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Executive Summary

The New Mexico (NM) Human Services Department (HSD) has contracted with the New Mexico Medical Review Association (NMMRA) as the New Mexico external quality review organization (EQRO) to conduct monitoring, auditing, and surveying activities regarding the performance of the contracted organizations and to provide HSD with valid and reliable information and data. HSD issued Letter of Direction (LOD) # 09-12 on December 18, 2008, to NMMRA to conduct an audit for the Individual Evaluation of the Behavioral Health (BH) single statewide entity (SE), ValueOptions of New Mexico (VONM) for the first two quarters of fiscal year (FY) 2009 (July 1, 2008 through December 31, 2008). The scope of work addressed all appropriate Medical Assistance Division (MAD) regulations, and was performed in accordance with NMMRA’s EQRO contract, Scope of Work 1.4.

The objectives of this report are to measure and score the performance of VONM against the quality standards in state regulations (HSD Managed Care Regulations 8.305.2 through 8.305.16), as well as other managed care standards not specific to the quality standards, and to make recommendations for improvement in the quality of BH services provided to consumers. NMMRA was directed by HSD to review the Managed Care processes and evaluate evidence that VONM is following its own established policies and procedures. This report describes how NMMRA completed the audit and scored VONM’s performance. Data were analyzed in aggregate, and in detail, to determine compliance with each section of review. The methodologies used to audit the completeness of documentation and measure compliance with the required standards and opportunities for improvement are described. Comparisons from previous compliance audits conducted by NMMRA are included.

Based on NMMRA’s compliance review of MAD regulations, documentation acquired during the scope of this audit, key personnel interviews, and the scoring criteria approved by HSD, NMMRA finds VONM earned an aggregate designation of Full Compliance (97.20%) for the MAD standards examined.

- 8.305.2. Member Education – Full Compliance (97.50%)
- 8.305.6. Provider Networks – Full Compliance (92.50%)
- 8.305.8.12. Quality Management – Full Compliance (96.00%)
- 8.305.8.13. Utilization Management – Full Compliance (98.66%)
- 8.305.8.14. Credentialing and Recredentialing – Full Compliance (92.85%)
- 8.305.8.15. Member Bill of Rights – Full Compliance (100%)
- 8.305.8.17. Standards for Medical Records – Full Compliance (95.90%)
- 8.305.8.18. Standards for Access – 3 of the four elements were Complaint
- 8.305.9. Coordination of Services – Full Compliance (91.60%)
- 8.305.10. Encounters – Full Compliance (100%)
- 8.305.11. Reimbursement for Managed Care – Full Compliance (100%)
- 8.305.12. Member Grievance System – Full Compliance (99.86%)
- 8.305.13. Fraud and Abuse – 2 of the two elements were Compliant
- 8.305.14. Reporting Requirements – Full Compliance (100%)
- 8.305.15. Services for Individuals with Special Health Care Needs (ISHCN) – Full Compliance (99.13%)
- 8.305.16. Client Transition of Care – Full Compliance (97.80%)

NMMRA developed an audit compliance score to determine timeliness and accuracy of documents submitted for each regulation element. This was the first audit this type of scoring
was used to track and trend any issues with submitting requested documents, clarification documents, closing documents and file review documents. NMMRA used a numerical system was used to arrive at a score for each regulation, and determined an overall score for the SE’s compliance with the audit process compliance was determined.

- 58 out of sixty points – Full Compliance (96.66%)

The SE has improved and further developed processes from previous audits; however, there remain opportunities for improvement. The scoring criteria approved by HSD requires that any single MAD regulation receiving a Minimal Compliance or Non-compliance designation be placed into corrective action. Based on this requirement, NMMRA informs HSD that there are no recommendations for corrective action based on these audit findings.
Background

In July 2005, HSD, along with multiple state agencies, implemented the first phase of its behavioral healthcare system transformation. This restructuring created one SE for BH services to serve as the single entity providing coordination, planning, administration and monitoring of all aspects of the NM BH managed care system. The contract, a prepaid capitation agreement, was awarded to VONM. VONM collaborated with the Behavioral Health Purchasing Collaborative and, in turn, contracted with community-based and independent providers to administer services throughout the state. As a requirement of its SE contract, VONM is required to comply with the New Mexico Medicaid managed care regulations.

NMMRA conducted a compliance audit of BH for the first two quarters of FY 2009 (July 1, 2008, through December 31, 2008). This is the fourth consecutive BH Compliance Audit that NMMRA has been directed to conduct and comparative results will follow within this report.

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 identify areas requiring further investigation. The audit and scoring criteria addressed a subset of New Mexico Administrative Code (NMAC) 8.305 regulations, specifically:

- 8.305.2. Member Education
- 8.305.6. Provider Networks
- 8.305.8.13. Utilization Management
- 8.305.8.15. Member Bill of Rights
- 8.305.8.17. Standards for Medical Records
- 8.305.8.18. Standards for Access
- 8.305.9. Coordination of Services
- 8.305.10. Encounters
- 8.305.11. Reimbursement for Managed Care
- 8.305.12. Member Grievance System
- 8.305.13. Fraud and Abuse
- 8.305.14. Reporting Requirements
- 8.305.15. Services for Individuals with Special Health Care Needs (ISHCN)
- 8.305.16. Client Transition of Care

The scoring criteria were developed using these regulations and Centers for Medicare & Medicaid Services (CMS) protocol for assessing a managed care organization’s performance. The final methodology consisted of the following sections:

- Rationale (understanding of the regulations and LOD specifications)
- Evidence required (documentation and case review)
- Data collection tools
- Scoring criteria
Audit Tools

The BH Compliance Audit Tools were developed using the same regulations as related to the LOD requirements for the audit. The audit tools were tested to ensure reliability and validity and were approved by HSD prior to implementation.

Universe Specifications

NMMRA provided VONM the universe specifications on January 22, 2009 at the audit overview meeting. The deadline for submittal of the universe data was on February 11, 2009. The following is a list of New Mexico MAD regulations requiring chart review:

If a universe has less than the required 15 to 30 cases, NMMRA reviewed 100 percent of the universe submitted.

8.305.8.13. UTILIZATION MANAGEMENT

The representative samples for utilization management (UM) were drawn from approvals and denials during the audit period.

The universe specification consisted of a list of all consumer approvals during the period from July 1, 2008, through December 31, 2008.

The universe specifications were identical to the HSD 2 Behavioral Health Detailed Denial Report. Reports for the months July 1, 2008, to December 31, 2008, were combined to form the universe for this standard.

A random stratified sample was selected from the universe consisting of 30 consumer approvals with a 10-record over sample.

A random stratified sample was selected from the universe consisting of 30 consumer denials with a 10-record over sample.

8.305.9. COORDINATION OF SERVICES

The universe specification consisted of a list of open and closed mixed services, behavioral health/physical health (BH/PH), care coordination files during the period of July 1, 2008, through December 31, 2008.

A random stratified sample was selected from the universe consisting of 30 open or closed mixed services BH/PH care coordination files with a 10-record over sample.

8.305.12. MCO MEMBER GRIEVANCE SYSTEM

The universe specification was identical to report #2 and #3, “Grievance, Appeals and Fair Hearings Report.” Reports for the months July 1, 2008, to December 31, 2008, were combined to form the universe for this standard.

A random stratified sample was selected from the universe consisting of 30 consumer grievance files with an over sample of 10.

A random stratified sample was selected from the universe consisting of 15 provider grievance files with an over sample of five.
A random stratified sample was selected from the universe consisting of 30 consumer appeal files with an over sample of 10.

A random stratified sample was selected from the universe consisting of 15 provider appeal files with an over sample of five.

A random stratified sample was selected from the universe consisting of 30 consumer expedited appeal files with an over sample of 10.

8.305.15. SERVICES FOR ISHCN
The universe specification consisted of a list of open and closed ISHCN care coordination files during the period from July 1, 2008, through December 31, 2008.

A random stratified sample was selected from the universe consisting of 30 open or closed ISHCN care coordination files with a 10-record over sample.

8.305.16. CLIENT TRANSITION OF CARE
The universe specification consisted of a list of open and closed Transition of Care coordination files during the period from July 1, 2008, through December 31, 2008.

A random stratified sample was selected from the universe consisting of 30 open or closed Transition of Care coordination files with a 10-record over sample.

8.305.8.17. STANDARDS FOR MEDICAL RECORDS
The universe specification consisted of a list of all consumers having at least one encounter with any BH provider during the period from July 1, 2008, through December 31, 2008.

A random stratified sample was selected from the universe consisting of 30 consumer records with a 10-record over sample. If VONM was unable to obtain a record from one of the listed providers, it was to select a record from the over sample.

Audit Overview

On January 22, 2009, NMMRA conducted an audit overview meeting with representatives from VONM and HSD. The meeting provided an opportunity to review the audit scope, audit timeline, audit tools, regulations, and the prior data source documentation lists. In order to perform the medical record and file reviews for the audit, NMMRA provided, in writing at the close of the meeting, the information for the universe selection and the documentation required. VONM was required to submit requested data sources within 20 business days. The deadline for submittal was February 20, 2009.

Prior to the on-site visit, NMMRA examiners reviewed the requested prior data source documents to expedite the on-site process and encourage communication between NMMRA and VONM. On March 9, 2009, NMMRA requested additional documents based on the review of the prior data source documents submitted. These were due to NMMRA on March 17, 2009, and were submitted on timely.
On-site Meeting

NMMRA conducted an opening conference with key personnel at VONM on March 23, 2009. HSD staff was present via telephone. The audit team was introduced, audit goals were distributed and discussed, the audit process and scope were described and the timetable for completion of the audit was identified. VONM received a detailed site-visit agenda at the opening conference. Following NMAC Standards and NMMRA’s BH Audit Tools, NMMRA examiners collected detailed information to assess VONM’s compliance with the defined standards.

The records selected were a representative sample of universes submitted by VONM for file review. All file review records that did not score 100 percent were discussed on-site with VONM’s staff to ensure all documentation was made available to NMMRA examiners and to obtain clarification on incomplete cases. One exception to this process was the review of the medical records files as the NMMRA examiner and VONM staff held a telephone conference to review the file on Monday, April 6, 2009.

At the conclusion of the on-site visit, NMMRA presented its preliminary findings, provided feedback, and answered questions. At NMMRA’s request, VONM’s attendees completed an event evaluation. The evaluation was based on a five-point scale, with five being the highest and one the lowest rating. The aggregate average score was 4.58, indicating well-above average satisfaction with the audit.

Scoring Criteria

This section explains the numerical system used to arrive at a score for each standard, each category, and an overall score for the SE’s performance. Additionally, NMMRA implemented a component of this audit that will indicate VONM’s compliance with the audit process.

Allocation of Points:
Each regulation category was assigned a specific number of points based on the number of operational tasks defined in the MAD regulations, as summarized in Table 1. The maximum number of points the SE could achieve was 144.

Additionally, if a universe fell below the sample size threshold, a penalty was deducted from the file review score.

Table 1: Allocation of Points

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Standard</th>
<th>Available Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.2</td>
<td>Member Education</td>
<td>10</td>
</tr>
<tr>
<td>8.305.6</td>
<td>Provider Networks</td>
<td>10</td>
</tr>
<tr>
<td>8.305.8.12</td>
<td>Standards for Quality Management and Improvement</td>
<td>10</td>
</tr>
<tr>
<td>8.305.8.13</td>
<td>Utilization Management</td>
<td>15</td>
</tr>
<tr>
<td>8.305.8.14</td>
<td>Credentialing and Recredentialing</td>
<td>7</td>
</tr>
<tr>
<td>8.305.8.15</td>
<td>Member Bill of Rights</td>
<td>5</td>
</tr>
<tr>
<td>8.305.8.17</td>
<td>Standards for Medical Records</td>
<td>10</td>
</tr>
<tr>
<td>8.305.8.18</td>
<td>Standards for Access</td>
<td>Compliant/Non-compliant*</td>
</tr>
<tr>
<td>8.305.9</td>
<td>Coordination of Services</td>
<td>15</td>
</tr>
</tbody>
</table>
Calculation of Final Overall Score

The final overall score was calculated by summing the points earned from file review and points earned from document review. The overall points earned were then calculated as a percentage and presented as a final overall score.

As approved by HSD, each element on the audit tool is an “all or nothing” designation. Therefore, if the element consists of five components, all components must be present to receive the “all” designation or “Full Compliance.”

Audit Process Compliance

A numerical system is used to arrive at a score for each regulation and an overall score for the SE’s audit process compliance.

The audit process compliance is determined by the timeliness and accuracy of documents submitted for each regulation element. Each regulation is assigned a specific number of points. These points are then distributed within each category as summarized below. The total number of points the SE could achieve is 60 displayed in Table 2.

Timeliness and accuracy violations per regulation for requested documents, clarification documents, closing documents and file review documents receive no more than a one-point deduction. If necessary, a request for an extension submitted to NMMRA from VONM would be discussed with HSD. If an extension was approved by HSD, VONM would not be penalized for timeliness.

Table 2: Allocation of Points

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Standard</th>
<th>Available Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.10.</td>
<td>Encounters</td>
<td>10</td>
</tr>
<tr>
<td>8.305.11.</td>
<td>Reimbursement for Managed Care</td>
<td>7</td>
</tr>
<tr>
<td>8.305.12.</td>
<td>Member Grievance System</td>
<td>15</td>
</tr>
<tr>
<td>8.305.13.</td>
<td>Fraud and Abuse Compliant/Non-compliant*</td>
<td>10</td>
</tr>
<tr>
<td>8.305.14.</td>
<td>Reporting Requirements</td>
<td>10</td>
</tr>
<tr>
<td>8.305.15.</td>
<td>Services for ISHCN</td>
<td>15</td>
</tr>
<tr>
<td>8.305.16.</td>
<td>Client Transition of Care</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td><strong>144</strong></td>
</tr>
</tbody>
</table>

*Note: As directed by HSD, processes for Standards for Access and Fraud and Abuse were evaluated and each element of the regulation was scored compliant or non-compliant
### Levels of Performance

The level of performance is determined by the earned score. Table 3 displays a list of the performance levels and their corresponding score ranges and descriptions for both the regulation and audit compliance scores:

**Table 3: Levels of Performance**

<table>
<thead>
<tr>
<th>Performance Levels</th>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90% – 100%</td>
<td>SE met or exceeded regulation requirements</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80% – 89%</td>
<td>SE met most requirements of the regulation but may be deficient in a few areas</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50% – 79%</td>
<td>SE met some requirements of the regulation, but has significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>&lt; 50%</td>
<td>SE did not meet requirements of the regulation and has significant deficiencies requiring mandatory corrective action</td>
</tr>
</tbody>
</table>

*Ten of the 16 regulation reviewed did not include file review; therefore, universe submission and chart preparation were not applicable.*

### Inter-rater Reliability (IRR)

Examiner IRR was maintained through the assignment of audit responsibility to specific examiners, the use of standardized data collection tools, the use of common audit resources, ongoing communication, and coordination among the audit team. NMMRA’s EQRO program director reviewed all audit tools and scoring tables to ensure consistency across examiners, and
internal logic and reasonability. NMMRA examiners also conducted peer review of each data collection tool to ensure consistency in assigning designation, scoring and language. Ensuring the data accuracy, integrity of the audit and completeness of information is accomplished in the data validation task of the IRR process. Data validation detects issues with analytical procedures, quality control results and confirms that the needs of HSD audit instructions are met.

Findings and Recommendations

The data collected from VONM, either pre-on-site or during the on-site visit, were the principal information source considered in determining VONM’s compliance with NMAC and CMS standards. This section presents descriptive findings and overall compliance findings as reported in the audit tools, relating to the MAD regulations.

This section indicates a composite score for each regulation, which includes file review and document review. The compliant and non-compliant headings indicate compliance with the document review. Therefore, the composite score is calculated by including the points earned from file review and points earned from document review. The overall points earned are then presented as a percentage as indicated in the composite score heading. The actual audit tools and file review scores are included in the Appendices.

The recommendations from this audit are aimed at facilitating the continuous quality improvement (CQI) of the BH services managed by VONM. Full compliance for each standard is both the goal and the expectation. The standards are clearly delineated by HSD. This section also presents NMMRA’s suggestions for recommended follow-up of activities by HSD and VONM.

8.305.2. MEMBER EDUCATION

The SE shall educate Medicaid consumers about their rights, responsibilities, service availability and administrative roles under the managed care program. The SE is responsible for providing each consumer with a consumer handbook and provider directory within 30 days of enrollment. The SE shall follow the guidelines provided by MAD for the information to be in the consumer handbook and provider directory.

The SE shall have a policy and procedure governing the development and distribution of educational materials for consumers. The SE shall have a policy and procedure regarding the utilization of information on race, ethnicity, and the primary language spoken by its membership. The SE shall have documentation of health education programs available to consumers.

Composite Score: 97.50%
Performance Level: Full Compliance

Compliant
- SE demonstrated that the Consumer Handbook has the components required by MAD regulations
- SE ensured the Consumer Handbook was available in Spanish
- SE evaluated membership to determine prevalent population based on policies and procedures and performs a population analysis report
- SE developed a provider directory which is available for viewing on the VONM Web site and can be obtained by hard copy format
- SE has established policies and procedures governing the development and distribution of educational materials for consumers.
- SE provided a documented process to ensure BH information is distributed to consumers or to ensure a consumer handbook and provider directory are distributed within 30 days of enrollment.
- SE has established policies and procedures regarding the utilization of information on race, ethnicity and the primary language spoken by its membership.
- SE maintains toll-free telephone lines according to specified MAD regulations as evidenced by an afterhours protocol and policies and procedures.

Non-Compliant
- SE did not demonstrate it provides a description of mandatory benefits in informational materials such as the consumer handbook.

Recommendations
- SE shall ensure that a description of mandatory benefits is included in informational materials such as the consumer handbook and is provided to consumers.
- SE shall ensure it has the two documents provided to meet the regulation that the SE maintains toll-free lines according to specified MAD regulations as evidenced by an afterhours protocol and that policies and procedures are formalized and the origin of the document is indicated.

8.305.6. PROVIDER NETWORKS
The SE shall contract with a number of providers sufficient to maintain access for all consumers. Evidence of written documentation shall describe to consumers and providers instructions on how to access various services. A formal process shall be documented to ensure that referrals for all medically necessary services are available to consumers as well as take into consideration the characteristics and health care needs of its individual Medicaid populations.

In accordance with MAD regulations, the SE shall maintain policies and procedures on provider recruitment and termination of provider participation with the SE. Each contracted network provider must comply with the Health Insurance Portability and Accountability Act (HIPAA). All contracted or subcontracted providers must meet applicable federal and state requirements for licensing, certification, accreditation and recredentialing. The SE is responsible for the development and distribution of education and informational materials regarding managed care, including BH, to its network providers. The SE shall demonstrate evidence of active solicitation of input from network providers to improve and resolve issues with the SE.

Composite Score: 92.50%
Performance Level: Full Compliance

Compliant
- SE maintains a report which contains information regarding the numbers of network providers not accepting new Medicaid consumers.
- SE has established a policy and procedure for recruitment, a network roster and provider directory that are consistent with MAD regulations.
- SE maintains its provider network and updates changes to the network regularly as evidenced by a documented process in the Letter of Direction #8 Transition Plans and an example of a change in the network.
- SE has established policies and procedures on provider recruitment and termination.
• SE maintains a list of contracted, subcontracted and terminated BH providers for both mental health and substance abuse as evidenced by a network roster and provider directory
• SE submits a report to HSD on a regular basis, as determined by HSD, and includes a clear delineation of all additions and terminations that have occurred since the last submission as evidenced by submission of the CI-5 Net Ops report
• SE verifies that contracted and subcontracted providers meet applicable federal and state requirements for licensing, certification, accreditation and credentialing as evidenced by credentialing and recredentialing policy and procedures which verify primary source verification at the time of credentialing and recredentialing
• SE maintains policies and procedures describing how consumers and providers receive instructions on access to services
• SE ensured policies and procedures are available in an accessible format, upon request from HSD, network providers and consumers
• SE contracted with federally qualified health centers (FQHCs), school-based clinics, state-run institutions, Indian Health Services (IHS) and Healthcare for the Homeless as evidenced by the submission of the execution page of the contracts
• SE actively solicits providers in an effort to improve and resolve problem areas and incorporates their input into the SE’s quality improvement program as evidenced by the submission of Quality Management Committee and Clinical Advisory Committee meeting minutes
• SE has established policies and procedures governing the development and distribution of educational and informational material to its network providers regarding BH care to include the following:
  – Conditions of participation
  – ISHCN care and other populations
  – Cultural competency
  – Ongoing educational opportunities for providers and their staff on cultural competency
• SE ensured that the provider education training schedule is available to HSD and was able to provide evidence as requested

Non-Compliant
• SE did not comply with all access standards delineated under the Medicaid managed care contract in relation to geographic location, scheduling time and waiting times as evidenced by submission of two quarters of the New Mexico GEO Access Report that identified areas that did not meet performance standards
• SE did not provide evidence of how it incorporates provider satisfaction survey results into the SE’s quality improvement program as evidenced by submission of the 2007 Provider Survey Results and Quality Management Committee meeting minutes which did not demonstrate incorporation of provider satisfaction survey results in the quality improvement program

Recommendations
• SE shall continue to implement interventions to ensure access in the areas in which performance standards were not met
• SE shall incorporate provider satisfaction survey results into the SE’s quality improvement program
8.305.8.12. STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT

Quality management (QM) incorporates a method that links knowledge, structure and processes together throughout the SE’s system to assess and improve quality. The goal is to improve the quality of clinical care and services provided to consumers in the areas of health care delivery as well as supportive administrative systems. The SE’s QM and quality improvement structures and processes shall be at least as stringent as federal requirements. The Quality Improvement (QI) program for the SE shall be reviewed and approved annually.

The QI Committee shall evaluate the results of all quality improvement activities. The SE’s QI/QM activities shall demonstrate how QI projects are compared to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from certain technical requirements in the SE contract and the annual New Mexico Behavioral Health Purchasing Collaborative Consumer Satisfaction Survey, (in lieu of the Mental Health Statistics Improvement Program (MHSIP) survey (SE only), consumer and provider surveys, as well as any findings identified by HSD.

The SE shall ensure that recommended practice guidelines are distributed to network providers and involve those providers in developing and adopting these guidelines. Decisions made utilizing these guidelines shall be applied to utilization management, consumer education and interpretation of covered benefits.

Composite Score: 96.00%
Performance Level: Full Compliance

Compliant

- SE’s QI program structure included all regulation standards and sub-standards as evidenced by Quality Management Program (QMP), Quality Management Work Plan and Quality Management Program Evaluation
- SE has established policies and procedures to complete the annual QI plan; SE’s annual QI plan addressed all required regulation standards and sub-standards
- SE has an established QI committee, and all regulation standards and sub-standards for the QI committee are being met as evidenced by submission of the QMP
- SE participated, with the BH Collaborative, in conducting an annual consumer satisfaction survey as evidenced by submission of the FY 2008 Consumer Satisfaction Project Report
- SE evaluated consumer grievance and appeals trends as evidenced by submission of the CI-02 Complaints and Grievances Report and CI-03 Appeals reports
- SE used input from a consumer advisory board to identify opportunities for improvement as evidenced by submission of QM Committee Meeting Minutes
- SE has established policies and procedures for:
  - Coordinating care between the managed care organizations (MCOs); proactively identifying consumers with chronic behavioral health conditions
  - Proactively identifying the number of adult severe disabled mentally ill (SDMI), severe emotionally, behaviorally and neurologically disturbed children (SED) and chronic substance abuse (CSA)
  - Reporting adverse events involving SDMI, SED, CSA, and co-occurring mental health and substance abuse consumers proactively
  - Identifying ISHCN
  - Informing and educating providers about using the health management programs for the consumers
– Participating with providers to reduce inappropriate use of psychopharmacological medications and adverse drug reactions
– Periodically updating providers regarding best practices and on the procedures for appropriate health care referral

SE demonstrated its health management system including all regulation standards and sub-standards related to continuity of care for consumers as evidenced by submission of policies and procedures

SE disseminated clinical practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic BH services as evidenced by a policy and procedure

SE annually measured practitioner performance against at least two important aspects of three clinical practice guidelines and determines consistency of decision-making as evidenced by submission of the HSD 23 BH Specific Clinical Measures Report and Analysis, Clinical Guidelines Adherence Indicators and Antidepressant and Schizophrenia Medication Reports

SE implemented the targeted disease management program as defined by HSD related to depression

SE implemented appropriate corrective interventions when it identified under utilization and over utilization as evidenced by Utilization Management Program Description, Encounter reports, Provider Profiling reports and policies and procedures, to name a few of the documents submitted to meet this regulation

Non-Compliant

SE did not demonstrate implemented interventions to improve its performance of consumer satisfaction. VONM provided slides from the Quality Improvement Project: Psychotropics in Children presentation that was dated November 20, 2008 and presented to the Purchasing Collaborative; however, this documentation does not demonstrate implemented interventions.

SE did not demonstrate that SE consumers were informed of results of consumer satisfaction activities. VONM provided meeting minutes and submitted a quality improvement project; however, this documentation does not demonstrate how consumers are informed of consumer satisfaction activities.

Recommendations

SE shall implement interventions to improve performance and measure the effectiveness of the interventions for consumer satisfaction

SE shall inform and document how SE consumers are informed of results of consumer satisfaction activities

8.305.8.13. UTILIZATION MANAGEMENT

A written program description defines and clarifies the structure and function of the UM program. The description articulates the scope and content of the program, the roles and responsibilities of the individuals involved, and the way the program was evaluated. The scope of the UM program will include preauthorization, concurrent review and retrospective review. The program’s goals are to ensure that consumers have equitable access to care across the network.

The SE must be able to demonstrate to consumers and practitioners that UM decisions are made in a fair, impartial and consistent manner that serves the best interest of the consumers. The UM program uses qualified health professionals whose education, training and experience are commensurate with the UM review process. Furthermore, the SE conducts UM in a timely
manner to minimize any disruption in the provision of health care. The SE is accountable for UM decisions. When the SE denies coverage of service, the denial determination shall be stated in clear understandable language with the reasons for the denial.

In addition, professionals with expertise related to the technology under review participate in the evaluation of each new technology and the creation of criteria for its application.

Composite Score: 98.66%
Performance Level: Full Compliance

**File Review Findings for Utilization Management**

Thirty (30) consumer files for approved services were reviewed and the following findings were noted and addressed in recommendations:
- 1 of the thirty cases did not meet the timeliness standard for making the decision
- 2 of the thirty cases did not cite the criteria used to make the decision

Thirty (30) consumer files for denials were reviewed and the following findings were noted and addressed in recommendations:
- 5 of the thirty cases did not meet the timeliness standard for making the decision

**Compliant**
- SE UM Program Description (UMPD) contained goals related to the immediate and long-term objectives for the contract year
- SE demonstrated physician involvement as evidenced by submission of the UMPD
- UM subcommittee documented aspects of the UM functions in the annual UM evaluation
- SE demonstrated that it documents evaluation and annual approval of the UM Program by senior management, the behavioral health director or the QI committee
- SE has established a policy and procedure for monitoring inter-rater reliability, however does not follow up on staff identified as not meeting 90 percent agreement on test cases
- SE maintains evidence that it has reviewed the UM decision criteria at specified intervals and that the criteria have been updated, as necessary
- SE provided utilization decision and notification in a timely manner that accommodates the clinical urgency of the situation
- SE provided documentation to support the policy and procedure for decision criteria availability to providers upon request
- SE demonstrated that the UM policy and procedures were consistent with MAD regulations in relation to decision criteria
- SE has established the policy and procedure that describes how new technology is included in the benefit package
- SE demonstrated that the UM policies and procedures define for providers what constitutes relevant clinical information
- SE provided evaluation of consumer and provider satisfaction with the UM process as part of its consumer satisfaction survey

**Non-Compliant**
- No non-compliant findings

**Recommendations**
- SE shall ensure inter-rater reliability trends are included in a formal report that is reported to a organizational committee and provide aggregate and individual detail
- SE shall revise the UMPD Appendices to include the revision of Attachment C Clinical Criteria to Level of Care Guidelines
▪ SE shall revise approval letters to ensure clarity and consistency of citing Residential Treatment Center – Child
▪ SE shall ensure compliance with timeliness standards for making a determination for approved and denied services
▪ SE shall ensure appropriate criteria citations when approving or denying services

8.305.8.14. CREDENTIALING AND REREDENTIALING
Practitioner participation and involvement is an important function of the relationship of the SE and its network providers. The SE shall have a process that allows feedback from providers regarding the process of applying to become a contracted provider.

Prior to becoming a network provider, the SE shall perform an initial visit to the offices of potential high-volume behavioral health care practitioners. The SE shall determine the method for identifying high volume behavioral health practitioners.

The SE shall have formalized recredentialing procedures, which include recredentialing its providers every three years. The SE shall verify that each provider meets applicable federal and state licensing, certification and accreditation regulations.

The SE shall confirm, at least every three years, that the provider is in good standing with state and federal regulatory bodies, including HSD and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the SE. The SE shall have an initial and ongoing process to assess providers with whom it intends to contract or with whom it is already contracted.

Composite Score: 92.85%
Performance Level: Full Compliance

Compliant
▪ SE provided the mechanism for credentialing and recredentialing of providers
▪ SE provided an established process for receiving provider input regarding credentialing and recredentialing as evidenced by the submission of National VO Credentialing Committee Meeting Minutes
▪ SE performed primary source verification at the time of credentialing a provider as evidenced by a policy and procedure
▪ SE used the HSD approved credentialing form as evidenced by submission of the Practitioner Data Form
▪ SE performed external source verification at the time of credentialing a provider as evidenced by a policy and procedure and submission of credentialing committee meeting minutes
▪ SE has documented an established method to determine high volume BH practitioners as evidenced by CI-5 Critical Indicator Instructions and submission of the CI-05A High Volume Practitioner Report
▪ SE documented evaluations of medical record keeping practices at each BH site for conformity to the SE’s organizational standards as evidenced by the Treatment Record Review Tool
▪ SE provided formalized recredentialing procedures
▪ SE provided policies and procedures for altering the conditions of the practitioner’s participation with the SE based on issues of quality of care and service
▪ SE provided policies and procedures for the initial and ongoing assessment of organizational providers with whom it is contracted or intends to contract
Non-Compliant
- SE did not demonstrate it performed initial site visits of potential high volume BH practitioners as required by MAD regulation

Recommendations
- SE shall comply with MAD regulation and perform initial site visits of potential high volume BH practitioners

8.305.8.15. MEMBER BILL OF RIGHTS
In accordance with the MAD regulations, the SE shall have policies and procedures governing consumer rights and responsibilities. The SE shall have a consumer handbook in all media formats available and shall include other languages as appropriate to consumer demographics. The SE shall have policies and procedures regarding confidentiality and shall follow federal and state laws and regulations. The SE shall have policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint. The SE shall have written policies and procedures regarding treatment of minors.

The SE shall have a consumer handbook, which thoroughly describes the consumer bill of rights. The SE shall have a toll-free telephone number for consumers to file grievances telephonically.

Composite Score: 100%
Performance Level: Full Compliance

Compliant
- SE provided a policy and procedure for a Consumer Bill of Rights that was reviewed for specific subsections in accordance with MAD regulations
- SE provided the Consumer Handbook and it was reviewed for the published Bill of Rights
- SE provided a documented process to distribute the Consumer Handbook to consumers upon request
- SE demonstrated completion of consumer trainings related to cultural, ethnic and linguistic topics
- SE demonstrated a documented process to provide cultural competence materials to consumers
- SE provided policies and procedures that are in compliance with state and federal confidentiality requirements
- SE provided a confidentiality policy and procedure that is in compliance with state and federal processes to protect consumer information during an investigation of a complaint
- SE provided a policy and procedure for allowing a consumer direct access to a BH provider without a referral from a primary care physician (PCP)

Non-Compliant
- No non-compliant findings

Recommendations
- No recommendations for this standard

8.305.8.17. STANDARDS FOR MEDICAL RECORDS
The medical record, whether electronic or on paper, communicates the consumer’s past medical treatment, past and current health status, and treatment plans for further health care. The SE demonstrates organizational accountability through the establishment and promulgation
of medical records standards including timeliness and legibility. Well-documented medical records, whether electronic or on paper, facilitate communication, coordination and continuity of care and promote the efficiency and effectiveness of treatment. The SE shall comply with state and federal guidelines as well as HIPAA regulations.

Composite Score: 95.90%
Performance Level: Full Compliance

**File Review Findings for Medical Records**
Thirty (30) provider records were reviewed and a potential HIPAA violation was identified and reported to VONM and HSD. The following elements were not documented consistently in the consumer medical record:
- Past medical history for consumers seen two or more times
- Allergies and adverse reactions to medication
- History of smoking, alcohol use and substance abuse
- Advance directives for adults

**Compliant**
- SE provided a policy and procedure regarding medical record confidentiality in compliance with state and federal guidelines and HIPAA regulations
- SE provided policies and procedures regarding medical record documentation standards which are enforced with its SE providers and subcontractors and which require that medical records reflect all aspects of patient care, including ancillary services
- SE demonstrated a mechanism to assess the effectiveness of organization-wide plans as well as practice-site follow-up plans to increase compliance with the SE’s established medical record standards and goals
- SE provided evidence that it maintains a policy that ensures the confidential transfer of BH information from one practitioner to another. Evidence submitted (Provider Contract excerpts sections 5.1 and 5.2, LOD #8 Transition Plans, LOD #8A Overall Transition Plans, LOD #8B Client Specific Transition Plans, CL227 Transition of Care Discharge Planning, CL233 Transition of Care When Benefits End, CMP412 Identify and Updating Designated Record Set and Master Document and LC400 Member Privacy Rights) and Policy N701 Practitioner and Provider Compliance demonstrates the practitioner must comply with established performance and contractual requirements.

**Non-Compliant**
- No non-compliant findings

**Recommendations**
- SE shall incorporate regulation language into its policies and procedures such as, “ensures the confidential transfer of BH information from one practitioner to another”
- SE shall continue to provide training for providers to ensure potential HIPAA violations are decreased

**8.305.8.18. STANDARDS FOR ACCESS**
The SE shall ensure the accessibility, availability and referral to health care providers for each medically necessary service. The SE shall inform HSD yearly that it is able to serve the enrolled consumers in its service area with the full array of covered services within the benefit package.

The SE shall coordinate all transportation for BH issues with the consumer’s respective MCO. Prior authorization is not required for emergency conditions and consumers may obtain emergency services either in or out of network.
The SE shall ensure that there are sufficient numbers of BH providers available statewide to consumers to allow consumers a reasonable choice.

Composite Score: 3 of four elements reviewed were compliant
Performance Level: NA

Compliant
- SE demonstrated access to health care services for non-urgent appointments for urgent conditions within specified timeframes as evidenced by submission of CI-25 2008 Access Standards Report, 2008 consumer Access Survey results, excerpt from Provider Handbook tab 8.1 and Provider Treatment Record Review Tool Definitions
- SE demonstrated access to health care services for outpatient appointments for urgent conditions within specified timeframes as evidenced by submission of CI-25 2008 Access Standards Report, 2008 consumer Access Survey results, excerpt from Provider Handbook tab 8.1 and Provider Treatment Record Review Tool Definitions
- SE demonstrated the use of state-of-the-art technology to ensure access and availability of services statewide as evidenced by two quarters of the CI-31 Pilot Project Telehealth Report

Non-compliant
- SE did not comply with protocols to ensure the accessibility, availability, and referral to health care providers for each medically necessary service as evidence by submission of two quarters of the New Mexico GEO Access Report that identified areas that did not meet accessibility performance standards

Recommendations
- SE shall continue to implement interventions to ensure access in the areas in which performance standards were not met

8.305.8 COORDINATION OF SERVICES
BH services and Physical Health (PH) are provided through an integrated, clinically coordinated system. Both BH and PH care providers need access to relevant medical records of mutually served consumers to ensure maximum benefits of services to the consumer. Confidentiality laws apply during this coordination process.

Composite Score: 91.60%
Performance Level: Full Compliance

File Review Findings for Coordination of Services
Twenty-seven (27) coordination of service cases were reviewed for care coordination between PH and BH. The following elements were not documented consistently in the case files:
- Developed and monitored a consumer’s plan of care
- Assurance that all necessary information is shared with key providers with the consumer’s written or documented verbal permission

Compliant
- SE demonstrated policies and procedures to ensure the following:
  – Effectiveness of monitoring the referral and coordination with multiple providers
  – Coordination with Medicaid external programs (e.g., home and community-based waiver program)
  – Assurance that the PCP receives communication regarding patient status
  – Coordination with Medicaid and non-Medicaid services external to the SE


- Coordination with waiver programs
- Coordination of services with Children, Youth and Families Department (CYFD), Juvenile Justice System (JJS) and Adult Protective Services (APS)
- Access to BH services without referral from the PCP
- Access and coordination of psychopharmacotherapy and diagnostic evaluations when clinically appropriate

- **SE demonstrated that VONM is offering training throughout the state to all providers regarding specific referral policies and procedures**
- **SE demonstrated that VONM is educating and assisting BH providers to make appropriate referrals for PH consultation**
- **SE demonstrated a process for ensuring the BH providers keep the PCP informed (with the consumer’s written consent) of the following:**
  - Drug therapy
  - Laboratory and radiology results
  - Sentinel events such as hospitalizations, emergencies and incarceration
  - Discharge from psychiatric hospital, residential treatment services, treatment foster care placement or from other BH service
  - All transitions in level of care

**Non-Compliant**
- No non-compliant findings

**Recommendations**
- **SE shall ensure that the Specialized Care Coordinator (SCC) completes a Care Coordination Plan (CCP) within 10 days of contact with a consumer, per VONM policy and procedure**
- **SE shall ensure the SCC documents consumer’s written or documented verbal permission to share information with key providers**

**8.305.10. ENCOUNTERS**
Encounter data is used for setting SE capitation rates under Medicaid managed care and is the basis for other management tools. Thus, it is essential that encounter data be captured and reported in an accurate, timely and complete manner. Accurate and complete encounter data will translate into rate-making, which is fiscally sound and equitable for all stakeholders. The review of encounters included verification of encounter processes with the SE and did not include encounter data validation.

Composite Score: 100%
Performance Level: Full Compliance

**Compliant**
- SE submitted encounter data to HSD according to established guidelines; this was verified by the encounter data reports provided to NMMRA
- SE utilized encounter data to determine compliance with performance measures as evidenced by submission of Validation Protocol and performance measure reports
- SE submitted encounter data to HSD within 120 days of the service delivery date or discharge; this was verified by batch report tracking logs and HSD acceptance reports

**Non-Compliant**
- No non-compliant findings
Recommendations
- SE shall include the term “adjust” in all work flows that state “delete” to ensure clarity of instructions that data are not deleted

8.305.11. REIMBURSEMENT FOR MANAGED CARE
The SE receives a monthly capitation amount for each Medicaid consumer for whose care it is responsible. In turn, the SE pays its care providers by either a fee-for-service or a capitation arrangement. The SE must conduct its operations in a responsible fiduciary manner and comply with regulatory financial guidelines governing its solvency, timeliness of payments, and minimum proportion of its capitation expended for services. It may not transfer its liabilities to those whom it is serving.

Composite Score: 100%
Performance Level: Full Compliance

Compliant
- SE paid contracted and non-contracted providers interest on the SE’s liability at the rate of 1½ percent per month on the amount of a clean claim
- SE reimbursed FQHCs at 100 percent of the reasonable cost under the Medicaid managed care program unless waived by the FQHC for a negotiated rate
- SE reimbursed the Indian Health Services (IHS) providers at the rate established for specified services or the Medicaid FFS rate for all other services or at a fee negotiated between the provider and the SE
- SE met 100 percent of the timeliness standard to pay clean claims according to the prescribed time frames every month
- SE provided evidence of payment for a Medicaid consumer hospitalized at the time of disenrollment

Non-Compliant
- No non-compliant findings

Recommendations
- SE shall revise work flow for third-party liability (TPL) to include other MCOs (i.e., Coordination of Long-Term Care)
- SE shall trend its data and conduct an analysis of outliers in interest paid to providers and follow-up with network operations as appropriate

8.305.12. MEMBER GRIEVANCE SYSTEM
The SE shall demonstrate thorough and consistent procedures for responding to consumer and provider grievances. The procedures facilitate the thorough evaluation of grievances from both sides. If the grievance involves clinical issues, such as timeliness of care, access to care or appropriateness of care, the evaluation includes a review of the clinical judgments involved in the case. Furthermore, the organization’s procedures are designed to recognize that a complaint may indicate a problem that the SE needs to address across its system.

The SE acknowledges that disputes may arise with its consumers, particularly over the coverage of services, which may result in appeals. The organization is prepared to resolve these disputes. The policies for resolution are not simply a defense of the organization’s own decisions but rather constitute a process of evaluating the consumer’s appeal from both sides. When a consumer appeals a decision, the SE conducts a review of the case using a peer reviewer who was not involved in any prior decisions regarding the appeal.
The SE sets standards for timeliness in resolving grievances and appeals, which recognize the urgency of the consumer’s problem.

The SE maintains documentation of its handling and monitoring of grievances and appeals in order to monitor the actions taken and the compliance with standards for timeliness.

A grievance is an expression of dissatisfaction, either oral or written. An appeal is a request from a consumer to change a previous decision made by the SE.

Composite Score: 99.86%
Performance Level: Full Compliance

File Review Findings for Consumer and Provider Grievance
Thirty (30) consumer and fourteen (14) provider grievance files were reviewed for adherence to time frames, notification requirements and resolution requirements and the following findings were noted and addressed in recommendations:

- Consumer Grievance
  - 1 of the thirty cases did not meet the timeliness standard for date of request to date of decision
  - 14 of the thirty resolution letters did not include assignment of an SCC which is not a requirement; however, indicated an inconsistent process

- Provider Grievance
  - 9 of the fourteen cases were from one provider

File Review Findings for Consumer and Provider Appeals
Thirty (30) consumer and 15 provider appeal files were reviewed for adherence to time frames, notification requirements and resolution requirements and the following findings were noted and addressed in recommendations:

- Consumer Appeal
  - 8 of the thirty consumer appeals were overturned in favor of the consumer

- Provider Appeal
  - 6 of the fifteen were overturned in favor of the provider
  - 9 of the fifteen were requests for residential treatment services which are noted to assist the SE in identifying trends and possible opportunities for improvement

File Review for Expedited Appeals
Thirty (30) consumer files were reviewed for adherence to time frames, notification requirements and resolution requirements and the following findings were noted and addressed in recommendations:

- 1 of the thirty cases was not appropriate for this audit as it was a Department of Health consumer
- 7 of the thirty cases were overturned in favor of the consumer

Compliant

- SE implemented written policies and procedures describing how the consumer may submit a request for a grievance, appeal and fair hearing with HSD
- SE provided a written description of the grievance and appeals process to service providers as evidenced by Provider Handbook excerpts and the enrollment and billing manual
- SE assisted consumers with completing forms and taking other procedural steps as evidenced by submission of the Consumer Handbook and a policy and procedure
- SE provided interpreter services and toll-free numbers that have TTY/TTD and interpreter capability as evidenced by Appeal and Grievance letter templates, the Consumer Handbook and a policy and procedure
- SE ensured that a specific individual is designated as the SE’s Medicaid consumer grievance and/or appeal coordinator, and has the authority to administer the policies and procedures for resolution of a grievance or an appeal to review patterns/trends in grievances or appeals, and to initiate corrective action as referenced in three Quality Management policies and procedures
- SE ensured that individuals who make decisions about grievances and appeals were not involved in any previous decisions. Health care professionals with appropriate clinical expertise made decisions on the following:
  - An appeal of a SE denial based on lack of medical necessity as evidenced in the UM policy and procedure
  - A denial that is upheld in an expedited resolution as evidenced in the QM policy and procedure
  - A grievance or appeal that involved clinical issues evidenced in the QM policy and procedure
- SE provided consumers with an information sheet or handbook that included information on how to file a grievance or appeal and the resolution process and on the right to file a request for and administrative hearing with the HSD hearing bureau as evidenced in the Consumer Handbook
- SE continued benefits while the appeal and/or the HSD fair hearing process was pending as evidenced in a QM policy and procedure and Appeal Letter templates
- If the SE reverses a decision to deny, limit or delay services, the consumer received the disputed services while the appeal was pending; the SE paid for these services as evidenced in a QM policy and procedure

Non-Compliant
- No non-compliant findings

Recommendations
- SE shall consistently assign an SCC for grievances related to access of services
- SE shall continue to identify trends and implement interventions of consumer and provider complaints, appeals and grievances

8.305.13. FRAUD AND ABUSE
VONM fraud and abuse policies and procedures were reviewed to determine if processes were present for prevention, detection and reporting of suspected or actual fraud and abuse. A review of a program description was assessed to determine if VONM complied with state and federal regulations. An internal staff training program was reviewed for efficacy and efficiency.

Composite Score: 2 of two elements reviewed were compliant
Performance Level: NA

Compliant
- The SE maintained policies and procedures that address the prevention, detection and reporting of potential or actual Medicaid fraud and abuse cases
- The SE demonstrated a mechanism to further develop prevention and detection methods and best practices and to monitor outcomes for Medicaid managed care

Non-compliant
- No non-compliant findings
Recommendations

- No recommendations for this standard

8.305.14. REPORTING REQUIREMENTS

The SE shall provide to HSD managerial, financial, delegation, suspicious activity and utilization and quality reports. The content, format and schedule for submission shall be determined by HSD. HSD may require the SE to prepare and submit ad hoc reports.

Composite Score: 100%
Performance Level: Full Compliance

Compliant

- SE provided cover sheets for reports with attestation that all information and data had been reviewed and is correct
- Reports or other required data were received on or before scheduled due dates
- Reports or other required data conformed to HSD's defined standards
- SE submitted reports with information that was fully disclosed in a responsive manner and with no material omissions as evidenced by the few reports reviewed
- Based on the documents reviewed by NMMRA, the SE was analyzing reports prior to submitting to HSD

Non-Compliant

- No non-compliant findings

Recommendations

- No recommendations for this standard

8.305.15. SERVICES FOR ISHCN

The SE shall provide ISHCN consumers with a broad range of primary, specialized medical, BH and related services. ISHCN applies to individuals who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition, and who require health and related services of a type or amount beyond that required by the general population. The guiding principle for this definition is that the individuals must be considered at risk and have a functional need. The primary purpose of the definition is to identify ISHCN so that the SE can facilitate access to appropriate services, both PH and BH. The definition also allows for flexible targeting of individuals based on clinical justification.

Composite Score: 99.13%
Performance Level: Full Compliance

File Review Findings for ISHCN

Thirty (30) ISHCN cases were reviewed for care coordination of ISHCN services. The following elements were not documented consistently in the case files:

- List of key resource people and telephone numbers or designated single point of contact to consumer
- Documentation of the CCP for care coordination

Compliant

- SE established policies and procedures for:
  - Ensuring identified ISHCN are assessed by the appropriate health care professional
  - Educating ISHCN that care coordination is available
– Ensuring information and materials are specific to the needs of the population
– Educating ISHCN on how to access the emergency room and what clinical history to provide
– Ensuring the emergency room physician has access to ISHCN’s BH clinical history
– Ensuring clinical practice guidelines and practice parameters consider the needs of ISHCN
  ▪ SE demonstrated an internal operational process in accordance with the MAD regulation to identify ISHCN
  ▪ SE provided health education information to assist an ISHCN or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness, including chronic BH conditions
  ▪ SE did provided documentation that a quality strategy was initiated with the QM annual plan utilizing a performance measure specific to ISHCN

Non-Compliant
  ▪ No non-compliant findings

Recommendations
  ▪ SE shall ensure performance measure data related to ISHCN are valid
  ▪ SE shall ensure a list of key resource people and telephone numbers or designated single point of contact available is consistently documented in the case file
  ▪ SE shall ensure SCC are documenting consistently the CCP for care coordination within 10 days of contact with consumer based on VONM’s policy and procedure

8.305.16. CLIENT TRANSITION OF CARE
The SE shall actively assist with transition of care issues. Medicaid-eligible clients may initially receive PH and BH services under fee-for-service Medicaid prior to enrollment in managed care. The SE shall have the resources, policies and procedures in place to ensure continuity of care without disruption in service to consumers.

Composite Score: 97.80%
Performance Level: Full Compliance

File Review Findings for Client Transition of Care
Thirty (30) Transition of Care files were reviewed. The following was determined:
  ▪ SE did not consistently document the care coordination of transition from one level of care to another level of care in the UM system

Compliant
  ▪ SE maintained policies and procedures for consumer transition of care to ensure continuity of care without disruption in services
  ▪ SE maintained policies and procedures regarding provider responsibility for discharge planning

Non-Compliant
  ▪ No non-compliant findings

Recommendations
  ▪ SE shall ensure UM staff is documenting care coordination of consumers transitioning from one level of care to another
Overall Recommendations for HSD

- Ensure the SE provides a description of mandatory benefits in information materials provided to the consumer
- Ensure the SE incorporates provider satisfaction survey results into the SE’s quality improvement program
- Ensure SE informs SE consumers of results of consumer satisfaction activities
- Ensure the SE complies with the regulation of performing a site visit for potential high volume BH practitioners

Calculations of Final Score

Table 4 presents the final overall score, by category, for VONM. As described in the scoring criteria, determining compliance and scoring sections of this report, the final score was calculated by summing the points earned from file review and points earned from document review. The overall points earned were then calculated as a percentage that is presented as the final overall score. The maximum number of points VONM could earn was 144.

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Standard</th>
<th>Points Available</th>
<th>Points Scored</th>
<th>Final Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.2.</td>
<td>Member Education</td>
<td>10</td>
<td>9.75</td>
<td>97.50%</td>
</tr>
<tr>
<td>8.305.6.</td>
<td>Provider Networks</td>
<td>10</td>
<td>9.25</td>
<td>92.50%</td>
</tr>
<tr>
<td>8.305.8.12.</td>
<td>Standards for Quality Management &amp; Improvement</td>
<td>10</td>
<td>9.6</td>
<td>96.00%</td>
</tr>
<tr>
<td>8.305.8.13.</td>
<td>Utilization Management</td>
<td>15</td>
<td>14.80</td>
<td>98.66%</td>
</tr>
<tr>
<td>8.305.8.14.</td>
<td>Credentialing and Recredentialing</td>
<td>7</td>
<td>6.5</td>
<td>92.85%</td>
</tr>
<tr>
<td>8.305.8.15.</td>
<td>Member Bill of Rights</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>8.305.8.17.</td>
<td>Standards for Medical Records</td>
<td>10</td>
<td>9.59</td>
<td>95.90%</td>
</tr>
<tr>
<td>8.305.8.18.</td>
<td>Standards for Access</td>
<td>3 of 4*</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>8.305.9.</td>
<td>Coordination of Services</td>
<td>15</td>
<td>13.74</td>
<td>91.60%</td>
</tr>
<tr>
<td>8.305.10.</td>
<td>Encounters</td>
<td>10</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>8.305.11.</td>
<td>Reimbursement for Managed Care</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>8.305.12.</td>
<td>Member Grievance System</td>
<td>15</td>
<td>14.98</td>
<td>99.86%</td>
</tr>
<tr>
<td>8.305.13.</td>
<td>Fraud and Abuse</td>
<td>2 of 2*</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>8.305.14.</td>
<td>Reporting Requirements</td>
<td>10</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>8.305.15.</td>
<td>Services for ISHCN</td>
<td>15</td>
<td>14.87</td>
<td>99.13%</td>
</tr>
<tr>
<td>8.305.16.</td>
<td>Client Transition of Care</td>
<td>5</td>
<td>4.89</td>
<td>97.80%</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td><strong>144</strong></td>
<td><strong>139.97</strong></td>
<td><strong>97.20%</strong></td>
</tr>
</tbody>
</table>

* Note: Three of the four elements for Standards for Access were compliant; two of the two elements for Fraud and Abuse were compliant

Audit Comparison Results

Table 5 displays VONM’s comparison results from FY 2006, FY 2007, FY 2008 and FY 2009.

<table>
<thead>
<tr>
<th>Standard</th>
<th>FY 2006 Results</th>
<th>FY 2007 Results</th>
<th>FY 2008 Results</th>
<th>FY 2009 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Education</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Full</td>
</tr>
<tr>
<td>Provider Networks</td>
<td>Minimal</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
</tbody>
</table>
Table 6 presents the score for each regulation for the audits conducted in FY 2006, FY 2007, FY 2008 and FY 2009.

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Standard</th>
<th>FY 2006 Score</th>
<th>FY 2007 Score</th>
<th>FY 2008 Score</th>
<th>FY 2009 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.2.</td>
<td>Member Education</td>
<td>70%</td>
<td>79%</td>
<td>72.50%</td>
<td>97.50%</td>
</tr>
<tr>
<td>8.305.6.</td>
<td>Provider Networks</td>
<td>79%</td>
<td>93%</td>
<td>92.50%</td>
<td>92.50%</td>
</tr>
<tr>
<td>8.305.8.12.</td>
<td>Quality Management &amp; Improvement</td>
<td>80%</td>
<td>83%</td>
<td>96.00%</td>
<td>96.00%</td>
</tr>
<tr>
<td>8.305.8.13.</td>
<td>Utilization Management</td>
<td>92%</td>
<td>87%</td>
<td>93.16%</td>
<td>98.66%</td>
</tr>
<tr>
<td>8.305.8.14.</td>
<td>Credentialing and Recredentialing</td>
<td>71%</td>
<td>100%</td>
<td>100.00%</td>
<td>92.85%</td>
</tr>
<tr>
<td>8.305.8.15.</td>
<td>Member Bill of Rights</td>
<td>70%</td>
<td>90%</td>
<td>90.00%</td>
<td>100%</td>
</tr>
<tr>
<td>8.305.8.17.</td>
<td>Standards for Medical Records</td>
<td>100%</td>
<td>85%</td>
<td>79.60%</td>
<td>95.90%</td>
</tr>
<tr>
<td>8.305.8.18.</td>
<td>Standards for Access</td>
<td>100%</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>8.305.9.</td>
<td>Coordination of Services</td>
<td>62%</td>
<td>89%</td>
<td>77.85%</td>
<td>91.60%</td>
</tr>
<tr>
<td>8.305.10.</td>
<td>Encounters</td>
<td>70%</td>
<td>100%</td>
<td>70.00%</td>
<td>100%</td>
</tr>
<tr>
<td>8.305.11.</td>
<td>Reimbursement for Managed Care</td>
<td>83%</td>
<td>100%</td>
<td>57.14%</td>
<td>100%</td>
</tr>
<tr>
<td>8.305.12.</td>
<td>Member Grievance System</td>
<td>70%</td>
<td>96%</td>
<td>99.90%</td>
<td>99.86%</td>
</tr>
<tr>
<td>8.305.13.</td>
<td>Fraud and Abuse</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>8.305.14.</td>
<td>Reporting Requirements</td>
<td>70%</td>
<td>100%</td>
<td>60.00%</td>
<td>100%</td>
</tr>
</tbody>
</table>

1 FY 2006 no medical record review and FY 2007 only 10 medical records reviewed
2 FY 2008 HSD directed NMMRA to not include Standards for Access score
3 FY 2009 first year Fraud and Abuse was evaluated
4 Standards for Access evaluated, but not scored for FY08 and FY09
5 Fraud and Abuse evaluated but not scored for FY 09
Audit Compliance Results

NMMRA developed an audit compliance score to determine timeliness and accuracy of documents submitted for each regulation element. This was the first audit this type of scoring was used to track and trend any issues with submitting requested documents, clarification documents, and closing documents and file review documents. Table 7 displays VONM’s actual scores for the audit compliance results for FY 2009.

Table 7: Audit Compliance Results

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Standard</th>
<th>FY 2006 Score</th>
<th>FY 2007 Score</th>
<th>FY 2008 Score</th>
<th>FY 2009 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.15.</td>
<td>Services for ISHCN</td>
<td>36%</td>
<td>86%</td>
<td>73.68%</td>
<td>99.13%</td>
</tr>
<tr>
<td>8.305.16.</td>
<td>Client Transition of Care</td>
<td>100%</td>
<td>95%</td>
<td>95.33%</td>
<td>97.80%</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td><strong>75%</strong></td>
<td><strong>93%</strong></td>
<td><strong>82.65%</strong></td>
<td><strong>97.20%</strong></td>
</tr>
</tbody>
</table>

Reconsideration Review

VONM reviewed the preliminary findings of the BH Compliance Audit Draft Report and was provided an opportunity to respond with specific questions, comments and requests.

The following requests for reconsideration were submitted by VONM on May 6, 2009. VONMs’ comments are italicized. The reconsideration review completed by NMMRA was in collaboration.
with HSD and comments are in bold. The additional information submitted by VONM as of May 14, 2009, was included in the reconsideration review process.

VONM is seeking a reconsideration of the evidence provided to meet the Provider Networks requirements in 8.305.6.17. B. (1): incorporates provider satisfaction survey results into the SE’s quality improvement program. In addition to providing a copy of the 2007 Provider Satisfaction Survey results, VONM provided the Quality Management Committee (QMC) meeting minutes from January and February 2008, and documentation of two metrics developed to track issues raised by the Provider Satisfaction Survey. When reviewing these minutes you will see in the January 2008 QMC began a discussion of the Provider Satisfaction Survey results. That discussion continues in detail through the February 2008 QMC meeting minutes (note: beginning on page 3 of 13). Specifically, on page 4 of 13 in the section titled “Claims Services” the survey points to a noted drop in timely payments. As a result, the Quality and Claims Departments began tracking the turnaround time of payments in order to identify any opportunities for improvement. The documentation of these metrics was submitted in March of 2009 in response to the call for clarification documentation for the Behavioral Health Compliance Audit (July – December 2008).

NMMRA reviewed all evidenced provided for this element and determined that VONM appears to be in the beginning phases of incorporating provider satisfaction survey results into the quality improvement program as evidence by the submission of two metrics report. However, VONM has not established a formalized comprehensive approach to incorporate additional findings and results into the quality improvement program. Therefore, the score remains unchanged.

VONM is seeking a reconsideration of the evidence provided to meet the Standards for Medical Records 8.305.8.17. C. 4.: SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another. VONM offers one additional piece of evidence of meeting this New Mexico regulation. VONM submits Provider Networks Policy N701 – Practitioner and Provider Compliance. Please see page 1, Section III. “Policy: It is the policy of ValueOptions®: A. That all practitioners and facility/organizational providers participating in the network must comply with established performance and contractual requirements.” This policy clearly indicates the responsibility of the provider to abide by contractual obligation. Therefore, VONM ensures the confidential transfer of behavioral health information from one practitioner to another through their network provider contract in section 5.1 (previously provided): “Provider is required to maintain Consumer records in compliance with the policies and procedures of ValueOptions New Mexico, Inc. and accrediting bodies,” and in section 5.2 (previously provided): “ValueOptions New Mexico, Inc. and Provider shall ensure that all of each Consumer’s medical records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of patient records” which includes 8.305.8.17. C. 4. as incorporated by reference.

NMMRA will accept the additional information provided for reconsideration to meet the Medical Record element that the SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another. The score has been adjusted upwards.

VONM is seeking a reconsideration of the evidence provided to meet the Standards for Quality Management and Improvement 8.305.8.12. E. (6): SE shall inform providers, HSD, and SE members of results of member satisfaction activities. VONM participated in the FY08 Consumer Satisfaction Project Committee but was not assigned the role of distributing the results to the
stakeholders (i.e., providers, HSD, and SE members); this role was assigned to State by the Committee. VONM requested that the State verify that VONM was not required to perform the distribution function. In an email dated 5/14/09, VONM was provided the following statement by Lesley Urquhart from the State: “I have confirmed that the State (BHSD) was responsible for the distribution, and I have informed NMMRA staff.”

On May 15, 2009 HSD informed NMMRA that “VONM does data collection for the satisfaction project and the State does distribute the completed survey; however, VONM is responsible for the notification of consumers, and providers about the survey results”. Therefore, the score remains unchanged.

Conclusion

Based on NMMRA’s compliance review of MAD regulations, evidence acquired during the scope of this audit, key personnel interviews, and the scoring criteria approved by HSD, NMMRA finds VONM earned an aggregate designation of Full Compliance (97.20%) for the MAD standards examined. NMMRA finds VONM earned a designation of Full Compliance (96.66%) for audit compliance.

The specific findings, by standard and sub-standards, for VONM are included in the Appendices.

The SE has improved and further developed processes from previous audits; however, there remain opportunities for improvement. The scoring criteria approved by HSD requires that any single MAD regulation receiving a Minimal Compliance or Non-compliance designation be placed into corrective action. Based on this requirement, NMMRA informs HSD that there are no recommendations for corrective action based on these audit findings.