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July 2005 – March 2006

Background
The New Mexico Medical Review Association (NMMRA) serves as the External Quality Review Organization (EQRO) for the State of New Mexico Human Services Department (HSD). This Medicaid Managed Care Compliance 2006 report is presented to comply with the federal Centers for Medicare & Medicaid Services (CMS) protocol and state Medicaid managed care regulations.

In July 2005, HSD as well as multiple state agencies implemented the first phase of its Behavioral Healthcare System Transformation. This restructuring created one statewide entity (SE) for behavioral health services across multiple state funding streams. The contract was awarded to ValueOptions of New Mexico (VONM). As part of the overall state’s transformation of the behavioral health system, VONM partnered with the Behavioral Health Purchasing Collaborative in managing the New Mexico publicly funded behavioral health service system.

As a requirement of its participation in the SALUD! Program, VONM is required to comply with the New Mexico Medicaid managed care regulations. HSD’s Medical Assistance Division (MAD) has requested a comprehensive compliance audit of the managed care regulations. NMMRA reviewed 144 standards from the 13 domains. In addition, a comprehensive audit of VONM’s information systems (IS) and technology was performed. Results of the audit and recommendations for improving the quality of compliance with state and federal regulations have been addressed.

For the purpose of this report, NMMRA is specifically referring to Medicaid consumers when discussing managed care Medicaid consumers.

Methodology
For the purposes of the BH Compliance Audit, the measurement and scoring methodology addressed a subset of New Mexico Administrative Code (NMAC) 8.305 regulations, specifically:

- 8.305.2 Member Education
- 8.305.3 Contract Management
- 8.305.6 Provider Networks
- 8.305.7 Benefit Package
- 8.305.8 Quality Management
- 8.305.9 Coordination of Services
- 8.305.10 Encounters
- 8.305.11 Reimbursement for Managed Care
- 8.305.12 Member Grievance System
- 8.035.13 Fraud and Abuse
The CMS Protocol Information Systems Capabilities Assessment (ISCA) was utilized to conduct the review of VONM’s information/technology systems. The review included the following domains:

- IS Capability Assessment
- Information Systems Data Processing Procedures and Personnel
- Staff Access Designation
- Integrity of Security
- Data Acquisition Capabilities
- Enrollment Systems
- Ancillary Systems
- Integration and Control of Data
- Vendor Data Integrity
- Performance Measure Repository
- Report Production
- Provider Data
- Summary of Requested Documentation

Data Collection Tools
Data collection audit tools, interpretive guidelines, and scoring methodology were developed using NMAC, NM MAD regulations and the CMS protocol for assessing MCO information systems. The interpretive guidelines contained detailed criteria regarding each standard and substandard. The audit tools and guides were approved by HSD prior to the on-site audits. The compliance audit consisted of document review, file review and on-site interviews with VONM staff.

Pre-evaluation Workshop
NMMRA conducted one-day training with VONM and HSD staff five weeks prior to the on-site evaluation that included a detailed overview of the standards, documentation requirements and a thorough review of the process flow. The overall timeline of the audit was presented. In response to the meeting, minor revisions were made to the audit tools, interpretive guidelines and scoring methodology.

On-site Evaluation
In preparation for the on-site audit, NMMRA auditors reviewed all hard copy documentation submitted by VONM, which consisted of many of the required policies and procedures. The audit tools were updated as appropriate. The site visit consisted of documentation review and interviews with key VONM staff. VONM received an introductory packet, including an on-site agenda, interview schedule with appropriate VONM staff, and an audit timeline.

An opening session was undertaken to discuss the activities of the day. The on-site visit occurred over three days and was conducted by six NMMRA staff. At the conclusion of the
on-site visit, a closing conference was conducted by NMMRA staff and attended by VONM staff and HSD staff. Auditors presented their preliminary findings, provided feedback and answered VONM staff questions. At NMMRA’s request, an event evaluation was completed. The evaluation is based on five (5) points, with the highest approval score being five (5) and the lowest being one (1). An aggregate average of 4.3 indicated overall satisfaction with the on-site compliance audit.

A summary of the key topics covered during the pre-on-site evaluation and on-site evaluation is discussed below.

**Member Education 8.305.2**
During this portion of the audit, VONM was reviewed to ensure that Medicaid consumers were informed about their rights, responsibilities, service availability and administrative roles under the managed care program. Documents were reviewed to determine whether VONM provided the consumer with a member handbook and provider directory within 30 days of enrollment. A policy and procedure was assessed to evaluate the development and distribution of education materials for consumers. Documents related to health education programs were assessed to determine availability to consumers.

**Contract Management 8.305.3**
This portion of the audit included a review of an organizational structure/chart, policies and procedures and job descriptions for key personnel. A boilerplate and sample practitioner and facility contract was reviewed to ensure that language referenced all subcontracting requirements. VONM was assessed to ensure a consumer advisory board had been established with the appropriate membership, was collaborative in nature, met within required time frames and documented activities.

**Provider Networks 8.305.6**
VONM was reviewed to determine whether a comprehensive provider network was sufficient to serve consumers in compliance with access standards. Consumer and provider handbooks were evaluated for evidence of documentation on how to access various services. The Geo Access report was evaluated to determine the number of providers, geographic location and distance of Medicaid members to access providers. Policies and procedures were reviewed regarding provider recruitment and determination. Each contracted network provider must be in compliance 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. Policies and procedures relating to the development, distribution of education and informational materials regarding managed care to its network providers were reviewed. Clinical advisory committee minutes were reviewed to assess active solicitation of input from network providers to improve and resolve issues with the VONM.

**Benefit Package 8.305.7**
The benefit package was examined to determine the extent of covered behavioral health services, including behavioral health-related educational and preventive services and outreach. This portion of the review evaluates if the managed care contractor is providing the full array of the New Mexico MAD benefit package. As directed by HSD, the educational
materials were also assessed to ensure they contained a detailed explanation for the services covered by Medicaid, limitation and exclusions to covered services, and services that are not covered by Medicaid. Benefits were reviewed to ensure that enhanced benefits were listed and distributed to consumers. This portion of the audit also included a review of report HSD 24 – Enhanced Services Report.

**Quality Management 8.305.8**

**Quality Management and Improvement 8.305.8.12**

During this portion of the review, quality management and improvement structures were evaluated relating to VONM's Quality Improvement (QI) Program description, QI work plan, committee minutes and other related documentation. Clinical practice guidelines were reviewed to determine distribution avenues to network providers and the process of involving those providers in developing and adopting these guidelines. Quality of care and over/under utilization file reviews were performed to assess opportunities for improvement and whether implementation of corrective interventions might be initiated.

**Utilization Management (UM) 8.305.8.13**

The UM Program description was examined to evaluate the scope, processes and information sources used to determine benefit coverage, preauthorization, concurrent review and retrospective review. Policies and procedures and UM cases were reviewed to assess whether UM decision criteria were applied in a fair, impartial, timely and consistent manner to serve the best interest of all consumers. The UM program was evaluated to determine that its execution was based on the New Mexico MAD definition for medically necessary services. The UM program was evaluated to determine if qualified health professionals' education, training, and experience were commensurate with the UM review process. Cases were reviewed to ensure denial language was explained in clear understandable format addressing the reasons for the denial. In addition, policies and procedures for the assessment of technology were reviewed to determine if professionals with the appropriate expertise reviewed technology and participated in the creation of criteria for its application.

**Credentialing and Recredentialing 8.305.8.14**

This portion of the audit included review of policies and procedures relating to provider participation in the credentialing and recredentialing process. The program was also reviewed to verify providers had a mechanism to allow for feedback regarding the process for applying to become a contracted provider. Procedures were assessed to ensure that providers meet applicable federal and state licensing, certification and accreditation regulations. Policies and procedures were examined to verify a three-year time frame was instituted for the recredentialing process. The credentialing site-visit form used to assess high volume behavioral health care providers was reviewed for content.

**Member Bill of Rights 8.305.8.15**

Included in the review were policies and procedures governing consumer rights and responsibilities. This review included the following: confidentiality, confidential information relating to resolution of complaints, treatment of minors and direct access without primary care provider (PCP) referral. The consumer handbook was reviewed to verify that member rights and responsibilities reflect MAD regulation components. Provider newsletters and consumer materials were reviewed for aspects relating to cultural competency.
Preventive Health Services 8.305.8.16
VONM’s acceptance and integration of national behavioral health preventive services were evaluated. Additionally, the process for performing an initial assessment of the Medicaid members’ health care needs within 90 days of enrollment was reviewed. Policies were reviewed relating to counseling for prevention of tobacco use, benefits of physical activity and benefits of a healthy diet. The toll-free health advisor telephone hotline was assessed to ensure the general health information on topics appropriate to the various Medicaid populations was performed and completion of a clinical assessment triage.

Medical Records 8.305.8.17
Medical records policies and procedures were reviewed to determine evidence of medical record confidentiality processes and for a process to verify Health Insurance Portability and Accountability Act (HIPAA) compliant transfer of behavioral health information from one provider to another. A process to review medical records was assessed relating to specific documentation criteria and reporting mechanisms. Medical record documentation was reviewed in relation to the effectiveness of organization wide and practice-site follow-up plans that were established to increase compliance with VONM standards and goals.

Access to Care 8.305.8.18
The VONM protocols to ensure the accessibility, availability and referral to varied health care providers for each medically necessary service were evaluated. Policies and procedures related to access to urgent emergency services and access to health care services were reviewed.

Coordination of Services 8.305.9
Coordination of service policies and procedures were reviewed to determine the coordination of physical and behavioral health services. Policies and procedures relating to the home and community-based waiver programs, school-based services and children’s medical services were reviewed for coordination of services components. Additional policies and procedures focusing on care coordination services within the Juvenile Justice System and Children, Youth and Families Department (CYFD) were evaluated. A sample behavioral health provider care coordination plan was evaluated. This section included a random sample review of care coordination files for compliance with MAD regulations.

Encounters 8.305.10
Policies and procedures were evaluated to ensure they explained mechanisms for data handling, reporting, submission and correction of encounter data. Flow charts were analyzed to ensure that encounter data was charted correctly. A network operations log was reviewed for timeliness. Schedules for lunch-and-learn sessions were reviewed for training related to how to submit accurate and valid data. Claims and services utilization reports were reviewed for accuracy. A comprehensive encounter validation study is scheduled for fiscal year 2007 with VONM.

Reimbursement for Managed Care 8.305.11
The review included the evaluation of several reimbursement processes to include: timely provider payment for services; capitation disbursement; payment time frames; per-enrollee cash reserve; reimbursement for federally qualified healthcare centers (FQHCs);
reimbursement for providers furnishing care to Native Americans; and reimbursement for consumers who disenrolled while hospitalized.

**Member Grievance System 8.305.12**

Policies and procedures were reviewed to ensure the process of submitting a grievance and filing an appeal were in accordance MAD regulations. In addition, the policies and procedures were examined to determine if VONM resolved grievances and appeals within mandated time frames. If the grievance involved clinical issues, such as timeliness of care, access to care or appropriateness of care, the evaluation included a review of the clinical judgments involved in the case. If an appeal is filed, VONM conducts a review of the case using reviewers who were not involved in any prior decision. Expedited appeals refer to decisions that may seriously jeopardize the consumers’ life, health or ability to attain, maintain, or regain maximum function. The expedited appeal review process was evaluated for timeliness and notification standards. This section included a random sample file review of grievance, appeal and expedited appeals for compliance with MAD regulations. VONM submitted updated template letters for both grievances and appeals. Required HSD grievance and appeals reports were reviewed for consistency and accuracy.

**Fraud and Abuse 8.305.13**

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 the program description was assessed to determine if VONM was in compliance with state and federal regulations. An internal staff training program was reviewed for efficacy and efficiency.

**Reporting Requirements 8.305.14**

A review of managerial, financial, utilization management and quality management reports were analyzed to establish if VONM met the MAD reporting requirements in regard to report submission, analysis and frequency-of-submission standards.

**Services for Individuals with Special Health Care Needs 8.305.15**

Individuals with Special Health Care Needs (ISHCN) policies and procedures were reviewed to determine if consumers with multiple and complex physical and behavioral health care needs were proactively identified by VONM staff. VONM’s process of applying stratification criteria to identify ISHCN was examined. Documents related to the development and distribution of health education materials was assessed to determine availability to the ISHCN population. Specific VONM clinical practice guidelines for ISHCN were evaluated for compliance with MAD regulation. Policies and procedures were assessed to determine if VONM provides care coordination for ISHCN, and a random sample of coordination cases was reviewed for compliance with MAD regulations. A performance measure specific to ISHCN was included in the review.

**Client Transition of Care 8.305.16**

Policies and procedures were evaluated to ensure continuity of care during transition in services. Prior authorizations and provider payment requirements relating to transition of services were evaluated. Member eligibility was assessed to verify Medicaid managed care.
funding. This section included a random sample of transition of care cases reviewed for compliance with MAD regulations.

**Information Systems Capability Assessment (ISCA)**

This portion of the evaluation included a review of a VONM-completed ISCA tool. The ISCA information pertains to the collection and processing of data for VONM's Medicaid line of business. Additionally, HIPAA policies and procedures were reviewed for regulatory content and compliance.

**Information Systems**

VONM's systems development cycle and supporting environments were assessed via a detailed review of data processing policies and procedures, evidence of database management systems (DBMS), programming languages, and training for programmers.

**Staff Access Designation**

Physical access by staff to information technology (IT) assets as well as electronic records was evaluated by reviewing VONM's IT organizational chart and responses included in the ISCA tool. Specific training requirements for programmers and new staff were reviewed via the ISCA tool and during the on-site visit.

**Integrity of Security**

System integrity was evaluated for preventing data loss and corruption by reviewing VONM's disaster policies and procedures. On-site interviews clarified disaster recovery processes. Security of the computer area was investigated for the possibility of a breach in safety measures.

**Data Acquisition Capabilities**

This portion of the evaluation included a detailed review of the following; accurate submission of information, process for description differences when verifying accuracy of submitted claims and data assessment and retention. In addition, claims processing and encounter data processes were reviewed.

**Enrollment Systems**

VONM’s Medicaid enrollment systems pertaining to enrollment/disenrollment processes, tracking claims and encounter data, Medicaid enrollment data updates, Medicaid enrollment code, and data verification was reviewed. VONM’s responses were evaluated in accordance with the ISCA tool.

**Ancillary System**

This section pertains to recording information on stand-alone systems or benefits provided through subcontracts, such as pharmacy. VONM's ancillary systems were reviewed for vendor data and information.
Integration and Control of Data
Procedure for consolidating claims, encounter, and consumer and provider data was reviewed. A flowchart outlining the structure of the management information systems and data integration was assessed. This review included accuracy of Medicaid claims reports.

Vendor Data Integration
This portion of the review examined the number of contracted vendors. A review of how VONM integrates vendor data with administrative data was assessed for completeness of data, and quality of data.

Performance Measure Repository
The structure of the performance measure repository was assessed to determine system characteristics and processes used to collect and analyze performance measure data.

Report Production
Report production was evaluated to include a detailed review of Medicaid report generation, program revisions, Medicaid claim encounters and provider data as well as how revisions are implemented in this process.

Provider Database
A review of mechanisms VONM incorporates to maintain its provider directory was examined as well as a review of the fee schedules and contractual payments updates.

Requested IS/IT Documents
Prior to the on-site evaluation, requested documents were reviewed for accuracy and completeness. The following documents were requested and reviewed if submitted:

- Data integration flow chart
- Program query language for performance measure repository
- Continuous enrollment source code
- Medicaid member months source code
- Medicaid claims edits
- Statistics on Medicaid claims and encounters
- Notice of privacy practices

Defining and Measuring Compliance with NMAC and CMS Standards
The data collected from VONM, either pre-on-site or during the on-site visit, were considered in determining the extent to which VONM was in compliance with NMAC and CMS standards. NMMRA auditors reviewed completed audit tools as part of the evaluation of specific MAD regulations.

The designation is determined by the level of compliance found in the standard elements, not on the number of elements determined to be deficient. Consequently, it is possible that a deficiency for a single standard element may result in a designation of “Minimal Compliance” because the element is considered essential. Conversely, it is also possible that...
several deficiencies may have little impact on the SE's overall compliance, in which case the standard could be given a designation of "Moderate Compliance." The tables at the end of each standard-specific data collection tool show the level of compliance required to meet each designation. The following is a list of the standard designations and their corresponding definitions:

<table>
<thead>
<tr>
<th>Designation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>SE has met or exceeded standard</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>SE has met most requirements of the standard, but may be deficient in a small number of areas</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>SE has met some requirements of the standard, but has significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>SE has not met standard, requires mandatory corrective action</td>
</tr>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Each designation is weighted as follows:

<table>
<thead>
<tr>
<th>Designation</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>

**Scoring Methodology**

This section explains the numerical system used to arrive at a score for each standard, each category, and an overall score for VONM's performance.

**Allocation of Points**

Each category of standards is assigned a specific number of points. These points are then distributed among the standards included in each category as summarized below. As indicated in Table 1, the total number of points or score VONM can achieve on the NMAC standards is 150. As indicated in Table 2, the total number of points or score VONM can achieve on the CMS standards is 97.
Table 1: Allocation of Points

<table>
<thead>
<tr>
<th>Regulation Number</th>
<th>Regulation Description</th>
<th>Available Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.2.</td>
<td>Member Education</td>
<td>5</td>
</tr>
<tr>
<td>8.305.3.</td>
<td>Contract Management</td>
<td>7</td>
</tr>
<tr>
<td>8.305.6.</td>
<td>Provider Network</td>
<td>7</td>
</tr>
<tr>
<td>8.305.7.</td>
<td>Benefit Package</td>
<td>5</td>
</tr>
<tr>
<td>8.305.8.12.</td>
<td>Quality Management and Improvement</td>
<td>8</td>
</tr>
<tr>
<td>8.305.8.13.</td>
<td>Utilization Management</td>
<td>15</td>
</tr>
<tr>
<td>8.305.8.15.</td>
<td>Member Bill of Rights</td>
<td>5</td>
</tr>
<tr>
<td>8.305.8.16.</td>
<td>Preventive Health Services</td>
<td>2</td>
</tr>
<tr>
<td>8.305.8.17.</td>
<td>Medical Records</td>
<td>7</td>
</tr>
<tr>
<td>8.305.8.18.</td>
<td>Access to Care</td>
<td>6</td>
</tr>
<tr>
<td>8.305.9.</td>
<td>Coordination of Services</td>
<td>14</td>
</tr>
<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</td>
<td>6</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 Individuals with Special Health Care Needs</td>
<td>10</td>
</tr>
<tr>
<td>8.305.16.</td>
<td>Client Transition of Care</td>
<td>4</td>
</tr>
</tbody>
</table>

**Total Score** 150

Table 2: Allocation of Points

<table>
<thead>
<tr>
<th>Domains</th>
<th>Available Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS Capability Assessment (ISCA)</td>
<td>10</td>
</tr>
<tr>
<td>IS System Data Processing Procedures and Personnel</td>
<td>9</td>
</tr>
<tr>
<td>Staff Access Designation</td>
<td>9</td>
</tr>
<tr>
<td>Integrity of Security</td>
<td>9</td>
</tr>
<tr>
<td>Data Acquisition Capabilities</td>
<td>9</td>
</tr>
<tr>
<td>Enrollment Systems</td>
<td>14</td>
</tr>
<tr>
<td>Ancillary Systems</td>
<td>8</td>
</tr>
<tr>
<td>Integration and Control of Data</td>
<td>10</td>
</tr>
<tr>
<td>Vendor Data Integrity</td>
<td>2</td>
</tr>
<tr>
<td>Performance Measure Repository</td>
<td>2</td>
</tr>
<tr>
<td>Report Production</td>
<td>2</td>
</tr>
<tr>
<td>Provider Data Base</td>
<td>3</td>
</tr>
<tr>
<td>Requested Documents</td>
<td>10</td>
</tr>
</tbody>
</table>

**Total Score** 97
Surveyor Training and Oversight
NMMRA auditors conducted the evaluation for the compliance audit, which included document review, chart review and interviews. The auditors completed an inter-rater reliability (IRR) assessment for all sections with a chart review. The NMMRA auditors also conducted a peer-review of each other’s sections to ensure consistency in assigning designations, scoring and language.

Data Validation
All auditor-completed instruments were validated against final reports to ensure the accuracy of information. Discrepancies were discussed with NMMRA EQRO staff and with the NMMRA EQRO medical director to ensure accurate reporting of information.

In addition, data entry into the database was reviewed at 100 percent to provide error-free data entry prior to analyzing results. During the on-site audit, VONM data provided with the universe submission were validated against the hard-copy records. Discrepancies were discussed with VONM and with NMMRA EQRO staff to ensure accurate collection of information.

Calculation of Final Score
Tables 3 and 4 present the final overall score, by category, for VONM. As described in the scoring methodology of this report, the final score was calculated using these methods:

- The percentage score range associated with each compliance category is as follows:

<table>
<thead>
<tr>
<th>Compliance Category</th>
<th>Percentage 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>

- The available points per standard are multiplied by the appropriate weight according to the assigned designation to calculate the achieved points for that standard.

- The achieved points for all the standards in the category are then summed to calculate the total assigned points for the category.

- The final overall score is then derived by summing the total points assigned per category.

- The total number of points or score the SE can achieve for the NMAC standards is 150.

- The total number of points or score the SE can achieve for the CMS standards is 97.
ValueOptions of New Mexico Specific Evaluation Findings

Using NMMRA’s scoring methodology, the category and specific overall scores for VONM are presented in Table 3 and Table 4.

Table 3: Behavioral Health Compliance Audit Overall Scores

<table>
<thead>
<tr>
<th>Regulation Number</th>
<th>Regulation Description</th>
<th>Available Points</th>
<th>Assigned Points</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.2.</td>
<td>Member Education</td>
<td>5</td>
<td>3.50</td>
<td>70%</td>
</tr>
<tr>
<td>8.305.3.</td>
<td>Contract Management</td>
<td>7</td>
<td>6.50</td>
<td>93%</td>
</tr>
<tr>
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<td>8.305.7.</td>
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<td>8.305.8.12.</td>
<td>Quality Management and Improvement</td>
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<td>8.305.8.17.</td>
<td>Medical Records</td>
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</tr>
<tr>
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<td>Access to Care</td>
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</tr>
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<td>8.305.9.</td>
<td>Coordination of Services</td>
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<td>8.63</td>
<td>62%</td>
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<td>8.305.10.</td>
<td>Encounters</td>
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<td>7.00</td>
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<tr>
<td>8.305.11.</td>
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<td>Reporting Requirements</td>
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<td>Client Transition of Care</td>
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**Totals** 150 112.02 75%
Table 4: Behavioral Health Compliance Audit IS Scores

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<tr>
<th>Domains</th>
<th>Available Points</th>
<th>Assigned Points</th>
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<tr>
<td>IS Capability Assessment (ISCA)</td>
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</tr>
<tr>
<td>IS System</td>
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<td>Staff Access Designation</td>
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<td>9</td>
<td>100%</td>
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<tr>
<td>Integrity of Security</td>
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<td>9</td>
<td>100%</td>
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<td>Data Acquisition Capabilities</td>
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<tr>
<td>Enrollment Systems</td>
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<tr>
<td>Ancillary System</td>
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<tr>
<td>Integration and Control of Data</td>
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<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Vendor Data Integration</td>
<td>2</td>
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</tr>
<tr>
<td>Performance Measure Repository</td>
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<td>2</td>
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</tr>
<tr>
<td>Report Production</td>
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<tr>
<td>Provider Data</td>
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<td>0%</td>
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<tr>
<td>Requested IS/IT Documents</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>97</strong></td>
<td><strong>72</strong></td>
<td><strong>74%</strong></td>
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Audit Findings

Member Education 8.305.2
Minimally Compliant
Upon NMMRA’s review, the Member Education standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- **Compliant**
  - Member handbook included the applicable content and was available in Spanish
  - Membership was evaluated to determine a prevalent population within 5 percent
  - Mechanisms for development and distribution of member education is reflected in the policy and procedure
  - Utilization of race, ethnicity and primary language for member education are contained within the policy and procedure
  - Recovery and resiliency documentation included health education for consumers
  - Toll-free lines are maintained according to specified MAD regulations

- **Non-Compliant**
  - Behavioral health information is not distributed to consumers upon enrollment
  - Provider directory was not developed
  - Consumer handbook is not distributed within 30 days of enrollment

Contract Management 8.305.3
Fully Compliant
Upon NMMRA’s review, the Contract Management standard was determined to be fully compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:
• Compliant
  o Boilerplate contract and sample contracts were submitted for various types of subcontracts
  o Credentialing policy and procedures include a process to verify credentials of providers and subcontractors
  o Organization structure/chart identify appropriate lines of accountability
  o Organizational mission is documented
  o Documents describe board and committee composition
  o Organizational documents describe the relationship to parent affiliated and related business entities
  o Guidelines provide direction for the development, review and approval of policies, procedures and job descriptions
  o Provider handbook and Web-based provider information detailed contract requirements
  o Customer/family advisory meeting report submitted

• Non-compliant
  o Consumer advisory board meetings were not conducted quarterly per MAD regulation

Provider Networks 8.305.6
Minimally Compliant
Upon NMMRA’s review, the Provider Network standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

• Compliant
  o Site-visit documentation indicated provider locations were assessed to determine if members with disabilities could be accommodated
  o Policies and procedures reflect MAD regulatory requirements for provider recruitment and termination
  o Documentation indicated that each provider’s qualifications and credentials is verified to meet applicable federal and state requirements
  o Policies and procedures specific to specialty providers were reviewed
  o Policies and procedures provide appropriate information on access to care
  o Contract information related FQHCs, school-based health care centers, state-run institutions and Indian Health Services was reviewed
  o Meeting minutes relating to the clinical advisory committee were submitted for review

• Non-compliant
  o Provider directory was not developed
  o Geo Access Report was not submitted for review within audit time frame
Benefit Package 8.305.7
Minimally Compliant
Upon NMMRA’s review, the Benefit Package standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- Compliant
  - Provider handbook indicated benefits as well as enhanced benefits
  - Report HSD 24 indicates utilization of enhanced benefits for Medicaid consumers
  - Policies and procedures included information regarding distribution and education of consumer benefits

- Non-compliant
  - Consumer handbook does not contain benefit information
  - Consumer newsletter, December 2005, did not contain benefit information
  - Provider newsletter, Fall 2005, did not contain benefit information

Quality Management and Improvement 8.305.8.12
Moderately Compliant
Upon NMMRA’s review, the Quality Management and Improvement standard was determined to be moderately compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- Compliant
  - Quality Improvement Program description contained goals related to the immediate and long-term objectives for the contract year
  - Quality Work Plan addresses the activities related to improving consumer behavioral health services
  - Quality Improvement Committee minutes report organizational quality activities
  - Clinical practice guidelines include: Attention Deficient Hyperactivity Disorder, Schizophrenia, Co-occurring Mental and Substance Related Disorders, Opioid Related Disorders, Eating Disorders, Major Depressive Disorder and Bi-polar Disorder
  - Policies and procedures regarding quality of care and over and under utilization document processes to improve clinical care
  - Refer to Appendix 1 for specific quality of care file review (80%)

- Non-compliant
  - Refer to Appendix 2 for specific over and under utilization file review (40%)

Utilization Management 8.305.8.13
Fully Compliant
Upon NMMRA’s review, the Utilization Management (UM) standard was determined to be fully compliant based on MAD regulations. The following findings reflect compliant components:
Compliant
- UM program description contained goals related to the immediate and long-term objectives for the contract year
- Physician involvement is evident in documentation within the UM subcommittee minutes
- UM subcommittee recorded aspects of the UM functions to be documented in the annual UM evaluation
- Policy and procedure for inter-rater reliability (IRR) documented the process used to evaluate UM staff decisions
- IRR program report conveyed evaluation of staff decision reliability rate and recommendations for training and re-assessment
- UM policy and procedures adhere to the MAD regulations in relation to decision criteria
- UM reports reviewed:
  - Report #13 BH Staff Credentials
  - Report PM 13 Denials/1000 Services Requests
  - Report #1 Prior Authorization Report
  - HSD 2 BH Detail Denial Report
  - Report PM 9 RTC Readmissions
  - Report #4 Critical Incidents Report
- Policy and procedure related to compensation for UM activities was reviewed for compliance with federal regulations
- Policy and procedure describes how new technology is included in the benefit package
- Member satisfaction survey will be completed in June 2006 and results will be available in October 2006
- Refer to Appendix 3 for review of summary scores (85%)
- Refer to Appendix 4 for denial file review (92%)
- Refer to Appendix 5 for approval file review (54%)

Credentialing and Recredentialing 8.305.8.14
Minimally Compliant
Upon NMMRA's review, the Credentialing and Recredentialing standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

Compliant
- Practitioner site-visit form reviewed for consistency with the MAD credentialing regulation
- Policy and procedure compliant with MAD regulation for recredentialing of providers
- Process was examined to ensure credentialing personnel review state certification or accreditation for each facility

Non-compliant
- Process for receiving input from participating providers regarding credentialing and recredentialing
**Member Bill of Rights 8.305.8.15**

**Minimally Compliant**

Upon NMMRA’s review, the Member Bill of Rights standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- **Compliant**
  - Policy and procedure for Member Bill of Rights was reviewed for specific subsections in accordance with MAD regulations
  - Member handbook assessed for published Bill of Rights
  - Policy and procedure reviewed for compliance with confidentiality state and federal requirements
  - Confidentiality policy and procedure examined to determine if VONM was compliant with process to protect consumer information when filing a complaint
  - Direct access policy and procedure qualified a process allowing consumers access to behavioral health providers without a referral a PCP

- **Non-compliant**
  - Policy and procedure for treatment of minors lacking MAD regulation elements
  - Cultural competency was not addressed in provider newsletters and/or classes

**Preventive Health Services 8.305.8.16**

**Non-compliant**

Upon NMMRA’s review, the Preventive Health Services standard was determined to be non-compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- **Compliant**
  - Accessed health hotline after-hours to determine if clinical assessment triage protocols are followed for appropriateness in relation to acuity and severity of consumer’s symptoms

- **Non-compliant**
  - Preventative health standards were not developed or submitted for review
  - Initial assessment process not developed or submitted for review
  - Policies and procedures clarifying how counseling for the prevention of tobacco use, benefits of physical activity and benefits of a healthy diet is administered were not developed
  - Preventative wellness counseling was not available in the form of a preventive telephone hotline

**Medical Records 8.305.8.17**

**Fully Compliant**

Upon NMMRA’s review, the Medical Records standard was determined to be fully compliant based on MAD regulations. The following findings reflect compliant components:
• Compliant
  o Medical record documentation standards were demonstrated in the review of the VONM medical record audit form
  o Behavioral health documentation standards were assessed for compliance with MAD regulation medical record documentation requirements
  o On-site provider medical record documentation process was reviewed via VONM’s automated system
  o Policy and procedure and provider treatment record results forms were reviewed to assess medical record standards and goals
  o Provider contracts include provision for access to consumer medical records
  o Confidentiality policy and procedure reviewed for compliance with MAD regulation

Access to Care 8.305.8.18
Fully Compliant
Upon NMMRA’s review, the Access to Care standard was determined to be fully compliant based on MAD regulations. The following findings reflect compliant components:

• Compliant
  o The process a consumer utilizes to access urgent emergency services and all other health care services were reviewed
  o Policies and procedures, protocols and the consumer handbook were evaluated

Coordination of Services 8.305.9
Minimally Compliant
Upon NMMRA’s review, the Coordination of Services standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

• Compliant
  o Policies and procedures were reviewed for the following coordination of behavioral health services:
    ▪ Coordination of physical and behavioral services
    ▪ Coordination of care for ISHCN
    ▪ Access to Medicaid external programs (e.g., home and community-based waiver program)
    ▪ Ongoing reporting of psychiatric care to the PCP
    ▪ Coordination with waiver programs
    ▪ Coordination of services with CYFD
    ▪ Coordination of services with schools
    ▪ Access to behavioral health services without referral from the PCP

• Non-compliant
  o Educational materials for behavioral health providers relating to the referral process for physical health consultation was not submitted
State-wide training occurred detailing the transition from the managed care organizations (July 1, 2005) to VONM; however, training documents submitted did not include referrals for care coordination.

Provider handbook and the provider newsletter were reviewed for care coordination in relation to topics concerning referrals for physical health and behavioral health services.

Sample plan of care did not indicate interventions, community planning and information sharing with multiple providers.

The process for the development and implementation of the plan of care by the case manager or community case manager was inconsistent in the review of care coordination cases.

Refer to Appendix 6 for specific care coordination case review (53%).

**Encounters 8.305.10**

*Minimally Compliant*

Upon NMMRA’s review, the Encounters standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- **Compliant**
  - Schedule of provider lunch-and-learn sessions was reviewed for content
  - Encounter and claims reports reviewed:
    - Report # 9 Services Utilization Report (Encounters)
    - Report # 6 Claims Report

- **Non-compliant**
  - Network operations log was not developed or submitted for review
  - Policy and procedure for encounters was not developed or submitted for review
  - Flow charts were not detailed in relation to encounter reporting process

**Reimbursement for Managed Care 8.305.11**

*Moderately Compliant*

Upon NMMRA’s review, the Reimbursement for Managed Care standard was determined to be moderately compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- **Compliant**
  - Provider and facility contracts reviewed for member liability clause
  - Expenditures for behavioral health services meets the 85 percent ratio required by MAD regulation
  - Reports were reviewed to determine if claims payment were timely
  - HSD legal counsel memorandum reflected VONM was not required to meet the standards for reimbursement coverage and fidelity bonds
  - Letters to providers were reviewed detailing the third-party liability process
  - HSD Report # 12 reviewed for reimbursement for providers furnishing care to Native Americans
Per MAD third-part liability in relation to Coordination of Benefits was not required
Special reimbursement for FQHC’s waived and discussed on-site

Non-compliant
Report was submitted for evidence of per enrollee cash reserve; however, the report did not reflect the reserve amount of 3% required
Provider contracts did not contain required provisions for reimbursement for consumers who disenrolled while hospitalized

Member Grievance System 8.305.12
Minimally Compliant
Upon NMMRA’s review, the member grievance resolution standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

Compliant
General requirements for grievance and appeals policies and procedures were reviewed
Grievance and Appeals reports reviewed:
- Report # 2 Complaints/Grievance
- Report # 3 Appeals
Member Handbook reviewed regarding consumer filing of grievance or appeal and the resolution process
Refer to Appendix 7 for grievance file review (83%)
Refer to Appendix 8 for appeals file review (61%)
Refer to Appendix 9 for expedited appeals file review (100%)

Non-compliant
Policy and procedures for grievances included inappropriate timeliness requirements and did not include portions of the MAD regulations
Policies and procedures for appeals neglected to include critical time frame for consumer notification and did not include portions of the MAD regulations
Process for expedited appeals included inappropriate timeliness requirement and did not include portions the MAD regulations
Policy and procedure for provider appeals was not submitted

Fraud and Abuse 8.305.13
Minimally Compliant
Upon NMMRA’s review, the Fraud and Abuse standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

Compliant
Policy and procedure for fraud and abuse were reviewed to verify detection, specific controls and reporting elements
Fraud and abuse program description was reviewed
o Fraud and abuse report, HSD 47, was reviewed

- Non-compliant
  o Training program description and documentation not submitted within the required audit timeframe
  o Efficiency and efficacy of fraud and abuse training was not submitted within the required audit timeframe
  o Reports were not submitted documenting modifications to the fraud and abuse training program to increase internal referrals for potential fraud cases

**Reporting Requirements 8.305.14**

**Minimally Compliant**

Upon NMMRA’s review, the Reporting Requirements standard was determined to be minimally compliant based on MAD regulations. The following findings reflect compliant components:

- Compliant
  o Reporting Grid reviewed
  o Sample of UM/QM reports reviewed
    - Report # 13 BH Staff Credentials
    - Report PM 13 Denials/1000 Services Requests
    - Report # 1 Prior Authorization Report
    - HSD 2 BH Detail Denial Report
    - Report PM 9 RTC Readmissions
    - Report # 4 Critical Incidents Report
  o Policy and procedure for record retention were reviewed for record retention requirements

- Non-compliant
  o Process to submit accurate, timely reports is required per MAD regulation

**Services for Individuals with Special Health Care Needs (ISHCN) 8.305.15**

**Non-compliant**

Upon NMMRA’s review, the ISHCN standard was determined to be non-compliant based on MAD regulations. The following findings reflect compliant and non-compliant components:

- Compliant
  o Care coordination for ISHCN policies and procedures were reviewed
  o Policies and procedures for network providers submitted

- Non-compliant
  o Policies and procedures for the identification of enrolled ISHCN
  o Informational and educational materials was not submitted within the audit timeframe
  o Policies and procedures for emergency, inpatient and outpatient ambulatory surgery hospital requirements for ISHCN not submitted
Clinical practice guidelines and criteria not submitted
- Policies and procedures for utilization management for services to ISHCN not submitted
- Performance measures not developed during audit timeframe
- Refer to Appendix 10 for ISHCN case review (53%)

**Client Transition of Care 8.305.16**

*Fully Compliant*

Upon NMMRA’s review, the Client Transition of Care standard was determined to be fully compliant based on MAD regulations. The following findings reflect compliant components:

- **Compliant**
  - Policies and procedures for member transition of care reviewed
  - Refer to Appendix 11 for transition of care file review (100%)

**Information Systems Capability Assessment (ISCA)**

*Fully Compliant*

Upon NMMRA’s review, the ISCA standard was determined to be fully compliant based on CMS standards. The following findings reflect compliant components:

- **Compliant**
  - ISCA tool and appropriate HIPAA policies and procedures were reviewed

**Information Systems**

*Fully Compliant*

Upon NMMRA’s review, the Information Systems standard was determined to be fully compliant based on CMS standards. The following findings reflect compliant components:

- **Compliant**
  - Provided draft data processing policies and procedures
  - DBMS, programming languages, and training for programmers were reviewed

**Staff Access Designation**

*Fully Compliant*

Upon NMMRA’s review, the Staff Access Designation standard was determined to be fully compliant based on CMS standards. The following findings reflect compliant components:

- **Compliant**
  - Training process for current staff and new hires was reviewed
  - IS/IT organizational chart reviewed

**Integrity of Security**

*Fully Compliant*

Upon NMMRA’s review, the Integrity of Security standard was determined to be fully compliant based on CMS standards. The following findings reflect compliant components:
- Compliant
  - Disaster recovery policies and procedures reviewed
  - Physical location for computer system was assessed and determined to be in a secured area

Data Acquisition Capabilities
Minimally Compliant
Upon NMMRA’s review, the Data Acquisition Capabilities standard was determined to be minimally compliant based on CMS standards. The following findings reflect compliant and non-compliant components:

- Compliant
  - Documents regarding the process to accurately submit information were reviewed
  - Data access and retention were reviewed
  - Process to submit claims and encounter data was reviewed
  - Timeliness of processing claims was reviewed
  - Validation of payment process was reviewed

- Non-compliant
  - Process for description differences in relation to data entry was not submitted

Enrollment Systems
Minimally Compliant
Upon NMMRA’s review, the Enrollment Systems standard was determined to be minimally compliant based on CMS standards. The following findings reflect compliant and non-compliant components:

- Compliant
  - Process for enrollment/disenrollment, tracking claims and encounter data was reviewed

- Non-compliant
  - Code to calculate Medicaid enrollment was not submitted
  - Data verification reports were not submitted

Ancillary Systems
Non-compliant
Upon NMMRA’s review, the Ancillary Systems standard was determined to be non-compliant based on CMS standards. The following findings reflect compliant and non-compliant components:

- Compliant
  - Vendor information reviewed

- Non-compliant
  - Vendor data reports were not submitted
Integration and Control of Data
Minimally Compliant
Upon NMMRA’s review, the Integration and Control of Data standard was determined to be minimally compliant based on CMS standards. The following findings reflect non-compliant components:

- Compliant
  - Flow chart was provided for review; however, the chart did not detail training of programmers and analyst
  - Procedure for consolidating claims, encounters, consumer and provider was reviewed

- Non-compliant
  - Medicaid reports were checked for accuracy by VONM; however, HSD began accepting encounter data as of April 30, 2006, not within audit time frame

Vendor Data Integration
Fully Compliant
Upon NMMRA’s review, the Vendor Data Integration standard was determined to be fully compliant based on CMS standards. The following findings reflect compliant components:

- Compliant
  - Medicaid claim/encounter data table from one vendor, SXC pharmacy, was reviewed

Performance Measure Repository
Fully Compliant
Upon NMMRA’s review, the Performance Measure Repository standard was determined to be fully compliant based on CMS standards. The following findings reflect compliant components:

- Compliant
  - Performance measure repository structure was reviewed

Report Production
Non-compliant
Upon NMMRA’s review, the Report Production standard was determined to be non-compliant based on CMS standards. The following findings reflect compliant and non-compliant components:

- Compliant
  - Medicaid report generation programs were reviewed
• Non-compliant
  o Logs or run controls for Medicaid claims, encounter membership and provider
data system were not submitted

Provider Database
Non-compliant
Upon NMMRA’s review, the Provider Data standard was determined to be non-compliant
based on CMS standards. The following findings reflect non-compliant components:

• Non-compliant
  o Documentation demonstrating updates to the provider directory was not
submitted

Requested IS/IT Documents
Non-compliant
Upon NMMRA’s review, the Requested Documents standard was determined to be non-
compliant based on CMS standards. The following findings reflect compliant and non-
compliant components:

• Compliant
  o Data integration flow chart
  o Program query language for measure repository
  o Notice of privacy practices

• Non-compliant
  o Continuous enrollment source code
  o Medicaid members months source code
  o Medicaid claims edits
  o Statistics on Medicaid claims/encounters and other administrative data
Recommendations
The conclusions of this review are aimed at facilitating continuous improvement of the behavioral health care managed by VONM. With that purpose in mind, NMMRA offers the following recommendations for VONM and HSD consideration. Below are the recommendations per MAD regulation:

Member Education 8.305.2
- Produce and institute a comprehensive provider directory
- Institute process for providing and distributing education materials to consumers
- Verify tracking system to validate that consumers receive a member handbook
- Coordinate with SALUD! managed care organizations (MCOs) to develop a brochure listing behavioral health benefits and enhanced benefits that would be distributed with the MCO’s consumer welcome packet
- Develop brochures and other educational materials and distribute at consumer advisory board meetings, health fairs, etc. describing the behavioral health program

Provider Networks 8.305.6
- Produce and distribute VONM provider directory
- Include in the Geo Access documentation the calculation of the distance to the nearest provider using the entire universe of providers (e.g., Sandoval County)

Benefit Package 8.305.7
- Develop and distribute a behavioral health brochure for consumers
- Establish publication schedule with the required information per publication listed
- Expand the policy to include development of a summary benefit package brochure

Quality Management and Improvement 8.305.8.12
- Formalize approval process and documentation of committee approval for clinical practice guidelines

Utilization Management 8.305.8.13
- Include clinical information utilized to make an approval determination in VONM’s UM documentation system
- Establish a process for urgent requests requiring an expedited appeal
- Correctly identify expedited appeals and include a mechanism for tracking
- Notify the consumer and provider when an expedited appeal has already occurred (MAD 8.305.8.13 E.(5))
- Include in the denial letter “a copy of clinical criteria is available upon request” to the provider or consumer

Credentialing and Recredentialing 8.305.8.14
- Formalize process for receiving input from participating provider’s regarding credentialing and recredentialing of providers
Member Bill of Rights 8.305.8.15
- Policy and procedure should include the right to seek second opinion from a qualified health care professional within the VONM network
- Develop statement of advance directives in the consumer handbook
- Treatment of minors policy and procedure include informed consent and distribution of information to provider
- Develop specific section of the provider newsletter to be dedicated to cultural competency

Preventive Health Services 8.305.8.16
- Development of preventive behavioral health guidelines
- Institute a process to obtain assessment data with initial contact with consumer
- Develop policy to ensure applicable asymptomatic consumers are provided counseling regarding: tobacco use, benefits of physical activity, and benefits of healthy diet
- Incorporate preventive wellness counseling within the toll free health advisor hotline functions

Medical Records 8.305.8.17
- Revise provider site-visit review form to include: advance directives, preventive services, preventive health history, consumer’s mailing address and residential address, marital status, past medical history
- Confidentiality policy and procedure should include the transfer of behavioral health information from one practitioner to another when a provider leaves the network and from one collaborative agency to another

Access to Care 8.305.8.18
- Develop and implement quarterly consumer access standard reports

Coordination of Services 8.305.9
- Develop and include coordination of services as a component of educational briefings during a provider site visit
- Include specific referral information in the provider handbook
- Develop a VONM care coordination form to capture the required information related to care coordination issues and include the behavioral health plan of care components

Encounters 8.305.10
- Develop a formal reporting process for encounters to be accurately documented
- Establish detailed encounter flow charts in accordance with Appendix Z of the CMS protocol
- Develop a log for submission of encounter data to the state

Reimbursement for Managed Care 8.305.11
- Include required provisions in the provider contracts for reimbursement for consumers who disenroll while hospitalized
Member Grievance System 8.305.12
- Policies and procedures for grievance and appeals should be closely aligned with the MAD regulations in relation to timeliness standards, assisting consumers with the written appeal process, and notification standards
- Develop policy and procedure for provider appeal process
- Include in the process for expediting appeals all MAD regulatory requirements

Fraud and Abuse 8.305.13
- Policy and procedure should include mechanisms to prevent fraud and abuse
- Include, in the fraud and abuse program description, a training section detailing frequency of sessions and monitoring its efficiency and efficacy

Reporting Requirements 8.305.14
- Formalize a tracking process for submission of reports to HSD
- Document and track multiple versions of the same report submitted to HSD

Services for ISHCN 8.305.15
- Develop education materials for distribution when ISHCN are identified with a particular problem or to assist members, caregivers, parents, and/or legal guardians
- Formalize and distribute ISHCN clinical practice guidelines to providers
- Develop and implement policy and procedure for utilization management to include services for ISHCN
- Develop performance measures specific to ISHCN

Client Transition of Care 8.305.16
- No recommendations for this standard

Information Systems Capability Assessment (ISCA)
- No recommendations for this standard

Information Systems
- Finalize and implement what are currently draft policies and procedures

Staff Access Designation
- No recommendations for this standard

Integrity of Security
- Install an auditable electronic key system for the computer room

Data Acquisitions Capabilities
- Implement a process to calculate an accurate rejection rate
- Develop and implement a process for auditing provider data
- Establish a validation process for description differences
- Develop and implement a formalized policy and procedure for claims processing and encounter data

**Enrollment Systems**
- Develop and implement a process to verify data between past and recent roster information from HSD within the data warehouse
- Develop and implement a process for data verification

**Ancillary Systems**
- Develop and implement a process to validate, review and monitor pharmacy data

**Integration and Control of Data**
- Design a detailed flow chart to include training of programmers and analysts

**Vendor Data Integration**
- No recommendations for this standard

**Performance Measure Repository**
- No recommendations for this standard

**Report Production**
- Finalize and implement what is currently a draft policy and procedure

**Provider Database**
- Produce detailed provider directory
Summary and Corrective Action Recommendation

Based on this first Behavioral Health Compliance Audit since the transition from MCO oversight to a sole state-wide entity, VONM has received a designation of “Minimally Compliant” for both the Behavioral Health Compliance Audit and the Behavioral Health Compliance IS/IT Audit.

The summary of this review is aimed at recognizing continuous improvement of behavioral health care provided by VONM. With this goal in mind, NMMRA would like to recognize areas where VONM excels as well as areas needing immediate focus in order to meet the needs of the behavioral health consumer.

Upon review of the regulations standards, VONM scored “Fully Compliant” in the following areas:

- 8.305.3 Contract Management
- 8.305.8.13 Utilization Management
- 8.305.8.17 Medical Records
- 8.305.8.18 Access to Care
- 8.305.16 Client Transition of Care
- Information Systems
- Information Systems Capability Assessment (ISCA)
- Staff Access Designation
- Integrity of Security
- Vendor Data Integration
- Performance Measure Repository

The following standards were scored “Moderately Compliant”:

- 8.305.8.12 Quality Management and Improvement
- 8.305.11 Reimbursement for Managed Care

The scoring methodology approved by HSD mandates that any MAD regulation (e.g., Member Education, Provider Network, etc.) receiving a “Minimally Compliant” or “Non-compliant” be placed into corrective action. With this requirement in mind, NMMRA informs HSD that the following regulation standards met some requirements with significant deficits or did not meet the MAD regulations and require corrective action:

- 8.305.2 Member Education          Minimally Compliant
- 8.305.6 Provider Networks          Minimally Compliant
- 8.305.7 Benefit Package            Minimally Compliant
- 8.305.8.14 Credentialing and Recredentialing Minimally Compliant
- 8.305.8.15 Member Bill of Rights   Minimally Compliant
- 8.305.8.16 Preventive Health       Non-compliant
- 8.305.9 Coordination of Services   Minimally Compliant
- 8.305.10 Encounters                Minimally Compliant
- 8.305.12 Member Grievance System   Minimally Compliant
- 8.305.13 Fraud and Abuse           Minimally Compliant
- 8.305.14 Reporting Requirements: Minimally Compliant
- 8.305.15 Services for ISHCN: Non-compliant
- Data Acquisition Capabilities: Minimally Compliant
- Enrollment Systems: Minimally Compliant
- Ancillary Systems: Non-compliant
- Integration and Control of Data: Minimally Compliant
- Report Production: Non-compliant
- Provider Database: Non-compliant
- Requested IS/IT Documents: Non-compliant
Reconsideration Review
VONM reviewed the preliminary findings of the BH Compliance Audit Draft Report and responded with specific questions, comments and requests. The reconsideration review was completed in collaboration with HSD and NMMRA. Additional evidence submitted as of July 10, 2006 was reviewed as part of the reconsideration process. Documentation that fell outside the audit timeframe was not allowed. Evidence that was introduced that did not exist at the time of the original survey was not allowed. This decision was made in collaboration with HSD and formally communicated to NMMRA on July 18, 2006. The evidence submitted by VONM was reviewed multiple times, with the final review on August 17, 2006. Please refer to NMMRA’s response per category.

Contract Management 8.305.3
Per HSD regulation 8.305.3.11A(6)(a), consumer advisory board meetings are to be held at least “quarterly.” VONM submitted the board charter indicating the meetings were to be scheduled quarterly. NMMRA received one report from VONM as evidence for the quarterly meetings. As instructed by HSD, VONM was held to “immediate and full compliance” as of July 1, 2005. After a re-review of documentation provided by VONM, the intent of the regulation was not met and the score remains unchanged.

Provider Networks 8.305.6
The April 2006 Geo Access report does not fall within the audit timeframe. VONM did not submit evidence of a monthly Geo Access report. The January 2006 report submitted during the rebuttal is within the audit timeframe, however no other monthly reports were submitted for review at that time. After a re-review of documentation provided by VONM the score remains unchanged.

Benefit Package 8.305.7

Benefit Package 8.305.7.11
Consumer Newsletter and Handbook
HSD has agreed to re-evaluate the evidence required for this standard prior to the fiscal year 2007 compliance audit. After a re-review of comments provided by VONM, the score remains unchanged.

Benefit Package 8.305.7.12
Provider Newsletter
HSD has agreed to re-evaluate the evidence required for this standard prior to the fiscal year 2007 compliance audit. After a re-review of comments provided by VONM, the score remains unchanged.

Quality Management and Improvement 8.305.8.12
Over/Under Utilization 8.305.8.12.I(3)
Five cases were submitted for over/under utilization. Of those five cases, three were identified as over utilization cases. The over utilization cases did not indicate implementation of appropriate corrective interventions. These results were reviewed with the NMMRA EQRO medical director. The two under utilization cases did indicate appropriate corrective
interventions. These cases were scored appropriately. After a re-review of comments provided by VONM, the score remains unchanged.

**Credentialing and Recredentialing 8.305.8.14**

The documentation submitted indicated the requirements for this element are “under development.” The policy and procedure submitted on July 10, 2006 does not describe a process for receiving input from participating “network” providers regarding credentialing and recredentialing of providers. After a re-review of documentation provided by VONM, the score remains unchanged.

**Member Bill of Rights 8.305.8.15**

**Treatment of Minors 8.305.8.15.Q(8)**
The policy and procedure submitted during the audit timeframe was issued May 1, 2006. The date of issue falls outside the acceptable audit timeframe. The policy and procedure submitted on July 10, 2006 does not include informed consent or the process to educate providers. After a re-review of documentation provided by VONM, the score remains unchanged.

**Preventive Health 8.305.8.16**

**High Risk Behavioral Health Screen 8.305.8.16.Q(15)**
Points adjusted upward 0.25 points based on review of VONM comments.

**Counseling 8.305.8.16.D**
The Recovery and Resiliency documentation submitted does not directly address MAD prevention standards. After a re-review of documents provided by VONM, the score remains unchanged.

**Coordination of Services 8.305.9**

**Independent Access 8.305.9.A**
Points adjusted upward 0.5 points based on review of VONM comments.

**Plan of care 8.305.9.B**
The original document submission from VONM did not include a sample behavioral health plan of care. The sample behavioral health plan of care was submitted May 4, 2006. This plan of care is the responsibility of the behavioral health provider. Per MAD regulation the “SE care coordinators and community case managers shall be responsible for monitoring the coordination of the plan of care and information sharing for members receiving behavioral health care from multiple providers.” The behavioral health plan of care lacked the components of the MAD regulation and was scored appropriately.

The case review included validation of VONM’s ‘process’ regarding monitoring and updating of the plan of care. This process was inconsistently documented in the case review files. After a re-review of documentation provided by VONM, the score remains unchanged.
Encounters 8.305.10
The encounter submission process had not been operationalized during the audit timeframe. The current VONM process will meet the intent of the fiscal year 2007 compliance audit. After discussion with HSD regarding the comments provided by VONM, the score remains unchanged.

Reimbursement 8.305.1
Reimbursement 8.305.11.9.G(2)
Points adjusted upward 0.4 points based on review of VONM comments.

Per Enrollee Cash Reserves 8.305.11.9.G(6)
Per MAD regulation three percent of the monthly capitation payments per consumer during each month of the first year of the agreement must be maintained. Based on the reports submitted by VONM, the cash reserve rate calculated based on the monthly capitation payments per member was two percent. This calculation was performed by the NMMRA actuary. After re-calculting the data submitted by VONM, the score remains unchanged.

Reimbursement for FQHCs 8.305.11.9.I(1)
Points adjusted upward one point based on review of VONM comments.

Member Grievance System 8.305.12
File Review – Grievance
Grievance file review # 06-13-6166-M7100 documentation changed to reflect correct date and the aggregate file review score was adjusted.

File Review - Appeals
The intent of the MAD regulations concerning consumer or representative being offered a review of the appeals case file is specific to the appeals file and not the denial letter file. The denial letter is specific to the denial case file and process and therefore does not meet the intent of the appeals notification process noted in the MAD regulation. After a re-review of documentation provided by VONM, the score remains unchanged.

Reporting Requirements 8.305.14
Reporting Standards 8.305.14.10.A
A policy and procedure is not required for this standard, however a process to submit accurate, timely reports is required per MAD standards. The process to submit reports to HSD must include the following; accuracy, timeliness, conforms to MAD standards, contains complete information and is internally analyzed prior to submission to HSD. The audit tool has been updated to reflect the accurate non-compliance reason. After re-reviewing the documentation provided by VONM with HSD, the score remains unchanged.

Points adjusted upward two points based on review of VONM comments.
Services for Individuals with Special Health Care Needs (ISHCN)
8.305.15
Identification of Enrolled ISHCN 8.305.15.9.B
Policy and procedure submitted May 8, 2006 will meet the intent of the MAD regulations for fiscal year 2007 compliance audit.

Specialty Providers 8.305.15.12
Points adjusted upward 0.5 points based on review of VONM comments.

Clinical Practice Guidelines for Provision of Care to ISHCN 8.305.15.18
Although seven clinical practice guidelines were submitted, these guidelines do not encompass the breadth of diagnoses for the ISHCN population. Per MAD regulations the SE is to develop clinical practice guidelines, practice parameters and other criteria. The guidelines must be based on professionally accepted standards of practice and national guidelines. The submitted clinical practice guidelines do not meet the intent of the regulations. After a re-review of documentation provided by VONM and discussion with HSD, the score remains unchanged. The ISHCN MAD regulation will be reviewed for appropriateness in relation to behavioral health.

Utilization Management for Services to ISHCN 8.305.15.19
This MAD standard specifically indicates that policies and procedures must be developed for utilization management for services relating to ISHCN. VONM did not submit a policy and procedure for this portion of the standard. After a re-review of documentation provided by VONM, the score remains unchanged.

Information Systems

Enrollment Systems
Per VONM contract, the Behavioral Health Collaborative is responsible for verifying Medicaid enrollment updates. As directed by HSD based on the VONM contract, the points were adjusted upward three points.

Code to Calculate Medicaid (Continuous) Enrollment
The specific requirement for this element was a source code to calculate the continuous enrollment in Medicaid. The response from VONM was that the code is “not applicable.” Per CMS, the requirement for the source code is applicable and was not submitted. After a re-review of comments provided by VONM, the score remains unchanged.

Data Verification
Eligibility of the consumer should be verified before claims and encounters are processed. Dates of enrollment and disenrollment are key reporting fields for Medicaid HEDIS measures. Eligibility status for Medicaid consumers is dynamic and should be updated frequently. A list of error codes was submitted but not the edits that would generate the error codes. The documentation requirements were noted on the ISCA and the audit tool. This
process is an integral component of data verification. After a re-review of comments provided by VONM, the score remains as documented.

**Ancillary System**
The required documentation for vendor data was noted on the ISCA and the audit tool. In addition, page 40 of VONM's ISCA response states “not limited to providing only the documentation listed, encouraged to provide any additional documentation that helps clarify an answer or eliminate the need for a lengthy response”. Examples of vendor data are found within the ISCA and suggest monthly hard copy reports and full claims data. While conducting the on-site audit, VONM communicated to NMMRA staff that they have not seen nor reviewed Pharmacy reports. Additional documentation submitted as of July 10, 2006 will meet the intent of the CMS protocol for fiscal year 2007 compliance audit. After a re-review of documentation provided by VONM, the score remains unchanged.

**Integration and Control of Data**
This element specifically pertains to evidence of Medicaid reports updated and checked for accuracy and not HSD accepting encounter data from VONM. A process or evidence of reports being reviewed for accuracy was not submitted. After a re-review of comments provided by VONM, the score remains unchanged.

**Provider Data Base**
While conducting the on-site audit with VONM, an online provider directory was not submitted nor was there evidence of the directory per VONM staff. NMMRA was to verify the existence of a provider directory and was unable to do so. Per VONM Web site, URL [www.valueoptions.com/newmexico/provider/resources.htm](http://www.valueoptions.com/newmexico/provider/resources.htm), the provider directory is “coming soon” as of July 25, 2006. A hard copy provider directory was not submitted to NMMRA. An Excel spreadsheet has been developed for internal departmental use. Per the CMS protocol “evidence of how Medicaid provider directories are updated” is specifically addressed.

While on-site, NMMRA conducted interviews with key VONM staff and the provider database was not demonstrated. After a re-review of comments provided by VONM, the score remains unchanged.

**Evidence of Fee Schedules Updated**
This element of the IS audit was eliminated based on HSD direction. The audit tool reflects the change and the scoring methodology were adjusted accordingly.

**Requested Documents**

**Continuous Enrollment Source Code**
VONM reconsideration document states they were unaware of the requirement for the continuous enrollment source code as evidence for NMMRA. Per the ISCA, page 40 of VONM response, the requested documentation for the continuous enrollment source code is listed. This documentation was initially requested on March 9, 2006. A second request for documentation was sent to VONM on April 7, 2006. Both requests included the details of
the required documentation for the continuous enrollment source code. After a re-review of comments provided by VONM, the score remains unchanged.

**Medicaid Member Months Source Code**

The requirement for this section was to provide a detailed copy of the source code to calculate member months. The source code was not provided. Additional documentation received on July 10, 2006 did not include the source code requested to satisfy the requirement of this element. After a re-review of documentation provided by VONM, the score remains unchanged.

**Medicaid Claims Edits**

New evidence submitted as of July 10, 2006 was reviewed. The error code list is one component of the Medicaid claims edit process. Other specific edits such as the authorization list, authorization table, accumulated visits and fee schedule were not submitted. After a re-review of documentation provided by VONM, the score remains unchanged.

**Statistics on Medicaid Claims/Encounters and Other Administrative Data**

Specific documentation requested to explain statistics reported in the ISCA is located on page 40 of VONM response. This information was requested in advance with the prior documentation request and is an element of the audit tool. VONM did not supply the requested documentation with the prior documentation request nor within the completed ISCA. After a re-review of comments provided by VONM, the score remains unchanged.