



New Mexico Health & Human Services System Market Profile: 2024



Health & Human Services System Market Profile Overview

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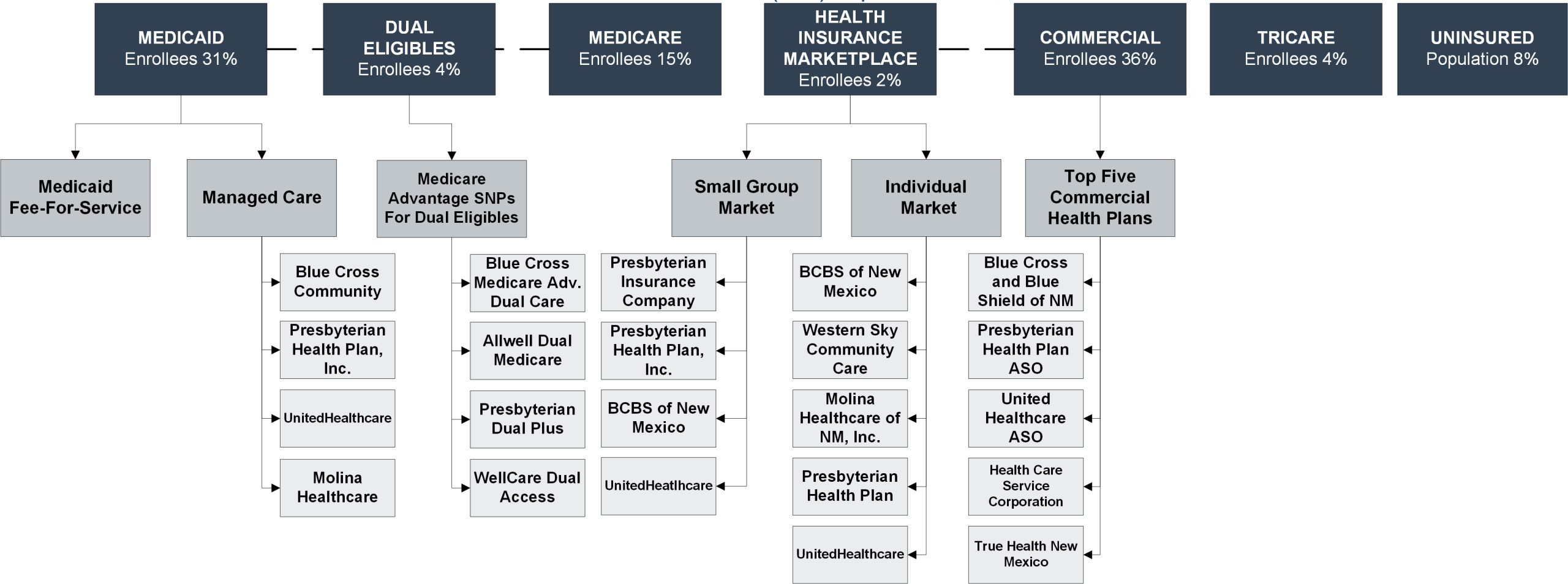
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A. Executive Summary

A.1. New Mexico Physical Health Care Coverage by Payer

Total New Mexico Population- 2,113,344

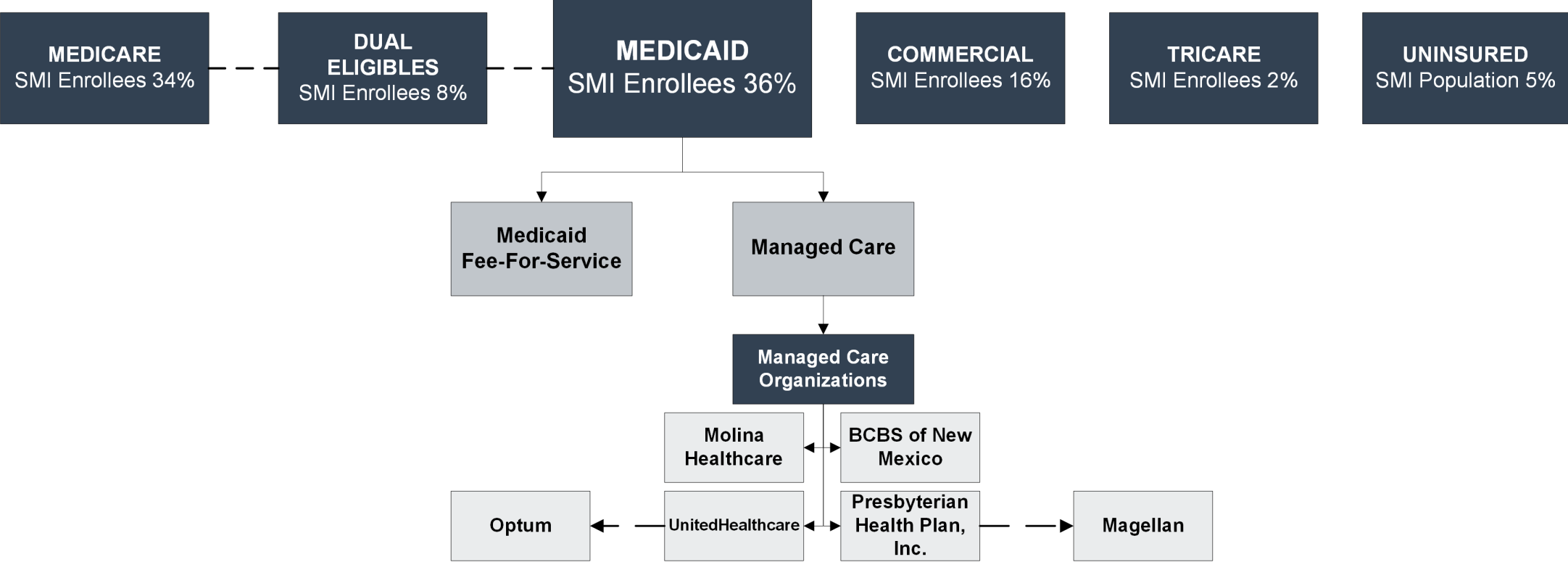
Estimated Serious Mental Illness (SMI) Population- 169,068



“Enrollees” refers to the percentage of the state’s total population enrolled with each payer.

Totals may not equal 100% due to rounding

A.1. New Mexico Behavioral Health Care Coverage by Payer



- “Enrollees” refers to the percentage of the state’s total SMI population enrolled with each payer
- — — ➔ Denotes a behavioral health subcontractor

Totals may not equal 100% due to rounding

A.2. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	The health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home	✓	The state's health home program called CareLink serves individuals with SMI and children with SED.
Patient-Centered Medical Home (PCMH)	✓	The state incentivizes PCMHs through the health plan contracts.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	Most long-term services and supports are included in the health plan's capitation rate.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	New Mexico has three planning and implementation grants for CCBHCs.

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Office of Primary Care and Rural Health within the New Mexico Department of Health provides safety-net funding for physical health services.

Mental Health Services

- The New Mexico Health Care Authority, Behavioral Health Services Division (BHSD) is the agency responsible for safety-net funding for mental health. BHSD funds are coordinated with those of other state agencies through the Behavioral Health Collaborative (BHC) to deliver services to the uninsured population. The BHC contracts with Falling Colors as the administrative services organization for non-Medicaid behavioral health services.

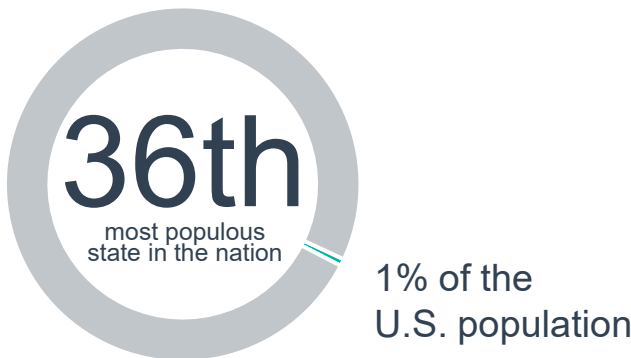
Addiction Treatment Services

- The New Mexico Health Care Authority, BHSD is the agency responsible for safety-net funding for addiction treatment services. BHSD funds are coordinated with those of other state agencies through the BHC to deliver services to the uninsured population. The BHC contracts with Falling Colors as the administrative services organization for non-Medicaid behavioral health services.

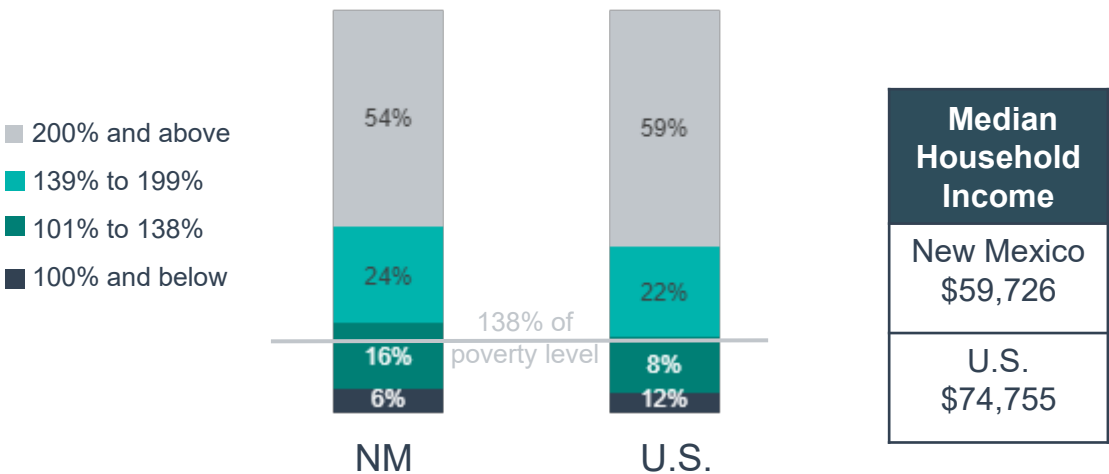
B. New Mexico Health Financing System Overview

B.1. Population Demographics

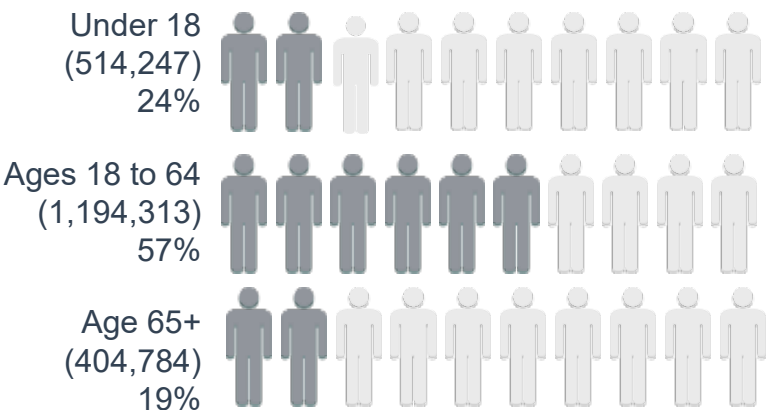
Total New Mexico Population- 2,113,344
Estimated SMI Population- 169,068



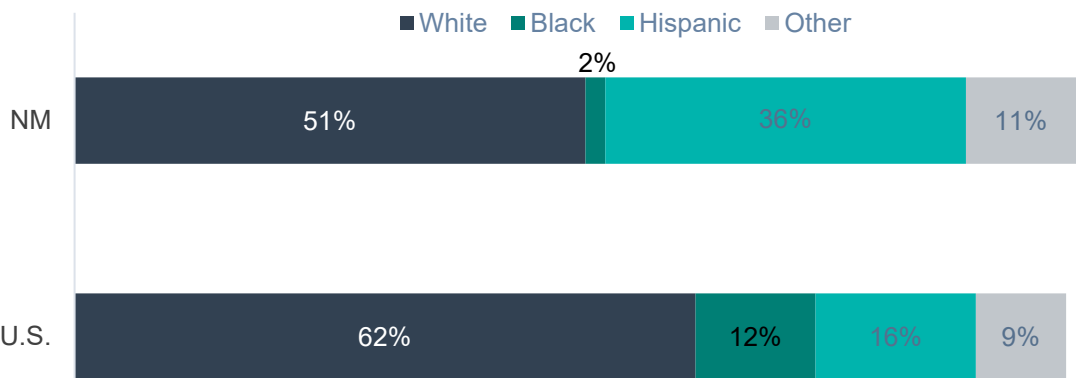
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age



New Mexico & U.S. Racial Composition



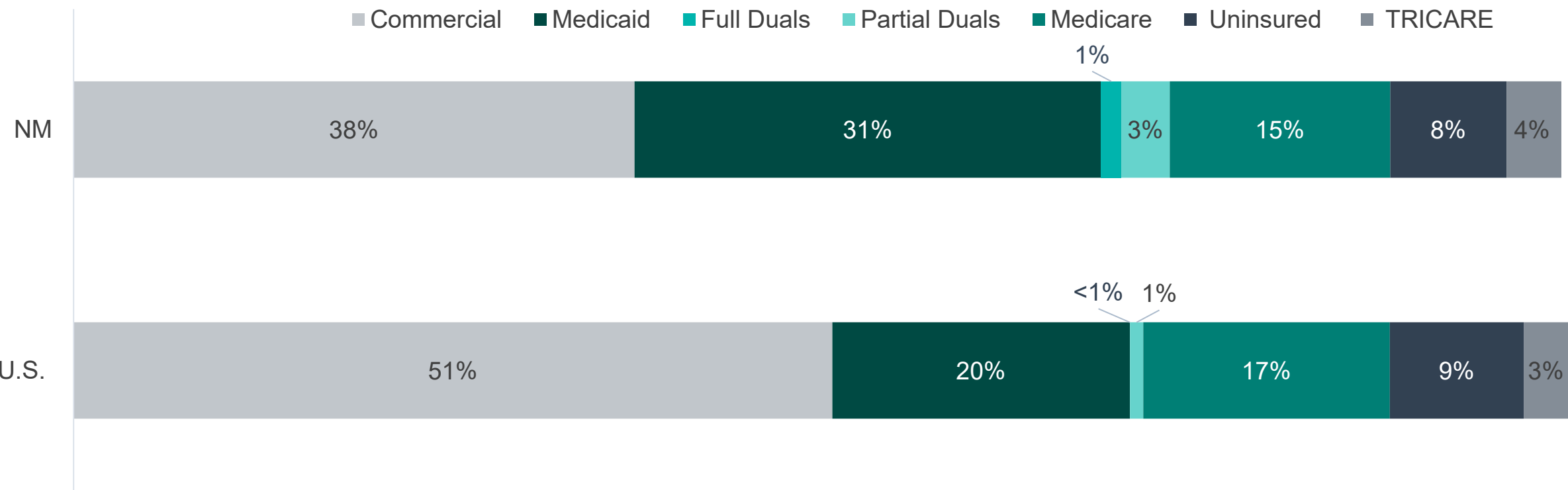
Totals may not equal 100% due to rounding

B.2. Population Centers

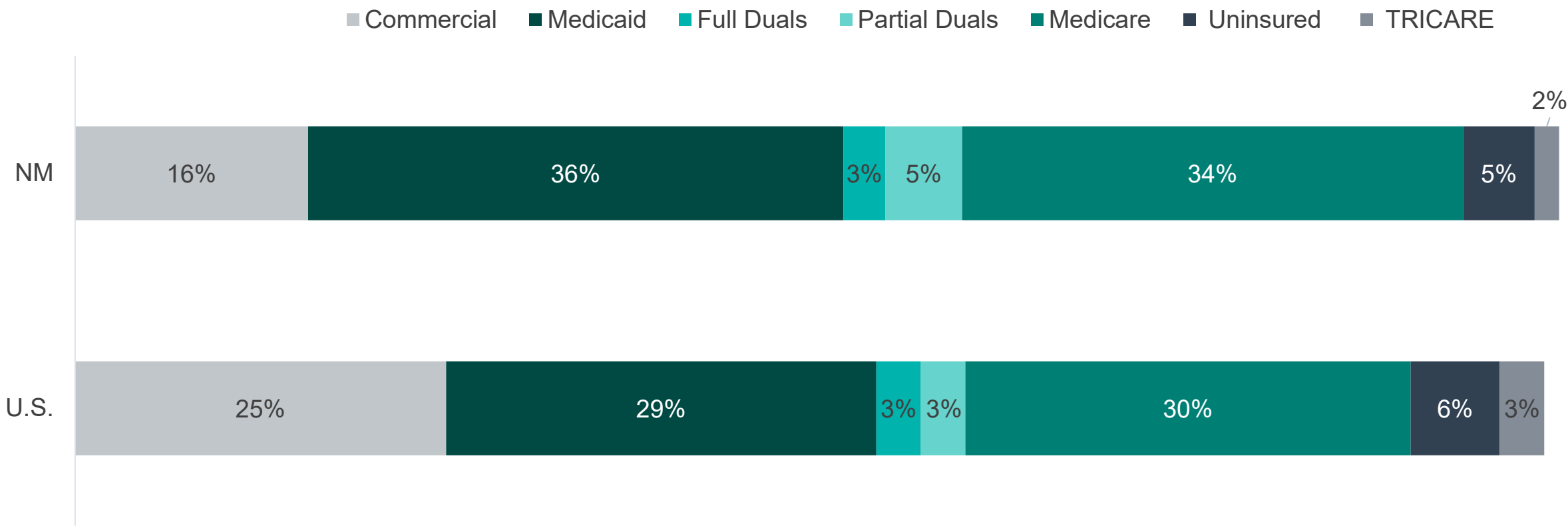
Metropolitan Statistical Areas (MSAs)		
MSA	MSA Residents	Percent Of Population
Total MSA Population	1,424,137	67%
Albuquerque, NM	922,296	44%
Las Cruces, NM	225,210	11%
Santa Fe, NM	155,956	7%
Farmington, NM	120,675	6%



B.3. Population Distribution By Payer: National vs. State



B.3. SMI Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding

B.4. Largest New Mexico Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
Presbyterian Health Plan	Medicaid managed care	373,830
Blue Cross and Blue Shield of New Mexico	Commercial	279,124
Health Care Service Corporation	Commercial	275,561
Blue Cross Community	Medicaid managed care	272,287
Medicare fee-for-service (FFS)	Medicare	232,244
Medicaid FFS	Medicaid	163,779
UnitedHealthcare ASO	Commercial administrative services only (ASO)	92,975
Presbyterian Health Plan	Commercial	92,686
TRICARE	Other public	83,908
Presbyterian Senior Care	Medicare Advantage	58,194

*Medicaid enrollment as of July 2024; TRICARE as of December 2023; Commercial as of March 2023; Medicare enrollment as of June 2023.

B.4. Largest New Mexico Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicare FFS	Medicare	232,244	52,719
Presbyterian Health Plan	Medicaid managed care	373,830	43,364
Blue Cross Community	Medicaid managed care	272,287	31,585
Medicaid FFS	Medicaid	163,779	18,998
Presbyterian Senior Care	Medicare Advantage	58,194	13,210
Health Care Service Corporation	Commercial	275,561	11,574
Care Improvement Plus South Central Insurance Co.	Medicare Advantage	42,926	9,744
HumanaChoice	Medicare Advantage	38,958	8,843
Health Care Service Corporation	Medicare Advantage	22,329	5,069
UnitedHealthcare Community Plan	Medicaid managed care	41,388	4,801

*Medicaid enrollment as of July 2024; TRICARE as of December 2023; Commercial as of March 2023; Medicare enrollment as of June 2023.

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Plan Marketplace Percentage	2%
Type of Marketplace	State-based
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	http://www.bewellnm.com/small-business-health-insurance
	1-800-204-4700

2024 Individual Market Health Plans
1. Blue Cross Blue Shield of New Mexico 2. Molina Healthcare of New Mexico, Inc. 3. Western Sky Community Care 4. Presbyterian Health Plan 5. UnitedHealthcare
2024 Small Group Market Health Plans
1. Presbyterian Health Plan, Inc. 2. Presbyterian Insurance Company 3. Blue Cross Blue Shield of New Mexico 4. UnitedHealthcare

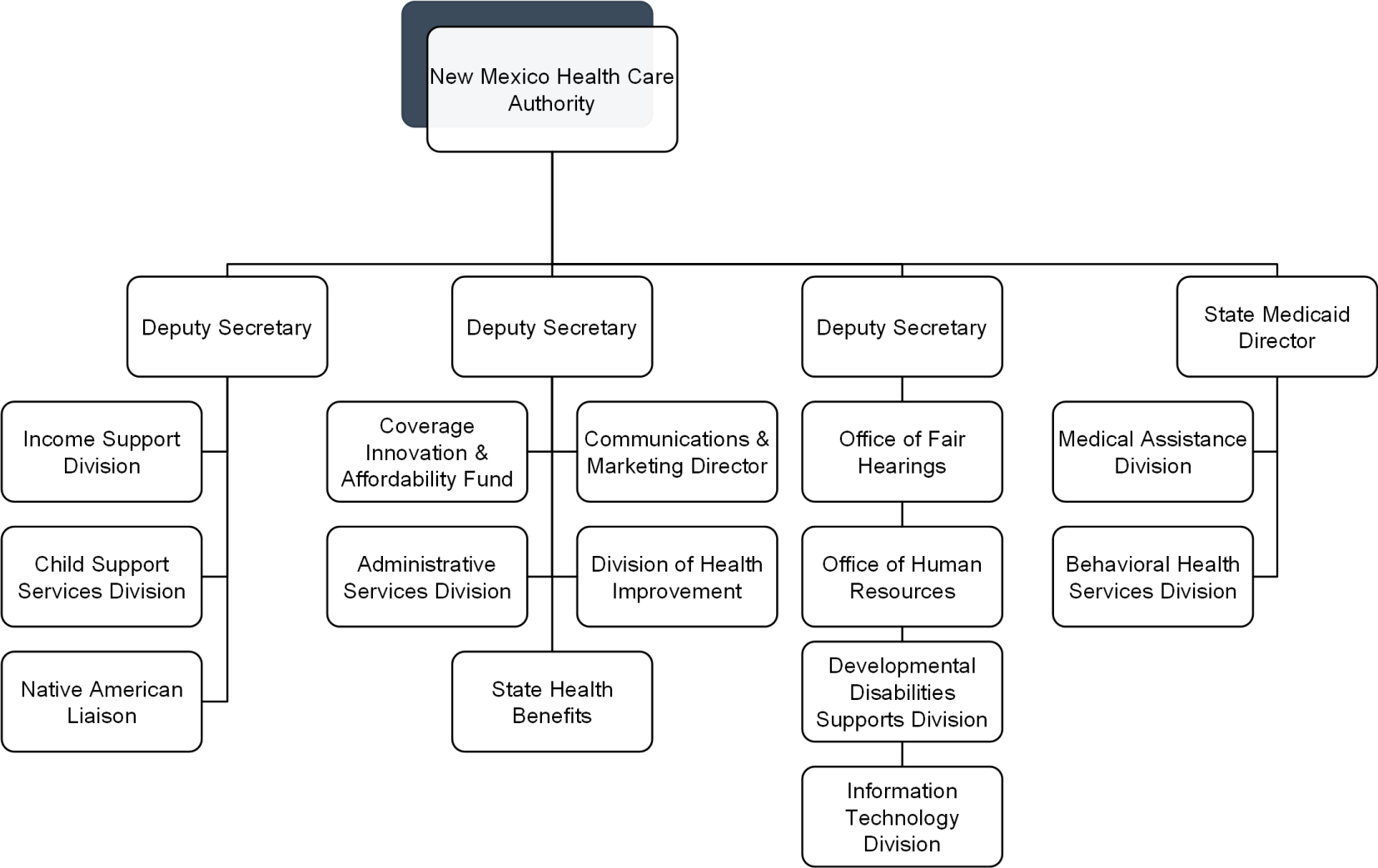
B.6. Accountable Care Organizations (ACOs)

Medicare Shared Savings Model ACOs	
1.	Caravan Collaborative Pathways
2.	Wellvana Essential Care LLC
3.	Collaborative ACO 30, LLC
4.	Main Street Rural Health Cottonwood ACO LLC
5.	Aledade Western Sky MSSP Enhanced
6.	IntraCare Premier ACO
7.	Gather Health
8.	Sound Physicians Long Term Care Management, LLC
9.	National MSSP 2019
10.	Emergent ACO 24.1, LLC
11.	CHRISTUS Health Quality Care Alliance
12.	CHSPSC ACO 17, LLC
13.	Texas Panhandle Clinical Partners ACO LLC
14.	Accountable Care Coalition of Quality Health II, LLC
15.	Covenant ACO, Inc

Commercial	
ACO	Commercial Insurer
Presbyterian Healthcare Services	UnitedHealthcare

C. Medicaid Administration, Governance & Operations

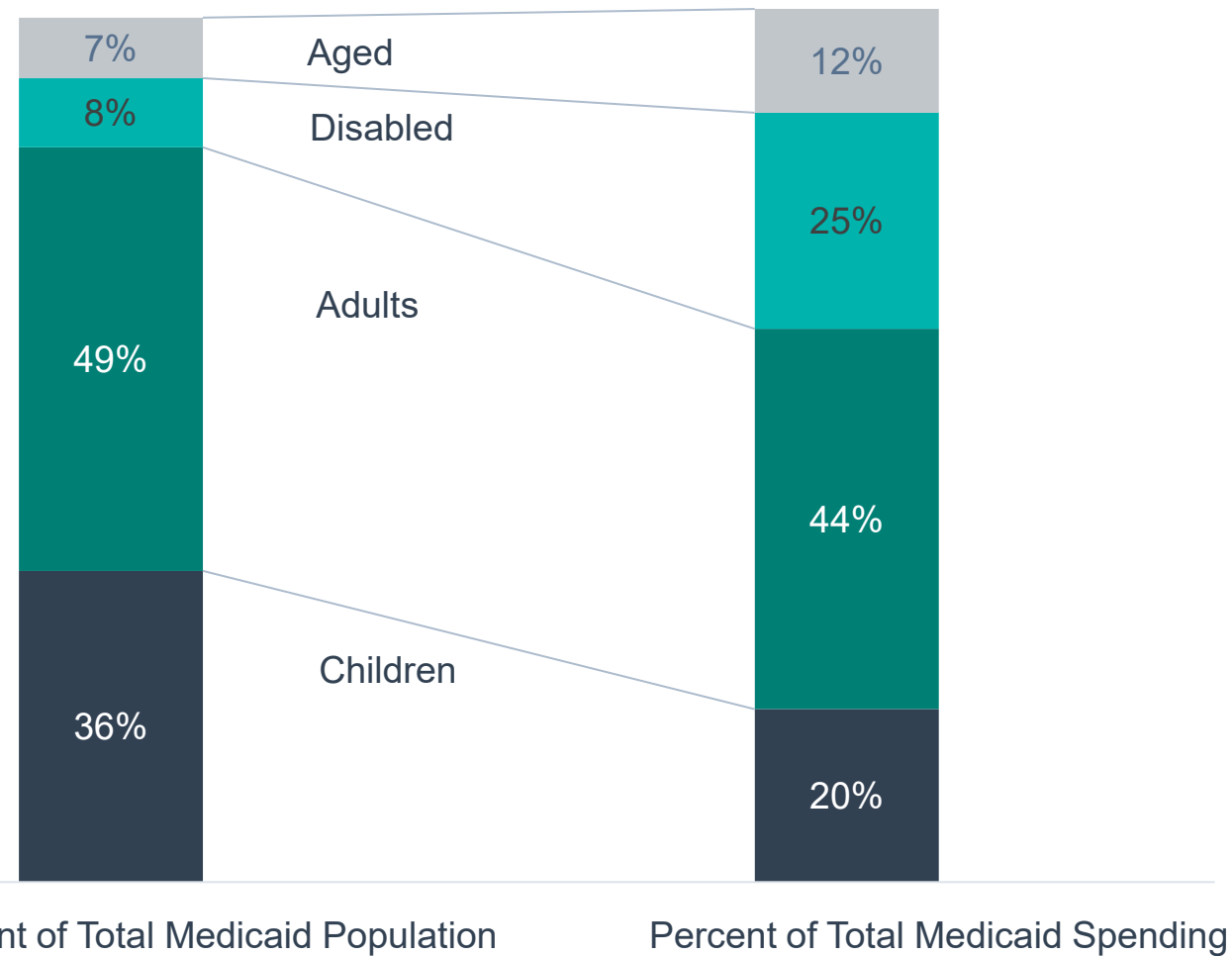
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Kari Armijo	Cabinet Secretary	New Mexico Health Care Authority	kari.armijo@hca.nm.gov
Alex Castillo Smith	Deputy Secretary	NM HCA	alex.castillosmith@hca.nm.gov
Kyra Ochoa	Deputy Secretary	NM HCA	Not available
Kathy Slater-Huff	Deputy Secretary	NM HCA	katherine.slater-huff@hsd.nm.gov
Dana Flannery	Division Director, State Medicaid Director	NM HCA, Medical Assistance Division	dana.flannery@hsd.nm.gov

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2021		
	U.S.	NM
All populations	\$8,651	\$7,716
Children	\$3,584	\$4,284
Adults	\$5,462	\$5,968
Expansion adults	\$7,486	\$7,301
Blind and disabled	\$23,935	\$23,305
Aged	\$18,514	\$13,246

Based on FY 2021 data

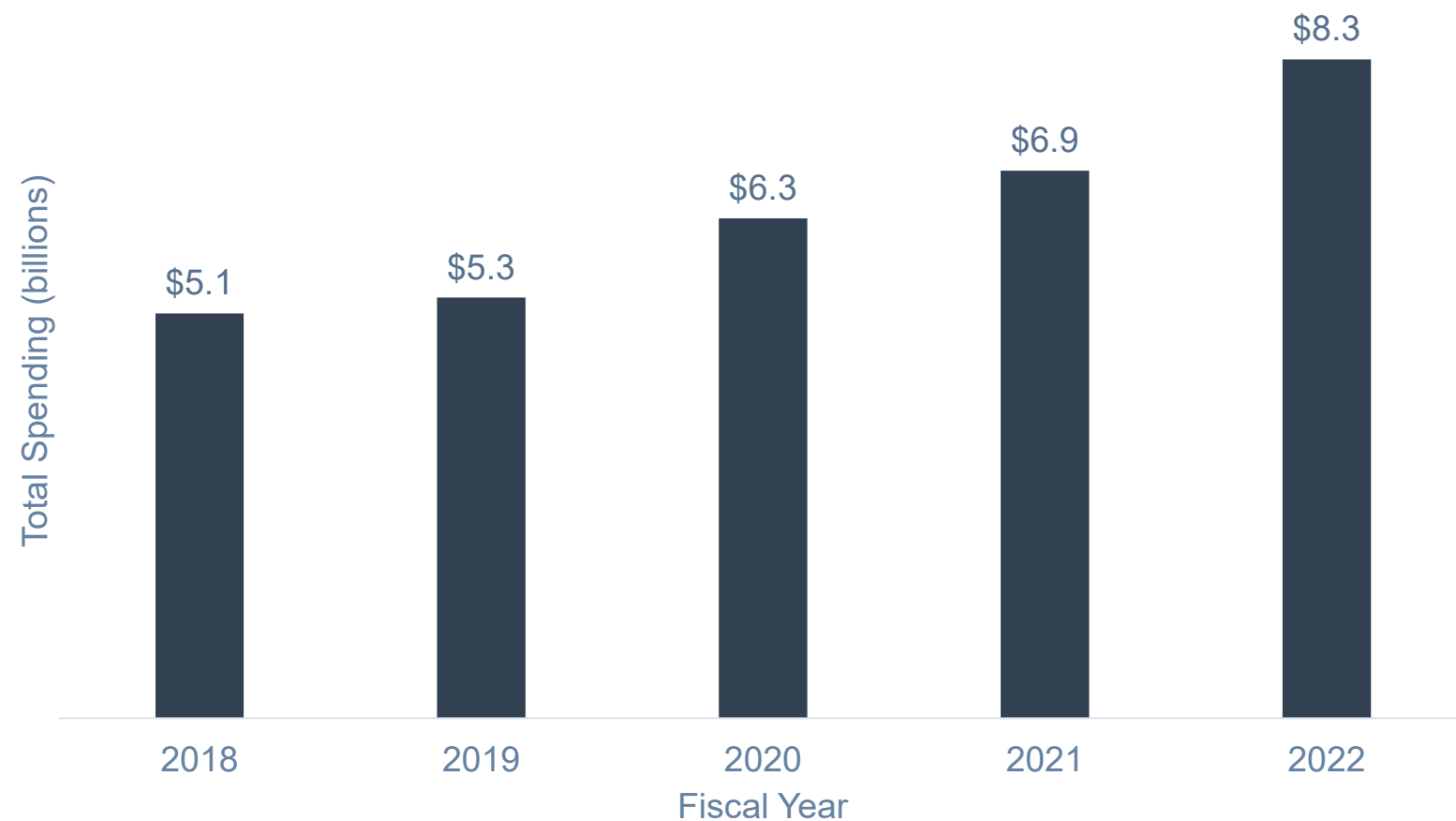
Totals may not equal 100% due to rounding.

C.2. Medicaid Program Spending: Budget

Budget Item	SFY22 Spending	Percent Of Budget
Managed care and premium assistance	\$6,606,000,000	80%
Home- and community-based LTSS	\$706,000,000	9%
Hospital	\$503,000,000	6%
Medicare premiums and coinsurance	\$209,000,000	3%
Other acute	\$120,000,000	1%
Other practitioner	\$51,000,000	1%
Institutional LTSS	\$40,000,000	<1%
Physician	\$22,000,000	<1%
Dental	\$8,000,000	<1%
Clinic and health center	\$6,000,000	<1%
Drugs	\$2,000,000	<1%
Budget Total: \$8,273,000,000		

Federal & County Financial Participation	
FY 2024 Federal Medical Assistance Percentage (FMAP)	72.6%
CY 2024 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	No

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of the Federal Poverty Level (FPL) Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded when determining eligibility
Legislation Used To Expand Medicaid	General Appropriation Act of 2013
Number Of Individuals Enrolled In The Expansion Group (September 2023)	268,125
Number Of Enrollees Newly Eligible Due To Expansion	268,125
Benefits Plan For Expansion Population	• The state uses an alternative benefit plan that is more restrictive than the state plan option. • Medically frail individuals must be offered the full array of state plan services. • Individuals with SMI or chronic addiction are considered to be medically frail.

C.4. Medicaid Program Benefits

Federally Mandated Services

- 1. Inpatient hospital services other than services in an institution for mental disease (IMD)
- 2. Outpatient hospital services
- 3. Rural Health Clinic services
- 4. Federally Qualified Health Center (FQHC) services
- 5. Laboratory and x-ray services
- 6. Nursing facilities for individuals 21 and over
- 7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
- 8. Family planning services and supplies
- 9. Free standing birth centers
- 10. Pregnancy-related and postpartum services
- 11. Nurse midwife services
- 12. Tobacco cessation programs for pregnant women
- 13. Physician services
- 14. Medical and surgical services of a dentist
- 15. Home health services
- 16. Nurse practitioner services
- 17. Non-emergency transportation to medical care

New Mexico's Optional Services

- 1. Podiatry services
- 2. Optometry services
- 3. Physical and occupational therapy
- 4. Services for individuals with speech, language, and hearing disorders
- 5. Clinic services
- 6. Prescribed drugs
- 7. Dentures, eyeglasses, and prosthetic devices
- 8. Rehabilitative services
- 9. Services for individuals 65 and older in an IMD
- 10. Services in an intermediate care facility for individuals with I/DD
- 11. Case management
- 12. Nursing facility services for individuals under age 21

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (July 2024)	163,779	729,394
SMI Enrollment	• New Mexico does not specifically preclude individuals with SMI from enrolling in managed care; therefore, the majority of the SMI population is enrolled in managed care. • Estimated 18% of population in FFS, 82% in managed care	
Management	Department of Human Services	Four health plans
Payment Model	Fee-for-service	Capitated rate
Geographic Service Area	Statewide	Statewide

Total Medicaid: 893,173 | Total Medicaid With SMI: 103,608

D1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment		
Total Medicaid population distribution	As of July 2024: 18% in fee-for-service (FFS), 82% in managed care	
SMI population inclusion in managed care	• New Mexico does not specifically preclude individuals with SMI from enrolling in managed care; therefore, the majority of the SMI population is enrolled in managed care. • Estimated 18% of population in FFS, 82% in managed care	
Dual eligible population inclusion in managed care	• Managed care is mandatory for full benefit dual eligibles. • Estimated 100% of population in managed care	
Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	Included in the health plan’s capitation rate
Specialty behavioral health	Covered FFS by the state	Included in the health plan’s capitation rate
Pharmaceuticals	Covered FFS by the state	Included in the health plan’s capitation rate
Long-term services and supports (LTSS)	Covered FFS by the state	Included in the health plan’s capitation rate except for the NM Developmental Disabilities Waiver Program, NM Mi Via-ICF/MR waiver, and NM Medically Fragile waiver.

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	X (Partial benefit)		X (Full benefit)
Medicaid expansion			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD	X		
Individuals in foster care			X
Other populations	• Family planning service only participants • Non-citizens eligible for emergency assistance only	• Individual in the Breast and Cervical Cancer program • HCBS waivers outside of the demonstration	• Former foster care youth • Refugees • Transitional Medical Assistance • Qualified working disabled individuals

D.2. Medicaid FFS Program: Overview

- As of July 2024, FFS enrollment was 163,779.
- Comagine Health, formerly known as Qualis Health, provides utilization review and prior authorization for the FFS program, including for behavioral health services.

D.2. Medicaid FFS Program: Behavioral Health Benefits

FFS Mental Health Benefits	
1.	Inpatient services
2.	Assessment and evaluation
3.	Treatment assessment
4.	Psychosocial rehabilitation
5.	Assertive community treatment (ACT)
6.	Comprehensive community support services
7.	Multi-systemic therapy
8.	Intensive outpatient services
9.	Medication administration
10.	Crisis intervention
11.	Day treatment
12.	Individual, group, and family therapy
13.	Partial hospitalization
14.	Residential treatment for under age 21
15.	Crisis triage center
16.	Pharmacological Management
17.	Applied Behavioral Analysis for Autistic individuals
18.	Multi Symptomatic Therapy

FFS Addiction Treatment Benefits	
1.	Medication assisted treatment
2.	Outpatient services
3.	Intensive outpatient services
4.	Medical detoxification
5.	Crisis services
6.	Partial hospitalization
7.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)
8.	Peer support and family support services
9.	Withdrawal management services
10.	Accredited residential treatment center services

D.2. Medicaid FFS Program: SMI Population

- New Mexico does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.
- As of July 2024, *OPEN MINDS* estimates that 18% of the SMI population was enrolled in FFS.

D.2. Medicaid FFS Program: Pharmacy Benefit

New Mexico FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	No
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the preferred drug list is called the New Mexico Master Drug Program list.
State Uses A PDL For Mental Health Drugs	Yes, mental health drugs are included on the pharmacy PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, addiction treatment drugs are included on the pharmacy PDL.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	Mental health and addiction treatment drugs may be subject to quantity limits, prior authorization, step therapy, and age restrictions.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Individual suspected of prescription drug misuse may be enrolled in the pharmacy's lock-in program. An individual's time in the lock-in program is determined on a case-by-case basis. Therefore, there are no set rules for how long a member may be subject to a lock-in program.

D.3. Medicaid Managed Care Program: Overview

- As of July 2024, managed care enrollment was 729,394.
- The Medicaid managed care program is called Turquoise Care.
- New managed care contracts with BlueCross BlueShield, Presbyterian Health Plan, UnitedHealthcare, and Molina Health Plan started July 1, 2024.
- The managed care contracts include a quality withhold of 1.5% to be returned if the following delivery system improvements are met:
 - Serve at least 3% of members through community health workers
 - Move 10% to 15% of physical and behavioral health visits in rural, frontier, and medically underserved urban areas to telehealth
 - Increase PCMH participants by 5%
 - Move provider organization payments to value-based reimbursement (VBR)
 - Treat at least 90% of the target number of individuals receiving Hepatitis C drug treatments

D.3. Medicaid Managed Care Program: Health Plan Characteristics

Blue Cross Blue Shield of New Mexico

1. Profit status: For-profit
2. Parent company: Health Care Services Corporation (Mutual Company)
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Prime Therapeutics
5. Enrollment share: 37%

UnitedHealthcare Community Plan

1. Profit status: For-profit
2. Parent company: UnitedHealthcare
3. Behavioral health subcontractor: Optum
4. Pharmacy benefits manager: OptumRx
5. Enrollment share: 6%

Presbyterian Health Plan

1. Profit status: Non-profit
2. Parent company: Presbyterian Healthcare Services
3. Behavioral health subcontractor: Magellan Healthcare
4. Pharmacy benefits manager: Capital Rx
5. Enrollment share: 51%

Molina Healthcare

1. Profit status: For-profit
2. Parent company: None
3. Behavioral health subcontractor: None
4. Pharmacy benefits managers: CVS Pharmacy
5. Enrollment share: 6%

D.3. Medicaid Managed Care Program: VBR Requirements

- New Mexico breaks VBR payment requirements into three categories, which represent levels of increasing risk.
 - Health plans must meet the minimum in each category, which add up the aggregate requirements.
 - Health plans may shift a larger percentage of payments into the higher levels in lieu of meeting the lower-level requirements.
- Each year, the health plans must show that small physical health provider organizations, behavioral health organizations, and long-term care organizations are participating in VBR initiatives.

Level	Definition	2025	2026	2027
1	Fee schedule based with bonus/incentive payments and/or withhold payable when outcome/quality scores are met	8%	10%	11%
2	Fee schedule based, upside-only shared savings—available when outcome/quality measures are met	11%	13%	14%
3	Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk	5%	7%	8%
Total		24%	30%	33%

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

- Behavioral health and pharmacy benefits are included in the health plan’s capitation rate.
- Adult residential treatment, medically supervised withdrawal management, and medication assisted treatment may be provided in institutions of mental disease (IMDs).

Managed Care Mental Health Benefits	
1.	Inpatient services
2.	Assessment and evaluation
3.	Treatment assessment
4.	Psychosocial rehabilitation
5.	Assertive community treatment (ACT)
6.	Comprehensive community support services
7.	Multi-systemic therapy
8.	Intensive outpatient services
9.	Medication administration
10.	Crisis intervention
11.	Day treatment
12.	Individual, group, and family therapy
13.	Partial hospitalization
14.	Residential treatment for individuals under age 21
15.	Crisis triage centers*

Managed Care Addiction Treatment Benefits	
1.	Admission and discharge assessment
2.	Outpatient services
3.	Intensive outpatient treatment
4.	Inpatient detoxification
5.	Medication assisted treatment
6.	Peer support and family support services
7.	Withdrawal management services
8.	Accredited residential treatment center services*
9.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)*
10.	Partial hospitalization for addiction treatment*

D.3. Medicaid Managed Care Program: SMI Population

- New Mexico does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.
- As of July 2024, *OPEN MINDS* estimates that 82% of the SMI population was enrolled in managed care.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

New Mexico Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	Health plans
Responsible For Financing Mental Health Pharmacy Benefit	Health plans
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	• Health plans are responsible for maintaining a formulary or preferred drug list for general pharmacy, addiction treatment drugs, and mental health drugs. • The health plans are required to establish an open formulary for all psychotropic drugs and medications. Medications, such as anxiolytics, are not included on the open formulary.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	The health plans may determine their own utilization controls including, but not limited to, step therapy and prior approval.
Health Plan Allowed To Implement Pharmacy Lock-In Program	The health plans are able to set their own pharmacy lock-in programs for members suspected of medication misuse.

D.4. Medicaid Program: Care Coordination Initiatives

			
Accountable Care Organization (ACO) Program None	Affordable Care Act Health Home The state's health home program for individuals with SMI is called NM Carelink.	Patient-Centered Medical Home (PCMH) The state requires that the health plans operate PCMHs.	Other Care Coordination Initiatives None

D.4. State Medicaid Health Home Characteristics

NM CareLink Characteristics	
Target Population	Individuals with SMI, SED, or SUD.
Enrollment Model	Passive enrollment with the ability to opt-out
Geographic Service Area	10 counties: Bernalillo, Curry, DeBaca, Grant, Hidalgo, Lea, Quay, Roosevelt, San Juan, and Sandoval
Care Delivery Model	• Use of the six core health home functions • Delivered by FQHCs, Core Service Agencies, Indian health centers, or certified mental health clinics • Other provider organizations may participate if they are licensed to provide community support services.
Payment Model	• The per member per month (PMPM) payment is specific to each health home based on staffing and administrative costs for the six health home core services. • For managed care beneficiaries, health home rates are included in the health plan’s capitation rate. The state pays the health home directly for FFS enrollees.
Practice Performance & Improvement	• Measures required by CMS: 30-day all-cause readmissions, emergency room visits, and skilled nursing facility admissions • Health homes will be required to report on additional quality measures developed by the state, including adult body mass index assessment, follow-up for hospitalization after mental illness, and controlling high blood pressure

D.4. State Patient-Centered Medical Home Characteristics

- The health plans are required to operate PCMH programs.
 - For new health plans, at least 10% of membership must be attributed to PCMHs in the first year. After the first year, health plans must increase their PCMH membership by 5% each year.
 - Health plans that do not meet these requirements lose a portion of their quality withhold.
- PCMHs are encouraged—but not required—to seek Joint Commission or National Committee for Quality Assurance (NCQA) accreditation as soon as possible.
 - The health plans are required to develop a series of initiatives to help PCMHs receive accreditation that include establishing a glide path; providing technical assistance and hands-on training; and standardizing all claims, prior authorizations, and administrative processes across health plans.
- PCMH models should incorporate the following:
 - Every member selects a primary care provider, and has improved access to care through flexible scheduling, telemedicine, or after hours and weekend availability;
 - Care is provided collectively by a physician-directed team dedicated to treating health care needs across the continuum;
 - Care coordination prioritizes individual's highest needs, addresses social determinants of health, and integrates public health services;
 - Use of quality and outcome measures to improve members' outcomes; and
 - Promotion of health information technology.

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
New Mexico Turquoise Care (formerly Centennial Care 2.0)	Authorizes the state's managed care program, which provides physical health, behavioral health, and long-term services and supports. The waiver also authorizes the state's addiction treatment disorder, which allows coverage of addiction treatment services in IMDs.	1115	None	01/01/2019	12/31/2029

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2024 Enrollment Cap	Operating Unit	Concurrent Management Authority
NM Developmental Disabilities Waiver Program (0173.R07.00)	Individuals with autism or I/DD of any age	4,795	Department of Health/Developmental Disabilities Supports Division (DOH/DDSD)	No
NM Supports Waiver (1726.R00.00)	Individuals who are on the I/DD waiting list.	5,000	DOH/DDSD	Yes, the NM Human Services Division
NM Mi Via-ICF/IDD Waiver (0448.R03.00)	Individuals who are medically fragile of any age, and individuals with autism or I/DD of any age	3,158	DOH/DDSD	No
NM Medically Fragile Waiver (0223.R06.00)	Individuals who are medically fragile of any age	210	DOH/DDSD	No

D.6. Medicaid Program: New Initiatives- Innovative Health Care Program Funding

- The New Mexico Health Care Authority (HCA) announced in July 2024 that the state has received federal approval for new Medicaid programs aimed at addressing individual health-related social needs.
- With a focus on expanding coverage to address health-related social needs and subject to legislative funding, New Mexico will be able to offer services that, to date, have not typically been covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.
- With this federal approval, the state has begun an implementation planning process in order to launch these new programs in 2025.
- New programs will include:
 - **Nutrition and Food as Medicine-** Food insecure pregnant beneficiaries will be eligible to receive meals or groceries to support their needs.
 - **Medical Recovery Housing-** Provide short-term housing stability during recovery.
 - **Health Care for Individuals Leaving Incarceration** - Connect eligible adults and youth to health care services up to 90 days prior to their release.

D.6. Medicaid Program: New Initiatives - Primary Care Payment Reform

- The New Mexico Primary Care Payment Reform Initiative, a mandatory program led by the New Mexico Health Care Authority is geared towards enhancing the efficiency and quality of health care delivery. It introduces new payment structures to reward patient outcomes and cost-effectiveness.
- The reform program includes a quality measurement framework with specific metrics for assessing patient care, focusing on effectiveness, satisfaction, and outcomes.
- All primary care providers participating in New Mexico's Medicaid program were enrolled in the soft launch of the program, which offers enhanced fee-for-service payments and incentive payments.
- The full three-tiered program will launch on January 1, 2026, offering the ability to participate in a full capitation arrangement with potential downside risk. Each subsequent tier will be tied to increased quality reporting requirements and higher performance standards.
 - Tier 1: Enhanced Reimbursement and Quality Rewards began July 1, 2024.
 - Tiers 2 and 3 are slated to begin July 1, 2026.

D.6. Medicaid Program: New Initiatives - Primary Care Payment Reform (cont.)

- Primary care providers will continue to deliver care as they currently are, with the quality framework focusing on reporting, access to care, and patient-centered metrics. Most proposed metrics will align with Turquoise Care, the state's managed Medicaid program.
- Over the first 18 months of the program, providers will be considered successful if they can maintain their historical level of performance reporting measures.
- The following quality metrics will begin in 2024:
 - Access to Care
 - Initiation and Engagement of alcohol and other Substance Use Treatment
 - Consumer Assessment of Health Care Providers and systems Survey
- Additional measures will begin throughout 2026-2028.
- Providers will work directly with MCOs and data intermediaries to establish arrangements for data collection and reporting. All metrics will be standardized across MCOs, which will allow for identical reporting structures to alleviate provider burden.

E. Medicare Financing & Service Delivery System

E.1. Medicare Financing & Service Delivery System

Medicare System Characteristics		
Characteristics	Traditional Medicare (FFS)	Medicare Advantage
Enrollment (June 2023)	232,244	221,505
SMI Enrollment	• <i>OPEN MINDS</i> estimates 49% of the population in Medicare Advantage, 51% in Traditional Medicare.	
Management	• Part A: Inpatient hospital, skilled nursing facility care, nursing home care, hospice and home health care • Part B: Clinical research, ambulance services, durable medical equipment, mental health and limited outpatient prescription drugs	• Medicare Advantage Plans provide Part A and Part B benefits, plus additional benefits based on plan chosen
Payment Model	• Part A & B cover up to 80%, remaining costs can be paid out of pocket	• Fixed amounts paid based on health plan chosen
Geographic Service Area	Statewide	Statewide

Total Medicare: 453,749 | Total Medicare With SMI: 103,001

E.1. Medicare Financing & Service Delivery System

Medicare Financial Delivery System Enrollment	
Total Medicare population distribution	As of June 2023: 49% Medicare Advantage, 51% in traditional Medicare.
SMI population inclusion in managed care	Estimated 49% of population in Medicare Advantage, 51% in traditional Medicare.
Medicare population inclusion in Chronic special needs plan or (C-SNP).	Estimated that less than 1% of the Medicare population is enrolled in a C-SNP plan.
Medicare population inclusion in Institutional Special Needs Plan (I-SNP).	There are no I-SNP plans in New Mexico.

E.2. Medicare System: Overview

- Medicare enrollment in North Dakota as of June 2023 was 453,749.
- It is estimated around 21% of the state's total population is enrolled in Medicare, compared with about 19.5% of the U.S. population enrolled in Medicare.
 - *OPEN MINDS* estimates approximately 34% of the state's Medicare population has an SMI.
- Nationwide, nearly 49% of Medicare beneficiaries have Medicare Advantage plans. The same is true in New Mexico.
 - For 2024, the total number of Medicare Advantage plans available in New Mexico is dropping to 62, down from 72 in 2023, but not all plans are available in all areas.
- There were 31 separate insurers that offered Medigap plans in New Mexico in 2023.
- A total of 343,672 New Mexico Medicare beneficiaries had Medicare Part D prescription drug coverage as of June 2023. That included 134,505 with stand-alone Medicare Part D prescription drug plans, and 209,167 with Part D prescription drug coverage integrated with Medicare Advantage.
 - There were 24 stand-alone Medicare Part D prescription drug plans in New Mexico in 2023, with premiums that start at \$8.80 per month.
- Many Medicare beneficiaries receive financial assistance through Medicaid with the cost of Medicare premiums, prescription drug expenses, and services not covered by Medicare – such as long-term care.

E.3. Medicare ACOs

Medicare Shared Savings Model ACOs	
1.	Caravan Collaborative Pathways
2.	Wellvana Essential Care LLC
3.	Collaborative ACO 30, LLC
4.	Main Street Rural Health Cottonwood ACO LLC
5.	Aledade Western Sky MSSP Enhanced
6.	IntraCare Premier ACO
7.	Gather Health
8.	Sound Physicians Long Term Care Management, LLC
9.	National MSSP 2019
10.	Emergent ACO 24.1, LLC
11.	CHRISTUS Health Quality Care Alliance
12.	CHSPSC ACO 17, LLC
13.	Texas Panhandle Clinical Partners ACO LLC
14.	Accountable Care Coalition of Quality Health II, LLC
15.	Covenant ACO, Inc

E.4. Medicare System: New Initiatives

- There are no new or pending initiatives currently.

F. Dual Eligible Financing & Service Delivery System

F.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics		
Characteristics	Medicaid Managed Care	PACE
Enrollment (June 2023)	28,291	532
Estimated SMI Enrollment	5,941	111
Management	Four health plans	One nonprofit organization
Payment Model	Capitated rate	Per-member per-month (PMPM)
Geographic Service Area	Statewide	Bernalillo county, and parts of Sandoval and Valencia counties.

Total Dual Eligible Enrollment: 28,823 | Total Dual Eligible Enrollment With SMI: 6,052

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

F.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	April 2024 Enrollment	Estimated SMI Enrollment
Presbyterian Dual Plus	Presbyterian Health Plan	Medicare Advantage D-SNP	14,692	3,085
Allwell Dual Medicare	Western Sky Community Care	Medicare Advantage D-SNP	3,055	642
WellCare Dual Access	WellCare Access	Medicare Advantage D-SNP	2,865	602
Blue Cross Medicare Advantage Dual Care	Blue Cross Blue Shield of New Mexico	Medicare Advantage D-SNP	1,858	390
InnovAge Greater New Mexico PACE	InnovAge Greater New Mexico	PACE	532	112

F.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- As of June 2023, dual eligible enrollment was 28,823.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- All full benefit dual eligibles are enrolled in managed care; all partial benefit dual eligibles are excluded from managed care and served through the FFS system.
- D-SNP enrollment as of April 2024 is 22,470, SMI enrollment for D-SNP is 4,719.

F.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- New Mexico does not have a dual eligible demonstration with CMS at this time.

G. Long-Term Services & Supports Financing & Service Delivery System

G.1. LTSS Financing & Service Delivery System

- New Mexico provides long-term services and supports to MLTSS beneficiaries through the state’s Medicaid managed care program. A majority of Medicaid beneficiaries, with the exception of partial duals and individuals residing in an ICF/IDD, receive comprehensive physical health, behavioral health, and LTSS through New Mexico’s Medicaid managed care program.

LTSS Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (March 2024)	39,246
Estimated SMI Enrollment	8,241
Management	Four health plans
Payment Model	Four health plans
Geographic Service Area	Statewide

Total LTSS: 39,246 | Total LTSS With SMI: 8,241

G.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

- The state excludes most individuals in need of Long-term Services and Supports (LTSS) and dual eligible beneficiaries from enrolling in managed care. Therefore, most beneficiaries are enrolled in FFS.

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults			X
Disabled children			X
Blind individuals			X
Aged individuals			X
Dual eligibles	X (partial benefit)		X (Full benefit)
Individuals with I/DD			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD	X		
Other HCBS Recipients			X
Other populations			

G.2. LTSS Medicaid Financing & Delivery System: Overview

- New Mexico provides long-term services and supports to MLTSS beneficiaries through the state's Medicaid managed care program.
- A majority of Medicaid beneficiaries, with the exception of partial duals and individuals residing in an ICF/IDD, receive comprehensive physical health, behavioral health, and LTSS through New Mexico's Medicaid managed care program, Turquoise Care.

G.3. Medicaid LTSS Program: Health Plan Characteristics

Blue Cross Blue Shield of New Mexico

1. Profit status: For-profit
2. Parent company: Health Care Service Corporation (Mutual Company)
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Prime Therapeutics
5. Enrollment share: 37%

UnitedHealthcare Community Plan

1. Profit status: For-profit
2. Parent company: UnitedHealthcare
3. Behavioral health subcontractor: Optum
4. Pharmacy benefits manager: OptumRx
5. Enrollment share: 6%

Presbyterian Health Plan

1. Profit status: Non-profit
2. Parent company: Presbyterian Healthcare Services
3. Behavioral health subcontractor: Magellan Healthcare
4. Pharmacy benefits manager: Capital RX
5. Enrollment share: 51%

Molina Healthcare

1. Profit status: For-profit
2. Parent company: None
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: CVS Pharmacy
5. Enrollment share: 6%

G.4. Medicaid LTSS Program: Health Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

New Mexico's Optional Services

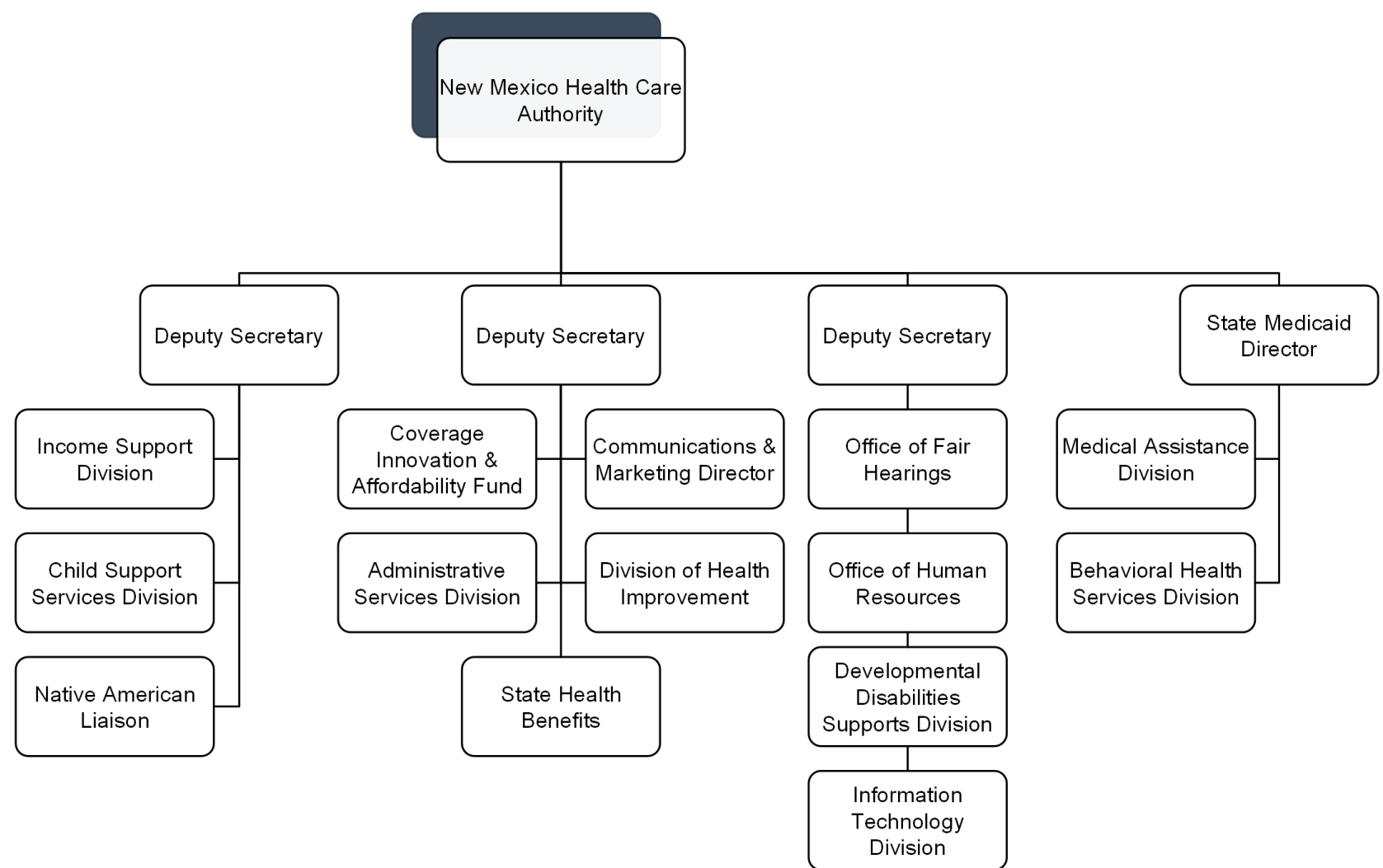
1. Podiatry services
2. Optometry services
3. Physical and occupational therapy
4. Services for individuals with speech, language, and hearing disorders
5. Clinic services
6. Prescribed drugs
7. Dentures, eyeglasses, and prosthetic devices
8. Rehabilitative services
9. Services for individuals 65 and older in an IMD
10. Services in an intermediate care facility for individuals with I/DD
11. Case management
12. Nursing facility services for individuals under age 21

G.5. LTSS Medicaid Financing & Delivery System: New Initiatives

- New Mexico has no pending initiatives that will influence the finance or delivery systems of the LTSS population.

H. State Behavioral Health Administration & Finance System

H.1. Behavioral Health Services Division: Organization Chart



The responsibility for the state's psychiatric hospital, the New Mexico Behavioral Health Institute, rests with the Department of Health.

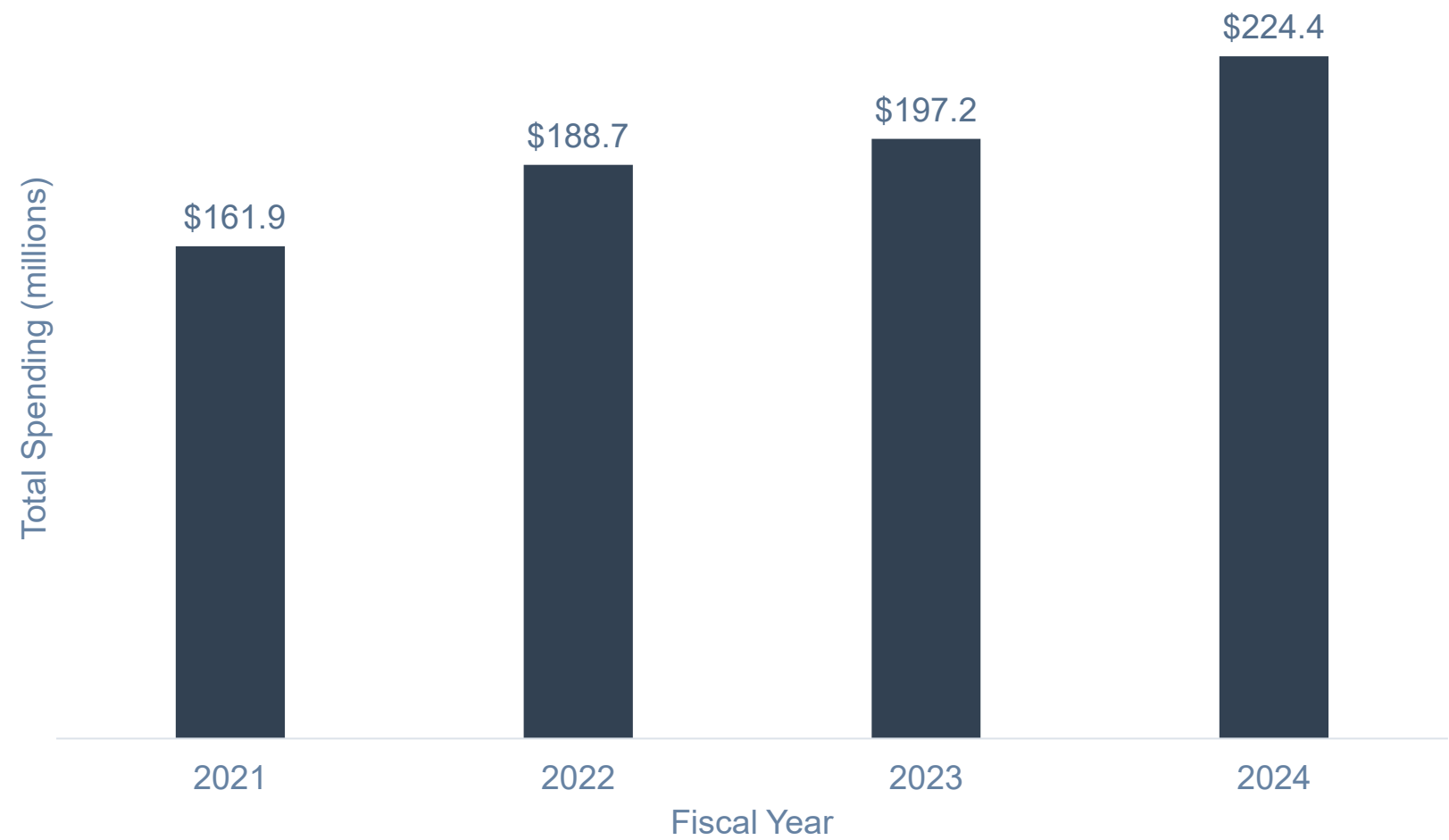
H.1. Behavioral Health Services Division: Key Leadership

Name	Position	Department	Email
Kari Armijo	Cabinet Secretary	New Mexico Health Care Authority	kari.armijo@hca.nm.gov
Alex Castillo Smith	Deputy Secretary	NM HCA	alex.castillosmith@hca.nm.gov
Kyra Ochoa	Deputy Secretary	NM HCA	Not available
Kathy Slater-Huff	Deputy Secretary	NM HCA	katherine.slater-huff@hsd.nm.gov
Dana Flannery	Division Director, State Medicaid Director	NM HCA, Medical Assistance Division	dana.flannery@hsd.nm.gov
Nick Boukas	Division Director	NM, HCA, Behavioral Health Services Division	nick.boukas@hca.nm.gov

H.2. Behavioral Health Services Division: Spending

Budget Item	SFY 2024 Recommended Budget	Percent Of Budget
Medicaid Behavioral Health	\$163,691,000	73%
Behavioral Health Services Division	\$60,690,000	27%
Budget Total: \$224,381,000		

H.2. Behavioral Health Services Division: Spending Over Time



H.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	Location	Beds
New Mexico Behavioral Health Institute (adult services)	Las Vegas, NM	94
New Mexico Behavioral Health Institute (forensic services)	Las Vegas, NM	116
Total		210

H.4. Behavioral Health Safety-Net Delivery System

- The Behavioral Health Collaborative (BHC) is a cabinet-level organization created by the state legislature to plan, design, and direct a statewide behavioral health system. The BHC coordinates and streamlines the behavioral health policies of 15 state agencies.
- The Behavioral Health Services Division (BHSD) funds are consolidated with those of other state agencies through the BHC to deliver mental health and addiction treatment services to the uninsured population.
 - No funding is allocated to operate the BHC. Instead, the BHC manages the funds of its partnering agencies.
 - The Director of BHSD also serves as the BHC's chief executive officer.
- Through a BHC contract, Falling Colors serves as the ASO for non-Medicaid behavioral health services. The ASO is responsible for claims processing, utilization management, network development, and quality improvement.
- Individuals access treatment through the Health Care Authority field office in their area by contacting a state-funded provider organization in the BHC's network, or by calling the state's behavioral health crisis telephone line.

H.5. Behavioral Health System: New Initiatives - CCBHCs

- New Mexico was selected as one of 10 new states to participate in the Certified Community Behavioral Health Clinic (CCBHC) Medicaid Demonstration Program in 2024.
- The program offers states sustainable funding to expand access to mental health and substance use services.
- Starting on January 1, 2025, New Mexico will launch certified community behavioral health clinics (CCBHCs) in the state.
- HCA, in collaboration with the Children's Youth and Families Department (CYFD), provisionally certified six providers as CCBHCs, giving them the option to participate in the program:
 - University of New Mexico Health System in Bernalillo and Sandoval Counties
 - All Faiths Children's Advocacy Center in Bernalillo County
 - Carlsbad Life House in Eddy County
 - Families & Youth Innovations Plus in Doña Ana County
 - Santa Fe Recovery Center in Santa Fe and McKinley Counties
 - Mental Health Resources in Curry County
- CCBHCs are required to meet rigorous established criteria developed by SAMHSA and augmented by New Mexico for care coordination, service delivery, behavioral health crisis response, and are evaluated by a common set of quality measures.

I. Appendices

I.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.2% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicaid	11.6% of persons enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicare	22.7% of persons in the Medicare population, not dually eligible for Medicaid	Figueroa, J. F., Phelan, J., Orav, E. J., Patel, V., & Jha, A. K. (2020). Association of mental health disorders with health care spending in the Medicare population. Retrieved July 2024 from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948#:~:text=Results%20Of%204%20358%20975,had%20no%20known%20mental%20illness

I.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	21% of persons in the Medicare population dually eligible for partial Medicaid benefits	ATI Advisory. (2022). A Profile of Medicare-Medicaid Dual Beneficiaries. Retrieved March 2023 from https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf
	16% of persons in the Medicare population dually eligible for full Medicaid benefits	
Other Public	4.5% of persons served by the Veterans Administration health care system or the TRICARE military health system	U.S. Census Bureau (2022). Table HHI-01. Health Insurance Coverage Status and Type of Coverage--All Persons by Sex, Race and Hispanic Origin: 2017 to 2021. Retrieved March 2023 from https://www2.census.gov/programssurveys/demo/tables/health-insurance/time-series/hic/hhi01.xlsx
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabSect6pe2021.htm#tab6.8a

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(1) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC’s mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2024, the FPL is \$14,580 for an individual and \$30, 000 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit by unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A “whole person” care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals ages 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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