Behavioral Health Compliance Audit

July 1, 2007 - December 31, 2007

Prepared for New Mexico Human Services Department
Under PSC 06-630-8000-02
Table of Contents:

Executive Summary ..........................................................................................................1
Background .......................................................................................................................3
Audit Approach and Methodology .....................................................................................3
Audit Tools ........................................................................................................................4
Universe Specifications ......................................................................................................7
Audit Overview ................................................................................................................10
On-site Meeting ...............................................................................................................10
Scoring Methodology ......................................................................................................10
Inter-rater Reliability (IRR) .............................................................................................12
Findings ...........................................................................................................................12
Calculation of Final Score ...............................................................................................21
Recommendations ............................................................................................................22
Audit Comparison Results ...............................................................................................25
Reconsideration Review .................................................................................................27
Conclusion ......................................................................................................................40

Appendices

1. 8.305.8.13. Utilization Management
2. 8.305.8.17. Standards for Medical Records
3. 8.305.9. Coordination of Services
4. 8.305.12. Member Grievance System
5. 8.305.15. Services for Individuals with Special Health Care Needs (ISHCN)
6. 8.305.16. Client Transition of Care
Executive Summary

The New Mexico (NM) Human Services Department (HSD) has contracted with the New Mexico Medical Review Association (NMMRA) as the NM external quality review organization (EQRO) to conduct monitoring, auditing, 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) No. 08-07 on August 22, 2007 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) 2008 (July 1, 2007 through December 31, 2007). The scope of work addressed all appropriate Medical Assistance Division (MAD) regulations, and was performed in accordance with NMMRA’s EQRO contract, Article 1.3.3.

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. In the previous two compliance audits, NMMRA was tasked to review VONM’s processes based on MAD regulation. For this audit, NMMRA was directed by HSD to review the processes and evaluate evidence VONM is following their own processes. 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 methodology approved by HSD, NMMRA finds VONM earned an aggregate designation of Moderate Compliance (82.65%) for the MAD standards examined.

VONM provided policies, processes, procedures and documentation to indicate that MAD regulations are met. However, there remain opportunities for improvement in seven of the categories audited related to providing evidence that VONM’s processes are being followed based on MAD regulations.

- 8.305.2. Member Education – Minimal Compliance (72.50%)
- 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 (93.16%)
- 8.305.8.14. Credentialing and Recredentialing – Full Compliance (100%)
- 8.305.8.15. Member Bill of Rights – Full Compliance (90.00%)
- 8.305.8.17. Standards for Medical Records – Minimal Compliance (79.60%)
- 8.305.9. Coordination of Services – Minimal Compliance (77.85%)
- 8.305.10. Encounters - Minimal Compliance (70.00%)
- 8.305.11. Reimbursement for Managed Care – Minimal Compliance (57.14%)
- 8.305.12. Member Grievance System – Full Compliance (99.90%)
- 8.305.14. Reporting Requirements – Minimal Compliance (60.00%)
- 8.305.15. Services for Individuals with Special Health Care Needs (ISHCN) Minimal Compliance (73.68%)
- 8.305.16. Client Transition of Care – Full Compliance (95.33%)
Seven of 14 standards were in Full Compliance. Action by VONM should be taken to ensure Full Compliance across all standards.

The scoring methodology 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 seven regulations recommended for corrective action based on these audit findings.

- 8.305.2. Member Education – Minimal Compliance (72.50%)
- 8.305.8.17. Standards for Medical Records – Minimal Compliance (79.60%)
- 8.305.9. Coordination of Services – Minimal Compliance (77.85%)
- 8.305.10. Encounters - Minimal Compliance (70.00%)
- 8.305.11. Reimbursement for Managed Care – Minimal Compliance (57.14%)
- 8.305.14. Reporting Requirements – Minimal Compliance (60.00%)
- 8.305.15. Services for Individuals with Special Health Care Needs (ISHCN) Minimal Compliance (73.68%)

Included in the detailed report are recommendations by standard for VONM to achieve full compliance with MAD regulations. In addition, HSD-specific recommendations are included to continue ongoing oversight of the SE.

\^FY 2007 Standards for Access were not evaluated in this audit
Background

In July 2005, HSD, along with multiple state agencies, implemented the first phase of its Behavioral Healthcare System Transformation. This restructuring created one statewide entity (SE) for behavioral health 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 partnered with the Behavioral Health Purchasing Collaborative and in turn contracted with community-based and independent providers to administer services statewide. As a requirement of its SE contract, VONM is required to comply with the NM Medicaid managed care regulations.

NMMRA conducted a compliance audit of BH for the first two quarters of FY 2008 (July 1, 2007 through December 31, 2007) therefore, this is the third 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 provide audit assurance and to identify areas requiring further investigation. The audit and scoring methodology addressed a subset of NM Administrative Code (NMAC) 8.305 regulations, specifically:

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

The scoring methodology was developed using NMAC, NM MAD regulations and Centers for Medicare and 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 NMAC and MAD regulations 8.305 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.

The following is a list of the regulatory guidelines covered during the audit and the rationale for each standard:

8.305.2. MEMBER EDUCATION
The SE shall educate Medicaid members about their rights, responsibilities, service availability and administrative roles under the managed care program. The SE shall be responsible to provide the member with a consumer handbook and provider directory within 30 days of enrollment. The SE shall follow the guidelines provided by HSD MAD for the information to be in the member handbook and provider directory.

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

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 members 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 members as well as take into consideration the characteristics and health care needs of its individual Medicaid populations.

In accordance with HSD 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 show evidence of active solicitation of input from network providers to improve and resolve issues with the SE.

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 members in the areas of health care delivery as well as supportive administrative systems. The SE’s quality management and improvement (QI) structures and processes shall be at least as stringent as federal requirements. The 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 quality improvement 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, member education and interpretation of covered benefits.

8.305.8.13. UTILIZATION MANAGEMENT (UM)

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 members. 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 its 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.

8.305.8.14. CREDENTIALING AND RECREDENTIALING

Practitioner participation and involvement is an important function of the relationship of the SE and its network providers. The SE shall have a process which 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 its 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 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.

8.305.8.15. MEMBER BILL OF RIGHTS

In accordance with the HSD MAD regulations, the SE shall have polices and procedures governing member rights and responsibilities. The SE shall have a member handbook in all media available and shall include other languages as appropriate to member 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 member handbook, which thoroughly describes the member bill of rights. The SE shall have a toll-free telephone number for members to file grievances telephonically.

8.305.8.17. STANDARDS FOR MEDICAL RECORDS
The medical record, whether electronic or on paper, communicates the member’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 will be in compliance with state and federal guidelines as well as HIPAA regulations.

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

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.

8.305.11. REIMBURSEMENT FOR MANAGED CARE
The SE receives a monthly capitation amount for each Medicaid member 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, minimum proportion of its capitation expended for services. It may not transfer its liabilities to those whom it is serving.

8.305.12. MEMBER GRIEVANCE SYSTEM
The SE shall demonstrate thorough and consistent procedures for responding to member 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 members, 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 member’s appeal from both sides. When a member
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 member’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 member to change a previous decision made by the SE.

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.

8.305.15. SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (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 physical health and BH. The definition also allows for flexible targeting of individuals based on clinical justification.

8.305.16. CLIENT TRANSITION OF CARE
The SE shall actively assist with transition of care issues. Medicaid-eligible clients may initially receive physical 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.

Universe Specifications

NMMRA provided VONM the universe specifications on November 13, 2007 at the audit overview meeting. The deadline for submittal of the universe data was on January 9, 2008. The following is a list of NM MAD regulations requiring chart review:

8.305.8.13. UTILIZATION MANAGEMENT
The representative sample for utilization management included approvals and denials during the audit time frame.

The universe specification consisted of a list of all consumer approvals during July 1, 2007 – December 31, 2007.
The universe specifications were identical to the HSD 2 Behavioral Health Detailed Denial Report. Reports for the months July 1, 2007 – December 31, 2007, 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 July 1, 2007 – December 31, 2007.

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.*

* If a universe had less than 20 cases/files NMMRA reviewed 100% of the universe submitted.

**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, 2007 – December 31, 2007, 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 5.

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 5.

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

* If a universe had less than 20 cases/files NMMRA reviewed 100% of the universe submitted.

**8.305.15. SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN)**
The universe specification consisted of a list of open and closed ISHCN care coordination files during July 1, 2007 – December 31, 2007.

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.*
* If a universe had less than 20 cases/files NMMRA reviewed 100% of the universe submitted.

8.305.16. CLIENT TRANSITION OF CARE (TOC)
The universe specification consisted of a list of open and closed TOC care coordination files during July 1, 2007 – December 31, 2007.

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

* If a universe has less than 20 cases/files, NMMRA reviewed 100% of the universe submitted.

8.305.8.17. STANDARDS FOR MEDICAL RECORDS
The universe specification consisted of a list of all consumers having at least one encounter during the July 1, 2007 – December 31, 2007 time frame with any BH provider.

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.

The universe specifications were reviewed by the NMMRA data analyst on January 14, 2008. VONM was notified that it had not submitted the universe specifications for Client TOC and ISHCN. VONM acknowledged they had not submitted the universe specifications and submitted them to NMMRA on January 14, 2008.

On January 17, 2008 NMMRA provided VONM with universe samples for all chart review sections.

NMMRA received a call on January 29, 2008 from HSD explaining VONM contacted them to explain the universe specifications for Coordination of Services and ISHCN were inaccurate and requested an approval to submit the corrected universes. HSD granted approval for VONM to resubmit the universe specifications. NMMRA documented that there were discrepancies between the original submittal of the universe specifications and the re-submittal of the universe specifications. VONM’s explanation for incorrect universe specifications was based on data issues with their computer system. Table 1 displays the discrepancies between the original and re-submittal of universe specifications. Universe samples were taken from the re-submitted universe after a comparison report was run to ensure a representative sample was taken from both submitted universes.

Table 1: Universe Specification Discrepancies

<table>
<thead>
<tr>
<th>Universe Specification Discrepancies</th>
<th>NM MAD Regulations</th>
<th>Original Universe Specifications</th>
<th>Re-submittal Universe Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination of Services</td>
<td>66</td>
<td></td>
<td>984</td>
</tr>
<tr>
<td>ISHCN</td>
<td>196</td>
<td></td>
<td>940</td>
</tr>
<tr>
<td>Client Transition of Care</td>
<td>326</td>
<td></td>
<td>197</td>
</tr>
</tbody>
</table>
Audit Overview

On November 13, 2007, 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 prior data source documentation lists. VONM was given 40 business days to submit the required data source documents; the deadline for submittal was January 9, 2008.

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 January 30, 2008, NMMRA requested additional documents based on the review of the prior data source documents submitted. These were due to NMMRA by 12:00 p.m. on February 6, 2008, however, VONM submitted the documents on February 6, 2008 after the 12:00 p.m. deadline.

On-site Meeting

NMMRA conducted an opening conference with key personnel at VONM on February 26, 2008. HSD staff was present via phone. The audit team was introduced, audit goals were distributed and discussed, the audit process and scope, was described and the timetable for completion of the audit was identified. The audit team explained the role of the EQRO medical director in relation to potential quality of care cases, suspected fraud and abuse cases and second-level review. 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% 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.

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. An aggregate average of 3.67 was scored, indicating average satisfaction with the audit.

Scoring Methodology

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.

Allocation of Points

Each regulation category is assigned a specific number of points based on the number of operational tasks defined in the MAD regulations, as summarized in Table 2. The maximum total number of points (measured score) the SE can achieve is 144.
Table 2: Allocation of Points

<table>
<thead>
<tr>
<th>Regulation Number</th>
<th>Regulation Description (category)</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 Network</td>
<td>10</td>
</tr>
<tr>
<td>8.305.8.13.</td>
<td>Utilization Management</td>
<td>15</td>
</tr>
<tr>
<td>8.305.8.15.</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>8.305.9.</td>
<td>Coordination of Services</td>
<td>15</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>8.305.14.</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>15</td>
</tr>
<tr>
<td>8.305.16.</td>
<td>Client Transition of Care</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Total Score</strong></td>
<td><strong>144</strong></td>
</tr>
</tbody>
</table>

**Earned Designation**

- The earned designation is determined by the level of compliance, not by the number of elements determined to be deficient.
- It is possible that a deficiency for a single element will result in a designation of “Minimal Compliance” because the element is considered essential.
- It is also possible that several deficiencies may have little impact on the SE’s overall compliance and, thus, the standard may earn a designation of “Moderate Compliance.”
- As approved by HSD each element on the audit tool is an “all or nothing” designation. Therefore, if element consists of five components all components must be present to receive the “all” designation or “Full Compliance.”

Table 3 details the earned designations and their corresponding descriptions:

Table 3: SE Earned Designation Scale

<table>
<thead>
<tr>
<th>SE Earned Designation Scale</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90-100%</td>
<td>SE met or exceeded standard</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80-89%</td>
<td>SE met most requirements of the standard, but has deficiencies in a small number of areas</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50-79%</td>
<td>SE met some requirements of the standard, but has significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-compliance</td>
<td>&lt; 50%</td>
<td>SE has not met standard and has significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
Calculation of Final Overall Score

The available points per level of 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.

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

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

The following 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.

8.305.2. MEMBER EDUCATION

Composite Score: 72.5%
Earned Designation: Minimal Compliance
Compliant
- SE demonstrated that the Member Handbook has the components required by HSD MAD regulations
- SE ensures the Member Handbook was available in Spanish
- SE evaluates 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 education materials for members
- SE has established policies and procedures regarding the utilization of information on race, ethnicity and primary language spoken by its membership
- SE maintains toll-free lines according to specified MAD regulations as evidenced by after hours protocol and policies and procedures

Non-Compliant
- SE did not provide 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

8.305.6. PROVIDER NETWORKS
Composite Score: 92.5%
Earned Designation: Full Compliance
Compliant
- SE maintains 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 documented process in Letter of Direction #8
- 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 list 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 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 credentialing and recredentialing
- SE complies with all access standards delineated under the Medicaid managed care contract in relation to geographic location, scheduling time and waiting times as evidenced by draft Network Management Plan, NM Facility Map, NM Practitioners Map, CI25 Access Standards Report FY2007 and Provider Treatment Record Review Tool
- SE maintains policies and procedures describing how consumers and providers receive instructions on access to services
- SE made these policies and procedures available in an accessible format, upon request from HSD, network providers and consumers
- SE contracts 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 execution page of contract
- SE actively solicits providers in an effort to improve and resolve problem areas and incorporates their input into 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

Non-Compliant

- SE did not provide information regarding the numbers of network providers not accepting new Medicaid consumers
- SE did not provide information of how it incorporates provider satisfaction survey results into the SE’s quality improvement program
- SE did not document and submit provider education training schedule to HSD and provide evidence as requested

8.305.8.12. STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT

Composite Score: 96%
Earned Designation: Full Compliance

Compliant

- SE’s Quality Improvement (QI) program structure included all regulation standards and sub-standards as evidenced by Quality Management Program, Quality Management Work Plan and Quality Management Evaluation
- SE has established policies and procedures to complete 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 QM Committee Meeting Minutes
- SE participated, with the BH Collaborative, in conducting an annual consumer satisfaction survey as evidenced by submission of FY2007 Consumer Satisfaction Project Report
- SE evaluates member grievance and appeals trends as evidenced by submission of CI-02 Complaints and Grievances Report and CI-03 Appeals reports
- SE uses 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 MCOs; proactively identifying members 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 members
  - 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 healthcare referral
- SE demonstrates its health management system included all regulation standards and sub-standards related to continuity of care for consumers as evidenced by submission of policies and procedures
- SE disseminates clinical practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic BH services as evidenced by policy and procedure
SE did provide a consumer satisfaction analysis that included interventions to improve its performance
SE did measure the effectiveness of the interventions
SE did inform consumers of results of member satisfaction activities

Non-Compliant
SE did not annually measure practitioner performance against at least two important aspects of three clinical practice guidelines and determine consistency of decision-making
SE did not implement the targeted disease management program as defined by HSD related to Depression
SE did not implement appropriate corrective interventions when it identified under utilization and over utilization

8.305.8.13. UTILIZATION MANAGEMENT
Composite Score: 93.16%
Earned Designation: Full Compliance

File Review Findings for Utilization Management
Thirty (30) consumer files for approved services were reviewed and the following observations were noted:
- One file had the denial determination overturned 30 days after the initial decision

Thirty (30) consumer files for denials were reviewed and the following observations were noted:
- One chart did not meet the notification timeliness standard

Compliant
- SE UM Program Description (UMPD) contains goals related to the immediate and long-term objectives for the contract year
- SE demonstrates physician involvement as evidence by documentation within the UM subcommittee minutes
- UM subcommittee documents aspects of the UM functions in the annual UM evaluation
- SE provides documentation to support their policy and procedure for decision criteria availability to providers upon request
- SE demonstrates that the UM policy and procedures are consistent with MAD regulations in relation to decision criteria
- SE 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

Non-Compliant
- SE did not document evaluation and annual approval of the UM Program by senior management, the behavioral health director or the QI committee
- SE has a policy and procedure for monitoring inter-rater reliability, however does not follow up on staff identified as not meeting 90% agreement on test cases
- SE did not maintain evidence that it has reviewed the UM decision criteria at specified intervals and that the criteria have been updated, as necessary
- SE did not provide utilization decision and notification in a timely manner that accommodates the clinical urgency of the situation
- SE did not provide evaluation of member and provider satisfaction with the UM process as part of its member satisfaction survey

8.305.8.14. CREDENTIALING AND REcredentialing
Composite Score: 100%
Earned Designation: Full Compliance

Compliant
- SE provided the mechanism for credentialing and recredentialing of providers
- SE has an established process for receiving provider input regarding credentialing and recredentialing as evidenced by submission of National VO Credentialing Committee Meeting Minutes
- SE performed primary source verification at the time of credentialing a provider as evidenced by policy and procedure
- SE used the HSD approved credentialing form as evidenced by submission of Practitioner Data Form
- SE performed external source verification at the time of credentialing a provider as evidenced by policy and procedure and submission of credentialing committee meeting minutes
- SE performed initial site visit of potential high volume BH practitioners as evidenced by policy and procedure
- SE has an established method to determine high volume BH practitioners as evidenced by CI-5 Report Instructions
- 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 maintains formalized recredentialing procedures
- SE maintains 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 maintains policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted

Non-Compliant
- No non-compliant findings at this time

8.305.8.15. MEMBER BILL OF RIGHTS
Composite Score: 90%
Earned Designation: Full Compliance

Compliant
- SE maintains a policy and procedure for Member Bill of Rights that was reviewed for specific subsections in accordance with MAD regulations
- SE provided the Member Handbook and was reviewed for published Bill of Rights
- 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 PCP
Non-Compliant
- SE does not have a documented process to distribute Member Handbook to consumers upon request
- SE did not demonstrate completion of consumer trainings related to cultural, ethnic and linguistic topics
- SE did not demonstrate a documented process to provide cultural competence materials provided to consumers

8.305.8.17. STANDARDS FOR MEDICAL RECORDS
Composite Score: 79.6%
Earned Designation: Minimal Compliance

File Review Findings for Medical Records
Thirty (30) provider records were reviewed and the following elements were not documented consistently in the consumer medical record:
- Personal biographical data in medical records, i.e. complete face sheet
- Allergies and adverse reactions to medication
- History of smoking, alcohol use and substance abuse
- Advance Directives for adults
- Treatment plan consistent with diagnosis
- Documentation of progress
- Preventive services – Relapse prevention and stress management

Compliant:
- SE maintains a policy and procedure regarding medical record confidentiality in compliance with state and federal guidelines and HIPAA regulations
- SE maintains policies and procedures that medical record documentation standards which are enforced with its SE providers and subcontractors, and require that medical records reflect all aspects of patient care, including ancillary services
- SE maintains a policy that ensures the confidential transfer of BH information from one practitioner to another

Non-Compliant
- SE demonstrated a mechanism to assess the effectiveness of “organization-wide and practice-site” follow-up plans to increase compliance with the SE’s established medical record standards and goals, however, VONM did not comply with the policy to present the aggregate analysis to the Clinical Quality Committee

8.305.8 COORDINATION OF SERVICES
Composite Score: 77.85%
Earned Designation: Minimal Compliance

File Review Findings for Coordination of Services
Twenty-three (23) coordination of service cases were reviewed for care coordination between physical and behavioral health. The following elements were not documented consistently in the case files:
- Primary point of contact
- Coordination to a quality provider
- Coordination of necessary services and assist consumers in obtaining such services
- Develop and monitor a consumers plan of care
Compliant
- SE demonstrated policies and procedures to ensure the following:
  - Effectiveness of monitoring the referral and coordinating 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 behavioral health services without referral from the PCP
  - Access and coordination of psychopharmacotherapy and diagnostic evaluations when clinically appropriate

Non-Compliant
- SE did not demonstrate that VONM is offering statewide training to all providers regarding specific referral policies and procedures
- SE did not demonstrate that VONM is educating and assisting BH providers to make appropriate referrals for PH consultation
- SE did not demonstrate a process for ensuring the BH provider keeps the PCP informed (with the consumer’s written consent) of the following:
  - Drug therapy
  - Laboratory and radiology results
  - Sentinel events such hospitalizations, emergencies, and incarceration
  - Discharge from psychiatric hospital, residential treatment services, treatment foster care placement or from other BH service and
  - All transitions in level of care

8.305.10. ENCOUNTERS
Composite Score: 70%
Earned Designation: Minimal Compliance

Compliant
- SE submits encounter data to HSD according to established guidelines; this was verified by the encounter data reports provided to NMMRA
- SE submits 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
- SE did not utilize encounter data to determine compliance with performance measures

8.305.11. REIMBURSEMENT FOR MANAGED CARE
Composite Score: 57.14%
Earned Designation: Minimal Compliance

Compliant
- SE pays contracted and non contracted providers interest on the SE’s liability at the rate of 1½% per month on the amount of a clean claim as evidenced by interest paid on claims
- SE reimburses FQHCs at 100% of the reasonable cost under the Medicaid managed care program unless waived by the FQHC for a negotiated rate as evidenced by paid claims
- SE reimburses 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 as evidenced by paid claims

**Non-Compliant**
- SE does not meet 100% of the timeliness standard to pay clean claims according to the prescribed time frames every month
- SE did not provide evidence of payment for a Medicaid member hospitalized at the time of disenrollment

**8.305.12. MEMBER GRIEVANCE SYSTEM**
Composite Score: 99.9%
Earned Designation: 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

**File Review Findings for Consumer and Provider Appeals**
Twenty-nine (29) consumer and fifteen (15) provider appeal files were reviewed for adherence to time frames, notification requirements and resolution requirements
- Consumer Appeal
  - One case had the wrong acknowledgment letter in which two elements were not included in the letter

**File Review for Expedited Appeals**
Thirty (30) consumer files were reviewed for adherence to time frames, notification requirements and resolution requirements

**Compliant**
- SE implemented written policies and procedures describing how the consumer may submit a request for a grievance, for an appeal, and for a fair hearing with HSD
- SE provides 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 assists consumer with completing forms and taking other procedural steps as evidenced by submission of Consumer Handbook and a policy and procedure
- SE provides interpreter services and toll-free numbers that have TTY/TTD and interpreter capability as evidenced by Appeal and Grievance letter templates, Consumer Handbook and a policy and procedure
- SE ensures 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 ensures that individuals who make decisions about grievances and appeals are not involved in any previous decisions. Health care professionals with appropriate clinical expertise will make decisions on the following:
  - an appeal of a SE denial based on lack of medical necessity as evidenced in UM policy and procedure
- A denial that is upheld in an expedited resolution as evidenced in QM policy and procedure
- A grievance or appeal that involves clinical issues evidenced in QM policy and procedure
  - SE provides consumers with an information sheet or handbook that includes information on how to file a grievance or appeal and the resolution process, and the right to file a request for an administrative hearing with HSD hearing bureau as evidenced in the Consumer Handbook
  - SE continues benefits while the appeal and/or the HSD fair hearing process is pending as evidenced in QM policy and procedure and Appeal Letter templates
  - If the SE reverses a decision to deny, limit or delay services, the consumer receives the disputed services while the appeal was pending; the SE will pay for these services as evidenced in QM policy and procedure

Non-Compliant
- No non-compliant findings

8.305.14. REPORTING REQUIREMENTS
Composite Score: 60%
Earned Designation: Minimal Compliance

Compliant
- SE provided cover sheets for reports with attestation that all information and data has been reviewed and is correct
- SE submitted reports with information that is 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 analyzes reports prior to submitting to HSD. Documents reviewed for this audit indicate identification of pattern changes and trends. The number of reports reviewed for this audit was small compared to the number of reports the SE submits to HSD.

Non-Compliant
- Reports or other required data are not received on or before scheduled due dates; report tracking initiated December 2007
- Reports or other required data do not conform to HSD’s defined standards, specifically performance measures

8.305.15. SERVICES FOR ISHCN
Composite Score: 73.68%
Earned Designation: Minimal Compliance

File Review Findings for ISHCN
Twenty nine (29) ISHCN cases were reviewed for care coordination of ISHCN services. The following elements were not documented consistently in the case files:
- Original date of identification as an ISHCN consumer is not indicated in the VONM care management system
- List of key resource people and telephone numbers or designated single point-of-contact to consumer
- Documentation of stratification, based on HSD regulation
- Documentation of the Care Coordination Plan (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 ISHCNs’ BH clinical history
  - ensuring clinical practice guidelines and practice parameters consider the needs of ISHCN

Non-Compliant
- SE demonstrated an internal operational process in accordance with the MAD regulation to identify ISHCN but does not apply stratification criteria to identify ISHCN
- SE provided health education information located on the VONM web-site to assist an ISHCN or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness, including chronic behavioral health conditions, however, VONM does not have a documented process to provide consumers with educational information if they do not have access to the web-site
- SE did not provide valid ISHCN performance measures

8.305.16. CLIENT TRANSITION OF CARE (TOC)
Composite Score: 95.33%
Earned Designation: Full Compliance

File Review Findings for Client TOC
Thirty (30) TOC 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 maintains policies and procedures for member TOC to ensure continuity of care without disruption in services
- SE maintains policies and procedures regarding provider responsibility for discharge planning

Non-Compliant
- No non-compliant findings

Calculations of Final Score
Table 4 presents the final overall score, by category, for VONM. As described in the methodology for determining compliance and scoring sections of this report, the final score was calculated by:
- Assigning a designation based upon the examiners’ findings for each standard
- The awarded points for all standards in each category were then summed to calculate the total assigned points for the category
- The final score was then derived by summing the total points assigned to each category
- The maximum number of points VONM could earn was 144;
Table 4. VONM Final Scores

<table>
<thead>
<tr>
<th>Regulation Element</th>
<th>Points Available</th>
<th>Points Scored</th>
<th>Final Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.2. Member Education</td>
<td>10</td>
<td>7.25</td>
<td>72.50%</td>
</tr>
<tr>
<td>8.305.6. Provider Network</td>
<td>10</td>
<td>9.25</td>
<td>92.50%</td>
</tr>
<tr>
<td>8.305.8.12. Standards for Quality Management &amp; Improvement</td>
<td>10</td>
<td>9.60</td>
<td>96.00%</td>
</tr>
<tr>
<td>8.305.8.13. Utilization Management</td>
<td>15</td>
<td>13.97</td>
<td>93.16%</td>
</tr>
<tr>
<td>8.305.8.14. Credentialing and Recredentialing</td>
<td>7</td>
<td>7.00</td>
<td>100.00%</td>
</tr>
<tr>
<td>8.305.8.15. Member Bill of Rights</td>
<td>5</td>
<td>4.50</td>
<td>90.00%</td>
</tr>
<tr>
<td>8.305.8.17. Standards for Medical Records</td>
<td>10</td>
<td>7.95</td>
<td>79.60%</td>
</tr>
<tr>
<td>8.305.9. Coordination of Services</td>
<td>15</td>
<td>11.67</td>
<td>77.85%</td>
</tr>
<tr>
<td>8.305.10. Encounters</td>
<td>10</td>
<td>7.00</td>
<td>70.00%</td>
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<tr>
<td>8.305.11. Reimbursement for Managed Care</td>
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<td>8.305.12. Member Grievance System</td>
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<td>8.305.14. Reporting Requirements</td>
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<td>8.305.15. Services for Individuals with Special Health Care Needs</td>
<td>15</td>
<td>11.05</td>
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</tr>
<tr>
<td>8.305.16. Client Transition of Care</td>
<td>5</td>
<td>4.76</td>
<td>95.33%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>144</strong></td>
<td><strong>119.01</strong></td>
<td><strong>82.65%</strong></td>
</tr>
</tbody>
</table>

**Recommendations**

The recommendations from this audit are aimed at facilitating 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 well-delineated by HSD. This section presents NMMRA’s suggestions for recommended follow-up of activities by HSD and VONM.

**Overall Recommendations for VONM**

- All meeting minute templates should be consistent and indicate action items, responsible party and due date (i.e., Quality Management Committee)
- SE should include in the prior data sources all documentation related to policies and procedures and provide supporting documentation
- SE should review prior data sources to ensure all appropriate documentation is included prior to submission to auditors for review
- Improve case documentation to ensure all care coordination activities are captured in the record

**Specific MAD Regulation Recommendations for VONM**

**8.305.2. MEMBER EDUCATION**

- Ensure distribution of behavioral health information upon enrollment
- Document the process for distributing behavioral information to consumers upon enrollment
- Ensure distribution of Member Handbook and provider directory within 30 days of enrollment
- Document the process for distributing the member handbook and provider directory to consumers within 30 days of enrollment
8.305.6. PROVIDER NETWORKS
- Include providers not accepting new Medicaid members on CI-05 report Table 2 as indicated on GM
- Incorporate provider satisfaction survey results into the SE’s QI program
- Develop and implement a policy and procedure that instructs how members can access policies and procedures which includes hard copy, website access and consumer handbook.

8.305.8.12. STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT
- Annually measure practitioner performance against at least two important aspects of three clinical practice guidelines and determine consistency of decision-making
- Finalize and implement the Depression Recovery Program and ensure goals and objectives are reported on an ongoing basis
- Implement and finalize Facility Management Plan that includes definitions of over and under utilization and documents all aspects of the process

8.305.8.13. UTILIZATION MANAGEMENT
Ensure UM program is approved annually by senior management, the BH medical director or the QI committee and presented to Quality Management Committee
- Ensure UM program is approved annually by senior management, the BH medical director or the QI Committee and presented to Quality Management Committee
- Document corrective action plan for UM staff who score below 90% on Inter-Rater Reliability
- Ensure that the UM decision criteria have been reviewed at specified intervals and that criteria are updated and presented to Quality Management Committee
- Revise policy and procedure CL 203P to include UM decision time frames for Residential Services
- Develop process to evaluate member and provider satisfaction with UM process as part of the member satisfaction survey
- Develop and implement a policy and procedure for the BH medical director to overturn a denial determination that exceeds the 3-day reconsideration process

8.305.8.14. CREDENTIALING AND RECredentialING
- No recommendations for this standard

8.305.8.15. MEMBER BILL OF RIGHTS
- Formalize a documented process for distributing the Member Handbook to consumers upon request
- Demonstrate completion of consumer trainings related to cultural, ethnic and linguistic topics
- Develop and implement a documented process for providing culturally competent or appropriate materials to consumers

8.305.8.17. STANDARDS FOR MEDICAL RECORDS
- Implement and provide practice-site follow-up aggregate analysis to the Clinical Quality Committee

8.305.9. COORDINATION OF SERVICES
- Offer statewide training to providers to include the referral process for care coordination and include appropriate referrals for PH consultation
Implement a process that ensures the BH provider will keep the PCP informed of drug therapy, laboratory and radiology results, sentinel events, and all TOC
- Document in the record that letters are sent to consumers by the SCC (This recommendation has been addressed in previous audits)
- Develop a VONM care coordination form to capture the required information related to include care coordination into the behavioral health plan of care
- Ensure that the SCC contacts consumer within 5 days per VONM policy and procedure, and documents the contact
- Ensure the SCC completes a Care Coordination Plan (CCP) within 10 days of contact with consumer, per VONM policy and procedure
- Per HSD direction VONM shall provide a detailed description of the discrepancy between the original submittal of the universe specifications and the re-submittal of the universe specifications for this regulation

8.305.10. ENCOUNTERS
- SE documentation submitted for this standard should have clearly identified headers, footers, and dates
- Ensure encounter reports are dated with initial submission to HSD and subsequent resubmissions, to effectively track report status
- Follow specifications as delineated by HSD for reports; if unable to follow, document VONM/HSD meeting outcomes to ensure encounter reports are prepared according to HSD/SE agreement

8.305.11. REIMBURSEMENT FOR MANAGED CARE
- Continue to involve corporate support for timely claims processing to ensure clean claims are paid within the established time frames
- Develop and implement a process to pay providers accurately and timely when members disenroll while hospitalized

8.305.12. MEMBER GRIEVANCE SYSTEM
- No recommendations for this standard

8.305.14. REPORTING REQUIREMENTS
- Utilize the monthly report tracking grid to ensure timely delivery of all reports
- Ensure reports are dated with initial submission to HSD as well as subsequent resubmissions to effectively track report status
- Consistently follow specifications as delineated by HSD for reports
- Narratives for a given report should relate to the data in that report and should be submitted timely with the report

8.305.15. SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN)
- Develop and implement stratification criteria to identify ISHCN
- Develop and implement process to provide health education information to assist in understanding how to cope with day-to-day stress caused by chronic illness for consumers who do not have computer access
- Ensure performance measure data related to ISHCN are valid
- Ensure the original date of ISHCN identification is maintained in the AIS system
- Develop and implement process to provide a list of key resource people and telephone numbers or designated single point of contact available
- Ensure documentation of stratification, based on HSD regulation
- Ensure SCC are documenting consistently the CCP for care coordination within 10 days of contact with consumer based on VONM’s policy and procedure
- Per HSD direction VONM shall provide a detailed description of the discrepancy between the original submittal of the universe specifications and the re-submittal of the universe specifications for this regulation

8.305.16. CLIENT TRANSITION OF CARE
- Ensure UM staff are documenting care coordination of consumers transitioning from one level of care to another
- Per HSD direction VONM shall provide a detailed description of the discrepancy between the original submittal of the universe specifications and the re-submittal of the universe specifications for this regulation

Overall Recommendations for HSD
- Develop and implement a corrective action plan for minimally compliant standards. Monitor on a monthly basis
- Ensure the SE performs a site visit for the top five individual practitioners in each of the five regions annually; the top five facilities in each region have received a site visit based on current policy and procedure
- Develop and incorporate in the guidance memorandum (GM) for the Appeal report to
  - Include a column to track all funding streams when a provider calls to file an appeal
  - Add two columns to identify or indicate consumer and provider appeals
- Develop and incorporate in the guidance memorandum (GM) for Grievance report to
  - Include a column to track all funding streams when a provider calls to file a complaint regarding more than one compliant
  - Add two columns to identify or indicate consumer and provider grievances

Audit Comparison Results

Table 5 displays VONM’s compliance audit comparison results from the previous audits in FY 2006, FY 2007 and FY 2008.

Table 5: SE Compliance Audit Comparison Results

<table>
<thead>
<tr>
<th>SE Compliance Audit Comparison Results</th>
<th>FY 2006 Audit Results</th>
<th>FY 2007 Audit Results</th>
<th>FY 2008 Audit Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Education</td>
<td>Minimal Compliance</td>
<td>Minimal Compliance</td>
<td>Minimal Compliance</td>
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<td>Provider Networks</td>
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<td>Standards for Quality Management &amp; Improvement</td>
<td>Moderate Compliance</td>
<td>Moderate Compliance</td>
<td>Full Compliance</td>
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<tr>
<td>Utilization Management</td>
<td>Full Compliance</td>
<td>Moderate Compliance</td>
<td>Full Compliance</td>
</tr>
<tr>
<td>Credentialing &amp; Recredentialing</td>
<td>Minimal Compliance</td>
<td>Full Compliance</td>
<td>Full Compliance</td>
</tr>
<tr>
<td>Member Bill of Rights</td>
<td>Minimal Compliance</td>
<td>Full Compliance</td>
<td>Full Compliance</td>
</tr>
</tbody>
</table>
SE Compliance Audit Comparison Results

<table>
<thead>
<tr>
<th>Standard</th>
<th>FY 2006 Audit Results</th>
<th>FY 2007 Audit Results</th>
<th>FY 2008 Audit Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards for Medical Records¹</td>
<td>Full Compliance</td>
<td>Moderate Compliance</td>
<td>Minimal Compliance</td>
</tr>
<tr>
<td>Coordination of Services</td>
<td>Minimal Compliance</td>
<td>Moderate Compliance</td>
<td>Minimal Compliance</td>
</tr>
<tr>
<td>Encounters</td>
<td>Minimal Compliance</td>
<td>Full Compliance</td>
<td>Minimal Compliance</td>
</tr>
<tr>
<td>Reimbursement for Managed Care</td>
<td>Moderate Compliance</td>
<td>Full Compliance</td>
<td>Minimal Compliance</td>
</tr>
<tr>
<td>Member Grievance System</td>
<td>Minimal Compliance</td>
<td>Full Compliance</td>
<td>Full Compliance</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>Minimal Compliance</td>
<td>Full Compliance</td>
<td>Minimal Compliance</td>
</tr>
<tr>
<td>Services for ISHCN</td>
<td>Minimal Compliance</td>
<td>Moderate Compliance</td>
<td>Minimal Compliance</td>
</tr>
<tr>
<td>Client TOC</td>
<td>Full Compliance</td>
<td>Full Compliance</td>
<td>Full Compliance</td>
</tr>
</tbody>
</table>

Although VONM has improved in some areas, some regression was noted in a few areas from the previous audit. There remain several opportunities for improvement. In particular, seven of the review standards are below Full Compliance and actions should be taken by VONM to ensure Full Compliance across all standards. Table 6 presents the score per regulation for the audits conducted in FY 2006, FY 2007, and FY 2008.

Table 6: Compliance Audit Comparison Results

<table>
<thead>
<tr>
<th>Regulation Number</th>
<th>Regulation Description</th>
<th>FY 2006 Score</th>
<th>FY 2007 Score</th>
<th>FY 2008 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>
</tr>
<tr>
<td>8.305.6.</td>
<td>Provider Network</td>
<td>79%</td>
<td>93%</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>
</tr>
<tr>
<td>8.305.8.13.</td>
<td>Utilization Management</td>
<td>92%</td>
<td>87%</td>
<td>93.16%</td>
</tr>
<tr>
<td>8.305.8.14.</td>
<td>Credentialing and Recredentialing</td>
<td>71%</td>
<td>100%</td>
<td>100.00%</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>
</tr>
<tr>
<td>8.305.8.17.</td>
<td>Medical Records</td>
<td>100%</td>
<td>85%</td>
<td>79.60%</td>
</tr>
<tr>
<td>8.305.8.18.</td>
<td>Standards for Access²</td>
<td>100%</td>
<td>100%</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>
</tr>
<tr>
<td>8.305.10.</td>
<td>Encounters</td>
<td>70%</td>
<td>100%</td>
<td>70.00%</td>
</tr>
<tr>
<td>8.305.11.</td>
<td>Reimbursement for Managed Care</td>
<td>83%</td>
<td>100%</td>
<td>57.14%</td>
</tr>
<tr>
<td>8.305.12.</td>
<td>Member Grievance System</td>
<td>70%</td>
<td>96%</td>
<td>99.90%</td>
</tr>
<tr>
<td>8.305.14.</td>
<td>Reporting Requirements</td>
<td>70%</td>
<td>100%</td>
<td>60.00%</td>
</tr>
<tr>
<td>8.305.15.</td>
<td>Services for ISHCN</td>
<td>36%</td>
<td>86%</td>
<td>73.68%</td>
</tr>
<tr>
<td>8.305.16.</td>
<td>Client TOC</td>
<td>100%</td>
<td>95%</td>
<td>95.33%</td>
</tr>
</tbody>
</table>

Total Score: 75% to 93% to 82.65%

²FY 2007 Standards for Access were not evaluated in this audit

¹FY 2006 no medical record review and FY 2007 only 10 medical records reviewed
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 April 17, 2008. 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 April 17, 2008 was included in the reconsideration review process.

BACKGROUND

1. NMMRA’s stated goal in both audit reports is to “provide HSD with valid and reliable information and data.” We offer the following response in order to further that goal. We want to emphasize that VONM values the use of an audit process to identify compliance issues as well as initiate quality improvement activities to address deficient areas. However, as is true for HSD, VONM’s ability to use these audit reports in an effective, pro-active manner rests on the reports’ provision of “valid and reliable information and data.” Although VONM appreciates the substantial time and effort expended by NMMRA in performing the audits and preparing the reports, we nonetheless believe, as set forth below, that due to structural issues in the audit process adopted by NMMRA, the audit and its reports fail to achieve, to varying degrees, its goal, that is, to “provide HSD [and VONM] with valid and reliable information and data” upon which to act.

The Executive Summary presents our concerns, first those applicable to both audits, then those specific to the PM/PIP audit. We then provide a detailed description of issues related to the Compliance audit. Our detailed response to the PM/PIP audit is embedded into the audit tools themselves (separate documents).

NMMRA has reviewed VONM’s reconsideration comments. This report presents the third-year findings based on a two-phase audit approach consisting of document review and on-site review. This audit approach has been approved by HSD and has been consistent for the last three years. NMMRA provides findings based on documentation and information obtained through the audit process. The results presented demonstrate valid and reliable data based on documentation provided by VONM. Scoring is not impacted in this section.

EXECUTIVE SUMMARY

2. Documentation Requirements: We wish to reaffirm our commitment to the audit process which may have been placed in doubt by certain statements within the reports. VONM sought to demonstrate its commitment to the audit process by striving to collect all requested documentation, as best we understood those requests, in a timely and comprehensive manner. Asking for an extension, or failure to submit all documents the first time around, is not a reflection of a casual attitude. Rather it reflects the complexity of the Collaborative’s work, the extensive data and documents required, the clarity needed on the communication of those requirements and submission due dates that fell only a few days after the end of a data collection period.

NMMRA has reviewed VONM’s reconsideration comments. The audit process is structured for VONM to submit documentation to NMMRA on the scheduled due date,
which was approved by HSD. These deadlines were presented to VONM at the audit overview meeting, verbally and in writing on November 13, 2007. The scheduled due dates were determined in advance to plan for the on-site review and for timely completion of the audit. NMMRA provided VONM the opportunity to provide feedback regarding the audit process during the overview meeting, while on-site and after the closing conference.

Although the draft Compliance Audit report explains, in detail, all the audit preparation and communication steps, it presents a misleading view that requirements are always clearly identified, communicated and understood. It does not reflect the numerous verbal and e-mail communications needed to clarify requirements, since many aspects of the program are new. (See comments for Member Bill of Rights and PM Audit related to requested 'final report' for Ambulatory Follow-up.)

NMMRA has reviewed VONM's reconsideration comments. NMMRA presents the documentation required for the audit at the audit overview meeting. NMMRA provides the opportunity for clarifications and questions regarding documentation requirements during the meeting. In addition, NMMRA is available by telephone and e-mail during the audit process. NMMRA tracks all communication in a contract management database and notes that VONM had made limited contact with NMMRA to discuss documentation clarifications. Please refer to the detailed response to the compliance audit findings for Member Bill of Rights.

Finally, it is worthwhile to note that while NMMRA has the right to indicate its preferred form of documentation, its unwillingness to accept alternative forms which satisfied the intent of the regulation and resulted in a zero score seems unreasonable. (See comments for Provider Networks.)

NMMRA has reviewed VONM’s request for reconsideration regarding submission of documents. NMMRA’s process indicates all documentation should be submitted through the secure file transfer process (FTP). This process is intended to decrease HIPAA violations, reduce administrative costs and provide NMMRA with the ability to track all submitted documents. NMMRA’s process includes a review of hard copy documents on-site. During the audit process, additional documents were requested from VONM and in mutual agreement with VONM; the documents were to be transferred to NMMRA via the secure FTP. NMMRA was willing to accept additional hard copy documents while on-site, if VONM had supplied them.

The preferred form of documentation did not impact the score. Lack of documentation for specific standards impacted scoring. Please refer to the detailed response to the Compliance Audit findings for Provider Networks.

3. Scoring Methodology: The allocation of points was changed for this year’s Compliance audit. Thus, year-to-year comparison is not appropriate and, in fact, is misleading. Nonetheless, the audit report emphasizes such year to year comparisons without noting this change and its impact on the significance on the purported comparison.

NMMRA has reviewed VONM’s request for reconsideration regarding the scoring methodology. The compliance audit has evolved from year to year to reflect changes in the applicable regulations and the concerns of HSD. Four sections previously audited were not examined in the FY2008 audit. Such changes require shifting the weights assigned to each section in determining the Total Score, but do not affect the validity of
each category’s earned designation. Thus the comparisons shown in Table 5 are a valid reflection of measured compliance in each comparable category over the three-year period. The HSD approved scoring methodology is comprised of four earned designations and the score for each designation did not change from previous audits.

In addition, the “all or nothing” scoring approach on a number of individual elements is inappropriate in that it implies that VONM made no effort whatsoever to comply with the regulation. Such scoring does not reflect the actual facts and caused the compliance designation to be one or two levels lower than it should have been, impacting multiple standards. (See comments for Member Education, Reimbursement, and Reporting.)

NMMRA has reviewed VONM’s request for reconsideration regarding the “all or nothing” scoring approach. The scoring methodology was designed by NMMRA and approved by HSD prior to the completion of this audit. The “all or nothing” scoring approach has been utilized for previous VONM compliance audits. Maintaining scoring consistency ensures comparisons reported are accurate and reflect valid comparisons over the three-year period.

4. **Audit Time frame:** Some regulations require activities to be performed on an annual basis or do not specify how often. As a practical matter, certain other actions can only be done on an intermittent basis. Nonetheless, the audit time frame was 6 months and points were lost if the required activity did not happen to fall within the 6 month time frame, even if it was required to be performed only on an annual basis. This approach to the audit impacted multiple elements and caused the compliance designation to be at least one or two levels lower than it should have been (Medical Records) and impacted the overall score for several other standards (Provider Networks, QM/QI, and UM).

NMMRA has reviewed VONM’s request for reconsideration regarding audit time frames. HSD directed the audit time frame for the Compliance Audit. Although it was a six month time frame, NMMRA requested documentation submitted prior to the on-site audit include VONM’s annual documentation. NMMRA was willing to accept annual documentation that was not within the six month time frame which would satisfy the requirements of the audit. This documentation was not provided to NMMRA examiners prior to the audit or during the on-site audit.

The NMMRA audit approach was comprised of documentation and file reviews. The scoring was based on these two categories; documentation and files. The category’s earned designation has not changed from previous audits.

Please refer to the following detailed responses to the Compliance Audit findings for Medical Records (8.305.8.17), Provider Networks (8.305.6), Standards for Quality Management and Improvement (8.305.8.12) and Utilization Management (8.305.8.13). The specific documentation requirements have been addressed in each standard as requested by VONM. Potential scoring changes are addressed in specific sections.

5. **Redundancy:** Some aspects of the Compliance audit duplicate previously audited activities or time frames with the result that this audit, in some cases, does not offer new information. The audit time frame spanned July 07 thru Dec 07 with consumer clinical records pulled randomly over the entire time frame. Issues with care coordination documentation, stratification of identified special needs individuals, outreach and education, and continuity of care have been identified in previous targeted audits. VONM is in the process of implementing corrective action
plans and working closely with a Collaborative subgroup to improve these processes. The findings of this audit for ISHCN and Coordination of Services were already known and improvements already underway. The value of the audit would have been enhanced had NMMRA selected clinical records for review from later in the time span rather than from the entire time period in order to capture improvements. This audit was also redundant in that findings from the PM/PIP audit, a separate audit conducted simultaneously with the Compliance audit, were simply duplicated and applied to several standards in the Compliance audit. (See comments for Reporting and ISHCN.)

NMMRA has reviewed VONM’s request for reconsideration regarding the VONM topic of redundancy. Although VONM is in the process of implementing corrective action plans and working closely with a Collaborative subgroup to improve these processes, NMMRA was instructed by HSD to audit specific areas.

The PM and PIP audit was conducted simultaneously with the Compliance audit as directed by HSD for the previous three years.

Please refer to the following detailed responses to the Compliance Audit findings for Reporting Requirements (8.305.14) and ISHCN (8.305.15) that address VONM’s concerns regarding redundant findings. Potential scoring changes are addressed in specific sections.

6. Interpretation of Regulations: We believe that the interpretation of several of the audited regulations was inappropriate and contrary to the intent of the regulation causing the compliance designation to be lower than it should have been. (See comments for Medical Records and Encounters.) In both cases, such an interpretation of the regulations (combined with an ‘all or nothing’ scoring approach) lowered VONM from ‘full compliance’ to ‘minimal compliance’. Furthermore, in another instance it is unclear how the regulations are being interpreted and the audit report gives no indication as to interpretation and why VONM was scored as non-compliant. (See comment for QM/QI 8.12.I.)

NMMRA has reviewed VONM’s request for reconsideration regarding the interpretation of regulations and the “all or nothing” scoring approach. The “all or nothing” scoring approach has been the HSD approved methodology for three years.

NMMRA discussed interpretation of regulations with HSD based on VONM’s comments. In addition, research was conducted in the federal statutes to ensure consistency of the interpretations. Please refer to the detailed response to the Compliance Audit findings for Medical Records (8.305.8.17), and Encounters (8.305.10). Potential scoring changes are addressed in specific sections.

Member Education
2.9.A. and 2.9.D.(1). – Finding: The SE did not provide 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.

Response: VONM does distribute a consumer handbook, provider directory and summary of benefits to new enrollees within 30 days of enrollment. VONM also identifies ‘prevalent populations’ and all of these materials are translated accordingly to address that population’s need. The score of ‘0’ points for these 2 elements is apparently based on what NMMRA determined to be insufficiently detailed documentation. NMMRA could have made us aware of
their determination but did not. However, VONM is substantially compliant with these regulations. Failure to credit us with any points out of the maximum of 2 incorrectly and unfairly suggests complete failure to comply with this regulation. The scoring should be adjusted by adding no less than 1 point and the designation changed from ‘minimal’ to ‘moderate compliance’.

NMMRA has reviewed VONM’s request for reconsideration with the following decision:

VONM submitted the following documentation for Member Education 2.9.A.:
- Packet of materials sent to newly enrolled consumers each month
- Welcome Letter & Summary of Benefits with services requiring prior authorization noted - available on site
- 2007 Consumer Handbook
- 2007 Provider Directory
- Screen print of www.valueoptions.com/newmexico/consumers.htm

Although VONM provided the above documentation, they did not provide a policy or procedure or a description of the process to distribute behavioral health information, the consumer handbook and provider directory based on the MAD regulation. VONM submitted an Excel spreadsheet detailing only names of consumers but did not provide documentation related to the distribution of the consumer handbook or provider directory within 30 calendar days of enrollment. The Excel spreadsheet did not include enrollment dates or distribution dates. After a review of comments provided by VONM, the score remains unchanged.

VONM submitted the following documentation for Member Education 2.9.D.(1):
- Vendor Acknowledgement of Consumer Handbooks mailed in October, November and December 2007
- Consumer mailing lists – available on-site

VONM did not provide or offer the consumer mailing lists while the examiners were on-site. During clarification, VONM submitted an Excel spreadsheet detailing only names of consumers but did not provide documentation related to the distribution of the consumer handbook or provider directory within 30 calendar days of enrollment. There were no enrollment and distribution dates. After a review of comments provided by VONM, the score remains unchanged.

**Provider Networks**

Although this section was scored ‘full compliance’, VONM would like to note the following: 6.17.B.(1). Finding: The SE did not provide information of how it incorporates provider satisfaction survey results into the SE’s quality improvement program.

Response: To demonstrate compliance with this regulation, VONM pointed to the VONM FY08 QM Work Plan which lists as one of the goals ‘Assess and evaluate provider satisfaction’ for a number of areas. Provider surveys are conducted annually, with the most recent survey done in December 2007. The audit time frame is limited to a 6 month window and does not take into consideration that some activities conducted on an annual basis may happen before or after the audit time frame, as in this instance. The latest survey was reviewed by the Quality Management Committee in January and February 2008. At a minimum, VONM has met the intent of this regulation and either should be given full credit or this element should simply be removed from the scoring.
NMMRA has reviewed VONM’s request for reconsideration regarding Provider Networks. Per the VONM Provider Network Road Map, evidence to meet the annual requirement for a provider survey referred to the Quality Management (QM) work plan, goal #4 E page 5. The work plan indicated a date of completion for May 31, 2008 and indicated that this is an annual survey. The work plan did not provide verification of a completion of a FY2007 survey.

The reconsideration letter from VONM indicated that there had been a provider survey conducted in FY2007; however, no evidence of the 2007 survey was provided to NMMRA for this audit. The regulation indicates this is an annual requirement. NMMRA would have accepted results outside the audit time frame to satisfy the requirement. After a review of comments provided by VONM, the score remains unchanged.

6.17.B.(3). Finding: The SE did not document and provide provider education training schedule to HSD and provide evidence as requested.

Response: VONM submitted to NMMRA the provider education training schedule, an HSD required report CI21 Training Activity Report. Since it is a required report, we did not foresee that the auditor’s assessment of compliance would rely on the actual submission to HSD as opposed to actual production of the report. VONM also submitted provider training sign-in sheets and offered to make available onsite several binders full of provider education and training materials. It is not clear why this regulation was determined to be non-compliant. At a minimum, VONM has met the intent of this regulation, however the audit approach did not allow for this consideration.

Overall, the scoring for this standard should be adjusted by adding 0.5 points for the two elements noted above.

NMMRA has reviewed VONM’s request for reconsideration regarding provider education. NMMRA requested the sign in sheets for the provider trainings conducted in second quarter FY2008. Although VONM did submit some of the sign in sheets the request was for all sign in sheets which were not provided or offered while examiners were on-site. After a review of comments provided by VONM, the score remains unchanged.

Quality Management and Improvement
Although this section was scored ‘full compliance’, VONM would like to note the following:
8.12.E. Finding: The SE did not provide a consumer satisfaction analysis that included interventions to improve its performance; did not measure the effectiveness of the interventions; did not inform consumers of results of member satisfaction activities.

Response: VONM pointed out that consumer satisfaction surveys are conducted annually and that we did not receive results of the most recent survey (11/07) from the Collaborative until November 2007. As a result, it was impossible for us to implement interventions, measure effectiveness or communicate results during the period covered by the audit. The audit time frame is limited to a 6 month window and does not take into consideration that some activities conducted on an annual basis may happen before or after the audit time frame, as in this instance. VONM made a good faith effort to initiate the required process by presenting the survey results to the Quality Management Committee in December 2007, and informed NMMRA of this activity. At a minimum, VONM has met the intent of this regulation and, either should be given full credit by adding no less than 0.6 points or this element should simply be removed from the scoring.
NMMRA has reviewed VONM’s request for reconsideration regarding Quality Management and Improvement.
NMMRA has addressed each element based on the MAD regulations separately:

VONM provided the following prior data sources for this element:
- Policy QM 303 Quality Improvement Activities
- Refer to materials submitted for the PM/PIP audit

8.305.8.12.E.(5). Measure the effectiveness of the interventions
VONM provided the following prior data sources for this element:
- Refer to materials submitted for the PM/PIP audit

8.305.8.12.E.(6). Inform providers, HSD, SE members of results of member satisfaction activities
VONM provided the following prior data sources for this element:
- QM Committee minutes from 12/31/07
- www.valueoptions.com/newmexico/provider/resources.htm

Based on the prior data sources provided by VONM, NMMRA was unable to assign points to these three elements. After a review of comments provided by VONM, the score remains unchanged.

HSD recognizes that VONM does not have complete authority or control over the implementation, analysis and final review of the consumer satisfaction survey. Therefore, it is decided that VONM’s request for reconsideration of the elements E.4, E.5 and E.6 has merit and the score will be changed for each element.

8.12.I. Finding: SE did not implement appropriate corrective interventions when it identifies under utilization and over utilization.

Response: This is not sufficient detail to understand why the case examples we submitted were considered ‘inappropriate’. Despite repeated requests for clarification in past years, this is the third audit in which NMMRA has scored VONM as non-compliant for this element with no clear explanation.

NMMRA has reviewed VONM’s request for reconsideration regarding under utilization and over utilization.

During the first Compliance Audit conducted by NMMRA, VONM provided a policy and procedure that included definitions and criteria for over and under utilization. The case samples provided by VONM did not meet the criteria as indicated in the P&P. Therefore, VONM was non-compliant with this element. During the second compliance audit NMMRA conducted, VONM did not provide a P&P or documentation of the definitions and criteria for over and under utilization. Therefore, NMMRA was unable to determine if the two case examples provided were over and/or under utilization cases. For the current audit VONM provided the following case samples; National Outlier model, Policy and Procedure QM 314, excerpt from the FY08 Utilization Management Program Description (UMPD) regarding the development of a Facility Management Program that will detect and correct potential under and over utilization of services. However, VONM did not include how over and under utilization cases are defined.
On November 13, 2007 during the audit overview NMMRA discussed with VONM the policy and procedure for defining over and under utilization that had been provided in a previous compliance audit. On November 13, 2007 NMMRA provided VONM with questions and answers from the audit overview meeting which included a definition of under and over utilization based on the following reference: Case Management in Healthcare: A Practical Guide. During the on-site clarification interviews NMMRA requested VONMs definition and criteria of under and over utilization. VONM provided the National Outlier Model and UMPD excerpt which did not define under and over utilization. Therefore, NMMRA is unable to determine if the two case examples provided were over and under utilization cases. After a review of comments provided by VONM, the score remains unchanged.

**Utilization Management**

Although this section was scored ‘full compliance’, VONM would like to note the following:

8.13.A. Finding: SE did not document UM Program shall be evaluated and approved annually by senior management, the behavioral health director or the QI committee.

Response: Again, approval is an annual event. The audit time frame is only a 6 month window and does not take into consideration that some activities conducted on an annual basis may happen before or after the audit time frame. Approval of these documents was pended until we received feedback from the Collaborative; this was ongoing throughout most of the audit time frame. The VONM Quality Management Committee officially approved these documents after the audit time frame after receiving final feedback from the Collaborative. At a minimum, VONM has met the intent of the regulation and either should be given full credit or this element should simply be removed from the scoring.

NMMRA has reviewed VONM’s request for reconsideration regarding Utilization Management. NMMRA received the FY07 UM Program Evaluation as evidence for this element. NMMRA received the following note from VONM in relation to evaluation and approval of the QMC meeting minutes: “QMC minutes showing annual approval of the UMPD and UM Program Evaluation will be available onsite. Although January 2008 is beyond the audit time frame, the intent of the regulation will have been met for FY2008.” VONM did not provide these documents to examiners while on-site. After a review of comments provided by VONM, the score remains unchanged.

8.13.B. Finding: SE did not maintain evidence that it has reviewed the UM decision criteria at specified intervals and that the criteria have been updated, as necessary.

Response: Again, approval is an annual event. The audit time frame is only a 6 month window and does not take into consideration that some activities conducted on an annual basis may happen before or after the audit time frame. VONM stated in the audit roadmap that the annual review process was initiated at the November 2007 meeting of the Clinical Quality Committee. VONM has met the intent of the regulation. At a minimum, VONM has met the intent of the regulation and either should be given full credit or this element should simply be removed from the scoring.

NMMRA has reviewed VONM’s request for reconsideration regarding UM decision criteria. NMMRA received the following documents as evidence from VONM for this MAD regulation: Clinical Quality Committee Minutes dated November 27, 2007 documented a plan to obtain provider input and approval. The provider input and approval would be documented in December 17, 2008 minutes. VONM did not provide the December Clinical
Quality Committee Minutes to examiners while on-site. After a review of comments provided by VONM, the score remains unchanged.

8.13.E. Finding: SE did not provide utilization decision and notification in a timely manner that accommodates the clinical urgency of the situation.

Response: There is insufficient information to determine why VONM received ‘0’ points for this element. NMMRA stated at the audit overview meeting that submission of policies and procedures were all that were required for this regulation. VONM submitted the requested documentation. The UM timeliness grid that VONM utilizes is fully compliant with HSD timeliness requirements. One would hope that the results of the file review, even though 99% compliant with timeliness requirements, were not used to justify a ‘0’ score for this element. VONM meets the intent of the regulation and should be given full credit for this element.

NMMRA has reviewed VONM’s request for reconsideration regarding timely utilization decisions.

NMMRA received the following prior data sources as evidence from VONM:
- Policy CL303 Medical Necessity Determination, Section III.H., pg. 2,
- Attachment CL303A UM TAT Grid

However, the CL303 policy had not been updated to include the timeliness of decisions and notifications for residential services which was effective July 1, 2007. The NMMRA audit approach was comprised of documentation and file reviews. The scoring was based on these two categories; documentation and files. The category’s earned designation has not changed from previous audits. After a review of comments provided by VONM, the score remains unchanged.

8.13.J. Finding: SE did not provide evaluation of member and provider satisfaction with the UM process as part of its member satisfaction survey.

Response: Again, approval is an annual event. The audit time frame is only a 6 month window and does not take into consideration that some activities conducted on an annual basis may happen before or after the audit time frame. See explanations above for member and provider satisfaction surveys. VONM has met the intent of this regulation. At a minimum, VONM has met the intent of the regulation and either should be given full credit or this element should simply be removed from the scoring.

NMMRA has reviewed VONM’s request for reconsideration regarding the member satisfaction survey.

NMMRA received the 2006 Provider Satisfaction Survey Excerpt. In addition, VONM provided the following documentation in their road map for this regulation “Note: VONM is contractually required to utilize the MHSIP survey which does not include questions about member and provider satisfaction with the UM process.” VONM did not provide documentation to indicate how VONM incorporates satisfaction survey information into the UM process. After a review of comments provided by VONM, the score remains unchanged.

File Review Finding: Two files were deemed deficient for exceeding timeliness requirements. In counting days, it appears the auditors failed to consider holidays and counted calendar days
rather than business days. The total score for this file review should be corrected to be 100% compliant.

Overall, the scoring for this standard should be adjusted by adding .8 points for the elements noted above.

NMMRA has reviewed VONM’s request for reconsideration regarding timeliness. NMMRA reviewed the two approvals files for decision timeliness and the decision was completed within five working days. The total score for file review has been adjusted upward.

Member Bill of Rights
Although this section was scored ‘full compliance’, VONM would like to note the following:
8.15.C.(1). Finding: SE does not have a documented process to distribute Member Handbook to consumers upon request.

Response: VONM provided a written description, at NMMRA’s request, of the process for supplying a member handbook to consumers upon request. It is not clear why this description was not sufficient when the description described the process that was in place during the audit time frame. Additionally, this particular regulation also addresses inclusion of the Member Rights and Responsibility statement in the consumer handbook. That statement is reprinted in the VONM Consumer Handbook and meets all requirements. VONM is compliant with both aspects of this regulation but this was not reflected in the audit report. The score should be adjusted by adding .15 points for this standard.

NMMRA has reviewed VONM’s request for reconsideration regarding Member Bill of Rights. NMMRA received the documented Process for Consumers Requesting Consumer Handbook in English and Other Languages dated February 4, 2008. Although this process was received by NMMRA it was dated outside the audit time frame. After review of the comments from VONM the score will remain unchanged.

Medical Records
8.17.B.(2). Finding: SE demonstrated a mechanism to assess the effectiveness of “organization-wide and practice-site” follow-up plans to increase compliance however, VONM did not comply with the policy to present the aggregate analysis to the Clinical Quality Committee.

Response: The purpose of this audit is to assess VONM compliance with HSD managed care regulations; not adherence to internal operational policy. The Executive Summary of the audit report, page 1, states “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).” The regulation does not stipulate how often, what time of year, nor how this assessment must be conducted, including whether committee review is required. VONM meets the intent of this regulation and requests the score for Standard for Medical Records be adjusted by adding 1.25 points and the designation changed from ‘minimal’ to ‘full compliance’.

NMMRA has reviewed VONM’s request for reconsideration with the following decision: NMMRA reviewed VONM’s policy and procedure, QM402 Performance Improvement Plans, which documents the SE, will present the aggregate analysis to the Clinical Quality Committee. NMMRA did not receive evidence that the aggregate analysis was presented to the Clinical Quality Committee. Although, NMMRA does focus on reviewing compliance with MAD regulation, an additional component of NMMRA audits includes a
review of evidence to support organizational policies and procedures. After review of the comments from VONM the score will remain unchanged.

**Encounters**

Response: The regulation reads “SE encounter data shall be used to determine compliance with performance measures.” The regulation does not specify who is to use that data but would presumably be HSD, not the SE. Additionally, HSD dictates to the SE what the performance measures shall be; the two performance measures that were chosen by HSD happen to be based on claims data, not encounter data; a not unimportant distinction. This is not within VONM’s control and VONM should not be held accountable for this regulation, however it is interpreted.

Furthermore, if this regulation was intended to somehow reflect VONM adherence to PM requirements, this duplicates what is already under review in the PM/PIP Audit.

Lastly, the scoring methodology for this section is questionable with 30% of the points assigned to this regulation.

VONM objected to the inclusion of this regulation in the audit at the audit overview meeting, stating that this appeared to be a regulation directed at the state Medicaid agency, not at the SE. It is inappropriate to hold VONM accountable for this regulation when implementation is outside of our control. VONM is compliant with the Encounters regulations. Therefore, this regulation should be deleted from the audit tool and the scoring adjusted to reflect 100% and the designation changed to ‘full compliance’.

**Reimbursement**
11.9.C. Finding: SE does not meet 100% of the timeliness standard to pay clean claims according to the prescribed time frames every month.

Response: The reports show that VONM met the clean claims timely payment requirements for all months, for both 30 days and 90 days, except once, when payment within 90 days fell below the 99% requirement by less than 1 percentage point in August 2007. An ‘all or nothing’ scoring methodology does not adequately reflect VONM’s performance; the requirement was met 11 of 12 times. VONM is substantially in compliance with this regulation however the score and subsequent designation of ‘minimal compliance’ for this standard is inaccurate. The scoring should be corrected by adding no less than 1.80 points to the score and the designation for this standard should be changed from ‘minimal’ to ‘moderate compliance’.

NMMRA has reviewed VONM’s request for reconsideration regarding reimbursement. The intent of the regulation is to ensure that performance measure data be calculated appropriately by the SE based on encounter data. As the SE is responsible for reporting accurate performance measure data to HSD, the responsibility for using data lies with the SE. After a review of comments from VONM the score will remain unchanged.
**Reporting Requirements**

10.A. Findings: Reports or other required data are not received on or before scheduled due dates; reports or other required data do not conform to HSD’s defined standards; specifically performance measures.

Response: VONM acknowledges there have been issues regarding timely submission of required reports to the Collaborative and as well as clarity on report requirements. VONM has implemented a corrective action plan, as requested by the Collaborative in unrelated correspondence, and has requested formation of a Collaborative work group to address all report requirements. NMMRA’s audit captured a time frame that had already been reviewed by the Collaborative.

Despite these issues, an ‘all or nothing’ scoring methodology is not appropriate; it does not accurately reflect VONM compliance with this regulation. It is certainly not appropriate to base the entire score on the performance measure reports. Firstly, report feedback received by VONM for the audit time frame reflected there was no ‘error’ identified for these reports (CI-24 and PM4.2.i.1 and 2). Secondly, the reports are already scored separately in the PM/PIP audit. (VONM has responded to that audit separately and disagrees with the audit results.) Additionally, not all HSD reports are at issue in the above mentioned corrective actions. In fact, the majority of HSD reports have been submitted timely and conform to HSD report specifications. VONM is substantially in compliance with these regulations. Failure to credit us with any points out of the maximum of 4 suggests, incorrectly, a complete failure by VONM which is misleading. The scoring should be adjusted accordingly by adding no less than 2 points to the score and the designation for this standard should be changed from ‘minimal’ to ‘moderate compliance’.

NMMRA has reviewed VONM’s request for reconsideration regarding reporting requirements. Although the “majority” of reports may be submitted timely and conform to HSD report specifications, there continues to be issues with reporting to HSD as mentioned in the findings. The “all or nothing” scoring has been addressed in other areas of this report. After a review of comments provided by VONM, the score will remain unchanged.

**ISHCN**

15.9.B. Findings: SE does not apply stratification criteria to identify ISHCN.

Response: The audit time frame was such that the review duplicated previous evaluations and offers nothing new. VONM, as well as HSD, were already aware of issues related to applying stratification criteria; these were identified on previous audits. VONM is working closely with HSD to address these issues and has implemented corrective actions.

NMMRA has reviewed VONM’s request for reconsideration regarding ISHCN. VONM did not provide documentation describing how it applies stratification criteria to identify ISHCN. Although this issue may have been identified on previous audits, HSD instructed NMMRA to include this element in the audit. After a review of comments provided by VONM, the score remains unchanged.

15.21. Findings: SE did not provide valid ISHCN performance measures.

Response: PMs are dictated by HSD. Furthermore, this finding duplicates audit results from the separate PM/PIP Audit, findings with which VONM disagrees. (See separate audit response.)
NMMRA has reviewed VONM’s request for reconsideration regarding ISCHN performance measures. VONM did not provide a quality strategy related to ISHCN within the QM annual plan utilizing a performance measure specific to ISHCN based on MAD regulation 8.305.8.15.21. After a review of comments provided by VONM, the score remains unchanged.

In sum, a rescoring of the elements detailed above results in a change of compliance designation for 5 standards (Member Education, Medical Records, Encounters, Reimbursements, and Reporting) – 3 by 1 level (minimal to moderate); 2 by 2 levels (minimal to full). The overall score increases to 89.82% which is, practically speaking, full compliance. VONM believes this is a more accurate reflection of our compliance with HSD’s managed care regulations and results in an improved audit that “provides HSD with valid and reliable information and data.”

NMMRA and HSD reviewed VONMs comments with the following decision:

After a re-review of the above mentioned standards (Member Education, Medical Records, Encounters, Reimbursements, and Reporting), NMMRA was not able to adjust the score based on the documentation provided, therefore, the designation for the specified standards did not change.

The score has been revised for two standards as described below based on a re-review of the documentation and discussion with HSD.

Quality Management and Improvement (8.305.8.12.E. (4), (5)(6) was adjusted upward from 9.0 to 9.6 for an aggregate score of 96% for this regulation. The following elements were adjusted upward:

- Implement interventions to improve its performance
- Measure the effectiveness of the interventions
- Inform providers, HSD, SE members of results of member satisfaction activities

Utilization Management (8.305.8.13) was adjusted upwards from 13.90 to 13.97 for an aggregate score of 93.16% for this regulation.

- The score was adjusted upward in the file review section, specifically Approvals

The overall aggregate score for the entire Compliance audit was adjusted upwards from 82.23% to 82.65% for an earned designation of Moderate Compliance.
Conclusion

Based on NMMRA’s compliance review of MAD regulations, documentation provided during the scope of this audit, key personnel interviews, and the scoring methodology approved by HSD, NMMRA finds VONM earned an aggregate designation of Moderate Compliance (82.65%) for the MAD standards examined,

VONM provided policies, descriptions of processes, procedures, and documents verifying that MAD regulations are met. However, there remain opportunities for improvement related to providing evidence that VONM’s own policies, procedures and processes are being followed.

The following list includes the compliance designation and percentage score for the MAD Regulations reviewed:

- Member Education – Minimal Compliance (72.50%)
- Provider Networks – Full Compliance (92.50%)
- Quality Management – Full Compliance (96.00%)
- Utilization Management – Full Compliance (93.16%)
- Credentialing and Recredentialing – Full Compliance (100%)
- Member Bill of Rights – Full Compliance (90.00%)
- Standards for Medical Records – Minimal Compliance (79.60%)
- Coordination of Services – Minimal Compliance (77.85%)
- Encounters - Minimal Compliance (70.00%)
- Reimbursement for Managed Care – Minimal Compliance (57.14%)
- Member Grievance System – Full Compliance (99.90%)
- Reporting Requirements – Minimal Compliance (60.00%)
- Services for Individuals with Special Health Care Needs (ISHCN) Minimal Compliance (73.68%)
- Client Transition of Care – Full Compliance (95.33%)

Seven of 14 standards reviewed measured below Full Compliance. Action by VONM should be taken to ensure Full Compliance across all standards. The scoring methodology 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 seven regulations recommended for corrective action based on these audit findings:

- Member Education – Minimal Compliance (72.50%)
- Standards for Medical Records – Minimal Compliance (79.60%)
- Coordination of Services – Minimal Compliance (77.85%)
- Encounters - Minimal Compliance (70.00%)
- Reimbursement for Managed Care – Minimal Compliance (57.14%)
- Reporting Requirements – Minimal Compliance (60.00%)
- Services for Individuals with Special Health Care Needs (ISHCN) Minimal Compliance (73.68%)

Included within this detailed report are recommendations, by standard, describing actions which VONM needs to implement in order to obtain full compliance with MAD regulations. In addition, HSD-specific recommendations are included to continue ongoing oversight of the SE.

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