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TURQUOISE CARE PROGRAM

New Mexico State Medicaid Managed Care

Information Systems Capabilities Assessment 2024–2025

Final
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Prepared on behalf of:
The New Mexico Health Care Authority

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Abbreviations Used in This Report

A&G:	appeals and grievances
ABD:	adverse benefit determination
ACE:	advanced customer engagement
ALM:	application lifecycle management
AMA:	American Medical Association
AOR:	absence on roster
APA:	alternate payment arrangements
API:	application programming interface
ASP:	active server pages
ATS:	appeal tracking system
B2B:	business to business
BCBSA:	Blue Cross Blue Shield Association
BCBSNM:	Blue Cross Blue Shield of New Mexico, Inc.
BCRT:	Blended Census Reporting Tool
BDS:	Business Data Solutions
BH:	behavioral health
CA:	customer advocate
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	corrective action plan
CCBHC:	certified community behavioral health clinic
CCD:	continuity of care document
CCPD:	claim capability and product delivery
CDI:	Clinical Documentation Improvement

CEMS: capitated encounter management system

CES: claims edit system

CFE: Claims Front-End

CFR: Code of Federal Regulations

CHESS: claims handling enterprise software solution

CHIP: Children's Health Insurance Program

CMS: Centers for Medicare and Medicaid Services

CNA: comprehensive needs assessment

COB: coordination of benefits

COBOL: common business-oriented language

COPD: chronic obstructive pulmonary disease

CPT: Current Procedural Terminology

CRST: claims resource and support team

CSP: Community Strategic Platform (Facets)

DBP: dental benefits provider

DCN: document control number

DOB: date of birth

DOS: date of service

DQR: data quality review

DR: disaster recovery

DRG: diagnosis-related group

ECDS: Electronic Clinical Data System

ECG: Electronic Communications Gateway

ECP: essential community provider

EDI:	Electronic Data Interchange
EDW:	Enterprise Data Warehouse
EHR:	electronic health record
EISO:	Enterprise Information Security Organization
EMET:	Enterprise Medicaid Enrollment Team
EMR:	electronic medical record
EPPS RW:	employee performance profile system rewrite
EQR:	External Quality Review
EQRO:	External Quality Review Organization
EQS:	encounter quality system
ETS:	escalation tracking system
FFS:	fee-for-service
FLN:	film locator number
FQHC:	federally qualified health center
HCA:	Health Care Authority
HCPCS:	Healthcare Common Procedure Coding System
HCSC:	Health Care Service Corporation
HEDIS:	Healthcare Effectiveness Data and Information Set
HgA1c:	hemoglobin A1c
HIE:	health information exchange
HIPAA:	Health Insurance Portability and Accountability Act
HITECH:	Health Information Technology for Economic and Clinical Health
HR:	human resources
HRP:	HealthRules Payer

HRSN:	health-related social needs
HSD:	Human Services Department
I/T/U:	Indian/tribal/urban
IAM:	identity access management
ICD-10:	International Classification of Diseases, Tenth Revision
ICD-10-CM:	International Classification of Diseases, Tenth Revision, Clinical Modification
ICUE:	Integrated Clinical User Experience
ID:	identification
IHCP:	Indian health care provider
IHS:	Indian Health Services
IRADW:	Integrated Reporting and Analytics Data Warehouse
ISCA:	information systems capabilities assessment
IT:	information technology
JOC:	joint operating committee
LAN:	learning and action network
LGC:	Let's Get Checked
LoD:	line of duty
LOINC:	Logical Observation Identifiers Names and Codes
LTC:	long-term care
M&PCC:	member and provider contact center
MCG:	Molina claims gateway
MCO:	managed care organization
MFA:	multi-factor authentication
MFT:	managed file transfer

MHCNM: Molina Healthcare of New Mexico, Inc.

MN: Minnesota

MS-DRG: Medicare severity-diagnosis related group

MTM: member touchpoint measures

MY: measurement year

NCPDP: National Council for Prescription Drug Programs

NCQA: National Committee for Quality Assurance

NDB: National Data Base

NEMIS: national encounter management information system

NEMT: nonemergency medical transportation

NM: New Mexico

NPI: National Provider Identifier

NSF: nonstandard file

OCR: optical character recognition

ODS: operational data store

OMB: Office of Management and Budget

OU: organizational unit

P4P: pay for performance

PACDR: post-adjudicated claims data reporting

PBM: pharmacy benefit manager

PCOR: Patient Care Opportunity Report

PCP: primary care provider

PDM: provider data management

PHI: protected health information

PHM: population health management

PHPNM: Presbyterian Health Plan New Mexico

PHS: Presbyterian Healthcare Services

PI: paperless inventory

PIF: Provider Information Form

PII: personal identifiable information

PIP: performance improvement project

PL-SQL: Procedural Language-Structured Query Language

PM: performance measure

PMF: provider master file

PMPM: per member per month

PoA: plan of action

PPW: Premier provider web

PROS: Provider Reimbursement Operations Solutions

QA: quality assurance

QAI: quality assessment and improvement

QDR: quality data repository

QI: quality improvement

QOI: quality optimization and insights

QSI-XL: Quality Spectrum Insight, Catalyst

QuEST: Quality Every Single Time

RA: resolving analyst

RBAC: role-based access control

RCA: root cause analysis

RDBMS: relational database management system

REDCap: Research Electronic Data Capture

RHC: rural health clinic

RMO: regional mail operations

RN: registered nurse

RPO: recovery point objective

RTIS: Real-Time Interface System

RTO: recovery time objective

SAM: SMART audit master

SAS: Statistical Analysis System

SBHC: school-based health center

SCA: single case agreement

SDCB: self-directed community benefit

SDLCM: Software Development Life Cycle Model

SDoH: Social Determinants Of Health

SDR: supplemental data repository

SFTP: Secure File Transfer Protocol

SMART: Service Management Automation Reporting Technology (warehouse)

SME: Subject Matter Expert

SNOMED: Systematized Nomenclature of Medicine

SOP: Standard Operating Procedure

SQL: structured query language

SSAS: SQL Server Analysis Services

SSIS: SQL Server Integration Services

SSN:	Social Security Number
SSRS:	SQL Server Reporting Services
SUD:	Substance Use Disorder
SVN:	Apache Subversion
TIN:	Taxpayer Identification Number
T-MSIS:	Transformed Medicaid Statistical Information System
T-SQL:	transact-SQL
TX:	Texas
UCI:	universal customer identifier
UHCNM:	UnitedHealthcare of New Mexico
UI:	User Interface
VB.NET:	Visual Basic.NET
VBA:	Visual Basic for Applications
VBP:	Value-Based Purchasing
VPN:	Virtual Private Network

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I. Introduction

The Centers for Medicare and Medicaid Services (CMS) *External Quality Review (EQR)*[1] *Protocols* published in February 2023, state that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1 [Validation of Performance Improvement Projects], 2 [Validation of Performance Measures], 3 [Review of Compliance with Medicaid Managed Care Regulations], and 4 [Validation of Network Adequacy]." To comply with this federal requirement, the New Mexico (NM) Health Care Authority (HCA) instructed IPRO to perform the 2024–2025 ISCA for each managed care organization (MCO) participating in the Turquoise Care program.

IPRO conducted the ISCA in accordance with Appendix A of the *CMS External Quality Review (EQR) Protocols* published in February 2023. The purpose of this assessment is to pose standard questions to assess an MCO's strengths with respect to the tasks outlined in the list below. Responses to these questions assisted IPRO in assessing the extent to which the MCO's information systems were capable of the following essential tasks:

- assessment of the MCO's capacity to manage the health care of their enrollees;
- adjudicating and reviewing claims data received from various sources;
- submitting encounter data to the state and ensuring the completeness and accuracy of the MCO's encounter data;
- calculation and submission of the MCO's performance measures (PMs), including Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Adult and Child Core Set, and state-specific measures;
- conducting quality assessments and improvement initiatives and linking to other information sources;
- review of the MCO's grievance systems; and
- maintaining a provider directory and processes ensuring the network adequacy of the provider network based on the state's travel time and distance standards.

[1] CMS External Quality Review (EQR) Protocols (medicaid.gov)

II. Molina Healthcare of New Mexico

General Information

IPRO worked with HCA to customize the ISCA worksheet provided in Appendix A of the *CMS External Quality Review (EQR) Protocols* published in February 2023. Turquoise Care, the NM Medicaid program began July 1, 2024.

In addition to customizing the ISCA survey tool for NM's Medicaid products, the ISCA was also modified to include questions related to the HEDIS Electronic Clinical Data Systems (ECDS) measures and race and ethnicity categories, quality assessment and improvement initiatives, grievances and encounter data submissions to the state.

On December 11, 2024, IPRO uploaded the NM ISCA tool to Research Electronic Data Capture (REDCap®) and the NM MCOs were requested to complete and return the responses by January 31, 2025.

A 5-hour virtual meeting was held for Molina Healthcare of New Mexico, Inc. (MHCNM) on April 9, 2025, to discuss the MCO's ISCA responses, interview the MCO's staff, and review the MCO's information system capabilities. MHCNM staff, HCA, and IPRO staff attended the virtual meeting.

The MCO's information system assessment covered the following areas:

- Data Integration and Systems Architecture
- Membership Data Systems and Processes
- Claims Data Systems and Processes
- Performance Measure Reporting, Race and Ethnicity, and ECDS Measures
- Provider Data Systems and Processes
- Provider Network Adequacy
- Oversight of Contracted Vendors
- Grievance Systems
- Encounter Data Submissions to State

MHCNM's completed ISCA worksheet can be found in **Appendix A**.

Data Integration and Systems Architecture

During the data integration and systems architecture session, the MCO provided a comprehensive walkthrough of all data sources maintained by the MCO for operations and reporting. Data sources included transactional systems, including claims, enrollment, provider, and vendor data. The MCO provided a review of all warehouses maintained by the MCO used for regulatory and financial reports, analysis, and PM reporting. MHCNM provided a review of data control and security procedures, including disaster recovery (DR) plans. The discussion also included the frequency of load of claims, vendor and enrollment data, and any control checks in place for data warehouse loads.

MHCNM utilizes QNXT®, a core integrated information management system developed by TriZetto Corporation, for storing Medicaid or Children's Health Insurance Program (CHIP) claims and encounter data while using Infosys Helix® as their membership platform. This system is built using Microsoft® technologies and employs a centralized relational database, Microsoft Structured Query Language (SQL) Server. MHCNM also uses a comprehensive capitated encounter management system (CEMS) and other platforms like the operational data store (ODS) and Molina claims gateway (MCG) for bidirectional flow of information to

produce operational reporting. The end-to-end view and flow of information of these platforms supports a solid framework for analytic reporting. MHCNM follows a standard software development methodology known as the Software Development Life Cycle Model (SDLCM).

MHCNM has the capabilities of maintaining 10 years of Medicaid and CHIP data online. As per MHCNM's ISCA response, historical data are preserved within their data lake environment for up to 7 years, with older data stored on tape. For extracting analytical reports, programmers utilize various programming languages, including Transact-SQL (T-SQL), SQL Server® Integration Services (SSIS), SQL Server Analysis Services (SSAS), SQL Reporting Services (SSRS), and other Microsoft tools.

For version control during software development at MHCNM, Git® is used. MHCNM indicated that they have an ODS dedicated to encounter data submissions that performs validation prior to submission to the state.

MHCNM's HEDIS repositories are built and maintained using an NCQA-certified HEDIS software vendor, ClaimSphere®, that receives monthly data updates. ClaimSphere is utilized in the development of HEDIS and CMS Adult and Child Core Set PMs.

Disaster Recovery

MHCNM utilizes multiple data centers that provide failover capabilities. MHCNM advised that their primary DR system is based at Microsoft Azure® North Central DR site (located in Illinois), with backup data stored in Microsoft Azure U.S. South Central Region (located in Texas), and replicated to Microsoft Azure U.S. North Central Region. As per MHCNM's response, daily differential backups, weekly full backups, and transactional log backups every 30 minutes or 1 hour are performed on all production and test servers, and stored on disk. MHCNM indicated that the failover to additional data centers is immediate, with a recovery time objective (RTO) of 24 hours or less for tier-1 business processes. The recovery point objective (RPO) for tier-1 and tier-2 applications is 24 hours.

MHCNM reports that its DR system is tested at least annually. Backup restoration procedures are conducted at a minimum once per year, with an increasing emphasis on performing them multiple times annually.

Access to System

MHCNM has a robust security infrastructure. As per MHCNM's ISCA response, access to their system is granted on an as-needed basis utilizing role-based access control (RBAC). Sensitive access granted outside of a role requires approval from the management and a data owner, where applicable. MHCNM utilizes multi-factor authentication (MFA) provisioned through Microsoft Azure Active Directory®. MHCNM remote access users are required to take computer-based training that reviews safeguards and procedures for countering risks related to remote access use. Telecommuters cannot print information or save to a local drive or external device. MHCNM's systems within the cloud are also subject to the same control objective as those in their data centers. MHCNM encrypts personally identifiable information (PII) both at rest and in transit using strong encryption algorithms to protect against unauthorized access. MHCNM maintains a cybersecurity monitoring and analysis service to proactively review security logs for unusual or unauthorized activity within the network and information systems.

As per MHCNM's ISCA response, user access credentials are promptly deactivated upon the termination of an employee's employment.

MHCNM mandates that all employees and affiliated staff members complete an annual, computer-based training program encompassing key areas, such as cybersecurity, privacy, regulatory compliance, and physical

security. Participation in this training is a condition of continued access to organizational systems and resources. According to MHCNM, both course completion and assessment performance are systematically tracked through an internal monitoring system. This ensures adherence to corporate training requirements and supports ongoing organizational compliance with applicable policies and standards.

Membership Data System and Processes

The membership data systems and processes review included a demonstration of enrollment/membership data systems for Medicaid and CHIP members, and processes used to verify and update enrollment information.

MHCNM's reconciliation process of HCA's 834 daily and monthly eligibility files and audit processes was reviewed. The demonstration included workflow of systems and databases used to store membership data, details on control checks in place by the MCO to manage membership and eligibility related to multiple member identification (ID) numbers, demographic changes and movement, and notification for newborns and deaths to the state.

MHCNM receives daily and monthly 834 file(s) from HCA. Eligibility is determined by the state, and membership information received on the files is loaded within 24 hours of receipt into Infosys Helix and other systems for Medicaid and CHIP. MHCNM enrollees are assigned a unique subscriber ID number in QNXT, which is linked to their state-assigned Medicaid ID. MHCNM retains and stores all historical addresses for its members. As per MHCNM, fallout data from the file loads are manually reviewed by the enrollment team, and changes are applied to QNXT to match the incoming record. The enrollment team is responsible for applying enrollment and disenrollments in QNXT. On average, 50–100 daily and monthly exception records are manually reviewed by the plan.

Upon notification of a member's disenrollment via the daily file, a termination date is entered in the QNXT system. MHCNM advised that updates, including addition of members or termination of membership, are based upon review with the NM Medicaid portal and confirmation with the state as needed.

When MHCNM identifies a member's death in the daily 834 file(s), MHCNM‘s enrollment team submits a critical incident report to the designated internal Microsoft Outlook® mailbox within 24 hours. All deaths, regardless of the member's eligibility category in Turquoise Care, are reported for clinical review. The quality management department investigates by forwarding the incident to a quality improvement (QI) registered nurse (RN), who may request medical records, investigation outcomes, root cause analysis (RCA), and Office of the Medical Investigator reports to determine the cause of death. Deaths under investigation are marked as "under review" until the investigation is concluded, and the enrollment department and care coordinators are notified via email on the same day. Once the investigation is completed, the member’s record is flagged for disenrollment, pending a state enrollment update, after which the member record is deactivated in Infosys Helix.

Newborns are auto enrolled and tracked through MHCNM’s HCA enrollment file. Multiple births are stored with individual Medicaid IDs. Newborn records are linked to the newborns parent(s). MHCNM advised that newborns are loaded in the enrollment system with a temporary ID, which is attached to the mother’s Medicaid ID.

MHCNM indicated that each member generally has only one unique Member ID. If a member has more than one Medicaid ID, Infosys Helix uses multiple data elements in the member record in the state eligibility file to associate the record with an already existing member record in its Medicaid enrollment data system.

However, if a member has more than one Medicaid ID received via the eligibility file, relevant enrollment segments are linked, and continuous enrollment is calculated based on the original enrollment date. MHCNM indicated that enrollment records are merged so the member would have an enrollment span under one ID number and then a new enrollment span created with the new ID number all housed under one record. All member-specific information is accessible in the systems and links to the Member ID (unique assigned ID) which does not change. MHCNM indicated that they also provide 6 weeks' extensive training for their enrollment team on QXNT and Infosys Helix.

MHCNM receives race and ethnicity data provided by HCA on the daily enrollment files and stores the information in QNXT and other systems. During the virtual meeting, MHCNM indicated their finance department utilizes the monthly 820 Health Insurance Portability and Accountability Act (HIPAA) capitation file for reconciliation. MHCNM's average unduplicated member enrollment counts for Medicaid and CHIP enrollments from 2022 to 2024 are listed in **Table 1**.

Table 1: MHCNM Average Unduplicated Member Enrollment Counts, 2022–2024

Product Type	Year 1 – 2022[1]	Year 2 – 2023[1]	Year 3 – 2024
Medicaid	N/A	N/A	34,981[2]
CHIP	N/A	N/A	1,608[2]

[1] MHCNM was incorporated in 2024, member enrollment counts for 2022 and 2023 are not applicable.
[2] CHIP enrollment was asked as a follow-up item to the virtual meeting.
CHIP: Children's Health Insurance Program; N/A; not applicable.

Claims Data Systems and Processes

The claims/encounter data systems and processes evaluation included a review of responses provided by the MCO on the ISCA worksheet, verification of the accuracy of information provided through direct review of claims systems, review of audit processes and audit results, and a walkthrough of professional and facility claims for the Medicaid product. Discussion covered claim sources, clearinghouse, and provider portal, percentage of paper versus electronic claims, and auto-adjudication rates by product lines. The review also included the use of Diagnosis-Related Groups (DRGs), high dollar thresholds, and alternative payment agreements (APAs) to providers.

MHCNM provided a detailed walkthrough of individual claims from receipt to payment for professional and facility claims for the Medicaid and CHIP product lines. During the virtual meeting, MHCNM demonstrated examples for institutional and professional claim types for Medicaid and CHIP.

According to MHCNM's ISCA response, claims are received through multiple channels, including electronic submissions via clearinghouses, direct data entry through the provider portal, and paper-based claim submissions. MHCNM reports that approximately 99% of claims are submitted electronically, either through the provider portal or in electronic file formats.

Providers have the capability to enter claims directly into the QNXT system via the provider portal. These entries are transmitted through an electronic data interchange (EDI) process. Upon receipt, each claim is assigned a unique MHCNM claim number, and an image of the claim is generated for legal retention purposes. This image is stored and can be retrieved through a claim viewer.

Electronic claims submitted through the clearinghouse are received daily in standard 837I (institutional) or 837P (professional) formats. These claims are initially processed by a preprocessor before being routed

through MCG. During this process, a claim number is assigned, and a corresponding image is stored within the QNXT system for recordkeeping and audit purposes.

Approximately 82% of Medicaid claims are auto-adjudicated, while the remaining claims require manual processing. Claims that do not meet auto-adjudication criteria are systematically routed to designated work queues based on claim type and date of receipt. These claims are placed in a pended status either automatically by the system or manually by a claims examiner when additional departmental review or processing support is necessary.

Pended claims are subject to close monitoring to ensure timely resolution. The claims management team generates and reviews a daily pended-claims report, which tracks the status of all unresolved claims. This process ensures that any outstanding information is obtained promptly and that adjudication occurs within established timeframes.

MHCNM receives and stores the provider-submitted DRG code but also relies on grouper software to calculate and compute DRGs. This software allows MHCNM to accurately classify inpatient cases and determine appropriate reimbursement rates based on the assigned DRGs. By leveraging grouper software, MHCNM ensures that its payment processes are aligned with industry standards and that hospitals receive fair compensation for the services rendered. The use of grouper software also helps MHCNM to maintain consistency and efficiency in its claims processing. Given the complexity of medical coding and the vast amount of data involved in healthcare reimbursement, the automation provided by grouper software is invaluable in minimizing errors and streamlining operations.

As per MHCNM's ISCA response, up to 12 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes and unlimited procedure codes are accepted and stored for professional claims utilizing the CMS-1500 (or the electronic comparative, 837P) and up to 25 ICD-10-CM diagnosis codes and unlimited procedure codes for facility institutional claims utilizing the UB-04 (or the electronic comparative, 837I).

MHCNM states that claims that pay $25,000.00 or more (or $15,000.00 or more for coordination of benefits [COB] only) will be routed to the high dollar review queue. Claims are reviewed based on the dollar payment amount.

MHCNM indicated that training is typically 30 days for all claim reviewers followed by remediation and refreshers for the next 90 days. This is also supplemented through the Corporate Audit Program as an internal department audit program. MHCNM advises that 10% of their claims are used as a sample size for monthly audits with every claim processor. Identified issues are then reviewed to determine whether they were examiner, documentation, or systemic errors. Appropriate actions are taken based on findings, such as examiner coaching, updating documentation/standard operation procedures (SOPs), staff education, and system modification. **Table 2** lists paper and electronic claim types received.

Table 2: MHCNM Claims/Encounter Data Sources and Types

Data Source	Data Type
Hospital	Paper: UB-04 Electronic: 837I
Physician	Paper: CMS-1500 and UB04 Electronic: 837P
Drug	Electronic: NCPDP
Nursing home	Paper: UB-04 Electronic: 837I
Home health	Paper: UB-04 and CMS-1500 Electronic: 837P or 837I
Mental health	Paper: UB-04 and CMS-1500 Electronic: 837I or 837P
Dental	Electronic: 837D
Transportation	Electronic: 837P

UB-04: Uniform Billing Form; CMS: Centers for Medicare and Medicaid Services; CMS-1500: professional paper claim form; NCPDP: National Council for Prescription Drug Programs; 837I: institutional claims form; 837P: professional claims form; 837D: dental claims form.

Performance Measures Reporting, Race and Ethnicity, and ECDS Measures

The performance measures reporting, race and ethnicity, and ECDS measures review included data sources, supplemental data received and integrated into the PM reporting for HEDIS, CMS Adult and Child Core Set, and NM-specific PMs. Further review included the discussion of race and ethnicity data, sources, assignment of NCQA-certified vendor and state-specific categories, and discussion of the submission of ECDS measures for HEDIS NCQA measures reporting. The detailed crosswalk of MCO race and ethnicity and supplemental data sources for ECDS measures was presented by MHCNM.

MHCNM's HEDIS repositories are developed and maintained by a certified vendor. MHCNM uses ClaimSphere to generate HEDIS PMs. Data files are updated monthly, and software upgrades are released from the vendor monthly or more often as needed. HEDIS measure rates are trended year after year to validate rate reasonableness. Data are pulled from member demographics, enrollment, provider demographics, medical claims, pharmacy claims, and lab results, and are stored in the quality data repository (QDR). QDR is refreshed daily at the end of the day. Other supplemental files are collected in various ways from vendors, external entities, and internal collection activities by MHCNM plans and staged in a similar fashion. This is the first collection step in data consolidation and is done for all measures. Data are obtained from the QDR environment, staged and then loaded into HEDIS software. A full refresh is completed monthly.

Continuous enrollment, member months, and member years are calculated within Infosys Helix with rates compared to prior year benchmarks to validate variances. Relevant enrollment segments are linked, and continuous enrollment is calculated based on an original enrollment date. MHCNM does not have a system limitation that precludes the MCO from fully implementing continuous enrollment requirements. MHCNM produces HEDIS PMs annually and reports PMs monthly to their quality committee and quarterly to the state.

MCHNM indicated they have processes in place to meet state requirements related to population health management and QI intervention strategies. MHCNM integrates diverse data sources into its QI and population health strategies, including claims data, vendor data, electronic medical records (EMRs) from

providers, health information exchange (HIE) data, case management data and data that are collected through State Registry. MHCNM's quality and population health strategy is built around provider engagement, member-focused initiatives, and data-driven improvements. MHCNM indicated their quality team manages a work plan that incorporates goals and interventions across departments and maintains an intervention tracker to monitor QI efforts and outcomes. By tracking and monitoring regular outcomes for each of the interventions, programs, and projects, MHCNM can identify positive or negative trends and adjust the interventions as needed to continuously improve QI efforts.

MHCNM indicated on their ISCA response that they use direct data sources for NCQA for all race and ethnicity categories. MHCNM has full capabilities to meet all requirements for *2024 Office of Management and Budget (OMB) Statistical Directive Standard No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, which includes the new Middle Eastern and North African race category and has updated all systems with the same logic to ensure the new race and ethnicity categories are mapped to include Middle Eastern and North African race categories.

MHCNM follows the NCQA hierarchy for HEDIS ECDS measures, utilizing data from pharmacies, electronic medical records (EMRs,) non-EMR medical records, state registries, and historical files. They receive Systematized Nomenclature of Medicine (SNOMED) and Logical Observation Identifier Names and Codes (LOINC®) codes from some continuity of care document (CCD) sources, with supplemental data provisioned for state membership and included in final reports. **Table 3** lists ECDS sources and order.

Table 3: MHCNM ECDS Sources and Order

ECDS Data Source	MCO's Hierarchical Order
1. Electronic health record (EHR)/personal health record (PHR)	1
2. Health information exchange (HIE)/clinical registry	3
3. Case management registry	2
4. Administrative (i.e., claims)	4

ECDS: electronic clinical data systems; MCO: managed care organization.

Provider Data Systems and Processes

The provider data systems and processes review included a detailed review of the health plan provider network and credentialing processes and a discussion of maintenance of provider directories. The discussion included access and availability of the provider portal and percentage of claims received via provider portal.

MHCNM's provider information is maintained and fed through QNXT. MCHNM indicated that they maintain information like demographic data, such as name, location, Taxpayer Identification Number (TIN), gender, specialty, hospital affiliations, medical group affiliations (if applicable), board certification with expiry dates, acceptance of new patients, languages spoken by practitioner or clinical staff, and office locations. MHCNM indicated that their provider data teams perform ongoing monitoring of provider information, including credentialing and recredentialing.

MHCNM reported that its provider directory is available in up to 10 languages to accommodate the diverse linguistic needs of its members. The directory is accessible online through a provider search tool available on the organization's website. Oversight and authority for updates and modifications to the directory rest with the provider network management and operations team. The online provider directory is updated at least weekly to ensure accuracy. In contrast, data for the printed directory are refreshed on a quarterly basis, and printed copies are made available upon member request.

About 88–90% of MHCNM's providers are reimbursed based on fee-for-service (FFS) reimbursement. MHCNM has implemented some APAs that MHCNM has in place whereby they pay some providers based on a per-member-per-month (PMPM) basis. MHCNM indicated they have value-based purchasing (VBP), where they pay for performance and have some quality type metrics with incentives that are built in, but the majority of the providers are paid based on FFS.

Provider Network Adequacy

The provider network adequacy review included a discussion of network adequacy processes for collecting, storing, analyzing, and reporting network adequacy data. The review of network standards, methods and calculations was used for calculating network adequacy indicators and detailed overview on geo-access analysis, state standards and compliance, along with any prior network adequacy validation results. Further review of prior network adequacy reports was conducted, and any challenges meeting state standards for network adequacy were discussed. The MCO also provided information on network gaps with provider availability, time, and distance.

MHCNM utilizes Quest Analytics® software along with SQL and QNXT to evaluate their network accessibility and adequacy. MCHNM indicated that their network adequacy requirements, which are outlined in their contract with the state and programmed into Quest Analytics, align with state expectations. This allows them to understand and manage the provider network in accordance with the contract with the state. MHCNM uses Quest Analytics for network adequacy reporting sent to the state. MHCNM's network operations team is involved in analyzing and reporting network adequacy data, and the team's training is standardized at all levels.

As per MHCNM's ISCA response, network adequacy data are refreshed daily, and analyzing, collecting, reporting, and storage of data are automated processes. MHCNM utilizes QNXT, Quest Analytics, and EDI platforms to have the ability to reconcile and bring forward data discrepancies for resolution and to help prevent missing or incomplete network adequacy data. If network adequacy gaps are identified through a grievance or complaint, MHCNM identifies strategies to fill gaps and communicates with their members about solutions to meet their needs. To achieve this, MHCNM continuously analyzes data related to access and availability within the provider network. These analyses help MHCNM identify gaps or areas for improvement. One of the key ways MHCNM uses this information is by pinpointing geographic areas or specialties where there may be a shortage of providers. By identifying these gaps, MHCNM can actively recruit and contract with new providers to fill these provider specialty needs, ensuring their members have better access to care.

MHCNM submits quarterly network adequacy reports and analyses to the state. MHCNM indicated that there are no existing corrective action plans (CAPs) for network adequacy. MHCNM advised gaps exist in rural, urban and frontier counties in multiple specialties, including but not limited to dermatology, urology, assisted living facilities, rural health clinics (RHCs), certified community behavioral health clinics (CCBHCs) and others. MHCNM indicated that they are actively working to expand their network and are working with their existing providers to improve services in areas where there are gaps in care.

MHCNM uses incentive payments, VBP arrangements, and extended telehealth arrangements that cover the entire state to increase provider participation and provide members access in certain rural areas.

MHCNM indicated that they ensure all essential community providers (ECPs) are fully contracted. As per MHCNM's ISCA response, Indian health care providers (IHCPs) do not require to be contracted. Additionally, MHCNM has established the Office of Native American Affairs that serves as MCHNM's liaison for all tribal entities. MHCNM utilizes the information from their access and availability analysis to make targeted

improvements in their provider network, ultimately enhancing the quality of care and access for their members. MHCNM advised that network adequacy analyses and results are presented at quarterly health plan committee meetings.

Oversight of Contracted Vendors

The review of oversight of contracted vendors focused on contracted vendors and delegated functions, and included detailed discussion on the health plan's vendor oversight policies, activities, reports and review of vendor data reporting requirements, submission patterns, and data completeness. Data submitted included all required elements for PM reporting, encounter reporting to the state, and performance improvement projects (PIPs).

MHCNM has vendors for dental, vision, pharmacy, and transportation services (**Table 4**). MHCNM's vendors include DentaQuest® for dental claims, MARCH Vision® for vision services, CVS® for pharmacy services, and Superior® for non-essential transportation services. As per MHCNM's ISCA response, data from carved out benefits or from delegated entities are submitted to MHCNM from the vendors' systems. MHCNM utilizes Edifecs® inbound and CEMS outbound for encounter data validation. Encounter reconciliation is validated through submitted claims.

MHCNM conducts regular biweekly joint operating committee (JOC) meetings with all material subcontracts with data concerns currently. During the virtual meeting, MHCNM indicated that BH gaps currently exist, but that there are currently no CAPs with their vendors. MHCNM indicated that, when they do have a CAP, they monitor the CAP monthly to ensure that they are meeting the requirements with their vendors with respect to their credentialing and claims.

Table 4: MHCNM Vendors by Claim Type

Claim Type	Vendor	Vendor Contract Begin Date	Frequency of Encounter Submission
Dental	DentaQuest	7/1/2024	Weekly
Vision	MARCH Vision	7/1/2024	Weekly
Pharmacy	CVS	7/1/2024	Weekly
Transportation	Superior	7/1/2024	Weekly

Grievance Systems

Review of grievance systems included demonstrations of the systems used for Medicaid and CHIP. The review included interfaces with other systems, such as eligibility, claims, and providers, and discussion of processes for reporting to the state.

MHCNM's grievance systems do not interface directly with the transactional systems. However, nightly member and provider loads to the grievance systems from the transactional systems ensure that member and provider information are current. The application has multiple reporting and tracking tools to allow managers to monitor cases. Reports for the state are generated from the grievance systems. Discussion included the production of quarterly reports to the state and an overview of grievance systems for Medicaid and CHIP product lines.

MHCNM utilizes the Pega Appeals and Grievance Solution® to manage Medicaid member and provider grievances. SOPs guide the handling of complaints and grievances, ensuring compliance with regulatory

requirements. When an adverse benefit determination (ABD) is issued, members receive a written notice outlining their right to appeal, in accordance with *Title 42 Code of Federal Regulations (CFR) Section (§) 438.402(b)*.

Members are supported throughout the appeal process by the member and provider contact center (M&PCC) and appeals staff, who assist with documentation, translation, and other needs, particularly for members with literacy or language barriers. MHCNM ensures the process is accessible, efficient, and member-centered.

Provider grievances and appeals are reviewed impartially and in a timely manner to maintain compliance with state and federal regulations. MHCNM adheres to the HCA requirements and applicable NCQA standards and regulations as outlined in the *Medicaid Managed Care Services Agreement*.

Providers have the right to file a grievance or an appeal. MHCNM ensures that providers may bring concerns regarding the operation of the MCO, reimbursement disputes, claims denials due to lack of prior authorization, timeliness, quality of and access to health care services, choice of health care providers and the adequacy of the MHCNM network through the grievance and appeals process.

Enhanced complaint and grievance training is well established and incorporated within the call center new hire training.

When a member call is received in the call center to update the member's primary care provider (PCP), the reason(s) for changing the PCP is documented.

Complaints and grievances are reported to HCA on a quarterly basis via Report #37. Currently, there are no complaints and grievances that are not included in the report to the state. MHCNM indicated that they currently have no challenges in identifying member or provider issues. Challenges on the provider side are about focused-claim payments for appeals based on line of duty (LoD) determinations providers are not informed of or did not review before submitting claims.

Encounter Data Submissions to State

The review of encounter data submissions to state section focused on a detailed review of encounter data systems, encounter data submission, and reconciliation processes. A walkthrough and demonstration of the encounter data systems and any available reports were also discussed in detail. The MCO provided details on timeliness and accuracy of submission of encounters to HCA.

MHCNM's encounter data are stored within Edifecs inbound or CEMS outbound systems, which perform validation of encounter data prior to submission to HCA. Contractually MHCNM is required to submit both paid and denied encounters. MHCNM submits denied service lines to the state but, as per MHCNM's ICSCA response, HCA has not provided guidance on the submission of denied claims.

MHCNM submits encounter files to HCA on a weekly basis. Each Thursday morning, claims processed during the prior week are extracted and prepared for submission. Encounter reconciliation is conducted weekly and validated against claims submitted by vendors for medical, vision, dental, transportation, and home care services. Encounters failing validation are reviewed by MHCNM's Medicaid encounters team, which conducts backlog monitoring, error tracking, analysis, resolution, and completion monitoring for encounter data submissions.

MHCNM's top-3 encounter data submission denial reason codes are:

1. 0051 – E - Accommodation Revenue Codes Does Not Equal The Covered Days
2. 1361 – E - Exact Duplicate
3. 0072 – E - Accommodation Revenue Codes Missing

MHCNM's encounter data submission denial reason codes were updated after follow-up with the plan.

MHCNM adheres to NM's timeliness standards regarding the submission of encounters; encounters are submitted within 5 business days of claim adjudication. Total encounters submitted to HCA in January 2025 were 32,423.

Summary of Findings

CMS prescribes that at the conclusion of the ISCA review, the external quality review organization (EQRO) is to compile and analyze the information gathered through the preliminary ISCA review and from the MCO staff interviews. After completing its analysis, the EQRO writes a statement of findings about the MCO's information system review and assigns an assessment level to each assessment topic.

Table 5 contains the four assessment levels and their definitions. MHCNM's summary of findings is presented in **Table 6**.

Table 5: IPRO Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

MCO: managed care organization.

Table 6: MHCNM Summary of Findings

Assessment Topic	Assessment Finding	Review Note
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	MHCNM has processes and procedures in place to maintain member enrollment information and ensure eligibility standards are met. MHCNM receives daily and monthly 834 file(s) from HCA. Eligibility is determined by the state, and membership information received on the files is loaded within 24 hours of receipt into Infosys Helix and other systems for Medicaid and CHIP. MHCNM enrollees are assigned a unique subscriber identification (ID) number in QNXT, which is linked to their state-assigned Medicaid ID. No issues were noted in MHCNM's enrollment processes and procedures.
Adjudication and review of claims data received from multiple sources	Met	MHCNM receives claims through clearinghouses, via their provider portal, and on paper. MHCNM advised 99% of claims are submitted electronically, via provider portal or in electronic HIPAA file format. No issues were noted in MHCNM's current claim adjudication process of claims.
Validation and/or calculation of performance measures	Met	MHCNM utilizes NCQA-certified HEDIS software, ClaimSphere to generate HEDIS and CMS Adult and Child Core set PMs. MHCNM loads claims, provider, membership, pharmacy, and encounter data into ClaimSphere's HEDIS engine, Converged for processing PMs. For HEDIS ECDS PMs, MHCNM adheres to the NCQA-prescribed hierarchy order for incorporating supplemental data sources. No issues were noted in MHCNM validation and calculation of PMs.
Utility of the MCO's IS for linking to other information sources for quality related reporting	Met	MHCNM's information systems support various data reporting requests, both internally and externally. No issues were noted.

Assessment Topic	Assessment Finding	Review Note
Identification and reporting of NCQA's and CMS's race and ethnicity categories	Met	MHCNM collects race and ethnicity data during member enrollment through claims submissions and from supplemental data sources, such as health information exchanges (HIEs) to ensure robust stratification. Race and ethnicity data from all sources are integrated into MHCNM's data repository and mapped to ClaimSphere's crosswalk for member race and ethnicity reporting. MHCNM can capture the race and ethnicity values based on the *2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, which includes the new Middle Eastern and North African race category. No issues were identified in MHCNM's identification and reporting of NCQA's and CMS's race and ethnicity categories
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	The quality department manages a work plan that incorporates goals and interventions from departments across the MCO in relation to QI efforts. The other departments contribute to this work plan at least once a quarter with updates. For the quality team's specific interventions for quality measure improvement an intervention tracker is in place to monitor efforts and outcomes for each intervention. By tracking and monitoring regular outcomes for each of the interventions, programs, and projects, MHCNM is able to identify positive or negative trends and adjust the interventions as needed to continuously improve MHCNM's QI efforts. No issues were noted in MHCNM ability to conduct MCO quality assessment and improvement initiatives.
Completeness and accuracy of tracking of member and provider grievances and appeals	Met	MHCNM utilizes Pega Appeals and Grievance Solution as their grievances and complaints processing system for NM Medicaid member and provider grievances. MHCNM accepts verbal, written, and electronic grievance submissions. All grievances and complaints are investigated and tracked by MHCNM's customer service associates in Pega Appeals and Grievance Solution until resolved. No issues were noted in MHCNM's systems used for handling grievances and reporting to the state.

Assessment Topic	Assessment Finding	Review Note
Validation and/or calculation of network adequacy reports	Met	MHCNM utilizes Quest Analytics and QNXT along with SQL software for assessing, monitoring, and reporting network adequacy. MHCNM submits network adequacy reports to the state daily, as per HCA's regulatory requirements. MHCNM currently does not have any active CAPs. But MHCNM has provider network deficiencies across the state in dermatology, in BH and CCBHCs in Southeastern NM, and in urology and dermatology in other parts of the state. No issues were noted with MHCNM provider network adequacy validation and calculation processes.
Ability of the information system to generate complete, accurate and timely T-MSIS data	Not Applicable	MHCNM does not submit encounter data directly to CMS; MHCNM submits encounter data to HCA.
Completeness and accuracy of encounter data collected and submitted to the state	Met	MHCNM submits encounter data to the state, complying with the standards for timeliness and accuracy of submissions of paid encounters. No issues were noted with the completeness and accuracy of encounter data collected and submitted to the state.

MCO: managed care organization; HCA: Health Care Authority; CHIP: Children's Health Insurance Program; Health Insurance Portability and Accountability Act; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; CMS: Centers for Medicare and Medicaid Services; PM: performance measure; ECDS: Electronic Clinical Data Systems; QI: quality improvement; NM: New Mexico; IS: information systems; SQL: Structured Query Language; CAP: corrective action plan; BH: behavioral health; CCBHC: certified community behavioral health clinic; T-MSIS: Transformed Medicaid Statistical Information System.

III. Blue Cross Blue Shield New Mexico

General Information

IPRO worked with HCA to customize the ISCA worksheet provided in Appendix A of the *CMS External Quality Review (EQR) Protocols* published in February 2023. Turquoise Care, the NM Medicaid program began July 1, 2024.

In addition to customizing the ISCA survey tool for NM's Medicaid products, the ISCA was also modified to include questions related to the HEDIS Electronic Clinical Data Systems (ECDS) measures and race and ethnicity categories, quality assessment and improvement initiatives, grievances, and encounter data submissions to the state.

On December 11, 2024, IPRO uploaded the NM ISCA tool to Research Electronic Data Capture (REDCap®) and the NM MCOs were requested to complete and return the responses by January 31, 2025.

A 5-hour virtual meeting was held for BCBSNM on April 1, 2025, to discuss the MCO's ISCA responses, interview the MCO's staff, and review the MCO's information system capabilities. BCBSNM staff, HCA, and IPRO staff attended the virtual meeting.

The MCO's information system assessment covered the following areas:

- Data Integration and Systems Architecture
- Membership Data Systems and Processes
- Claims Data Systems and Processes
- Performance Measure Reporting, Race and Ethnicity, and ECDS Measures
- Provider Data Systems and Processes
- Provider Network Adequacy
- Oversight of Contracted Vendors
- Grievance Systems
- Encounter Data Submissions to State

BCBSNM 's completed ISCA worksheet can be found in **Appendix A**.

Data Integration and Systems Architecture

During the data integration and systems architecture session, the MCO provided a comprehensive walkthrough of all data sources maintained by the MCO for operations and reporting. Data sources included transactional systems, including claims, enrollment, provider, and vendor data. The MCO provided a review of all warehouses maintained by the MCO used for regulatory and financial reports, analysis, and PM reporting. BCBSNM provided a review of data control and security procedures, including disaster recovery (DR) plans. The discussion also included the frequency of load of claims, vendor and enrollment data, and any control checks in place for data warehouse loads.

BCBSNM utilizes Health Care Service Corporation (HCSC©) Facets and Blue Chip as their membership and claims processing platforms. BCBSNM uses enterprise data warehouse (EDW), which is a Teradata® environment as their relational database management system (RDBMS). BCBSNM has multiple data platforms, including operational data store (ODS) and cloud-based Hadoop data lake (DL). BCBSNM also utilizes HCSC's care coordination system, GuidingCare®, and HCSC's medical management authorization referral input system

(ARIS). BCBSNM follows a standard software development methodology, Software Development Life Cycle Model (SDLCM).

BCBSNM advised that 11 years of data are retained in their transactional claims system, Blue Chip, which is available and accessible to them. BCBSNM's ODS stores 18 months of claims data and 30 months of membership data. BCBSNM's historical data are maintained in their DL and EDW. BCBSNM indicated that there has been no major systems changes or updates in their Medicaid or Children's Health Insurance Program (CHIP) claims or encounter system in last 3 years. For data extracts and analytical reporting, BCBSNM programmers and analysts utilize various programming languages and software, including a combination of Structured Query Language (SQL), Visual Basic for Applications.NET (VBA.NET), and Teradata Assistant. BCBSNM uses commercially available tools for version control, such as GITHUB® and CA Endevor®.

BCBSNM has a separate repository for encounter data that is submitted to the state. BCBSNM utilizes encounter quality system (EQS) as their encounters repository that performs validation of encounter data prior to submission to the HCA.

BCBSNM's HEDIS repositories are stored in house and developed and maintained by their National Committee for Quality Assurance (NCQA)-certified HEDIS vendor, Inovalon. BCBSNM uses Inovalon's Converged Analytics™ (formerly known as QSI®-XL) to produce HEDIS and CMS Adult and Child Core Set PMs.

Disaster Recovery

BCBSNM utilizes multiple data centers that provide failover capabilities. BCBSNM advised that their primary data center is in Waukegan, IL, and the backup data center is located in Fort Worth, Texas, and Microsoft® Azure®. As per BCBSNM's ISCA response, Fort Worth, Texas, and Microsoft Azure sites serve as offsite storage for backup data with center-to-center data replication. All production and test servers are backed up daily to disk. BCBSNM indicated that full and incremental backups are taken, and the failover to additional data centers is immediate, with varying recovery times for the applications. Backup restores are performed at a minimum annually with increased focus on performing them multiple times annually. BCBSNM advised that the recovery time objective (RTO) for their tier 1 critical applications is less than 4 hours and for tier 2 essential applications is less than 24 hours. The recovery point objective (RPO) for tier 1 and tier 2 applications is 24 hours.

BCBSNM indicated that their disaster recovery (DR) system is tested semi-annually.

Access to System

BCBSNM has a robust security infrastructure. As per BCBSNM's ISCA response, access to their systems is granted on an as-needed basis utilizing role-based access control (RBAC). Sensitive access granted outside of a role requires approval from the management and a data owner, where applicable. BCBSNM utilizes multi-factor authentication (MFA) provisioned through their identity access management (IAM) system. BCBSNM remote access users are required to take computer-based training that reviews safeguards and procedures for countering risks related to remote access use. Telecommuters cannot print information or save to a local drive or external device. BCBSNM's systems within the cloud are also subject to the same control objectives as those in their data centers. BCBSNM encrypts personally identifiable information (PII) both at rest and in transit using strong encryption algorithms to protect against unauthorized access. BCBSNM maintains a cybersecurity monitoring and analysis service to proactively review security logs for unusual or unauthorized activity within the network and information systems.

As per BCBSNM, in the event of an employee's termination, employee logons are deactivated within 1 business day when a term date is entered by a manager in PeopleSoft®, a human resources (HR) tool that feeds their security provisioning system overnight to remove access to all systems.

BCBSNM requires all their employees and other staff members to participate in an annual computer-based training course that covers cybersecurity, privacy, compliance, and physical security. As per BCBSNM, course attendance and performance on an assessment are tracked and monitored to ensure compliance with corporate requirements.

Membership Data System and Processes

The membership data systems and processes review included a demonstration of enrollment/membership data systems for Medicaid and CHIP members, and processes used to verify and update enrollment information.

BCBSNM's reconciliation process of HCA's 834 daily and monthly eligibility files and audit processes was reviewed. The demonstration included workflow of systems and databases used to store membership data, details on control checks in place by the MCO to manage membership and eligibility related to multiple member identification numbers, demographic changes and movement, and notification for newborns and deaths to the state.

BCBSNM receives daily and monthly 834 file(s) from the HCA. Eligibility is determined by the state, and membership information received on the 834 file(s) is loaded within 24 hours of receipt into ODS and HCSC Facets application for Medicaid and CHIP. BCBSNM enrollees are assigned and identified by their unique subscriber identification number (Subscriber ID) in Facets, which is linked to their state-assigned Medicaid ID. BCBSNM's member enrollment effective date and termination date in Facets are based on the daily 834 file(s). BCBSNM retains and stores all historical addresses for its members. As per BCBSNM, fallout data from the 834 file loads are reviewed manually by enterprise Medicaid enrollment team (EMET), and changes are applied to Facets to match the incoming 834 record. EMET is responsible for applying enrollment and disenrollments in HCSC Facets. According to BCBSNM, the typical volume included in the daily exception reports that required manual review and/or updates for the month of February 2025 was less than 1%. On average, 22% of daily and monthly submissions are manually reviewed by the MCO.

Upon notification of a member's disenrollment via the daily 834 file, a termination date is entered in the Facets system. BCBSNM advised that EMET updates, including addition or termination of members, are based upon a review with NM Medicaid portal and confirmation with the state as needed. BCBSNM's indicated that EMET retrieves the absence on roster (AOR) and prebill reports by the 10th of the month.

Records identifying deceased members are received from HCA via the daily 834 file(s). Newborn information is also received on the 834 file(s). The newborn record is loaded into Facets with their own Subscriber ID, which is linked to a Family Link ID noted on the newborn's member record.

BCBSNM indicated that each member has only one unique Subscriber ID. However, if a member has more than one Medicaid ID received via the 834-eligibility file, their Medicaid operations team notifies the state to provide confirmation on the member record. The member record is then merged on the NM Medicaid portal, and updated information is received in the 834 file from the state. The duplicate member records are updated in Facets system as received. During the virtual meeting, BCBSNM indicated that they generate and utilize multiple internal discrepancy reports for enrollments. BCBSNM indicated that they also provide extensive training for their enrollment team.

BCBSNM receives race and ethnicity data provided by HCA on the 834 daily enrollment files and stores the information in ODS and Facets system.

During the virtual meeting, BCBSNM indicated their finance department utilizes the monthly 820 Health Insurance Portability and Accountability Act (HIPAA) capitation file for reconciliation of member enrollments.

BCBSNM's average unduplicated member enrollment counts for Medicaid and CHIP enrollments from 2022 to 2024 are listed in **Table 7**.

Table 7: BCBSNM Average Unduplicated Member Enrollment Counts, 2022–2024

Product Type	Year 1 – 2022	Year 2 – 2023	Year 3 – 2024
Medicaid	270,046	242,256	235,179
CHIP	2,164	3,024	3,371

CHIP: Children's Health Insurance Program.

Claims Data Systems and Processes

The claims/encounter data systems and processes evaluation included a review of responses provided by the MCO on the ISCA worksheet, verification of the accuracy of information provided through direct review of claims systems, review of audit processes and audit results, and a walkthrough of professional and facility claims for the Medicaid product. Discussion covered claim sources, clearinghouse, and provider portal, percentage of paper versus electronic claims, and auto-adjudication rates by product lines. The review also included the use of Diagnosis-Related Groups (DRGs), high dollar thresholds, and alternative pay arrangements to providers. BCBSNM provided a detailed walkthrough of individual claims from receipt to payment for professional and facility claims for the Medicaid and CHIP product lines. During the virtual meeting, BCBSNM demonstrated examples for institutional and professional claim types for Medicaid and CHIP.

BCBSNM receives claims electronically through their electronic data interface (EDI), provider portal, or on paper. As per BCBSNM's ISCA response, 96.70% of claims are electronically submitted, via the provider portal or in electronic file format, with 91.65% of claims received in 2024 via the provider portal, Availity®. BCBSNM indicated that 1.30% of electronic claims are received through direct data entry via the provider portal. BCBSNM advised that they receive a large volume of electronic claims through the Availity clearinghouse, their HCSC Intelligent Gateway. As per BCBSNM's ISCA response, a small volume of paper claims are received. Paper claims are received by mail, and scanned images are created and run through optical character recognition (OCR) technology that auto-indexes documents. BCBSNM utilizes PowerEntry system as their claims front-end (CFE) processor. Once the claim passes validation edits, it gets loaded in their Blue Chip claims processing system. BCBSNM Medicaid claims are stored in Blue Chip (stores and retrieve claim history) and the EDW.

BCBSNM advised that 100.00% of claims are processed daily, via a batch process on the Blue Chip real-time interface system (RTIS), where they get validated against membership, provider and contract benefit files. In 2024, 83.63% of claims were processed via automation within 4 days of receipt. During adjudication, claims needing additional review are suspended in the Blue Chip claims system with specific reason codes. Pended claims are received by BCBSNM's claims technicians via an electronic inventory tool, called paperless inventory (PI). After RTIS, claims which fail auto-adjudication logic are processed using an automation tool, known as claims handling enterprise software solution (CHESS). Pended claims are monitored and tracked in PI until they are resolved by the specialized team of claims technicians that finalizes suspended claims. PI is also used for real-time reporting of all open pended claims.

BCBSNM advised that they utilize Lyric's ClaimsXten™ and Cotiviti® to perform additional correct coding and billing accuracy of professional claims. BCBSNM indicated that they receive DRGs from providers and store them in Blue Chip claims processing system along with the DRG computed by BCBSNM's DRG grouper. BCBSNM indicated that they are using DRG software version 42 for grouping. As per BCBSNM's ISCA response, up to 25 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes and 199 procedure codes are accepted and stored for professional claims utilizing the CMS-1500 (or the electronic comparative, 837P) and up to 25 ICD-10-CM diagnosis codes and 199 procedure codes for facility institutional claims utilizing the UB-04 and CMS-1450 (or the electronic comparative, 837I).

BCBSNM's Medicaid claims are regularly audited for financial and procedural accuracy by their quality assessment and improvement (QAI) quality analysts. BCBSNM utilizes employee performance profile system rewrite (EPPS RW) as their claim auditing system. Claims are randomly selected for specific claim types for review, and audit results are documented in EPPS RW. BCBSNM indicated that QAI quality analysts submit audit results to the NM Human Services Division (HSD) quarterly for the timeframe of the reporting period. BCBSNM advised that Blue Chip system automatically pends a claim at the claim release screen to a high dollar queue to be reviewed and worked by a specialized team. Claims where the payout was $100,000 or greater require a robust high dollar review process. QAI quality analysts also conduct a corporate audit for member touchpoint measures (MTMs), and the results are reported to the Blue Cross Blue Shield Association (BCBSA) quarterly. As per BCBSNM's ISCA response, from July 2024 to September 2024, claims timeliness and processing for 30 days was 91.3% and 90 days was 100.0%.

BCBSNM also provides training for their new claim technicians. BCBSNM advised that in 2024, the new hire training program consisted of 7 weeks of onsite instruction under the guidance of experienced learning coaches. Following the initial training, new hires also participate in a 2-week–long follow-up sessions at 30 and 60 days post-training. Claim technicians and senior claim technicians receive ongoing training through monthly communications as well as mandatory "Back to Basics" development sessions. **Table 8** lists paper and electronic claim types received.

Table 8: BCBSNM Claims/Encounter Data Sources and Types

Data Source	Data Type
Hospital	Paper: UB-04 and CMS-1450 Electronic: 837I
Physician	Paper: UB-04 and CMS-1500 Electronic: 837P
Drug	Electronic: NCPDP
Nursing home	Paper: UB-04 and CMS-1500 Electronic: 837I
Home health	Paper: UB-04 and CMS-1500 Electronic: 837I
Mental health	Paper: UB-04 and CMS-1500 Electronic: 837I or 837P
Dental	Electronic: 837D

UB-04: Uniform Billing Form; CMS: Centers for Medicare and Medicaid Services; CMS-1450: institutional paper claim form; CMS-1500: professional paper claim form; NCPDP: National Council for Prescription Drug Programs; 837I: institutional claims form; 837P: professional claims form; 837D: dental claims form.

Performance Measures Reporting, Race and Ethnicity, and ECDS Measures

The performance measures reporting, race and ethnicity, and ECDS measures review included data sources, supplemental data received and integrated into the PM reporting for HEDIS, CMS Adult and Child Core Set, and NM-specific PMs. Further review included the discussion of race and ethnicity data, sources, assignment of NCQA-certified vendor and state-specific categories, and discussion of the submission of ECDS measures for HEDIS NCQA measures reporting. The detailed crosswalk of MCO race and ethnicity and supplemental data sources for ECDS measures was presented by BCBSNM.

BCBSNM's HEDIS repositories are developed and maintained in house and BCBSNM uses Inovalon® as their NCQA-certified software vendor. BCBSNM's data are stored in house and sent to Inovalon for PM processing.

As per BCBSNM's ISCA response, extracts are pulled from their EDW. BCBSNM indicated that they load claims, provider, membership, pharmacy, and encounter data into Inovalon's HEDIS engine Converged Analytics engine for PM processing. Data are formatted, and the file creation preparation process follows the Inovalon platform data specification guide. Data quality review (DQR) process is conducted every month to ensure the data are validated and accurate, and regular collaborations occur between enterprise quality reporting team, business data solutions (BDS) team, and the performance measurement team. For the annual warehouse, data are pulled and available in January each year with claim lag refresh done in April. Monthly warehouses are also built and used for identifying gaps in care and to monitor the PMs throughout the year. BCBSNM indicated that they maintain 10 years of supplemental and HEDIS reported data in their secure data repository.

Continuous enrollment, member months, and member years are defined and calculated within Inovalon's HEDIS engine Converged Analytics, which has all data elements included in the input files that are needed for calculation of PMs. BCBSNM advised that after processing, rates are extracted and compared against state and national benchmarks to assess relative performance and identify areas for improvement. BCBSNM produces HEDIS PMs annually. BCBSNM advised that they create a prospective reporting warehouse on their platform to facilitate year-round monitoring of rates, provide gap-in-care information and to allow for quality reporting.

BCBSNM indicated they have processes in place to meet state requirements related to population health management (PHM) and quality improvement (QI) intervention strategies. BCBSNM integrates diverse data sources into its QI and PHM strategies, including claims and encounter data, member enrollment and eligibility data, electronic medical records (EMRs), pharmacy data on prescription fills and medication usage, lab data, public health data, health information exchange (HIE) data, State Immunization Registry and Vital Statistics data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and internal satisfaction survey data, internal case management systems data and data that are collected through screenings, member interactions, and external sources (e.g., census data).

BCBSNM advised there have been some challenges with the transition from their existing care management system to the state-required system, findhelp™ (findhelp.org). BCBSNM indicated challenges with the collection of demographic data from state enrollment and/or clinical datasets for their Native American and Indigenous population. BCBSNM currently uses WellSky® as a platform to connect and track referrals to community-based organizations.

BCBSNM conducts population risk stratification and integrates diverse data sources and predictive modeling tools to stratify members into risk categories (low, moderate, rising, and high-risk). This stratification supports resource allocation for preventive, chronic, and acute care interventions. BCBSNM uses an internal tool, PopArt, to aggregate clinical and population data from claims as well as HEDIS to create maps and geographic-focused data sets and aid development of statewide equity-centered interventions. BCBSNM employs an Turquoise Care Program

integrated care management model, GuidingCare, to deliver tailored, member-centered support. BCBSNM advised that their internal committees regularly review data, member feedback, and provider performance to refine interventions and improve outcomes.

BCBSNM advised that they conduct preventive health campaigns, such as flu vaccination drives and cancer screening reminders. BCBSNM identifies and manages the health-related social needs (HRSN) of their members and provides housing assistance, transportation and food programs that target specific populations based on risk factors or care gaps identified through data analytics.

BCBSNM indicated that they use direct and indirect data sources to report required NCQA race and ethnicity categories. BCBSNM advised that they use race and ethnicity data collected during member enrollment. Race and ethnicity data from all sources are integrated into BCBSNM's data repository and mapped to Inovalon's crosswalk for members' race and ethnicity reporting. BCBSNM can capture the race and ethnicity values, based on the *2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity,* which includes the new Middle Eastern and North African race category.

BCBSNM follows the prescribed NCQA hierarchy order for the HEDIS ECDS measures. BCBSNM indicated supplemental data from multiple sources are utilized, including data from pharmacies, provider EMRs, non-EMR medical records from providers, registry data from the state, and care management sources. BCBSNM indicated that they receive and capture Systematized Nomenclature of Medicine (SNOMED) codes and Logical Observation Identifiers Names and Codes (LOINC®) that are used in certain PMs and are received from some supplemental data sources. **Table 9** lists ECDS sources and order.

Table 9: BCBSNM ECDS Sources and Order

ECDS Data Source	MCO's Hierarchical Order
1. Electronic health record (EHR)/personal health record (PHR)	1
2. Health information exchange (HIE)/clinical registry	2
3. Case management registry	3
4. Administrative (i.e., claims)	4

ECDS: electronic clinical data systems; MCO: managed care organization.

Provider Data Systems and Processes

The provider data systems and processes review included a detailed review of the health plan provider network and credentialing processes and a discussion of maintenance of provider directories. The discussion included access and availability of the provider portal and percentage of claims received via provider portal.

BCBSNM uses Premier, as their provider data repository for Medicaid and CHIP providers. BCBSNM indicated that they receive provider information from HCA via a daily provider master file (PMF). BCBSNM advised that provider information is verified in Premier, and the state's registration information is stored in the provider operational data store (ODS). BCBSNM utilizes Availity as the provider portal for their providers. BCBSNM's providers can use a web-based tool in Availity Essentials to update and validate their information. BCBSNM indicated that provider profile database contains provider information that is necessary to update online and paper directories including provider name, phone number, website, locations and hours of operation, directions, specialties, areas of expertise, types of services offered, accepting new patients, hospital affiliations, telehealth services, practice limitations, accreditations, provider awards and recognitions, patient ratings, hospital quality scores, accessibility services, languages, cultural competency and provider race and

ethnicity information, as available. BCBSNM's provider data teams perform ongoing monitoring of provider information, including credentialing and recredentialing.

BCBSNM advised that their online and print directories are available in English and Spanish for their members. BCBSNM's maintains an online, searchable Provider Finder® directory, which is updated twice daily (except for Sundays) to reflect the latest information available from the provider database. BCBSNM's printed provider directory is published monthly, and members can call customer service to request a paper directory in Spanish, and additional languages are printed by BCBSNM's vendor. The printed provider directory is updated on their member and provider websites and submitted to HCA for approval each month.

During the ISCA review meeting, BCBSNM provided a demonstration of data maintained in their online and paper provider directories. As per BCBSNM's ISCA response, for Medicaid services, fee schedules and contractual payment terms are mostly automated for all provider types, and there are a few exceptions. Provider compensation rules are maintained based on contractual terms (both standard and negotiated), and updating authority is limited and typically performed by contract implementation specialists.

BCBSNM advised that, for bonus or incentive payments offered to providers, updates related to results and projections are reported to their valuation department monthly, and status reports are shared with the providers quarterly. BCBSNM has a bundled program for maternity for their Medicaid population. BCBSNM also has alternative payment agreements (APAs) that include four levels aligning with the learning and action network (LAN) categories, including rewards for pay-for-performance, shared savings with upside risk only, shared savings and downside risk, and condition-specific population-based payment. NM Medicaid offers value-added services, such as Native American traditional healing and wellness, and self-directed community benefit (SDCB).

Provider Network Adequacy

The provider network adequacy review included a discussion of network adequacy processes for collecting, storing, analyzing, and reporting network adequacy data. The review of network standards, methods and calculations was used for calculating network adequacy indicators and detailed overview on geo-access analysis, state standards and compliance, along with any prior network adequacy validation results. Further review of prior network adequacy reports was conducted, and any challenges meeting state standards for network adequacy were discussed. The MCO also provided information on network gaps with provider availability, time, and distance.

BCBSNM utilizes Quest Analytics® to evaluate their network accessibility and adequacy. Quest Analytics is set up to incorporate all network adequacy standards established by the state, including provider capacity, minimum providers, and time or distance requirements. BCBSNM advised that Premier provider web (PPW) system is used to collect provider data, and Microsoft Excel® spreadsheets are used to store provider data. Membership geographic data that are housed in the EDW is also collected via SQL queries and exported into Excel spreadsheets. These data spreadsheets are then uploaded into the Quest Analytics Desktop Suite by the network adequacy team to run the geo-access reports. BCBSNM has a dedicated staff of analysts that analyzes network adequacy data and performs necessary analytics.

As per BCBSNM's ISCA response, network adequacy data are updated on a quarterly basis, or more frequently as needed based on regulatory requests. BCBSNM indicated that Microsoft Access® databases have been built to automate manual processes and produce results that adhere to regulatory templates. BCBSNM uses Quest Analytics for network adequacy reporting sent to the state. BCBSNM advised that HCSC adheres to the parameters set forth by NM HCA. As per BCBSNM's ISCA response, if missing or incomplete network adequacy

data are identified, their network team collaborates with internal business partners, such as the provider data maintenance (PDM) team to research, outreach, and update the system, as appropriate. Network adequacy results, including maps, tables, reports and results, are reviewed by multiple team members in addition to being subject to tiered review by other HCSC teams. Network adequacy reports are also run for ad hoc network requests based on network changes as well as membership needs.

BCBSNM submits network adequacy reports to the state on a quarterly basis. BCBSNM indicated that there are no existing corrective action plans (CAPs) for network adequacy. BCBSNM has identified some gaps in their network where no providers exist for targeting. BCBSNM advised gaps exist in rural, urban and frontier counties in multiple specialties, including but not limited to Indian/tribal/urban (I/T/U), assisted living facilities, rural health clinics (RHCs), certified community behavioral health clinics (CCBHCs), RHCs providing behavioral health (BH) services and others. As per BCBSNM's ISCA response, there continues to be a shortage of RHC, I/T/U and assisted living providers statewide resulting in percentages that are below access standards for these types of providers.

BCBSNM advised that they continue to monitor access to identify trends and irregularities in comparison to previous quarters. BCBSNM's contracting team continues to evaluate provider applications for network adequacy needs, seek input from their utilization management and care coordination teams, and evaluate in-network and out-of-network utilization requests for single case agreements (SCAs) to actively recruit providers. Telehealth/telemedicine is utilized as a solution in instances where applicable. BCBSNM continues to reach out to available essential community providers (ECPs) and Indian health care providers (IHCPs) for contracting. BCBSNM conducts network reviews and considers any valid information, including member complaints and grievances, in the management of their provider network. BCBSNM has regular, ongoing process to continually review network adequacy as required by the state and federal regulators.

Oversight of Contracted Vendors

The review of oversight of contracted vendors focused on contracted vendors and delegated functions, and included detailed discussion on the health plan's vendor oversight policies, activities, reports and review of vendor data reporting requirements, submission patterns, and data completeness. Data submitted included all required elements for PM reporting, encounter reporting to the state, and performance improvement projects (PIPs).

BCBSNM has vendors for dental, vision, pharmacy, and transportation services (**Table 10**). BCBSNM advised that Palco, Inc., is the vendor for processing SDCB on behalf of Conduent® and the HCA, which are submitted via FOCoS®. Prime Therapeutics® is BCBSNM's vendor for pharmacy claims and encounters. Prime Therapeutics owns the claims and encounter process, and drug encounters are a pass-through to the state. BCBSNM advised that they have access to pharmacy claims, which is Prime Therapeutics' adjudication system. BCBSNM vendors are DentaQuest® for dental claims, Davis Vision® for claims for vision services, and ModivCare® for nonemergency medical transportation (NEMT), lodging and meals services. BCBSNM advised that encounters from Davis Vision, DentaQuest and PALCO® are submitted through the HCSC's BlueGateway system, which results in reimbursing these vendors for the cost of the service. DentaQuest and ModivCare are paid a monthly capitation fee for each eligible Medicaid member via the HCSC BlueCap system.

BCBSNM conducts regular monthly meetings with its vendors. During the virtual meeting, BCBSNM indicated that there were currently no CAPs with their vendors. BCBSNM advised that their annual audits include vendors, and their audit results are shared with vendor network owners. As per the July 2024 annual audit results, ModivCare passed the audit with a plan of action (PoA) status in remediation, and all other vendors passed the audit without PoA.

Table 10: BCBSNM Vendors by Claim Type

Claim Type	Vendor	Vendor Contract Begin Date	Frequency of Encounter Submission
Dental	DentaQuest	1/1/2021	Weekly
Vision	Davis Vision	1/1/2021	Weekly
Pharmacy	Prime Therapeutics	10/27/2018	Weekly
Transportation	ModivCare	1/1/2021	Weekly

Grievance Systems

Review of grievance systems included demonstrations of the systems used for Medicaid and CHIP. The review included interfaces with other systems, such as eligibility, claims, and providers, and discussion of processes for reporting to the state.

The grievance systems do not interface directly with the transactional systems. However, nightly member and provider loads to the grievance systems from the transactional systems ensure that member and provider information are current. The application has multiple reporting and tracking tools to allow managers to monitor cases. Reports for the state are generated from the grievance systems. Discussion included the production of quarterly reports to the state and an overview of grievance systems for Medicaid and CHIP product lines.

BCBSNM utilizes GuidingCare and advanced customer engagement (ACE) system as their grievances and complaints processing system for NM Medicaid member and provider grievances. BCBSNM accepts verbal, written, and electronic grievance submissions. BCBSNM advised that members and providers can submit a complaint or grievance at any time. BCBSNM's call center customer advocate (CA) enters each grievance or complaint in their GuidingCare system. A case number is assigned, and the CA enters all relevant information including the member/provider name, date and time grievance was received, date and time grievance was resolved, required categorization, and copies of any documentation or records reviewed. BCBSNM indicated that if grievances are received for a delegated subcontractor, subcontractors are notified and must respond within 5 days. BCBSNM's CA can outreach to the member reporting the grievance for additional information and clarification. BCBSNM indicated care coordinators, delegated subcontractors and provider network services are notified as applicable.

BCBSNM advised that complaints and grievances are acknowledged within 5 business days of receipt, and the standard resolution is within 30 days. BCBSNM indicated that their grievance department has developed policies and procedures to ensure that an efficient and effective system is in place to process complaints and grievances. BCBSNM provides initial new hire and ongoing call center trainings throughout the year to their call center staff.

BCBSNM indicated that all grievances and complaints are investigated and tracked by their CA in GuidingCare and ACE system until resolved. When a member contacts a CA to update their primary care provider (PCP), the reason for changing the PCP is documented in their ACE system. A resolution letter is sent for all grievances and appeals that are resolved, and the case is closed in grievance system.

BCBSNM indicated that complaints and grievances are reported to the state on a quarterly basis via Report #37. BCBSNM advised that currently the report submission have been put on hold by the state. BCBSNM

indicated that they utilize multiple tools for reporting and tracking complaints and grievances to ensure effective and ongoing quality of care and services.

Encounter Data Submissions to State

The review of encounter data submissions to state section focused on a detailed review of encounter data systems, encounter data submission, and reconciliation processes. A walkthrough and demonstration of the encounter data systems and any available reports were also discussed in detail. The MCO provided details on timeliness and accuracy of submission of encounters to HCA.

BCBSNM encounter data are stored within their encounter quality system (EQS), which performs validation of encounter data prior to submission to HCA. NM Medicaid encounters are validated and housed in the EQS include Blue Chip adjudicated claims, vendor encounter submissions and care coordination data. BCBSNM advised that the vendor encounter files are received through a managed file transfer process. BCBSNM's encounter team performs remediation or vendor outreach in case any correction is needed. BCBSNM utilizes Edifecs® to validate the claims files conform to the standard 837 or post-adjudicated claims data reporting (PACDR) file layout. All inbound vendor files are tracked to confirm files are received at the correct frequency, that they have successfully passed inbound editing and are loaded for encounter processing in EQS. BCBSNM also performs quality checks and passes the data back through EQS and Statistical Analysis System (SAS®) applications to validate each claim prior to sending each encounter to HCA. An integrated audit table also logs the status of the encounter as it passes through validation editing through submission of the encounter to the state. Nightly EQS validation programs bring in new encounters, maintain encounters that require analyst review and submit state-ready encounters to the outbound file creation process. All inbound and outbound files are tracked to ensure completeness and timeliness.

Encounter files are submitted to the state each weekday night for encounters processed by automated validation programs the previous night. All encounters received in EQS are assigned an EQS claim ID with a "created date." Encounter data are maintained in electronic data interchange (EDI) X12 claim loops and segments. As per BCBSNM's ISCA response, they manage encounter submissions for medical, dental, vision, transportation and home care services. BCBSNM indicated that received drug encounters are a pass-through and managed by Prime Therapeutics pharmacy benefit manager (PBM). Encounter files are received from FOCoS for SDCB. BCBSNM submits the vendor encounters to the state.

Encounters that fail validation are reviewed by BCBSNM's Medicaid encounters team. This team conducts backlog monitoring, error tracking, analysis, resolution, and completion monitoring for encounter data submissions.

BCBSNM indicated that all paid and partially paid claims/encounters are submitted to the state. Denied claims/encounters are only submitted when it is an adjustment to void to a previously accepted encounter.

BCBSNM's top-3 encounter data submission denial reason codes are:

1. 0367 – Billing Provider Review for Type/Procedure
2. 0422 – Rendering Provider Not Enrolled
3. 0299 – Billing NPI Match Multi Medicaid ID

BCBSNM indicated that they adhere to NM timeliness standards regarding the submission of encounters. As per BCBSNM's ISCA response, total encounters submitted to HCA in December 2024 were 1,203,407.

Summary of Findings

CMS prescribes that at the conclusion of the ISCA review, the external quality review organization (EQRO) is to compile and analyze the information gathered through the preliminary ISCA review and from the MCO staff interviews. After completing its analysis, the EQRO writes a statement of findings about the MCO's information system review and assigns an assessment level to each assessment topic.

Table 11 contains the four assessment levels and their definitions. BCBSNM's summary of findings is presented in **Table 12**.

Table 11: IPRO Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

MCO: managed care organization.

Table 12: BCBSNM Summary of Findings

Assessment Topic	Assessment Finding	Review Note
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	BCBSNM has processes and procedures in place to maintain member enrollment information and ensure eligibility standards are met. BCBSNM enrollees are assigned and identified by their unique subscriber identification number (Subscriber ID) in Facets. BCBSNM retains and stores all historical addresses for its members. No issues were noted in BCBSNM's enrollment processes and procedures.
Adjudication and review of claims data received from multiple sources	Met	BCBSNM receives claims electronically through their EDI, provider portal, or on paper. BCBSNM advised that 100.00% of claims are processed daily, via a batch process on the Blue Chip real-time interface system (RTIS), where they get validated against membership, provider and contract benefit files. No issues were noted in BCBSNM's current claim adjudication process of claims.
Validation and/or calculation of performance measures	Met	BCBSNM uses Inovalon's Converged Analytics (formerly known as QSI-XL) to produce HEDIS and CMS Adult and Child Core Set PMs. BCBSNM indicated that they load claims, provider, membership, pharmacy, and encounter data into Inovalon's HEDIS engine Converged Analytics engine for PM processing. Regarding HEDIS ECDS PMs, BCBSNM follows the prescribed NCQA hierarchy order for the inclusion of supplemental data sources. No issues were noted in BCBSNM's validation and calculation of PMs.
Utility of the MCO's IS for linking to other information sources for quality-related reporting	Met	BCBSNM's information systems support various data reporting requests, both internally and externally. No issues were noted.

Assessment Topic	Assessment Finding	Review Note
Identification and reporting of NCQA's and CMS's race and ethnicity categories	Met	BCBSNM advised that they use race and ethnicity data collected during member enrollment. Race and ethnicity data from all sources are integrated into BCBSNM's data repository and mapped to Inovalon's crosswalk for member race and ethnicity reporting. BCBSNM can capture the race and ethnicity values, based on the *2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, which includes the new Middle Eastern and North African race category. No issues were identified.
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	BCBSNM's information systems can conduct quality assessments and improvement initiatives. BCBSNM integrates diverse data sources into its quality improvement (QI) and population health management (PHM) strategies, including claims and encounter data, member enrollment and eligibility data, electronic medical records (EMRs), pharmacy data on prescription fills and medication usage, lab data, public health data, health information exchange (HIE) data, State Immunization Registry and Vital Statistics data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and internal satisfaction survey data, internal case management systems data and data that are collected through screenings, member interactions, and external sources (e.g., census data). No issues were noted in BCBSNM's ability to conduct MCO quality assessment and improvement initiatives.

Assessment Topic	Assessment Finding	Review Note
Completeness and accuracy of tracking of member and provider grievances and appeals	Met	BCBSNM utilizes GuidingCare and advanced customer engagement (ACE) system as their grievances and complaints processing system for NM Medicaid member and provider grievances. BCBSNM accepts verbal, written, and electronic grievance submissions. BCBSNM indicated that all grievances and complaints are investigated and tracked by their CA in GuidingCare and ACE system until resolved. BCBSNM advised that currently the report #37 submission has been put on hold by the state. No issues were noted in BCBSNM's systems used for handling grievances and reporting to the state.
Validation and/or calculation of network adequacy reports	Met	BCBSNM utilizes Quest Analytics software for assessing, monitoring, and reporting network adequacy. BCBSNM submits network adequacy reports to the state on a quarterly basis as per HCA's regulatory requirements. BCBSNM advised gaps exist in rural, urban and frontier counties in multiple specialties, including but not limited to Indian/tribal/urban (I/T/U), assisted living facilities, rural health clinics (RHCs), certified community behavioral health clinics (CCBHCs), RHCs providing BH services and others. No issues were noted with BCBSNM's provider network adequacy validation and calculation processes.
Ability of the information system to generate complete, accurate and timely T-MSIS data	Not Applicable	BCBSNM does not submit encounter data directly to CMS; BCBSNM submits encounter data to HCA.
Completeness and accuracy of encounter data collected and submitted to the state	Met	BCBSNM submits encounter data to the state complying with the standards for timeliness and accuracy of submissions of paid encounters. No issues were noted with completeness and accuracy of encounter data collected and submitted to the state.

MCO: managed care organization; EDI: electronic data interchange; HEDIS: Healthcare Effectiveness Data and Information Set; CMS: Centers for Medicare and Medicaid Services; PM: performance measure; ECDS: electronic clinical data systems; NCQA: National Committee for Quality Assurance; IS: information systems; CA: customer advocate; HCA: Health Care Authority; BH: behavioral health; T-MSIS: Transformed Medicaid Statistical Information System.

IV. Presbyterian Health Plan New Mexico

General Information

IPRO worked with HCA to customize the ISCA worksheet provided in Appendix A of the *CMS External Quality Review (EQR) Protocols* published in February 2023. Turquoise Care, the NM Medicaid program began July 1, 2024.

In addition to customizing the ISCA survey tool for NM's Medicaid products, the ISCA was also modified to include questions related to the HEDIS Electronic Clinical Data Systems (ECDS) measures and race and ethnicity categories, quality assessment and improvement initiatives, grievances and encounter data submissions to the state.

On December 11, 2024, IPRO uploaded the NM ISCA tool to Research Electronic Data Capture (REDCap®) and the NM MCOs were requested to complete and return the responses by January 31, 2025.

A 5-hour virtual meeting was held for Presbyterian Health Plan New Mexico (PHPNM) on April 8, 2025**,** to discuss the MCO's ISCA responses, interview the MCO's staff, and review the MCO's information system capabilities. PHPNM staff, HCA, and IPRO staff attended the virtual meeting.

The MCO's information system assessment covered the following areas:

- Data Integration and Systems Architecture
- Membership Data Systems and Processes
- Claims Data Systems and Processes
- Performance Measure Reporting, Race and Ethnicity, and ECDS Measures
- Provider Data Systems and Processes
- Provider Network Adequacy
- Oversight of Contracted Vendors
- Grievance Systems
- Encounter Data Submissions to State

PHPNM's completed ISCA worksheet can be found in **Appendix A**.

Data Integration and Systems Architecture

During the data integration and systems architecture session, the MCO provided a comprehensive walkthrough of all data sources maintained by the MCO for operations and reporting. Data sources included transactional systems including claims, enrollment, provider, and vendor data. The MCO provided a review of all warehouses maintained by the MCO used for regulatory and financial reports, analysis, and PM reporting. PHPNM provided a review of data control and security procedures, including disaster recovery (DR) plans. The discussion also included the frequency of load of claims, vendor and enrollment data, and any control checks in place for data warehouse loads.

As of September 1, 2022, PHPNM uses HealthRules Payor® (HRP) for membership and claims processing, replacing TriZetto Facets. Historical data remain accessible in Facets. The transition was smooth with no disruption to member services. PHPNM follows a standard software development methodology, Software Development Life Cycle Model (SDLCM).

PHPNM uses Microsoft® Azure®-based data hubs to integrate HRP and Facets data for reporting, file generation, and real-time exchanges. HRP handles medical claims, while a proprietary system manages third-party claims, such as vision, dental, behavioral health (BH), transportation, and pharmacy.

PHPNM leverages Boomi® for real-time support application programming interfaces (APIs) integrations and IBM® Sterling® for secure batch file transfers. Data pipelines consolidate inputs from systems including HRP (for membership and claims processing), Facets (for legacy membership and claims system), Jiva® (for utilization and care management for Medicaid and Children's Health Insurance Program [CHIP]), Optum® (for clinical and provider data tools), Cognos TM1® (for financial planning and reporting), Quadient® (for member communications management), Siebel® (for complaints and grievance tracking), provider data management (PDM; for the provider data system using Quest Analytics®), proprietary PHP Encounters system (for encounter data management), and the operational data store (ODS; for reporting). Boomi orchestrates these integrations, with all processed data centralized in Microsoft Azure for downstream analytics, reporting, and operational use.

Online access to Medicaid or CHIP data is available through HRP for records beginning September 1, 2022. Over 20 years of Medicaid data can be accessed via the data warehouse. Updates to the encounters platform included a new user interface (UI), enhanced reporting capabilities and minor processing improvements to support higher-quality data submissions to HCA.

PHPNM indicated that programmers utilize a combination of native Statistical Analysis System (SAS®) language and structured query language (SQL) tailored for the SAS environment for Medicaid and CHIP data management, data extracts, and analytical reporting. PHPNM code management team utilizes Bitbucket® and Apache Subversion® (SVN) for version control.

PHPNM maintains a proprietary encounter platform as a separate repository to house and manage encounter data submitted to the state.

PHPNM indicated on the ISCA that, in September 2024, they transitioned their National Committee for Quality Assurance (NCQA)-certified vendor from Inovalon® to CitiusTech PERFORM+®. HEDIS data are exported monthly and loaded into CitiusTech PERFORM+, which is hosted in the Microsoft Azure cloud environment, for processing. This process is further supported by PHPNM'S in-house DataMart, also hosted by Microsoft Azure.

Disaster Recovery

PHPNM utilizes multiple DR sites to support failover capabilities, with the primary site located in Houston, Texas (TX), and the secondary site in The Woodlands, TX. The Woodlands site also serves as the location for offsite backup storage. In the event of a system failure, PHPNM indicated that switching HRP operations to the DR environment takes approximately 20 hours. PHPNM advised that the recovery time objective (RTO) for their critical applications is 72 hours, and the recovery point objective (RPO) for their applications is 24 hours.

PHPNM indicated that the DR system is tested annually. As per PHPNM backup strategy, backups are stored in The Woodlands location, with incremental backups performed daily and full backups completed weekly. Backups are monitored for failures, and any failed backup jobs are analyzed and restarted as necessary. Backup restores are conducted through restore requests and used as a validation method. PHPNM advised that multiple versions of HRP database backups are maintained to ensure data availability and accessibility. All batch systems are backed up daily to mitigate data loss due to unexpected failures or data corruption.

Access to System

PHPNM has a robust security infrastructure with access to sensitive systems being granted based on a user's defined role, following the principle of least privilege. Role-based access control (RBAC) governs access to personally identifiable information (PII) and protected health information (PHI) in systems such as HRP and Facets. Access outside of defined roles requires appropriate approval. PHPNM utilizes phishing-resistant multi-factor authentication (MFA), provisioned through Microsoft Authenticator®, as part of its identity access management (IAM) strategy. Remote access to PHPNM's secure network is permitted only through virtual private network (VPN) connections from devices that meet strict security standards, and accounts must reside within a designated Microsoft Active Directory® organizational unit (OU). Account login activity is reviewed every 90 days, and inactive accounts are suspended within the OU to disable remote access.

Access to production systems by programming and analysis staff is restricted. User passwords must be changed every 120 days after initial setup or reset. At termination or during transfers, logins are deactivated within 24 business hours upon notification of termination, with emergency terminations processed immediately in coordination with human resources (HR).

PHPNM's IAM function oversees system access security and user administration. The security administration team manages access to HRP and Facets, with roles structured across three levels: associate, intermediate, and senior security admin analysts. All users are required to complete annual computer-based training via the Presbyterian Enterprise Parte Training platform. Training includes two modules: Use of PHPNM's Information Systems and Information Security: Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH), which define user responsibilities in handling Presbyterian Healthcare Services (PHS) data and systems. Course completion is monitored to ensure compliance with corporate security requirements.

Membership Data System and Processes

The membership data systems and processes review included a demonstration of enrollment/membership data systems for Medicaid and CHIP members, and processes used to verify and update enrollment information.

PHPNM receives proprietary monthly and daily enrollment roster files from HCA and stores them in the HRP enrollment processing system. PHPNM's reconciliation process of HCA's 834 daily and monthly eligibility files and audit processes was reviewed. The demonstration included workflow of systems and databases used to store membership data, details on control checks in place by the MCO to manage membership and eligibility related to multiple member identification numbers, demographic changes and movement, and notification for newborns and deaths to the state.

PHPNM receives proprietary monthly and daily 837 enrollment roster files from HCA, which are automatically imported into the MCO's core administrative system upon receipt. During this import process, the records are compared with existing data in the system and updated as necessary. The only authorized personnel who is permitted to modify enrollment data is the enrollment business group. On average, the daily exception reports contain 10– 20 records that require manual review and data entry. Race and ethnicity data are provided through the HCA monthly and daily 834 files, and the values are stored in the enrollment processing system. The race and ethnicity data are then populated into the certified HEDIS vendor data repository.

PHPNM identifies enrollees by their universal customer identifier (UCI) as well as a member identification (ID). The member ID is a unique identification number generated when a member is enrolled while the UCI is used primarily for reporting purposes. Both are unique to that member. Members are compared based on name,

date of birth (DOB), Social Security Number (SSN), and Medicaid ID. Re-enrolling members retain the same Medicaid ID and the same member ID in PHPNM's enrollment system. If a Medicaid member receives a new Medicaid ID, a new member ID will be created in PHPNM's enrollment system. Enrollees' initial enrollment dates, previous claim/encounter data across product lines, member demographic updates, historical addresses and ZIP code changes in the enrollment system are all tracked.

Medicaid and CHIP members may exist under more than one identification system if they are enrolled in both. They will have separate IDs for each program. A member's ID number may change if their Medicaid ID changes. PHPNM has a process in place to review and merge the two member records, including the claims, encounters and authorizations. Newborns born to an existing Medicaid or CHIP enrollee are assigned a unique member ID and linked to the family through the case assignment (Family Link) provided by HCA. Death dates are ingested daily from HCA. External sources trigger a verification workflow, submitting the data to HCA for validation and integration into the master feed. Disenrollments are processed based on information received through the HCA enrollment file feed, and any terminations received through other means are submitted to HCA to be reflected in a daily or monthly file update. Information on involuntary disenrollments is received through the daily or monthly HCA roster files and is loaded into the system accordingly. PHPNM uses the monthly 820 file to reconcile member payments. If discrepancies cannot be resolved internally, PHPNM escalates the issue to HCA for resolution.

PHPNM's average unduplicated member enrollment counts for Medicaid and CHIP enrollments from 2022 to 2024 are listed in **Table 13**.

Table 13: PHPNM Average Unduplicated Member Enrollment Counts, 2022–2024

Product Type	Year 1 – 2022	Year 2 – 2023	Year 3 – 2024
Medicaid	412,444	371,683	346,647
CHIP only[1]	3,304	4,398	5,057

[1] For CHIP only, the counts for year 1 (2022), year 2 (2023) and year 3 (2024) were updated after follow-up with the plan.
CHIP: Children's Health Insurance Program.

Claims Data Systems and Processes

The claims/encounter data systems and processes evaluation included a review of responses provided by the MCO on the ISCA worksheet, verification of the accuracy of information provided through direct review of claims systems, review of audit processes and audit results, and a walkthrough of professional and facility claims for the Medicaid product. Discussion covered claim sources, clearinghouse, and provider portal, percentage of paper versus electronic claims, and auto-adjudication rates by product lines. The review also included the use of Diagnosis-Related Groups (DRGs), high dollar thresholds, and alternative pay arrangements to providers.

PHPNM provided a detailed walkthrough of individual claims from receipt to payment for professional and facility claims for the Medicaid and CHIP product lines. During the virtual meeting, PHPNM demonstrated examples for institutional and professional claim types for Medicaid and CHIP.

PHPNM accepts claims via 837 HIPAA electronic file extracts, the ProviderConnect® portal, and paper submissions. Per their ISCA response, 20.00% of claims are submitted through ProviderConnect and directly integrated into the HRP system. Overall, 93.14% of claims are submitted electronically. PHPNM receives 837 institutional and professional claim files daily from multiple clearinghouses. These files are processed through

an internal system that standardizes and converts them into a format compatible with HRP. Enrollment files follow a similar daily process.

Electronically submitted claims undergo member validity and field-level edits using McKesson® software before being routed to the processing system. All claim receipts are logged, with reports generated for both internal and external stakeholders. PHPNM's HRP system achieves an automated processing rate of 90.85% for electronic claims.

PHPNM receives 6.34% paper claims, collected daily by an external vendor for imaging and data entry. Upon return, PHPNM staff matches bundle numbers to the delivery ticket. The imaging vendor provides image and data files, which are batched and submitted to the Facets system. Claims needing special handling are imaged and processed internally by PHPNM staff. All claims receive a document control number (DCN) at the start of processing. Paper claims have a 37.80% automated processing rate. The balance of the claims are assigned to workbaskets within the claims system and require processing staff intervention. Those claims that are assigned to workbaskets have a trigger (edit) associated with the claim. From those triggers, the processor can review the job aids to correct the trigger and allow for finalization.

PHPNM reported that pended claims are routed to designated workbaskets based on specific system flags, where they are assigned for manual review and processing. Inventory is monitored daily, with emphasis on the date of receipt to prioritize timely handling. Claims managers work closely with supervisors to ensure efficient processing. Currently, 85.60% of claims are auto-adjudicated, while the remaining 14.40% require manual intervention.

Pended encounters are reviewed weekly by encounter specialists, who collaborate with subcontractors and internal departments, such as the provider network and provider configuration departments, to identify root causes and implement resolutions. In some cases, this includes returning the encounter to the subcontractor for correction. For institutional data, medical coding sets from Optum, including Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, Tenth Revision (ICD-10), and DRG, are loaded into HRP and validated to ensure accuracy and up-to-date compliance. DRG pricing is tested, and claims are processed using these codes. System-generated edits (warnings or errors) help catch issues like incorrect formats, incompatible codes, or invalid billing details. Professional data include the same checks as institutional data, plus an additional layer using Optum Claims Editing Service software. This software uses pattern recognition and rules from AMA and CMS to catch errors such as miscoding, modifier misuse, and duplicate claims, improving payment accuracy.

PHPNM receives DRG information from providers on the UB-04 form which is stored and associated with the claim data received in the 837I format. For noncontracted claims, DRG calculations are performed using Optum's Web.Strat (Optum/Rate Manager) software. DRGs are also received on encounters and are stored within the encounter processing system. These submitted DRGs are retained exactly as received, and no DRG calculations are performed during the inbound processing of encounter data. If a calculated DRG from the grouper is used instead, it would be indicated in a separate section.

PHPNM conducts annual audits of all major subcontractors delegated to pay Medicaid claims. These audits are performed by PHPNM subject matter experts (SMEs) and include specifications regarding the frequency and type of audits. The MCO has a high-dollar threshold for manual claim processing. For Medicaid claims, Trigger 44 is activated when the total billed amount is $75,000 or more. These claims require manual review, completion of a high-dollar checklist, and secondary review by a claims coordinator. Only authorized staff can release high-dollar claims due to security limits. PHPNM internal audit conducts weekly financial and

procedural accuracy audits on claims paid or denied in the previous week. A random, 1% sample is selected, covering all claim types and including up to five claims per processor to ensure a broad review. Duplicate claims paid during the week are sampled and reviewed, with a focus on the highest-dollar duplicates to ensure accuracy and make necessary corrections. The claims samples do not overlap, and selections are not duplicated from one sample to another.

PHPNM complies with all regulatory timeliness requirements, processing 99.4% of clean claims within 30 days and 100% within 90 days, while capitated claims are processed as zero-dollar paid claims in the HRP system and stored as paid encounters without displaying a message, though payment information is retained in the records. PHPNM provides a comprehensive 6–8 week training program for new claims processing staff, combining training materials with hands-on system experience. Staff has access to work instructions, job aids, and various support documents, which are used based on claim type or situation. Refresher courses are offered as needed based on quality results or trends and are coordinated by the claims resource and support team (CRST) manager and trainer.

Table 14 lists paper and electronic claim types received. PHPNM Medicaid claims are stored in HRP.

Table 14: PHPNM Claims/Encounter Data Sources and Types

Data Source	Data Type
Hospital	Paper: UB-04 Electronic: 837I
Physician	Paper: CMS-1500 Electronic: 837P
Drug	Electronic: NCPDP
Nursing home	Paper: UB-04, CMS-1500 Electronic: 837I, 837P
Home health	Paper: UB-04, CMS-1500 Electronic: 837I
Mental health	Paper: UB-04, CMS-1500 Electronic: 837I or 837P
Dental	Electronic: 837D

UB-04: Uniform Billing Form; CMS: Centers for Medicare and Medicaid Services; CMS-1500: professional paper claim form; NCPDP: National Council for Prescription Drug Programs; 837I: institutional claims form; 837P: professional claims form; 837D: dental claims form.

Performance Measures Reporting, Race and Ethnicity, and ECDS Measures

The performance measures reporting, race and ethnicity, and ECDS measures review included data sources, supplemental data received and integrated into the PM reporting for HEDIS, CMS Adult and Child Core Set, and NM-specific PMs. Further review included the discussion of race and ethnicity data, sources, assignment of NCQA-certified vendor and state-specific categories, and discussion of the submission of ECDS measures for HEDIS NCQA measures reporting. The detailed crosswalk of MCO race and ethnicity and supplemental data sources for ECDS measures was presented by PHPNM.

PHPNM compiles administrative data in their Integrated Reporting and Analytics Data Warehouse (IRADW), which supports HEDIS reporting using data from current systems, legacy platforms, and third-party partners (e.g., Magellan Rx®, the pharmacy benefits manager [PBM]). No issues have been identified with

administrative data integration. An internal DataMart aligns with the NCQA-certified vendor's data layouts, with monthly extracts loaded into the vendor's Microsoft Azure-hosted platform for processing.

PHPNM indicated they use NCQA-certified vendor CitiusTech Perform+®, to calculate continuous enrollment, member months, member years, and Medicaid HEDIS quality rates in accordance with HEDIS specifications. For Medicaid PMs reporting, PHPNM extracts monthly updated datasets for each measure from relational databases and transfers them to the HEDIS system. Monthly files undergo QA by CitiusTech, followed by additional review by PHPNM's Analytics team and HEDIS Manager to ensure data accuracy, population integrity, and rate trends.

PHPNM is prioritizing IRADW integration. IRADW consolidates data from systems such as Facets, HRP, and external payers for enrollment and claims management. Clinical data from Epic® and partner systems are linked by member or provider IDs and stored in repositories, such as Epic's electronic health record (EHR) system, Clinical Documentation Improvement (CDI). Supplemental clinical and administrative data are integrated into the CitiusTech PERFORM+ data model via Secure File Transfer Protocol (SFTP) feeds, including CMS member files. Data integrity is maintained through internal and vendor-led checks, including row count validations, unmatched ID reviews, and referential integrity checks. While no formal testing is conducted on report generation, regular assessments ensure data quality and completeness. Final counts are validated against membership data. PHPNM retains data in its HEDIS measure repository for up to 60 months, with a 42-month lookback for HEDIS source data.

PHPNM indicated they use data-driven strategies and cross-functional collaboration to improve population health and quality outcomes. Population Health and Quality Operations partners with analytics to identify priority populations and implement targeted outreach through calls, texts, emails, and events. Monthly workgroups across departments review data and coordinate improvement efforts. While PHPNM's extensive provider network across NM supports broad access, it also presents data challenges, particularly with timely, consistent demographic and social determinants of health (SDoH) information. Limited collection of language and demographic data hinders accurate patient-provider matching. Ongoing collaboration with providers aims to enhance data quality and sharing.

Race and ethnicity data are provided via the HCA monthly and daily 834 enrollment files. The race and ethnicity values are stored in HRP and populated into the NCQA-certified HEDIS vendor repository. PHPNM advised that race and ethnicity values are captured based on the *2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, which includes the new Middle Eastern and North African race category. Middle Eastern and North African category is added and transmitted through the 834 enrollment file, and minimal configuration updates would be required to support mapping and integration.

PHPNM captures Systematized Nomenclature of Medicine (SNOMED) and Logical Observation Identifiers Names and Codes (LOINC®) codes in its clinical data repository and currently reports ECDS measures without submission issues. Case management data are not currently used in ECDS reporting. PHPNM does not integrate SNOMED or LOINC codes for reporting purposes but retains and utilizes them as they appear in the clinical data. **Table 15** lists ECDS sources and order.

Table 15: PHPNM ECDS Sources and Order

ECDS Data Source	MCO's Hierarchical Order
1. Electronic health record (EHR)/personal health record (PHR)	1
2. Health information exchange (HIE)/clinical registry	2
3. Case management registry	N/A
4. Administrative (i.e., claims)	3

ECDS: electronic clinical data systems; MCO: managed care organization; N/A: not applicable.

Provider Data Systems and Processes

The provider data systems and processes review included a detailed review of the health plan provider network and credentialing processes and a discussion of maintenance of provider directories. The discussion included access and availability of the provider portal and percentage of claims received via provider portal.

PHPNM manages their provider data through multiple channels, including emails, phone calls, individual updates, and rosters submitted to their provider servicing team. These updates are entered either through the older Provider Information Form (PIF) log system or their current internal PDM system, which is gradually replacing the PIF system. Providers can also update their information directly via secure ProviderConnect portal. Once updates are made, the information goes through a validation process and flows into the claims processing system. Any errors are flagged through fallout reports and resolved accordingly. Separately, data are passed to provider directory staging tables, informed by the EchoCredentialing® system. The provider directory team reviews these data, resolving any issues before final approval. The team incorporates external data feeds from Capital Rx® and Magellan Rx for BH and pharmacy information. Ultimately, all validated data flow into online and paper provider directories.

PHPNM's online provider directory is updated daily and supports translation into 249 languages through Google® Cloud Translation® API. Paper directories are updated every 30 days and are available in Spanish. Provider directory updates originate from various sources, such as provider groups, individual practitioners, member complaints, and internal teams, including PHPNM's Member Advocate group. Once validated by the provider servicing team, requests are sent to the provider configuration team to update systems, such as PDM or HRP. Updated data from PDM are sent nightly to directory tables, standardized, and reviewed by the provider data management and integrity team. Once approved, the data are stored in a master provider directory table and published to PHPNM's directory system and paper directories. While provider servicing can request changes, both the provider configuration and provider data management and integrity teams have authority to make updates and manage directory content.

PHPNM maintains provider profiles on its website and internal systems, including key details, such as provider name, National Provider Identifier (NPI), gender, specialty, race and ethnicity, hospital and group affiliations, board certifications, taxonomy, and whether the provider is accepting new patients. Profiles also include spoken languages (by the provider and staff), addresses and phone numbers for the practice, remit, and directory locations, hours of operation (including after-hours), accommodations for members with disabilities, public transit access, website links, cultural competency training, directory and service categories, and any service limitations (e.g., telehealth or home visits). Telehealth options are clearly indicated on the online directory for applicable providers.

PHPNM's portfolio of alternative payment arrangements (APAs) are based on HEDIS quality metrics, performance reporting, and provider participation. PHPNM maintains value contracts with providers that include fee-for-service (FFS) arrangements with bonus opportunities, global risk agreements, and other APAs.

PHPNM administers a pay-for-performance (P4P) program that offers fixed-dollar incentives for providers who meet specified quality measures. Shared savings models are also utilized, providing financial rewards for reducing the total cost of care, with quality performance as a core component of eligibility. PHPNM holds a full-risk capitation agreement with a large federally qualified health center (FQHC).

Provider Network Adequacy

The provider network adequacy review included a discussion of network adequacy processes for collecting, storing, analyzing, and reporting network adequacy data. The review of network standards, methods and calculations was used for calculating network adequacy indicators and detailed overview on geo-access analysis, state standards and compliance, along with any prior network adequacy validation results. Further review of prior network adequacy reports was conducted, and any challenges meeting state standards for network adequacy were discussed. The MCO also provided information on network gaps with provider availability, time, and distance.

PHPNM uses Quest Analytics to collect network adequacy data, which it receives from the internally developed PDM. PHPNM utilizes Quest Analytics and Microsoft Access® to analyze network adequacy data. Quest Analytics is set up to incorporate all network adequacy standards established by the state, including provider capacity, minimum providers, and time or distance. PHPNM receives provider data through the PDM system. Member information is fed into Quest Analytics for the geospatial mapping component. Pharmacy location data are integrated into the same system. All these data flow into the centralized database, which connects directly to Quest Analytics. Quest Analytics then pulls in the HCA requirements related to time and distance standards and generates the geo-access reports required by the state. Although resource constraints are always a challenge, PHPNM employs a dedicated team of provider analysts who have consistently delivered high-quality network adequacy analyses using the Quest Analytics software.

As per PHPNM's ISCA response, data are collected in Quest Analytics and updated quarterly or on an ad-hoc basis, depending on individual provider negotiations. PHPNM prevents and corrects errors in network adequacy data through a multistep review process involving analytics, provider contracting, and network management teams, and enhances data accuracy by using LexisNexis® as a secondary data-scrubbing vendor. PHPNM calculates network adequacy by using Quest Analytics to map member-to-provider distances against Medicaid geographic standards set by HCA. PHNMP acknowledges that some information may be missing due to data collection issues; however, PHPNM does not knowingly report incomplete or missing data. While resource constraints are always a challenge, PHPNM has adequate staffing resources, as its dedicated provider analysts consistently deliver high-quality network adequacy analyses using the Quest Analytics software.

PHPNM has identified network gaps, particularly in maternity care and assisted living, and is implementing improvement plans reported quarterly to the state. These plans include expanding telehealth services, offering providers value-based incentives, supporting provider recruitment, and funding service expansions. PHPNM also uses secret shopper surveys and outbound calls to monitor appointment availability and assist members with scheduling care. PHPNM increases provider access in rural areas by promoting nonemergency transportation, offering reimbursement for part-time rural specialty clinics, and providing the tytocare™ telehealth platform at no cost to network providers. PHPNM partners with rural FQHCs in Cuba and Farmington counties for electronic consultations and remote specialty visits, and tracks telehealth utilization for reporting to HCA.

PHPNM maintains contracts with all essential community providers (ECPs) in the state, ensuring access to critical services in rural areas and specialized, culturally attuned care. Through its provider engagement model, PHPNM fosters positive relationships and aligns ECPs with the network through participation and value-based

partnerships. Indian Health Services (IHS) providers are always considered in-network, regardless of contract status, and PHPNM has mutual partnership agreements with many tribal, IHS, and urban Native American providers. PHPNM employs tribal liaisons to maintain strong connections with the communities they serve and support ongoing partnerships with Indian/tribal/urban (I/T/U) facilities. The analysis of access and availability helps PHPNM improve the network by guiding provider recruitment efforts and allowing the MCO to focus on problem areas or potential providers that can enhance the network.

Oversight of Contracted Vendors

The review of oversight of contracted vendors focused on contracted vendors and delegated functions, and included detailed discussion on the health plan's vendor oversight policies, activities, reports and review of vendor data reporting requirements, submission patterns, and data completeness. Data submitted included all required elements for PM reporting, encounter reporting to the state, and performance improvement projects (PIPs).

PHPNM contracts with vendors for dental, vision, pharmacy, BH and transportation services (**Table 16**). For dental services, DentaQuest® manages credentialing, claims, and network management is subject to annual audits and biweekly encounter reviews by PHPNM. Versant Health®, the vision vendor, is delegated for claims and network services and also undergoes annual audits. As of March 1, 2025, PHPNM changed their transportation vendor from Secure Transportation® to ModivCare®. PHPNM audits their processes to ensure claims are accurate, timely, and compliant. Capital Rx, PHPNM's PBM, manages pharmacy claims and benefits. PHPNM conducts biannual audits and oversees timely, accurate encounter and financial data submission to HCA. Magellan Health oversees BH claims, credentialing, and utilization management. PHPNM audits their contracted vendors annually to ensure regulatory and contract compliance.

As of 2024, PHPNM does not have any open corrective action plans (CAPs), or improvement plans with any of the five vendors. PALCO® processes payments to individuals who provide personal care services, then those encounters are submitted to PHPNM for payment.

Table 16: PHPNM Vendors by Claim Type

Claim Type	Vendor	Vendor Contract Begin Date	Frequency of Encounter Submission
Dental	DentaQuest	01/07/2006	Bi-Weekly
Vision	Versant Health	01/07/2020	Weekly
Pharmacy	Capital Rx	01/01/2024	Daily
Behavioral Health	Magellan Health	07/18/2013	Daily
Transportation	Secure Transportation ModivCare	01/07/2020 3/1/2025	N/A

N/A: not applicable.

Grievance Systems

Review of grievance systems included demonstrations of the systems used for Medicaid and CHIP. The review included interfaces with other systems, such as eligibility, claims, and providers, and discussion of processes for reporting to the state.

The grievance systems do not interface directly with the transactional systems. However, nightly member and provider loads to the grievance systems from the transactional systems ensure that member and provider information are current. The application has multiple reporting and tracking tools to allow managers to

monitor cases. Reports for the state are generated from the grievance systems. Discussion included the production of quarterly reports to the state and an overview of grievance systems for Medicaid and CHIP product lines.

PHPNM utilizes the Oracle-based Siebel system as their platform for processing, tracking, and trending complaints and grievances. Appeals and grievances submitted to the appeals and grievances (A&G) department are logged and managed in this system. PHPNM advised that cases are typically assigned electronically, particularly those received via the customer service center. Call center representatives may submit appeals and grievances on behalf of members or providers. Members and providers can also submit appeals and grievances directly through their website, ProviderConnect or via email. A tracking number is generated and provided to the submitter, enabling case monitoring from submission through resolution. Once a letter is finalized, it's uploaded to the system and marked "complete." All letters submitted are sent out on the same day. Acknowledgment letters arrive within 5 days, and resolution letters are mailed within 30 days.

PHPNM advised that when a provider submits information online, the system records the date and time of submission. Provider profiles are retrieved electronically using a unique provider ID, allowing verification through internal systems, including claims and pharmacy databases. The system displays relevant case information, including dates of service, regulatory due dates, and claims data, such as claim number, dollar amount, and payment or denial status. Submitters may view the final decision, access determination letters, and download related correspondence, including scanned copies of mailed or faxed documents. Appeals received via mail or fax are processed by the mailroom vendor, manually reviewed, and assigned for case processing. The resolution timeframe is 30 days for standard appeals and grievances, and 72 hours for expedited appeals.

PHPNM advised that data fields from the Siebel system feed into internal and regulatory reports, including Report #37. Currently, this reporting has been suspended, pending guidance from the state. PHPNM generates both monthly and quarterly data extracts from the Siebel system, with the reporting schedule determining frequency. Quarterly reports reflect activities over a 3-month span, while monthly reports cover a single month. Only actions completed within the specified reporting period are included.

PHPNM indicated that once an appeal or grievance is created, it is assigned to a research specialist by the coordinator. The research specialist reviews the case and generates a resolution letter within internal due dates. A copy of the letter is uploaded to the system and routed through the mailroom. PHPNM advised that resolution letters are sent no later than 30 days following case closure.

PHPNM maintains close collaboration with its subcontractor manager through regular audits and quarterly performance reviews to address issues, enhance processes, and escalate concerns. Relevant case data are shared to support continuous quality care and service delivery.

Encounter Data Submissions to State

The review of encounter data submissions to state section focused on a detailed review of encounter data systems, encounter data submission, and reconciliation processes. A walkthrough and demonstration of the encounter data systems and any available reports were also discussed in detail. The MCO provided details on timeliness and accuracy of submission of encounters to HCA.

PHPNM encounter data are housed and managed within HRP, which processes healthcare claims data submitted by subcontractors, including BH, dental, vision, and pharmacy services. These paid claims are submitted on a weekly or biweekly basis and are loaded into an IRADW equipped with a UI for managing

rejected records. Encounter data undergo various edits to ensure compliance with state requirements and are stored in a dedicated encounter database.

PHPNM compiles encounters along with physical health claims from HRP to generate standard 837 files for submission to the state. The state reviews these files, accepts valid encounters, and returns rejected records. PHPNM ensures adherence to state-mandated acceptance and timeliness standards. Upon completion of the inbound encounter processing cycle, PHPNM reconciles vendor-submitted data by sending each vendor a text file via SFTP containing the processed file name and claim count.

PHPNM indicated that due to system limitations, HCA only accepts paid claims and does not permit the submission of denied claims or denied lines. Standard reports are submitted to the state by the analytics team, while the state independently monitors and evaluates encounter accuracy metrics for each MCO. PHPNM reported that no concerns have been raised by the state to date.

PHPNM's top-3 encounter data submission denial reason codes are:

1. 0032 – E-Provider/Claim Type Conflict
2. 0367 – Bill Prov Review For Type/Proc
3. 0336 – Billing Provider Not Authorized By LTC Span Or Lockin

PHPNM reported that encounter submissions follow a weekly schedule rather than a fixed submission date. Submissions occur as follows: 837P administrative encounters on Mondays; 837I, 837P, 837D voids, and pharmacy encounters on Tuesdays; and 837I, 837P, and 837D adjustments and original encounters on Wednesdays and Thursdays. According to PHPNM's ISCA response, a total of 982,171 encounters were submitted to HCA in December 2024.

Summary of Findings

CMS prescribes that at the conclusion of the ISCA review, the external quality review organization (EQRO) is to compile and analyze the information gathered through the preliminary ISCA review and from the MCO staff interviews. After completing its analysis, the EQRO writes a statement of findings about the MCO's information system review and assigns an assessment level to each assessment topic.

Table 17 contains the four assessment levels and their definitions. PHPNM's summary of findings is presented in **Table 18**.

Table 17: IPRO Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

MCO: managed care organization.

Table 18: PHPNM Summary of Findings

Assessment Topic	Assessment Finding	Review Note
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	PHPNM has processes and procedures in place to maintain member enrollment information and ensure eligibility standards are met. PHPNM enrollees are assigned both a universal customer identifier and a member ID, each of which is unique to that individual. PHPNM tracks member demographic updates. No issues were noted in PHPNM's enrollment processes and procedures.
Adjudication and review of claims data received from multiple sources	Met	PHPNM accepts claims via 837 HIPAA electronic file extracts, the ProviderConnect portal, and paper submissions. PHPNM advised that 90.85% of the electronic and 37.80% of the paper claims are auto-adjudicated. No issues were noted in PHPNM's current claim adjudication process of claims.
Validation and/or calculation of performance measures	Met	As of September 2024, PHPNM transitioned their NCQA-certified vendors from Inovalon to CitiusTech PERFORM+. PHPNM integrates administrative, clinical, and enrollment data from multiple legacy and external sources into its Integrated Reporting and Analytics Data Warehouse (IRADW) to support HEDIS and Medicaid PM reporting, using structured processes, regular data quality checks, and a CitiusTech PERFORM+ platform for processing. PHPNM is currently not incorporating case management information into their HEDIS measures. No issues were noted in PHPNM's validation and calculation of PMs.

Assessment Topic	Assessment Finding	Review Note
Utility of the MCO's IS for linking to other information sources for quality related reporting	Met	PHPNM uses the Boomi platform for real-time API integrations and IBM Sterling MFT for batch data transfers. Inbound data, similar to claims and enrollment files, are staged, validated, and processed into core systems, then organized into data hubs for reporting and integrations with digital platforms. Regular reconciliation and reporting ensure data accuracy and support both internal operations and external member and provider portals. No issues were noted, since PHPNM's information systems support various data reporting requests, both internally and externally.
Identification and reporting of NCQA's and CMS's race and ethnicity categories	Met	PHPNM has race and ethnicity data that are provided through the HCA proprietary enrollment roster files, both monthly and daily, and are stored in HRP. These data are then populated into the certified HEDIS vendor data repository. All enrollment roster files are processed internally. Race and ethnicity data are provided via the HCA proprietary enrollment rosters, which include monthly and daily files. PHPNM aligns with the *2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, and is capable of capturing race and ethnicity values, including the new Middle Eastern and North African race category, as long as the data are available from source systems. No issues were identified.
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	PHPNM uses data-driven strategies to improve population health and quality performance, with close collaboration between population health, quality operations, and analytics to identify and engage priority populations. No issues were noted in PHPNM's ability to conduct MCO quality assessment and improvement initiatives.

Assessment Topic	Assessment Finding	Review Note
Completeness and accuracy of tracking of member and provider grievances and appeals	Met	PHPNM utilizes the Oracle-based Siebel system as their platform for processing, tracking, and trending complaints and grievances. Appeals and grievances submitted to the appeals and grievances department are logged and managed in this system. PHPNM advised that, currently, Report# 37 has been put on hold by the state. No issues were noted in PHPNM's systems used for handling grievances and reporting to the state.
Validation and/or calculation of network adequacy reports	Met	PHPNM uses Quest Analytics to collect network adequacy data, which it receives from the internally developed provider data management system to analyze network adequacy data. PHPNM has identified network gaps, particularly in maternity care and assisted living, and is implementing improvement plans reported quarterly to the state. These include expanding telehealth, offering value-based incentives, supporting provider recruitment, and funding service expansions. No issues were noted with PHPNM's provider network adequacy validation and calculation processes.
Ability of the information system to generate complete, accurate and timely T-MSIS data	Not Applicable	PHPNM does not submit encounter data to CMS; PHPNM submits encounter data to HCA.
Completeness and accuracy of encounter data collected and submitted to the state	Met	PHPNM encounter data are housed and managed within IRADW, which processes healthcare claims data submitted by subcontractors, including behavioral health, dental, vision, and pharmacy services. No issues were noted with completeness and accuracy of encounter data collected and submitted to the state.

MCO: managed care organization; ID: identification; HIPAA: Health Insurance Portability and Accountability Act; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; API: application programming interface; MFT: managed file transfer; CMS: Centers for Medicare and Medicaid Services; HCA: Health Care Authority; T-MSIS: Transformed Medicaid Statistical Information System.

V. UnitedHealthcare of New Mexico

General Information

IPRO worked with HCA to customize the ISCA worksheet provided in Appendix A of the *CMS External Quality Review (EQR) Protocols* published in February 2023. Turquoise Care, the NM Medicaid program began July 1, 2024.

In addition to customizing the ISCA survey tool for NM's Medicaid products, the ISCA was also modified to include questions related to the HEDIS Electronic Clinical Data Systems (ECDS) measures and race and ethnicity categories, quality assessment and improvement initiatives, grievances, and encounter data submissions to the state.

On December 11, 2024, IPRO uploaded the NM ISCA tool to Research Electronic Data Capture (REDCap®) and the NM MCOs were requested to complete and return the responses by January 31, 2025.

A 5-hour virtual meeting was held for UHCNM on April 3, 2025, to discuss the MCO's ISCA responses, interview the MCO's staff, and review the MCO's information system capabilities. UHCNM staff, HCA, and IPRO staff attended the virtual meeting.

The MCO's information system assessment covered the following areas:

- Data Integration and Systems Architecture
- Membership Data Systems and Processes
- Claims Data Systems and Processes
- Performance Measure Reporting, Race and Ethnicity, and ECDS Measures
- Provider Data Systems and Processes
- Provider Network Adequacy
- Oversight of Contracted Vendors
- Grievance Systems
- Encounter Data Submissions to State

UHCNM 's completed ISCA worksheet can be found in **Appendix A**.

Data Integration and Systems Architecture

During the data integration and systems architecture session, the MCO provided a comprehensive walkthrough of all data sources maintained by the MCO for operations and reporting. Data sources included transactional systems, including claims, enrollment, provider, and vendor data. The MCO provided a review of all warehouses maintained by the MCO used for regulatory and financial reports, analysis, and PM reporting. UHCNM provided a review of data control and security procedures, including disaster recovery (DR) plans. The discussion also included the frequency of load of claims, vendor and enrollment data, and any control checks in place for data warehouse loads.

UHCNM utilizes Community Strategic Platform (CSP) Facets as their membership and claims processing platform. The CSP Facets production database contains claims, provider, membership, and eligibility data. UHCNM has a relational database management system (RDBMS) utilizing Oracle® database. UHCNM's member enrollment, claims, and provider information is stored in their service management automation reporting technology (SMART) data warehouse. UHCNM follows a standard software development methodology, Software Development Life Cycle Model (SDLCM).

UHCNM went live with NM on July 1, 2024, and data since July 2024 are retained and available online. As per UHCNM's response, standard repositories can maintain 3 years' worth of data, and historical data can be accessed via batch job that can be completed within 24 hours. UHCNM indicated that they upgraded their Facets claims and enrollment system in September 2024 with no impact to historical data. For data extracts and analytical reporting, UHCNM programmers utilize various programming languages and software, including procedural language-structured query language (PL-SQL), Visual Basic.NET (VB.NET), C++, Active Server Pages (ASP), ASP.NET, Crystal Reporting, Visual Basic for Applications (VBA), Common Business-Oriented Language (COBOL), IBM® DataStage®, Apache Spark™, Java®, Apache Airflow®, and Talend®. UHCNM's code management team utilizes GITHUB®, CA Endevor®, and HP® Application Lifecycle Management (ALM).

UHCNM has a separate repository for encounter data that is submitted to the state. UHCNM's encounter data are stored within their national encounter management information system (NEMIS).

UHCNM's HEDIS repositories are stored in house and developed and maintained by their National Committee for Quality Assurance (NCQA)-certified HEDIS vendor, Inovalon®. UHCNM uses Inovalon's Converged Analytics™ to produce HEDIS and CMS Adult and Child Core Set PMs. UHCNM indicated that since they went live in July 2024, they will not be reporting HEDIS PMs for NM until measurement year (MY) 2025.

Disaster Recovery

UHCNM has a DR site located in Minnesota (MN), which provides failover capabilities. UHCNM's CSP Facets application data center is in Elk River, MN. The CSP Facets recovery environment data center is in Chaska, MN. UHCNM performs daily backups of all production and test servers, storing them on disk to ensure data availability and minimize loss during outages. UHCNM advised that the recovery time objective (RTO) for their critical applications is less than 72 hours, and the recovery point objective (RPO) for their applications is near 0 hours.

UHCNM indicated that their DR system is tested annually. As per UHCNM's backup strategy, their systems and databases are backed up daily and weekly. UHCNM retains database backups for 28 days and maintains two copies of operational data at their secure technology centers. UHCNM performs a thorough review of backup and standard operating procedures (SOPs) on an annual basis.

Access to System

UHCNM has a robust security infrastructure. As per UHCNM's ISCA response, access to their systems is granted on an as-needed basis utilizing role-based access control (RBAC). UHCNM indicated that all users of their information technology (IT) systems are uniquely identified and authenticated before access to information assets and/or IT systems is granted. As per UHCNM's ISCA response, access to IT systems may only be granted when based upon documented business justification and approved by management. UHCNM utilizes multi-factor authentication (MFA) for all remote access connections. UHCNM remote access users receive security awareness training aligned with compliance standards to ensure secure practices. UHCNM uses a combination of logical, physical, and procedural controls to protect sensitive customer data.

As per UHCNM, in the event of an employee's transfer or termination, safeguards exist to notify appropriate parties in a timely manner, and the individual's access to company physical and IT systems are revoked or restricted upon transfer or termination. UHCNM indicated that managers notify the relevant human capital resources of all terminated employees or contractors. Platform access is revoked within 2 business days of termination; application access within 10.

UHCNM indicated that their enterprise information security organization (EISO) is responsible for information security awareness training and briefings. Security education is ongoing and all employees and contractors complete formal education requirements on an annual basis. Security awareness trainings include an overview of enterprise information security program and managing protected information, and are reviewed on a periodic basis.

Membership Data System and Processes

The membership data systems and processes review included a demonstration of enrollment/membership data systems for Medicaid and Children's Health Insurance Program (CHIP) members, and processes used to verify and update enrollment information.

UHCNM's reconciliation process of HCA's 834 daily and monthly eligibility files and audit processes was reviewed. The demonstration included workflow of systems and databases used to store membership data, details on control checks in place by the MCO to manage membership and eligibility related to multiple member identification numbers, demographic changes and movement, and notification for newborns and deaths to the state.

UHCNM receives daily and monthly 834 file(s) from the HCA. Eligibility is determined by the state, and the membership information received on the 834 file(s) via a secure electronic communications gateway (ECG) is loaded daily into CSP Facets. UHCNM indicated that their CSP enrollment management system (CEMS) processes the 834 file(s) for loading into CSP Facets. CSP Facets autogenerates a unique Subscriber identification (Subscriber ID) number for newly enrolled members, which is linked to the enrollee's state-assigned Medicaid ID. In CSP Facets, the enrollee's plan is aligned to a unique Group ID. The NM Medicaid Group ID in CSP Facets is called "NMTC." UHCNM retains and stores all historical addresses for its members. As per UHCNM, any fallout data from the 834 file loads are manually reviewed and reconciled through the NM Medicaid portal by their enrollment operations team. As per UHCNM's ISCA response, 20 records on average are included on the daily exception reports that need to be manually reviewed each day.

Upon notification of a member's disenrollment via the daily 834 file, a termination date is entered in the CSP Facets system. UHCNM loads all Medicaid disenrollment and re-enrollment information into their CSP Facets system from the 834 file(s). The member disenrollment and re-enrollment dates are easily accessible for tracking and viewing in the CSP Facets system.

Records identifying deceased members are received from HCA via the daily 834 file(s) and are subsequently loaded into the member file within CSP Facets. Information regarding newborns is also transmitted through the 834 file(s). The newborn record is loaded in CSP Facets with their own Subscriber ID, which is linked to Family Link ID, and newborns can be tracked in CSP Facets.

UHCNM indicated that each member is expected to have a unique Subscriber ID. However, if a member has more than one Medicaid ID received via the 834-eligibility file, CSP Facets may create a duplicate Subscriber ID. The member records get merged, the additional record is voided, and a note is added in the enrollment system with the correct CSP Facets Subscriber ID. UHCNM indicated that membership information received on the supplemental and corresponding 834 file(s) is the source of truth for membership. UHCNM runs a weekly report to identify members with multiple Subscriber IDs. UHCNM provides extensive training for their enrollment team.

UHCNM receives race and language data provided by HCA on the 834 daily enrollment files and stores the information in their CSP Facets system. UHCNM indicated that a crosswalk is utilized to map race and ethnicity values received on incoming 834 file(s) to matching values in CSP Facets.

During the virtual meeting, UHCNM indicated their finance department utilizes the monthly 820 Health Insurance Portability and Accountability Act (HIPAA) capitation file for reconciliation of member enrollments.

UHCNM's average unduplicated member enrollment counts for Medicaid and CHIP enrollments from 2022 to 2024 are listed in **Table 19**.

Table 19: UHCNM Average Unduplicated Member Enrollment Counts, 2022–2024

Product Type	Year 1 – 2022[1]	Year 2 – 2023[1]	Year 3 – 2024
Medicaid	N/A	N/A	26,798
CHIP	N/A	N/A	435

[1] UHCNM was incorporated in 2024; member enrollment counts for the years 2022 and 2023 were not applicable (N/A).
CHIP: Children's Health Insurance Program.

Claims Data Systems and Processes

The claims/encounter data systems and processes evaluation included a review of responses provided by the MCO on the ISCA worksheet, verification of the accuracy of information provided through direct review of claims systems, review of audit processes and audit results, and a walkthrough of professional and facility claims for the Medicaid product. Discussion covered claim sources, paper vs. electronic claim ratios, and auto-adjudication rates by product line. The review also included the use of Diagnosis-Related Groups (DRGs), high dollar thresholds, and alternative pay arrangements to providers.

UHCNM provided a detailed walkthrough of individual claims from receipt to payment for professional and facility claims for the Medicaid and CHIP product lines. During the virtual meeting, UHCNM demonstrated examples for institutional and professional claim types for Medicaid and CHIP.

UHCNM receives claims through the clearinghouse, via the provider portal, or on paper. As per UHCNM's ISCA response, 95.145% of the claims are submitted electronically, via provider portal or electronic file format. Paper claims received by UHCNM are scanned by their regional mail operations (RMO) and assigned a film locator number (FLN). The image is loaded to Doc 360. Claims are entered into nonstandard file (NSF) format that is loaded into Business to Business (B2B) which routes the claims to CSP Facets system for processing. UHCNM indicated that all scanning is completed within 24 hours of receipt in the mail room and audited daily.

Claims are processed using the first-in-first-out method, and 100.00% of claims are processed daily, via a batch process on the CSP Facets claims processing platform. From July 2024 to December 2024, approximately 93.77% of Medicaid claims were auto-adjudicated, and the remaining were manually processed. Claims that do not auto-adjudicate are routed to a queue by claim type and received-date order. Claims are placed in a pended status by the system or manually by a claims examiner if a claim requires additional department review or processing assistance. Pended claims are monitored closely to ensure that the necessary information is obtained, and the claim is adjudicated in a timely manner. A pended-claims report is generated and reviewed daily by the claims management team, and status is tracked for all unresolved claims.

UHCNM utilizes CSP Facets and Optum® claims edit system (CES) to analyze professional and facility health care claims on a prepayment basis. UHCNM receives DRGs from providers and stores them in CSP Facets system. UHCNM uses Medicare severity-diagnosis related groups (MS-DRGs) for grouping, which is calculated in the EASYGroup/WebStrat payment system. As per UHCNM's ISCA response, up to 12 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes and 50 procedure codes are accepted and stored for professional claims utilizing the CMS-1500 (or the electronic comparative, 837P) and up to 41 ICD-10-CM diagnosis codes and 999 procedure codes for facility institutional claims utilizing the UB-04 (or the electronic comparative, 837I).

UHCNM's Medicaid claims are regularly audited for financial and procedural accuracy by their quality every single time (QuEST) Team. Each week, claims are randomly sampled from the platform universe via the SMART audit master (SAM) tool. SAM divides all claims into eight buckets called "strata," depending on the total dollars paid. High dollar threshold for UHCNM's institutional claims is $5,000, and $9,000 for professional claims. UHCNM advised that their claim capability and product delivery (CCPD) team conducted pre– and post–go-live NM Medical claim audits between July 2024 and November 2024 to ensure claims were adjudicated appropriately. UHCNM advised that from July 2024 to December 2024, the percentage of medical claims audited for NM Medicaid and CHIP was 0.09%. As per UHCNM's ISCA response, in December 2024, claims timeliness and processing for 30 days was 99.97% and 90 days was 100.00%.

UHCNM provides training to their new claim processors. New hire training includes topics such as duplicate processing, timely filing, coordination of benefits, authorizations, and manual pricing. Ongoing training and coaching are provided based on skill progression, quality initiatives, new systems, and process updates. **Table 20** lists paper and electronic claim types received.

Table 20: UHCNM Claims/Encounter Data Sources and Types

Data Source	Data Type
Hospital	Paper: UB-04 Electronic: 837I
Physician	Paper: CMS-1500 Electronic: 837P
Drug	Electronic: NCPDP
Nursing home	Paper: UB-04 Electronic: 837I
Home health	Paper: UB-04 and CMS-1500 Electronic: 837I or 837P
Mental health	Paper: UB-04 and CMS-1500 Electronic: 837I or 837P
Dental	Electronic: 837D

UB-04: Uniform Billing Form; CMS: Centers for Medicare and Medicaid Services; CMS-1500: professional paper claim form; NCPDP: National Council for Prescription Drug Programs; 837I: institutional claims form; 837P: professional claims form; 837D: dental claims form.

Performance Measures Reporting, Race and Ethnicity, and ECDS Measures

The performance measures reporting, race and ethnicity, and ECDS measures review included data sources, supplemental data received and integrated into the PM reporting for HEDIS, CMS Adult and Child Core Set, and NM-specific PMs. Further review included the discussion of race and ethnicity data, sources, assignment of NCQA-certified vendor and state-specific categories, and discussion of the submission of ECDS measures for

HEDIS NCQA measures reporting. The detailed crosswalk of MCO race and ethnicity and supplemental data sources for ECDS measures was presented by UHCNM.

UHCNM's HEDIS repositories are developed and maintained in house. UHCNM uses Inovalon as their certified NCQA vendor. UHCNM's supplemental data are stored in the supplemental data repository (SDR). As per UHCNM's ISCA response, data are pulled from member demographics, enrollment, provider demographics, medical claims, pharmacy claims, and lab results. The CSP Facets production database can be directly accessed, which contains claims, provider, and member data. Data are extracted weekly and loaded to the SMART data warehouse, which also contains vendor data (pharmacy, dental, lab, and vision), which are loaded weekly, and care management system data (Community Care and Integrated Clinical User Experience [ICUE]), which are loaded daily. UHCNM indicated that during data extractions from the source systems, the SMART data warehouse also performs independent quality assurance (QA) extracts. QA reports are run for all input data sets and reviewed by analysts before processing to confirm completeness and accuracy of data. UHCNM's Optum enterprise clinical performance team extracts, transforms and loads data into Inovalon's HEDIS engine, Converged Analytics, for measure processing.

Continuous enrollment, member months, and member years are defined and calculated within Converged Analytics, which has all the data elements included in the input files that are needed for the calculation of PMs. UHCNM advised that after processing, rates are extracted and compared to prior year benchmarks to identify and validate any material variances. UHCNM produces HEDIS PMs annually. UHCNM advised that the MCO went live in July 2024 and would not be reporting HEDIS in NM until MY 2025. UHCNM indicated that they are currently producing PMs monthly for their quality committee, tracking measures, and conducting comparisons to ensure that monthly goals are met. There are 17 measures that are submitted quarterly to the state.

UHCNM indicated they have processes in place to meet state requirements related to population health management (PHM) and quality improvement (QI) intervention strategies. Data related to HEDIS have been integrated into operational areas as appropriate and include Quality, Population Health, Health Services, Health Equity, and Customer Service. Data from medication reconciliations performed by the plan's team of clinical pharmacists for members discharged from a hospital are also ingested into the monthly data integration process. The results are analyzed by internal workgroups and quality committees to review trends, identify opportunities, and develop an action plan. For PHM, UHCNM uses a dynamic set of tools including Population Insight Tool, Blended Census Reporting Tool (BCRT), Hot Spotting Tool, Index of Disparity Dashboard, Patient Care Opportunity Report (PCOR) and Impact Pro to stratify populations and provide utilization and key indicators to drive clinical QI strategies.

UHCNM indicated there are currently no concerns related to care management and population health data. UHCNM's PHM includes rigorous monitoring, coordinated and collaborative activities, as well as initiatives that contribute to positive health outcomes in a cost-efficient and cost-effective manner. UHCNM indicated PHM encompasses national priority areas, including maternal (prenatal and postpartum care) and newborn health, healthy adult and child (pediatric preventive health, adolescent health, and adult preventive health services), chronic conditions (diabetes, hypertension, chronic obstructive pulmonary disease [COPD], asthma, etc.), behavioral health (BH), and substance use disorder (SUD). The PHM program operations and oversight functions are integrated into the QI program activities.

UHCNM utilizes a dynamic set of tools to identify and stratify populations and provides utilization, disease prevalence and key indicators to drive clinical QI for their members. UHCNM's quality optimization and insights (QOI) team performs unique and specialized functions to support quality management and

improvement, including but not limited to prospective (year-round) collection of supplemental data, ongoing analysis of HEDIS data for improvement efforts, support of health plan and enterprise wide efforts toward optimal health for their members, fulfilment of regulatory and state reporting requirements, and stakeholder education.

UHCNM advised that some of their notable QI initiatives in NM include provider incentives for prescribing hepatitis C medications, eye exams for members with diabetes, "Let's Get Checked" (LGC) hemoglobin A1c (HgA1c) in-home test kit program, provider outreach programs, school-based health centers (SBHCs) and tribal health liaisons, care coordination outreach and innovative gaps-in-care dashboards.

UHCNM indicated on their ISCA response that they only use direct data sources to report required NCQA race and ethnicity categories. UHCNM indicated that they only use the data provided by the state in the 834-enrollment file, which is mapped to Inovalon's crosswalk for members' race and ethnicity reporting. UHCNM advised that the comprehensive needs assessments (CNAs), which are developed and directed by the state, and which ask questions about race and ethnicity, do not include the new Middle Eastern and North African race category. UHCNM currently does not capture the race and ethnicity values, based on the *2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, which includes the new Middle Eastern and North African race category.

UHCNM follows the prescribed NCQA hierarchy order for the HEDIS ECDS measures. UHCNM indicated supplemental data from multiple sources are utilized, including data from pharmacies, provider electronic medical records (EMRs), non-EMR medical records from providers, state immunization registry data, state lead registry data, and state historical files data. UHCNM indicated that they receive Systematized Nomenclature of Medicine (SNOMED) codes and Logical Observation Identifiers Names and Codes (LOINC®) from some continuity of care document (CCD) sources. **Table 21** lists ECDS sources and order.

Table 21: UHCNM ECDS Sources and Order

ECDS Data Source	MCO's Hierarchical Order
1. Electronic health record (EHR)/personal health record (PHR)	1
2. Health information exchange (HIE)/clinical registry	2
3. Case management registry[1]	N/A
4. Administrative (i.e., claims)	3

[1] UHCNM captures all information from their case management platforms under the EHR electronic clinical data systems (ECDS) data source.
MCO: managed care organization; N/A: not applicable.

Provider Data Systems and Processes

The provider data systems and processes review included a detailed review of the health plan provider network and credentialing processes and a discussion of maintenance of provider directories. The discussion included access and availability of the provider portal and percentage of claims received via provider portal.

UHCNM's provider data are maintained in the National Database (NDB) and transmitted daily to the CSP Facets system. UHCNM indicated that they receive provider information from HCA via a daily provider master file (PMF). UHCNM utilizes UHCprovider.com as the portal for their providers. UHCNM's providers can use My Practice Profile, a web-based tool, to update and validate their demographic information. UHCNM indicated that their provider profile database contains provider information that is necessary to update online and

paper directories, including but is not limited to provider demographics, office hours, gender, age limits, areas of expertise, registration information (National Provider Identifier [NPI], Taxpayer Identification Number [TIN], Medicaid IDs, license numbers, Medicare number, taxonomy), specialties, languages, services provided, new membership acceptance, network status, affiliations, certifications, accessibility, cultural competency, and disclosures. UHCNM's provider data teams perform ongoing monitoring of provider information, including credentialing and recredentialing.

UHCNM's online directory is available in English, Spanish, Vietnamese, Somali, Burmese and other languages for their members. UHCNM advised that their online directories are also available as a provider search tool online via their website. UHCNM's print directories are available in English and Spanish, and other languages are available to their members upon request through customer service. UHCNM advised that, as of June 2024, updates that reflect the latest information available from provider database within 6 hours online include provider name, office hours, languages, electronic communication, handicap accessibility, license, age/gender restrictions, telehealth, and cultural competency. Provider directory updates that occur overnight include provider address, phone, degree, specialty, tiering, contracting, accepting patients, specialty updates and directory indicator information. UHCNM's printed provider directory is updated twice a month. Virtual care indicator is displayed on the online directory if the provider offers this service.

During the ISCA review meeting, UHCNM demonstrated the data maintained in their online provider directory and CSP Facets. As per UHCNM's ISCA response, for Medicaid services, fee schedules and contractual payment terms are mostly automated for all provider types, and there are some exceptions. UHCNM indicated their provider reimbursement operations solutions (PROS) team is responsible for updating internal systems with the Medicaid fee schedule rates published by the state.

UHCNM stated no bonus payment models were offered to providers in 2024 following their July go-live. UHCNM was able to implement one singular value-based purchasing (VBP) provider agreement in 2024. UHCNM advised that a few alternative payment agreements (APAs) were offered to providers in 2024. UHCNM is "standing up" incentive programs encourage providers to close gaps in care, and provide shared savings arrangements with providers (including both upside risk and downside risk).

Provider Network Adequacy

The provider network adequacy review included a discussion of network adequacy processes for collecting, storing, analyzing, and reporting network adequacy data. The review of network standards, methods and calculations was used for calculating network adequacy indicators and detailed overview on geo-access analysis, state standards and compliance, along with any prior network adequacy validation results. Further review of prior network adequacy reports was conducted, and any challenges meeting state standards for network adequacy were discussed. The MCO also provided information on network gaps with provider availability, time, and distance.

UHCNM utilizes Quest Analytics® to evaluate their network accessibility and adequacy. Quest Analytics is set up to incorporate all network adequacy standards established by the state, including provider capacity, minimum providers, and time or distance. UHCNM indicated that they collect network adequacy data via the 834-enrollment file for member data and via the CSP Facets system for provider data. UHCNM's network adequacy analytics are performed on a national basis, which includes NM. UHCNM has a network access specialist dedicated to pulling together NM state reporting, analyzing network gaps, and directing the contracting team's strategy for recruitment.

As per UHCNM's ISCA response, network adequacy data are refreshed monthly, and analyzing, collecting, reporting, and storage of data are automated processes. UHCNM utilizes Quest Analytics geo-coding, and also has an internal data quality team that monitors provider data for completeness and accuracy. For geo-access, the provider network is reviewed quarterly to determine if the health plan meets contract requirements. UHCNM uses Quest Analytics for network adequacy reporting sent to the state. UHCNM uses Network360®, a competitive tool used to identify providers participating in other health plans. UHCNM's network/market teams have access to third-party vendor applications (e.g., Quest Analytics) for adequacy and accessibility. UHCNM utilizes multiple tools, including PhyCon® and Predict®, to perform quality checks for network adequacy data that are collected and stored in NDB.

UHCNM submits network adequacy reports to the state on a quarterly basis. UHCNM indicated that there are no existing corrective action plans (CAPs) for network adequacy. UHCNM has identified some gaps in their network where no providers exist for targeting. UHCNM advised gaps exist in rural, urban and frontier counties in multiple specialties, including but not limited to dermatology, Indian/tribal/urban (I/T/U), assisted living facilities, rural health clinics (RHCs), certified community behavioral health clinics (CCBHCs), intensive outpatient services and others. As per UHCNM's ISCA response, no Medicaid optometry providers are available in Curry and Roosevelt counties, resulting in gaps in care in these rural areas. Similarly, gaps exist in assisted living facilities in the urban, rural and frontier areas, and there are no opportunities available to close these gaps. UHCNM also indicated gaps for private duty nursing in the urban, rural and frontier areas.

UHCNM indicated that, as a new health plan, they continue to recruit and negotiate with providers across all network specialties, with a focus on those shown as deficient. Telehealth is utilized as a solution in instances where providers do not exist in certain geographical areas (e.g., rural areas). Essential community providers (ECPs) and Indian health care providers (IHCPs) are setup in NDB, and the data are fed to the provider directory. Geographical network deficiencies identified during the quarterly analysis and grievances and complaints around network adequacy are sent to the NM network access specialist. For valid network gaps, the network access specialist contacts their contracting team for provider targeting and outreach. UHCNM indicated that a standing workgroup meets every other week to review all provider network access concerns and strategizes recruitment. UHCNM advised that network adequacy analyses and results are presented at quarterly health plan committee meetings.

Oversight of Contracted Vendors

The review of oversight of contracted vendors focused on contracted vendors and delegated functions, and included detailed discussion on the health plan's vendor oversight policies, activities, reports and review of vendor data reporting requirements, submission patterns, and data completeness. Data submitted included all required elements for PM reporting, encounter reporting to the state, and performance improvement projects (PIPs).

UHCNM has vendors for dental, vision, pharmacy, BH and transportation services (**Table 22**). UHCNM advised that home care services are submitted via FOCoS®. UHCNM vendors are dental benefits providers (DBPs) for dental claims, MARCH Vision Care for claims for vision services, OptumRx® for pharmacy services, Optum Behavioral Health for BH services, and TripMaster for transportation services. UHCNM advised that MARCH Vision Care, UHC Dental, TripMaster and FOCoS all submit encounter files in an 837 format. OptumRx submits a pharmacy claim file, which is loaded into NEMIS. UHCNM's BH claims are pulled from their internal CSP Facets claim platform. UHCNM also uses vendor Galileo® for Nurseline call center reports. UHCNM advised that the accuracy of the vendor encounter data is monitored, and a vendor data load monitoring report is used for tracking.

UHCNM conducts regular monthly and quarterly joint operating committee (JOC) meetings with its vendors. UHCNM indicated monthly report monitoring and ad-hoc meetings are conducted with their vendors. During the virtual meeting, UHCNM indicated that there are currently no CAPs with their vendors. UHCNM advised that their annual audits that include vendors will be conducted in July 2025.UHCNM indicated that their current transportation vendor, TripMaster, was going to be changed to Kinetic® on May 1, 2025.

Table 22: UHCNM Vendors by Claim Type

Claim Type	Vendor	Vendor Contract Begin Date	Frequency of Encounter Submission
Dental	Dental Benefits Providers, Inc.	7/1/2024	Weekly
Vision	MARCH Vision Care, Inc.	7/1/2024	Weekly
Pharmacy	OptumRx	7/1/2024	Weekly
Behavioral health	United Behavioral Health Optum	7/1/2024	Weekly
Transportation	Foster Opcp LLC dba CTS Software (TripMaster)	7/1/2024	Weekly

LLC: limited liability company; dba: doing business as.

Grievance Systems

Review of grievance systems included demonstrations of the systems used for Medicaid and CHIP. The review included interfaces with other systems, such as eligibility, claims, and providers, and discussion of processes for reporting to the state.

The grievance systems do not interface directly with the transactional systems. However, nightly member and provider loads to the grievance systems from the transactional systems ensure that member and provider information are current. The application has multiple reporting and tracking tools to allow managers to monitor cases. Reports for the state are generated from the grievance systems. Discussion included the production of quarterly reports to the state and an overview of grievance systems for Medicaid and CHIP product lines.

UHCNM utilizes the appeal tracking system (ATS) and escalation tracking system (ETS) for NM Medicaid member and provider grievances. UHCNM accepts verbal, written, and electronic grievance submissions. UHCNM advised that members, providers, or authorized representatives can submit complaints or grievances at any time. UHCNM's appeals and grievances (A&G) resolving analyst (RA) enters each grievance or complaint in their ETS/ATS system. A case number is assigned, and the RA enters all relevant information, including the member/provider name, date and time grievance was received, date and time grievance was resolved, required categorization, and copies of any documentation or records reviewed. An acknowledgement letter is sent to the member/provider reporting the grievance, and a case is assigned in the ETS/ATS system.

UHCNM advised that complaints and grievances are acknowledged within 5 business days of receipt, and the standard resolution is within 30 days. UHCNM indicated that providers can submit complaints within 90 days of the incident. UHCNM indicated that their grievance and complaints process ensures transparency and informs members of their rights, treating all grievances with equal importance. Records pertaining to member/provider grievances are maintained in a manner accessible to CMS and the state for a minimum of 10 years. UHCNM provides initial new hire and ongoing call center trainings throughout the year to their call center staff.

UHCNM indicated that all grievances and complaints are investigated and tracked by their RA in the ETS/ATS system until resolved. When a member contacts an RA to update their primary care provider (PCP), the reasoning for changing the PCP is documented in their Maestro® processing system. A resolution letter is sent for all grievances and appeals that are resolved, and the case is closed in the system.

UHCNM indicated that complaints and grievances are reported to the state on a quarterly basis via Report #37. UHCNM advised that currently the report submissions have been put on hold by the state. UHCNM indicated that they have regular meetings with their Ras, and the A&G supervisors monitor reports daily to ensure compliance and quality. Each month a random sample of cases are reviewed by their quality department, and compliance/trending decks are reported and presented to the health plan.

Encounter Data Submissions to State

The review of encounter data submissions to state section focused on a detailed review of encounter data systems, encounter data submission, and reconciliation processes. A walkthrough and demonstration of the encounter data systems and any available reports were also discussed in detail. The MCO provided details on timeliness and accuracy of submission of encounters to HCA.

UHCNM encounter data are stored within NEMIS, which performs validation of encounter data prior to submission to HCA. General data validation is applied to the claims during the load process to ensure all the HIPAA-required fields are present and in the correct data format. Encounters failing these edits are bypassed with an error reason for manual review. All NM-required encounter data elements are generated on outbound 837 or National Council for Prescription Drug Programs (NCPDP) encounter files in standard formats to the state. As per UHCNM's ISCA response, NEMIS performs end-to-end encounter process of loading and validating claims, outbound file generation along with response file loading and submission to response reconciliation. Controls are in place to ensure all records are loaded and any issues are communicated back to the vendor for resolution. All inbound and outbound files are tracked to ensure completeness and timeliness.

Encounter files are submitted to the state weekly. Every Monday, claims processed in the prior weeks are pulled into the encounter system for submission the same week. As per UHCNM's ISCA response, they manage encounter submissions for services provided by their own organization and their vendors for medical, vision, dental, transportation and home care services. The medical health and BH claims are pulled from the internal CSP Facets claim platform. These claims are then loaded from the vendor database to NEMIS for processing. UHCNM indicated that pharmacy claim files are received and loaded into the NEMIS Vendor Database and follow the same processing as internal medical claims. UHCNM advised MARCH Vision Care, UHC Dental, TripMaster and FOCoS all submit encounter files in an 837 format. UHCNM submits the vendor encounters to the state.

Encounters that fail validation are reviewed by UHCNM's Medicaid encounters team. The encounters team conducts backlog monitoring, error tracking, analysis, resolution, and completion monitoring for encounter data submissions.

UHCNM indicated that paid claims/encounters and paid service line details are submitted to the state. Denied claims/encounters are not submitted to HCA.

UHCNM's top-3 encounter data submission denial reason codes are:

1. 0367 – Provider Review for Type/Procedure
2. 0097 – Plan Payment Missing/Invalid
3. 0032 – E-Provider/Claim Type Conflict

UHCNM indicated that they adhere to NM timeliness standards regarding the submission of encounters. As per UHCNM's ISCA response, total encounters submitted to HCA in January 2025 were 160,912.

Summary of Findings

CMS prescribes that at the conclusion of the ISCA review, the external quality review organization (EQRO) is to compile and analyze the information gathered through the preliminary ISCA review and from the MCO staff interviews. After completing its analysis, the EQRO writes a statement of findings about the MCO's information system review and assigns an assessment level to each assessment topic.

Table 23 contains the four assessment levels and their definitions. UHCNM's summary of findings is presented in **Table 24**.

Table 23: IPRO Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

MCO: managed care organization.

Table 24: UHCNM Summary of Findings

Assessment Topic	Assessment Finding	Review Note
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	UHCNM has processes and procedures in place to maintain member enrollment information and ensure eligibility standards are met. UHCNM enrollees are assigned and identified by their unique subscriber identification number (Subscriber ID) in Facets. The NM Medicaid Group ID in CSP Facets is "NMTC." UHCNM retains and stores all historical addresses for its members. No issues were noted in UHCNM's enrollment processes and procedures.
Adjudication and review of claims data received from multiple sources	Met	UHCNM receives claims through the clearinghouse, via the provider portal, or on paper. UHCNM advised that claims are processed using the first-in-first-out method, and 100.00% of claims are processed daily, via a batch process on the CSP Facets claims processing platform. No issues were noted in UHCNM's current claim adjudication process of claims.
Validation and/or calculation of performance measures	Met	UHCNM uses Inovalon as their certified NCQA vendor. UHCNM's supplemental data are stored in the supplemental data repository (SDR). UHCNM indicated that data are pulled from member demographics, enrollment, provider demographics, medical claims, pharmacy claims, and lab results for producing results. Regarding HEDIS ECDS PMs, UHCNM follows the prescribed NCQA hierarchy order for the inclusion of supplemental data sources. UHCNM captures all information from their case management platforms under the EHR ECDS data source. UHCNM advised that the MCO went live in July 2024 and would not be reporting HEDIS in NM until measurement year (MY) 2025. No issues were noted in UHCNM's validation and calculation of PMs.
Utility of the MCO's IS for linking to other information sources for quality related reporting	Met	UHCNM's information systems support various data reporting requests, both internally and externally. No issues were noted.

Assessment Topic	Assessment Finding	Review Note
Identification and reporting of NCQA's and CMS's race and ethnicity categories	Met	UHCNM indicated that they only use the data provided by the state in the 834-enrollment file, which are mapped to Inovalon's crosswalk for member race and ethnicity reporting. UHCNM advised that the comprehensive needs assessments (CNAs), which are developed and directed by the state, and which ask questions about race and ethnicity, do not include the new Middle Eastern and North African race category. UHCNM currently does not capture the race and ethnicity values, based on the *2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, which includes the new Middle Eastern and North African race category. No issues were identified.
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	UHCNM's information systems can conduct quality assessments and improvement initiatives. UHCNM advised that some of their notable quality improvement initiatives in NM include provider incentives for prescribing hepatitis C medications, eye exams for members with diabetes, "Let's Get Checked" (LGC) hemoglobin A1c In home test kits program, provider outreach programs, school-based health centers (SBHCs) and tribal health liaison, care coordination outreach and innovative gaps-in-care dashboards. No issues were noted in UHCNM's ability to conduct MCO quality assessment and improvement initiatives.
Completeness and accuracy of tracking of member and provider grievances and appeals	Met	UHCNM utilizes the appeal tracking system (ATS) and escalation tracking system (ETS) for NM Medicaid member and provider grievances. UHCNM accepts verbal, written, and electronic grievance submissions. UHCNM advised that members, providers, or authorized representatives can submit complaints or grievances at any time. UHCNM indicated that all grievances and complaints are investigated and tracked by their RA in the ETS/ATS system until resolved. UHCNM advised that currently the report #37 submission has been put on hold by the state. No issues were noted in UHCNM's systems used for handling grievances and reporting to the state.

Assessment Topic	Assessment Finding	Review Note
Validation and/or calculation of network adequacy reports	Met	UHCNM utilizes Quest Analytics software for assessing, monitoring, and reporting network adequacy. UHCNM submits network adequacy reports to the state on a quarterly basis as per HCA's regulatory requirements. UHCNM has identified some gaps in their network where no providers exist for targeting. UHCNM advised gaps exist in rural, urban and frontier counties in multiple specialties, including but not limited to dermatology, Indian/tribal/urban (I/T/U), assisted living facilities, rural health clinics (RHCs), certified community behavioral health clinics (CCBHCs), intensive outpatient services and others. UHCNM indicated that, as a new health plan, they continue to recruit and negotiate providers for all network specialties, with a focus on those shown as deficient. No issues were noted with UHCNM's provider network adequacy validation and calculation processes.
Ability of the information system to generate complete, accurate and timely T-MSIS data	N/A	UHCNM does not submit encounter data directly to CMS; UHCNM submits encounter data to HCA.
Completeness and accuracy of encounter data collected and submitted to the state	Met	UHCNM submits encounter data to the state complying with the standards for timeliness and accuracy of submissions of paid encounters. No issues were noted with completeness and accuracy of encounter data collected and submitted to the state.

MCO: managed care organization; NCQA: National Committee for Quality Assurance; ECDS: electronic clinical data systems; PM: performance measure; HEDIS: Healthcare Effectiveness Data and Information Set; CMS: Centers for Medicare and Medicaid Services; IS: information systems; RA: resolving analyst; HCA: Health Care Authority; T-MSIS: Transformed Medicaid Statistical Information System.