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

Due date	Last edited	Edited by	Status
12/27/2024	02/28/2025	Maria Kniskern	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

Section A: Program Information

Point of Contact

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.	Charles M. Canada, Special Projects Officer
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	charles.canada@hca.nm.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Maria Kniskern
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	maria.kniskern@hca.nm.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	02/28/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2024
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.

	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.

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

Add In Lieu of Services and Settings (A.9)

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

	Indicator	Response
	ILOS name	

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

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.	1,103,257
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.	939,304

Topic III. Encounter Data Report

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

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. If no PI activities were performed, enter “No PI activities were performed during the reporting period” as your response. “N/A” is not an acceptable response.	The OIG 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 topics (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 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).	HSD establishes and maintains member eligibility and enrollment information and electronically transfers eligibility and 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.	State monitors this also through a monthly report from the MCOs. However, state does not use metric or indicator. If the report is submitted untimely by an MCO, state reports MCO's untimeliness to Managed Care Oversight Bureau.
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.	No
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 subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
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, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were	https://www.hsd.state.nm.us/external-quality-review-organization-eqro-reports/

conducted, please enter “No such audits were conducted during the reporting year” as your response. “N/A” is not an acceptable response.

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Yes
BXIII.1a	**Timeframes for standard prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	Yes
BXIII.1b	**State's timeframe for standard prior authorization decisions** Indicate the state's maximum timeframe, as number of days, for plans to provide notice of their decisions on standard prior authorization requests.	7
BXIII.2a	**Timeframes for expedited prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	Yes
BXIII.2b	**State's timeframe for expedited prior authorization decisions** Indicate the state's maximum timeframe, as number of hours,	24

for plans to provide notice of their decisions on expedited prior authorization requests.

Section C: Program-Level Indicators

Topic I: Program Characteristics

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]. Contract and contract amendments are generally effective upon signature by all parties.
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2023
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**	939,304

	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).	939,304
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. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	Physical Health new programs include Human Donor Milk -Inpatient, Prenatal Genetic Screening and Community Health Workers. The following programs were expanded: NEMT Referrals for Outside of the Home Community Guidance, Legally Responsible Individuals as Caregivers, and Non-Emergency Transportation Network Companies. Behavioral Health new programs include High-Fidelity Wraparound Program effective 7/1/23. HFW was implemented in a phased approach. Phase One will be children in protective services custody who are most at risk and Phase Two will include all children who meet high fidelity wraparound intensive care coordination. Other BH programs implemented were the Evidence Based Practices effective 7/1/2023. These programs aim to improve healthcare outcomes that uses the best available evidence, clinical expertise, and patient values to make informed decisions about patient care.

Topic III: Encounter Data Report

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 year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

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, 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.	MCO Contract Section 4.16.4 - 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).
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	MCO Contract Section 4.16.2 - 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

	of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	resolution letter to the Grievant.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

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 access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	Provider shortages, 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, engagement of professional organizations

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.

Access measure total count: 4

Complete

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

C2.V.2 Measure standard

Distance Requirements: For PCPs, including internal medicine, general practice, and family practice provider types, offer Members a choice of at least two (2) PCPs accepting new patients that meet the following distance requirements: •Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles; •Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles; and •Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles. For pharmacies, including twenty-four (24) hours a day, seven (7) days-a-week pharmacies where such are available, at least one (1) pharmacy that meets the following distance requirements: •Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles; •Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles; and •Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles. For Behavioral Health, Physical Health, Long-Term Care, Hospitals, Ancillary Service, and Transportation providers: •Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles; •Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of Provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HCA; and •Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of Provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HCA.

C2.V.3 Standard type

Maximum distance to travel

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

GeoAccess 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

C2.V.2 Measure standard

Time standards: • For Asymptomatic/Routine, Member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than thirty (30) Calendar Days, unless the Member requests a later time; • For Asymptomatic/Routine Member-initiated dental appointments, the request to appointment time shall be no more than sixty (60) Calendar Days unless the Member requests a later date; • For symptomatic, Member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than fourteen (14) Calendar Days, unless the Member requests a later time; • For non-urgent Behavioral Health care, the request-to-appointment time for an initial assessment shall be no more than seven (7) Calendar Days, unless the Member requests a later time. The request-to-appointment time for Behavioral Health care following an initial assessment shall be no more than seven (7) Calendar Days, unless the Member requests a later time. All non-urgent Behavioral Health care follow-up appointment shall be available within thirty (30) Calendar Days of the request; • Primary medical, dental, and Behavioral Health care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours; • For specialty outpatient referral and consultation appointments, excluding Behavioral Health, the request-to-appointment time shall be consistent with the clinical urgency, but no more than twenty-four (24) hours for urgent appointments, fourteen (14) Calendar Days for symptomatic appointments, and forty-five (45) Calendar Days for routine Asymptomatic appointments, unless the Member requests a later time; • For maternity care appointments, the request-to-appointment time shall be no more than twenty-four (24) hours for urgent appointments. For routine prenatal care appointments, within fourteen (14) Calendar Days of the request during the first trimester, within seven (7) Calendar Days of the request during the second trimester, and within three (3) Business Days of the request during the third trimester; • For routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Member requests a later time; • For outpatient diagnostic laboratory, diagnostic imaging, and other testing, if a “walk-in” rather than an appointment system is used, the Member wait time shall be consistent with severity of the clinical need; • For urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing, the request-to-appointment time shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours; • The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes from the time of request. A prescription phoned in or electronically submitted by a practitioner shall be filled within ninety (90) minutes from the time of request; • The timing of scheduled follow-up outpatient visits with practitioners from the request, excluding Behavioral Health, shall be

consistent with the clinical need; • For Behavioral Health crisis services, face-to-face appointments shall be available within ninety (90) minutes of the request; and • For Non-Emergency Medical Transportation (NEMT) Appointment Arrival and Pick-Up. The CONTRACTOR and its Major Subcontractors shall ensure the Member arrives on time for the appointment but no sooner than one (1) hour before the appointment and is not dropped off before the facility/office is open. Scheduled pick-up shall occur within fifteen minutes prior to or after the scheduled pick-up time.

C2.V.3 Standard type

Appointment wait time

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

Complete

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

3 / 4

C2.V.2 Measure standard

Non-dual member caseload of any Primary Care Provider does not exceed 1500 members per MCO.

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	All - Urban, Rural and Frontier Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Network Adequacy Report

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

4 / 4

C2.V.2 Measure standard

Members have access to a twenty-four (24) hours a day, seven (7) days a week pharmacy in each geographic location where such pharmacy is available and comply with the Distance Requirements.

C2.V.3 Standard type

Hours of operation

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacies	All - Urban, Rural and Frontier Counties	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) 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

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 XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	No
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	State
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	Yes
C1XII.7b	**Describe the event(s) that necessitated an update to the parity analysis(es).** Select all that apply.	Other, specify – A renewed 1115 demonstration waiver and contractors necessitated an update to the parity analysis(es) conducted in 2018 and 2019.
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent	01/01/2019

	date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	
C1XII.9	**When was the last parity analysis(es) for this program submitted to CMS?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	11/22/2024
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/ analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	**Provide the URL link(s).** Response must be a valid	https://www.hca.nm.gov/public-information-and-communications/centennial-care/reports/

Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

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** 259,504 **Presbyterian Health Plan** 367,229 **Western Sky Community Care** 88,643
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** 23.5% **Presbyterian Health Plan** 33.3% **Western Sky Community Care** 8%
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** 27.6% **Presbyterian Health Plan** 39.1% **Western Sky Community Care** 9.4%

Topic II. Financial Performance

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. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Blue Cross Blue Shield** 89.2% **Presbyterian Health Plan** 92% **Western Sky Community Care** 93.2%
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** Yes **Presbyterian Health Plan**

		Yes **Western Sky Community Care** Yes
N/A	Enter the start date.	**Blue Cross Blue Shield** 01/01/2023 **Presbyterian Health Plan** 01/01/2023 **Western Sky Community Care** 01/01/2023
N/A	Enter the end date.	**Blue Cross Blue Shield** 12/31/2023 **Presbyterian Health Plan** 12/31/2023 **Western Sky Community Care** 12/31/2023

Topic III. Encounter Data

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 year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year 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 year.	**Blue Cross Blue Shield** 100% **Presbyterian Health Plan** 100% **Western Sky Community Care** 100%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) 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 year.	**Blue Cross Blue Shield** 100% **Presbyterian Health Plan** 100% **Western Sky Community Care** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter “N/A”.

Appeals Overview

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** 2,059 **Presbyterian Health Plan** 3,145 **Western Sky Community Care** 270
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Blue Cross Blue Shield** 1,171 **Presbyterian Health Plan** 2,434 **Western Sky Community Care** 207
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Blue Cross Blue Shield** 14 **Presbyterian Health Plan** 30 **Western Sky Community Care** 6

D1IV.1c

Appeals resolved in favor of enrollee

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.

Blue Cross Blue Shield

1,115

Presbyterian Health Plan

849

Western Sky Community Care

122

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

1,919

Presbyterian Health Plan

1,740

Western Sky Community Care

240

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 year 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 year 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”.

Blue Cross Blue Shield

N/A

Presbyterian Health Plan

N/A

Western Sky Community Care

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 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 within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Blue Cross Blue Shield** 2,052 **Presbyterian Health Plan** 3,091 **Western Sky Community Care** 270

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 within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Blue Cross Blue Shield** 225 **Presbyterian Health Plan** 166 **Western Sky Community Care** 69
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** 1,788 **Presbyterian Health Plan** 3,156 **Western Sky Community Care** 300
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** 26 **Presbyterian Health Plan** 73 **Western Sky Community Care** 36
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 already rendered.	**Blue Cross Blue Shield** 484 **Presbyterian Health Plan** 85 **Western Sky Community Care** 0

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** 0 **Presbyterian Health Plan** 0 **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** 0 **Presbyterian Health Plan** 0 **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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR

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.

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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of	**Blue Cross Blue Shield** NR

	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”.	**Presbyterian Health Plan** NR **Western Sky Community Care** NR
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
D1IV.7f	**Resolved appeals related to 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”.	**Blue Cross Blue Shield** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan	**Blue Cross Blue Shield** NR

	during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**Presbyterian Health Plan** NR **Western Sky Community Care** NR
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
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 paid primarily by Medicaid, enter “N/A”.	**Blue Cross Blue Shield** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR

State Fair Hearings

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** 256 **Presbyterian Health Plan** 118 **Western Sky Community Care** 13
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** 63 **Presbyterian Health Plan** 13 **Western Sky Community Care** 1
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** 19 **Presbyterian Health Plan** 26 **Western Sky Community Care** 1
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** 0 **Presbyterian Health Plan** 75 **Western Sky Community Care** 5

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 of external medical review 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).	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A

Grievances Overview

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** 2,447 **Presbyterian Health Plan** 1,584 **Western Sky Community Care** 302
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** 1,755 **Presbyterian Health Plan** 1,118 **Western Sky Community Care** 179
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	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A

	of critical incidents filed within the reporting year 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 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.	**Western Sky Community Care** N/A
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	**Blue Cross Blue Shield** 2,426 **Presbyterian Health Plan** 1,522

reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Western Sky Community Care** 298

Grievances by Service

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

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** 17 **Presbyterian Health Plan** 25 **Western Sky Community Care** 4
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** 5 **Presbyterian Health Plan** 24 **Western Sky Community Care** 17
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
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	**Blue Cross Blue Shield** NR **Presbyterian Health Plan**

	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”.	NR **Western Sky Community Care** NR
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** 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”.	**Blue Cross Blue Shield** 2 **Presbyterian Health Plan** 55 **Western Sky Community Care** 1
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** 0 **Presbyterian Health Plan** 2 **Western Sky Community Care** 0
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.	**Blue Cross Blue Shield** 137 **Presbyterian Health Plan** 104

	If the managed care plan does not cover this type of service, enter “N/A”.	104 **Western Sky Community Care** 18
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** 1,656 **Presbyterian Health Plan** 366 **Western Sky Community Care** 71
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 paid primarily by Medicaid, enter “N/A”.	**Blue Cross Blue Shield** N/A **Presbyterian Health Plan** N/A **Western Sky Community Care** N/A

Grievances by Reason

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

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** 98 **Presbyterian Health Plan** 15 **Western Sky Community Care** 1
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** 0 **Presbyterian Health Plan** 0 **Western Sky Community Care** 0
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** 62 **Presbyterian Health Plan** 72 **Western Sky Community Care** 1

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** 45 **Presbyterian Health Plan** 274 **Western Sky Community Care** 26
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. 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.	**Blue Cross Blue Shield** 0 **Presbyterian Health Plan** 5 **Western Sky Community Care** 6
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** 865 **Presbyterian Health Plan** 37 **Western Sky Community Care** 11
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	**Blue Cross Blue Shield** 8 **Presbyterian Health Plan** 15

	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.	**Western Sky Community Care** 1
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** 6 **Western Sky Community Care** 11
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** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** 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),	**Blue Cross Blue Shield** NR **Presbyterian Health Plan** NR **Western Sky Community Care** NR

	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.	
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** 2 **Presbyterian Health Plan** 62 **Western Sky Community Care** 1

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.

Quality & performance measure total count: 55

Complete

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

1 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

64.34%

Presbyterian Health Plan

69.31%

Western Sky Community Care

58.09%

Complete

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

2 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

64.96%

Presbyterian Health Plan

64.34%

Western Sky Community Care

62.29%

Complete

D2.VII.1 Measure Name: Maternal and perinatal health

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

85.16%

Presbyterian Health Plan

75.52%

Western Sky Community Care

71.78%

Complete

D2.VII.1 Measure Name: Postpartum Care

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

72.26%

Presbyterian Health Plan

74.63%

Western Sky Community Care

73.24%

Complete

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

5 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

64.72%

Presbyterian Health Plan

72.75%

Western Sky Community Care

58.39%

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

42.52%

Presbyterian Health Plan

51.14%

Western Sky Community Care

45.59%

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

45.93%

Presbyterian Health Plan

54.22%

Western Sky Community Care

44.77%

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

55.07%

Presbyterian Health Plan

55.14%

Western Sky Community Care

57.67%

Complete

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

9 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

58.28%

Presbyterian Health Plan

51.04%

Western Sky Community Care

47.3%

Complete

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

10 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

80.55%

Presbyterian Health Plan

84.08%

Western Sky Community Care

81.15%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 15 Months of Life (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.) 11 / 55

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

51.27%

Presbyterian Health Plan

42.87%

Western Sky Community Care

59.48%

Complete

D2.VII.1 Measure Name: Counseling for Physical Activity for Children/ Adolescents (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.) 12 / 55

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

21.45%

Presbyterian Health Plan

20.27%

Western Sky Community Care

40%

Complete

D2.VII.1 Measure Name: Timeliness of Prenatal Care (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP 13 / 55

WSCC was not required to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

59.49%

Presbyterian Health Plan

64.98%

Western Sky Community Care

52.9%

Complete

D2.VII.1 Measure Name: Maternal and perinatal health (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

49.9%

Presbyterian Health Plan

60.94%

Western Sky Community Care

53.7%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status : Combination 3 (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

37.62%

Presbyterian Health Plan

38.43%

Western Sky Community Care

36.44%

Complete

16 / 55

D2.VII.1 Measure Name: Antidepressant Medication Management: Continuous Phase (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

37.02%

Presbyterian Health Plan

50.17%

Western Sky Community Care

46.6%

Complete

17 / 55

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

47.26%

Presbyterian Health Plan

46.83%

Western Sky Community Care

49.79%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 30 Day (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

51.06%

Presbyterian Health Plan

53%

Western Sky Community Care

49.31%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 30 Day (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

52.52%

Presbyterian Health Plan

44.65%

Western Sky Community Care

42.42%

Complete

D2.VII.1 Measure Name: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

20 / 55

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

63.26%

Presbyterian Health Plan

65.16%

Western Sky Community Care

66.67%

Complete

D2.VII.1 Measure Name: Fall Risk Management

21 / 55

D2.VII.2 Measure Domain

Long-term services and supports

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Number of Medicaid Members > 65 years of age with an outpatient visit during the measurement year that have a diagnosis of a fall or problems with balance/walking (ICD10 diagnosis) AND were screened/managed by a practitioner for fall risk (CPT screening/management) on the date of the diagnosis. (Numerator) Number of Medicaid Members > 65 years of age with an outpatient visit during the measurement period. (Denominator)

Measure results

Blue Cross Blue Shield

0.01%

Presbyterian Health Plan

1.05%

Western Sky Community Care

0.17%

Complete

D2.VII.1 Measure Name: Diabetes Short-Term Complications Admission Rate Ages 18-64

D2.VII.2 Measure Domain

Disease Management

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

Medicaid Adult Core Set

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

23.32

Presbyterian Health Plan

19.29

Western Sky Community Care

15.89

Complete

D2.VII.1 Measure Name: Screening for Clinical Depression and Follow-up Plan Ages 18-64

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

Medicaid Adult Core Set

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

1.75%

Presbyterian Health Plan

1.96%

Western Sky Community Care

2.23%

Complete

D2.VII.1 Measure Name: Follow-up after Hospitalization for Mental Illness Ages 6-17

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Denominator: Medicaid beneficiaries who are enrolled with a Managed Care Organization (MCO) within Centennial Care state plan. The beneficiary must be enrolled within an MCO at the time of discharge. Note: Members in hospice are excluded from the eligible population. Numerator: Seven (7) Day follow-up visit for ages six (6) to seventeen (17) with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

Measure results

Blue Cross Blue Shield

58.66%

Presbyterian Health Plan

48.57%

Western Sky Community Care

52.84%

Complete

D2.VII.1 Measure Name: Follow-up after Hospitalization for Mental Illness Ages 18+

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Denominator: Medicaid beneficiaries who are enrolled with a Managed Care Organization (MCO) within Centennial Care state plan. The beneficiary must be enrolled within an MCO at the time of discharge. Note: Members in hospice are excluded from the eligible population. Numerator: Seven (7) Day follow-up visit for ages eighteen (18) and above with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

Measure results

Blue Cross Blue Shield

32.21%

Presbyterian Health Plan

31.93%

Western Sky Community Care

27.83%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) Combination 1

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

80.66%

Presbyterian Health Plan

82.94%

Western Sky Community Care

81.51%

Complete

D2.VII.1 Measure Name: Long Acting Reversible Contraceptive (LARC) 27 / 55

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Number of LARCs utilized in female Medicaid Members 15 - 19 years of age.

Measure results

Blue Cross Blue Shield

628

Presbyterian Health Plan

1,217

Western Sky Community Care

215

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services.

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications).

Measure results

Blue Cross Blue Shield

3,390

Presbyterian Health Plan

5,273

Western Sky Community Care

922

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services.

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Total number of units for smoking and tobacco cessation products/services (NRT etc.)

Measure results

Blue Cross Blue Shield

200,774

Presbyterian Health Plan

428,128

Western Sky Community Care

1,410

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services.

30 / 55

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Total dollar amount for smoking and tobacco cessation products/services (NRT etc.)

Measure results

Blue Cross Blue Shield

$518,270.02

Presbyterian Health Plan

$1,082,802.69

Western Sky Community Care

$87,621.93

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services. 31 / 55

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications) who had a successful quit attempt.

Measure results

Blue Cross Blue Shield

60

Presbyterian Health Plan

12

Western Sky Community Care

109

Complete

D2.VII.1 Measure Name: Ambulatory Care (AMB) Outpatient Visits 32 / 55

D2.VII.2 Measure Domain

Utilization

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

4139.43

Presbyterian Health Plan

3905.58

Western Sky Community Care

3373.04

Complete

D2.VII.1 Measure Name: Oral Evaluation Dental Services (OED)

33 / 55

D2.VII.2 Measure Domain

Dental and oral health services

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

50.69%

Presbyterian Health Plan

51.84%

Western Sky Community Care

48.48%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP)

34 / 55

D2.VII.2 Measure Domain

Cardiovascular Conditions

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

54.01%

Presbyterian Health Plan

41.52%

Western Sky Community Care

55.23%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD) Initiation Phase

35 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

46.02%

Presbyterian Health Plan

33.30%

Western Sky Community Care

50.00%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD) Continuation Phase

36 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

57.92%

Presbyterian Health Plan

39.26%

Western Sky Community Care

66.67%

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV) Ages 3-21

37 / 55

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

46.94%

Presbyterian Health Plan

44.77%

Western Sky Community Care

44.75%

Complete

D2.VII.1 Measure Name: Fall Risk Management

38 / 55

D2.VII.2 Measure Domain

Long-term services and supports

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Medicaid Members > 65 years of age with an outpatient visit during the measurement year that have a diagnosis of a fall or problems with balance/walking (ICD10 diagnosis) AND were screened/managed by a practitioner for fall risk (CPT screening/management) on the date of the diagnosis. (Numerator) Number of Medicaid Members > 65 years of age with an outpatient visit during the measurement period. (Denominator)

Measure results

Blue Cross Blue Shield

0.02%

Presbyterian Health Plan

0.86%

Western Sky Community Care

0.26%

Complete

D2.VII.1 Measure Name: Diabetes Short-Term Complications Admission Rate Ages 18-64

D2.VII.2 Measure Domain

Disease Management

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

Medicaid Adult Core Set

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

26.40

Presbyterian Health Plan

20.19

Western Sky Community Care

0

Complete

D2.VII.1 Measure Name: Screening for Clinical Depression and Follow-up Plan Ages 18-64

40 / 55

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

Medicaid Adult Core Set

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

1.34%

Presbyterian Health Plan

1.78%

Western Sky Community Care

1.58%

Complete

D2.VII.1 Measure Name: Follow-up after Hospitalization for Mental Illness Ages 6-17

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Denominator: Medicaid beneficiaries who are enrolled with a Managed Care Organization (MCO) within Centennial Care state plan. The beneficiary must be enrolled within an MCO at the time of discharge. Note: Members in hospice are excluded from the eligible population. Numerator: Seven (7) Day follow-up visit for ages six (6) and above with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

Measure results

Blue Cross Blue Shield

77.22%

Presbyterian Health Plan

45.19%

Western Sky Community Care

47.92%

Complete

D2.VII.1 Measure Name: Follow-up after Hospitalization for Mental Illness Ages 18+

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Denominator: Medicaid beneficiaries who are enrolled with a Managed Care Organization (MCO) within Centennial Care state plan. The beneficiary must be enrolled within an MCO at the time of discharge. Note: Members in hospice are excluded from the eligible population. Numerator: Seven (7) Day follow-up visit for ages eighteen (18) and above with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

Measure results

Blue Cross Blue Shield

45.64%

Presbyterian Health Plan

32.16%

Western Sky Community Care

27.14%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA) Combination 1 (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

79.96%

Presbyterian Health Plan

78.37%

Western Sky Community Care

71.33%

Complete

D2.VII.1 Measure Name: Long Acting Reversible Contraceptive (LARC) 44 / 55

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of LARCs utilized in female Medicaid Members 15 - 19 years of age.

Measure results

Blue Cross Blue Shield

310

Presbyterian Health Plan

504

Western Sky Community Care

104

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services. 45 / 55

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications).

Measure results

Blue Cross Blue Shield

1,904

Presbyterian Health Plan

2,713

Western Sky Community Care

683

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services. 46 / 55

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Total number of units for smoking and tobacco cessation products/services (NRT etc.)

Measure results

Blue Cross Blue Shield

105,347

Presbyterian Health Plan

122,437

Western Sky Community Care

1,046

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services.

47 / 55

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Total dollar amount for smoking and tobacco cessation products/services (NRT etc.)

Measure results

Blue Cross Blue Shield

$224,693.14

Presbyterian Health Plan

$197,737.79

Western Sky Community Care

$45,719.97

Complete

D2.VII.1 Measure Name: Utilization of smoking and tobacco cessation products and counseling services. 48 / 55

D2.VII.2 Measure Domain

Disease Management

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications) who had a successful quit attempt.

Measure results

Blue Cross Blue Shield

3

Presbyterian Health Plan

1

Western Sky Community Care

45

Complete

D2.VII.1 Measure Name: Ambulatory Care (AMB) Outpatient Visits (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. As WSCC is an exiting MCO, it was not required to 49 / 55

submit one-half year of annual HEDIS results.)

D2.VII.2 Measure Domain

Utilization

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

154.76

Presbyterian Health Plan

141.68

Western Sky Community Care

0.00

Complete

50 / 55

D2.VII.1 Measure Name: Ambulatory Care (AMB) Emergency Department Visits (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. As WSCC is an exiting MCO, it was not required to submit one-half year of annual HEDIS results.)

D2.VII.2 Measure Domain

Utilization

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

22.47

Presbyterian Health Plan

19.17

Western Sky Community Care

0.00

Complete

D2.VII.1 Measure Name: Oral Evaluation Dental Services (OED) (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. WSCC was not required to submit CY2024 HEDIS reports.)

51 / 55

D2.VII.2 Measure Domain

Dental and oral health services

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

42.45%

Presbyterian Health Plan

46.47%

Western Sky Community Care

8.11%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP) (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. As WSCC is an exiting MCO, it not required to submit one-half year of annual HEDIS results.)

52 / 55

D2.VII.2 Measure Domain

Cardiovascular Conditions

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

30.02%

Presbyterian Health Plan

36.67%

Western Sky Community Care

20.00%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD) Initiation Phase

53 / 55

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

State-specific

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

48.52%

Presbyterian Health Plan

34.67%

Western Sky Community Care

47.71%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD) Continuation Phase (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. As WSCC is an exiting MCO, it was not required to submit one-half year of annual HEDIS results.)

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

56.02%

Presbyterian Health Plan

41.05%

Western Sky Community Care

50.00%

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV) Ages 3-21 (Preliminary HEDIS data reported for Q1 and Q2 of CY2024, is administrative data only and not inclusive of medical record review. CY2024 annual audited HEDIS data will be available June 2025 from BCBS and PHP. As WSCC is an exiting MCO, it was not required to submit one-half year of annual HEDIS results.) 55 / 55

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

No, 01/01/2024 - 06/30/2024

D2.VII.8 Measure Description

N/A

Measure results

Blue Cross Blue Shield

21.81%

Presbyterian Health Plan

14.08%

Western Sky Community Care

16.59%

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.

Sanction total count: 4

Complete

D3.VIII.1 Intervention type: Fine

1 / 4

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Western Sky Community Care

D3.VIII.4 Reason for intervention

Failure to Report

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

11/06/2024

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

Yes, remediated 08/10/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

2 / 4

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

Did not meet required HEDIS performance metrics.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$18,581,383.52

D3.VIII.7 Date assessed

01/20/2025

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: Fine

3 / 4

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Presbyterian Health Plan

D3.VIII.4 Reason for intervention

Did not meet required HEDIS performance metrics.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$6,404,250.15

D3.VIII.7 Date assessed

11/04/2024

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: Fine

4 / 4

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

Western Sky Community Care

D3.VIII.4 Reason for intervention

Did not meet required HEDIS performance metrics.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$9,381,273

D3.VIII.7 Date assessed

10/07/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

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** 2 **Presbyterian Health Plan** 17 **Western Sky Community Care** 4
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** 136 **Presbyterian Health Plan** 2,049 **Western Sky Community Care** 38
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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Blue Cross Blue Shield** 1:1,659 **Presbyterian Health Plan** 1:0.1905 **Western Sky Community Care** 1:0
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** 149 **Presbyterian Health Plan** 1,912 **Western Sky Community Care** 72

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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Blue Cross Blue Shield** 1:1,514 **Presbyterian Health Plan** 1:0.2041 **Western Sky Community Care** 1:0
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) only **Presbyterian Health Plan** Makes referrals to the State Medicaid Agency (SMA) only **Western Sky Community Care** Makes referrals to the State Medicaid Agency (SMA) only
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	**Blue Cross Blue Shield** 136 **Presbyterian Health Plan** 2 **Western Sky Community Care** 38
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1).	**Blue Cross Blue Shield** 1:1,659 **Presbyterian Health Plan** 1:0.6668 **Western Sky Community Care** 1:0

Express this as a ratio per 1,000 beneficiaries.

D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Blue Cross Blue Shield** 01/01/2023 **Presbyterian Health Plan** 01/01/2023 **Western Sky Community Care** 01/01/2023
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Blue Cross Blue Shield** 06/30/2024 **Presbyterian Health Plan** 06/30/2024 **Western Sky Community Care** 06/30/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Blue Cross Blue Shield** $306,294.32 **Presbyterian Health Plan** $7,312,207.25 **Western Sky Community Care** $0
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Blue Cross Blue Shield** $3,711,794,901 **Presbyterian Health Plan** $5,123,818,119 **Western Sky Community Care** $90,204

D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Blue Cross Blue Shield** Promptly when plan receives information about the change **Presbyterian Health Plan** Promptly when plan receives information about the change **Western Sky Community Care** Monthly

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Blue Cross Blue Shield** No ILOSs were offered by this plan **Presbyterian Health Plan** No ILOSs were offered by this plan **Western Sky Community Care** No ILOSs were offered by this plan

Topic XIII. Prior Authorization

> ⚠ **Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

> ⚠ **Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If “Yes”, please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

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.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed 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