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Executive Summary

The following report details the annual External Quality Review (EQR) audit of the Physical Health (PH) Managed Care Organizations (MCOs) in the State of New Mexico. Four MCOs are contracted with the State of New Mexico to provide Medicaid Salud services. Three of those are also contracted with the State to provide State Coverage Insurance (SCI) services. Reviewers examined and scored Salud and SCI programs separately. This audit included a desktop review of the MCOs’ policies and procedures and other documentation. It also included an on-site review of medical records and case files. This audit compared structures and processes against 18 parts and sections of the New Mexico Administrative Code (NMAC). The audit timeframe was July 1, 2011 through June 30, 2012 (State Fiscal Year 2012).

This year’s audit was expanded to include an additional scored section. The Program Integrity section of the audit includes the NMAC Fraud and Abuse standards along with selected requirements of the Patient Protection and Affordable Care Act (ACA) as defined by the Code of Federal Regulations (CFRs.)

All 4 MCOs were found to be in overall full compliance with both the Salud and SCI programs (see below). Complete results begin on page 10. Recommendations for improvement begin on page 17.

Blue Cross and Blue Shield of New Mexico (BCBS)
   Full Compliance for Salud Program (98.47%)
   No SCI Program

Lovelace Community Health Plan (Lovelace)
   Full Compliance for Salud Program (94.04%)
   Full Compliance for SCI Program (94.55%)

Molina Healthcare of New Mexico (Molina)
   Full Compliance for Salud Program (99.97%)
   Full Compliance for SCI Program (99.46%)

Presbyterian Health Plan (Presbyterian)
   Full Compliance for Salud Program (99.90%)
   Full Compliance for SCI Program (99.70%)

Background

The Centers for Medicare & Medicaid Services (CMS) requires each state to ensure quality services for its enrollees. The New Mexico Human Services Department/Medical Assistance Division (HSD/MAD) developed a quality strategy to address the needs for quality healthcare services in New Mexico. HSD/MAD published the State of New Mexico Quality Assessment and Performance Improvement Strategy for Medicaid Services in May 2009. In the report, HSD outlines the strategy for MCOs in New Mexico to exceed standards for access to care, clinical quality of care and quality of service.

After years of traditional fee-for-service Medicaid, the state legislature mandated the creation of managed care programs to provide comprehensive medical and social services to the Medicaid
population. The Salud Program was developed to implement this mandate and was launched on July 1, 1997. The program was designed to improve the quality of healthcare, to improve the access to care and to make cost-effective use of state and federal funds.

In 2005, New Mexico launched the SCI Program, which combined some features of Medicaid with a basic commercial plan. New Mexico has focused on fostering cooperation among federal, state, and private organizations to increase funding for, and access to, care for SCI participants. Elements of this program include health insurance for small businesses, non-profit organizations, the self-employed, and families, children, and pregnant women who are not eligible for Medicaid.¹ The State of New Mexico initiated a waiting list for SCI benefits in November 2009.

In July 2008, New Mexico HSD/MAD re-contracted with Lovelace, Molina, and Presbyterian to continue administering the Salud and SCI programs. HSD/MAD contracted with BCBS in 2008 to administer a Salud program, which began operations in October of the same year.

HSD/MAD managed care contracts require MCOs to achieve and maintain accreditation from the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on, and improving the quality of health care. NCQA’s programs and services reflect a straightforward formula for improvement: measure, analyze, improve, [and] repeat.² Presbyterian, Lovelace, and Blue Cross Blue Shield were NCQA-accredited at the “commendable” level; Molina was NCQA-accredited at the “excellent” level for the audit time frame.

**Purpose**

The purpose of this audit was to measure the MCOs’ level of compliance with NMAC 8.305 and 8.306, pertaining to Medicaid managed care and with Letter of Direction (LOD) #44 pertaining to Program Integrity. *HealthInsight* New Mexico reviewed the MCOs’ processes, policies and procedures, and conducted on-site interviews and assessments. MCO and provider files were reviewed to measure compliance with applicable regulations.

**Methodology**

The audit methodology was designed to align the audit process with:

- Specifications of the HSD LOD issued to *HealthInsight* New Mexico,
- MCOs’ state contractual obligations,
- CMS EQR protocols, and
- Industry standards.

For the purposes of the physical health MCO audits, the measurement and scoring methodology addressed a subset of NMAC sections 8.305 and 8.306. Program Integrity, a federal regulation (specifically, 42 CFR 455 on disclosures), was added as a scored item for the first time in this audit. This item was integrated into the tool used to score the NMAC Fraud and Abuse regulations.

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The rules that regulate SCI are mirrored after the Salud regulation with two noticeable differences, namely:
- SCI Coordination of Benefits (COB) regulations have fewer requirements than the corresponding Salud Coordination of Services (COS) regulations.
- SCI-SHCN regulations have fewer requirements than the corresponding Salud ISCHN regulations.

Discussion of Regulations Reviewed

In the section below, there is a description of each regulation reviewed and the process that was used to evaluate it. For ease of understanding, only the Salud regulations will be discussed in detail. The requirements for the SCI program, although fewer in number, are identical to the corresponding Salud regulations.

Quality Management 8.305.8

Several sections of NMAC 8.305.8 were evaluated individually as follows:

Quality Management and Improvement 8.305.8.12

This portion of the review evaluated the quality management/quality improvement (QM/QI) plan including policies, procedures, and other implementation documents. Particular focus was given to program structure and operation, mechanisms for continuous QI, member satisfaction, health management systems, clinical practice guidelines, and program effectiveness.
Medical Records 8.305.8.17

Policies and procedures for medical records were reviewed to determine evidence of medical record confidentiality processes and compliance with the Health Insurance Portability and Accountability Act (HIPAA) in the transfer of information between the MCO and providers. The review also included policies and procedures designed to allow MCO and HSD/designee access to records. The MCO’s process for review of medical records to ensure proper documentation was also assessed. Provider medical records were reviewed for compliance with NMAC regulations.

Delegation 8.305.8.19

Policies, procedures, and delegate contracts with the MCO were examined for completeness and evidence of follow through (audits of the delegated entity’s records by MCO, etc.)

Coordination of Services 8.305.9

Policies, procedures, and structures regarding coordination of services between the MCO and the behavioral health Statewide Entity (SE); Aging and Long Term Services Department (ALTSD); schools; New Mexico Children, Youth and Families Department (CYFD); and waiver programs were reviewed. The evaluation also included mechanisms for appropriate reporting from primary care providers (PCPs), identification, and stratification of Individuals with Special Health Care Needs (ISHCN), member assessment, development of care coordination plans, and appropriate follow-up as determined by the service coordinator and the member. Case files were reviewed for compliance with relevant NMAC regulations.

Member Grievance System 8.305.12

Policies and procedures were reviewed for compliance with NMAC standards, including mandated timeframes, appropriateness of assigned staff, and dissemination of information to members and providers. Policies and procedures were also reviewed for inclusion of appropriate timeframes for expedited appeals and for grievance and appeals for both members and providers. This section included a random sample file review of grievances, appeals, and expedited appeals, with particular focus on adherence to timelines, policies and procedures.

Program Integrity (Fraud and Abuse 8.305.13)

This subject included the NMAC Fraud and Abuse regulations as reviewed in previous years. It also included requirements set forth in LOD #44 from HSD to the MCOs, which were taken from 42 CFR 455. These requirements included regulations from the CFR and the ACA.

Reporting Requirements 8.305.14

A review of the basic elements of reporting requirements, including accuracy, timeliness, conformity to HSD standards, content, and pre-submission analysis by the MCO was completed.

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

ISHCN policies and procedures were reviewed to determine if members with multiple and complex physical and behavioral health care needs were proactively identified by the MCO according to at least the minimum criteria defined in the NMAC. The process of applying stratification criteria to identify ISHCN and policies and procedures governing care coordination
for ISHCN were examined. A file review was conducted to evaluate compliance with NMAC regulations, including assessment and education of ISHCNs regarding care coordination.

**Client Transition of Care (TOC) 8.305.16**

TOC policies and procedures were reviewed to determine if the MCOs were preemptively identifying members who might be in need of TOC services and to determine if TOC services were offered at the time of enrollment in the MCO; transferring out of the MCO, if TOC services were provided during transition out of an inpatient facility; and if pre-authorizations were honored for the first thirty-days of enrollment.

**Data Collection Tools**

Data collection audit tools, interpretive guidelines, and scoring methodology were developed using the NMAC with the exception of Program Integrity. Program Integrity was developed using LOD # 44, the CFR, and the ACA. The interpretive guidelines contained detailed criteria regarding each regulation. The audit tools and guides were approved by HSD prior to the on-site audits. The compliance audit consisted of document reviews, file reviews, and on-site interviews with MCO staff.

**Defining and Measuring Compliance**

The data collected from the MCOs, either prior to the on-site audits or during the on-site audits, were considered in determining the extent to which the MCOs were in compliance with NMAC, CFR, ACA, and CMS regulations. Audit tools were completed as part of the evaluation.

**Table 1: Compliance Levels**

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

**Scoring Methodology**

This section presents the numerical system used to determine the score for each subject and an overall score for compliance.

**Allocation of Points**

Each subject is assigned a specific number of points according to the number of each discrete, measurable aspect of the regulation and its place in the hierarchy of the applicable regulation. These points are then distributed among the subjects included in each category as summarized in Table 2. The total number of points an MCO can achieve is 100.00.
### Table 2: Allocation of Points

<table>
<thead>
<tr>
<th>Regulation Number</th>
<th>Regulation Description</th>
<th>Available Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.305.8.12</td>
<td>Quality Management (Disease Management)</td>
<td>10</td>
</tr>
<tr>
<td>8.305.8.17</td>
<td>Medical Records</td>
<td>10</td>
</tr>
<tr>
<td>8.305.8.19</td>
<td>Delegation</td>
<td>6</td>
</tr>
<tr>
<td>8.305.9</td>
<td>Coordination of Services</td>
<td>17</td>
</tr>
<tr>
<td>8.305.12</td>
<td>Grievance System</td>
<td>17</td>
</tr>
<tr>
<td>8.305.13 and Selected CFRs</td>
<td>Program Integrity</td>
<td>3</td>
</tr>
<tr>
<td>8.305.14</td>
<td>Reporting Requirements</td>
<td>10</td>
</tr>
<tr>
<td>8.305.15</td>
<td>ISHCN</td>
<td>17</td>
</tr>
<tr>
<td>8.305.16</td>
<td>Client Transition of Care</td>
<td>10</td>
</tr>
<tr>
<td><strong>Overall Total:</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation Number</th>
<th>Regulation Description</th>
<th>Available Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.306.8.9</td>
<td>Quality Management (Disease Management)</td>
<td>10</td>
</tr>
<tr>
<td>8.306.8.9</td>
<td>Medical Records</td>
<td>10</td>
</tr>
<tr>
<td>8.306.8.10</td>
<td>Delegation</td>
<td>6</td>
</tr>
<tr>
<td>8.306.9</td>
<td>Coordination of Benefits</td>
<td>17</td>
</tr>
<tr>
<td>8.306.12</td>
<td>Grievance Resolution System</td>
<td>17</td>
</tr>
<tr>
<td>8.306.13 and Selected CFRs</td>
<td>Program Integrity</td>
<td>3</td>
</tr>
<tr>
<td>8.306.14</td>
<td>Reporting Requirements</td>
<td>10</td>
</tr>
<tr>
<td>8.306.15</td>
<td>SCI-SHCN</td>
<td>17</td>
</tr>
<tr>
<td>8.306.16</td>
<td>Member Transition of Care</td>
<td>10</td>
</tr>
<tr>
<td><strong>Overall Total:</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Auditor Inter-rater Reliability

The HealthInsight New Mexico auditors completed an inter-rater reliability (IRR) assessment for each audit section that had a file review element. A peer review of each section was conducted to help ensure consistency in assigning designations, scoring and language.

### Data Validation

Multiple reviewers validated all completed instruments to assure the accuracy of information in the final report. Discrepancies were discussed with HealthInsight New Mexico EQRO staff including the medical director.
In addition, all HealthInsight New Mexico file review data entry was reviewed to provide error-free data entry prior to analyzing results. During the on-site audit, hard-copy records were used to validate the sample selection. Reviewers discussed discrepancies with MCO staff to facilitate accurate collection and reporting of information.

**Potential Point Deductions from Overall Score**

The scoring methodology included criteria to reduce the overall score of each MCO program for late receipt or inaccurate identification of the documentation requested by HealthInsight New Mexico. One point was deducted from the overall score for each identified violation according to the following:

- **Timeliness**
  - MCO documentation sources
  - Universe submission
  - Case file/medical record preparation
  - Clarification documents
  - Documentation due at on-site closing

- **Accuracy**
  - Universe submission
  - Case file/medical record preparation

The potential existed for a seven-point deduction from the overall score in each program (Salud and SCI) for each MCO.

**Calculation of Final Score**

Final scores were calculated using the following method:

1. The points earned within each subject were divided by the points available to determine a percentage.
2. Each subject was reported individually as a percentage with a corresponding compliance level.
3. The total points earned for all subjects were divided by the total points available for all subjects to determine an overall percentage.
4. The overall percentage was multiplied by a weighted figure to determine the overall score.

The final overall score was reported as a percentage and determined the overall compliance level.

**Evaluation Activities Prior to On-site Audit**

Below is a detailed description of audit activities that took place prior to the on-site audit.

**Pre-evaluation Overview Meeting**

A meeting with MCO representatives and HSD staff was held five weeks prior to the on-site audit. The meeting included a detailed overview of the regulations, documentation requirements, and a review of the audit process including the overall timeline of the audit. Noted deficiencies from last year were highlighted during this meeting. At the meeting, the MCOs were

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3 A universe is defined as the list of case files that document the identified service.
presented with a list of data sources to submit for review prior to the on-site portion of the audit. In response to issues identified at the meeting, the HealthInsight New Mexico project manager made minor revisions to the audit tools, interpretive guidelines, and scoring methodology which were reapproved by HSD.

**Desktop Review**

In preparation for the on-site audit, the auditors reviewed all documentation submitted by each MCO. This documentation consisted of the required policies, procedures, the member handbook, the provider handbook, the Quality Management/Quality Improvement (QM/QI) plan, and multiple other documents. The MCOs were encouraged to ask clarification questions regarding requested data source documents and regulations during this time. Each MCO was required to submit file universes in an electronic workbook. Four weeks prior to each on-site audit, a random selection of files from the universe submissions was sent to each MCO for compilation of hard-copy files, including oversample files, to be audited on-site.

**On-site Audit Activities**

A three-day audit was conducted by four HealthInsight New Mexico auditors at each MCO. The on-site audit consisted of demonstrations by MCO staff of improvements from the previous audit, file reviews and interviews with key staff.

On the first day of each on-site audit, an opening session was held to discuss the on-site audit process. The MCO was allotted time to present any changes to the company and operations, including services and structures that might be relevant to the outcome of the audit. At the conclusion of the on-site audit, the HealthInsight New Mexico auditors conducted a closing conference attended by MCO staff. Auditors presented their preliminary findings, provided feedback and answered MCO staff questions.

**Report of Scoring Details**

The overall scores for the Compliance Audits for each MCO by program and year are presented in Table 3.

<table>
<thead>
<tr>
<th>MCO</th>
<th>SFY 2010 Score</th>
<th>SFY 2011 Score</th>
<th>SFY 2012 Score</th>
<th>SFY 2012 Compliance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS</td>
<td>98.52%</td>
<td>99.19%</td>
<td>98.47%</td>
<td>Full Compliance</td>
</tr>
<tr>
<td>Lovelace</td>
<td>98.87%</td>
<td>97.70%</td>
<td>94.04%</td>
<td>Full Compliance</td>
</tr>
<tr>
<td>Molina</td>
<td>98.22%</td>
<td>99.04%</td>
<td>99.97%</td>
<td>Full Compliance</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>99.44%</td>
<td>99.74%</td>
<td>99.90%</td>
<td>Full Compliance</td>
</tr>
</tbody>
</table>
## Individually Scored Subjects

Each NMAC part and section individually scored is detailed below, first for the Salud program, then for the SCI program. Discussion is found below each table.

### Salud Scores

**Table 4: Scores for Individual Salud Regulations, by MCO**

<table>
<thead>
<tr>
<th>Salud Regulation Description</th>
<th>BCBS Score</th>
<th>Lovelace Score</th>
<th>Molina Score</th>
<th>Presbyterian Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Management (Disease Management)</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Medical Records</td>
<td>98.61%</td>
<td>99.09%</td>
<td>99.73%</td>
<td>98.95%</td>
</tr>
<tr>
<td>Delegation</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Coordination of Services</td>
<td>97.72%</td>
<td>96.92%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Grievance System</td>
<td>99.95%</td>
<td>97.98%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Program Integrity</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>ISHCN</td>
<td>100.00%</td>
<td>76.47%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Client Transition of Care</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

**Point Deduction**

- BCBS: -1.00
- Lovelace: -1.00
- Molina: None
- Presbyterian: None

**Overall Totals:**

- BCBS: 98.47%
- Lovelace: 94.04%
- Molina: 99.97%
- Presbyterian: 99.90%

### Salud Discussion

One (1) point was deducted from BCBS’s overall score for inaccurate identification of the medical records universe. Of the forty (40) records in the sample, two (2) did not meet the specifications because they were for charges incurred while the members were confined in the hospital.

One (1) point was deducted from Lovelace’s overall Salud compliance score due to the submission of inaccurate or incomplete universes. In several of the universes (primarily grievance and appeals), there were concerns about the names of the consumers. Some names appeared incomplete because in some of the universes (e.g. consumer grievances), the consumer names were not capitalized; whereas in other universes the names were capitalized.
A second Lovelace issue was the omission of the provider name or facility in the provider grievance and provider appeals universes.

8.305.8.12 Standards for Quality Management and Improvement with a Focus on Disease Management

All of the MCOs demonstrated Full Compliance with all standards related to this regulation. QM policies and procedures and supporting documentation of the Disease Management Programs were explicit and completely referenced all aspects of the regulation.

- No adverse findings in this audit

Previous Audit Follow-up
- All MCOs earned Full Compliance last year

8.305.8.17 Standards for Medical Records

All of the MCOs demonstrated Full Compliance with all standards related to this regulation. Medical records policies and procedures and supporting documentation were explicit and completely referenced all aspects of the HSD/MAD regulation. Medical records were reviewed for each MCO. Although there is improvement, there continues to be documentation issues at the provider level. HealthInsight New Mexico recommends that provider education continue and some form of reminder be built in to prompt providers to consistently accomplish and document the following:

- History of smoking, alcohol use, and substance abuse for members 12 years of age and older
- Advance directives for members 18 years of age and older

Previous Audit Follow-up
- Improvement was noted in documenting history of smoking, alcohol use, and substance abuse for members 12 years of age and older, although still needs improvement
- Improvement was also noted in the compliance rates for documentation of a discussion of advanced directives with adults, although still needs improvement
- All MCOs earned Full Compliance last year

8.305.19 Delegation

All of the MCOs demonstrated Full Compliance with all standards related to this regulation. Delegation agreements and oversight processes were explicit and completely referenced all aspects of the HSD/MAD regulation. Documents were reviewed for oversight activities.

- No adverse findings in this audit

Previous Audit Follow-up
- All MCOs earned Full Compliance last year

8.305.9 Coordination of Services

(Joint Focus on Coordination with Behavioral Health and Services to ISHCN)

All four MCOs demonstrated Full Compliance with the standards related to coordination of services. Coordination of services policies and procedures and supporting documentation were explicit and completely referenced all aspects of the regulation. Case files were reviewed for care coordination of PH and behavioral health (BH) services and indicated the following:
No adverse findings in this audit

Previous Audit Follow-up
- All MCOs earned Full Compliance last year

8.305.12 Member Grievance System
All four MCOs demonstrated Full Compliance with the standards related to the member grievance regulations. Member grievance policies and procedures and supporting documentation were explicit and completely referenced all aspects of the regulation. Case files were reviewed for timeliness of MCO response and dissemination of information for grievance, appeals and expedited appeals. Case files were reviewed for each element of the Member Grievance System and the following was noted:
- No adverse findings in this audit

Previous Audit Follow-up
- Improvement was noted in rates of compliance with timeliness of acknowledgements and resolutions in all categories
- All MCOs earned Full Compliance last year

42 CFR 455. Program Integrity (Fraud and Abuse 8.305.13)
All four MCOs demonstrated Full Compliance with reviewed regulations. This section was scored for the first time this year. It included the NMAC Fraud and Abuse regulations as well as the requirements set forth in LOD #44 from the HSD to the physical health MCOs. These requirements included regulations from the CFR and the ACA.
- No adverse findings in this audit

Previous Audit Follow-up
This was not a scored element in previous audits

8.305.14 Reporting Requirements
All four MCOs demonstrated Full Compliance with all standards related to reporting requirements. Reporting requirements, policies and procedures, and supporting documentation were explicit and completely referenced all aspects of the regulation.
- No adverse findings in this audit

Previous Audit Follow-up
- All MCOs earned Full Compliance last year

8.305.15 Services for Individuals with Special Health Care Needs (ISHCN)
Three of the four MCOs demonstrated Full Compliance with the identified standards for this regulation. The fourth MCO earned a Minimal Compliance designation. All four of the MCOs had sufficient policies and procedures in place to identify ISHCNs. A review of the case files for each MCO indicated the following:
- One of the four MCOs did not consistently document the following:
  - Documentation of criteria used to identify ISHCN members
  - Documentation of the process used to stratify care coordination needs of ISHCN members
Previous Audit Follow-up

- Three of the four MCOs consistently documented the following:
  - Criteria used to identify ISHCN members
  - Process used to stratify care coordination needs of ISHCN members
  - Assessment of care coordination needs
  - Evidence that the member was advised that care coordination is available and when it might be appropriate
  - Involvement of the member, member’s family, and/or member’s caregiver in the plan of care
  - Communication with the member to advise of key MCO resources, single point of contact (SPOC), and corresponding telephone numbers
  - How to access emergency room (ER) care and the clinical history to provide when ER or inpatient care is needed

- All four MCOs earned Full Compliance last year

8.305.16 Client Transition of Care

All four MCOs demonstrated Full Compliance with the standards related to client transition of care. The MCOs identified many, but not all, appropriate members and have processes in place to identify the transition-of-care cases. A review of the case files for each MCO indicated the following:

- No adverse findings in this audit

Previous Audit Follow-up

- All four MCOs scored 100.00 percent compliance this year
- Improvement was noted in the documentation of identification of members while they are still in the hospital in order to assist with care coordination upon discharge
- All MCOs earned Full Compliance last year

State Coverage Insurance Scores

Table 5 presents SCI scores for individual regulation compliance followed by discussion of the findings. MCO-specific findings are included in the appropriate appendices. Lovelace, Molina, and Presbyterian all operate an SCI program. BCBS did not operate an SCI program during the audit period.
<table>
<thead>
<tr>
<th>SCI Regulation Description</th>
<th>Lovelace</th>
<th>Molina</th>
<th>Presbyterian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Management (Disease Management)</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Medical Records</td>
<td>96.76%</td>
<td>96.22%</td>
<td>98.02%</td>
</tr>
<tr>
<td>Delegation</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Grievance Resolution System</td>
<td>99.89%</td>
<td>100.00%</td>
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</tr>
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<td>Program Integrity</td>
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<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>100.00%</td>
<td>100.00%</td>
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<tr>
<td>SCI-SHCN</td>
<td>76.61%</td>
<td>99.07%</td>
<td>99.72%</td>
</tr>
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<td>Member Transition of Care</td>
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<td>99.46%</td>
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**State Coverage Insurance Discussion**

One (1) point was deducted from the overall Lovelace compliance score due to the submission of inaccurate or incomplete universes. In several of the universes (primarily grievance and appeals), there were concerns about the names of the consumers. Some names appeared incomplete because in some of the universes (e.g. consumer grievances), the consumer names were not capitalized; whereas in other universes the names were capitalized. A second Lovelace issue was the omission of the provider name or facility in the provider grievance and provider appeals universes.

**8.306.8.9 Standards for Quality Management and Improvement with a Focus on Disease Management**

All three MCOs demonstrated full compliance with all standards related to this regulation. QM policies and procedures and supporting documentation of the Disease Management Programs were explicit and completely referenced all aspects of the regulation.

- No adverse findings in this audit

**Previous Audit Follow-up**

- All MCOs earned Full Compliance designations last year

**8.306.8.9 Standards for Medical Records**

All three MCOs demonstrated full compliance with all standards related to this regulation. Medical records policies and procedures and supporting documentation were explicit and completely referenced all aspects of the HSD/MAD regulation. Medical records were reviewed for each MCO and the following elements from the medical records reviews had the lowest compliance scores:

- Advance directives for members 18 years of age and older
• Discussion of smoking, alcohol use, and/or substance abuse for members 12 years of age and older

Previous Audit Follow-up
• Improvement was noted in the documentation of screening for smoking, alcohol use, and substance abuse issues for members age 12 and over
• All MCOs earned Full Compliance last year

8.306.8.10 Delegation
All three MCOs demonstrated full compliance with all standards related to this regulation. Delegation agreements and oversight processes were explicit and completely referenced all aspects of the HSD/MAD regulation.
• No adverse findings in this audit

Previous Audit Follow-up
• All MCOs earned Full Compliance last year

8.306.9 Coordination of Benefits
All three MCOs demonstrated full compliance with the standards related to coordination of benefits. Coordination of benefits policies and procedures and supporting documentation were explicit and completely referenced all aspects of the regulation. Case files were reviewed for coordination of benefits between PH and BH services and indicated the following:
• No adverse findings in this audit

Previous Audit Follow-up
• Improvement was noted in the consistency of documentation of the name and phone number of a single point of contact for the member
• All MCOs earned Full Compliance last year

8.306.12 Member Grievance Resolution
All three MCOs demonstrated full compliance with the standards related to the member grievance regulations. Member grievance policies and procedures and supporting documentation were explicit and completely referenced all aspects of the regulation. Case files were reviewed for timeliness of MCO response and dissemination of information for grievance, appeals, and expedited appeals. Case files were reviewed for each element of the Member Grievance System and the following was noted:
• No adverse findings in this audit

Previous Audit Follow-up
• All MCOs earned Full Compliance last year

42 CFR 455. Program Integrity (Fraud and Abuse 8.305.13)
All three MCOs demonstrated full compliance with reviewed regulations. This section was scored for the first time this year. It included the NMAC Fraud and Abuse regulations as well as the requirements set forth in LOD #44 from the HSD to the physical health MCOs. These requirements included regulations from the CFR and the ACA.
• No adverse findings in this audit
Previous Audit Follow-up
- All three MCOs scored 100.00 percent this year
- This was not a scored element in previous audits

8.306.14 Reporting Requirements
All of the MCOs demonstrated full compliance with all standards related to reporting requirements. Reporting requirement policies and procedures and supporting documentation were explicit and completely referenced all aspects of the regulation.
- No adverse findings in this audit

Previous Audit Follow-up
- All MCOs earned Full Compliance last year

8.306.15 Services for SCI Members with Special Health Care Needs (SCI-SHCN)
Two MCOs demonstrated full compliance and one MCO demonstrated minimal compliance with the standards for this regulation. All of the MCOs had sufficient policies and procedures in place to identify SCI-SHCN members. Case files were reviewed for each MCO. One MCO did not consistently document the following three elements in the case files:
- Provision of member education regarding ER care and clinical history to provide when ER or inpatient care is necessary
- Provision of access to clinical history by ER physician
- Provision of education and information to member and/or family related to specific needs

Previous Audit Follow-up
- Improvement was noted in the compliance level of documenting that a list of key MCO resources with identified SPOC and related telephone numbers was provided to member
- Improvement was noted in the documentation that coordination of care occurred between the PCP and hospitalist when member was admitted to the hospital
- All of the MCOs consistently documented the provision of member education related to specific needs in this audit
- All MCOs earned Full Compliance designations last year

8.306.16 Member Transition of Care
The MCOs demonstrated full compliance with the standards related to member transition of care. A review of the case files for each MCO indicated the following:
- No adverse findings in this audit

Previous Audit Follow-up
- All MCOs consistently documented evidence of care being coordinated during member transition out of the MCO
- All MCOs consistently documented evidence of care being coordinated during member transition out of an inpatient facility
- All MCOs earned full compliance designations last year

Rebuttal and Reconsideration Review
Each MCO was given an opportunity to comment on the draft report and submit requests for reconsideration.

BCBS stated the technical specifications for the medical records universe were not clear and requested a reconsideration of the penalty point. In discussion with HSD/MAD the penalty point was upheld. Therefore, the overall score remained at 98.47% for the Salud plan.

Lovelace requested a list of specific cases with the missing information from the ISCHN and SCI-ISCHN files and the expectations in this area. A list of the specific cases with the missing information from the ISCHN and SCI-SHCN files was provided via email. A discussion was held between HealthInsight New Mexico and Lovelace about the expectation that when educational materials are mailed to individual ISCHN and SCI-SHCN member, it is documented and provided for audit. Specific case files were reviewed. Evidence of consumer education was not provided in 70-percent of the total case files reviewed. In discussion with HSD/MAD the penalty point was upheld. Therefore, the overall score remained at 94.04% for the Salud plan and 94.55% for the SCI plan.

Molina stated that the irregularities noted in the TOC universe were immaterial since they did not affect the selected audit sample. In discussion with HSD/MAD the penalty point was removed. The overall score was restored to 99.97% for the Salud plan and 99.46% for the SCI plan.

Presbyterian stated that they had no comments or requests for reconsideration. The overall score remained at 99.90% for the Salud plan and 99.70% for the SCI plan.

**Recommendations**

This audit was conducted to discover the extent to which the MCOs were compliant with federal and state regulations in the provision of Salud and SCI services. Recommendations for improvement are listed separately for each regulation and each program. Specific recommendations for each MCO are listed in the appendices provided to the MCOs and HSD/MAD.

**Salud Recommendations**

8.305.8.12. Standards for Quality Management and Improvement (Focus on Disease Management)
- No recommendations from this audit

8.305.8.17 Medical Records
- Although there is improvement, there continues to be documentation issues at the provider level. HealthInsight New Mexico recommends that provider education continue and some form of reminder be built in to prompt providers to consistently accomplish and document the following:
  - Discussion of smoking, alcohol use, and substance abuse with members 12 years of age and older
  - Advance directives for adults 18 years and older
8.306.8.19  Delegation
- No recommendations from this audit

8.305.9.  Coordination of Services
- No recommendations from this audit

8.305.12.  Member Grievance System
- Recommend that MCOs investigate and resolve member and provider grievances and appeals consistently within the 30-day timeframe established by the regulations

42 CFR 455. Program Integrity (Fraud and Abuse 8.305.13)
- No recommendations from this audit

8.305.14.  Reporting Requirements
- No recommendations from this audit

8.305.15  Services for Individuals with Special Health Care Needs (ISHCN)
- Recommend that MCOs consistently provide and document the following items:
  o Information provided to each ISHCN member advising of key MCO resources and name and telephone number for identified single point of contact
  o Involvement of the member, member’s family, and/or member’s care giver in the plan of care
  o Criteria used to identify ISHCN members in each case file
  o Process used to stratify care coordination needs of each ISHCN member
  o Assessment for care coordination needs
  o Evidence that the member was provided with information and education related to specific needs
  o Evidence that the member was advised that care coordination is available and when it might be appropriate
  o Education regarding access to ER care and clinical history to provide when ER in in-patient admission is needed
  o Access to clinical history by ER physician

Client Transition of Care
- Recommend that MCOs provide and document evidence of identifying members upon discharge from the hospital in order to coordinate care

SCI Recommendations

8.306.8.9  Standards for Quality Management and Improvement (Focus on Disease Management)
- No recommendations from this audit
8.306.8.17 Medical Records

- Recommend that MCOs consider collaborating with PCPs to utilize electronic health records to encourage documentation of the following elements in the medical record:
  - Discussion of advance directives for members 18 years and older
  - Discussion of smoking, alcohol use, and/or substance abuse for members 12 years of age and older

8.306.9 Coordination of Benefits

- Recommend that the MCOs consistently provide and document that:
  - Information was provided to each member eligible for coordination of benefits advising of key MCO resources and name and telephone number for identified single point of contact

8.306.12 Member Grievance System

- Recommend that the MCOs provide resolution for provider appeals within the time frames in NMAC regulations.

42 CFR 455. Program Integrity (Fraud and Abuse 8.306.13)

- No recommendations from this audit

8.306.14 Reporting Requirements

- No recommendations at this time

8.306.15 Services for SCI Members with Special Health Care Needs (SCI-SHCN)

- Recommend that MCOs consistently document the following:
  - Assessment for care coordination
  - Criteria used to identify each ISHCN member
  - Evidence of stratification for care coordination

8.306.16 Member Transition of Care

- No recommendations from this audit

Recommendations to HSD

*HealthInsight* New Mexico recommends that HSD/MAD implement a corrective action plan to assist Lovelace to come into compliance with 8.305.15 (ISHCN) and 8.306.15 (SCI-SHCN); specifically by consistently documenting and recording the following:

- Evidence that information and education related to specific needs was provided to consumer and/or family
- Evidence of education that care coordination is available and when it may be appropriate for needs
- Evidence that the consumer was educated regarding access to ER care and clinical history to provide when ER or inpatient admission is needed
- Evidence that the ER physician has access to clinical history
Conclusion

The MCOs continue to meet contractual requirements in both the Salud and SCI programs based on this audit. MCO policies and procedures are effective and are being followed at both the organizational and provider levels. Continuous improvements to services and system changes are demonstrating positive results in compliance levels. Lovelace earned Full Compliance with all but two regulations: Salud ISHCN and SCI-SHCN. BCBS, Molina, and Presbyterian earned Full Compliance for each regulation.