Managed Care Program Annual Report (MCPAR) for New Mexico: Centennial Care 2.0

Due date	Last edited	Edited by	Status
06/29/2023	02/19/2024	Ashley Deubel	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	New Mexico
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Ashley Deubel
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	ashley.deubel@hsd.nm.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Ashley Deubel
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	ashley.deubel@hsd.nm.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	02/19/2024

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2022
A6	**Program name** Auto-populated from report dashboard.	Centennial Care 2.0

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
Plan name	Blue Cross Blue Shield
	Presbyterian Health Plan
	Western Sky Community Care

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
BSS entity name	Blue Cross Blue Shield
	Presbyterian Health Plan
	Western Sky Community Care
	New Mexico Human Services Department, Income Support Division

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	979,316
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	814,466

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff

Topic X: Program Integrity

Find in the Excel Workbook
B_State

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/ overutilization, and other activities.	The Human Services Department, Office of Inspector General conducts, with the assistance of a CMS audit contractor, data analytics and audits/reviews of Medicaid providers who exhibit under/overutilization and other activities.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	MCO Contract Section 4.17.4.3 and all its subparts.
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	All self-reported refunds for Overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless: HSD, the RAC or MFEAD independently notified the provider that an Overpayment existed; The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the Claim; or The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the Claim. The provider may request that the CONTRACTOR permit installment payments of the refund; such request shall be agreed to by the CONTRACTOR and the provider; or In cases where HSD, the RAC or MFEAD identifies the overpayment, HSD shall seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	Pursuant to their contracts, MCOs are required to report their provider identified and recovered overpayments to the Human Services Department, Office of Inspector General on a quarterly basis; Report 56. Report 56 is reviewed.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures	HSD establishes and maintains member eligibility and enrollment information and electronically transfers eligibility and

	Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	enrollment information to the MCO to ensure appropriate enrollment and assignment. Data shall be updated or uploaded to the MCOs eligibility/enrollment database(s) within twenty-four (24) hours of receipt from HSD. Additionally, the MCOs shall promptly notify HSD when they receive information about changes in a Member's circumstances that may affect the Member's eligibility, including Members moving out of state and the death of a member.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	The CONTRACTOR shall notify HSD within five (5) Business Days, via email, when a formal, written action is taken by the CONTRACTOR against a Contract Provider. Such action being defined for purposes of this Section as: (i) denial of credentialing or enrollment, or contract termination, when the denial or termination is "for cause", as such term is defined in the Contract Provider's agreement with the CONTACTOR; or (ii) due to concerns other than fraud, such as integrity or quality.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
BX.8b	**Federal database checks: Summarize instances of exclusion** Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.	For providers that were terminated and/or had sanction records in another state, NM denied their request for enrollment and provided them with notification in accordance with 438.602(d.
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and	No

	§455.104 and required by 42 CFR 438.602(g)(3).	
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	EQRO performs an encounter data validation and the results of their review can be found at https://www.hsd.state.nm.us/external-quality-review-organization-eqro-reports/

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	State of New Mexico Human Services Department Medicaid Managed Care Services Agreement among New Mexico Human Services Department, New Mexico Behavioral Health Purchasing Collaborative and [MCO]. Contracts are generally effective upon signature by all parties. For CY 2022, Contract Amendment #5 was in effect 12/23/21 until 12/29/22.
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	12/23/2021
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.hsd.state.nm.us/lookingforinformation/medical-assistance-division/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	There are value added services that each MCO offers that can vary by MCO.
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	814,466
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	Implemented 12-month postpartum Medicaid for MAGI Medicaid categories, implemented APRISS prisoner match, and implemented three automated administrative renewal improvements: 1) evaluation of newborn category at administrative renewal for MAGI Child; 2) allowance for MAGI/MSP categories to cascade to other full coverage Medicaid categories; 3) automated administrative renewal to approve at an individual level, rather than only a case level.

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	MCO Contract Section 4.19.2
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	MCO Contract Section 7.3.3
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/ validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	The state did not experience any barriers to collecting and/or validating managed care plan encounter data during the reporting period.

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Within the managed care program, a critical incident is defined as a reportable incident that may include, but is not limited to: abuse, neglect, exploitation, death, environmental hazard, law enforcement intervention and emergency Services. Critical Incident reporting is not specific to LTSS members. Currently reportable Critical Incidents are limited to members with the following Category of Eligibility (COE) 001, 003, 004, 081, 084, 090, 091, 092, 093, 094, 095, 100 (only COE 100 recipients and NF LOC) and 200 (recipients with a NF LOC).
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The CONTRACTOR has thirty (30) Calendar Days from the date the initial oral or written Appeal is received by the CONTRACTOR to resolve the Appeal. - MCO Contract Section 4.16.3
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The CONTRACTOR shall resolve the expedited Appeal within 72 hours of CONTRACTOR's receipt of the appeal, per 42 C.F.R. § 438.408(b)(3) and (d)(2). - MCO Contract Section 4.16.4
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The CONTRACTOR shall complete the investigation and final resolution process for Grievances within thirty (30) Calendar Days of the date the Grievance is received by the CONTRACTOR or as expeditiously as the Member's health condition requires and shall include a resolution letter to the Grievant. - MCO Contract Section 4.16.2

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Provider shortages and aging provider population.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	Provider rate increases, quarterly reporting by the MCOs, and engagement of professional organizations.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
C2_Program_State

Access measure total count: 2

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 1 / 2

C2.V.2 Measure standard

Attainment of a specified number.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, Physical Health, Behavioral Health, Long Term Care	NM Counties are designated in contract as Urban, Rural, or Frontier.	Adult and pediatric

C2.V.7 Monitoring Methods

Network Adequacy and Geo Access reports provided by the MCOs.

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 2 / 2

C2.V.2 Measure standard

Percentages or ratios computed through the use of a numerator and denominator.

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary Care, Physical Health, Behavioral Health, Long Term Care	NM Counties are designated in contract as Urban, Rural, or Frontier.	Adult and pediatric

C2.V.7 Monitoring Methods

Secret Shopper Surveys conducted by Contractors of the MCOs.

C2.V.8 Frequency of oversight methods

Semi-annual

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	BSS are provided to the member by the MCO upon enrollment. https://www.bcbsnm.com/provider/network-participation/network-participation/medicaid, https://www.phs.org/health-plans/centennial-care-medicaid, https://www.westernskycommunitycare.com/members/medicaid.html
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Phone, internet, in-person, and auxiliary aids and services.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	The MCOs must have a full-time staff person who shall act as the Grievances and Appeals manager to manage Member and provider disputes arising under the MCOs Grievances and Appeals systems including Member and provider Grievances, Appeals, requests for Fair Hearings and provider Claim disputes.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	NM evaluates the provision of BSS by the MCOs through program reports, member satisfaction surveys, Member complaints filed directly with the state.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Blue Cross Blue Shield** 297,141 **Presbyterian Health Plan** 426,769 **Western Sky Community Care** 90,556
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Blue Cross Blue Shield** 30.3% **Presbyterian Health Plan** 43.6% **Western Sky Community Care** 9.2%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Blue Cross Blue Shield** 36.5% **Presbyterian Health Plan** 52.4% **Western Sky Community Care** 11.1%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Blue Cross Blue Shield** 84% **Presbyterian Health Plan** 90% **Western Sky Community Care** 91%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Blue Cross Blue Shield** Statewide all programs & populations **Presbyterian Health Plan** Statewide all programs & populations **Western Sky Community Care** Statewide all programs & populations
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Blue Cross Blue Shield** No **Presbyterian Health Plan** No **Western Sky Community Care** No

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Blue Cross Blue Shield** At least ninety percent (90%) of MCO claims, paid originals and adjustments must be submitted to HSD within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication in accordance with the specifications included in HIPAA Technical Review Guides, the New Mexico Medicaid MCO Companion Guide and the MCO Systems Manual, regardless of whether the Encounter is from a Subcontractor or Major Subcontractor, subcapitated arrangement, or performed by the CONTRACTOR. The CONTRACTOR may not withhold submission of Encounters for any reason. **Presbyterian Health Plan** At least ninety percent (90%) of MCO claims, paid originals and adjustments must be submitted to HSD within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication in accordance with the specifications included in HIPAA Technical Review Guides, the New Mexico Medicaid MCO Companion Guide and the MCO Systems Manual, regardless of whether the Encounter is from a Subcontractor or Major Subcontractor, subcapitated arrangement, or performed by the CONTRACTOR. The CONTRACTOR may not withhold submission of Encounters for any reason. **Western Sky Community Care** At least ninety percent (90%) of MCO claims, paid originals and adjustments must be submitted to HSD within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication in accordance with the specifications included in HIPAA Technical Review Guides, the New Mexico Medicaid MCO Companion Guide and the MCO Systems Manual, regardless of whether the Encounter is from a Subcontractor or Major Subcontractor, subcapitated arrangement, or performed by the CONTRACTOR. The CONTRACTOR may not withhold submission of Encounters for any reason.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Blue Cross Blue Shield** 96% **Presbyterian Health Plan** 98% **Western Sky Community Care** 91%

D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Blue Cross Blue Shield** 100% **Presbyterian Health Plan** 100% **Western Sky Community Care** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Blue Cross Blue Shield** 1,401 **Presbyterian Health Plan** 2,113 **Western Sky Community Care** 119
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Blue Cross Blue Shield** 1,083 **Presbyterian Health Plan** 1,036 **Western Sky Community Care** 92
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A

	critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Blue Cross Blue Shield** 1,237 **Presbyterian Health Plan** 1,986 **Western Sky Community Care** 91
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Blue Cross Blue Shield** 164 **Presbyterian Health Plan** 127 **Western Sky Community Care** 28
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Blue Cross Blue Shield** 20 **Presbyterian Health Plan** 7 **Western Sky Community Care** 2
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was	**Blue Cross Blue Shield** 888 **Presbyterian Health Plan** 1,544

already rendered.

		Western Sky Community Care 80
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Blue Cross Blue Shield** 10 **Presbyterian Health Plan** 39 **Western Sky Community Care** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Blue Cross Blue Shield** 10 **Presbyterian Health Plan** 39 **Western Sky Community Care** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF)**	**Blue Cross Blue Shield**

	skilled nursing facility (SNF) services Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**Blue Cross Blue Shield** 204 **Presbyterian Health Plan** 35 **Western Sky Community Care** 48

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Blue Cross Blue Shield** 41 **Presbyterian Health Plan** 43 **Western Sky Community Care** 6
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Blue Cross Blue Shield** 2 **Presbyterian Health Plan** 3 **Western Sky Community Care** 2
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Blue Cross Blue Shield** 2 **Presbyterian Health Plan** 10 **Western Sky Community Care** 2
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Blue Cross Blue Shield** 19 **Presbyterian Health Plan** 14 **Western Sky Community Care** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A

	process, enter the total number of external medical review	N/A
	decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Western Sky Community Care** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Blue Cross Blue Shield** 1,487 **Presbyterian Health Plan** 1,602 **Western Sky Community Care** 173
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Blue Cross Blue Shield** 830 **Presbyterian Health Plan** 967 **Western Sky Community Care** 104
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A

	submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Blue Cross Blue Shield** 1,487 **Presbyterian Health Plan** 1,602 **Western Sky Community Care** 173

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** 8 **Presbyterian Health Plan** 561 **Western Sky Community Care** 1
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** 15 **Presbyterian Health Plan** 20 **Western Sky Community Care** 0
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** 11 **Presbyterian Health Plan** 52 **Western Sky Community Care** 5
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** 0 **Presbyterian Health Plan** 0 **Western Sky Community Care** 0
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** 39 **Presbyterian Health Plan** 26 **Western Sky Community Care** 1
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services**	**Blue Cross Blue Shield** N/A

	Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** 55 **Presbyterian Health Plan** 172 **Western Sky Community Care** 6
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Blue Shield** 786 **Presbyterian Health Plan** 1,092 **Western Sky Community Care** 50
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Blue Cross Blue Shield** 561 **Presbyterian Health Plan** 263 **Western Sky Community Care** 96

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Blue Cross Blue Shield** 38 **Presbyterian Health Plan** 80 **Western Sky Community Care** 2
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/ case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Blue Cross Blue Shield** 23 **Presbyterian Health Plan** 55 **Western Sky Community Care** 15
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Blue Cross Blue Shield** 38 **Presbyterian Health Plan** 80 **Western Sky Community Care** 2
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Blue Cross Blue Shield** 31 **Presbyterian Health Plan** 247 **Western Sky Community Care** 0
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.	**Blue Cross Blue Shield** 0 **Presbyterian Health Plan** 12

	Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Western Sky Community Care** 0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Blue Cross Blue Shield** 13 **Presbyterian Health Plan** 62 **Western Sky Community Care** 4
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Blue Cross Blue Shield** 4 **Presbyterian Health Plan** 7 **Western Sky Community Care** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Blue Cross Blue Shield** 0 **Presbyterian Health Plan** 1 **Western Sky Community Care** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Blue Cross Blue Shield** 0 **Presbyterian Health Plan** 1 **Western Sky Community Care** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of	**Blue Cross Blue Shield** 0

	Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Presbyterian Health Plan** 3 **Western Sky Community Care** 1
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Blue Cross Blue Shield** 561 **Presbyterian Health Plan** 263 **Western Sky Community Care** 96

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 10

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 15 Months of Life 1 / 10

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

61.7%

Presbyterian Health Plan

65.98%

Western Sky Community Care

55.77%

Complete

D2.VII.1 Measure Name: Counseling for Physical Activity for Children/ Adolescents 2 / 10

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

59.61%

Presbyterian Health Plan

58.35%

Western Sky Community Care

51.34%

Complete

D2.VII.1 Measure Name: Timeliness of Prenatal Care

3 / 10

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

82.97%

Presbyterian Health Plan

78.14%

Western Sky Community Care

78.35%

Complete

D2.VII.1 Measure Name: Postpartum Care

4 / 10

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

70.8%

Presbyterian Health Plan

72.95%

Western Sky Community Care

67.64%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status : Combination 3

5 / 10

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

70.8%

Presbyterian Health Plan

70.56%

Western Sky Community Care

60.1%

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management: Continuous Phase

6 / 10

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

40.83%

Presbyterian Health Plan

42.33%

Western Sky Community Care

43.32%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation"

7 / 10

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
N/A

Measure results

Blue Cross Blue Shield
45.97%

Presbyterian Health Plan
55.10%

Western Sky Community Care
48.30%

Complete

D2.VII.1 Measure Name: "Follow-Up After Hospitalization for Mental Illness: 30 Day"

8 / 10

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
N/A

Measure results

Blue Cross Blue Shield
54.61%

Presbyterian Health Plan
55.03%

Western Sky Community Care
56.22%

Complete

D2.VII.1 Measure Name: "Follow-Up After Emergency Department Visit for Mental Illness: 30 Day"

9 / 10

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

N/A

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
N/A

Measure results

Blue Cross Blue Shield
56.06%

Presbyterian Health Plan
59.36%

Western Sky Community Care
54.61%

Complete

D2.VII.1 Measure Name: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

10 / 10

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
N/A

Measure results

Blue Cross Blue Shield
78.21%

Presbyterian Health Plan
80.59%

Western Sky Community Care
79.04%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count: 6

Complete

D3.VIII.1 Intervention type: Civil monetary penalty 1 / 6

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$13,864,452.76

D3.VIII.7 Date assessed
11/06/2023

D3.VIII.8 Remediation date non-compliance was corrected
No, no remediation

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty 2 / 6

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Presbyterian Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$12,817,145.01

D3.VIII.7 Date assessed
11/06/2023

D3.VIII.8 Remediation date non-compliance was corrected
No, no remediation

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty 3 / 6

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Western Sky Community Care

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$6,072,544.18

D3.VIII.7 Date assessed

11/06/2023

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

4 / 6

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Presbyterian Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

05/08/2023

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

5 / 6

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Western Sky Community Care

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$15,000

D3.VIII.7 Date assessed

11/06/2023

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

6 / 6

D3.VIII.2 Intervention topic

MCO contract MLR percentage of 88% was not met

D3.VIII.3 Plan name

Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$91,586,608.22

D3.VIII.7 Date assessed

01/08/2024

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Blue Cross Blue Shield** 3.2 **Presbyterian Health Plan** 12.8 **Western Sky Community Care** 3
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Blue Cross Blue Shield** 70 **Presbyterian Health Plan** 1,112 **Western Sky Community Care** 39
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Blue Cross Blue Shield** 6:25 **Presbyterian Health Plan** 261:100 **Western Sky Community Care** 43:100
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Blue Cross Blue Shield** 71 **Presbyterian Health Plan** 1,173 **Western Sky Community Care** 51
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Blue Cross Blue Shield** 6:25 **Presbyterian Health Plan** 123:100 **Western Sky Community Care** 43:100
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Blue Cross Blue Shield** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Presbyterian Health Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

		Western Sky Community Care Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Blue Cross Blue Shield** 72 **Presbyterian Health Plan** 525 **Western Sky Community Care** 39
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	**Blue Cross Blue Shield** 6:25 **Presbyterian Health Plan** 123:100 **Western Sky Community Care** 43:100
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Blue Cross Blue Shield** "New Mexico HSD Report 56 1/23/23 $215,081.41 0%" **Presbyterian Health Plan** New Mexico HSD Report 56 1/20/23 $4,013,500.72 0% **Western Sky Community Care** New Mexico HSD Report 56 1/1/23 $38,335.00 0%
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Blue Cross Blue Shield** Monthly **Presbyterian Health Plan** Monthly **Western Sky Community Care** Monthly

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Find in the Excel Workbook

E_BSS_Entities

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Blue Cross Blue Shield** Other, specify – MCO **Presbyterian Health Plan** Other, specify – MCO **Western Sky Community Care** Other, specify – MCO **New Mexico Human Services Department, Income Support Division** State Government Entity
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Blue Cross Blue Shield** LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data **Presbyterian Health Plan** LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data **Western Sky Community Care** LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data **New Mexico Human Services Department, Income Support Division** LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data