largest is UNM), providing between 1500- 4000 rotations a year. Students include medical, nursing, pharmacy, PAs, NPs, PT, etc. We have an NP residency program. We also have a UNM continuity clinic for Internal medicine. We are actively building a collaborative family medicine residency in Española with a local FQHC there.
- **Presbyterian manages the academic agreements for all nursing and allied health programs that are present in New Mexico** and is working with UNM for increasing support for their programs including increasing clinical sites for their clinical programs at all levels as well as looking at provide some of our team members as adjunct faculty.
- Presbyterian was only one of 32 national organizations awarded a grant through a HRSA-funded program designed to **increase the number of family nurse practitioners and nurse midwives in rural communities**. As of today we have graduated 20 residents who are all serving now in rural communities.
- **We are a provider of nursing continuing education credits** through the national ANCC umbrella. This service has been in place for many years.

Utilization Trends (Days/Units) by Service Date: Q1 2019 to Present



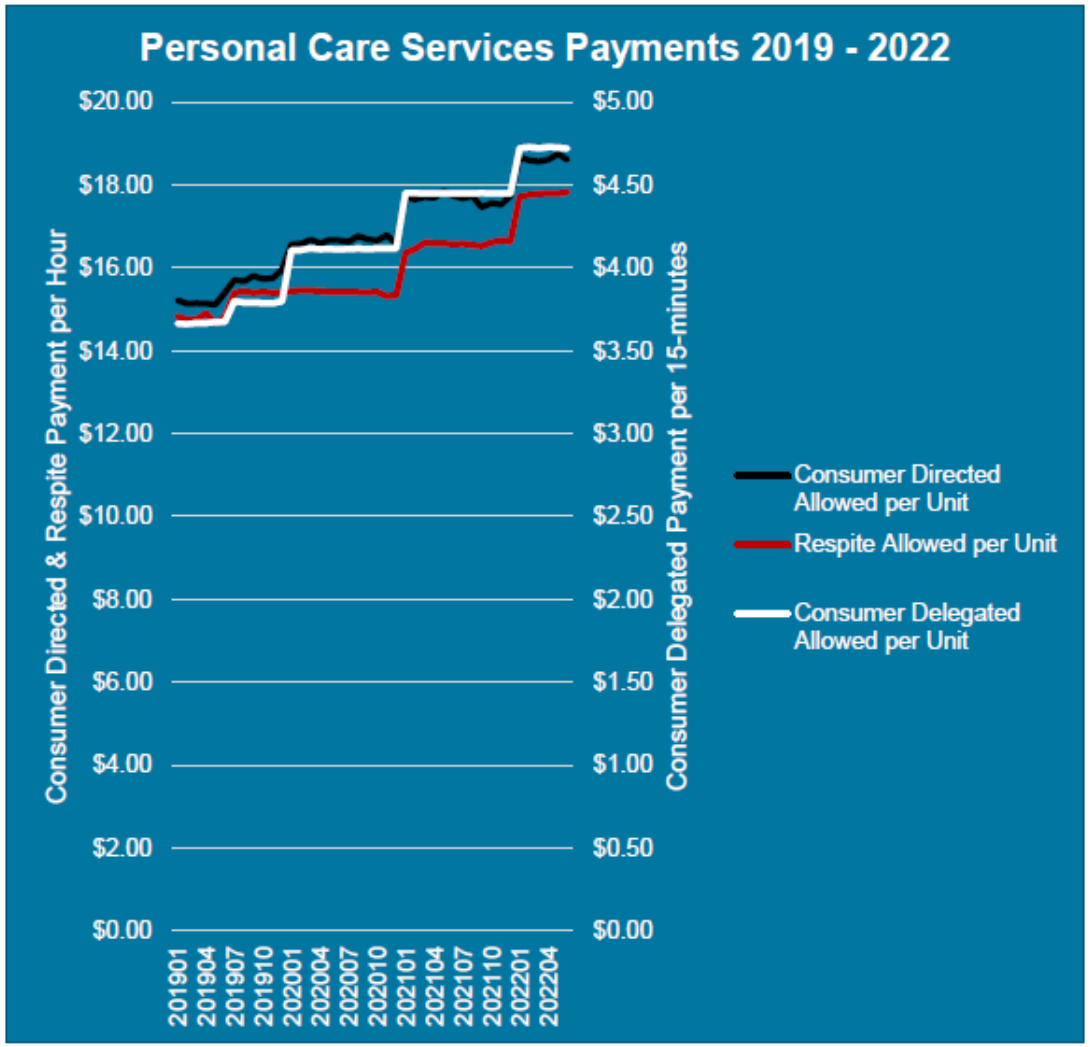
Value-Based Purchasing Arrangements – providers paid for overall care

- Percent of medical expenses paid under VBP arrangements = **81%**
  - **29%** capitated + **29%** shared savings + **23%** pay-for-performance
- **Effectively designed VBPs** align provider incentive payments with Medicaid priority measures
- One of PHP's large unaffiliated provider partners under a capitated arrangement provided the feedback below:

"We were able to make technology improvements and interfaces that allowed MCO and providers to better share data. We purchased /built new facilities, expanded our capacity in 3 facilities, opening a virtual clinic so providers can treat clients from multiple rural areas, and technology improvements. This helped us tremendously with massive labor cost increases, increase in vacancies that have to be filled with locum firms and temp agencies, and supply cost increases."

Provider Rates and Payments

- In 2022, **HSD increased capitation rates to PHP by $15.8M** for minimum wage increases and paid sick leave ($12.5M & $3.3M, respectively).
  - → So far this year, **we've increased providers a total of $19.2M in 2022 alone** for minimum wage and paid sick leave.
  - → Personal care services were increased by $15.7M, and
  - → Other services including: assisted living facilities, private duty nursing, nursing facilities and home health agencies by another $3.5M
- Comparing 2022 rates to 2019, PHP **increased personal care service (PCS) agency payments by $54M annually**. These agencies employ caregivers near minimum wage and were the hardest hit by rising wages and sick leave.
- Since 2019, PHP has disseminated provider rate increases in accordance with HSD Letters of Direction.
  - → **973,136 claims reprocessed** within HSD's deadlines
  - → Additionally, **distributed $115M** in temporary COVID relief funding via direct payments to a variety of providers.



HUMAN SERVICES DEPARTMENT

APPENDIX

INVESTING FOR TOMORROW, DELIVERING TODAY.

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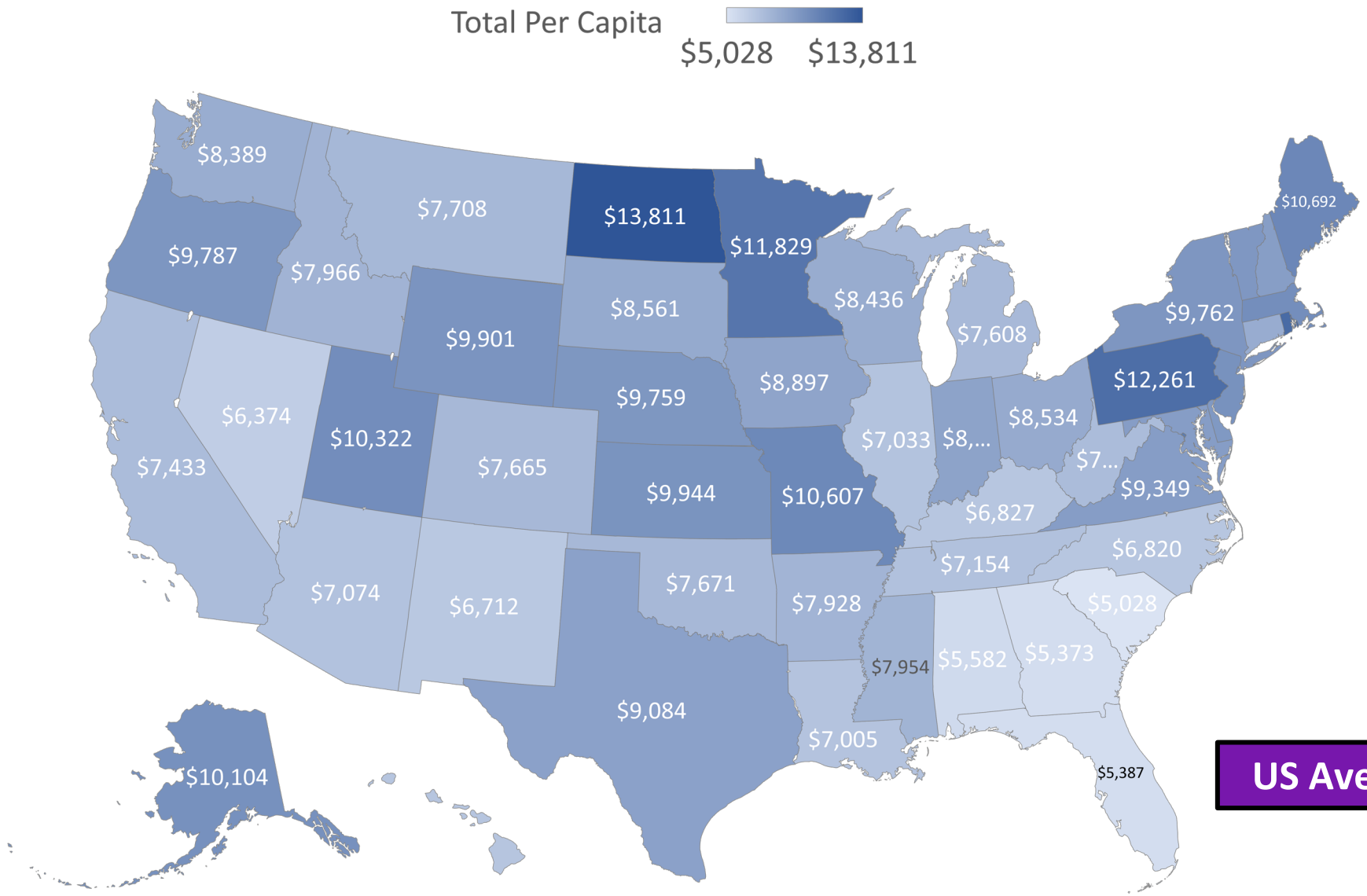
MEDICAID TOTAL PER CAPITA SPENDING



US Average: $8,672

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HUMAN SERVICES DEPARTMENT

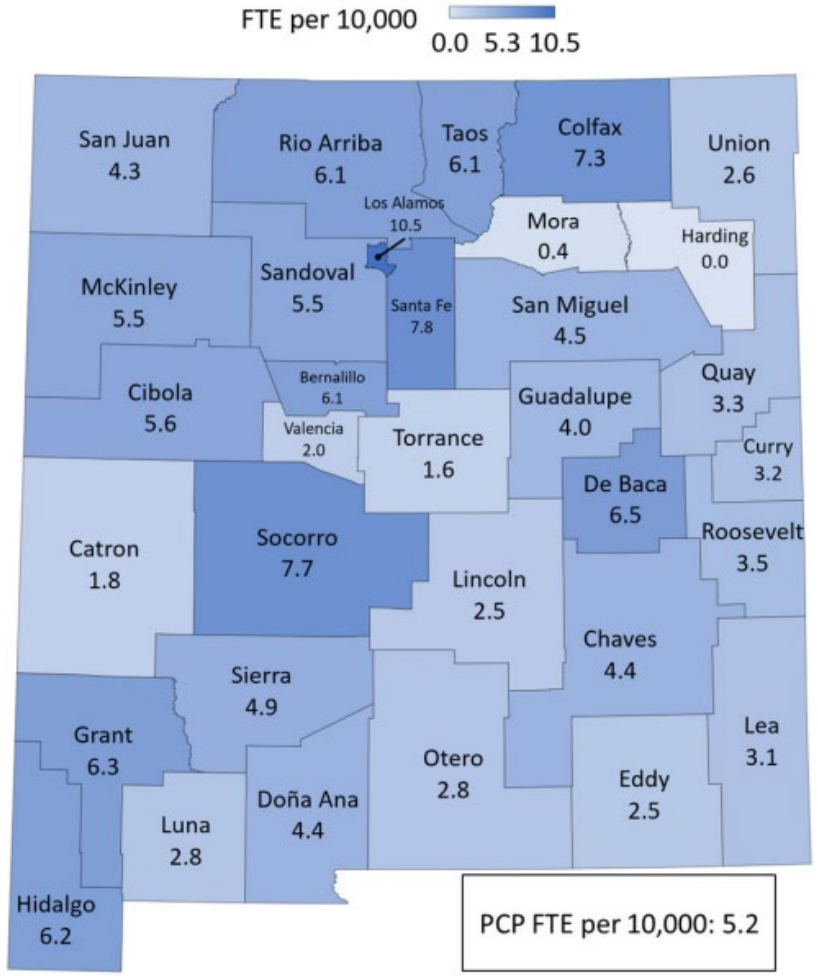
NETWORK ADEQUACY

Primary Care Providers

	MCO A	MCO B	MCO C	Contract Requirement
PCPs	2,163	3,981	3,420	N/A
PCP to Member Ratio*	1:131	1:106	1:24	1:2000
PCPs with Open Panels	87.7%	79.6%	95.0%	*New contract consideration*

***Excludes dual members who select a Medicare PCP**

Primary Care Physician Full-Time Equivalent Count by County per 10,000 Population, 2020

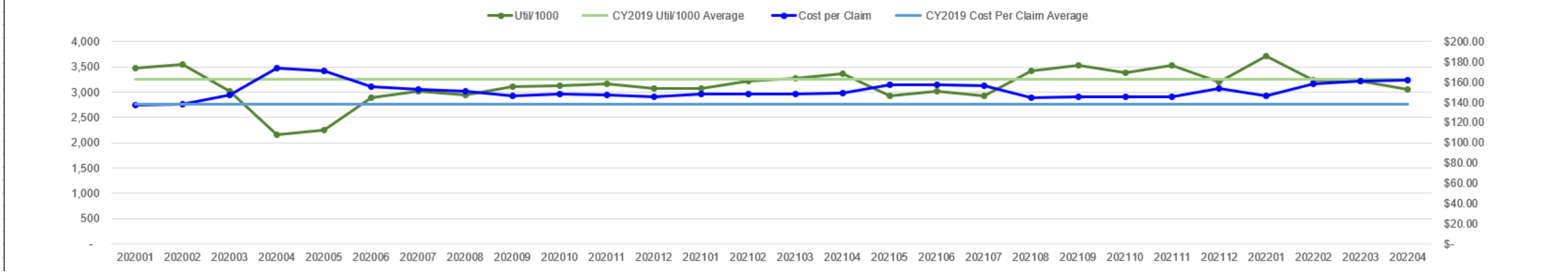


Source: Report #3 Q1CY22

The content of these slides, specifically references to the end of the Public Health Emergency, 6.2% FMAP, and Maintenance of effort requirements and timelines, is subject to change as a result of evolving federal guidance, experience, new information, changes in process requirements, and the availability of resources.

MEDICAID UTILIZATION

Service:	Cost per Claim and Util/1000 (Actuals) Adjusted for Days																												
All Other	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112	202201	202202	202203	202204	CY2019 Avg
Actual MMs	677,782	678,108	679,863	691,731	701,484	708,412	715,889	723,439	729,096	734,765	741,561	748,741	753,187	757,132	761,191	764,982	767,919	771,195	775,274	779,845	783,300	786,918	790,046	792,900	796,504	799,138	800,551	803,299	**668,499**
Cost per Claim	$ 137.19	$ 138.62	$ 147.71	$ 173.48	$ 170.93	$ 155.49	$ 152.97	$ 150.69	$ 146.82	$ 148.31	$ 147.63	$ 145.98	$ 148.13	$ 148.34	$ 148.14	$ 148.89	$ 157.42	$ 157.18	$ 156.34	$ 145.02	$ 145.47	$ 145.36	$ 145.54	$ 153.84	$ 146.04	$ 158.67	$ 161.35	$ 161.62	**$ 138.11**
Util/1000	3,479	3,552	3,017	2,166	2,259	2,884	3,020	2,938	3,119	3,125	3,163	3,076	3,074	3,221	3,279	3,361	2,932	3,028	2,935	3,430	3,537	3,395	3,525	3,209	3,710	3,236	3,219	3,052	**3,254**



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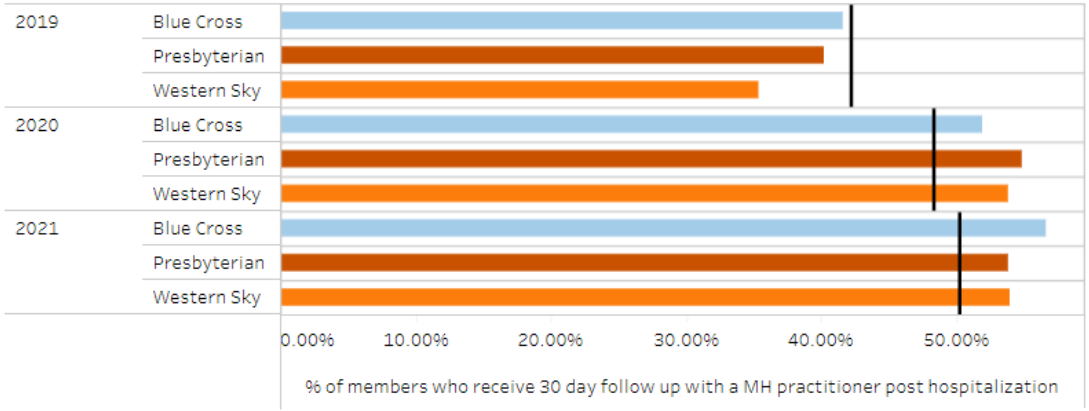
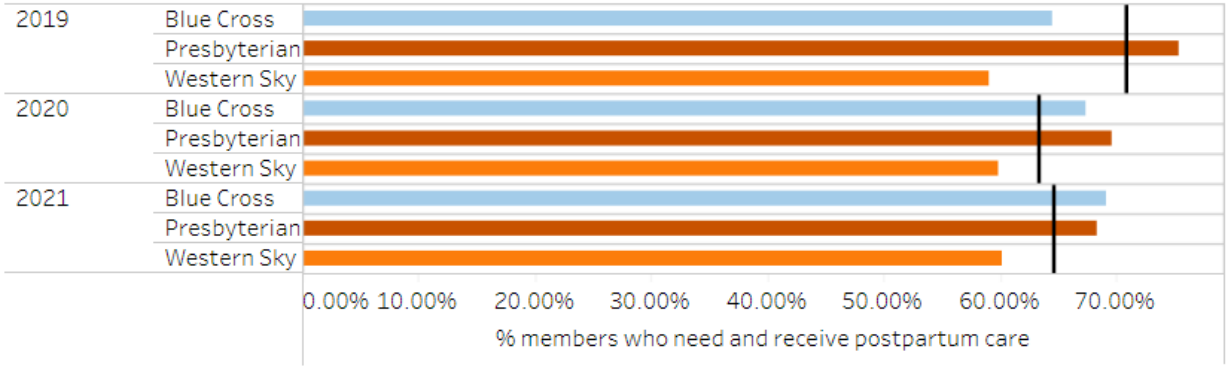
MCO PERFORMANCE

How good is my Managed Care Organization (MCO) at working with providers to ensure I receive a follow-up with a mental health practitioner within 30-days after a hospitalization for mental illness?



Last updated: 8/24/2022, Regional average coming in September

I'm pregnant. How good is my MCO at working with providers to ensure I receive the postpartum care that I need?

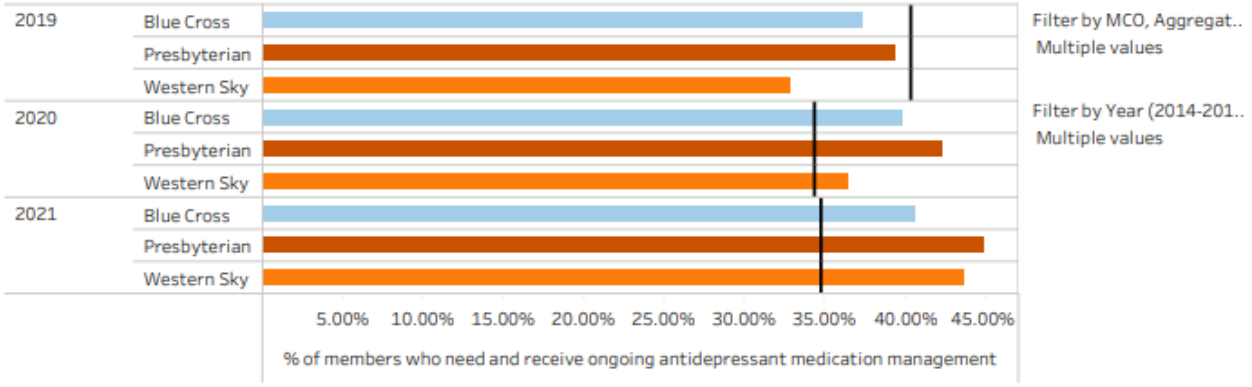


Last updated: 8/28/2022, regional average coming in September

Source: https://sites.google.com/view/nmhsdscorecard

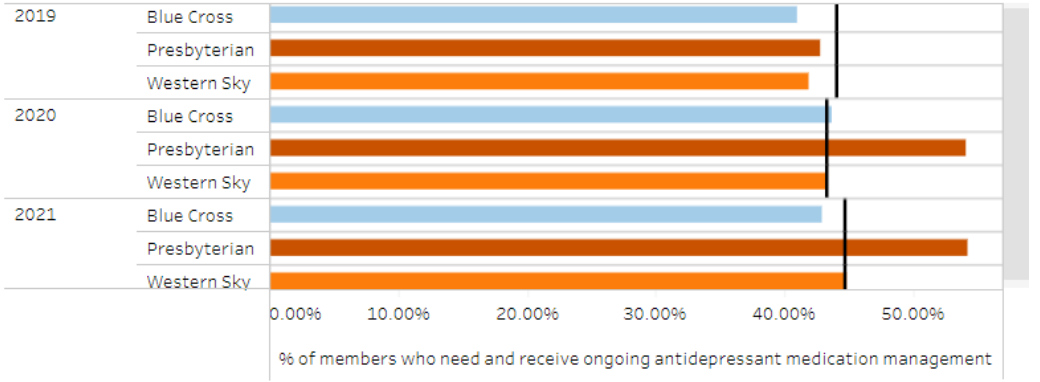
MCO PERFORMANCE

How good is my Managed Care Organization (MCO) at working with providers to ensure I receive ongoing antidepressant medication management, should I need it?



Last updated: 8/24/2022, regional average coming in September

How good is my MCO at working with providers to ensure I receive treatment initiation for alcohol or other drug dependency, should I need it?



Last updated: 8/24/2022, Regional average coming in September

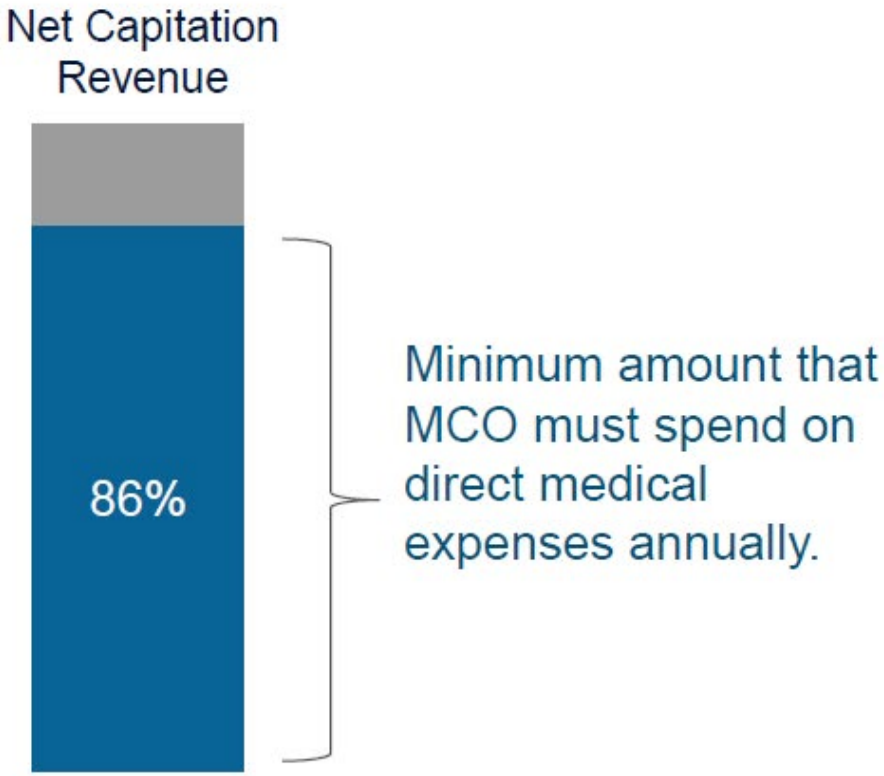
Source: https://sites.google.com/view/nmhsdscorecard

MLR/UW GAIN LIMIT PROCESS AND TIMING

Centennial Care MCO Contract Requirements

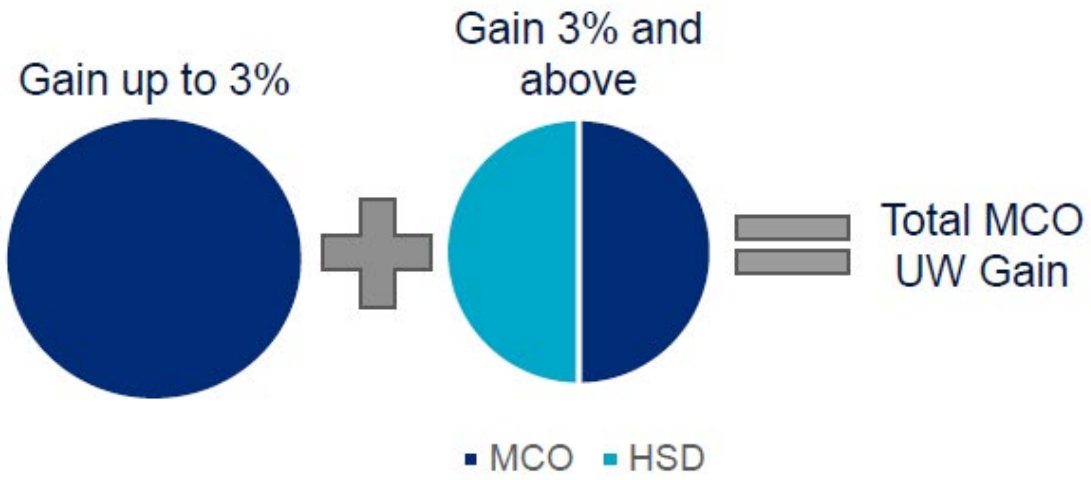
7.2.10 Medical Expense Ratio

The CONTRACTOR shall spend no less than eighty-six percent (86%) of net Medicaid line of business Net Capitation Revenue on direct medical expenses on an annual basis.



7.2.1 Underwriting Gain Limitation

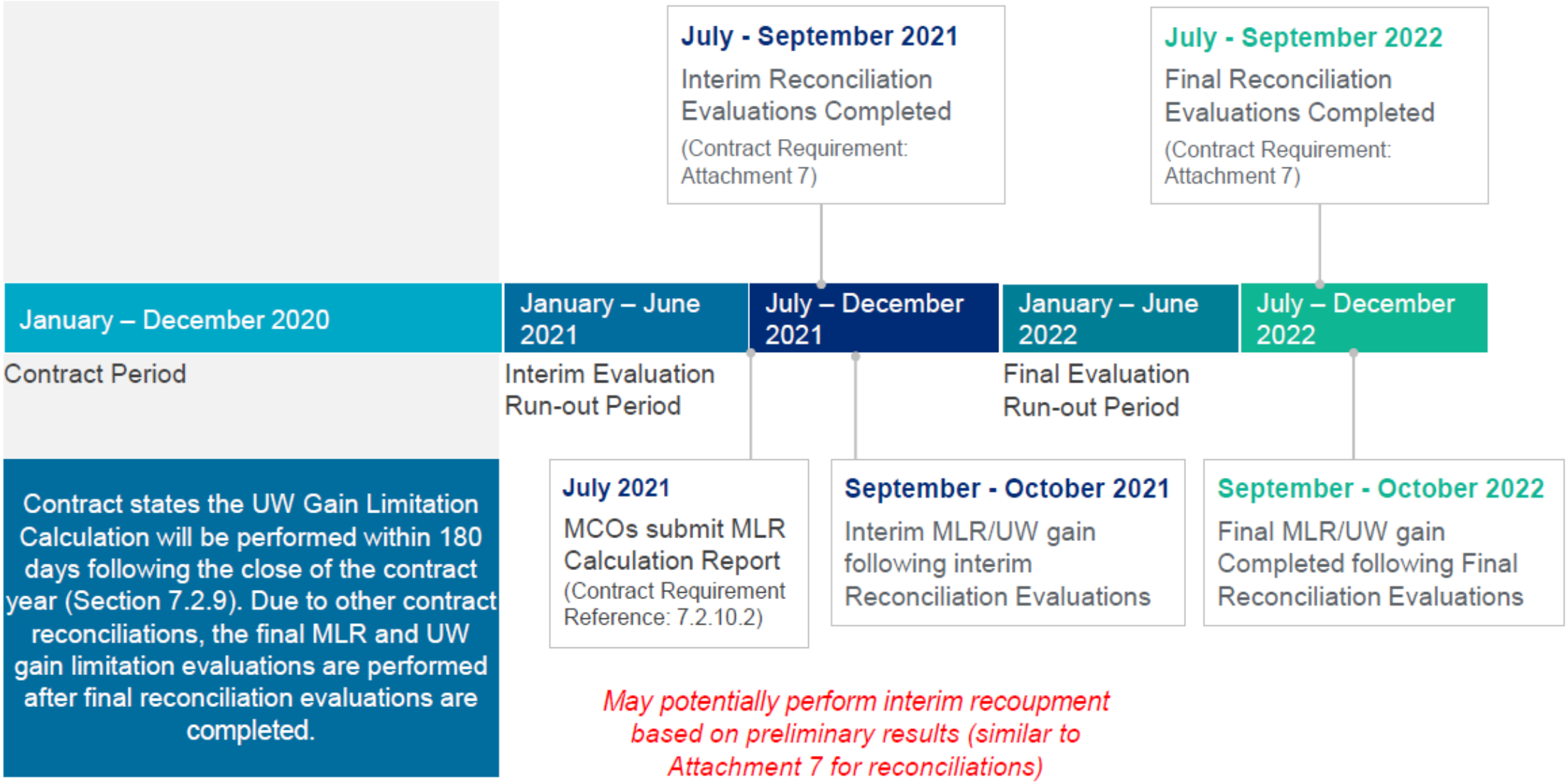
The CONTRACTOR is permitted to retain one-hundred percent (100%) of any underwriting gain generated under this Agreement up to three percent (3.0%) of net capitation revenue generated annually as defined in Section 7.2.2 of this Agreement. The CONTRACTOR shall share fifty percent (50%) of any underwriting gain generated in excess of three percent (3.0%) with HSD.



HUMAN SERVICES DEPARTMENT

MLR/UW GAIN LIMIT PROCESS AND TIMING

High level rate-setting timeline for CY2020 UW gain limit process



HUMAN SERVICES DEPARTMENT

OPTIONS FOR ADJUSTING 2020 MCO CAPITATION RATES

MCOs may implement changes voluntarily (ex. NEMT),through similar contract mechanisms as FFS (ex. DRG increase), or through directed payments (ex. NF rate increase)

- CMS will require 2-sided risk mitigation for new directed payments on all medical services, likely for full calendar year

Increase or decrease rates up to 1.5% per rate cell without requiring new certification; requires contract amendment

- May not fully account for the expected impact of changes

Review rate setting assumptions retrospectively with more recent experience as it becomes available

- Takes time for complete data to become available for analysis

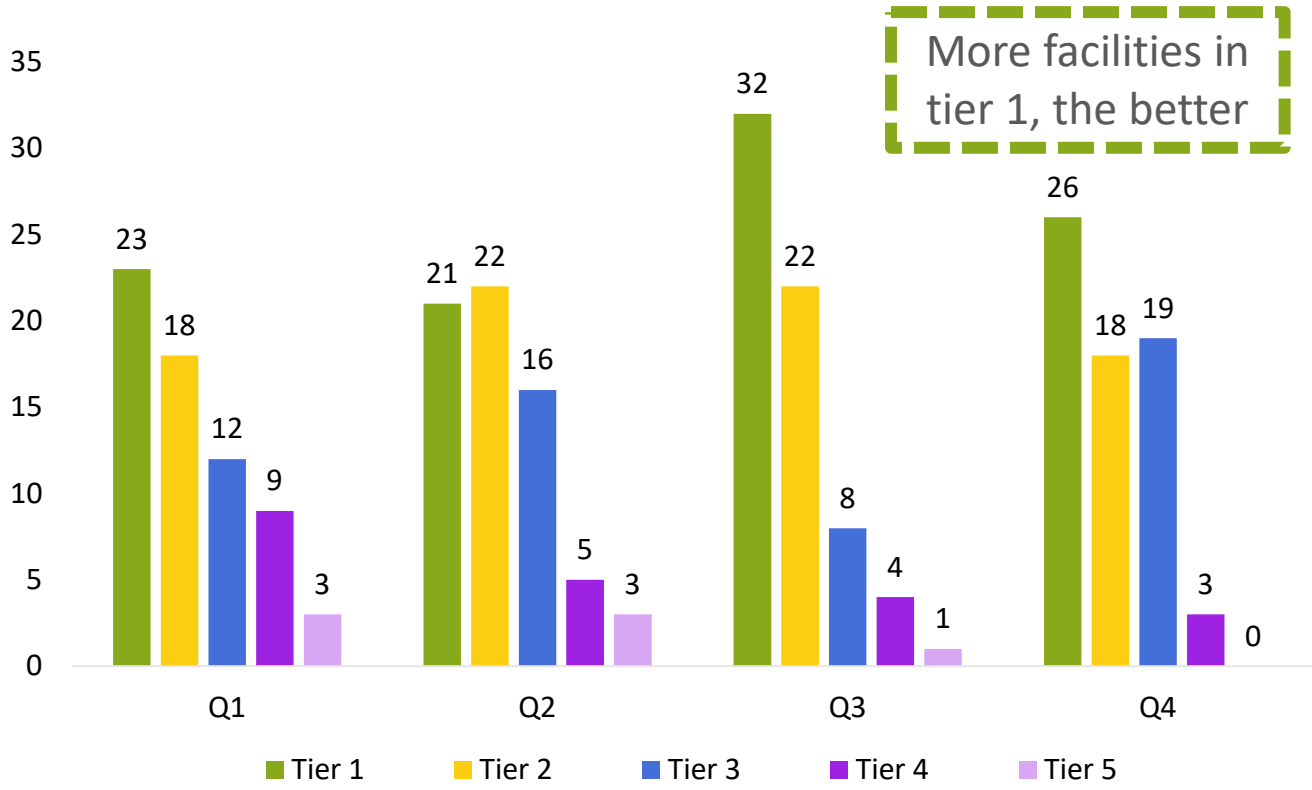
CMS may require certification amendments and/or additional documentation under many of these approaches

UMAN SERVICES DEPARTMENT

HCQS PROGRAM IS RESULTING IN BETTER QUALITY PERFORMANCE IN NURSING FACILITIES - REDUCES COST

- Switch to quality payments resulted in **improvements in quality scores**.
  - Year 1 – quality payments were based on reporting data to establish a baseline.
  - Year 2 – switch to performance scoring in Q3 resulted in **better Tier 1 performance**.

HCQS Participating Facilities Achieving Quality Measures, by Quality Tier, by Quarter (7/1/20 – 9/30/21)



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OVERVIEW OF DISTRIBUTION OF SFY22 APPROPRIATION FOR COVID RELATED COSTS TO PROVIDERS

Provider Type	Directed Payment	SFY 22 Payment Amount
Hospitals	A uniform dollar increase for the delivery of inpatient and outpatient hospital services for hospitals from January 1, 2022 through June 30, 2022. The amount of the increase will vary for frontier/rural and urban class for both inpatient and outpatient services, with larger increases for frontier/rural hospitals.	Total Computable - $137.6 Million • Federal Share - $109.1 Million • State Share - $28.5 Million
Nursing Facilities	Uniform 8.1% to short term skilled and custodial nursing facility services for January 1, 2022 through June 30, 2022.	For NF, FQHC, NEMT Combined Total Computable - $21.2 Million • Federal Share - $16.2 Million • State Share - $5.0 Million
Federally Qualified Health Centers (FQHCs)	Uniform rate increase of $15 to Federally Qualified Health Centers (FQHC) providers for January 1, 2022 through June 30, 2022.	
Non-Emergency Medical Transportation	Uniform 6.81% rate increase to non-emergency medical transportation providers for January 1, 2022 through June 30, 2022.	

SUPPLEMENTAL HOSPITAL PAYMENTS

	Payment (Year Payment Began)	Year Payment Began	Amount (TC)	Medicaid Program	Calendar Year 2021	Calendar Year 2022	Payment Methodology
1	Hospital Quality Improvement Initiative (HQII)	Pre-2019	$12 million	Fee-for-Service (FFS)	Payments complete	Payments complete	Supplemental payment paid annually by HSD
2	Disproportional Share Hospitals (DSH)	Pre-2019	$32 million	Fee-for-Service (FFS)	Payments complete	Approved by CMS	Supplemental payment paid annually by HSD
3	Indirect Medical Education (IME)	Pre-2019	$100 million	Fee-for-Service (FFS)	Payments complete	Approved by CMS	Supplemental payment paid quarterly by HSD
4	Graduate Medical Education (GME)	Pre-2019	$27 million	Fee-for-Service (FFS)	Payments complete	Approved by CMS	Supplemental payment paid quarterly by HSD
5	UC Pool	Pre-2019	$69 million	Fee-for-Service (FFS)5	Payments complete	Moved to HAP & TAP	Supplemental payment paid quarterly by HSD
6	Community Tribal Hospitals	2019	$14.4 million	Managed Care (MC)	Payments complete	Approved by CMS	Percentage rate increase per MC encounter
7	For-Profit and Government Owned Hospitals	2019	$12.6 million	Managed Care (MC)	Payments complete	Approved by CMS	Percentage rate increase per MC encounter

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SUPPLEMENTAL HOSPITAL PAYMENTS

	Payment (Year Payment Began)	Year Payment Began	Amount (TC)	Medicaid Program	Calendar Year 2021	Calendar Year 2022	Payment Methodology
8	Not-For-Profit Hospitals	2019	$12.4 million	Managed Care (MC)	Payments co mplete	Approved by CMS	Percentage rate increase per MC encounter
9	Temporary Hospital COVID Increases	2020	$70.3 million	FFS & Managed Care (MC)	Payments co mplete	Approved by CMS	Percentage rate increase
10	Hospital Access Payment (HAP)	2020	$58 million	Managed Care (MC)	Payments co mplete	Approved by CMS	Quarterly payment based on a per MC discharge add-on
11	Trauma Hospitals	2020	$6.1 million	Managed Care (MC)	Payments co mplete	Pending CMS Approval on 438.6 Directed Payment	Percentage rate increase per MC encounter
12	Targeted Access Payment (TAP)	2020	$23 million	Fee-for-Service (FFS)	Payments co mplete	Approved by CMS	Supplemental payment paid annually by HSD
13	Temporary Hospital COVID Increases	2022	$150.0 million	Managed Care (MC)	N/A	Pending CMS Approval on 438.6 Directed Payment	Quarterly payment based on a per MC discharge add-on
14	Community Tribal Hospitals	202213	$28.8 million	Managed Care (MC)	Payments co mplete	Approved by CMS	Percentage rate increase per MC encounter
	Total		**$532.2 million**				

HSD is issuing $280.2M more in hospital supplemental payments in 2022 than payments made in 2018.

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NURSING FACILITY PAYMENTS

Directed Payment	Amount	Medicaid Program	Calendar Year 2021	Calendar Year 2022	Payment Methodology
Nursing Facility Value Based Purchasing (NF VBP)	$4.5 million	Managed Care (MC)	Payments complete	Pending CMS Approval on 438.6 Directed Payment	Quarterly payments based on quality scorecards issued by HSD's data vendor. The Managed Care Organization (MCO) is to make payment in accordance with the contract terms between the MCO and the nursing facility.
Healthcare Quality Surcharge (HCQS)	$130.9 million	Managed Care (MC)	Payments complete	Approved by CMS	Per Managed Care encounter for per diem and MBI factor Quarterly for quality payment
Temporary Nursing Facility (NF), FQHC, Non-emergency medical transportation (NEMT) COVID Increases	$21.2 million	Managed Care (MC)	N/A	Pending CMS Approval on 438.6 Directed Payment	Rate increase per encounter
Total	**$156.6 million**				

CMS REQUIRES PAYMENT METHODOLOGY CHANGE

- In the past, payment programs like the Uncompensated Care Pool allowed HSD to provide support to rural hospitals above and beyond Medicaid volume-based payments
- Effective 2020, CMS no longer allows these types of payment methods
- All hospital payments (other than quality incentives) must be based on and distributed according to Medicaid patient volumes
  - The Hospital Access Payment Program (HAP) and the Targeted Access Payment (TAP) were designed using the CMS required utilization-based methodology

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PROPOSED MEDICAID RATE INCREASES METHODOLOGY

- 2022 Legislative session: $28M General Fund appropriation in HB2 for a temporary payment increase for Hospitals, Nursing Facilities, FQHCs to address higher costs from staffing shortages
- Leverage federal funds for a total $150M temporary increase to hospitals in FY2022
- Utilization is principal driver of reimbursement and is operationalized through inpatient and outpatient discharge add-ons. Increases effective for utilization between January 1, 2022, and June 30, 2022.
- Hospital classification (Urban, Rural/Frontier)
  - Urban: Bernalillo, Dona Ana, Los Alamos, Santa Fe
  - Rural/Frontier: All remaining counties
- The estimated per-discharge add-on for this directed payment. Note that while the total dollars to each of the provider classes are fixed, the amounts to each provider will vary based on actual utilization.
- HSD provided briefing to hospitals on 5/3/2022.
- HSD plans to get notices to Hospitals for Q1CY22 by the end of May with estimated amount of payment.
- 42 CFR 438.60 Directed Payment Pre-print pending CMS approval.

Region (Hospital Classes)
Rural/Frontier
Urban

Service Dollar Distribution	Percentage	Total Inpatient Distribution
Outpatient	50%	$68.8M
Inpatient	50%	$68.8M
	Total	$137.6M

Region (Hospital Classes)	Estimated Outpatient Per Episode Add on	Estimated Inpatient Per Discharge Add on
Rural/Frontier	$138.62	$2,642.67
Urban	$77.84	$1,018.44
# of claims	703,219	48,199

HOSPITAL ACCESS PAYMENT (HAP) AND TARGETED ACCESS PAYMENT (TAP)

PRE 2020 SAFETY NET CARE POOL (SNCP) PROGRAM

THE SAFETY NET CARE POOL (SNCP) PROGRAM

- Established in statute – NMSA 27-5-6.1
- Approved in Centennial Care 2.0 1115 waiver by CMS
- Supported by a 1/12th GRT tax on the counties
  - Creates the base of the payments for the SNCP Programs

1115 DEFINED ELIGIBLE HOSPITAL CLASSES

Hospital Size	Number of beds	UC Funding Allocation (%)
Smallest hospitals	30 or fewer hospital beds	60% of available funding
Small hospitals	31-100 hospital beds	30% of available funding
Medium hospitals	101-200 hospital beds	10% of available funding
Large hospitals	201-300 hospital beds	0%
Largest hospitals	more than 301 hospital beds	0%

PRE 2020 SAFETY NET CARE POOL (SNCP) PROGRAM

UNCOMPENSATED CARE (UC)

- CMS previously approved a budget that paid SNCP hospitals for UC
  - US budget for 2019 was $69M
  - UC budget for 2020 was $0.00
- CMS required a transition in UC applications to the S-10 Worksheet
  - Determined this requirement would decrease UC payments by 50%
  - Concern for hospitals - HSD and NMHA worked to design an alternative

HOSPITAL QUALITY INCENTIVE INITIATIVE (HQII)

- CMS approved program rewarding SNCP hospitals for improved quality
- CMS has approved the program through 2021
- Budget is set for $12 million for 2020 and 2021
- Dollars will be reallocated into another supplemental payment to be determined in consultation with hospitals

HOSPITAL ACCESS PAYMENT (HAP) AND TARGETED ACCESS PAYMENT (TAP)

Year	Program History	
2019	- Safety Net Care Pool (SNCP) Hospital Uncompensated Care (UC) program model was required to end December 31, 2019 - In accordance with the 1115 waiver for the Centennial Care program - Requiring a transition of the program to other supplemental payments; these payments must be utilization based	- $81M

2020	- In CY2020 with the pool of dollars previously allocated to the SNCP HSD established:
	  - Hospital Access Payment (HAP) - A Directed Payment program based on inpatient and outpatient discharges
	  - Target Access Payment (TAP) - A payment program based on remaining Upper Payment Limit (UPL) room based on prior year UPL
		- $58 (HAP)
		- $23 (TAP)

HOSPITAL ACCESS PAYMENT (HAP)

- **Hospital Access Payment**
  - In accordance with federal rule 42 CFR 438.60, the HAP program is paid through the Centennial Care Managed Care Organizations (MCOs); payments are not made directly by HSD/MAD.
- **Calculation**
  - HAP program payments are calculated based on each MCO's member utilization, at each hospital, for both inpatient and outpatient discharges.
  - Each discharge has an additional add-on that is paid based on a calculated formula. The formula is as follows:

SNCP Class Allocated Amount/SNCP Class Medicaid Discharges = Add-on Amount per Discharge

  - The add-on payment amount changes each quarter.
  - HAP is based on actual utilization, with no reconciliation of funds (unlike the SNCP program design).

HOSPITAL ACCESS PAYMENT (HAP)

- The inpatient and outpatient services subject to this directed payment are authorized in the State plan and the managed care delivery system for these services is authorized under the Centennial Care 2.0 section 1115 demonstration authority.
- SNCP hospitals are defined in the Centennial Care 2.0 1115 demonstration effective January 1, 2019 through December 31, 2023. The list of impacted hospitals is included in the Standard Terms and Conditions – Attachment E for the 1115 waiver.

SNCP Classes	Hospital Beds
Smallest	30 or fewer
Small	31-100
Medium	101-200
Large	201-300
Largest hospitals	301 or more

LIST OF SAFETY NET CARE POOL HOSPITALS BY SIZE

Smallest Hospitals (30 or fewer)	Small Hospitals (30-100)	Medium Hospitals (101-200)	Large Hospitals (201-300)
Cibola General Hospital	Alta Vista Regional Hospital	Eastern NM MC	University of New Mexico Hospital* * Does not receive HAP/TAP Funding
Dan C Trigg Memorial Hospital	Artesia General Hospital	Memorial MC	
Guadalupe Country Hospital	PHS Espanola Hospital	Mountain View Regional MC	
Holy Cross Hospital	Gerald Champion Regional MC	San Juan Regional MC	
Lincoln County MC	Gila Regional Medical Center	St. Vincent Regional MC	
Mimbres Memorial Hospital	Los Alamos Medical Center	Presbyterian Santa Fe	
Miners' Colfax MC	Plains Regional MC		
Nor-Lea General Hospital	Lea Regional Hospital		
Roosevelt General Hospital	Rehoboth McKinley Christian HC		
Lovelace Regional Hospital - Roswell	Carlsbad MC		
Sierra Vista Hospital			
Socorro General Hospital			
Union County General Hospital			

TARGETED ACCESS PAYMENT (TAP)

TARGETED ACCESS PAYMENT (TAP)

- The TAP program alleviates discrepancy between the Hospital Access Payment (HAP) and the CY2019 Uncompensated Care (UC) payment under the former SNCP model.
- Unlike the HAP program, HSD makes payments under TAP directly to the hospitals.

CMS Emergency State Plan Amendment (SPA) 20-0008 - Approved	Quarterly supplemental targeted access payments is based on New Mexico's most recent quarterly Upper Payment Limit (UPL) demonstration for a specified period within the Public Health Emergency (PHE).
CMS State Plan Amendment (SPA) 20-0024 - Approved	Targeted Access Payment (TAP) - *annual* payment based on the State Fiscal Year (SFY) UPL demonstration for the remainder of the PHE.
CMS State Plan Amendment (SPA) 21-0006 - Approved	Targeted Access Payment (TAP) - *annual* payment based on the State Fiscal Year (SFY) UPL demonstration upon the end of the PHE.
CMS State Plan Amendment (SPA) 22-0005 - Approved	Targeted Access Payment (TAP) - *annual* payment based on the State Fiscal Year (SFY) UPL demonstration upon the end of the PHE.

TARGETED ACCESS PAYMENT (TAP)

- Beginning in 2021, the amount of supplemental targeted access payments is based on New Mexico's most recent upper payment limit (UPL) demonstration for the State Fiscal Year (SFY) and will be paid annually to Safety-Net Care Pool (SNCP) hospitals.

- The payment amount will be based on the demonstrated UPL Room and paid to the hospitals if it falls within the UPL Gap of the respective hospital class as determined by the most recent UPL demonstration for the SFY.

TARGETED ACCESS PAYMENT (TAP) – PAYMENT DISTRIBUTION METHODOLOGY

- Targeted Access Payments is calculated and paid annually following the end of the state fiscal year (June 30). HSD expects to make these payments before the end of the calendar year.
- Providers will be grouped into one of three categories based on their ownership structure as follows:
  1. Privately Owned or Operated Facilities
  2. Non-State Government-Owned or Operated Facilities
  3. State Government-Owned or Operated Facilities

- Once facilities are classified into their ownership group, they are evaluated to determine if they are eligible to receive an Inpatient (IP) TAP. If not eligible for IP the provider will be evaluated for Outpatient (OP) TAP. To qualify a provider must meet the following criteria:
  1. Be a Safety Net Care Pool (SNCP) provider
  2. Have inpatient FFS utilization in the most recent Upper Payment Limit Demonstration
  3. Have a positive UPL in the most recent UPL demonstration
  4. Belong to a group that has UPL room to receive the payment

TARGETED ACCESS PAYMENT (TAP) – DISTRIBUTION METHODOLOGY

- Providers that are eligible for either an IP or OP TAP will have their respective UPL's utilized to pro-rate the available TAP budget. To achieve this each provider's UPL will be added to the other eligible provider UPL's to determine the total need in the population. The individual provider's need will be divided by the total need to arrive at the facility specific percentage of total need. This percentage will become the factor utilized to allocate TAP funds to each facility.
- After each facility TAP has been calculated, the payments for the providers in each ownership class will be compared to the estimated UPL for the subsequent state fiscal year. If the ownership class does not have sufficient UPL room to accept the funds in the subsequent fiscal year, the excess payments will be re-allocated to providers with room to accept the funds.

PAYMENT DETERMINATION SEQUENCE

1. Place Providers Into Ownership Groups (Based on UPL Requirements)

2. Exclude Non-SNCP Facilities

3. Identify Facilities with IP FFS Utilization and UPL Room

4. Providers that do not have IP FFS Utilization/UPL Room will have their payment determined with OP FFS Utilization and UPL Room

5. Facility UPLs are Combined to Determine Total Need in the State

PAYMENT DETERMINATION SEQUENCE CONT.

6. TAP Dollars are Allocated to Each Eligible Facility Based on Their UPL as a Percentage of Total Need

7. Calculated Payments are Compared to the Total UPL in the Current State Fiscal Year (SFY) for the Group to Ensure Compliance with Program Rules

8. Calculated Payments are Compared to the Total UPL for the Group in the Subsequent UPL Period

HOSPITAL QUALITY IMPROVEMENT INITATIVE (HQII)

- HQII pool was available in demonstration years 6 through 8 to incentivize hospitals' efforts to meaningfully improve health and quality of care of Medicaid and uninsured individuals.
- **Calculation**
  - Each hospital participating has submitted measures and has been paid their annual payment for DY 8 in the total amount of $12,000,000.
  - HQII payments are made annually (April).
  - These payments are paid through the FFS remits to providers
- To qualify for a HQII payment a provider must meet the following criteria
  - 1. Be an SNCP provider that elected to participate in the initial year
  - 2. Set target goals annually that will be used to compare against occurrences in the facility (Domain 1 measures)
  - 3. Meet or exceed the targets mentioned in bullet 2.
  - 4. Each target that is not met will have associated monies redistributed to eligible providers thru Domain 2 measures.

	DY 6 (CY 2019)	DY 7 (CY 2020)	DY 8 (CY 2021)
UC Pool	$68,889,323	$0 or TBD/S-10	$0 or TBD/S-10
HQII Pool	$12,000,000	$12,000,000	$12,000,000

COMMUNITY TRIBAL HOSPITAL METHODOLOGY

- Payment made to ensure access to hospitals with disproportionate Native American Utilization
- **Calculation**
  - The uniform percent increase to MCO-contracted rates for inpatient and outpatient services
  - **Provider Class 1:** The High Total Medicaid and High Native American Utilization class are hospitals having over 44% of Medicaid to total and over 22% of percentage of Native American utilization to total Medicaid.
  - **Provider Class 2:** The High Native American Utilization class are hospitals having over18% of Native American utilization to total Medicaid.

Provider Class	Hospitals	Uniform Percent Increase
High Total Medicaid and High Native American Utilization	• REHOBOTH MCKINLEY CHRISTIAN HOSPITAL • CIBOLA GENERAL HOSPITAL • SAN JUAN REGIONAL MEDICAL CENTER	33%
High Native American Utilization	• SAN JUAN REGIONAL REHAB HOSPITAL • UNM SANDOVAL REGIONAL MEDICAL CENTER • LINCOLN COUNTY MEDICAL CENTER	13%

DISPROPORTIONATE SHARE HOSPITALS (DSH)

- The DSH program was established to assist hospitals that serve a disproportionate number of low-income patients including Medicaid and the Uninsured.
- Determination of eligible providers occurs annually based on questionnaires completed by all hospitals in the state.
  - To be deemed eligible a provider must meet the following criteria:
    - 1. Have a Medicaid Utilization Ratio greater than the state average OR a Low-Income Utilization Ratio greater than 25%.
    - 2. Have at least 2 obstetricians with staff privileges at the hospital who have agreed to provider obstetric services to eligible recipients
    - 3. Demonstrate the facility has unmet financial needs arising from the care of the Medicaid and Uninsured populations (DSH limit)
- **Calculation**
  - The program has two components. The initial payments are calculated annually based on the state fiscal year, and the examination portion occurs 3 years after the conclusion of the state fiscal year.
- Providers deemed eligible will be placed into 1 of 3 pools (Teaching, Non-Teaching DRG, and PPS-Exempt (TEFRA).
- Quarterly payments made to eligible providers are based on Medicaid discharges in each pool. Providers receive a pro-rated amount of DSH funds based on their discharges as a percent to total discharges in their respective pools.
- DSH examinations are performed 3 years after the close of the SFY. These examinations compare the providers interim payments to the total need they had for servicing the Medicaid and Uninsured populations.
  - Providers that are deemed to have been overpaid are required to pay back DSH funds equal to the amount of their overpayment (repayment cannot exceed their interim DSH funds received)
  - Any reverted funds are allocated to providers with remaining need.

GRADUATE MEDICAL EDUCATION (GME)

- The GME program is designed to pay hospitals for the residents they train each year.
- **Calculation**
  - Graduate Medical Education (GME) payments are calculated annually at the beginning of each state fiscal year, utilizing resident counts reported to the state annually prior to December 31.
  - These counts are based on the most recently completed SFY, and account for expansion FTE's that will be in the program, and not already counted in the FTEs in the facility submissions.
  - The residents must work in either a hospital or FQHC/RHC setting, and part of an ACGME accredited program in order to be counted.
  - Residents are also classified into four groups
    - 1. Existing Primary Care FTE's
    - 2. Existing Other FTE's
    - 3. Expansion Primary Care FTE's and
    - 4. Expansion Other FTE's. Each cohort has a different per FTE payment rate which can be inflated annually.
- Timeline
  - Payments are made to each participating provider in four quarterly amounts at the beginning of the quarter. Total payments are limited to a total FTE cap of 510 (excluding the state teaching hospital).

GRADUATE MEDICAL EDUCATION (GME)

- Existing resident FTEs are allocated $50,000 per year in GME funding
- Expansion FTEs in the Primary Care and Psychiatric ACGME programs are allocated $100,000 annually
- Expansion FTEs are capped to limit the annual increase in total GME funds paid each year. The cap in SFY 2021 is 2 FTEs and increases annually until SFY 2025 when the cap is 101.
- Payments made are not subject to a retroactive settlement and are considered final at the time of payment.

INDIRECT MEDICAL EDUCATION (IME)

- Indirect Medical Education (IME) payments are made on a quarterly basis, with a final settlement occurring on the cost report. Interim payments are based on requests made by participating hospitals following each calendar quarter and are based on Medicaid inpatient utilization in the facility, as well as hospital size (beds) and residents participating in an ACGME accredited program. (See NMAC 8.311.3.12.F.(6) for the full calculation.)

6.2% FMAP EXTENSION TIMELINE

- https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx
- Secretary Azar first declared COVID-19 a nationwide public health emergency (PHE) on January 27, 2020, utilizing his authority under Sec. 319 of the Public Health Service Act.
- Letter from CMS on extension: "To assure you of our commitment to the ongoing response, we have determined that the PHE will likely remain in place for the entirety of 2021, and when a decision is made to terminate the declaration or let it expire, HHS will provide states with 60 days' notice prior to termination" (August 14, 2022)
- CURRENT GUIDANCE 8/13/21: states have up to 12 months from end of PHE to roll off MOE population

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SCENARIO 1: 1/11/2023 EXTENSION - PHE UNWINDING PLAN

Calendar Year	07/22	08/22	09/22	10/22	11/22	12/22	01/23	02/23	03/23	04/23	05/23	06/23	07/23	8/23	9/23	10/23	11/23	12/23	01/24
State Fiscal Year	*FY 2023*												*FY 2024*						
PHE Declaration	7/16 renewed			10/13 renewed			1/11 expires												
CMS Notice Commitment		8/16 Notice of term? NO NOTICE																	
6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	0%	0%	**6.2% through 6/31**	0%	0%	0%	0%	0 %	0%	0%	0%	0%	0%
Unwinding						1	2	3	4	5	6	7	8	9	10	11	12	13	14
Redetermination timing						12/15 Redetermination letters sent		**First Terminations effective 2/1**											
# ineligible Re-determinations								20K	20K	20K	20K								

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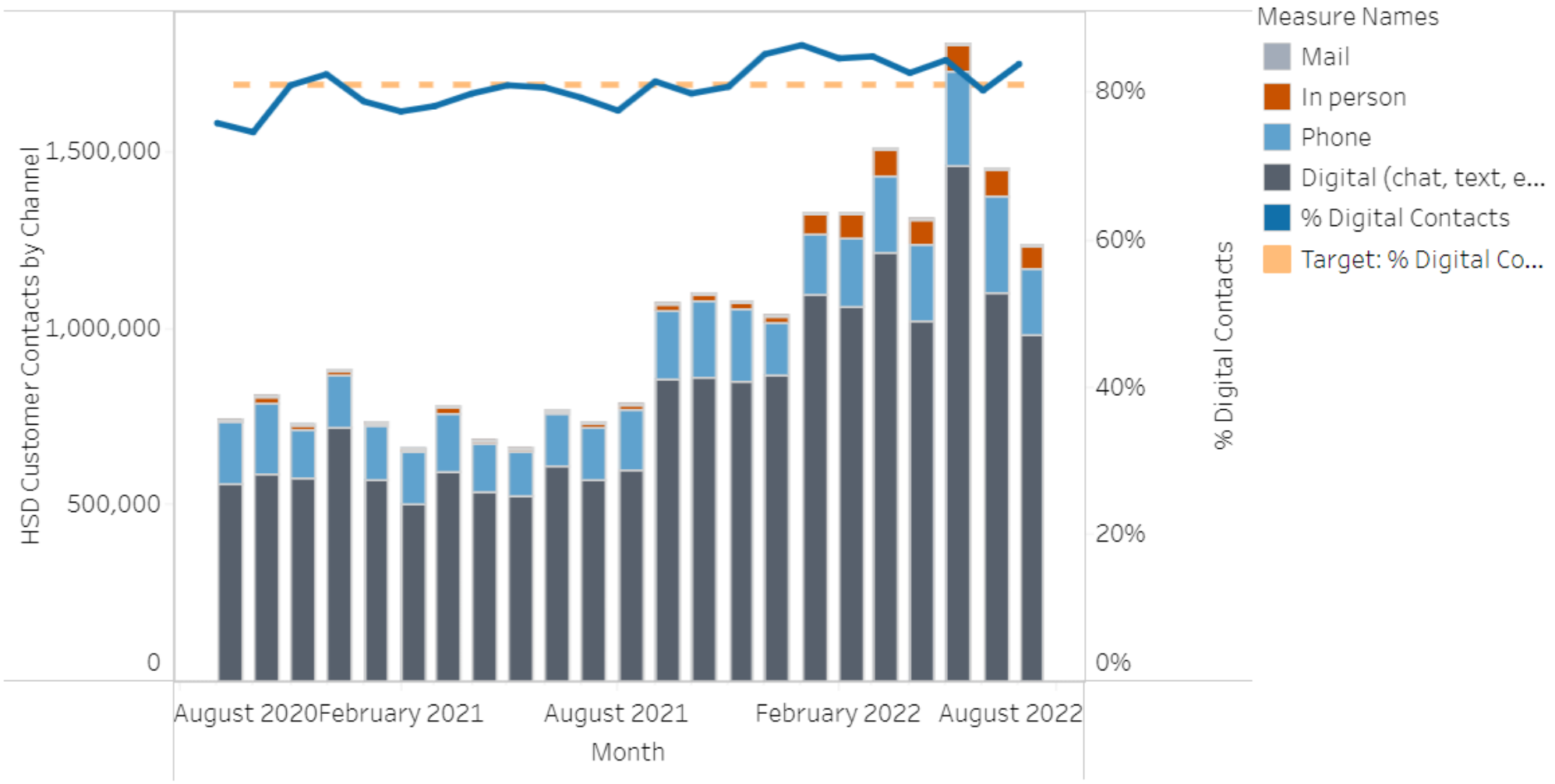
HSD PROGRAM OPERATIONS HAVE CHANGED

How often are people like me contacting HSD online, via the phone, and in person or by mail? (↑good)



Data updated: 8/10/2022

Source: https://sites.google.com/view/nmhsdscorecard/goal-2

IMPACT OF UNEMPLOYMENT RATE AND WORKFORCE PARTICIPATION ON MEDICAID ENROLLMENT

- Regression models show:
  - 2% *increase* in employment associated with a 1.11% *decrease* in Medicaid enrollment
  - Medicaid enrollment increased by 94,020 with a decrease in Labor Force Participation (58.6% 2/2020 to 56.7% 3/2022)

Factor	For Every…	Change in Medicaid Enrollment
Unemployment Rate	1% decrease	4,995 member decrease
Workforce Participation	1% decrease	49,484 member increase

MEDICAID MAINTENANCE OF EFFORT POPULATIONS

There are two ways Medicaid eligible individuals are being kept open during the PHE, which began in March of 2020:

- **Group 1:** Medicaid eligibility and benefit level sustained for those individuals who are known to be no longer eligible for Medicaid or who would be eligible for a lesser benefit category; and,
- **Group 2:** Extending renewal dates in 3 month increments for individuals who fail to complete the renewal process.

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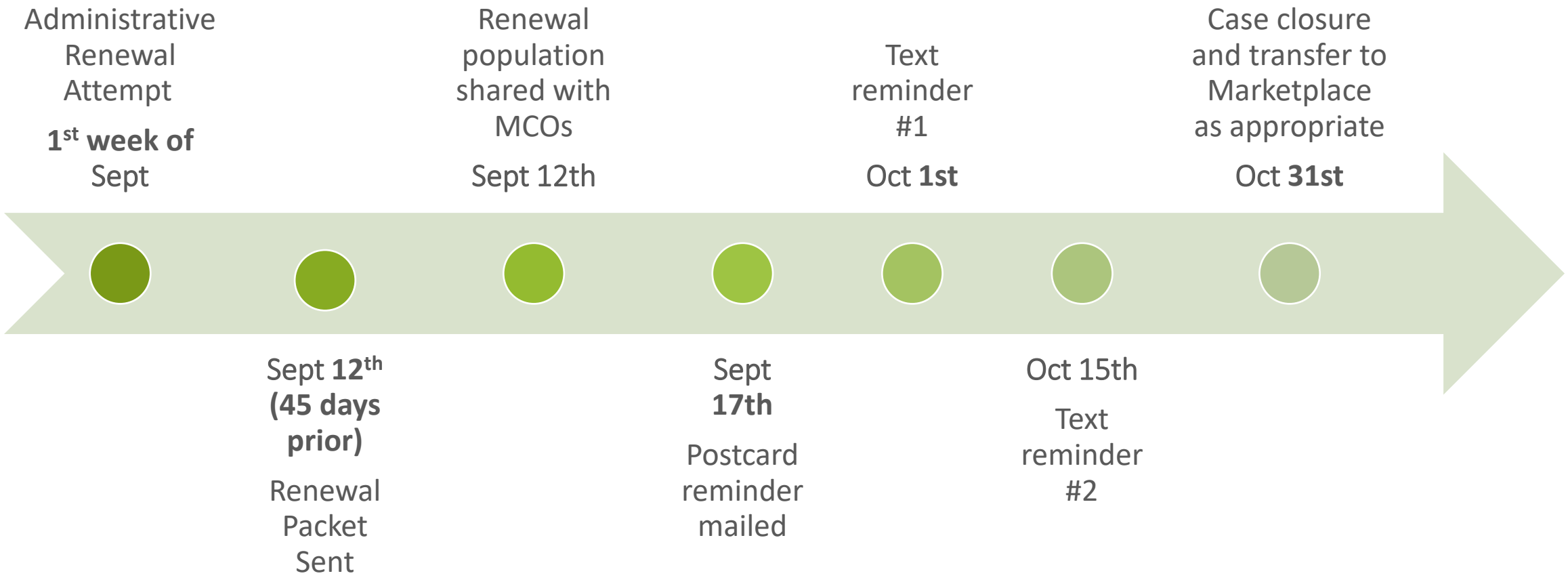
MEDICAID RECERTIFICATION PROCESS POST PHE



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RATE SETTING

- Minimum Wage
- HSD has increased provider reimbursement for PCS since the inception of the Centennial Care 2.0 Medicaid program in 2019.
  - Effective January 1, 2019, 1% increase
  - Effective July 1, 2019, $0.50 per hour increase
  - Effective January 1, 2020, minimum wage increase
  - Effective January 1, 2021, minimum wage increase
- PCS provider reimbursement increases were included within the MCO Managed Care capitation rates.
- Paid-time off
  - NM House Bill 20
  - Effective July 1, 2022
  - Reviewing available information to determine implications.

NEW MEXICO MINIMUM WAGE BY COUNTY

Hourly Minimum Wage	Bernalillo	Dona Ana	Santa Fe	All Other County	Statewide
2019	$9.05	$7.50	$11.80	$7.50	$8.03
2020	$9.20	$9.00	$12.10	$9.00	$9.18
2021	$10.50	$10.50	$12.32	$10.50	$10.58

Increase in Hourly Minimum Wage	Bernalillo	Dona Ana	Santa Fe	All Other County	Statewide
2019 to 2020	$0.15	$1.50	$0.30	$1.50	$1.14
2020 to 2021	$1.30	$1.50	$0.22	$1.50	$1.40

Notes:
1. Albuquerque minimum wage was $9.20 in 2019 and $9.35 in 2020. In 2021, Albuquerque and Bernalillo County are at the Statewide minimum wage of $10.50.
2. Las Cruces minimum wage was $10.10 in 2019 and $10.25 in 2020. In 2021, Las Cruces and Dona Ana County are at the Statewide minimum wage of $10.50.
3. Statewide is the weighted average minimum wage based on Centennial Care MCO utilization from MCO submitted encounter data incurred from January 2019 through June 2021, with data runout through June 2021 for Personal Care Service Procedure Codes 99509 and T1019.
4. Centennial Care populations included in the MCO Average Reimbursement are LTSS, excluding self-directed, and OAGPH.
5. County is based on the member county of residence and not the provider county.

CENTENNIAL CARE MCO AVERAGE REIMBURSEMENT BY COUNTY

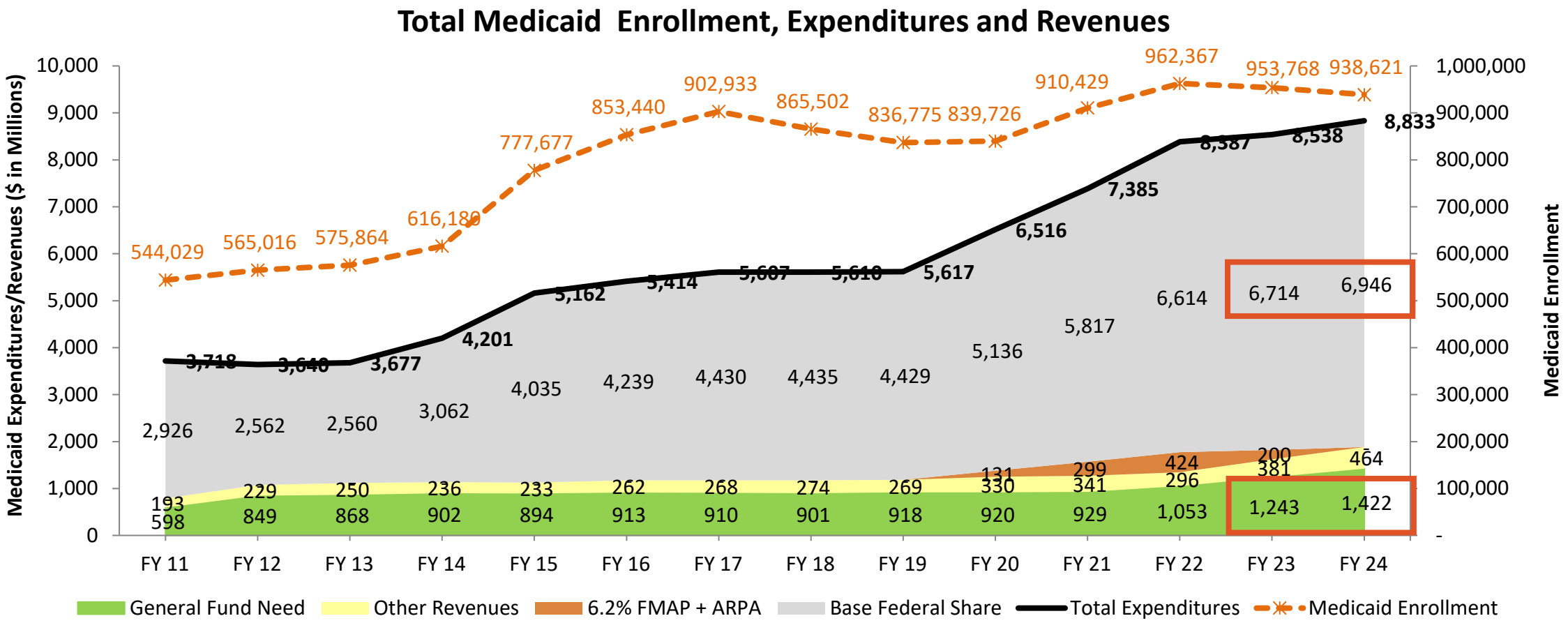
MCO Average Reimbursement	Bernalillo	Dona Ana	Santa Fe	Statewide
2019	$15.63	$15.62	$15.85	$15.54
2020	$16.59	$16.77	$17.00	$16.93
YTD June 2021	$17.46	$17.99	$17.89	$18.21

Increase in MCO Average Reimbursement	Bernalillo	Dona Ana	Santa Fe	Statewide
2019 to 2020	$0.96	$1.15	$1.15	$1.38
2020 to YTD June 2021	$0.86	$1.22	$0.89	$1.28

Notes:

1. Centennial Care MCO Average Reimbursement utilizes MCO submitted encounter data incurred from January 2019 through June 2021, with data runout through June 2021 for Personal Care Service Procedure Codes 99509 and T1019.
2. Centennial Care populations included in the MCO Average Reimbursement are LTSS, excluding self-directed, and OAGPH.
3. County is based on the member county of residence and not the provider county.

FEDERAL REVENUE SUPPORTING MEDICAID PROGRAM



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FY2024 MEDICAID EXPANSION REQUESTS

1115 Waiver Expansions	GF Source	FY2024 Total/ Half Year	FY2024 GF
Continuous Enrollment for Children Up to Age 6	HSD	$5,883,000	$1,587,822
Expanded HCBS CB Enrollment Opportunities through Additional Waiver Slots	HSD	$5,845,000	$1,577,566
Expanded Centennial Home Visiting Pilot Program	HSD	$414,000	$111,739
Expanded Access to Supportive Housing	HSD	$500,000	$134,950
Medicaid services for high-need justice-involved populations 30 days before release	HSD	$2,621,000	$707,408
Chiropractic Services Pilot	HSD	$1,440,000	$388,656
Member-Directed Traditional Healing Services for Native Americans	HSD	$5,062,500	$1,366,369
Waiver Investments in Small-Home Assisted Living and Nursing Facility Pilots	HSD	$0	$0
Medicaid reimbursement for room and board in Assisted Living Facility settings when cost-effective and clinically appropriate	HSD	$0	$0

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FY2024 MEDICAID EXPANSION REQUESTS

1115 Waiver Expansions	GF Source	FY2024 Total/ Half Year	FY2024 GF
Closed-Loop Referral Network	HSD	$2,850,000	$769,215
Environmental Modification Benefit Limit Increase	HSD (DOH – TBD)	$442,000	$119,296
Community-Based Transition Services Benefit Limit Increase	HSD	$61,500	$16,599
Meals for Enrollees Residing Independently (Home-Delivered Meals) for Pregnant Women w/ Gestational Diabetes (1 meal/day)	HSD	$2,232,924	$602,666
Meals for Enrollees Residing Independently (Home-Delivered Meals) Community Benefit	HSD	$4,283,640	$1,156,154
Rural Hospital Initiative (preliminary estimate)	HSD	$3,705,076	$1,000,000
Kevin S. EBP (as of 7/1/2023)	CYFD	$10,000,000	$2,700,000
Primary Care & Behavioral Health Provider & Clinician Performance Payments (as of 7/1/2023)	HSD	$3,705,076	$1,000,000
TOTALS		$49,045,716	$13,238,439
Operating Transfers from Other Agencies			$2,700,000

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BENEFIT OF 6.2% FMAP EXTENSION (ESTIMATED AND REPORTED)

ESTIMATED (State Fiscal Year)	SFY2020	SFY2021	SFY2022	SFY2023	TOTAL Benefit
Estimated additional Federal Funds from 6.2% FMAP (date of service)	130,593	264,467	296,935	146,723	838,718
CMS 64 REPORTED (Federal Fiscal Year)	**FFY2020**	**FFY2021**	**FFY2022**	**FFY2023**	**TOTAL Benefit**
CMS 64 Reported (As of 6/30/22) Federal Funds from 6.2% (date of payment)	206,116	291,544	252,293	TBD	749,953

* SFY Estimated with 6.2% FMAP through Q/E Dec 2022.
* CMS 64 Reported (As of 6/30/22) based on date of payment and includes all date of service years.

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ALL FMAP RATES

	FFY 2021	FFY 2021 6.2% increase	FFY 2022	FFY2022 6.2% increase	FFY2023	FFY2023 6.2% increase	FFY2024 Preliminary
FMAP	73.46%	**79.66%**	73.71%	**79.91%**	**73.26%**	**79.46%**	**72.92%**
E-FMAP	81.42%	**85.00%**	81.60%	**85.00%**	**81.28%**	**85.00%**	**81.04%**
CHIP E-FMAP	81.42%	**85.00%**	81.60%	**85.00%**	**81.28%**	**85.00%**	**81.04%**
Expansion FFP CY	90.00%	-	90.00%	**90.00%**	**90.00%**	**90.00%**	**90.00%**
HCBS FMAP + 10%		**89.66%**		**89.91%**	-		

- **CHIP E- FMAP**
  - 100% expired September 30, 2019.
  - Phase-out increased to states' E-FMAP by 11.5% through September 30, 2020.
  - E-FMAP reverted back on October 1, 2020.
- **Expansion FMAP -** is in effect by calendar year (CY) starting in 2014.
- **6.2% FMAP increase -** Families First Coronavirus Response Act (FFCRA) increased FMAP through the end of the quarter in which the public health emergency ends.
- COVID-19 testing and related services for uninsured are 100% FFP

COMPONENT CHANGE

FY2024 BUDGET REQUEST COMPARED TO FY2023 PROJECTION

FY2024 Budget Changes	Total Computable ($000s)	General Fund ($000s)	GF due to FMAP Impact ($000s)	GF w/o FMAP Impact ($000s)
Fee-For-Service	8,642	11,358	10,433	925
DD, MF & SW (Traditional and Mi Via Waivers)	125,078	50,875	-	50,875
Centennial Care MCO	93,279	173,082	151,345	21,737
Medicare	18,458	18,164	6,123	12,041
Other – Expansion Items	49,046	13,240	-	13,240
Total Changes in Expenditures	**294,502**	**166,719**	**167,901**	**98,818**
Total Changes in Revenues		**88,321**		
Total Changes from FY23 (Exp-Rev)	**294,502**	**178,397**		
FY2024 Projected General Fund Need	**8,832,608**	**1,421,636**		

*The General Fund need for DD, MF & SW (Traditional and Mi Via Waivers) is provided by DOH.

* The current quarterly budget projection is updated with data through June 30, 2022.

MEDICAID ENROLLMENT CHANGE RELATIVE TO FEB. 2020

	Projected Medicaid/CHIP Members	Difference from Feb. 2020	Projected Roll-off Start Date	Projected Roll-off End Date	
Feb 2020 Enrollment	***830,165***				1/27/20 1st PHE Declaration
6/1/2020 Enrollment	*866,398*	36,233			
6/1/2021 Enrollment	936,502	106,337			
6/1/2022 Enrollment	976,892	146,727			
Oct 2022 Peak Enrollment	**990,528**	**160,363**	**11/1/2022**	**2/28/2023**	7/15/22 10th PHE extension

- **A 1% increase in labor force employment levels will decrease Medicaid enrollment by 0.5%**

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Source: https://sites.google.com/view/nmhsdscorecard/goal-1/access-to-care-medicaid-and-snap

MEDICAID ENROLLMENT CHANGES AND MOE INCOME-INELIGIBLES

	Reporting Data	Projection Data	Difference	Why?
June 2022 Enrollment	976,892 (Current MER, with Retro Adj)			
October 2022 Enrollment (Peak)		990,528 (current projection)	+13,636 (from June)	Additional growth under MOE policy
Income Ineligible MOE population	97,725 (Deloitte, 6/15/2022)	85,509 (projected roll-off, Nov-Feb)	-12,216 (projected – reported)	COE transitions among MAGI and Family Planning resulting from redeterminations
February 2023 Enrollment (after roll-off)		919,433	919,433 - 990,528 (- 71,095 from Oct.)	MOE redeterminations, COE transitions and growth adjustments Oct to Feb

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MEDICAID PROGRAM BUDGET UPDATE

Budget Projection–($000s)	FY2020	FY2021	FY2022	FY2023
Total Expenditures Projection (6/31/22)	6,516,046	7,385,187	8,387,453	8,538,106
General Fund Need	920,224	928,642	1,053,061	1,243,238
Original GF Appropriation	985,697	1,076,462	1,015,385	1,265,902
GF Reduction & sweeps		(124,294)	(25,600)	(80,000)
Other GF Temporary Increases	34,000		28,000	
Revised Appropriation	1,019,697	952,168	1,017,785	1,185,902
State Revenue Surplus/(Shortfall) (Surplus is reverted to GF)	99,474	23,526	(9,677)	(57,336)
Estimated additional Federal Funds from 6.2% FMAP (date of service) – reduced GF need	*130,593*	*264,467*	*296,935*	*146,723*
General Fund Need prior to 6.2%	*1,050,817*	*1,193,109*	*1,349,996*	*1,389,961*

*The current quarterly budget projection is updated with data through June 30, 2022. Assumes PHE ends 10/13/2022 & 6.2% ends 12/31/2022. FY2020 and FY2023 include 2 quarters of 6.2% FMAP. FY2021 and FY2022 includes 4 quarters of 6.2% FMAP.

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