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New Mexico Medicaid Managed Care Programs

Centennial Care 2.0

Turquoise Care

Performance Measure Validation Report for Measurement Year 2024

Prepared on behalf of:
The New Mexico Health Care Authority

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State Medicaid Managed Care Program Changes that Occurred in 2024

In 2024, New Mexico's Medicaid managed care program underwent several key changes affecting program structure and data reporting.

Program Renaming

The New Mexico Medicaid managed care program transitioned from *Centennial Care 2.0* to *Turquoise Care* on July 1, 2024. Centennial Care 2.0 remained active through June 30, 2024.

Managed Care Organization Updates

In July 2024, the managed care organizations participating in New Mexico's Medicaid managed care program changed. Western Sky Community Care, Inc. exited the program on June 30, 2024. However, legacy managed care organizations, Blue Cross and Blue Shield of New Mexico and Presbyterian Health Plan, Inc. continued their participation under the newly launched Turquoise Care program. Additionally, Molina Healthcare of New Mexico and UnitedHealthcare Community Plan of New Mexico joined the program starting July 1, 2024.

Quarterly and Annual HEDIS Reporting Requirements

In 2024, the New Mexico Health Care Authority required all managed care organizations to submit quarterly performance measure reports. This quarterly reporting applied to every managed care organization participating in the Medicaid managed care program, ensuring consistent and timely data collection across managed care organizations.

Annual NCQA HEDIS submissions, however, were required for the two legacy plans — Blue Cross and Blue Shield of New Mexico and Presbyterian Health Plan, Inc. For other managed care organizations, annual NCQA HEDIS reporting was not mandated for the 2024 measurement year.

Throughout the year, the New Mexico Health Care Authority maintained ongoing monitoring of all reported performance measures. This continuous oversight enabled the agency to track managed care organization performance, identify trends, and ensure that each organization remained focused on improving outcomes for members. The quarterly data submissions were used to evaluate performance, inform stakeholders, and guide quality improvement efforts.

By structuring the reporting requirements in this way, the New Mexico Health Care Authority ensured robust accountability and transparency, while also adapting to the evolving needs of the managed care environment.

The New Mexico Health Care Authority uses the NCQA HEDIS program as a mechanism to monitor the performance of Medicaid managed care organizations. The annual reporting of HEDIS performance measure data by each managed care organization is required by the agreement with the New Mexico Health Care Authority and by the NCQA Accreditation program which the managed care organizations are required to achieve and maintain.

Impact on Oversight and Data

The New Mexico Health Care Authority's oversight of the Medicaid managed care program was not interrupted. Throughout the year, all managed care organizations were required to submit quarterly performance measure data. These quarterly submissions enabled the New Mexico Health Care Authority to conduct formal evaluations of managed care organization performance, with results presented to both stakeholders and the managed care organizations themselves during quarterly reviews.

Oversight and accountability were maintained through this ongoing, structured review process. The only element not implemented in 2024 was the imposition of monetary penalties for not meeting performance targets; all other aspects of oversight, including data-driven evaluation and feedback, remained in effect.

What This Means for Medicaid Members

These changes did not affect Medicaid managed care members' eligibility or benefits. Members continued to receive care through the available managed care organizations.

Figure 1 summarizes the operational status and reporting periods for the managed care organizations under Centennial Care 2.0 and Turquoise Care in 2024, along with descriptions of performance measure data and activities included in this report.

Figure 1: Summary of Managed Care Organization Operational Status, Performance Measure Data, and Activities – 2024

Managed Care Organization	Centennial Care 2.0 January 1, 2024–June 30, 2024	Turquoise Care July 1, 2024–December 31, 2024	Description of Performance Measure Data Presented in This Report	Schedule of Required Reporting of Measurement Year 2024 Data to the New Mexico Health Care Authority
Blue Cross and Blue Shield of New Mexico	Operational	Operational	Includes combined data for Centennial Care 2.0 and Turquoise Care for the period of January 1, 2024–December 31, 2024.	▪ Quarterly and Annually
Molina Healthcare of New Mexico	Not Operational	Operational	Includes data for Turquoise Care for the period of July 1, 2024–December 31, 2024.	▪ Quarterly
Presbyterian Health Plan, Inc.	Operational	Operational	Includes combined data for Centennial Care 2.0 and Turquoise Care for the period of January 1, 2024–December 31, 2024.	▪ Quarterly and Annually
UnitedHealthcare Community Plan of New Mexico	Not Operational	Operational	Includes data for Turquoise Care for the period of July 1, 2024–December 31, 2024.	▪ Quarterly
Western Sky Community Care, Inc.	Operational	Not Operational	Includes combined data for Centennial Care 2.0 for the period of January 1, 2024–June 30, 2024.	▪ Quarterly

Executive Summary

Introduction

The New Mexico Health Care Authority selects a set of performance measures to evaluate the quality of care delivered by Medicaid managed care organizations (hereafter referred to as MCOs) to members. *Title 42 Code of Federal Regulations Section 438.358(a)(1)* and *Section 438.358(b)(ii)*, requires that these performance measures be validated by the state, its agent, or an external quality review organization. The Centers for Medicare & Medicaid Services defines validation (*Title 42 Code of Federal Regulations Section 438.320*) as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis." To satisfy this requirement, the New Mexico Health Care Authority contracted with Island Peer Review Organization, Inc. (doing business as IPRO) to conduct the validation of performance measures for measurement year 2024.

During measurement year 2024, New Mexico Medicaid MCOs were governed by two distinct, non-overlapping agreements: one covering January through June, and the other covering July through December.

From January 1 to June 30, 2024, the Medicaid managed care program (Centennial Care 2.0) included three MCOs: Blue Cross and Blue Shield of New Mexico (hereafter referred to as BCBS), Presbyterian Health Plan, Inc. (hereafter referred to as PHP), and Western Sky Community Care, Inc. (hereafter referred to as WSCC). From July 1 to December 31, 2024, the program (Turquoise Care) included four MCOs: BCBS, Molina Healthcare of New Mexico (hereafter referred to as MHC), PHP, and UnitedHealthcare Community Plan of New Mexico (hereafter referred to as UHC).

The Centennial Care 2.0 Performance Measurement Program, in place from January 1 to June 30, 2024, consisted of 10 performance measures: two related to maternal care, three to child and adolescent preventive care, and five to behavioral health care.

The Turquoise Care Performance Measurement Program, in place from July 1 to December 31, 2024, consisted of 13 performance measures. Collectively, these measures evaluate maternal care, child and adolescent preventive care, women's health, chronic conditions, and behavioral health care.

The New Mexico Health Care Authority maintained strong accountability for all MCOs throughout 2024. Each MCO was required to report on assigned performance measures, and the New Mexico Health Care Authority actively monitored these submissions to ensure that MCOs were targeting the selected measures for improved outcomes. This accountability was enforced through structured quarterly reporting, ongoing data review, and regular feedback to MCOs. The only element not implemented in 2024 was the imposition of monetary penalties for not meeting performance targets; all other aspects of oversight and accountability, including expectations for continuous improvement, remained in effect.

Scope of External Quality Review Activities

This report focuses on one federally mandatory external quality review activity, validation of performance measures, which was conducted by IPRO on behalf of the New Mexico Health Care Authority for measurement year 2024. This activity assessed the accuracy of performance measures reported by each MCO and determined the extent to which the rates calculated by the MCO follow state reporting requirements and NCQA HEDIS technical specifications.

As part of the external quality review program, IPRO conducted an information systems capabilities assessment for each MCO participating in Turquoise Care. IPRO also reviewed pertinent quality improvement program documentation produced by each MCO to assess the impact of MCO-directed activities on health outcomes related to the performance measures in **Table 1**.

IPRO's methodologies for both the performance measure validation and information systems capabilities assessment aligned with the *CMS External Quality Review (EQR) Protocols*[1] published in February 2023.

High-Level Results

Validation of Performance Measures

IPRO's validation of the MCOs' performance measures confirmed the state's compliance with the standards of *Title 42 Code of Federal Regulations Section 438.330(a)(1)*. The results of the validation activity determined that the MCOs were compliant with the standards of *Title 42 Code of Federal Regulations Section 438.330(c)(2)*.

Information Systems Capabilities Assessment

The 2024–2025 information systems capabilities assessment determined that all four Turquoise Care MCOs met or exceeded the standards reviewed.

Further, independent HEDIS auditors for the three Turquoise Care MCOs that submitted measurement year 2024 data to NCQA, determined that the rates reported by the MCO were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified by the MCOs' HEDIS auditors.

Based on a review of the final audit reports issued by the three independent HEDIS auditors, IPRO found that audited Turquoise Care MCOs were determined to be *fully compliant* with HEDIS Specifications Standards and all four of the NCQA Information System Capabilities standards. HEDIS measurement year 2024 rates produced by the MCOs were reported to NCQA, the New Mexico Health Care Authority, and IPRO.

Performance Measure Outcomes

In measurement year 2024, the New Mexico Health Care Authority required all MCOs to submit quarterly performance measure data, ensuring robust and ongoing oversight of MCO performance. Annual HEDIS submissions were required only for the legacy plans—BCBS and PHP. For other MCOs, annual HEDIS reporting was not mandated. The 2024 rates calculated by the MCOs and presented in this report are for informational purposes and reflect the data submitted through these quarterly and, where applicable, annual processes.

2024 Quality Improvement Initiatives

In addition to the requirements of the Performance Measure Program, the New Mexico Health Care Authority's approach to improving the health of the New Mexico Medicaid population includes providing overall direction to the MCOs and establishing statewide programs. For 2024, the New Mexico Health Care Authority directed the MCOs to conduct performance improvement projects related to enhanced care for prenatal and postpartum mothers with substance use disorder, preventive care for children and adolescents, expanding access to assisted living for Medicaid members, expanding and enhancing the

[1] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

state's obstetrics and gynecology provider network (targeting obstetrics deserts in rural and frontier areas), and improving access to Hepatitis C Virus (HCV) treatment. The New Mexico Health Care Authority also continues to offer member reward programs to increase engagement, increase member completion of health-related activities, and encourage positive changes in member behavior. In 2024, approximately 124,383 members redeemed a reward for services related to adult and child primary and preventive care, behavioral health prescription maintenance, prenatal and postpartum care, smoking cessation, and other areas of care.[2]

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[2] Turquoise Care Demonstration 1115 Demonstration Quarterly & Annual Report Demonstration Year: 12 (7/1/2024–12/31/2024) Quarter 2 of the Demonstration Year & Annual Report, April 30, 2025, website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jul-dec-2024.pdf

New Mexico Medicaid Managed Care Performance Measure Programs

New Mexico selects quality metrics and performance targets by assessing gaps in care within the state's Medicaid population. The New Mexico Health Care Authority monitors and uses data to evaluate the strengths of MCOs and identify opportunities for improvement by specifying performance measures. The selected performance measures and targets are reasonable, based on industry standards, and consistent with the Centers for Medicare & Medicaid Services' external quality review protocols.

The New Mexico Health Care Authority conducts quarterly monitoring of these performance measures to observe trends and identify potential risks to meeting performance targets. This information is shared with MCOs during quarterly quality meetings. The MCOs are required to follow NCQA HEDIS specifications for reporting, and an external quality review organization validates their reported performance rates annually.

The Centennial Care 2.0 Performance Measure Program required participating MCOs to submit 10 quality metrics (**Table 1**) through both quarterly and annual HEDIS submissions. Quarterly reporting of performance measure data was mandated by the New Mexico Health Care Authority ensuring ongoing monitoring and evaluation throughout the year. The annual reporting requirement was satisfied by the MCO NCQA HEDIS submission, which provided a comprehensive evaluation of health outcomes for Medicaid enrollees. As Centennial Care 2.0 concluded, annual reporting transitioned to a focus on quarterly submissions only, reflecting the program's wind-down and the continued emphasis on timely performance monitoring.

Each Centennial Care 2.0 Performance Measure Program target was based on aggregated, audited HEDIS data from measurement year 2018, with an average increase calculated for each year until reaching the *NCQA 2018 Quality Compass*® (measurement year 2017) regional averages plus one percentage point. Failure to meet the New Mexico Health Care Authority-assigned target for an individual performance measure resulted in a monetary penalty based on 2% of the total capitation paid to the MCO for the agreement year, divided by the number of performance measures specified for that year.

The Turquoise Care Performance Measure Program requires participating MCOs to submit 13 quality metrics (**Table 2**) through quarterly and annual submissions. Quarterly reporting of performance measure data is mandated by the New Mexico Health Care Authority via Report #74 and annual reporting is satisfied by the MCO NCQA HEDIS submission. However, due to the mid-year start of the Turquoise Care program in 2024, the legacy MCOs (BCBS and PHP) were required to report measurement year 2024 data both quarterly and annually, while the new MCOs (MHC and UHC) were required to report quarterly only for measurement year 2024. All MCOs are required to submit both quarterly and annual HEDIS data for subsequent measurement years (2025, 2026, and 2027). Each Turquoise Care Performance Measure Program target is based on the NCQA *2023 Quality Compass*® (measurement year 2022) national average, with an average increase calculated for each year until reaching the NCQA *2023 Quality Compass*® (measurement year 2022) national averages plus one percentage point. Failure to meet the state's designated target for individual performance measures during the calendar year will result in a monetary penalty based on 3% of the total capitation paid to the MCO for the contract year, divided by the number of performance measures specified in the contract.

BCBS, MHC, PHP, UHC, and WSCC reported on 2024 quality metrics quarterly as required to the New Mexico Health Care Authority. BCBS, MHC, and PHP submitted their annual HEDIS rates for measurement year 2024 to the New Mexico Health Care Authority and IPRO. Annual HEDIS rates calculated by BCBS and PHP for measurement year 2024 represent services delivered under both

Centennial Care 2.0 and Turquoise Care, while MHC's annual HEDIS rates represent services delivered under Turquoise Care. The Turquoise Care aggregated rates for measurement year 2024 were calculated using BCBS and PHP data only.

The Centennial Care 2.0 Performance Measure Program

Table 1 displays performance measure names and definitions, steward, and method of data collection.

Table 1: Centennial Care 2.0 Performance Measure Descriptions, Measurement Year 2024

Performance Measures (PM)	Indicator Description	Steward	Data Collection Method[1]
PM 1 Well-Child Visits in the First 30 Months of Life (W30)	**First 15 Months:** The percentage of members who turned 15 months old during the measurement year and had six or more well-child visits.	NCQA	Administrative
PM 2 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	**Counseling for Physical Activity:** The percentage of members 3–17 years of age who had an outpatient visit with a primary care provider or obstetrician/ gynecologist and who had evidence of counseling for physical activity during the measurement year.	NCQA	Hybrid
PM 3 Prenatal and Postpartum Care (PPC)	**Timeliness of Prenatal Care:** The percentage of deliveries of live births that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the MCO.	NCQA	Hybrid
PM 4 Prenatal and Postpartum Care (PPC)	**Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	NCQA	Hybrid
PM 5 Childhood Immunization Status (CIS)	**Combination 3:** The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.	NCQA	Hybrid
PM 6 Antidepressant Medication Management (AMM)	**Effective Continuation Phase Treatment:** The percentage of members 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days (6 months).	NCQA	Administrative

Performance Measures (PM)	Indicator Description	Steward	Data Collection Method[1]
PM 7 Initiation and Engagement of Substance Use Disorder Treatment (IET)	**Initiation of Substance Use Disorder Treatment (IET):** The percentage of new substance use disorder episodes that result in treatment initiation through an inpatient substance use disorder admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	NCQA	Administrative
PM 8 Follow-Up After Hospitalization for Mental Illness (FUH)	**30 Days:** The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner provider within 30 days after discharge.	NCQA	Administrative
PM 9 Follow-Up After Emergency Department Visit for Mental Illness (FUM)	**30 Days:** The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the emergency department visit (31 total days).	NCQA	Administrative
PM 10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	Administrative

[1] Administrative rates are calculated from claims data. Hybrid rates are calculated from claims data and medical record documentation.
NCQA: National Committee for Quality Assurance.

The Turquoise Care Performance Measure Program

Table 2 displays performance measure names and definitions, steward, and method of data collection.

Table 2: Turquoise Care Performance Measure Descriptions, Measurement Year 2024

Performance Measure (PM)	Indicator Description	Steward	Data Collection Method[1]
PM 1 Well-Child Visits in the First 30 Months of Life (W30)	**First 15 Months:** The percentage of members who turned 15 months old during the measurement year and had six or more well-child visits with a primary care provider	NCQA	Administrative
	15 Months–30 Months: The percentage of members who turned 30 months old during the measurement year and had two or more well-child visits with a primary care provider	NCQA	Administrative
PM 2 Child and Adolescent Well-Care Visits (WCV)	**3–11 Years:** The percentage of members 3–11 years of age who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist practitioner during the measurement year.	NCQA	Administrative
	12–17 Years: The percentage of members 12–17 years of age who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist practitioner during the measurement year.	NCQA	Administrative
	18–21 Years: The percentage of members 18–21 years of age who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist practitioner during the measurement year.	NCQA	Administrative
PM 3 Prenatal and Postpartum Care (PPC)	**Timeliness of Prenatal Care:** The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.	NCQA	Hybrid
	Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	NCQA	Hybrid
PM 4 Oral Evaluation, Dental Services (OED)	The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.	NCQA	Administrative

Performance Measure (PM)	Indicator Description	Steward	Data Collection Method[1]
PM 5 Follow-Up After Hospitalization for Mental Illness (FUH)	**7 Days**: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider with 7 days.	NCQA	Administrative
PM 6 Breast Cancer Screening (BCS-E)	The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.	NCQA	Electronic Clinical Data Systems
PM 7 Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	**Initiation Phase:** The percentage of children newly prescribed attention-deficit/hyperactivity disorder medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	NCQA	Electronic Clinical Data Systems
PM 8 Immunizations for Adolescents (IMA)	**Combination 2:** The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	NCQA	Hybrid
PM 9 Pharmacotherapy for Opioid Use Disorder (POD)	The percentage of opioid use disorder pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of opioid use disorder and a new opioid use disorder pharmacotherapy event.	NCQA	Administrative
PM 10 Glycemic Status Assessment for Patients With Diabetes (GSD)	**Glycemic Status >9.0%:**The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c or glucose management indicator) was >9% during the measurement year. *(A lower rate indicates better performance.)*	NCQA	Hybrid
PM 11 Eye Exam for Patients With Diabetes (EED)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.	NCQA	Hybrid

Performance Measure (PM)	Indicator Description	Steward	Data Collection Method[1]
PM 12 Kidney Health Evaluation for Patients With Diabetes (KED)	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) *and* a urine albumin-creatinine ratio (uACR), during the measurement year.	NCQA	Administrative
PM 13 Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	NCQA	Hybrid

[1] Administrative rates are calculated from claims data. Hybrid rates are calculated from claims data and medical record documentation. Electronic Clinical Data Systems rates are calculated using data from electronic health records, health information exchanges, case management systems, and claims processing systems.
NCQA: National Committee for Quality Assurance.

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Validation of Performance Measures – Technical Summary

Objectives

The New Mexico Health Care Authority selects a set of performance measures to evaluate the quality of care delivered by the MCOs to Medicaid members. Performance measures required under the Performance Measure Program for Centennial Care 2.0 are presented in **Table 1** while the required measures for Turquoise Care are presented in **Table 2.**

To ensure compliance with the reporting requirements for HEDIS 2024 and the 2024 New Mexico Health Care Authority Performance Measure Program, BCBS, MHC, and PHP contracted with an NCQA-certified HEDIS vendor and an NCQA-certified HEDIS compliance auditor. Their HEDIS vendors collected data and calculated performance measure rates on behalf of the MCOs, while the HEDIS compliance auditor determined if the appropriate information processing capabilities were in place to support accurate and automated performance measurement. UHC contracted with an NCQA-certified HEDIS vendor but opted not to report measurement year 2024 HEDIS data. **Table 3** displays the NCQA-certified HEDIS vendors and compliance auditors for each MCO.

Table 3: MCO HEDIS Vendors and HEDIS Compliance Auditors, Measurement Year 2024

MCO	NCQA-Certified HEDIS Vendor	NCQA-Certified HEDIS Compliance Auditor
BCBS	Inovalon, Inc.	Attest Health Care Advisors
MHC	Cognizant TriZetto Software Group, Inc.	Advent Advisory Group, LLC
PHP	Inovalon, Inc.	Healthy People
UHC	Inovalon, Inc.	Not Applicable
WSCC	Not Applicable	Not Applicable

MCO: managed care organization; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; BCBS: Blue Cross and Blue Shield of New Mexico; MHC: Molina Healthcare of New Mexico; PHP: Presbyterian Health Plan, Inc.; UHC: UnitedHealthcare Community Plan of New Mexico; WSCC: Western Sky Community Care, Inc.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the New Mexico Health Care Authority for measurement year 2024.

Further, the *CMS External Quality Review (EQR) Protocols* published in February 2023 state that information systems capabilities assessment "is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." The information systems capabilities assessment data collection tool allows the state or external quality review organization to evaluate the strength of each MCO's information system capabilities to meet the regulatory requirements for quality assessment and reporting. Knowledge of the capabilities of an MCO's information system is essential to perform the following task elements effectively and efficiently:

- assessment of an MCO's information systems;
- validation of an MCO's encounter data;
- calculation or validation of an MCO's performance measures;

- assessment of an MCO's capacity to manage the health care of its enrollees; and
- review of an MCO's encounter data submission and reconciliation processes.

While the *CMS External Quality Review (EQR) Protocols* published in February 2023 stated that an information systems capabilities assessment is a required component of the mandatory external quality review activities, the Centers for Medicare & Medicaid Services later clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an information systems capabilities assessment. Although BCBS, MHC, and PHP underwent an information systems audit by an NCQA-certified HEDIS auditor for measurement year 2024, the New Mexico Health Care Authority contracted IPRO to conduct a full information systems capabilities assessment for each MCO during the 2024-2025 period. The results of the HEDIS measurement year 2024 compliance audits and 2024-2025 information systems capabilities assessments are presented in this report.

Technical Methods of Data Collection and Analysis

Information Systems Capabilities Assessment

IPRO conducted the 2024-2025 information systems capabilities assessment in accordance with *Appendix A* of the *CMS External Quality Review (EQR) Protocols* published in February 2023. *External Quality Review Protocol 2* specifies the activities to be undertaken by an external quality review organization for purposes of validating MCO-reported performance measure rates. The activities defined in *External Quality Review Protocol 2* include:

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, including 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.

The MCOs provided IPRO with completed information systems capabilities assessments on December 10, 2024 and supplemental documentation on January 31, 2025.

For each MCO, IPRO hosted a two-hour virtual meeting to discuss the MCO's information systems capabilities assessment submission and to conduct reviews of the MCO's systems. BCBS's virtual meeting was held on April 1, 2025; UHC's virtual meeting was held on April 3, 2025; PHP's virtual meeting was held on April 8, 2025; and MHC's virtual meeting was held on April 9, 2025.

The Centers for Medicare & Medicaid Services prescribes that at the conclusion of the information systems capabilities assessment review, the external quality review organization is to compile and analyze the information gathered through the preliminary information systems capabilities assessment review and from the MCO staff interviews. After completing its analysis, the external quality review organization writes a statement of findings about the MCO's information systems. The assessment levels used by IPRO are displayed in **Table 4** while the assessment results for each MCO are displayed in **Table 8**.

Table 4: IPRO's Information Systems Capabilities Assessment Determination Levels

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.

Performance Measure Calculation and Compliance Audit

BCBS, MHC, and PHP each contracted with an NCQA-certified HEDIS vendor to collect data and calculate performance measure rates for measurement year 2024. The NCQA-certified HEDIS vendor calculated rates using NCQA's *HEDIS 2024 Volume 2 Technical Specifications for Health Plans*.

BCBS, MHC, and PHP each contracted with an NCQA-certified HEDIS auditor to validate the MCO's adherence to the technical specifications and reporting requirements. The NCQA-certified HEDIS compliance auditor evaluated the MCO's information practices and control procedures, sampling methods and procedures, compliance with technical specifications, analytic file production, and reporting and documentation in two parts:

1. Information System Capabilities
2. HEDIS Specifications Standards

Auditors considered MCO compliance with the Information System standards and HEDIS Determination standards to fully assess the organization's HEDIS reporting capabilities.

Information System Capabilities

As part of the NCQA HEDIS Compliance Audit™, HEDIS compliance auditors assessed the MCO's compliance with NCQA's four information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the MCO has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. **Table 5** displays these standards as well as the elements audited for the standard.

Table 5: NCQA's Information System Capabilities Standards

Information System Standard Categories	Elements Audited
IS R: Data Management and Reporting	Transfer, Consolidation, and Control Procedures that Support Measure Reporting Integrity
IS C: Clinical and Care Delivery Data	Capture, Transfer, and Entry
IS M: Medical Record Review	Training, Sampling, Abstraction, and Oversight
IS A: Administrative Data	Sound Coding Methods, Data Capture, Transfer, and Entry

NCQA: National Committee for Quality Assurance; IS: information system.

The information system capabilities evaluation included the computer and software environment, data collection procedures, abstraction of medical records for hybrid measures, as well as the review of any manual processes used for HEDIS reporting. The HEDIS compliance auditor determined the extent to which the MCO had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

An MCO meeting all Information System standards required for successful HEDIS reporting and submitting HEDIS data to the Health Care Authority according to contractual requirements were considered strengths during IPRO's external quality review. An MCO not meeting an Information System standard was considered an opportunity for improvement during IPRO's review.

HEDIS Determination Standards

Auditors use the HEDIS Determination standards to assess the MCO's compliance with conventional reporting practices and HEDIS technical specifications. These standards describe required procedures for specific information such as proper identification of denominators, numerators and verifying algorithms and rate calculations.

Performance Measure Validation

Each MCO's calculated rates for the HEDIS measure set were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. **Table 6** presents these outcome designations and their definitions. Performance measure validation activities included but were not limited to:

- confirmation that rates were produced with certified code or automated source code review approved logic;
- medical record review validation;
- review of supplemental data sources;
- review of system conversions/upgrades, if applicable;
- review of vendor data, if applicable; and
- follow-up on issues identified during documentation review or previous audits.

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Table 6: NCQA's Performance Measure Designations

NCQA Performance Measure Outcome Designation	Outcome Designation Definition
R	**Reportable**. A reportable rate was submitted for the measure.
NA	**Small Denominator.** The organization followed the specifications, but the denominator was too small (e.g., less than 30) to report a valid rate. a. For Effectiveness of Care and Effectiveness of Care-like measures, when the denominator is less than 30. b. For utilization measures that count member months, when the denominator is less than 360 member months. c. For all risk-adjusted utilization measures, when the denominator is less than 150. d. For electronic clinical data systems measures, when the denominator is less than 30.
NB	**No Benefit.** The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	**Not Reported.** The organization chose not to report the measure.
NQ	**Not Required.** The organization was not required to report the measure.
BR	**Biased Rate.** The calculated rate was materially biased.
UN	**Unaudited.** The organization chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

NCQA: National Committee for Quality Assurance.

Each MCO's HEDIS compliance auditor produced a final audit report and audit review table at the conclusion of the audit. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. The MCOs submitted these documents, as well as final validated performance measure rates to the Health Care Authority and IPRO.

IPRO reviewed each MCO's final audit report and audit review table to confirm that all performance measures were deemed reportable by the HEDIS auditor, and that calculation of these performance measures aligned with Health Care Authority expectations. To assess the accuracy of the reported rates, IPRO:

- Recalculated performance measure rates using denominator and numerator member-level data and compared these recalculated rates to the rates reported by the MCO to NCQA via the Interactive Data Submission System tool;
- Compared performance measure rates reported by the MCO to NCQA's Quality Compass regional Medicaid benchmarks; and
- Analyzed performance-measure-rate–level trends to identify drastic changes in performance.

As part of the measurement year 2024 performance measure validation activity, IPRO reviewed MCO quality improvement program descriptions and work plans to assess the impact of MCO-directed improvement activities on health outcomes related to the performance measures in **Table 1** and **Table 2**.

Description of Data Obtained

To conduct the validation of performance measure activity, IPRO reviewed *the 2024–2025 Turquoise Care Information Systems Capabilities Assessment Report,* each MCO's final audit report and a locked copy of the audit review table, which were produced by the HEDIS compliance auditor.

The *2024–2025 Turquoise Care Information Systems Capabilities Assessment Report* included the results of IPRO's assessments and MCO-detailed information regarding data integration and systems architecture; enrollment systems and process; claims/encounter data systems; provider data systems and processes; and oversight of contracted vendors.

The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization registries, care management files, laboratory result files), descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited; **Table 6**).

The Audit Review Table displayed performance-measure–level detail including data collection methodology (administrative or hybrid), eligible population count, exclusion count, numerator event count by data source (administrative, medical record, supplemental), and reported rate. When applicable, the following information was also displayed in the Audit Review Table: administrative rate before exclusions; minimum required sample size, and minimum required sample size numerator events and rate; oversample rate and oversample record count; exclusions by data source; count of oversample records added; denominator; numerator events by data source (administrative, medical records, supplemental); and reported rate.

Comparative Results

BCBS, MHC, and PHP's NCQA-certified HEDIS auditor determined that the HEDIS rates reported by the MCO for measurement year 2024 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. There were no data collection or reporting issues identified for BCBS, MHC, and PHP. **Table 7** displays the results of Information System Capabilities review for the MCOs that underwent a HEDIS 2024 Compliance Audit.

Table 7: MCO NCQA Information System Capabilities Review Results, Measurement Year 2024

Information System Standard Categories	BCBS	MHC	PHP	UHC	WSCC
IS R: Data Management and Reporting	Met	Met	Met	Not Applicable	Not Applicable
IS C: Clinical and Care Delivery Data	Met	Met	Met	Not Applicable	Not Applicable
IS M: Medical Record Review	Met	Met	Met	Not Applicable	Not Applicable
IS A: Administrative Data	Met	Met	Met	Not Applicable	Not Applicable

MCO: managed care organization; NCQA: National Committee for Quality Assurance; BCBS: Blue Cross and Blue Shield of New Mexico; MHC: Molina Healthcare of New Mexico; PHP: Presbyterian Health Plan, Inc.; UHC: UnitedHealthcare Community Plan of New Mexico; WSCC: Western Sky Community Care, Inc.

At the conclusion of the 2024-2025 information systems capabilities assessment, IPRO determined that the MCOs met or exceeded the standards reviewed. **Table 8** displays the assessment topics reviewed and the assessment levels achieved for each topic by each MCO. (WSCC was no longer participating in the New Mexico Medicaid managed care program at the time of the 2024–2025 information systems capabilities assessment.)

Table 8: MCO IPRO Information Systems Capabilities Assessment Results, 2024–2025

Information Systems Capabilities Assessment Topic	BCBS	MHC	PHP	UHC	WSCC
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	Met	Met	Met	Not Reviewed
Adjudication and review of claims data received from multiple sources	Met	Met	Met	Met	Not Reviewed
Validation and/or calculation of performance measures	Met	Met	Met	Met	Not Reviewed
Utility of the MCO's IS for linking to other information sources for quality related reporting	Met	Met	Met	Met	Not Reviewed
Identification and reporting of NCQA's and CMS's race and ethnicity categories	Met	Met	Met	Met	Not Reviewed
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	Met	Met	Met	Not Reviewed
Completeness and accuracy of tracking of member and provider grievances and appeals	Met	Met	Met	Met	Not Reviewed
Validation and/or calculation of network adequacy reports	Met	Met	Met	Met	Not Reviewed
Ability of the information system to generate complete, accurate and timely T-MSIS data	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Reviewed
Completeness and accuracy of encounter data collected and submitted to the state	Met	Met	Met	Met	Not Reviewed

Note: Met means that the MCO met or exceeded standards.
MCO: managed care organization; BCBS: Blue Cross and Blue Shield of New Mexico; MHC: Molina Healthcare of New Mexico; PHP: Presbyterian Health Plan, Inc.; UHC: UnitedHealthcare Community Plan of New Mexico; WSCC: Western Sky Community Care, Inc.

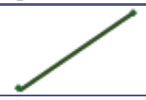
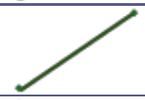
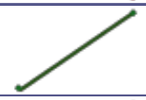
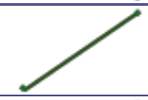
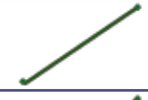
Table 9 displays Centennial Care 2.0 performance measures and rates reported to the New Mexico Health Care Authority by BCBS, PHP, and WSCC for the first quarter (January 1–March 31, 2024) and the second quarter (April 1–June 30, 2024). The quarterly rates presented in this table were used by the Health Care Authority for internal tracking and monitoring of MCO performance.

Table 10 presents Centennial Care 2.0 performance measures, annual HEDIS rates reported to NCQA by BCBS and PHP, and aggregate rates calculated by IPRO. The annual rates presented in this table reflect performance for measurement year 2024 (January 1–December 31, 2024). WSCC exited the New Mexico Medicaid managed care program on June 30, 2024, and was not required to submit annual HEDIS rates for measurement year 2024 to HCA.

Table 11 presents Turquoise Care performance measures and rates reported to the New Mexico Health Care Authority by BCBS, MHC, PHP, and UHC for the third quarter (July 1–September 30, 2024) and the fourth quarter (October 1–December 31, 2024). The quarterly rates presented in this table were used by the New Mexico Health Care Authority for internal tracking and monitoring of MCO performance.

Table 12 presents Turquoise Care performance measures, HEDIS rates reported to NCQA by BCBS, MHC, and PHP, and aggregate rates calculated by IPRO. The BCBS and PHP rates presented in this table reflect performance for measurement year 2024 (January 1–December 31, 2024), while the rates presented for MHC reflect performance for July 1–December 31, 2024. MHC and UHC joined the New Mexico Medicaid managed care program on July 1, 2024, and were not required to submit annual HEDIS rates for measurement year 2024 to HCA or NCQA. MHC voluntarily submitted HEDIS rates for measurement year 2024 to the New Mexico Health Care Authority and NCQA; however, MHC data are not included in the aggregate rates.

Table 9: Centennial Care 2.0 – Performance Measure Rates for Q1-2024 and Q2-2024

Performance Measure (PM)	BCBS Q1 2024 Rate	BCBS Q2 2024 Rate	BCBS Performance Between Q1 and Q2	PHP Q1 2024 Rate	PHP Q2 2024 Rate	PHP Performance Between Q1 and Q2	WSCC Q1 2024 Rate	WSCC Q2 2024 Rate	WSCC Performance Between Q1 and Q2
PM 1 W30 First 15 Months	36.90%	51.27%		34.73%	42.87%		33.54%	59.48%	
PM 2 WCC Physical Activity	15.65%	21.45%		15.46%	20.27%		13.78%	40.00%	
PM 3 PPC Prenatal Care	59.83%	59.49%		65.12%	64.98%		52.98%	52.90%	
PM 4 PPC Postpartum Care	44.46%	49.90%		54.39%	60.94%		44.93%	53.70%	
PM 5 CIS Combination 3	33.96%	37.62%		36.94%	38.43%		18.69%	36.44%	
PM 6 AMM Continuation	33.43%	37.02%		45.98%	50.17%		34.83%	46.60%	
PM 7 IET Initiation	45.47%	47.26%		54.75%	46.83%		47.34%	49.79%	
PM 8 FUH 30 Days	43.47%	51.06%		48.24%	53.00%		46.37%	49.31%	
PM 9 FUM 30 Days	49.16%	52.52%		39.55%	44.65%		41.18%	42.42%	
PM 10 SSD	43.66%	63.26%		47.61%	65.16%		43.15%	66.67%	

Green sparklines indicate that performance improved between Q1 and Q2. **Red** sparklines indicate that performance declined between Q1 and Q2.

Table 10: Centennial Care 2.0 – MCO Performance Measure Rates for Measurement Year 2024 (January 1-December 31, 2024)

Performance Measure (PM)	BCBS Measurement Year 2024 Rate	PHP Measurement Year 2024 Rate	WSCC Measurement Year 2024 Rate	Centennial Care 2.0 Measurement Year 2024 Aggregate Rate
PM 1 W30 First 15 Months	60.26%	66.50%	Not Required	63.92%
PM 2 WCC Physical Activity	59.12%[1]	26.18%[1]	Not Required	38.64%[1]
PM 3 PPC Prenatal Care	81.02%	72.27%	Not Required	77.19%
PM 4 PPC Postpartum Care	72.99%	71.34%	Not Required	72.27%
PM 5 CIS Combination 3	63.99%[1]	66.31%[1]	Not Required	65.34%[1]
PM 6 AMM Continuation	42.09%	58.83%	Not Required	52.15%
PM 7 IET Initiation	50.01%	50.77%	Not Required	50.48%
PM 8 FUH 30 Days	51.75%	56.47%	Not Required	54.55%
PM 9 FUM 30 Days	59.44%	48.53%	Not Required	52.75%
PM 10 SSD	82.30%	82.74%	Not Required	82.56%

Note: The reporting of annual HEDIS rates for measurement year 2024 was required for legacy MCOs, BCBS and PHP. Quarterly reporting for the January 1-June 30, 2024 period was required of all MCOs (see **Table 9**). [1] The BCBS rate was calculated using the hybrid methodology; the PHP rate was calculated using the administrative methodology; and the **Centennial Care 2.0 aggregate rate represents a weighted average.**

MCO: managed care organization; BCBS: Blue Cross and Blue Shield of New Mexico; PHP: Presbyterian Health Plan, Inc.; WSCC: Western Sky Community Care, Inc.

Table 11: Turquoise Care – MCO Performance Measure Rates for Q3-2024 and Q4-2024

Performance Measure (PM)	BCBS Q3 2024 Rate	BCBS Q4 2024 Rate	BCBS Performance Between Q3 and Q4	MHC Q3 2024 Rate	MHC Q4 2024 Rate	MHC Performance Between Q3 and Q4	PHP Q3 2024 Rate	PHP Q4 2024 Rate	PHP Performance Between Q3 and Q4	UHC Q3 2024 Rate	UHC Q4 2024 Rate	UHC Performance Between Q3 and Q4
PM 1 W30 First 15 Months	59.22%	59.69%		Denominator = 0	Denominator = 0	No Data	59.99%	65.55%		22.56%	25.95%	
PM 1 W30 15–30 Months	68.15%	67.70%		Denominator = 0	Denominator = 0	No Data	67.15%	70.24%		25.55%	26.37%	
PM 2 WCV 3–11 Years	42.17%	53.29%		Denominator = 0	Denominator = 0	No Data	38.43%	53.06%		11.40%	22.48%	
PM 2 WCV 12–17 Years	37.76%	46.75%		Denominator = 0	Denominator = 0	No Data	35.54%	47.80%		10.12%	20.44%	
PM 2 WCV 18–21 Years	16.58%	22.95%		Denominator = 0	Denominator = 0	No Data	15.01%	20.61%		4.42%	7.73%	
PM 3 PPC Prenatal Care	59.07%	60.22%		69.05%	41.94%		64.88%	65.02%		50.00%	71.43%	
PM 3 PPC Postpartum Care	51.57%	57.90%		11.90%	62.90%		63.46%	67.95%		0.00%	31.43%	
PM 4 OED	35.48%	40.90%		0.00%	0.00%		46.67%	53.71%		16.88%	24.05%	
PM 5 FUH 7 Days	32.14%	30.11%		25.35%	25.17%		26.95%	34.63%		15.09%	16.87%	
PM 6 BCS-E	43.52%	47.04%		66.67%	66.67%		38.98%	41.78%		17.43%	19.35%	
PM 7 ADD-E Initiation Phase	48.64%	49.45%		Denominator = 0	Denominator = 0	No Data	38.47%	38.56%		Denominator = 0	Denominator = 0	No Data
PM 8 IMA Combination 2	32.85%	33.36%		Denominator = 0	Denominator = 0	No Data	35.03%	35.80%		2.90%	2.97%	
PM 9 POD	13.47%	16.90%		Denominator = 0	Denominator = 0	No Data	21.05%	26.38%		Denominator = 0	Denominator = 0	No Data
PM 10 GSD [1] >9.0%	69.27%	66.15%		0.00%	20.00%		65.07%	53.59%		4.07%	9.20%	
PM 11 EED	33.80%	38.53%		100.00%	20.00%		43.05%	49.69%		14.99%	23.12%	
PM 12 KED	27.16%	32.65%		0.00%	40.00%		28.82%	35.63%		21.52%	28.45%	
PM 13 LSC	45.05%	45.29%		Denominator = 0	Denominator = 0	No Data	39.28%	39.57%		24.64%	24.80%	

Green sparklines indicate that performance improved between Q3 and Q4. **Red** sparklines indicate that performance declined between Q3 and Q4. **Blue** sparklines indicate no change in performance. [1] A lower rate indicates better performance.

Table 12: Turquoise Care – Performance Measure Rates for Measurement Year 2024 (January 1-December 31, 2024)

Performance Measure (PM)	BCBS Measurement Year 2024 Rate	MHC Measurement Year 2024 Rate	PHP Measurement Year 2024 Rate	UHC Measurement Year 2024 Rate	Turquoise Care Measurement Year 2024 Aggregate Rate
PM 1 W30 First 15 Months	60.26%	Denominator=0	66.50%	Not Required	63.92%
PM 1 W30 15–30 Months	67.83%	Denominator=0	70.82%	Not Required	69.58%
PM 2 WCV 3–11 Years	54.58%	Denominator=0	54.55%	Not Required	54.57%
PM 2 WCV 12–17 Years	47.99%	Small Sample[1]	49.50%	Not Required	48.97%
PM 2 WCV 18–21 Years	23.31%	Small Sample[1]	21.61%	Not Required	22.17%
PM 3 PPC Prenatal Care	81.02%	91.9%	72.27%	Not Required	77.19%
PM 3 PPC Postpartum Care	72.99%	62.9%	71.34%	Not Required	72.27%
PM 4 OED	49.46%	33.1%	55.03%	Not Required	52.86%
PM 5 FUH 7 Days	30.78%	29.1%	36.34%	Not Required	34.08%
PM 6 BCS-E	47.31%	Small Sample[1]	42.15%	Not Required	43.99%
PM 7 ADD-E Initiation Phase	49.56%	Denominator=0	43.81%	Not Required	46.27%
PM 8 IMA Combination 2	37.23%	Denominator=0	36.74%	Not Required	36.98%
PM 9 POD	17.26%	Denominator=0	23.51%	Not Required	20.89%
PM 10 GSD[3] >9.0%	47.45%	Small Sample[1]	41.12%	Not Required	44.28%
PM 11 EED	43.80%	Small Sample[1]	52.31%	Not Required	48.05%
PM 12 KED	33.65%	Small Sample[1]	35.93%	Not Required	35.07%
PM 13 LSC	45.31%[2]	Denominator=0	42.09%[2]	Not Required	43.44%[2]

Note: The reporting of annual HEDIS rates for measurement year 2024 was required for legacy MCOs, BCBS and PHP. Quarterly reporting for the July 1-December 31,2024 period was required of all MCOs (see **Table 11**).
[1] Small Sample means that the denominator is less than 30, and therefore not suitable for public reporting. [2] The BCBS rate was calculated using the administrative methodology; the PHP rate was calculated using the hybrid methodology; and the **Turquoise Care aggregate rate represents a weighted average.** [3] A lower rate indicates better performance. MCO: managed care organization; BCBS: Blue Cross and Blue Shield of New Mexico; MHC: Molina Healthcare of New Mexico; PHP: Presbyterian Health Plan, Inc.; UHC: United Healthcare Community Plan of New Mexico.

Blue Cross and Blue Shield of New Mexico

Performance Measure Validation Results

The 2024–2025 information systems capabilities assessment determined that BCBS's information systems met all requirements to support the:

- completeness and accuracy of encounter data collected and submitted to the state;
- validation and/or calculation of performance measures;
- completeness and accuracy of tracking of grievances and appeals;
- utility of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to oversee and manage the delivery of health care to the enrollees;
- utility of the information systems for review of provider network adequacy; and
- utility of the MCO's information systems for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, state vital statistics, public health data).

BCBS's HEDIS 2024 measurement year Final Audit Report[3] indicated the following:

- BCBS was compliant with all information systems standards required for HEDIS reporting. No deficiencies were noted. The MCO "reported their rates successfully with outliers and deviations from prior year explained during the benchmarking investigations and audit reviews."
- BCBS utilized supplemental data sources for a variety of measures including *Immunizations for Adolescents*, *Lead Screening in Children*, *Glycemic Status Assessment for Diabetes*, *Kidney Health Evaluation for Patients With Diabetes*, *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Mental Illness*, *Well-Child Visits in the First 30 Months of Life*, *Child and Adolescent Well-Care Visits*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Childhood Immunization Status,* and *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*. Supplemental data sources were approved by BCBS's certified HEDIS auditor.
- BCBS met review standards for medical record reviews. Medical record reviews included *Blood Pressure Control for Patients With Diabetes*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Physical Activity*, *Glycemic Status Assessment for Diabetes <8%*, and *Eye Exam Evaluation for Patients With Diabetes*.
- BCBS "continues to successfully report ECDS measures."

Performance Measure Trends

BCBS's Centennial Care 2.0 performance for measurement years 2020, 2021, 2022, 2023, and 2024 are presented in **Table 13**. Green shading indicates that the displayed rate met or exceeded the measurement year target. There were no target rates established for 2024. (Target rates for 2020, 2021, 2022, and 2023 are not displayed.)

BCBS's Turquoise Care performance for measure year 2024 is presented in **Table 12**.

[3] Attest Health Care Advisors, an NCQA-certified HEDIS auditor, conducted the HEDIS Measurement Year 2024 Compliance Audit and produced the HEDIS Measurement Year 2024 Final Audit Report for BCBS.

Table 13: BCBS's Centennial Care 2.0 Performance Measure Rates for Measurement Years 2020, 2021, 2022, 2023, and 2024

Performance Measure (PM)	BCBS Measurement Year 2020 Rate	BCBS Measurement Year 2021 Rate	BCBS Measurement Year 2022 Rate	BCBS Measurement Year 2023 Rate	BCBS Measurement Year 2024 Rate
PM 1 W30 First 15 Months	56.89%	58.54%	61.70%	64.34%	60.26%
PM 2 WCC Physical Activity	50.36%	55.72%	59.61%	64.96%	59.12%
PM 3 PPC Prenatal Care	79.32%	82.00%	82.97%	85.16%	81.02%
PM 4 PPC Postpartum Care	67.40%	69.10%	70.80%	72.26%	72.99%
PM 5 CIS Combination 3	70.56%	69.59%	70.80%	64.72%	63.99%
PM 6 AMM Continuation	39.81%	40.63%	40.83%	42.52%	42.09%
PM 7 IET Initiation	43.77%	42.91%	45.97%	45.93%	50.01%
PM 8 FUH 30 Days	51.94%	56.60%	54.61%	55.07%	51.75%
PM 9 FUM 30 Days	59.36%	56.57%	56.06%	58.28%	59.44%
PM 10 SSD	76.46%	77.59%	78.21%	80.55%	82.30%
Available Points	**10**	**10**	**10**	**10**	**No Points Available**
Points Earned	**8**	**7**	**7**	**6**	**Not Applicable**

Note: Green shading indicates that the displayed rate met or exceeded the target rate established by HCA for that measurement year. There were no targets established for measurement year 2024.
BCBS: Blue Cross and Blue Shield of New Mexico.

Quality Improvement Activities

Table 14 summarizes improvement activities reported by BCBS in the *Quality Program Strategy, January – June 2024* and *Quality Program Strategy, July – December 2024*.

Table 14: BCBS's Quality Improvement Activities, 2024

Area of Care	2024 Quality Improvement Activities
Primary and Preventive Care for Adults and Children	**Member-Focused Initiatives** ▪ Outreach, education, and reminders for well-child visits and immunizations. ▪ Education and reminders for the influenza vaccine, as well as screenings for colorectal, breast, and cervical cancer. ▪ Newsletters, website articles, and targeted educational materials on preventive care and healthy behaviors. ▪ Promotion of rewards programs for healthy behaviors. ▪ Education and outreach to increase compliance with Early and Periodic Screening, Diagnostic, and Treatment guidelines. ▪ Annual CAHPS survey to assess satisfaction and inform improvements. ▪ Resources and tools to help members navigate the healthcare system and understand benefits. ▪ Communication regarding the importance of age-appropriate immunizations and preventive visits. ▪ Information for Medicaid-eligible individuals under 21 about available preventive, dental, vision, and behavioral health services. ▪ Education for members and parents about the availability of providers offering extended hours. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to strengthen the delivery of primary and preventive care. ▫ Providers were incentivized to accurately document member encounters, including discussions related to a child's weight, counseling, and healthy eating habits. ▫ Providers were incentivized to offer extended hours to complete specific services. ▫ School-Based Health Care Centers received enhanced reimbursement payments for completed Early and Periodic Screening, Diagnostic, and Treatment assessments. ▪ Distribution of preventive care guidelines, updates, and toolkits. ▪ Regular feedback on HEDIS and other preventive care performance measures. ▪ Dissemination and implementation of clinical guidelines for preventive care. ▪ Provision of evidence-based guidelines for asthma, diabetes, attention-deficit/hyperactivity disorder, and major depressive disorder. ▪ Provider newsletters shared updates on quality improvement programs.

Area of Care	2024 Quality Improvement Activities
	▪ Ongoing monitoring and feedback to providers regarding documentation standards. **<u>Program-Focused Initiatives</u>** ▪ Annual evaluation and interventions based on HEDIS results for preventive care measures. ▪ Data-driven identification of gaps in preventive care and targeted interventions. ▪ Monitoring of well-child visits, immunizations, and preventive screenings. ▪ Development of culturally and linguistically appropriate materials and services. ▪ Tracking and improving measures such as immunizations, well-child visits, cancer screenings, and access to preventive/ambulatory services. ▪ Programs for keeping members healthy. ▪ Ensuring sufficient provider availability and access to care.

Prenatal and Postpartum Care	**<u>Member-Focused Initiatives</u>**
	
	▪ Promotion of programs like BabySmart and Special Beginnings℠.
	▪ Targeted mailings, newsletters, and website resources on prenatal and postpartum care.
	▪ Rewards for participation in maternity programs and completion of visits.
	▪ Support for high-risk pregnancies, neonatal intensive care unit transitions, and postpartum follow-up.
	▪ Education and outreach on the importance of early and timely prenatal/postpartum visits.
	▪ Extended support for prenatal and postpartum mothers with substance use disorder.
	▪ Screening and follow-up for depression during and after pregnancy.
	
	<u>Provider-Focused Initiatives</u>
	
	▪ Offered value-based arrangements to network providers.
	  ▫ Included the delivery of prenatal care in value-based purchasing provider contracts.
	  ▫ Providers participating in the Doula Incentive Program received a one-time financial incentive to hire a community doula to support pregnant members.
	▪ Educational flyers and performance feedback on prenatal and postpartum care measures.
	▪ Distribution of clinical guidelines for prenatal and postpartum care.
	▪ Regular feedback on the timeliness of prenatal and postpartum care.
	▪ Targeted efforts in obstetric deserts to improve access to care.
	▪ Focused training on prenatal and postpartum care best practices and substance use disorder management.

Area of Care	2024 Quality Improvement Activities
	Program-Focused Initiatives ▪ Annual evaluation and interventions for prenatal and postpartum care measures. ▪ Projects targeting timeliness of care and satisfaction with coordination. ▪ Monitoring of prenatal/postpartum care as state-mandated measures. ▪ Data-driven identification of high-risk pregnancies and targeted interventions. ▪ Tracking care, immunization status, and depression screening. ▪ Expanding access and enhancing services. ▪ High-risk obstetric case management and targeted outreach.
Behavioral Health	**Member-Focused Initiatives** ▪ Outreach and education to increase depression screening and follow-up. ▪ Access to integrated behavioral health programs and care coordination. ▪ Materials and outreach on behavioral health topics. ▫ Member-focused video on opioid use disorder launched through a social media campaign via you tube. ▪ Surveys and projects to assess and improve behavioral health member experience. ▪ Communication and education on attention-deficit/hyperactivity disorder and major depressive disorder. ▪ Ensuring timely follow-up care for members post-discharge. ▪ Rewarded members with timely medication refills. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to advance the integration of behavioral health care within primary care settings. ▫ The Enhanced Payment Initiative provided financial incentives to providers for offering timely follow-up appointments. ▫ Providers were incentivized to offer extended hours to complete specific services. ▫ The Facility Incentive Program offered partnering facilities a monetary incentive to ensure follow-up during discharge planning. ▪ Education on depression screening, behavioral health integration, and clinical guidelines. ▫ Live presentations and recordings of educational trainings on substance use and social determinants of health were offered to providers. ▪ Regular feedback on behavioral health HEDIS measures. Participation in behavioral health quality improvement committees and workgroups. ▪ Participation in steering committees and collaborative projects. ▪ Providers receive updated guidelines for behavioral health conditions.

Area of Care	2024 Quality Improvement Activities
	Program-Focused Initiatives ▪ Annual evaluation and interventions for behavioral health measures. ▪ Projects targeting depression screening, follow-up after hospitalization, and engagement in substance use treatment. ▪ Monitoring of behavioral health follow-up, depression screening, and medication management. ▪ System-level initiatives to integrate behavioral health into primary care and care coordination. ▪ Planning and implementing interventions based on HEDIS measures. ▪ Data collection, collaboration, and improvement actions for members with coexisting conditions. ▪ Annual assessment and improvement of access to behavioral health providers. ▪ Recovery Support Assistants continued to use the PointClickCare system to monitor emergency department utilization and, when possible, intervene with members in person to support follow-up appointments.
Chronic Conditions	**Member-Focused Initiatives** ▪ Outreach, education, and care coordination for chronic diseases. ▫ Members diagnosed with schizophrenia or bipolar disorder who were prescribed an antipsychotic medication were contacted by phone and offered HbA1c home test kits. ▫ A video encouraging members with schizophrenia and bipolar disorder to routinely check their blood glucose levels for their overall well-being was published on social media. ▪ Education and reminders to support medication adherence. ▪ Personalized coaching and resources to support self-management. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to reduce the total cost of care by strengthening the delivery of primary and preventive care. ▫ The Nursing Facility Value-Based Purchasing Payment Program was implemented to reduce avoidable hospitalizations and improve the quality of care in long-term care settings. ▪ Distribution of toolkits and guidelines for chronic disease management. ▪ Regular feedback on chronic disease–related HEDIS measures. ▪ Clinical guidelines for chronic disease management. ▪ Providers receive guidelines and are expected to implement them. ▪ Providers receive data on HEDIS and other quality measures. **Program-Focused Initiatives** ▪ Annual evaluation and interventions for chronic disease measures.

Area of Care	2024 Quality Improvement Activities
	▪ Projects targeting diabetes prevention/management, adult obesity, and depression screening. ▪ Monitoring of complications, blood pressure control, and medication adherence. ▪ Risk stratification and targeted interventions. ▪ Monitoring and improving outcomes. ▪ Case management for members with multiple chronic conditions. ▪ Programs for managing members with emerging risk.

Molina Healthcare of New Mexico

Performance Measure Validation Results

The 2024–2025 information systems capabilities assessment determined that MHC's information systems met all requirements to support the:

- completeness and accuracy of encounter data collected and submitted to the state;
- validation and/or calculation of performance measures;
- completeness and accuracy of tracking of grievances and appeals;
- utility of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to oversee and manage the delivery of health care to the enrollees;
- utility of the information systems for review of provider network adequacy; and
- utility of the MCO's information systems for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, state vital statistics, public health data).

MHC's HEDIS 2024 measurement year Final Audit Report[4] indicated the following:

- MHC was compliant with all information systems standards required for HEDIS reporting. No deficiencies were noted. The MCO "submitted measures were prepared according to measure specifications and present fairly, in all material respects, the organization's performance with respect to these specifications."
- MHC utilized supplemental data sources for the *Glycemic Status Assessment for Diabetes* measure. All supplemental data sources were approved by MHC's certified HEDIS auditor.
- MHC met review standards for medical record reviews. Medical record reviews included *Prenatal and Postpartum Care – Timeliness of Prenatal Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition, Glycemic Status Assessment for Diabetes,* and *Eye Exam Evaluation for Patients with Diabetes*.

Performance Measure Trends

MHC's Turquoise Care performance for measure year 2024 is presented in **Table 12**.

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[4] Advent Advisory Group, an NCQA-certified HEDIS auditor, conducted the HEDIS Measurement Year 2024 Compliance Audit and produced the HEDIS Measurement Year 2024 Final Audit Report for MHC.

Quality Improvement Activities

Table 15 summarizes improvement activities reported by MHC in the *Molina Healthcare Population Health Management Program Strategy*.

Table 15: MHC's Quality Improvement Activities, 2024

Area of Care	2024 Quality Improvement Activities
Primary and Preventive Care for Adults and Children	**Member-Focused Initiatives** ▪ Education and support for accessing preventive health services, including immunizations, screenings, and well-child visits. ▪ Health education and member incentives for preventive care. ▪ Risk stratification and targeted outreach for preventive services and health promotion. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to recognize and reward primary care providers who demonstrated success in closing gaps in care and optimizing care coordination and treatment planning for their members. ▪ Provision of evidence-based preventive health guidelines for adults and children. ▪ Monitoring provider adherence and providing feedback. ▪ Education materials and updates on preventive care best practices. **Program-Focused Initiatives** ▪ Tracking and reporting on preventive care measures and member experience through HEDIS and CAHPS. ▪ Monitoring provider network adequacy and access. ▪ Addressing cultural and linguistic barriers to preventive care.
Prenatal and Postpartum Care	**Member-Focused Initiatives** ▪ Support and education for timely prenatal and postpartum visits. ▪ Identification and enrollment of high-risk pregnancies in case management programs. **Provider-Focused Initiatives** ▪ Provision of guidelines and updates on best practices for prenatal and postpartum care. ▪ Ensuring adequate access to obstetrics/gynecological providers, especially in underserved areas. **Program-Focused Initiatives** ▪ Tracking prenatal and postpartum care rates, including timeliness and quality of visits. ▪ Implementation of projects to improve prenatal and postpartum care outcomes. ▪ Population health management focus on prenatal and postpartum care.

Area of Care	2024 Quality Improvement Activities
Behavioral Health	**Member-Focused Initiatives** ▪ Screening for behavioral health needs and connection to appropriate services. ▪ Behavioral health case management as needed. ▪ Analysis and improvement of behavioral health member experience. **Provider-Focused Initiatives** ▪ Guidelines for behavioral health screening, diagnosis, and treatment. ▪ Training and committee participation on behavioral health integration and best practices. **Program-Focused Initiatives** ▪ Tracking follow-up after hospitalization for mental illness, depression screening, and engagement in substance use disorder treatment. ▪ Facilitating coordination between medical and behavioral health providers. ▪ Implementation and evaluation of behavioral health-focused performance improvement projects.
Chronic Conditions	**Member-Focused Initiatives** ▪ Enrollment in disease management and complex case management programs for chronic conditions. ▪ Support and education to improve medication adherence. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to recognize and reward primary care providers who demonstrated success in closing gaps in care and optimizing care coordination and treatment planning for their members. ▫ The Nursing Facility Value-Based Purchasing Program was implemented, and Healthcare Quality Standards were introduced. ▪ Provision of guidelines for managing chronic diseases. ▪ Monitoring provider adherence and providing feedback. ▪ Participation in improvement activities. **Program-Focused Initiatives** ▪ Tracking outcomes for chronic conditions such as blood pressure control, diabetes management, and medication adherence. ▪ Case management for members with multiple or complex chronic conditions. ▪ Implementation and evaluation of projects focused on chronic disease management.

Presbyterian Health Plan, Inc.

Performance Measure Validation Results

The 2024–2025 information systems capabilities assessment determined that PHP's information systems met all requirements to support the:

- completeness and accuracy of encounter data collected and submitted to the state;
- validation and/or calculation of performance measures;
- completeness and accuracy of tracking of grievances and appeals;
- utility of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to oversee and manage the delivery of health care to the enrollees;
- utility of the information systems for review of provider network adequacy; and
- utility of the MCO's information systems for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, state vital statistics, public health data).

PHP's HEDIS measurement year 2024 Final Audit Report[5] indicated the following:

- PHP was compliant with all information systems standards required for HEDIS reporting. No deficiencies were noted.
- PHP utilized supplemental data sources for a variety of measures. PHP utilized supplemental data sources for a variety of measures including *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, *Childhood Immunization Status*, *Immunizations for Adolescents*, *Lead Screening in Children, Glycemic Status Assessment for Patients With Diabetes, Eye Exam for Patients With Diabetes, Kidney Health Evaluation for Patients With Diabetes, Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Mental Illness, Pharmacotherapy for Opioid Use Disorder, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, Well-Child Visits in the First 30 Months of Life,* and Child and Adolescent Well-Care Visits. All supplemental data sources were approved by PHP's certified-HEDIS auditor.
- PHP met review standards for medical record reviews. Medical record reviews included *Controlling High Blood Pressure, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition Counseling*, *Glycemic Status Assessment for Patients With Diabetes,* and *Eye Exam for Patients with Diabetes*.

Performance Measure Trends

PHP's Centennial Care 2.0 performance for measurement years 2020, 2021, 2022, 2023, and 2024 are presented in **Table 16**. Green shading indicates that the displayed rate met or exceeded the measurement year target. There were no target rates established for 2024. (Target rates for 2020, 2021, 2022, and 2023 are not displayed.)

PHP's Turquoise Care performance for measure year 2024 is presented in **Table 12**.

[5] Healthy People, an NCQA-certified HEDIS auditor, conducted the HEDIS Measurement Year 2024 Compliance Audit and produced the HEDIS Measurement Year 2024 Final Audit Report for PHP.

Table 16: PHP's Centennial Care 2.0 Performance Measure Rates for Measurement Years 2020, 2021, 2022, 2023, and 2024

Performance Measure (PM)	PHP Measurement Year 2020 Rate	PHP Measurement Year 2021 Rate	PHP Measurement Year 2022 Rate	PHP Measurement Year 2023 Rate	PHP Measurement Year 2024 Rate
PM 1 W30 First 15 Months	49.63%	44.37%	65.98%	69.31%	66.50%
PM 2 WCC Physical Activity	49.88%[1]	58.15%[1]	58.35%[1]	64.34%[1]	26.18%[1]
PM 3 PPC Prenatal Care	68.61%	67.22%	78.14%	75.52%	72.27%
PM 4 PPC Postpartum Care	69.59%	68.33%	72.95%	74.63%	71.34%
PM 5 CIS Combination 3	67.64%	63.02%	70.56%	72.75%	66.31%
PM 6 AMM Continuation	42.38%	44.80%	42.33%	51.14%	58.83%
PM 7 IET Initiation	54.12%	54.25%	55.10%	54.22%	50.77%
PM 8 FUH 30 Day	54.84%	53.84%	55.03%	55.14%	56.47%
PM 9 FUM 30 Day	64.83%	63.40%	59.36%	51.04%	48.53%
PM 10 SSD	75.14%	78.48%	80.59%	84.08%	82.74%
Available Points	**10**	**10**	**10**	**10**	**No Points Available**
Points Earned	**6**	**6**	**8**	**9**	**Not Applicable**

Green shading indicates that the displayed rate met or exceeded the target rate established by HCA for that measurement year. There were no targets established for measurement year 2024.

[1] The rates for measurement years 2020, 2021, 2022, and 2023 were calculated using the administrative methodology, while the rate for measurement year 2024 was calculated using the hybrid methodology.

PHP: Presbyterian Health Plan, Inc.

Quality Improvement Activities

Table 17 summarizes improvement activities reported by PHP in the *Quality Improvement Program Description and Work Plan, January 1, 2024 – December 31, 2024*.

Table 17: PHP's Quality Improvement Activities, 2024

Area of Care	2024 Quality Improvement Activities
Primary and Preventive Care for Adults and Children	**Member-Focused Initiatives** ▪ Digital health journeys for preconception, perinatal, healthy aging, and behavioral health self-assessment. ▪ Home visiting referrals for young children and pregnant/postpartum members. ▪ Member rewards for attending preventive care visits. ▪ Meal delivery for pregnant/postpartum members and young children. ▪ Fitness benefits for seniors. ▪ Outreach and education for children in state custody and seniors to reduce loneliness. ▪ Digital engagement, wellness at work, health coaching, screenings, and education. ▪ Improving compliance for well-child visits and immunizations, especially in high-disparity areas. ▪ Annual dental visits and lead screening for children. ▪ Weight assessment and counseling for children/adolescents. ▪ Preventive screenings for cancer and immunizations for all ages. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Presbyterian Quality Improvement Program incentivized primary care providers to deliver high-quality care, improve member outcomes, and develop the competencies needed to progress to the Patient-Centered Medical Home program. ▪ Provider education and training on trauma-informed care, cultural humility, and anti-ableism. ▪ Enhanced provider network for children in state custody. ▪ Performance meetings to review provider metrics and gaps in care. ▪ Expanded telehealth services for child psychiatry and perinatal care. ▪ Provider incentives and training on digital health literacy and telehealth navigation. ▪ Gap in care lists sent to providers for preventive screenings. ▪ Credentialing and recredentialing to ensure provider quality. **Program-Focused Initiatives** ▪ Population health risk stratification to identify and engage members for preventive interventions. ▪ Customized member education via digital platforms. ▪ Community partnerships for outreach and engagement in high-disparity areas.

Area of Care	2024 Quality Improvement Activities
	▪ Continuous monitoring and evaluation using dashboards and key performance indicators. ▪ Annual program evaluation and performance improvement projects targeting preventive care. ▪ Expanding obstetrics/gynecology and primary care in rural/frontier areas, telehealth expansion. ▪ Assessing and improving member digital skills for telehealth. ▪ Quality monitoring using HEDIS, CAHPS, and internal dashboards.
Prenatal and Postpartum Care	**<u>Member-Focused Initiatives</u>** ▪ Performance improvement projects focused on high-risk pregnancies and engagement in community programs. ▪ Prenatal and postpartum depression screening and follow-up. ▪ Access to community resources and care coordination for high-risk pregnant members. ▪ Lactation and doula support. **<u>Provider-Focused Initiatives</u>** ▪ Offered value-based arrangements to network providers. ▫ The PregnancyPLUS program offers provider incentives to perinatal groups to support the integration of community health workers, doulas, lactation specialists, and behavioral health specialists. ▪ Obstetrics/gynecology network expansion targeting rural and frontier areas. ▪ Provider education on perinatal care, substance use disorder screening, and postpartum follow-up. **<u>Program-Focused Initiatives</u>** ▪ Monitoring HEDIS rates for prenatal and postpartum care, member feedback, appeals, and grievances. ▪ Community partnerships for perinatal care. ▪ Population health management focus on prenatal and postpartum care.
Behavioral Health	**<u>Member-Focused Initiatives</u>** ▪ Digital behavioral health journeys and self-assessment tools. ▪ Access to crisis response teams and support lines. ▪ Member rewards for behavioral health preventive care. ▪ Outreach and recovery programs for justice-involved and behavioral health members. ▪ Enhanced care coordination for high-risk behavioral health members. ▪ Integration of behavioral health with primary care, especially for children in state custody. ▪ Crisis services, screening, and follow-up for depression and substance use disorder. ▪ Tele-mental health access.

Area of Care	2024 Quality Improvement Activities
	Provider-Focused Initiatives ▪ Provider and staff training to reduce behavioral health stigma and trauma response. ▪ Offered value-based arrangements to network providers. ▫ The Behavioral Health Quality Improvement Program incentivized behavioral health provider groups to enhance the quality, effectiveness, and efficiency of services provided to members. ▪ Delegated care coordination with Certified Community Behavioral Health Clinics. ▪ Expanded telehealth for psychiatry and subspecialties. ▪ Collaboration with assertive community treatment teams and community service agencies for complex cases. ▪ Pay-for-performance for outpatient behavioral health providers. ▪ Provider training on crisis intervention and trauma-responsive care. ▪ Annual review and dissemination of behavioral health clinical guidelines. **Program-Focused Initiatives** ▪ Risk stratification for behavioral health conditions to identify at-risk members. ▪ Partnerships with school-based health centers for behavioral health screening. ▪ Continuous monitoring and evaluation of behavioral health key performance indicators. ▪ Annual evaluation and adaptation of behavioral health strategies. ▪ Comprehensive crisis system partnerships and statewide crisis services. ▪ Dashboards for psychotropic medication use and crisis incidents. ▪ Stakeholder engagement through advisory boards.
Chronic Conditions	**Member-Focused Initiatives** ▪ Disease management programs for diabetes, asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, hypertension, and tobacco cessation. ▪ Remote patient monitoring for chronic conditions. ▪ Medication therapy management for seniors and long-term services and supports members. ▪ Insulin support for Native American members and children in state custody. ▪ Food is Medicine benefit for seniors and long-term services and supports members. ▪ Community reintegration programs for seniors. ▪ Diabetes prevention and management for Native American members. ▪ Adult obesity performance improvement projects. ▪ Hepatitis C treatment access. ▪ Medication adherence support.

Area of Care	2024 Quality Improvement Activities
	Provider-Focused Initiatives ▪ Provider education and training on chronic disease management and cultural competence. ▪ Offered value-based arrangements to network providers. ▪ The Care Transitions–Addus program offered incentives for closing gaps in care, enrolling members in the 30-day care transitions program, and reducing hospital readmissions. Collaborative care models for chronic condition management. ▪ Telehealth and digital care models for specialty care. ▪ Provider education on chronic disease management and medication adherence. ▪ Care coordination for members with complex health needs. **Program-Focused Initiatives** ▪ Population health dashboards and analytics to monitor chronic condition prevalence and outcomes. ▪ Community partnerships for chronic disease outreach and education. ▪ Continuous evaluation and adaptation of chronic condition interventions. ▪ Performance improvement projects targeting chronic conditions. ▪ Quality monitoring using HEDIS and internal dashboards. ▪ Pharmacy management for medication therapy and polypharmacy.

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UnitedHealthcare Community Plan of New Mexico

Performance Measure Validation Results

The 2024–2025 information systems capabilities assessment determined that UHC's information systems met all requirements to support the:

- completeness and accuracy of encounter data collected and submitted to the state;
- validation and/or calculation of performance measures;
- completeness and accuracy of tracking of grievances and appeals;
- utility of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to conduct quality assessment and improvement initiatives;
- ability of the information systems to oversee and manage the delivery of health care to the enrollees;
- utility of the information systems for review of provider network adequacy; and
- utility of the MCO's information systems for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, state vital statistics, public health data).

Performance Measure Trends

For the period under review, UHC was not required to submit annual HEDIS performance measure data to the New Mexico Health Care Authority.

Quality Improvement Activities

Table 18 summarizes improvement activities reported by UHC in the *2024 Quality Improvement Population Health Program Description*.

Table 18: UHC's Quality Improvement Activities, 2024

Area of Care	2024 Quality Improvement Activities
Primary and Preventive Care for Adults and Children	**Member-Focused Initiatives** ▪ Encouragement and support for age-appropriate immunizations and screenings. ▪ Education on preventive care, healthy behaviors, and regular check-ups. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to improve the delivery of preventive care. ▪ Provision of guidelines for preventive care, including immunizations and screenings. ▪ Feedback on preventive care measures to identify gaps and improve delivery. **Program-Focused Initiatives** ▪ Tracking and reporting on preventive care measures such as immunization rates, well-child visits, and cancer screenings. ▪ Initiatives to increase rates of preventive services and screenings. ▪ Ensuring sufficient access to primary care providers for preventive services.

Area of Care	2024 Quality Improvement Activities
Prenatal and Postpartum Care	**Member-Focused Initiatives** ▪ Encouragement and support for timely prenatal and postpartum care visits. ▪ Information on the importance of prenatal/postpartum care and available resources. **Provider-Focused Initiatives** ▪ Provision of evidence-based guidelines for prenatal and postpartum care. ▪ Feedback on prenatal and postpartum care measures. **Program-Focused Initiatives** ▪ Tracking prenatal and postpartum care rates, including timeliness of visits. ▪ Programs for mothers with substance use disorder or other high-risk conditions.
Behavioral Health	**Member-Focused Initiatives** ▪ Screening for behavioral health needs, including depression and substance use. ▪ Information and connection to behavioral health resources. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to improve behavioral health integration. ▪ Guidelines for screening, diagnosing, and treating behavioral health conditions. ▪ Training and support in integrating behavioral health into primary care. **Program-Focused Initiatives** ▪ Tracking follow-up after hospitalization for mental illness, depression screening, and engagement in substance use disorder treatment. ▪ Initiatives to improve coordination between medical and behavioral health services.
Chronic Conditions	**Member-Focused Initiatives** ▪ Enrollment in programs to support self-management and adherence. ▪ Reminders and support for medication adherence. ▪ Outreach and follow-up for Care Coordination Level I and II members who have been discharged to ensure that follow-up visits are scheduled. **Provider-Focused Initiatives** ▪ Offered value-based arrangements to network providers. ▫ The Primary Care Value-Based Purchasing Program was implemented to improve chronic disease management. ▫ The Nursing Facility Value-Based Purchasing Program was implemented to reward nursing facilities for improving the quality of care and reducing unnecessary hospitalizations.

Area of Care	2024 Quality Improvement Activities
	▪ Guidelines for managing chronic diseases. ▪ Feedback on chronic condition management measures. **Program-Focused Initiatives** ▪ Tracking outcomes for chronic conditions such as blood pressure control, diabetes management, and medication adherence. ▪ Programs for members with multiple or complex chronic conditions.

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Western Sky Community Care, Inc.

Performance Measure Validation Results

For the period under review, WSCC was not required to submit annual performance measure data to the New Mexico Health Care Authority. Additionally, WSCC was no longer operational under the New Mexico Medicaid managed care program during the implementation of the 2024 external quality review program.

Performance Measure Trends

For the period under review, WSCC was not required to submit annual HEDIS performance measure data to the New Mexico Health Care Authority. Additionally, WSCC was no longer operational under the New Mexico Medicaid managed care program during the implementation of the 2024 external quality review program.

Quality Improvement Activities

WSCC was no longer operational under the New Mexico Medicaid managed care program during the implementation of the 2024 external quality review program.