Behavioral Health Performance Measurement Program and Performance Improvement Projects Audit

July 1, 2007 - December 31, 2007

Final Report
July 28, 2008
Prepared for New Mexico Human Services Department
Under PSC 06-630-8000-02
Executive Summary

The New Mexico (NM) Human Services Department (HSD) has contracted with New Mexico Medical Review Association (NMMRA) as its external quality review organization (EQRO) to conduct monitoring, auditing, and surveying activities regarding the performance of contracted organizations, and to provide HSD with valid and reliable information and data. HSD issued Letter of Direction (LOD) No. 08-08 on August 22, 2007 to NMMRA to perform two separate audits for the Behavioral Health (BH) Statewide Entity (SE), ValueOptions New Mexico (VONM).

For the first audit, NMMRA was directed to review and validate VONM’s comprehensive Performance Measurement Program (PMP). The second audit was to review, assess and evaluate the efficacy of VONM’s internal quality Performance Improvement Projects (PIPs). NMMRA was tasked to evaluate all processes related to VONM’s overall continuous quality improvement (CQI) system of tracking, intervention, and re-evaluation for two clinically related quality PIPs.

The first objective was to review VONM’s infrastructure as it relates to its comprehensive PMP and to validate the performance measures. The audit scope included the review of quality initiatives, associated with three required Performance Measures (PMs), for auditing the mechanisms utilized by VONM for targeted improvement. This report includes an evaluation of VONM’s data tracking performed for monitoring purposes, and an assessment of VONM’s continuous quality improvement (CQI) program specifically established for targeted improvements in the three defined PM programs. The review period for the Validation of Performance Measures included data from Fiscal Year 2007 (06/30/06 – 06/30/07).

NMMRA has conducted two previous PM/PIPs audits to ensure VONM had developed and implemented procedures, processes and systems to document the complete submission of data as specified by the State. Validation of PMs with a HEDIS®-certified auditor did not previously occur. HSD directed NMMRA to conduct a validation of performance measures. NMMRA contracted with Health Services Advisory Group (HSAG) to validate the performance measures related to timely, accurate, and complete submission of data as specified by the HSD. HSAG is a National Committee for Quality Assurance (NCQA) licensed organization.

The second objective was to review VONM’s quality management and quality improvement processes associated with two internal clinically related PIPs. NMMRA evaluated all processes related to VONM’s CQI system of tracking, intervention and re-evaluation processes. HSD requested that the two projects reviewed be the same projects as those reviewed in the previous audit conducted in FY 2007. The review of the Performance Improvement Projects was from July 1, 2007 through December 31, 2007.

The scope of work addresses all appropriate HSD and Centers for Medicare & Medicaid Services (CMS) requirements, and completed according to the CMS protocols. This audit was performed in accordance with NMMRA’s EQRO contract, Article 1.3.1.1.

This report describes how NMMRA completed the audit and measured VONM’s performance. The methodologies used to audit the completeness of documentation and compliance with the standards and opportunities for improvement are explained. NMMRA’s analysis of the data obtained forms the basis for the findings presented to HSD.
Based on NMMRA’s review of CMS requirements, evidence acquired during the scope of this audit, and the scoring methodology approved by HSD, NMMRA finds VONM earned the following designation for the standards and contractual requirements examined:

- **Validation of Performance Measurement Program – Non-Compliance**
  - PM #1 – Residential Treatment Center (RTC) readmissions within 30 days to same level care or higher
  - PM #2 – Psychiatric hospital discharge follow-up within 7 days
  - PM #3 – Psychiatric hospital discharge follow-up within 30 days

- **Performance Improvement Projects – Non-Compliance**
  - PIP #1 – Improving follow-up for residential treatment clinical denials among consumers under 21 years of age and identified as ISHCN through automatic referral to specialized care coordination
  - PIP #2 – Improving Turn Around Times for UM Decision Making through Authorization Process Change

VONM earned a Non-Compliance designation for the PM and both PIPs. A corrective action plan based on these audit findings is recommended.

The following report details the findings and recommendations for VONM and HSD.
Preface

The New Mexico (NM) Human Services Department (HSD) has contracted with the New Mexico Medical Review Association (NMMRA) as its external quality review organization (EQRO) to conduct monitoring, auditing, and analysis regarding the performance of contracted organizations, and to provide HSD with valid and reliable information and data. HSD issued Letter of Direction (LOD) No. 08-08 on August 22, 2007 to NMMRA to perform two separate audits for the Behavioral Health (BH) Statewide Entity (SE), Value Options New Mexico (VONM). The first audit consisted of NMMRA review and validation of VONM’s comprehensive Performance Measurement Program (PMP). The second audit reviewed, assessed, and evaluated the efficacy of VONM’s internal quality Performance Improvement Projects (PIPs). NMMRA was tasked to evaluate all processes related to VONM’s overall continuous quality improvement (CQI) system process of tracking, intervention, and re-evaluation for two clinically related quality PIPs.

The first objective was to review VONM’s infrastructure as it relates to its comprehensive PMP programs and to validate the PMs. The audit scope associated with the three required PM programs included the review of processes, systems and quality initiatives for the mechanisms utilized by VONM for targeted improvement. This report includes an evaluation of the VONM’s data tracking performed for monitoring purposes, and an assessment of the VONM’s continuous quality improvement (CQI) program specifically established for targeted improvements in the three defined PM programs. The review period for the Validation of Performance Measures included data from Fiscal Year FY 2007 (06/07/06 – 06/30/07).

NMMRA subcontracted with Health Services Advisory Group (HSAG) to collaborate with NMMRA to complete PM validation audits requiring HEDIS®-like validation of performance measures. Per the Centers for Medicare & Medicaid Services (CMS), the validation of PMs is to be conducted by a certified HEDIS® auditor if the audited organization is not NCQA accredited.

HSAG was chosen as a partner for this task because of its NCQA certified HEDIS® auditors, and its extensive behavioral health and long-term care experience in validating PMs in multiple states, with hundreds of audits.

HSAG was responsible for a portion of the validation activity under NMMRA’s direction. Specific activities related to conducting performance measure validation and the primary performing entity are indicated below:

- Communicating with the State – NMMRA
- Preparing SE for on-site activities – NMMRA
- Reviewing and assessing procedures for collecting and integrating medical, financial, member and provider information, covering both clinical and service-related data, from internal and external sources – NMMRA with HSAG assistance
- Evaluating processes used to produce performance measures (sampling, calculating denominators and numerators) – HSAG
- Evaluating processes for reporting required performance measures to the State – NMMRA
- Conducting on-site interviews – NMMRA with HSAG assistance
- Evaluating findings and preparing report – NMMRA

The second objective was to review VONM’s QM and quality improvement processes associated with two internal clinically related PIPs. NMMRA evaluated VONM’s CQI system of
tracking, intervention and re-evaluation processes. HSD requested that the two clinically related PIPs reviewed be the same projects as previously audited in Fiscal Year (FY) 2007. The audit time range for the PIPs include the first six months of FY2008 (07/01/07 – 12/31/07).

NMMRA’s scope of work addressed appropriate HSD and CMS requirements, and was completed according to the CMS protocols. This audit was performed in accordance with NMMRA’s EQRO contract, Article 1.3.1.1.

Background

Validation of PMs is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. HSAG and NMMRA conducted the validation activities. NM HSD identified a set of PMs (indicators) that were calculated and reported by VONM for validation. HSAG conducted the validation activities as outlined in the CMS publication, Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol).

In accordance with specified CMS protocols, MAD regulations and contract requirements, VONM is required to conduct PIPs related to clinical (and non-clinical) areas that are expected to have a favorable effect on health outcomes and consumer satisfaction. The CMS Protocol – Conducting Performance Improvement Projects (PIPs) (42 CFR/438.240) specifies the SE will be evaluated on its conducting of PIPs that are designed to achieve, through ongoing measurement and intervention, significant improvement over a sustained period of time. As indicated in its contract with HSD, VONM must perform CQI that recognizes opportunities for improvement, and CQI projects must include the following elements based on MAD regulations:

- performed using objective quality indicators
- data driven
- employs continuous measurement
- implements programmatic improvements with re-measurement of effectiveness

As required in 42 CFR 438.240, PIPs include the following components:

- measurement of performance using objective quality indicators
- implementation of system interventions to achieve improvement
- evaluation of the effectiveness of the interventions
- planning and initiation of activities for increasing or sustaining improvement

Audit Approach and Methodology

The audit approach and methodology were designed to align the audit process with VONM’s contractual requirements and the LOD specifications. NMMRA used data collection and data analysis procedures to provide audit assurance and to identify areas requiring further investigation.

The methodologies were developed using NM Administrative Code (NMAC), NM MAD regulations and CMS protocol for assessing VONM performance. The final methodology consisted of the following sections:

- Rationale (understanding of the regulations and LOD specifications)
- Evidence required (documentation)
- Interpretive guidelines
- Data collection tools
- Scoring criteria

HSAG validated a set of performance indicators developed and selected by HSD. HSD specified the reporting cycle and review period specified for each indicator. The three PMs selected for validation were:

- PM #1 – Residential Treatment Center (RTC) Readmissions within 30 days
- PM #2 – Psychiatric Hospital Discharge Follow-up within 7 Days
- PM #3 – Psychiatric Hospital Discharge Follow-up within 30 Days

The process assessment included claims data based on the NM BH Purchasing Collaborative PM Instructions, along with a review of targeted quality interventions related to each individual measure. The PMs selected are HEDIS®-like metrics defined by HSD that address demonstrable improvements in each of the clinical areas and include technical specifications.

NMMRA reviewed VONM’s quality improvement processes associated with two internal clinically related PIPs. The PIPs were selected by HSD for the assessment and evaluation of the efficacy of the performance improvement processes established within VONM. The PIPs selected for review were:

- PIP # 1 – Improving Follow-up For Residential Treatment Clinical Denials Among Consumers Under 21 Years of Age and Identified as ISHCN, Through Automatic Referral to Specialized Care Coordination (SCC) and;
- PIP # 2 – Improving Turn Around Time for Utilization Management (UM) Decision Making Through Authorization Process Changes

**Audit Tools**

The audit tools were developed based upon the HSD/MAD LOD and the CMS Validation of Performance Improvement Projects Protocols and Validation of Performance Measures. NMMRA incorporated specific CMS protocols and components to be audited by the tools.

The audit tools address the regulatory requirements specific to the PMs and PIPs. The audit tools were tested prior to implementation to ensure accuracy, ease of use, and consistency. Review of the audit tools and guides were conducted in advance to ensure familiarity with the tools prior to application and scoring. Revisions were completed to adjust for the recommendations made during the testing time frame. The audit tools were approved by HSD prior to implementation.

The PM program audit tool was divided into three sections. The first section dealt with the data tracking process as it related to the ability of VONM to collect valid data from various internal and external sources. The second section addressed CQI program requirements, with identification of the opportunities for improvement, targeting the appropriate population, development of targeted interventions and implementation through CQI documentation. The third section reviewed the Information Systems Assessment related to Validation of Performance Measures.
The PIP audit tool was developed based on the CMS validation tools. This included assessing each project across 10 steps:

- Step 1: Review the Selected Study Topic
- Step 2: Review the Selected Study Question
- Step 3: Review the Study Indicators
- Step 4: Review the Identified Study Population
- Step 5: Review Sampling Methods
- Step 6: Review Data Collection Procedures
- Step 7: Assess Improvement Strategies
- Step 8: Review Data Analysis and Interpretation of Study Results
- Step 9: Assess Whether Improvement is “Real” Improvement
- Step 10: Assess Sustained Improvement

Audit Overview

On November 13, 2007, prior to the submission of documentation to NMMRA by VONM, NMMRA conducted a pre-audit meeting. The meeting, attended by VONM, HSD representatives, and HSAG via telephone, included a review of the LOD and documentation requirements for both the PM and PIP audits. The list of required documents to be submitted electronically prior to the on-site engagement, and an overview of the overall timeline were discussed. VONM was given 40 business days to prepare and submit the required documentation. On January 9, 2008, VONM requested an extension to submit the two PIPs due to system issues. HSD approved an extension with a new deadline of January 18, 2008 to submit the PIPs and required documentation.

Pre-On-site Meeting

On February 4, 2008, NMMRA provided VONM with clarification items relating to findings associated with the PIP portions of the audit. NMMRA requested that VONM complete the PIP tool a second time for PIP #1 “Improving Follow-up For Residential Treatment Clinical Denials Among Consumers Under 21 Years of Age and Identified as ISHCN, Through Automatic Referral to SCC,” to include baseline data from FY 2007. NMMRA requested clarification regarding step six, “data collection process,” for PIP #2 “Improving Turn Around Times for UM Decision Making through Authorization Process Change.” VONM was given three business days to complete this request.

Validation Team

The HSAG performance measure validation team was composed of a lead auditor and validation team members. The team was assembled based on the full complement of skills required for the validation and requirements of VONM. Some team members, including the lead auditor, participated in the on-site meetings at the SE office; others conducted their work off-site.
On-site Activities

On February 28, 2008, HSAG and NMMRA representatives conducted an on-site visit with VONM. Information was collected using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening meeting**—included introductions of the validation team and key VONM staff involved in the performance indicator activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.

- **Evaluation of system compliance**—included a review of the information systems assessment, focusing on the processing of claims and encounter data, patient data, and provider data. Additionally, the review evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

- **Review of the Information Systems Capabilities Assessment (ISCA) and supporting documentation**—included a review of the processes used for collecting, storing, validating, and reporting performance indicator data. This session was designed to be interactive with key VONM staff so that the review team could obtain a complete picture of all the steps taken to generate the performance indicators, and the degree of compliance with written documentation. Interviews were used to confirm findings from the documentation review, to expand or clarify outstanding issues, and to ascertain that written policies and procedures were used and followed in daily practice.

- **Overview of data integration and control procedures**—included discussion and observation of source code logic and a review of how all data sources were combined and how the analytic file was produced for the reporting of selected performance indicators. Primary source verification was performed to validate the output files. Backup documentation on data integration was reviewed. Data control and security procedures were also addressed during this session.

- **Closing conference**—summarized preliminary findings based on the review of the ISCA and the on-site visit, and revisited the documentation requirements for any post-visit activities.

HSAG and NMMRA representatives conducted several interviews with key VONM staff members who were involved with any aspect of performance indicator reporting.

Scoring Methodology

This section explains the methodology used to arrive at a score for each standard and each category, and an overall score for VONM’s performance.
PM Scoring Methodology

In assessing VONM’s performance, NMMRA and HSAG reviewed the following aggregate-level performance indicators related to CQI functions contained within the PM program:

- Assessment of VONM’s methodology for conducting their PM program related to:
  - PM #1 – RTC Re-admission within 30 days
  - PM #2 – Psychiatric Hospital Discharge follow-up within 7 days
  - PM #3 – Psychiatric Hospital Discharge follow-up within 30 days
- Verification of the data processes to confirm that the reported results were based on accurate source information; credit given for claims data based on the NM Purchasing Collaborative PM Instructions
- Assessment of consistent application of CQI functions when targeting interventions
- Evaluation of quality documents that demonstrate the CQI process in relation to;
  identifying opportunities for improvement, targeting appropriate populations, developing targeted interventions and demonstrating implementation

The CQI process for each BH PM was evaluated using the BH PM Review Audit Tool. A numeric score was assigned to each element in the performance criteria, within the following ranges:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic Data Tracking – Review of</td>
<td></td>
</tr>
<tr>
<td>1) C.I.24 RTC Readmission Report</td>
<td>(10)</td>
</tr>
<tr>
<td>2) PM 4.2.i.1 Review of PM 7 Days Report</td>
<td>(10)</td>
</tr>
<tr>
<td>3) PM 4.2.i.2 Review of PM 30 Days Report</td>
<td>(10)</td>
</tr>
<tr>
<td>4) Report Analysis</td>
<td>(10)</td>
</tr>
<tr>
<td>CQI Program</td>
<td>30</td>
</tr>
<tr>
<td>1) RTC Re-admission within 30 days</td>
<td>(10)</td>
</tr>
<tr>
<td>2) Psychiatric Hospital Discharge follow-up within 7 days</td>
<td>(10)</td>
</tr>
<tr>
<td>3) Psychiatric Hospital Discharge follow-up within 30 days</td>
<td>(10)</td>
</tr>
<tr>
<td>Information Systems Assessment</td>
<td>30</td>
</tr>
<tr>
<td>1) Eligibility</td>
<td>(5)</td>
</tr>
<tr>
<td>2) Claims/Encounters</td>
<td>(10)</td>
</tr>
<tr>
<td>3) Other Administrative Data</td>
<td>(5)</td>
</tr>
<tr>
<td>4) Data Integration</td>
<td>(10)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Overall scoring of 100 points total = Percent Overall

The elements for the measures were scored, summed and aggregated to determine an overall score. Table 1 presents the possible earned designation for VONM’s PM program:
Table 1: PM Earned Designation Scale

<table>
<thead>
<tr>
<th>Earned Designation</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90-100%</td>
<td>SE met or exceeded standard</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80-89%</td>
<td>SE met most requirements of the standard, but has deficiencies in certain areas</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50-79%</td>
<td>SE met some requirements of the standard, but has significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>&lt; 50%</td>
<td>SE did not meet standard and requires corrective action</td>
</tr>
</tbody>
</table>

**PIP Scoring Methodology**

In assessing VONM’s performance, NMMRA reviewed the following aggregate-level indicators related to CQI functions contained within the specified PIPs:

- Assessment of VONM’s methodology for conducting its PIPs
- Verification of the data processes to confirm that the reported results are based on accurate source information
- Assessment of consistent application of the CQI functions when targeting interventions
- Evaluation of quality documents that demonstrate the CQI process in relation to: identifying opportunities for improvement, targeting appropriate populations; reviewing measurement methods, data analysis, and demonstrated implementation; and assessing re-evaluation outcomes

The CQI process for VONM’s PIP measures was evaluated using the BH PIP Review Audit Tool. A numeric score was assigned to each element in the performance criteria, within the following ranges:

<table>
<thead>
<tr>
<th>Review Activity Elements</th>
<th>Maximum Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected Study Topic</td>
<td>5</td>
</tr>
<tr>
<td>Study Question</td>
<td>5</td>
</tr>
<tr>
<td>Selected Study Indicators</td>
<td>10</td>
</tr>
<tr>
<td>Identified Study Population</td>
<td>5</td>
</tr>
<tr>
<td>Sampling Methods</td>
<td>5</td>
</tr>
<tr>
<td>Data Collection Procedures</td>
<td>20</td>
</tr>
<tr>
<td>Improvement Strategies</td>
<td>20</td>
</tr>
<tr>
<td>Data Analysis and Interpretation of Study Results</td>
<td>5</td>
</tr>
<tr>
<td>Whether Improvement is &quot;Real&quot; Improvement</td>
<td>20</td>
</tr>
<tr>
<td>Sustained Improvement</td>
<td>5</td>
</tr>
</tbody>
</table>

**Total** 100

Overall scoring of 100 points total = **Percent Overall**

The individual PIP scores were then summed and aggregated and a percent overall score was determined, interpreted as follows:
Table 2: PIP Earned Designation Scale

<table>
<thead>
<tr>
<th>Earned Designation</th>
<th>Score</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Full Compliance</td>
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<td>Non-Compliance</td>
<td>&lt;50%</td>
<td>SE did not meet standard and requires corrective action</td>
</tr>
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</table>

Findings for Performance Measures

There are several elements involved in the calculation of performance indicators that are crucial to the process. These include data integration, data control, and documentation of performance indicator calculations. Each of the following sections describes the validation processes used and the validation findings.

Data Integration
The broad category of data integration includes not only the items listed on the scoring tool, but also evaluation and comparison of all performance measure reports submitted for review. Accurate data integration is essential to calculating valid performance indicators. The steps used to combine various data sources, including claims/encounter data, eligibility data, and other administrative data must be carefully controlled and validated. HSAG validated the data integration process used by VONM, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Overall, the data integration processes in place at VONM were determined by the audit team to be:

- Acceptable
- Not acceptable

The reports, titled “CI-24 RTC Readmits”, “PM4.2 Inpatient discharge follow up within 7(i.1) and 30 days (i.2)” reflected data compiled on a quarterly basis observed over a year’s time. In many instances, the numeric values fluctuated beyond what would appear to be reasonable. For example, the report “CI-24 RTC Readmits” which was run 4/2/07, shows the denominator “All” for the 3rd Quarter to be 928. The same report, with a run date of 6/25/07, shows the denominator “All” for the 3rd Quarter to be 698, which is a difference of 230 discharges. Similar variability exists in these reports with run dates of 6/25/07 and 10/02/07 for the 4th Quarter denominators: The 6/25/07 denominator “All” for 4th Quarter is 769, and the 10/2/07 denominator “All” for 4th Quarter is 568, a difference of 201 discharges. The variability in these data, as well as the finding that the Follow-up After Hospitalization (FUH) performance measure programming language included CPT codes not explicitly included in measure specification, are all taken into account in this area of the report, and the findings were not acceptable.
Data Control
The organizational infrastructure of VONM must support all necessary information systems. VONM's quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data, and to provide data protection in the event of a disaster. HSAG validated the data control processes used by VONM, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the data control processes in place at VONM were determined by the audit team to be:

☐ Acceptable
☒ Not acceptable

The Data Control aspect was reviewed to include procedures for report generation derived from information systems. Data security is only one element within the realm of data control. While there were no overt concerns with data security per se, there were concerns related to reports generated, and rates, which exhibited inexplicable fluctuations, with denominators decreasing over several quarters, as detailed above in “Data Integration”. Additionally, a step-by-step documented procedure used for RTC report generation, which was requested on-site by the auditors and provided post-on-site by VONM, was reviewed. The document specified that the measure would be pulled from data sources other than claims and encounter data, which is outside the performance measure specifications. This step-by-step document is crucial in demonstrating compliance with specifications, and maintaining consistency in processes in the event of staff vacancies. This documentation plays an integral part in the assessment of performance measure validity, and was found to contain directives contrary to specification language; the reviewers found that VONM’s data control processes were not acceptable.

Performance Indicator Documentation
Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations can provide supplementary information, the majority of the validation review findings were based on documentation provided by SE. HSAG reviewed all related documentation, which included the completed ISCA, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance indicator calculations, and other related documentation. Overall, the documentation of performance indicator calculations by SE was determined by the audit team to be:

☐ Acceptable
☒ Not acceptable

There was no consistent evidence provided to the auditors that showed these data came from claims. The primary source verification activity confirmed the presence of a numerator positive consumer for the RTC measure did not have an associated claim in the VONM claims system. Additionally, post-on-site, the step-by-step documentation requested for the calculation of this performance measure included Absolute Integrated Solutions (AIS) data which indicated that it was not pulled from claims/encounter data as stipulated by HSD.

Performance Indicator Specific Findings
Based on all validation activities, the HSAG validation team determined validation results for each performance indicator. Table 3 displays the key review results for the PMs:
### Table 3: Key Review Findings

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Key Review Findings</th>
</tr>
</thead>
</table>
| 1. Residential Treatment Center (RTC) readmissions within 30 days of discharge | Discussions with SE on-site revealed that SE generated two reports for this measure; one report was based on HSD specifications, and another RTC analysis report utilized data from the AIS system, which includes some enrollment, authorizations and some provider-supplied discharge date information. During the primary source verification activity, a numerator positive case chosen at random was apparently included in the numerator without any inpatient claims data, which indicated that it was not pulled from claims/encounter data as stipulated by HSD.  

There were discrepancies between the dual reports provided for auditor review. Auditors were told on-site that one was more accurate than the other and reflected a “truer” rate.  

Post on-site, a review of final rates revealed the following: the report run date was 10/2/07, but the numbers for each of the four quarters changed (decreased after the previous run date of 6/25/07), after the claims lag. The purpose of a claims lag period is to allow sufficient time for all claims to be submitted and processed before using the data to report rates. A standard claims lag period is usually 90 days (3 months after the date of service). At the end of a claims lag period, data should be complete and result in higher rates. For the readmission measure, allowing a three-month claims lag should actually increase the likelihood of additional claims coming in with readmission data, which would cause the numeric counts to increase instead of decrease. In addition, the reported rates match exactly the rates included in the supplemental RTC analysis report SE sent to HSD. The rates appear to represent the augmented data used from AIS, and would therefore be invalid. Additionally, the step-by-step process SE used for calculation of this measure included the use of AIS data, rather than following the specifications set forth by HSD, which stipulates using claims/encounter data for this calculation.  

Upon the review of final rates for FY07, as well as SE’s step-by-step document for report generation, preliminary findings were verified, and the RTC measure rates were found to be invalid. |
<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Key Review Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Psychiatric Hospital Discharge follow up within 7 days</td>
<td>Discussions with SE on-site revealed that SE generated two reports for this performance measure; one report was based on HSD specifications, and another Follow-Up after Hospitalization analysis report utilized data from the AIS system, which includes some enrollment, authorizations and some provider-supplied discharge date information. These discussions further revealed that SE used additional codes to pull follow-up visits, which were not included in HSD’s specifications (the codes appeared to mirror codes included in the HEDIS® FUH measure). The verbiage in HSD’s specifications reads as follows: “Ambulatory follow-up encounters are identified by the following codes: UB-92 Revenue Codes: 513, 900, 901, 909-916, 961 (all follow-up visits must be with a mental health practitioner; the MCO does not need to determine practitioner type for follow-up visits identified through UB-92 Revenue codes)”. The deviation from HSD specifications was confirmed by the auditors’ review of SE’s source code, both on-site and post-on-site, which included the following codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99351, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 9005, 9006, 9007, 905, 906, and 907. It was noted that SE explained their rationale for their modification to codes in the specification; SE felt that in order to more fully count the number of follow-up visits, these codes should be added, since the HSD specifications had included mostly facility-based revenue codes. Post on-site, a review of the final rate document submitted appeared to be the same document (run date in July 2007) that was observed on-site. There should have been a final report generated in October or November 2007, but this was not submitted for review. The rates in the July 2007 report match exactly what is represented in their supplemental AIS analysis report data, only the denominators were inexplicably omitted. Upon the review of final rates for FY07, as well as a review of SE’s source code, preliminary findings were verified, and the performance measure rates were found to be invalid. HSD notified NMMRA post on-site that the SE was given permission to utilize outpatient codes to meet the discharge follow-up within 7 days.</td>
</tr>
<tr>
<td>3. Psychiatric Hospital Discharge follow up within 30 days</td>
<td>Discussions with SE on-site revealed that SE generated two reports for this performance measure; one report was based on HSD specifications, and another Follow-Up after Hospitalization analysis report utilized data from the AIS system, which includes some enrollment, authorizations and some provider-supplied discharge date information. These discussions</td>
</tr>
</tbody>
</table>
Performance Measures | Key Review Findings
---|---

Further revealed that SE used additional codes to pull follow-up visits, which were not included in HSD’s specifications (the codes appeared to mirror codes included in the HEDIS® FUH measure). The verbiage in HSD’s specifications reads as follows: “Ambulatory follow-up encounters are identified by the following codes: UB-92 Revenue Codes: 513, 900, 901, 909-916, 961 (all follow-up visits must be with a mental health practitioner; the MCO does not need to determine practitioner type for follow-up visits identified through UB-92 Revenue codes).” The deviation from HSD specification was confirmed by the auditors’ review of SE’s source code, both on-site and post-on-site, which included the following codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99353, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 0905, 0906, 0907, 905, 906, and 907.

It was noted that SE explained their rationale for their modification to codes in the specification; SE felt that in order to more fully count the number of follow-up visits, these codes should be added since the HSD specifications had included mostly facility-based revenue codes.

Post-on-site, a review of the final rate document submitted appeared to be the same document (run date in July 2007) that was observed on-site. There should have been a final report generated in October or November 2007, but this was not submitted for review. The rates in the July 2007 report match exactly what is represented in their supplemental AIS analysis report data, only the denominators were inexplicably omitted.

Upon the review of final rates for FY07, as well as a review of SE’s source code, preliminary findings were verified, and the performance measure rates were found to be invalid.

HSD notified NMMRA post on-site that the SE was given permission to utilize outpatient codes to meet the discharge follow-up within 30 days.

Validation of Performance Measures (PM) Program

The data collected from VONM, either pre-on-site or during the on-site visit, was the only information considered in determining compliance with NMAC standards and CMS protocols. NMMRA examiners reviewed completed audit tools as part of the evaluation of specific MAD regulations. Additionally, the NMMRA EQRO medical director reviewed all PM and PIP findings. This section presents descriptive findings and overall compliance reported in the audit tools relating to the regulations.
Table 4 presents VONM’s overall score for BH PM program. As described in the scoring methodology section of this report, the score was calculated as follows:

- The available points per measure were multiplied by the appropriate weight according to the assigned designation to calculate the achieved points for that measure.
- The achieved points for all the measures were then summed to calculate the total assigned points.
- The final overall score was then derived by summing the total points and assigning one of the following compliance levels:

<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90 – 100%</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80 – 89%</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50 – 79%</td>
</tr>
<tr>
<td>Non compliance</td>
<td>&lt; 50%</td>
</tr>
</tbody>
</table>

Table 4: PM Program Review

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Score</th>
<th>Audit Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic Data Tracking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of C.I.24 RTC Readmission Report</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Review of PM 4.2.i.1 Review of PM 7 Days Report</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Review of PM 4.2.i.2 Review of PM 30 Days Report</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Review of Report Analysis</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>CQI Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTC Re-admission within 30 days</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Discharge follow-up within 7 days</td>
<td>10</td>
<td>2.5</td>
</tr>
<tr>
<td>Discharge follow-up within 30 days</td>
<td>10</td>
<td>2.5</td>
</tr>
<tr>
<td>Information Systems Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Claims/Encounter</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Other Administrative Data</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Data Integration</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Overall Program Score</td>
<td>100</td>
<td>28</td>
</tr>
</tbody>
</table>

VONM scored a designation of 28%, resulting in a rating of Non-compliance for the BH PM Program review. Based on the results of the validation of performance measures, the data in the reports submitted to HSD were determined to be invalid. The validation was completed to determine the extent to which Medicaid-specific performance measures calculated by VONM followed the specifications established by the State. The validation tool and examiners’ findings of the review are included in the Appendices.

SE earned the maximum points in two of the eleven measures:

- Eligibility
- Other Administrative Data

VONM submitted three performance measure reports based on the NM BH Purchasing Collaborative PM Instruction. These reports are as follows: C.I.24 RTC Readmission Report
  - PM 4.2.i.1 Review of PM 7 Days Report
  - PM 4.2.i.2 Review of PM 30 Days Report
The data tracking process is the ability of VONM to collect valid data. VONM did not earn the maximum points for the data tracking process of the three performance measures specified by HSD. The RTC readmission report was calculated with an invalid numerator positive from another data source. The 7 and 30 day reports were not calculated based on the specification language in the PM instructions. Based on the validation processes data integration, data control and documentation of performance indicator calculations utilized during the validation of performance measures the data in the reports submitted to HSD were determined to be invalid.

VONM did not earn the maximum points related to continuous quality improvement for RTC Re-admission within 30 days. VONM did not provide detailed documentation associated to interventions to decrease readmission within 30 days. In addition, VONM did not demonstrate and document reassessment of continued improvements through the Quality Management program description and Quality Improvement work plans.

VONM did not earn the maximum points related to continuous quality improvement (CQI) for Discharge follow-up within 7 days. VONM did not meet the HSD targeted goal of 90% of consumers discharged from psychiatric inpatient facilities receive follow-up care within 7 days. VONM did not provide detailed documentation associated with the identification of the opportunities for improvement and implementation through CQI. Based on the validation processes data integration, data control and documentation of performance indicator calculations utilized during the validation of performance measures the data in the reports submitted to HSD were determined to be invalid.

VONM did not earn the maximum points related to CQI for Discharge follow-up within 30 days. VONM did not meet the HSD targeted goal of 90% of consumers discharged from psychiatric inpatient facilities receive follow-up care within 30 days. VONM did not provide detailed documentation associated with the identification of the opportunities for improvement and implementation through CQI. Based on the validation processes data integration, data control and documentation of performance indicator calculations utilized during the validation of performance measures the data in the reports submitted to HSD were determined to be invalid.

Performance Improvement Projects (PIPs)
The first PIP project selected by the SE for review is Improving Follow-Up For Residential Treatment. Comparisons of the previous audit results are provided for review.

The data collected was reviewed and assessed by NMMRA examiners using the 10 steps described earlier. Tables 5 and 6 show the earned designation rates for VONM for the selected PIPs. The data reflects the reviewed standards received a rating of Non-compliance.

VONM’s performance improvement programs that focus on clinically-related areas for NM SALUD! Consumers did not demonstrate compliance in their processes and systems related to each of the required PIP measures.
Table 5: PIP #1

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Score</th>
<th>Assigned Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the Selected Study Topic</td>
<td>5</td>
<td>3.75</td>
</tr>
<tr>
<td>Review the Selected Study Question</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review the Study Indicators</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Review the Identified Study Population</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Sampling Methods</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Data Collection Procedures</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Assess Improvement Strategies</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Review Data Analysis and Interpretation of Study Results</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Assess Whether Improvement is &quot;Real&quot; Improvement</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Assess Sustained Improvement</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>Overall Project Score</strong></td>
<td><strong>100</strong></td>
<td><strong>34.75</strong></td>
</tr>
</tbody>
</table>

VONM scored a designation of 34.75% resulting in a rating of Non-compliance for the BH PIP review for Improving Follow-up For Residential Treatment Clinical Denials Among Consumers Under 21 Years of Age Who Are Identified as ISHCN Through Automatic Referral to SCC. In comparison to the prior years results, VONM did not demonstrate continued improvement across the measures; resulting in a decrease in the overall percent score from 100% to 34.75% for all measures. The validation tool and examiners' findings for this PIP are included in the Appendices section. The documentation provided by SE was in the defined formats provided by NMMRA during the audit overview meeting.

Table 6: PIP #2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Score</th>
<th>Assigned Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the Selected Study Topic</td>
<td>5</td>
<td>3.75</td>
</tr>
<tr>
<td>Review the Selected Study Question</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review the Study Indicators</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Review the Identified Study Population</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Sampling Methods</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Data Collection Procedures</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Assess Improvement Strategies</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Review Data Analysis and Interpretation of Study Results</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Assess Whether Improvement is &quot;Real&quot; Improvement</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Assess Sustained Improvement</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>Overall Project Score</strong></td>
<td><strong>100</strong></td>
<td><strong>40.25</strong></td>
</tr>
</tbody>
</table>

VONM scored a designation of 40.25% resulting in a rating of Non-compliance for the BH PIP review for Improving Turn Around Times for UM Decision Making Through Authorization Process Change. In comparison to the prior years results, VONM did not demonstrate continued improvement across the measures; resulting in a decrease in the overall percent score from 100% to 40.25% for all measures. The validation tool and examiners' findings for this PIP are included in the Appendices section. The documentation provided by SE was in the defined formats provided by NMMRA during the audit overview meeting.
Audit Comparison Results

Performance Measurement (PM) Program

Table 7 presents VONM’s overall score for BH PM Program. As described in the scoring methodology section of this report, the final overall score was calculated as follows:

- The available points per measure were multiplied by the appropriate weight according to the assigned designation to calculate the achieved points for that measure
- The achieved points for all the measures were then summed to calculate the total assigned points
- The final overall score was then derived by summing the total points and assigning one of the following compliance levels:
  
<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Percentage Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90 – 100%</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80 – 89%</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50 – 79%</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>&lt; 50%</td>
</tr>
</tbody>
</table>

Table 7: Performance Measurement Program Review for VONM

<table>
<thead>
<tr>
<th>Measure</th>
<th>2007 Score</th>
<th>2008 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic Data Tracking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of C.I.24 RTC Readmission Report</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Review of PM 4.2.i.1 Review of PM 7 Days Report</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Review of PM 4.2.i.2 Review of PM 30 Days Report</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Review of Report Analysis</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>CQI Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTC Re-admission within 30 days</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>Discharge follow-up within 7 days</td>
<td>100%</td>
<td>25%</td>
</tr>
<tr>
<td>Discharge follow-up within 30 days</td>
<td>100%</td>
<td>25%</td>
</tr>
<tr>
<td>Information Systems Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Claims/Encounter</td>
<td>N/A</td>
<td>80%</td>
</tr>
<tr>
<td>Other Administrative Data</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Data Integration</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Overall Project Score</td>
<td>100%</td>
<td>28%</td>
</tr>
</tbody>
</table>

VONM scored a designation of 28%, resulting in a rating of Non-compliance for the validation of PM program review. HSD directed NMMRA to conduct a validation of performance measures based on the CMS requirements and was completed according to the CMS Protocols. The audit scope included the review of quality initiatives, associated with three required PMs, for auditing the mechanisms utilized by VONM for targeted improvement. In FY 2007, NMMRA reviewed SE’s implementation of a PM process and establishment of baseline data. In FY 2008, NMMRA and HSAG reviewed the PM process for efficacy and effectiveness of the data collection process, which included the calculation of performance indicators, data integration, data control and documentation of performance measure calculation. In comparison to the prior years results, VONM did not demonstrate continued improvement across the measures; resulting in a decrease in the overall percent score from 100% to 28% for all measures.
Performance Improvement Projects (PIPs)

VONM's comparative final scores for BH PIPs are represented in Tables 8 and 9. As described in the scoring methodology section of this report, the final score was calculated as follows:

- The available points per measure are multiplied by the appropriate weight according to the assigned designation to calculate the achieved points for that measure.
- The achieved points for all the measures are then summed to calculate the total assigned points.
- The final overall score is then derived by summing the total points and assigning one of the compliance levels:
  
<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90 – 100%</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80 – 89%</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50 – 79%</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>&lt; 50%</td>
</tr>
</tbody>
</table>

Table 8: 1st PIP Review

1st PIP Review — Improving follow-up for residential treatment clinical denials among consumers under 21 years of age and identified as ISHCNs, through automatic referral to SCC

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Score</th>
<th>2006 Score¹</th>
<th>2007 Score</th>
<th>2008 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the Selected Study Topic</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>3.75</td>
</tr>
<tr>
<td>Review the Selected Study Question</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review the Study Indicators</td>
<td>10</td>
<td>N/A</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Review the Identified Study Population</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Sampling Methods</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Data Collection Procedures</td>
<td>20</td>
<td>N/A</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Assess Improvement Strategies</td>
<td>20</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Review Data Analysis and Interpretation of Study Results</td>
<td>5</td>
<td>N/A</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Assess Whether Improvement is “Real” Improvement</td>
<td>20</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Assess Sustained Improvement</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Overall Project Score</td>
<td>100%</td>
<td>N/A</td>
<td>63%</td>
<td>34.75%</td>
</tr>
</tbody>
</table>

VONM scored a designation of 34.75% resulting in a rating of Non-compliance for the PIP Review for RTC clinical denials. In comparison to the prior two audits, VONM did not meet NMAC standards and CMS requirements as demonstrated in the protocol and did not fulfill all documentation required to meet MAD regulations. There remain opportunities for improvement related to providing evidence that VONM’s processes are followed.

¹FY 2006 scoring methodology revised in FY 2007
Table 9: 2nd PIP Review

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Score</th>
<th>2006 Score²</th>
<th>2007 Score</th>
<th>2008 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the Selected Study Topic</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>3.75</td>
</tr>
<tr>
<td>Review the Selected Study Question</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review the Study Indicators</td>
<td>10</td>
<td>N/A</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Review the Identified Study Population</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Sampling Methods</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Review Data Collection Procedures</td>
<td>20</td>
<td>N/A</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Assess Improvement Strategies</td>
<td>20</td>
<td>N/A</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Review Data Analysis &amp; Interpretation of Study Results</td>
<td>5</td>
<td>N/A</td>
<td>4.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Assess Whether Improvement is “Real” Improvement</td>
<td>20</td>
<td>N/A</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Assess Sustained Improvement</td>
<td>5</td>
<td>N/A</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Overall Project Score</td>
<td>100%</td>
<td>N/A</td>
<td>84%</td>
<td>40.25%</td>
</tr>
</tbody>
</table>

VONM scored a designation of 40.25% resulting in a rating of Non-compliance for the PIP Review for improving turn around times. In comparison to the prior two audits, VONM did not meet the NMAC standards and CMS requirements as demonstrated in the protocol and did not fulfill all documentation required to meet MAD regulations. There remain opportunities for improvement related to providing evidence that VONM’s processes are being followed.

Recommendations

This final section presents NMMRA’s suggested recommendations related to SE’s performance of PMs and PIPs:

- Educate staff regarding the CMS Protocol for Conducting Performance Improvement Projects, as this is an annual CMS and HSD contractual requirement
- Assign responsibility for PIP development to qualified staff person, and ensure availability of design and data analysis expertise, such as a quality champion owning the PIP process
- Describe the rationale for selecting the study topic as a formal PIP
- Draft study questions in writing in order to clearly maintain the focus of the PIP and set the framework for data collection and analysis
- Document the characteristics of the study indicator(s) selected by incorporating a numerator, denominator, measurement period dates, benchmark, and baseline goal
- Document the data collection cycle
- Describe the data analysis plan and other pertinent methodological features of the project
- Include specific qualifications of staff and personnel who collected the data for selected PIPs
- Include barrier analysis when describing baseline to re-measurement intervention implementation and improvement strategies
- Calculate and include statistical differences between initial measurement and re-measurement metrics

² FY 2006 scoring methodology revised in FY 2007
Include the interpretation of the extent to which any changes in performance are statistically significant

- Ensure study indicators are clear and easily measured
- Design a data analysis plan that includes clearly defined indicators that reference a target performance or desired percent improvement
- Build data confidence factors into the data analysis plan
- Address identified barriers and identify relevant interventions to include data analysis plan that will provide meaningful information related to the results of interventions
- Apply statistical analysis tools to measure and evaluate validity of results
- For all manual data entry, the percent of claims audited for accurate data entry should be increased from 3 percent to 5 percent to better ensure accurate data entry. The audit of manual data entry should consist of a validation of the paper documentation to the electronic entry of the data to ensure they match.
- Encounter data completeness is always an area where improvement efforts can be focused since there is no monetary incentives for providers to submit encounter data. SE should look for ways to improve encounter data completeness, which could include tracking and trending provider data submissions on a monthly basis and reconciling data rejection reports to look for incomplete data.
- Develop and implement an encounter data to medical record audit process, evaluating the accuracy of encounter/claims data by comparing service codes to medical record documentation. This type of encounter data validation audit would confirm that the services being provided to members are the same services that are being submitted for payment on a claim form.
- To ensure that all performance measures are calculated correctly and are valid for reporting purposes, the specifications each PM should be followed exactly. Any verbal communication between SE and HSD should be documented and included in the measure specification as a document trail.

The following presents NMMRA’s suggested recommendations for HSD related to VONM’s performance for the review of PMs and PIPs:

- Develop, implement and monitor corrective action plan on a monthly basis
- Formalize oversight of VONM PIPs
  - Approve PIP projects
  - Receive data from VONM monthly
  - Meet with VONM and contract manager on a quarterly basis
  - Ensure data is accurate
- Utilize EQRO for technical assistance
- Collaborate with VONM to improve specification language
- Conduct an encounter data validation to compare to baseline data through EQRO
Reconsideration Review

VONM reviewed the preliminary findings of this audit report and was provided an opportunity to respond with specific questions, comments and requests. The following requests for reconsideration were submitted by VONM on April 17, 2008. The reconsideration review completed by NMMRA was in collaboration with HSD. The additional information submitted by VONM as of April 17, 2008 was included in the reconsideration review process.

**VONM Response:**
In the audit overview on November 13, 2007, VONM expressed concern regarding the January 9, 2007 due date given that the data necessary for Q2FY08 PM reports and for both PIPs would not be available until the first week in January, only a few days before the due date. NMMRA indicated to VONM that it would be acceptable to submit data that was available as of Jan 9, 2008, and the remaining data would be reviewed on-site. In the interim, NMMRA reversed their position and indicated that reports covering July 1, 2007 – December 31, 2007 in their entirety would be due on Jan 9, 2008. Given that both PIPs require manual validation, it was not possible to meet the Jan 9, 2008 deadline. VONM submitted the PIPs by the extended deadline of Jan 18, 2008.

**NMMRA Response:**
NMMRA provided VONM with a due date of January 9, 2008 for all prior data sources required for the Validation of PMs and for the two PIPs during the audit overview meeting with VONM, on November 13, 2007. At this time, VONM did not identify an issue with the due date. The following activity occurred prior to January 9, 2008:

- NMMRA did not receive correspondence from VONM regarding the PMs or PIPs from November 13, 2007 through January 9, 2008.
- NMMRA sent VONM the Audit Overview Meeting Minutes on December 13, 2007. There were no comments from VONM regarding PM and PIPs, specifically the due dates for the data.
- NMMRA sent a reminder e-mail on January 8, 2008 regarding the prior data sources for the PM and PIP audit. VONM responded the same day and indicated “we are on track and will be submitting tomorrow.”
- VONM requested an extension on January 9, 2008 at 4:59 p.m. to submit the PIPs. This was the first time NMMRA was made aware of any issues VONM had regarding the due date for the PIPs.
- HSD approved and granted an extension to January 18, 2008.

After review of comments provided by VONM, this clarification does not affect the score.

**Issues Specific to the PM/PIP Audit**

**VONM Response:**
Failure to Follow CMS Protocols:
Both PIPs were scored inaccurately, contrary to CMS Protocols - Conducting Performance Improvement Projects: A Protocol for use in conducting Medicaid EQRO activities, Final Protocol, Version 1.0, 5/1/2002. The Protocol addresses Activities 4: Review the Identified Study Population and 5: Use of Sound Sampling Techniques, and states that if the entire population is included in the study the MCO is directed to skip Activity 5: Use of Sound Sampling Techniques (p.8). VONM identified study population in both PIPs as the entire population. Thus, the sampling is not applicable and all elements in Step 5 on NMMRA’s tool should be scored as ‘n/a’ for both PIPs and the scores adjusted accordingly.
NMMRA Response:
NMMRA has reviewed VONM’s request for reconsideration with the following decision:
After a review of comments provided by VONM, the scored points were adjusted upward by 3 points for PIP #1, for a total score of 34.75. For PIP #2, the scored points were adjusted upward by 2 points for a total score of 40.25.

VONM Response:
*Errors in Validation of Numerator Positives*
The auditors requested a list of only 10 numerator positives for each PM when on-site and, then, only reviewed a total of 4 numerators for all 3 PMs. The 1 numerator positive reviewed for each of the Ambulatory Follow-up measures are incorrectly cited in the audit report as ‘invalid’ when, in fact, they are valid. (See comments for Performance Indicator Documentation in the audit tool.)

NMMRA and HSAG Response:
HSAG followed its standard primary source verification process that is used for all audits (Performance Measure Validation, Pay for Performance, and HEDIS®) that HSAG performs. HSAG requested a list of numerator positive consumers for each performance measure. From this list of numerator positive consumers HSAG then selected a random sample of consumers to conduct the primary source verification. Primary source verification is performed on a sample of numerator positive cases. This sample is representative of the entire numerator positive list, and the derivation of this sample is at the discretion of the auditor, not the SE. Any findings the auditors encounter can potentially be extrapolated, or applied to the entire sample if a systematic error is found. The purpose of primary source verification is to validate that the source code for calculating the measures is accurate. HSAG’s source code review team had not reviewed the source code since it was only received while HSAG was on-site. Individuals present in the room during primary source verification could not and did not dispute the fact that there were no claims data in the system for the member in question. It could not have been pulled to the numerator otherwise. After review of comments provided by VONM, the score remains unchanged.

VONM Response:
*Misunderstanding of PM Report Specifications:* The audit findings lead VONM to believe there was confusion on the part of the auditors as to (1) whether the PMs were based on claims or authorization data, (2) the distinction between required reports and supplementary analysis, and (3) problematic report specifications, which are required of VONM. (See comments in the audit tool for Data Tracking Process, Data Integration, Performance Indicator Documentation.) These misunderstandings underlie almost all findings of ‘non-compliance’ related to the Performance Measure Audit; findings which are duplicated in several elements of the Compliance Audit. We would be happy to discuss this with NMMRA representatives if they would like.

NMMRA and HSAG Response:
NMMRA and HSAG reviewed VONM’s request for reconsideration with the following decision: There was no misunderstanding by the auditors as to whether measures were based on claims or authorization data. During primary source verification, VONM’s staff were unable to produce primary data back to the claims system. VONM must demonstrate compliance with the written specifications, and as previously stated VONM failed to demonstrate that data utilized for performance measure reporting were drawn in a consistent manner, and according to specifications. All cases reported as numerator positive for the measure should be included in the measure from the same data source.
VONM could not demonstrate that the cases were all present in the claims data and therefore the process was considered non-compliant. After review of comments provided by VONM, the score remains unchanged.

**VONM Response:**

*Holding VONM Responsible for State Directives:* VONM is held accountable by HSD for generating PM reports in compliance with state specifications, yet it is understood by both VONM and HSD that the report results are problematic and do not serve as an adequate basis on which to move forward with improvement efforts. To rectify this, we generate a supplemental analysis (RTC PM) or follow alternative report specifications, which have been verbally agreed-upon through discussions with the Collaborative (Ambulatory Follow-up PMs) in order to generate more useful data. Notwithstanding this practical reality, and instead of acknowledging the defects of the report specifications, the audit report cites VONM for generating ‘duplicate reports’ and ‘not following report specifications’. (See comments in the tool for Data Tracking Process, Data Integration, Performance Indicator Documentation) These contradictions underlie the findings of ‘non-compliance’ related to the Performance Measure Audit, findings which are duplicated in several elements of the Compliance Audit.

**NMMRA and HSAG Response:**

NMMRA and HSAG have reviewed VONM’s request for reconsideration with the following decision: Although there is opportunity for improvement in specification language, the measures themselves do represent services provided as defined by the state, and therefore should not be subject to change based on a verbal agreement. HSAG was not informed that written performance measure specifications were to be replaced with any verbal agreement between VONM and HSD, thus, the auditors could not confirm VONM compliance with the HSD specifications that were provided to HSAG. After review of comments provided by VONM, this clarification does not affect the score.

**VONM Response:**

*Discrepancies between FY07 and FY08 Performance Measure Audit Results:* While the audit report’s description of the activities that took place during the on-site review is appreciated, from VONM’s perspective, many of these activities did not occur. This gap in perspective is particularly sharp as it relates to the on-site review of VONM’s Information Systems Capabilities Assessment (ISCA) and subsequent findings of ‘non-compliance’ for the Performance Measure Audit – Data Control. Last year, VONM submitted an ISCA nearly identical to that submitted for the current audit and NMMRA determined then that the ISCA was fully compliant and, in fact, scored it 100%. It is not clear why a previously 100% fully compliant ISCA is now deemed deficient and why the auditors did not address these issues while on-site. Furthermore, VONM was scored as fully compliant in all areas of the PM audit in FY07.

**NMMRA and HSAG Response:**

NMMRA and HSAG reviewed all documentation submitted, including the ISCA. HSAG’s on-site team members are Certified HEDIS® Compliance Auditors, and the method of review utilized was more in depth, with a greater technical focus, than the previous years’ audit. Performance measure validation activities identify areas for improvement from year to year, and assist with improving processes related to data reporting. There were no concerns with the prior data sources submitted, related to data security. During interview sessions, questions and clarifications on these items, if indicated, would have been discussed. The proprietary document provided on-site was voluminous, and the auditors had no reason to question security-related policies and procedures after reviewing other
related supporting documents regarding the Claims Processing System Diagram. The performance measure document with the step-by-step process for report generation, which VONM submitted, indicated that the performance measure in question was calculated using AIS data. Additionally, it should be noted that the ISCA document itself is not validated, and is not considered to be a finding as stated above in VONM’s response.

Although VONM scored fully compliant in the FY07 PM audit, it should be noted that the FY07 audit entailed a review of the processes related to performance measures. This year’s audit was a validation of performance measures conducted by HEDIS®-certified auditors. After review of comments provided by VONM, this clarification does not affect the score.

VONM Response:
VONM questions the statement that there was an overview of the ISCA and supporting documentation. The ISCA that VONM submitted included the following documents; these were not reviewed nor credited in the findings:

- Data Warehouse Backup Tables and Schedule
- Data Warehouse Tables
- ValueOptions Claims Processing System ERD Diagrams (please note that if this was reviewed it would have been very clear that the reports were claims based)
- Web Data Dictionary
- MIS flow chart
- Disaster Recovery Policies and Procedures IT201P (Disaster Recovery) Attachment which details the contents of the Disaster Recovery Plan, Attachment C which details the PC/LAN Support Recovery Team Contents Attachment D which details the Computer Operations Recovery Team Contents and policy IT203P (Records Storage, Maintenance, and Disposal)

Note: This is a proprietary and confidential plan. VONM informed the auditors that this document would be made available for review on-site. However, no request was made to review the document. The submitted ISCA included the other policies and procedures listed above.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision: HSAG reviewed the prior data sources submitted with the ISCA. There were no concerns with the documentation submitted, related to overall data security. The proprietary document provided on-site was voluminous, and the auditors had no reason to question security-related policies and procedures after reviewing other related supporting documents regarding the Claims Processing System Diagram. The performance measure document with the step-by-step process for report generation, which VONM also submitted, did indicate that the performance measure in question was calculated using AIS data. After review of comments provided by VONM, this clarification does not affect the score.

Overview of data integration and control procedures

VONM Response:
VONM disagrees that these activities were conducted during the on-site visit. Source code was provided on the day of the visit but was not reviewed. Primary source verification was minimal; a total of only 4 numerator positives were selected for all PMs. Documentation on back-up systems was provided as part of the ISCA documentation submitted previously, but was not
discussed during the on-site visit. Disaster recovery documentation, a proprietary document, was made available on-site but was not reviewed nor discussed by the auditors.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision: It is HSAG standard protocol to have their source code review team review the code. A thorough review was performed off-site, and findings were forwarded to NMMRA. Primary source verification involves review of data on members selected randomly by the auditor, from lists of numerator positive members for a given measure. This random selection assists in verification of data used to pull the cases into the measure, and its main purpose is to ensure that there was no chance for data to be prospectively altered by the client prior to this activity. HSAG followed its standard primary source verification process that is used for all audits (Performance Measure Validation, Pay for Performance, and HEDIS®) that HSAG performs. HSAG requested a list of numerator positive members for each of the performance measures. From this list of numerator positive members, HSAG then selected a random sample of members to conduct the primary source verification on; primary source verification is performed on a sample of numerator positive cases. This sample is representative of the entire numerator positive list, and the derivation of this sample is at the discretion of the auditor, not VONM. Any findings the auditors encounter can potentially be extrapolated, or applied, to the entire sample if a systematic error is found. Additionally, auditors did review the source code, because the binder was provided to HSAG on-site. It was noted that day, that it appeared as though codes not included in the specifications were used for the FUH measures, and this had been observed in other documentation submitted pre-on-site as well. This was verbally confirmed and discussed several times throughout the day. Auditors and interviewees discussed data security and back-ups, but did not go into a great deal of detail, or devote a lot of time to on-site document review, since the proprietary document was voluminous, and we had no reason to question policies/procedures after reviewing other supporting documents. After review of comments provided by VONM, the score remains unchanged.

Data Integration
VONM Response:
The processes listed above as part of the Data Integration assessment are not those listed in the Comments section on the PM Audit tool for data integration.
See also comments written above on p.7

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision: The broad category of data integration includes not only the items listed on the scoring tool, but also includes evaluation and comparison of all reports submitted for review. The variability in these data, as well as the finding that one of the performance measures included CPT and revenue codes not included in measure specification, are all taken into account in this area of the report, and the findings were not acceptable. After review of comments provided by VONM, the score remains unchanged.

Data Control
VONM Response:
VONM offered to the audit team the opportunity to view the Disaster Recovery plan, receive the data backup protocols, and all relevant policies and procedures. These were also included in
the ISCA, previously submitted to NMMRA. In fact, NMMRA reviewed the ISCA for FY07 and deemed it to be fully 100% compliant. The same ISCA was provided for this audit; no changes have been made over the past year. VONM believes that this is in full compliance. This audit report gives no rationale for the now non-compliant score. See also comments on page 7.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
The Data Control aspect was reviewed as a whole, including procedures for report generation derived from information systems. Data security is not the only element taken into consideration when assessing data control. There were concerns related to reports generated, and rates, which exhibited inexplicable fluctuations over several quarters. Additionally, a step-by-step documented procedure used for RTC report generation, which was requested on-site by auditors and provided post-on-site by VONM, was reviewed. The document specified that the measure would be pulled from data sources other than claims and encounter data, which is outside the measure specifications. This step-by-step document is crucial in demonstrating compliance with specifications, and maintaining consistency in processes in the event of staff vacancies. Because this documentation plays an integral part in the assessment of performance measure validity, and because the documentation was found to contain directives contrary to specification language, the reviewers found VONM’s data control processes were not acceptable. After review of comments provided by VONM, this score remains unchanged.

Performance Indicator Documentation
VONM Response:
The HSAG team believed that the RTC report was produced using authorization data – it was not. The report uses claims data only, which is clearly reflected in the report script. The analysis reflects authorization data as a secondary validation for use in the quality improvement process. Often the auth-based data is different from the claims-based data.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
There was no consistent evidence provided to the auditors that showed these data came from claims. The primary source verification activity confirmed the presence of a consumer in the numerator that did not get there from claims. Additionally, post-on-site, the step-by-step documentation requested for the calculation of this measure included AIS data. After review of comments provided by VONM, the score remains unchanged.

VONM Response:
HSAG believes that VONM did not follow HSD’s report specifications for the Ambulatory Follow Up Report. With regard to the specifications in the GM, VONM has regular communication and feedback from HSD regarding reporting directions and clarification. Although the GM is not clear on the services to be included, VONM received specific direction from HSD regarding the inclusion of all outpatient service codes in the ambulatory follow up measure. Had VONM generated reports using the revenue codes specified in the GM, it would have shown that no ambulatory follow up had occurred. Submission of a report using the specifications referenced in the GM would presumably have resulted in a directive from the State to resubmit with all appropriate outpatient service codes, regardless of GM specifications.

See also comments in next section.
HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
HSAG validates based on what is provided by the state based on written technical specifications, unless otherwise instructed. HSAG does not validate based on verbal agreements. The auditors agreed that written specification language could use clarification, but the validation focused on the performance measures reported against the written specifications currently in place. The scope of this audit was to validate the interpretation of the specifications, as well as how well the specifications were followed by VONM. The role of the auditor was to validate that the measures were being calculated and reported based on the specifications provided by HSD; ultimately, VONM was not able to provide the auditors with evidence of HSD-authorized, official changes to specification language. After review of comments provided by VONM, the score remains unchanged.

Residential Treatment Center (RTC) readmissions within 30 days of discharge
VONM Response:
Two reports were not generated – one document is a ‘report’ as required by HSD and generated in accordance with HSD specifications. The other document is an ‘analysis’. In the analysis, VONM describes how a second process of validation is conducted using authorization data and direct contact with providers to confirm discharge follow-up. This activity is part of the Quality Improvement process and is necessary given the problems with HSD specifications.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
The auditors observed that two reports for each of the performance measures were generated by VONM and sent to HSD. There were discrepancies in the rates in the reports that the auditors reviewed. The auditors were told on-site that the reports were run in two different ways and that one was more accurate than the other and reflected “truer” rates because of the source of data used to calculate the rates. The specifications for this measure stipulate that claims and encounter data should be used for calculating the rate, and although their analysis report may have been felt to contain more accurate rates for internal purposes, the rates within it were not pulled according to HSD specifications. After review of comments provided by VONM, the score remains unchanged.

VONM Response:
The required RTC report was not based on authorization (AIS) data – it was based on claims data. The analysis included additional information based on authorization data. The script for the required RTC report was provided to HSAG and clearly indicates that the report is pulled from the claims system. In addition the report programming code along with the data tables previously submitted to NMMRA clearly shows that this is a claims based report.

The auditor also indicates that numbers should go up not down over time. This is not true. The impact of the gap-in-service logic (3 days) as well as claims lag can combine to produce unexpected trends from one run date to the next. The findings imply that VONM substituted the auth-based data for the claims-based data; this is not true.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
The variability of some of the numbers and associated rates over time did not seem to support the logic that claims run-out and the application of the 3-day rule would otherwise explain. A standard claims lag period is usually 90 days (3 months after the date of service). At the end of a claims lag period, data should be fairly complete and result in more accurate rates. For the readmission measure, allowing a three-month claims lag should actually increase the likelihood of additional claims coming in with readmission data, which would cause the numeric counts to increase instead of decrease. Additionally, it was never explained on-site why the numerator positive case for the RTC measure was not found in the claims system. If the case had been pulled according to specifications, there would have been a claim associated with a hospitalization, and because it was not found, the case must have been pulled in as a numerator positive from another data source. After review of comments provided by VONM, the score remains unchanged.

VONM Response:
NMMRA did not request a list of enrollees included in the numerators prior to the on-site review. Once on-site, HSAG requested a list of only 10 numerator positives to use for validation process. VONM had to remind the auditors that they had not completed this portion of the audit near the end of the day of their visit. The validation process then consisted of a review of 2 numerator positives for RTC, one of which they believed could not be validated. VONM does not believe that a review of 2 numerator positives provides a true assessment of validity. Additionally, the CMS protocol requires completion of a validation worksheet; this was not made available to VONM.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision: The purpose of primary source verification is to validate the source code used to calculate the measures. Standard protocol used by HSAG for primary source verification includes requesting a list of numerator positive cases and pulling a sample, or subset, of cases to track back to the primary source of data. Individuals present in the room during primary source verification could not and did not dispute the fact that there was no claims data in the system for the member in question. It could not have been pulled to the numerator otherwise. After review of comments provided by VONM, the score remains unchanged.

Discharge follow up with in 7 days
VONM Response:
Contrary to the statement above, VONM does not validate ambulatory follow-up measures using authorization data. Both the analysis and the report submitted to HSD use claims data to determine ambulatory follow up. Given that VONM doesn’t authorize most outpatient services, it would not even be possible to use authorization (AIS) data to measure this. With regard to the specifications in the GM, VONM has regular communication and feedback from HSD regarding reporting clarification. Although the GM is ambiguous as to which service codes are to be counted as ambulatory follow-up, VONM received specific direction from HSD to include all outpatient service codes in the ambulatory follow up measure. Had VONM generated reports using only the revenue codes specified in the GM, the report would inaccurately show that no ambulatory follow up had occurred. VONM has acted responsibly to provide HSD with a report that meets their intent although this contradicts HSD’s written instruction.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
On-site discussions revealed that VONM used additional codes to pull follow-up visits, which were not included in HSD’s specifications (the codes appeared to mirror codes included in the HEDIS® FUH measure). The HSD specifications reads as follows: “Ambulatory follow-up encounters are identified by the following codes: UB-92 Revenue Codes: 513, 900, 901, 909-916, 961 (all follow-up visits must be with a mental health practitioner; the MCO does not need to determine practitioner type for follow-up visits identified through UB-92 Revenue codes)”. The deviation from HSD specification was confirmed by the auditors’ review of VONM’s source code, both on-site and post-on-site, which included the following codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 99405, 9006, 9007, 905, 906, and 907. It was noted that VONM’s rationale for their modification to codes in the specification; to obtain an exact number of follow-up visits, these codes were added. The HSD specifications had included facility-based revenue codes. Auditors were not informed that the SE was given verbal permission by HSD to use other codes and there was nothing in writing to support the additional codes. The auditors agreed that written specification language could use clarification, but the validation focused on the performance measures reported against the written specifications currently in place. The role of the auditor was to validate that the performance measures were calculated and reported based on the specifications provided by HSD. VONM was not able to provide the auditors with evidence of HSD-authorized official changes to specification language.

It was noted during the closing that the specifications did not have the codes in question. This was presented as a recommendation for VONM and HSD to work together to correct. After review of comments provided by VONM, the score remains unchanged.

**VONM Response:**
NMMRA and HSAG requested a report that reflected end of the year FY07 data. They did not indicate that they wished to review a report with a specific run date that would show refreshed data. VONM provided the report as requested.

**HSAG Response:**
HSAG has reviewed VONM’s request for reconsideration with the following decision: We requested final rates for performance measures during our closing summation and were requested post-on-site. VONM’s submitted the final rates for the RTC measure with appropriate run date according specifications. However, those numbers matched exactly the supplemental report using AIS data. The 7 and 30 follow-up had a run date of July 13, 2007, which was two weeks after the fiscal year. According to the specifications to reflect an accurate rate the fiscal year end report should have been submitted 120 days after the end of the fiscal year to capture claims lag data. After review of comments provided by VONM, the score remains unchanged.

**VONM Response:**
In fact, the one numerator positive that was reviewed was found by the auditors to be valid. But, as with the RTC readmissions report, only 10 numerator positives were requested on-site and only 1 was selected for validation.
HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
More than one numerator positive case was selected for validation. HSAG followed its standard primary source verification process that is used for all audits (Performance Measure Validation, Pay for Performance, and HEDIS®) that HSAG performs. HSAG requested a list of numerator positive members for each performance measure. From this list of numerator positive members HSAG then selected a random sample of members to conduct the primary source verification on; primary source verification is performed on a sample of numerator positive cases. This sample is representative of the entire numerator positive list, and the derivation of this sample is at the discretion of the auditor, not the entity. Any findings the auditors encounter can potentially be extrapolated, or applied, to the entire sample if a systematic error is found. Primary source verification is an additional method the auditors use to check compliance with specifications. The purpose of primary source verification is to validate the source code used to calculate the measures. The review of the source code used to calculate this measure revealed that VONM had included service codes within its programming language not included in HSD specifications. Therefore, the SE reported rates, were generated outside of HSD specifications, the rates for the FUH measure were found to be invalid.
After review of comments provided by VONM, the score remains unchanged.

Discharge follow up within 30 days
VONM Response:
See response to above

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
Auditors were not informed that the SE was verbally given permission by HSD to use other codes; more importantly, there was nothing in writing to support this, and the validation was based on specification language for each performance measure. It was noted during the closing that the specifications did not have the codes in question. This was presented as a recommendation for VONM and HSD to work together on to correct. After review of comments provided by VONM, the score remains unchanged.

VONM Response: See response to above

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision:
We requested final rates for performance measures during our closing summation and they were requested again post-on-site. VONM’s submitted the final rates for the RTC measure with appropriate run date according specifications. However, those numbers matched exactly the supplemental report using AIS data. The 7 and 30 follow-up had a run date of July 13, 2007, which was two weeks after the fiscal year. According to the specifications to reflect an accurate rate the fiscal year end report should have been submitted 120 days after the end of the fiscal year to capture claims lag data. After review of comments provided by VONM, the score remains unchanged.

VONM Response:
As with the RTC readmissions report, only 10 numerator positives were requested on-site, and only 1 was selected for validation. The HSAG auditors perceived it to be invalid because the
claim that was counted was denied. However, VONM includes denied claims in this measure as per HSD instruction. HSD instruction says that even denied outpatient claims are considered valid measures of ambulatory follow-up. VONM followed the report specifications.

HSAG Response:
HSAG has reviewed VONM’s request for reconsideration with the following decision: HSAG did not identify any non-compliant cases for the FUH measure during primary source verification. HSAG followed HSD specifications for interpretation and review of this measure during primary source verification. The non-compliant case HSAG found during primary source verification was for the RTC measure, not the FUH measure. This non-compliant case for the RTC measure did not have an associated claim within VONM’s claims system, and this finding was discussed on-site and during the closing conference. After review of comments provided by VONM, the score remains unchanged.
Conclusion

Based on NMMRA’s compliance review of CMS requirements, evidence acquired during the scope of this audit, interpretive guidelines and the scoring methodology approved by HSD, NMMRA finds VONM earned the following designation for the standards and contractual requirements examined:

- Validation of Performance Measurement Program – Non-Compliance
  - PM #1 – Residential Treatment Center (RTC) readmissions within 30 days to same level of care or higher
  - PM #2 – Psychiatric hospital discharge follow-up within 7 days
  - PM #3 – Psychiatric hospital discharge follow-up within 30 days

- Performance Improvement Projects – Non-Compliance
  - PIP #1 – Improving follow-up for residential treatment clinical denials among consumers under 21 years of age and identified as ISHCN through automatic referral to specialized care coordination
  - PIP #2 – Improving Turn Around Times for UM Decision Making through Authorization Process Change the scoring methodology approved by HSD requires

VONM earned a Non-Compliance designation for the PM and both PIPs. A corrective action plan based on these audit findings is recommended.

The following report details the findings and recommendations for VONM and HSD.