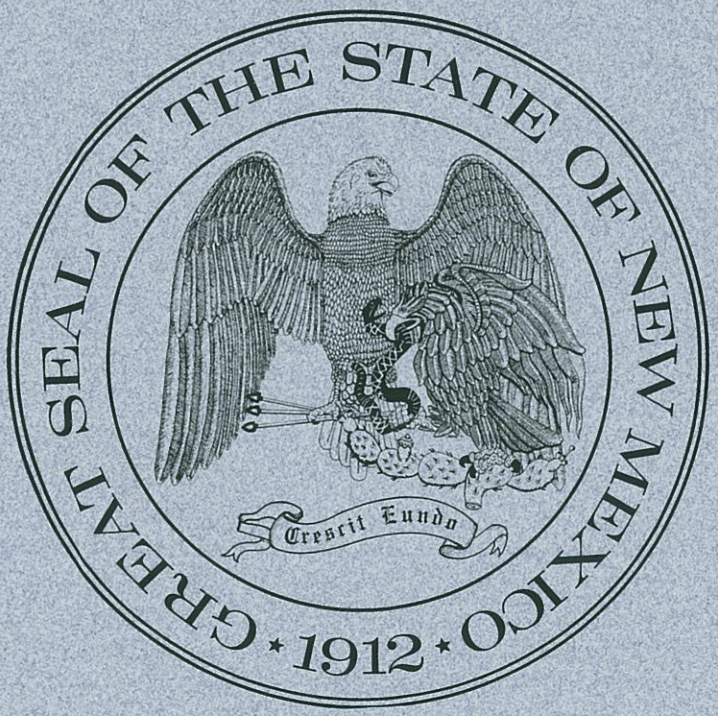
HUMAN SERVICES DEPARTMENT

Audit of Medicaid Managed Care Program (SALUD!)
Cost Effectiveness
Behavioral Health Services
Access to Salud! Services

October 27, 2000



Report to

the LEGISLATIVE FINANCE COMMITTEE

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DAVID ABBEY
DIRECTOR

October 26, 2000

Mr. Lou Gallegos, Acting Secretary
Ms. Robin Otten, Deputy Secretary
Human Services Department
Santa Fe, New Mexico 87504

Dear Mr. Gallegos and Ms. Otten:

On behalf of the Legislative Finance Committee (Committee), we are pleased to transmit the third audit report of the Medicaid care program (salud!).

The audit team interviewed key personnel, examined documents and prepared this report which will be presented at a public hearing of the Committee on October 27, 2000, The contents of this report were discussed with Human Services Department (department) staff at an exit conference held on October 5, 2000. We appreciate the department's cooperation and assistance.

We believe this report addresses the issues the Committee asked us to review and hope the Human Services Department will benefit from our efforts. Again, thank you for your cooperation and assistance.

Sincerely,

Dannette K. Burch

Dannette K. Burch
Deputy Director

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EXECUTIVE SUMMARY

HUMAN SERVICES DEPARTMENT
Audit of Medicaid Managed Care Program (SALUD!)
October 27, 2000

EXECUTIVE SUMMARY

Pursuant to a request from the Legislative Finance Committee (committee), the performance auditors have conducted an audit of issues relating to the New Mexico Human Services (department) Medicaid managed care program (*Salud!)*. This is the third report based on procedures performed from August 1, 1999 through October 6, 2000. The purpose of this audit was to:

- Update cost effectiveness (savings) estimate of the Salud! program;
- Determine amount of behavioral health funding paid directly to providers;
- Evaluate quality of behavioral health services under Salud!; and
- Determine access to Salud! services.

Results

Managed care organizations (MCOs) received approximately nine percent fee increase for FY01. Consequently, FY01 cost savings are now estimated to be $10.1 million rather than $22.3 million as reported by the department to the Health Care Financing Administration in January 2000.

The department has reported that 82 percent of behavioral health Salud! funds in FY99 were distributed to providers. However, we estimate that only $60.1 million of $109.7 million (55 percent) of Salud! behavioral health funds were distributed directly to providers. In a fee-for-service environment 100 percent of program funds would be distributed directly to providers. The only assumption that can be drawn from this analysis is that access to and quality of behavioral health services have been seriously reduced by Salud!.

We also estimate that 15 percent of all Salud! funding goes toward administration and profit by/for the MCOs.

Quality of mental health services provided by Salud! is not adequate. The department's Quality Assurance Bureau and legislative auditors found frequent incidences of poor case file documentation and non-compliance with industry standards in MCO/BHO utilization management functions. BHOs do not give adequate consideration to a patient's treatment plan, level of care criteria and achievement toward goals (outcomes) of the treatment plan.

MCO/behavioral health organizations' (BHOs) prior authorization processes are overly restrictive and time consuming. MCOs/BHOs tend to authorize lower levels of services than requested for shorter periods of time than patients' assessed needs which are clinically appropriate. UNM/Children's Psychiatric Hospital data indicate more frequent re-admissions of children for acute care since implementation of Salud! in 1997.

MCOs and BHOs have different definitions of *medical necessity.* The department did not provide MCOs with a single definition of *medical necessity* until September 2000 nor has it established in contracts the process/methodology by which such determinations will be made in accordance with professional standards.

MCOs do not provide the department provider listings in a format which facilitates analysis. MCOs also count providers more than one full-time equivalent when they have more than one specialty and/or serve more than one county.

Federal and state statistics indicate that New Mexico is doing better than most other western (mountain) states for the number of physicians available. However, certain specialities lack adequate numbers. For example, we confirmed a net loss of 17 child psychiatrists in New Mexico since 1997. Other data suggests that persons living in rural areas do not have sufficient access, not only to psychiatrists, but to psychologists as well and that BHOs are not meeting federal access standards.

Fees paid by MCOs to mental health providers are substantially lower than FY96 fee-for-service amounts even though MCOs have received at least 15 percent in rate increases in the past three years.

Untimely, cost settlement audits and the department's failure to timely reconcile and record accounting transactions make it difficult to determine true financial position of the Medicaid program.

Recommendations:

Evaluate Salud! based on an assessment of the numbers, types and quality of services provided rather than on cost savings. Require 90 percent of the behavioral health care related funding to be dedicated for behavioral health care service providers and eliminate unnecessary layer of administrative burden and profits in favor of quality services to Medicaid recipients.

Work with MCOs and legislative auditors to compile and analyze total Medicaid expenditures for FY00 and determine cost effectiveness and program efficiency.

Carving out behavioral health services from Salud! is an important option which HCFA directed the department to transition out to fee-for-service within 90 days. Twenty-nine states currently have full or partial carve out of behavioral health services.

Until behavioral health services are fully transitioned out of the Salud!, require MCOs to provide adequate written justification for all denials and/or downgrading of levels of care requested by providers. Require MCOs to report to the department the number and type of prior authorizations requested against services actually provided. Identify and investigate reasons for requested services which were not provided. Also require MCOs to use electronic media to facilitate the pre-authorization process and eligibility checks, and provide timely written notification to providers for services authorized and denied. Provide MCOs with one definition of medical necessity and establish a process and methodology by which such determinations will be made. Consider applying this recommendation to children with special needs and other physical health services.

Consider directing additional resources to attracting and retaining child psychiatrists such as increasing funding to the *loan for service* and the *loan repayment* programs administered by the Commission on Higher Education.

Develop a standardized procedure for reporting of providers by MCOs. Also require MCOs to report on provider availability and turnover by specialty type to facilitate analysis of shortages in certain specialty types.

Require MCOs to pay providers fees commensurate with FY96 levels which providers have indicated would provide sufficient resources for quality behavioral health care. Further establish fixed fees for services which MCOs would pay. In doing so, the financial incentive for MCOs to deny or reduce services would be eliminated.

Contract with a consultant to develop efficient business processes to record, reconcile and prepare needed financial data on a monthly basis for executive and program managers. Consultant must address Joint Accounting System (JAS) integration with the Department of Finance and Administration's Central Accounting System and department's other major information systems such as the Medicaid Management Information System (MMIS), Child Support Enforcement System, etc.

Consider establishing an operating reserve contingency fund to strictly make payments for prior year cost settlement audits including payments to the University of New Mexico for indirect medical education and graduate medical education. All refunds received from the cost settlement audits would be deposited in this contingency account.

DEPARTMENT REVISED RESPONSES

Estimates of savings in Salud! compared to the cost increases under Fee for Service have become more difficult and less precise an art with the passage of time. Claiming the savings now are only $10.1 million versus a previously estimated $22.3 million also misses the point as to why this may have occurred. First, these figures are reasonable estimates made at the time based on the best information available. Second, due to the carve out of the Native Americans and the institution of the Native American Opt-In policy, cost savings estimated at the time did not occur. Under Salud! Managed Care we have achieved not only savings, but improved access to, range of, and quality assurance for services as well as a number of other benefits.

Essentially, Fee for Service simply reacts to a bill with a payment, so of course most all of the "program funds" go to providers, virtually by definition. Under Salud!, however, money also goes to a whole range of services (data availability, quality monitoring, enhanced service availability, mandated service improvements, prevention programs, health education, etc.). In fact, some of them, such as EPSDT (which contain both physical and behavioral health components), are mandated by the federal government and have seen quantum improvements under Salud! compared to the failure of Fee for Service in this regard.

Profits last year for the MCO's were at pr just over 1%. In discussions with providers, the New Mexico Medical Society, advocacy groups and even HCFA, a 15% cost for administration, given the factors listed above that occur from managed care, is a very reasonable figure.

We assert that the quality of mental health services under Salud! is certainly no less "inadequate" than it was under fee-for-service and in many ways is far superior. We do concur, however, that our February utilization reviews found lack of documentation. We mandated individualized Corrective Action Plans from the MCOs and followed up. The results will be forthcoming when completed, as appropriate.

Current information from Utilization Management reviews indicates that appropriate levels of care are currently being approved for clients, and Salud! BHOs have simplified approval processes. Premature hospital discharge issue has been addressed at least in part by the increased use of DAP (Days Awaiting Placement), which allows the patient to stay hospitalized until a safe transition to a lower level of care is arranged. And it seems only logical that re-admission rates would increase if the old practice tended toward semi-permanent institutionalization of children, even when lower levels of care that might have been more appropriate. You can't have recidivism rates for those you didn't release in the first place.

All Salud! MCOs and BHOs use the same Medical Necessity definition. Criteria development for both physical and behavioral health services must comply with this definition.

Child Psychiatrists are in great demand nationwide. When New Mexico stops taxing them as 'the rich' at 8.2% and eliminates the Gross Receipts Tax on medical services (per January 28 Albuquerque *Journal* article citing a Research & Polling survey), it will be much less difficult to attract and retain such talent.

We required MCOs/BHOs to increase their rates to 95% of Medicare rates for all providers, including Child Psychiatrists.

We have likewise noted the need to gain nearer to real-time data on the financial position of the Medicaid program, and our ASD has recently presented a recommendation to DFA which includes greater utilization of outside professionals to help reconcile and bring accounting transactions up to date.

REVIEW INFORMATION

HUMAN SERVICES DEPARTMENT
Audit of Medicaid Managed Care Program (SALUD!)
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BACKGROUND

The Medicaid program is a jointly funded federal-state program that provides medical assistance to certain low-and moderate-income persons. The program began in 1965 with the enactment of Title XIX of the *Social Security Act.* Medicaid covers approximately 41 million people, including children, the aged, blind and disabled. As of March 2000, New Mexico had approximately 302,260 Medicaid recipients (approximately two thirds under managed care) and projected expenditures of $1.21 billion and $1.24 billion for fiscal years 2000 and 2001, respectively. Section 27-2-12 NASA 1978 designates the New Mexico Human Services Department (department) as the state agency for administering the program. The Medical Assistance Division is charged with that responsibility.

Section 27-2-12.6 NMSA 1978 (*Laws 1994, Chapter 62*) mandates the department to deliver "a statewide, managed care system to provide cost-efficient, preventative, primary and acute care for Medicaid recipients". In October 1996, the department submitted a section 1915(b) waiver request to HCFA of the U.S. Department of Health and Human Services (DHHS). Salud! implementation began July 1997 and was fully implemented by June 1998.

On October 19, 2000, HCFA approved the department's waiver renewal application for a two year period (October 22, 2000 through October 21, 2002) for physical health services only and directed the department to transition behavioral health services to fee-for-service within 90 days.

In 1999, the Legislature passed House Joint Memorial 18 (HJM 18) which requires the Health Policy Commission (HPC) to develop a strategic plan for an integrated, publicly funded health-care financing and delivery system, including Medicaid managed care. HJM 18 also requires the Legislative Finance Committee (committee), with assistance from HPC, to conduct a fiscal and performance audit of the department's managed care program and its impact.

OBJECTIVE AND SCOPE

This audit was conducted in accordance with applicable *Government Auditing Standards* issued by the comptroller general of the United States. The audit period included July 1, 1998 through July 31, 2000. The audit was conducted to provide an independent and objective evaluation of:

- Cost effectiveness (savings) of the Salud! program;
- Amount of behavioral health funding paid directly to providers;

- Quality of behavioral health services under Salud!; and
- Access to Salud! services.

PROCEDURES

Our procedures included:

- a review of federal and state statutes, regulations, policies and procedures;
- a review of the Medicaid state plan and amendments to the plan;
- a review of section 1915(b) waiver requests (original 1996 and 1999/2000 renewal);
- a review of MCO contract requirements;
- a review of reports prepared by consultants to the department;
- a review of cost savings estimates submitted to HCFA;
- attending public hearings and meeting with providers;
- a review of provider case file documentation; and
- a review and evaluation of other relevant data.

Exit Conference

The contents of this report were discussed with deputy secretaries Robin Otten and Barry Bitzer, and Rob Maruca, director of the Medical Assistance Division on October 5, 2000.

Other Future Audits

We have agreed to participate in the National State Auditors Association (NSAA) joint audit of Medicaid managed care encounter data of participating states. In that regard, we will work with the Human Services Department in analyzing encounter data to determine the numbers and types of services provided, the numbers of enrollees who received services and the types of services received to aid in analyzing the cost benefit of Medicaid managed care.

Distribution of Report

This report is intended for the information of the Office of the Governor, Human Services Department, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

We would like to thank Joe Fagan, M.D. who provided invaluable assistance with the clinical aspects of this audit and all the providers who gave information to us. Without their assistance, this audit would not have been possible.

Manu Patel
Performance Audit Manager
Legislative Finance Committee

FINDINGS AND RECOMMENDATIONS

HUMAN SERVICES DEPARTMENT
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FY01 COST EFFECTIVENESS UPDATE. Cost savings of $22.3 million as previously projected by the department are now estimated at $10.1 million following conclusion of rate negotiations with the managed care organizations (MCOs) and adjustments to the upper payment limit (UPL).

In the waiver renewal application submitted to the Health Care Financing Administration (HCFA) in January of this year, cost savings for FY01 (year four of Salud!) were estimated at $22.3 million. The department and Mercer assumed a rate increase of one percent in calculating the estimated savings. However, as a result of rate negotiations with the MCOs coupled with adjustments to the UPL for the same period, the projected savings is now estimated at $10.1 million. The average rate increase to the MCOs from FY00 to FY01 is nine (9) percent. In order to absorb such a significant rate increase and continue to maintain positive cost effectiveness, there was a substantial upward adjustment to the UPL. According to department's actuarial consultant William M. Mercer, Inc. (Mercer), the UPL increase was based on prospective trend adjustments and recognition of the effect of the reduction in Native American participation in Salud! While the UPL originally assumed a 50 percent Native American participation, it has now been determined that a 20 percent Native American participation rate is more realistic. The following schedules reflect the effects of the rate negotiations and the UPL increase for FY01:

Adjusted Estimated Savings after Rate Negotiations and UPL Increase

Savings as originally projected (1% increase to MCOs)	$22,288,850
Effect of Increase to the UPL	28,489,754*
Adjusted estimated savings prior to rate negotiations	50,778,604
Less: effect of rate negotiations (9% increase to MCOs)	40,683,809
Adjusted projected savings	$10,094,795

Federal and State Share of Estimated Savings

Federal share (75 percent)	$ 7,571,096
State share (25 percent)	2,523,699
Adjusted projected savings	$10,094,795

*Upper Payment Limit Adjustment

Reduction for change in Native American participation	$ 9,913,022
Increase resulting from trend revisions	18,576,732
Overall change from revision	$ 28,489,754*

Adjusted Estimated Loss if UPL Had Not Increased

Savings as originally projected (1% increase to MCOs)	$22,288,850
Effect of rate negotiations (9% increase to MCOs)	(40,683,809)
Adjusted projected loss	($18,394,959)

As reported to the committee on May 25, 2000 and described above, Medicaid managed care in New Mexico has not generated significant savings to the state. Hence, the success or failure of the Salud! program cannot be judged by expectations of significant savings, but by issues such as quality of medical care and access to such care. For example, early periodic screening diagnosis and treatment (EPSDT) data reported on HCFA 416 form by the department indicates New Mexico's EPSDT overall screening of 67 percent, 87 percent for children in age group one year and younger, and 80 percent in age group one to two years. According to the department, Salud! has had a major impact on EPDST improvement.

Recommendation:

Consider the most recent trends and utilization data to calculate the upper payment limits for rate negotiation and for calculating the cost effectiveness of the managed care program. Also identify increases and/or decreases in quality of medical care and access to such care that is directly measurable and attributable to Salud!

BEHAVIORAL HEALTH FUNDING. Unlike a fee-for-service Medicaid program which distributes 100 percent of program funds directly to providers, only 55 percent of Salud! behavioral health funds went to behavioral health providers in FY99.

Behavioral health services in New Mexico are included in Medicaid managed care (Salud!). The MCOs contract behavioral health services out to behavioral health organizations (BHOs). BHOs contract out the services to regional care coordinators (RCCs) who in turn contract with behavioral health providers. Under the previous Medicaid fee-for-service system, behavioral health providers contracted with the department directly. In effect, Salud! has added at least three levels of providers between the Medicaid program at the state level and providers of behavioral health services.

Behavioral health advocates assert that an inordinate portion of the behavioral health Salud! funds are being retained by the MCOs, BHOs and RCCs as profits and administration. Hence, amounts left for actual direct services are considered insufficient to adequately service the behavioral health needs of Salud! recipients.

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The department contracted with William M. Mercer, Incorporated (Mercer) to perform an analysis of behavioral health funding for fiscal years 1998 and 1999. In performing its analysis Mercer obtained and compiled un-audited financial information of all the Salud! BHOs and RCCs. In its August 2000 *Behavioral Health Funding* report, Mercer concluded that approximately 82 percent of all Salud! behavioral health funds were ultimately distributed to providers in FY99. We reviewed Mercer's FY99 calculations for reasonableness and conclude that:

- Mercer's FY99 analysis began with revenues of $84.3 million received by the BHOs from the MCOs. In accordance with specific instructions from department management, Mercer did not consider revenues of the MCOs from the department. To estimate the behavioral health part of the capitation amounts paid to the MCOs by the department, we performed an analysis of the upper payment limit (UPL) calculations in the waiver renewal request submitted to HCFA by the department in January 2000. Such UPL data contains sufficient detail of the specific components of health services that are paid for under Salud! From this data we identified major distinctive behavioral health services such as in-patient behavioral health, out-patient behavioral health and residential treatment centers. We determined that approximately 23.14 percent of the total costs under a fee-for-service system would go for such behavioral health services. By applying this percent to the total amounts that are paid to the MCOs, we estimated the portion of the capitation payment that would have gone directly to providers in a fee-for-service environment as $109.7 million (total capitation of $474.0 million multiplied by 23.14 percent). The difference of $25.4 million ($109.7 million minus $84.3 million) was not included in Mercer's report. The MCOs may have used this amount for administrative costs, profits and to supplement other non-behavioral health related Medicaid expenses;

- Mercer's calculation of the 82 percent of funds that go directly to providers includes risk settlement amounts that have not been distributed to the RCCs by the BHOs. These risk settlement amounts are withheld from distribution to the RCCs by the BHOs and set aside for future distribution. There are certain conditions that have to be met before they are released. Our review of the audited financial statements of Rio Grande Behavioral Health Services, Inc. indicated that Mercer's analysis should not have included the risk settlement withheld amounts as additional funds to providers because this RCC had already accrued the risk settlement amounts as expense to providers. The RCC was merely waiting to receive the funds from the BHO so it could distribute them to the providers. Because this expense was recognized in the accounting records of the RCC, Mercer had already included it in the calculation of payments to providers. In effect Mercer counted it twice; and

- Two of the RCCs told us that neither Mercer nor the department had contacted them about the financial information used in the report or about the accounting methodology used by them to account for risk settlement related revenues and expenses.

In summary, our estimate of the total behavioral health related Salud! expenditures for fiscal year 1999 is $109.7 million as indicated in Exhibits A-1 and A-2. Of this amount, $60.2 million (54.9 percent) was distributed to providers. Under a fee-for-service system the entire $109.7 million would have been paid to providers. The difference of $49.5 million (45.1 percent) was retained by the MCOs, BHOs and RCCs which translates to a significant reduction in direct behavioral health services. Without evidence to the contrary, the only assumption that can be made from this analysis is that quality of care and/or access to behavioral health care have been seriously reduced by Salud!

Recommendation:

It is the department's duty and responsibility to ensure that the quality of health care to Medicaid recipients under Salud! is the same or better than it was under the former fee-for-service system. Therefore, management must realistically assess the effects that these reductions in funds for behavioral health purposes have had on quality of care and access to care. If the department cannot produce clear and convincing evidence that such services are in fact the same or better than it was under fee-for-service, behavioral health services should be carved out from Salud!

ANALYSIS OF TOTAL MEDICAID EXPENDITURES. In a fee-for-service environment, 93.82 percentage of the total Medicaid expenditures go for direct medical services compared to 84.94% under Salud!.

As directed by the committee, we compiled financial information from various sources to provide an analysis of total Medicaid expenditures for calendar year 1999. Although the information presented in Exhibit A-3 is not audited, we believe it presents an adequate estimate of percentages of direct medical services, administrative costs and profits of the Medicaid program as a whole. Exhibit A-3 indicates that, overall, 90 percent of appropriated funds are expended for direct medical services for Medicaid recipients. A comparison of Salud! to fee-for-services expenditures, however, provides a different outlook. For example, under a fee-for-service environment, 93.8 percent is expended for direct medical related services while, under Salud!, only 84.9 percent of Medicaid funds are expended for direct medical services. The remaining 15.1 percent of Salud! Medicaid funds are consumed by administration and profits.

Recommendation:

Work with MCOs and legislative auditors to compile and analyze total Medicaid expenditures for FY00 to provide more updated data to determine cost effectiveness and program efficiency of having a dual Medicaid program delivery system.

QUALITY OF MENTAL HEALTH SERVICES PROVIDED. Both the department's quality assurance team and the legislative auditor found frequent incidences of lack of documentation and non-compliance with industry standards in quality utilization management functions performed by MCOs for Salud! enrollees.

In February 2000, the department's Medical Assistance Division sent a team of five professionals (two registered nurses, one PhD in psychology, one masters in social work, one masters in education) to perform on-site reviews of the three managed care organizations behavioral health systems. Their assignment was to assess the quality of utilization management (UM) functions performed by MCOs for Salud! enrollees. One hundred seventy nine (179) case files were examined for compliance with the following indicators:

- services provided to eligible (Salud!) members as defined by state regulations;
- array of *medically necessary* covered services provided as outlined by state regulations;
- evidence of current diagnosis using appropriate coding;
- evidence of adequate documentation for measurable goals and objectives included in patients' plans of care as indicated by the individual's condition;
- achievement of expected outcomes as evidenced by plan reassessments;
- evidence of proper care coordination; and
- adequacy of discharge plan.

As indicated in Exhibits B-1 and B-2, state reviewers found frequent incidences of:

- no plan of care with clinically appropriate measurable goals, objectives, action steps, and target dates;
- no documentation of any expected outcomes;
- no documentation of risk reassessment for the client prior to discharge;

- no documentation of adequate and realistic discharge planning and implementation. In some cases extent of discharge planning simply indicated client will stay with friend or home with parent; and

- clients readmitted to hospital.

Reviewers also observed case file documentation that a shelter could not find anyone to perform medication evaluation for one resident and commented that the BHO did not assist the shelter in finding a child psychiatrist, a source of frequent complaints by providers. In another instance the reviewer noted that a suicidal patient was discharged to the same house where she has access to guns and had threatened to use them.

For one case file review, a psychiatric consultant to the Legislative Finance Committee wrote that a provider gave care at the acute level to a Salud! patient who continued to manifest the problems that initially required hospitalization at the acute care level even though Lovelace/Cigna authorized care at a lower level and lower payment rate. There was no rationale by the Cigna case manager for this decision and it appears that Cigna in this case was using financial leverage to influence patient treatment rather than using its level of care clinical criteria to appropriately allocate care. This case illustrates misapplication of level of care clinical criteria by the Cigna case manager. In another case the consultant found that a Presbyterian Medical Services' decision to only authorize group home care was not supported by the clinical condition and treatment needs of this patient. The patient's overall level of functioning clearly merited residential treatment center (RTC) care which the provider continued despite the denial and reimbursement for only group home services level of care.

The Island Peer Review Organization (IPRO) also noted problems in these areas. Despite acceptable overall ratings for all three MCOs, IPRO reported that continuity of care documentation for all MCOs was "inaccurate/incomplete".

The department notified the MCOs of the deficiencies in an April 13, 2000 letter and requested corrective action plans. Each of the MCOs had the behavioral health organizations respond in a timely manner which included documentation that appropriate policies and procedures have been in place since the inception of Salud! Cimarron has had substantial written communication with the regional care coordinator, Presbyterian Medical Services. However, there was minimal documentation of active involvement of Presbyterian MCO oversight of Value Options and its regional care coordinators. Lovelace/Cigna training documents appeared to be very specific and should have provided appropriate guidance to staff. Department staff recognized the weakness in MCO responses and has had additional communication with them. However, MCO/BHO responses do not assure that there will be future compliance because they focus on existing policies, rather than specifying actions taken to ensure that staff follow proper guidelines.

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Maricopa County's (Phoenix, Arizona) April 2000 review of mental health services indicated that Medicaid managed care failed to meet the needs of Medicaid eligible children half of the time and that significant funding appropriated for children's behavioral health services was being diverted by the BHO (Value Options) to pay for adult services. Causes identified for the failure of Maricopa County include many of the issues present in New Mexico such as a malfunctioning service authorization process, focusing on immediate symptoms combined with a failure to provide adequate initial services, and poor coordination with schools, juvenile courts, and other governmental organizations.

Recommendations:

We commend department staff for its review. Immediately perform follow up reviews to ensure that corrective action plans were successfully implemented by the MCOs/BHOs. Continue to perform reviews until corrective action is assured, then periodically perform reviews to ensure continued compliance. Require MCOs to be actively involved in performing similar reviews on a recurring basis. Management should consider the seriousness of their findings, legislative audit findings, and provider complaints which have been substantiated.

Extend the quality management review to other medical services.

Mandate form which MCO/BHO care coordinators must use to assess patient's condition and authorize appropriate levels of care. Form should focus on treatment plan and progress toward goals to ensure consistency in case file documentation and development of appropriate treatment plans and outcomes.

AUTHORIZATION PROCESS FOR OBTAINING SERVICES. Prior authorization for many services is time consuming and a cumbersome process. In many instances, MCOs/BHOs authorized inexpensive lower level of services for shorter lengths of treatment which results in increased rate of readmission.

Consistent with other managed care plans, Salud! also requires prior authorization for many services rendered by providers other than a member's primary care physician (PCP). However, the prior authorization process has been the subject of much criticism. Behavioral health providers have been especially critical stating that it is:

- overly restrictive;
- extremely time consuming;
- delays/denies services to patients; and
- delays/denies payments to providers.

Thus our work in this phase of the audit has focused on authorizations for behavioral health services. MCO/BHO complaint logs document enrollee problems obtaining access to mental health providers and services, prior authorizations and/or denials, and quality of care issues. However, the most interesting aspect of behavioral health complaint logs is what is not there. Neither the MCOs nor the department added to the log the many complaints of professional and advocate organizations, such as the *Coalition for Effective Mental Health Care*, and the state departments of Health (DOH) and Children, Youth and Families (CYFD) received during public and private meetings and/or from written correspondence. Lovelace also failed to provide complaint logs for all of calendar year 1997 and the first three months of 1999. Many of those complaints were about the layers of complexity involved in obtaining a prior authorization and reimbursement for services provided.

The following chart demonstrates the layers of complexity and potential number of behavioral health organizations in the Salud! program which providers must work with to obtain services for their patients:

MCO	Albuquerque Area	Northern New Mexico	Southern New Mexico
Cimarron	Aspen (as of July 1, 1999)	Presbyterian Medical Services	Rio Grande
Lovelace	Cigna MCC	Cigna/Presbyterian Medical Services	Rio Grande
Presbyterian	Value Options	Presbyterian Medical Services	Rio Grande

This complexity makes accessing mental health services especially complex in the northern and southern parts of the state. Thus in order to provide services with a reasonable expectation of payment, a provider must know which MCO and BHO the patient has, even though it may be obvious who the regional care coordinator is. There may also be other third party payors (co-insurance), New Mexico Department of Health (DOH) and Children, Youth and Families Department (CYFD) requirements which must be met prior to rendering services. All third party payors must also be contacted whenever a prior authorization is required before Salud! which is the secondary payor when there is another insurer.

In addition to this, DOH has developed a *Regional Plan* for implementing and funding a statewide behavioral health and substance abuse system. There are five regions which are not consistent with the MCO/BHO regional care coordinator structure. There are also different processes for licensing and registration of providers with different

state agencies, and there are five different processes for credentialing of Salud! providers, one for each BHO (3) and each regional care coordinator (2). All of this impacts the ability of providers to render services timely and obtain payment.

We reviewed documentation (including case files) of different providers with the help of an independent consultant, a licensed psychiatrist, in order to independently assess how well the prior authorization process works. We found similar patterns/problems for all, including that:

- BHOs pressure providers to provide lower (cheaper) levels of care than the patient's condition requires;
- providers continue to give appropriate levels of care despite being paid and authorized for only lower levels of care;
- BHOs emphasize discharge from the first day of treatment rather than development of a treatment plan and the patient's progress toward achieving the goals of the plan;
- the authorization process is not individualized for each patient. BHO authorization periods are based on time tables which correlate to business office hours rather than patient's assessed need. For example:
  - authorizations often terminate on Mondays which require providers to contact BHOs at the same time in order to extend the authorization period;
  - in-patient acute care for adolescents and children is often authorized for lengths of stay as few as one or two days (three days over a weekend) even though the patient may be drug addicted and detoxification would require days or weeks (depending on the substance) before drug therapy could commence. Stabilization may require longer time frames than the authorization period granted. This forces providers to sometimes make daily calls for authorization of continuing care;
  - adults tend to be authorized for far shorter time periods than adolescents and children even though they may have serious disabling mental illness;
  - residential treatment center care (RTC) is generally authorized in periods of seven to 14 days even though industry standards (and some RTCs) require a minimum stay of at least 30 days or more (see Exhibit C-1). Some authorizations are for as few as 3 days; and

- treatment foster care (TFC) is rarely authorized for more than 28 days at a time, even though the usual length of stay is 12 to 14 months.

- several former employees of one BHO told us that they were instructed to tell providers they were authorized for longer periods of treatment, but enter only two or three days/units into the computer so that no long-term commitments would appear in computer generated reports. They would then have to enter additional units every couple of days, which they would sometimes forget to do.

- Presbyterian Medical Services requires a daily *acute care inpatient review* form which focuses on updating the patient's diagnosis, medication, and discharge rather than progress in the treatment plan and achievement of planned outcomes. Case notes documenting conversations with other BHOs indicate a similar emphasis;

- frequent readmissions of children for acute care;

- written documentation of authorization is provided after the treatment period, if provided (Exhibit C-1);

- BHOs authorize shorter length of stays than the primary insurer creating unnecessary work for providers, even though Salud! is the secondary insurer;

- there appeared to be problems obtaining timely and proper reimbursement for longer lengths of stay;

- services are cut off or reduced where the child's/adolescent's condition does not appear to be improving, regardless of need for active and on-going treatment. Exhibit C-2 is such an example;

- different interpretations and application of treatment criteria by BHOs;

- BHO care coordinators undermining *high risk precautions* established by the provider;

- denials are not always given to providers timely or in an inappropriate manner. For example:

  - as noted in our report dated May 25, 2000 the failure of the managed care organizations (MCOs) to enter an authorization code into their computer systems caused payments to physical health care providers to sometimes be denied or delayed. The same thing appears to happen with behavioral health. Case notes indicate a longer length of stay having been

authorized but written documentation from BHO indicates a shorter length of stay as having been authorized. Sometimes, the written authorization is not received by the provider until after the shorter authorized period has elapsed. This results in the provider having to absorb the cost of the "unauthorized" treatment or fight with the BHO for "retroactive" approval;

- BHOs tell providers they faxed documents that providers say they did not receive. Given the extent of documentation in some provider files, it is unlikely that the provider was sent a document which the provider subsequently lost; and

- denial of an admission to acute care was left on voice mail by Cigna on a Friday at approximately 6:00 p.m. after the provider's care coordinator had left. The patient had been admitted that morning as a medical emergency and was cared for until Monday morning before learning that admission had been denied;

- authorizations for non-urgent care sometimes are not provided within 14 days (request to appointment) as required in the MCO contract (section 2.A.4.c.iii) and other follow-up visits consistent with clinical need (section 2.A.4.c.ix); and

- the name of one Cigna care coordinator kept reappearing as someone whom providers felt rarely authorized higher levels of service or treatment periods.

Department findings were similar to those of the legislative auditors. For example:

- inexpensive services such as case management were usually approved;

- lower level of services (such as shelter care) were authorized rather than higher level of care documented as needed;

- discharges when patient's condition is still evident;

- lack of documentation supporting decision to downgrade levels of service; and

- lack of documentation supporting short lengths of treatment authorized by the BHOs.

Providers also allege that MCO/BHOs give bonuses to staff for downgrading/denying requested services. Nationally recommended standards for MCO/BHO contracts discourage bonus arrangements because of their tendency to restrict authorization of needed services.

The University of New Mexico's Children's Psychiatric Hospital (CPH) increased its staff of care coordinators from one to four persons in May 2000 to handle problems related to what it described as retroactive denial of services by BHOs. CPH hopes this move will help improve the likelihood of payment for services rendered. Other providers also state that they have increased staff to handle MCO/BHO administration and/or cut services.

Villa Santa Maria (VSM) which specializes in *reactive child disorder* has taken a different approach by requiring a minimum prior authorization of 18 months before it will accept a patient. Although VSM accepts Medicaid patients, there are none from New Mexico.

Provider statistics further document the general trend in shorter treatment periods for higher level services since 1996, but apparently resulting in more frequent readmissions of child and adolescent patients to acute care:

IP = inpatient (acute care) RTC = residential treatment	FY97 Days	FY99 Days	FY00 Days	% Reduction since FY97
IP - Adult	7.4	6.0	5.0	32.43%
IP - Teen	19.6	10.4	9.7	50.51%
IP - Child	32.5	17.2	20.5	36.92%
RTC - Child & Adolescent	81.8	69.5	60.2	26.41%
CPH Readmissions	47	101	110	234% Increase

Value Options data also indicates a high rate of readmission, 16 percent within 30 days of inpatient discharge as of February 14, 2000. We cannot determine whether the shorter lengths of stay, substantial deficiency in discharge planning, or both are responsible for the more frequent readmissions of Salud! patients. However, combining this data with the department's audit which found level of care criteria not being correctly applied in the majority of cases, it is reasonable to conclude that BHO pre-authorization is not correct.

According to the U.S. Public Health Service's (PHS) *Healthy People 2000,* "mental health is a general term used to refer not only to the absence of mental disorders but also to the ability of an individual to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional or behavioral dysfunction". PHS further cites inadequate prior treatment, psychiatric and medical illness, family

violence, alcohol and drug use as factors commonly seen in persons who are successful in committing suicide. Suicide is listed as the eighth leading cause of death in the United States and the second leading cause of death among 15 to19 year-olds.

The report further indicates that the presence of any or all of the following factors increases the likelihood of a child becoming mentally ill:

- poverty
- single-parent homes
- homelessness
- abuse/neglect
- inadequate prenatal care
- low birth weight
- mother infected with AIDS
- drug/alcohol abuse

"While a child with only one of these risk factors may develop without problems, each additional factor increases the likelihood of a mental disorder that interferes with the normal developmental process and functioning. Therefore, to achieve a major reduction in the prevalence of mental disorders in children, it is necessary to reduce the factors that put them at risk, to enhance protective factors such as social competency, and to increase the availability of treatment services for those who already have a disorder. Preventive interventions must address a number of risk factors over an extended period of time, and they must be ongoing and intensive."

The New Mexico Department of Health reported in *Hope for the Heart,* September 1999, that New Mexico had an average of 296 suicides per year over the previous eight years with an average of 57 among youth aged 15-24. DOH further states that the New Mexican youth suicide rate "has consistently ranked among the seven highest rates in the nation" and that rate has increased 300 percent since the 1950s compared to a 17 percent overall rate.

Thus it is very important for MCO/BHOs to follow appropriate guidelines and authorize needed levels of care. Failure to do so can cause additional harm to a person's mental health, particularly children, and can be life threatening.

Recommendations:

Carving out behavioral health services from physical medical services is an important option which deserves further consideration. Twenty-nine states with managed care currently have full or partial carve out of behavioral health services. Other alternatives include a partial carve out of children diagnosed with serious and/or complex mental and physical health disorders, differential/special treatment benefits for patients with high end needs, or returning the program to the department to operate under the

principles of managed care, but contracting directly with providers of all types at pre-established fees. In any case, the three plus layers of administrative complexity in mental health care must be eliminated.

Department perform the credentialing function for MCOs to ensure consistency of procedures and timeliness of response to providers.

Require MCO/BHOs to use electronic media to facilitate the authorization process. There could be certain questions which could be answered in electronic format with pre-specified criteria which could automatically (electronically) authorize a service and provide an immediate printout of the authorization. Eligibility checks could also be electronic as well as checking on the status of a claim. Limit extent of prior authorizations requiring person-to-person contact to high cost services, such as inpatient acute care and days of service which are beyond what is usual and customary for a particular diagnosis. Also consider electronic means for providers to check on MCO enrollment of patients.

Require MCOs to provide written justification for all denials or downgrading levels of care requested by providers.

Require MCOs to report the number and type of prior authorizations requested against services actually provided. Identify and investigate reasons (such as inability to locate a service provider) for requested services which were not provided.

Require MCOs/BHOs to have a child psychiatrist on staff.

Require MCOs/BHOs to authorize length of care consistent with professional standards. Those standards could be listed on the department's website. Also require MCOs/BHOs to authorize length of care consistent with the primary insurer, when applicable.

Prohibit MCOs/BHOs from paying bonuses to staff of the Salud! program.

DEFINING MEDICAL NECESSITY. There is a need to provide MCOs one definition of medical necessity and establish a process/methodology to determine medical necessity that meets professional standards.

A factor which complicates the prior authorization process is the definition of *medical necessity.* However, the department did not give the MCOs a single definition until September 2000 with the release of the request for Salud! proposals. Therefore, not only does each MCO, behavioral health organization, regional care coordinator, and each Salud! provider have their own definition, one MCO has at least four different definitions. The definition is important because it is the basis on which services are

approved or denied by the MCO/BHOs. Although, we noted few instances of services being denied, we more frequently observed reduction of services to lower levels than providers requested and considered *medically necessary* for their patients.

An April 1998 paper by the Bazelon Center for Mental Health Law (Bazelon), *Defining Medically Necessary Services to Protect Children,* recommends that states "incorporate more of the essential values and operating principles they desire in their mental health service system" to encourage desired patterns of utilization and promote cost effective care. Bazelon suggests that MCO contracts stipulate:

- the desired goals of services (e.g., to arrest symptoms, to promote appropriate development and improve functioning to enable children to live at home and succeed in school);
- the range of services considered to be "medically" necessary (e.g., day treatment and social-skills training);
- principles for service delivery (e.g., fully engaging families in services planning); and
- that plans are prohibited from subverting desired goals through arbitrary restrictions on amount, duration and scope of services.

The established process/methodology should indicate who should make decisions. For example, if psychiatric services for a child are being denied, then a child psychiatrist should make and document the basis for the denial.

Recommendation:

Provide MCOs with one definition of medical necessity and require MCOs to provide services in sufficient amount, duration and scope to reasonably achieve their purpose. Also establish in contracts with MCOs the process/methodology by which medical necessity determinations will be made in accordance with professional standards.

ACCESS TO PHYSICIANS. Federal statistics indicate New Mexico is doing better than most other western (mountain) states for number of physicians available. However, there are still shortages of physicians in New Mexico, especially child psychiatrists and mental health providers in rural areas.

The department is correct when it states that New Mexico lacks physicians. Exhibit D-1 compares the number of physicians licensed and practicing in New Mexico by county. As of December 31, 1999, the New Mexico Medical Examiner licensed 5,656 allopathic physicians; however, only 3,606 practice in New Mexico. There are an additional 345 osteopathic physicians licensed by the Regulation and Licensing Department (RLD),

but 171 have out-of-state addresses. New Mexico exempts from licensure physicians who are employed by the federal government (for example, the military, the Veterans Administration, the Indian Health Service, etc.) or those in residency at the University of New Mexico.

With information received from the three MCOs, legislative and department auditors (Office of the Inspector General) compiled a statistical database of Salud! providers. We adjusted MCO databases for physicians who contract with more than one MCO, have more than one specialty, and service more than one county to ensure that no physician would be counted more than 1.0 full time equivalent (FTE). However, we could not adjust for physicians who might be practicing on a part-time basis or are retired, but actively maintain their licensing because those persons could not be readily identified.

MCO databases are not organized in a manner which facilitates analysis; however, department auditors identified more than 3,000 physicians from neighboring states (Arizona, Colorado, and Texas) who provide Salud! services to New Mexicans. Some have satellite offices in New Mexico; however, department auditors found 46 who do not appear to be licensed in New Mexico and do not appear to meet the exemption provisions. According to state regulators, an out-of-state physician must have a New Mexico license if he or she practices in the state even on a part-time basis. Department auditors have contacted MCOs to follow up this matter.

Federal statistics (Exhibit D-2) indicate that New Mexico is doing better than most other western (mountain) states (except Colorado) for the number of physicians available to the civilian population. New Mexico has 19 physicians (all types) for every 10,000 persons whereas other mountain states have as few as 14. The New Mexico Health Policy Commission's (HPC) *Quick Facts 2000* (Exhibit D-3) further reports a substantial increase in physicians and other medical professionals from 1990 to 1999. HPC's report is supported by physician licensing data we analyzed from the Board of Medical Examiners. Therefore, it appears that substantial numbers of physicians are not leaving the state. In fact, a January 2000 study conducted by the New Mexico Medical Society (NMMS) indicates that 80 percent of the 402 NMMS physician members responding to the questionnaire, are satisfied with the state's quality of life even though many have considered leaving the state. Forty percent believe reimbursement rates are too low and 59 percent think that there is a shortage of health care providers.

However, there are several notable exceptions to the general increase of doctors in New Mexico. We confirmed a net decline of approximately 17 child psychiatrists in New Mexico in the past three years. Five retired, one is on personal leave (expects to return to practice), one is now employed by an MCO, one died, and 12 left the state and are presumed to be practicing elsewhere. Three have come to New Mexico. Currently, 47 child psychiatrists have been identified as being licensed in New Mexico, but three are not practicing and nine do not accept Medicaid (Salud!) patients.

Registrations of resident allopathic physicians by the Medical Examiner also indicate a net loss of 11 physicians in five rural counties (Cibola, Curry, Eddy, Guadalupe and Quay) since 1995, but a net increase of 345 overall.

Mental health providers also state that there has been a corresponding decline in the numbers of psychiatrists caring for adults, but we were unable to obtain sufficient data to test this hypothesis. However, Value Options geo-access data for January 2000 (Exhibit D-4) suggests that access to mental health providers is not adequate in rural areas. In rural counties, 34.4 percent of enrollees are more than 45 minutes/45 miles from a psychiatrist and 10 percent do not meet the access standard for a psychologist. In frontier counties more than a fifth of all Salud! members do not have reasonable access (60 minutes/60 miles) to a psychiatrist (22.5 percent) or psychologist (24.5 percent).

Recommendations:

Standardize the reporting of providers by MCOs to facilitate analysis. Require MCOs to transmit provider listings in one format which counts an individual provider as no more than one FTE regardless of whether the person practices in more than one county or service type. For primary care physicians, indicate the number of enrollees assigned to each. Also require report of the state of licensure, the license number(s), and the percent of time spent practicing in different counties, states and service types.

Also require MCOs/BHOs to report on provider availability and turnover by specialty type.

Complete investigation of out-of-state practitioners with offices in New Mexico who appear not to have a state license. Require all Salud! providers to have a state license.

Consider directing additional resources to attracting and retaining child psychiatrists. One possibility is to increase funding for the *loan for service* and the *loan repayment* programs handled by the Commission on Higher Education and earmark it for retention of child psychiatrists.

MENTAL HEALTH PROVIDER FEES. In many instances, fees paid by MCOs to mental health providers are substantially lower than FY96 fee-for-service rates even though MCOs have been granted 15 percent rate increases since inception of Salud!.

Providers of mental health services have called for a moratorium on contractually established fees paid by the managed care organizations and have asked for a return

to fee levels of FY96. They have also distributed rate comparisons to demonstrate the reduction in fees paid for Salud! patients. In calling for a return to FY96 Medicaid fee levels, providers point to:

- extreme number of facility closures and reductions in services offered by other facilities (Exhibit E-1) in the past three years;
- financial difficulties of providers still in operation;
- the loss of psychiatrists in New Mexico [see comment *Access to Physicians]*;
- limited number of acute and residential care beds now available;
- possible future loss of facilities, personnel and programs;
- more than 15 percent increase in rates paid by the department to the MCOs per Salud! enrollee since FY97; and
- the lack of fee increase paid by the MCOs to providers.

Legislative auditors have reviewed provider documents, and in some instances developed our own data, to assess potential negative effects of Salud! rates on providers. Such data included reviewing provider contracts with the behavioral health organizations, including commercial and Medicaid (Salud!) fee schedules, the department's fee-for-service payment rates in FY96 and FY00, and other related documents.

Some providers, particularly those in southern New Mexico, are sub-capitated. In essence, providers receive a set payment every month for each Salud! enrollee. For example, if a provider is paid $5,000 monthly, services must be provided to all persons on the provider's enrollment list regardless of how many members receive services, the number and frequency of services, or the cost of services.

Initially, the University of New Mexico (UNM) also had a capitated fee arrangement with Salud! MCOs. However, UNM felt that the cost of providing services exceeded the revenues received, particularly by the Children's Psychiatric Hospital. Exhibit E-2, prepared from documents submitted by UNM, indicates a net loss (unaudited) of $8.8 million in FY99 for Salud! services. As of July 1, 1999 UNM contracts were renegotiated and fees generally returned to an established minimum rate for specified services. In addition to the minimum fee, UNM also has an arrangement with the Cimarron Health Plan where it shares risk with Cimarron and may receive a variable cost settlement each year. But most providers do not receive a cost settlement and say that managed care of all types has lowered profits and made it more difficult to supplement services for the poor.

Memorial Psychiatric Hospital (Memorial) incurred net operating losses in FY98 ($254,316) and FY99 ($453,630) when Medicaid declined from 65 percent (FY97) to 10 percent (FY99) of total patient service revenues (FY99). Due to financial losses combined with slow payments and short authorization periods, Memorial closed its 22 residential treatment beds (RTC) in September 2000, but re-opened some as acute care beds. Management indicated that it had originally opened the RTC beds at the request of the state.

Rio Grande Behavioral Health notified Value Options BHO/Presbyterian MCO in August that it was terminating its sub-capitated contract effective September 30, 2000 due to financial problems. Rio Grande states that Value Options currently owes Rio Grande $7 million. Value Options has only agreed to $2.5 million. However, Rio Grande has renegotiated its contract for a substantially higher capitated fee and will provide services through December 31, 2000.

Hogares, a residential (RTC) and treatment foster care provider (TFC) in Albuquerque, shows monthly accounts receivable averaging one million dollars and states that slow payment and low fees are creating a severe financial strain. This problem does not appear to be unique to Hogares. We consistently noted large account receivable balances for all Salud! providers we visited.

We compared FY96 fee-for-service rates paid by Medicaid to FY00 Salud! rates. FY00 fee-for-service rates were approximately three percent higher than FY96. As noted in the following table, there is substantial disparity in FY96 and FY00 rates paid to Salud! providers particularly with respect to partial inpatient services and RTC at the higher levels:

Percentage of FY00 Salud! Rates Compared to FY96 Fee-for-Service Rates

Service type	Cimarron	Lovelace	Presbyterian
Acute care*	78 to 89	85 to 90	78 to 79
RTC-level 3*	100	100	100
RTC -level 4 plus*	59	59	59
Partial inpatient-full day	56	52	50
Psych evaluation	83	44	29
Group counseling	200	183	150
Treatment foster care (TFC)- level 2*	69	80	6

* Under Salud!, inpatient services are generally inclusive of room and board, patient history and physical, medication, routine lab tests, physician fees, and counseling by licensed social workers and PhDs. (Psychiatrists are generally used for medication management, but not counseling.) Under Medicaid fee-for-service, physician fees were charged separately which generated additional revenue for providers. Most treatment foster care (TFC) rates are also all inclusive. In making these comparisons, rates consistent with the usual lengths of authorizations (e.g., under 60 days for RTCs) were used. For longer treatment periods, rates decline which would lower the calculated percentages.

We also reviewed commercial managed care contracts in the Albuquerque area and found Salud! fees approximate the following percentages of commercial fees for the services specified:

Percentage of FY00 Salud! Rates Compared to Commercial Insurance Rates

Service Type	Cimarron	Lovelace	Presbyterian
Acute Care*	90	100	69
Residential Treatment Level 3*	48	100	53
Residential-level 4 plus*	48	100	53
Partial Inpatient-full day	100	100	Commercial rate negotiated for each case
Psych Evaluation	100	73	55
Group Counseling	124	100	74

Some services are paid at the same rate as commercial insurance, an occasional few at slightly higher rates (usually lower level services), and others at lower rates (usually the more costly inpatient services). Nevertheless, the higher cost, inpatient services are reimbursed at lower rates than commercial insurance. Accredited hospital facilities receive slightly higher rates than non-accredited facilities. Whether commercial or Salud!, managed care fee schedules appear to be structured to encourage utilization of lower cost, out-patient services.

When the lower rates are viewed in conjunction with shorter lengths of treatment being authorized, it is probable that mental health providers have incurred substantial loss of revenue as a consequence of Salud! Facilities such as Charter Heights (Albuquerque) and Piñon Hills (Santa Fe) have closed, and others have cut services as indicated in Exhibit E-1. It is unknown whether the remaining facilities are adequate to meet the mental health needs of the state. However, providers report that on some days in calendar year 2000 there have been no acute care beds available and children have been "days awaiting placement".

Another factor which should be considered is encounter data. Encounter data could be used to determine the number and type of services provided, the number of enrollees who received services, and the overall cost effectiveness of the Salud! program.

Recommendations:

Require MCOs to pay providers fees commensurate with FY96 rates which providers have indicated would provide sufficient resources for quality behavioral health care. Further establish fixed fees for services. In doing so, the financial incentive for MCOs to deny or reduce services would be eliminated.

Commission a study separate from the managed care organizations to determine the state's needs for various mental health services and facilities based on current and future estimated population. Then require the MCOs to support the development of such services and facilities as part of their Medicaid and state health plan contracts.

When evaluating bids for FY02 contracts, assess MCOs development of specific new programs for past contracts. Also, provide in new contracts sanctions for failing to develop such programs.

Cross match FY00 encounter data with Salud! enrollees. Analyze the number and types of services provided. Determine the number of enrollees who received services and the types of services received to aid in analyzing cost benefit of the Salud! program.

MEDICAID BUDGET SHORTFALL AND FINANCIAL SYSTEM. Untimely, cost settlement audits and failure to timely record and reconcile accounting transactions make it difficult to determine true financial position of the Medicaid program.

The committee directed auditors to review documentation related to prior year expenditures and verify that sufficient FY00 budget is currently available to pay providers. As of August 2000, the department was projecting a FY00 budget shortfall of $16.4 million and $13.7 million in general fund and federal fund revenue, respectively. The FY01 budget shortfall of $18.8 million and $34.3 million in general fund and federal funds was projected by the department. However, these projections do not take into consideration cost shifting of prior years expenditures to FY01. The department indicated that, by the end of October 2000, new projections will be provided based on September 30, 2000 actual expenditures. Untimely, cost settlement audits cause uncertainty in providing accurate data on Medicaid funding need.

HUMAN SERVICES DEPARTMENT
Audit of Medicaid Managed Care Program (SALUD!)
October 27, 2000

Pursuant to Section 6-10-4 NMSA 1978, the Department of Finance and Administration (DFA) can allow payments to be made if the department can demonstrate that sufficient budget would have been available in the prior fiscal year(s) if invoices had then been presented for payment. It is proposed that such payments would, however, be made from FY01 appropriations. Our observations are:

- the department had not performed timely reconciliations of its books with DFA during FY00 and consequently was not current in recording adjustments to its books or DFA;

- numerous vacancies in the department (administrative and Medical Assistance divisions) result in limited staff available to perform necessary accounting functions for the department;

- errors and omissions in Consultec reports to the department including:

  - old account codes used by Consultec which are not consistent with newer account codes used by DFA and the department's Joint Accounting System (JAS);

  - two reports prepared by Consultec which should agree with each other (but do not), require department administrative staff to spend an unreasonable amount of time reviewing the *A1019* report to identify and report errors on the monthly *Expenditure Transaction Edit Report* and then instruct Consultec to make corrections to the edit report. For June 30, 2000 the department submitted changes to Consultec three times before they were made;

  - the *Edit Report* only breaks out payments for prior year expenditures from the current fiscal year as a "lump-sum"--not by each prior fiscal year;

  - department prepared a journal voucher (JV) in August 1999 (FY00) instructing DFA to record $4.1 million (not $42 million as reported by the press) of prior year expenditures paid by the department's fiscal agent, Consultec. However, DFA recorded this JV as expenditures in FY00 rather than FY99. That error was not detected nor corrected by either agency until July 14, 2000, after DFA had stopped payments to providers. Encumbrances not broken separately by fiscal year on JAS which causes

reconciliation to be performed as a "lump sum"; therefore, the department staff cannot easily detect erroneous postings on the DFA system such as the $41 million discussed above; and

- Consultec's failure to make timely upgrades to its computer system as requested by the department. One such upgrade was first requested in FY93, but has yet to be made.

- Substantial difference in total reserve for encumbrances as of June 30, 2000 recorded by DFA and the department. Multiple errors in DFA books and *JAS* make it difficult to rely on either or to determine with certainty what the department's true encumbrance reserves were as of June 30, 2000. However, our best estimate of available FY00 encumbrance reserve is as follows:

Per DFA *Listing of Encumbrances*		
By Organization/Program	Line item 150	$ 47.3
	Line item 073	29.3
Shifting of cost settlements paid in FY00 to FY01		31.0
	Total Available	107.6
Less: Non-cost settlement amount paid as of October 2, 2000		69.7
Estimated available balance as of October 2, 2000		$ 37.9

- As of October 2, 2000, the department made payments of $39.7 million for cost settlements relating to prior fiscal years and is withholding payment for $22 million for cost settlements relating to prior fiscal years. However, HSD made no estimate of these liabilities as of June 30, 1999 (or for prior fiscal years) as required by the American Institute of Certified Public Accountants (AICPA) industry audit guide. Of this unpaid amount, $21.7 million is owed to the University of New Mexico for the following:

1996 cost settlement	$12.1
2000 indirect medical education (IME)	8.2
2000 graduate medical education (GME)	1.4
	$21.7

Recommendations:

Work with legislative audit staff to determine budget shortfall for FY00 and FY01 utilizing most current financial information available including review of cost projection methodology utilized by the department.

Develop and submit a plan to DFA and the committee that provides for recruiting staff to fill vacant positions and identify training requirements for staff to meet.

Require Consultec fulfill its contract obligations and, if it fails to do so on a timely basis, seek another fiscal agent. Such solutions should include an automatic interface with JAS and the DFA to record Consultec activity without manually preparing a journal voucher entries.

Contract with a consultant to develop efficient business processes to record, reconcile and prepare needed financial data on a monthly basis for the executive and program managers. Consultant must address JAS integration with the DFA central accounting system and department's other major information systems such as the medicaid management information system, child support enforcement system, etc.

Consider contract resources to bring department accounting activities to current status, including reconciliations, estimating cost settlement liabilities and program financial statements.

Increase DFA's monitoring of journal vouchers recording large financial transactions, reconciliation of cash, expenditure, budget and encumbrance balances by warrant issuing agencies.

Consider establishing an operating reserve contingency fund to strictly make payments for prior year cost settlement audits including payments to the University of New Mexico for indirect medical education and graduate medical education. All refunds received from the cost settlement audits would be deposited in this contingency account.

EXHIBITS

Exhibit A-1

New Mexico Human Services Department
Behavioral Health Funding Analysis
Fiscal Year 1999

	Mem Months	Providers	Admin	Risk Settle	Profit	MCO	Total
CIMARRON	601,179	12,746,132	2,111,303	409,543	524,565	10,912,871	26,704,414
		47.73%	7.91%	1.53%	1.96%	40.87%	100.00%
LOVELACE	509,094	12,928,426	3,320,873		401,295	6,164,066	22,814,660
		56.67%	14.56%	0.00%	1.76%	27.02%	100.00%
PRESBYTERIAN	1,313,741	34,497,417	8,233,819	8,572,978	504,013	8,372,483	60,180,710
		57.32%	13.68%	14.25%	0.84%	13.91%	100.00%
TOTAL	2,424,014	60,171,975	13,665,995	8,982,521	1,429,873	25,449,420	109,699,784
Percent		54.85%	12.46%	8.19%	1.30%	23.20%	100.00%

	Mem Months	Providers	Risk Pools	Admin/ Profit	MCO	Total
MCOs						
CIMARRON	601,179				10,912,871	10,912,871
LOVELACE	509,094				6,164,066	6,164,066
PRESBYTERIAN	1,313,741				8,372,483	8,372,483
Total	2,424,014				25,449,420	25,449,420
BHOs						
VALUE - CIM	601,179	(1)		1,271,997		1,271,996
M C C - LOVELACE	509,094	18,392		2,637,360		2,655,752
OPTIONS - PRES	1,313,741	3,313,273		7,801,819		11,115,092
Total BHOs	2,424,014	3,331,664		11,711,176		15,042,840
RCC - ALB						
UNM -CIM	149,569	3,522,937	103,879	56,000		3,682,816
M C C - LOVELACE	268,425	7,462,458	0	630,517		8,092,975
OPTIONS - PRES	297,883	9,313,781	1,425,326	1,127,404		11,866,511
Total RCC-Alb	715,877	20,299,176	1,529,205	1,813,921		23,642,302
RCC-Rural						
PMS - North	618,461	11,049,493	2,940,964	2,782,883		16,773,340
Rio Grande - South	1,089,676	25,491,642	4,512,352	(1,212,112)		28,791,882
Total RCC-Rural	1,708,137	36,541,135	7,453,316	1,570,771		45,565,222
TOTAL RCC	2,424,014	56,840,311	8,982,521	3,384,692		69,207,524
Grand Total	7,272,042	60,171,975	8,982,521	15,095,868	25,449,420	109,699,784
Percent		54.85%	8.19%	13.76%	23.20%	100.00%

Exhibit A-2

New Mexico Human Services Department
Behavioral Health Funding Analysis
Fiscal Year 1999

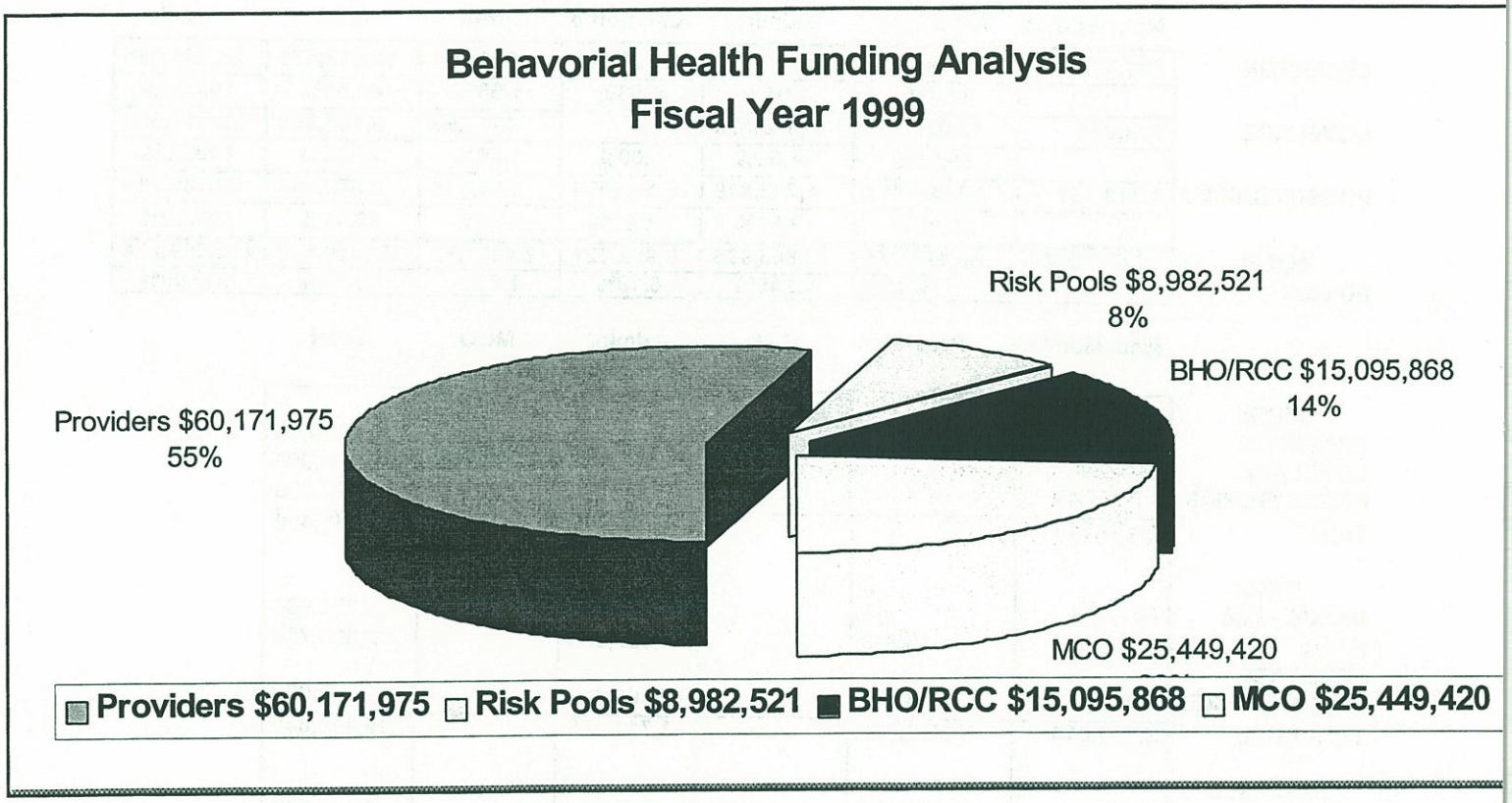


Exhibit A-3

New Mexico Human Services Department
Analysis of Total Medicaid Expenditures
Calendar Year 1999

	Salud	Percent	Fee For Service	Percent	Total	Percent
Direct Payments for Medical Services	$452,400,879	84.94%	$663,583,000	93.82%	$1,115,983,879	90.00%
HSD Administration	3,463,144	0.65%	43,744,706	6.18%	47,207,850	3.81%
MCO Administration & Profit	52,544,109	9.87%		0.00%	52,544,109	4.24%
BHO & RCC Administration & Profit	24,211,931	4.55%		0.00%	24,211,931	1.95%
Total	$532,620,063	100.00%	$707,327,706	100.00%	$1,239,947,769	100.00%

Notes

1. Financial Information reflected in this schedule was compiled from data provided by the department, MCO reports submitted to the Department of Insurance and Mercer's August 2000 Behavioral Health Funding Report.

2. Department provided data for Fiscal Years 1999 and 2000 which we converted to calendar year 1999 to enable comparison to MCO calendar year 1999 financial information submitted to the Department of Insurance.

3 Mercer's August 2000 Behavioral Health Funding Report was used for estimating BHO and RCC administrative costs and profits.

4. Data reflected in this schedule is unaudited and presented for informational purposes only.

Human Services Department
Review of Behavioral Health Services
Summary of General Findings by MCO

Exhibit B-1

Finding	Presbyterian	Lovelace	Cimarron
1 Admission criteria for accredited RTC restrictive			X
2 Home & community waiver enrollment status not consistently screened	X	X	
3 Inadequate discharge planning & inadequate discharge criteria documentation	X	X	X
4 Inadequate documentation of care coordination	X	X	X (2)
5 Inconsistent review documentation	X	X	X
6 Lack of clinical criteria for Shelter Care	X	X	X
7 Lack of documentation re: patients' creased risk to self/others			X
8 Minimal denials noted for initial requests for BH services	X		
9 Patients had more than one case file	X		
10 RCCs using their own versions of level of care & diagnostic guidelines	X		X

An" X" indicates a finding.
A shaded area with an "X" in it shows review team finding that department did not include in request for corrective action plan.

Exhibit B-2

Human Services Department
Review of MCO/BHO Records
Percentage of Non-Compliance

	Cimarron	Lovelace	Presbyterian
MAD reviewer disagreed with UM* of BHO review decisions	44%	48%	83%
MAD reviewer disagreed with UM* of child/teen psychiatric hospitalizations	40%	78%	86%
MAD reviewer disagreed with UM* of adult psychiatric hospitalizations	100%	80%	100%
Inadequate discharge planning/criteria	100%	60%	83%
EPSDT* residential treatment services (RTC)- case file lacks documentation supporting appropriateness and level of care provided	31%	71%	83%
EPSDT* residential treatment services (RTC)- lacked documentation of care coordination with PCP, CYFD, JPPOs if warranted	substantial compliance	100%	75%
EPSDT* treatment foster care (TFC)- MAD reviewer disagreed with UM* decision	15%	27%	82%
EPSDT* shelter care- MAD reviewer disagreed with UM* decision	43%	67%	67%
SED&SDMI* case management- disagreed with UM* decisions	38%	100%	77%

* CYFD=Children, Youth and Families Dept.
EPSDT= early periodic screening, diagnosis and treatment
JPPOs=juvenile probation & parole officers
PCP= primary care physician
SED=seriously emotionally disturbed children
SDMI=serious disabled mentally ill adults
UM= utilization management

EXHIBIT C-1

Presbyterian Salud
Behavioral Health Care

Member
[redacted]
MEM #: [redacted]
DOB: [redacted]
EFF: [redacted] EXP: 99/99/99
Account
PRESBYTERIAN SALUD BEHAVIORAL
Certification Number
01 011000 003 39
Primary Care Physician: DEFAULT PROVIDER
PCP Phone Number: () -

January 25, 2000

UNM CHILDRENS PSYCH HOSPITAL
1001 YALE BLVD
ALBUQUERQUE NM 87131-0001

Presbyterian Salud Behavioral Health Care's Clinical Management Department has authorized treatment as indicated below. Approved or denied services are indicated with the status next to each line.

This notice supersedes all prior letters for this *authorization number*.

Authorization of services is not guarantee of payment. Payment is subject to continued client eligibility, medical necessity, provider licenser/certification, and provider contract status at the time services are rendered.

Level of Care: INPATIENT

Service	POS	From	To	Units	Cert Line #	Cert Status
INPATIENT/RESIDENTIAL (RTC)	51	01/06/00	01/19/00	0000000	001	OPTIONS IS SECONDARY

If continuation of services is required, approval must occur prior to the use of all previously approved visits or the certification end date, which ever comes first.

FOR CONTINUATION OF OUTPATIENT SERVICES: Outpatient reviews should be submitted in writing using the Presbyterian Salud Behavioral Health Care Concurrent Clinical Assessment form in the provider handbook. Additionally, the provider should call the Presbyterian Salud Behavioral Health Service Care Center 48 hours after submission of the form to complete the telephonic review process.

FOR CONTINUATION OF ALL OTHER SERVICES: Contact the Presbyterian Salud Behavioral Health Care Services Center to complete all other reviews telephonically.

Please call Presbyterian Salud Behavioral Health Care at (800) 998-2375 for questions or clarifications. For provider/facility credentialling and network status information please call Presbyterian Salud Behavioral Health Care Provider line at (800) 998-2375.

Claims for services should be submitted to Option Health Care, ATTN: Claims Department, P.O. Box 12008, Norfolk, VA 23541-0008.

Sincerely,
Presbyterian Salud Behavioral Health Care
Clinical Management

EXHIBIT C-2

June 2000

Ms.

Albuquerque, NM

Re:

Dear

CIGNA Behavioral Health

2300 Menaul NE, Suite 400
Albuquerque, NM 87107
Telephone 505.830.5400
Facsimile 505.830.5401
Toll Free 1.800.333.5415

This letter is to let you know that as of 6/5/00, CIGNA Behavioral Health (CBH), will no longer pay for Residential Treatment We have reviewed your childs need's and he does not meet the guidelines for RTC. CBH guidelines on p18 state in part that current behaviors must indicate the need for round the clock supervisiopn in an RTC setting, the client continues to suffer from symptoms leading to admission despite active treatment efforts, and treatment has not led to enough improvement to enable the patient to safely move to a less restrictive level of care.. As an alternative to RTC, we are recommending day treatment at a facility such as Children's Treatment Center (or other) with psychiatric followups and respite availability.

If you do not agree with this decision, you may ask us to consider your request again. This is also known as filing a complaint. You can call CBH at 505-830-5400 (Albuquerque) or 1-888-333-5415 to file a complaint. You can also send a complaint in writing to:

CIGNA Behavioral Health
2300 Menaul Boulevard, N.E.
Suite 400
Albuquerque, New Mexico 87107

Members and/or legal guardians or representatives can file complaints. Providers can also file for you if there is benefit suspension, reduction, termination or denial. If someone else is going to file for you, CBH must have proof of that person's legal authority. You can call CBH Customer Services for a form. This is to assign your right to file a complaint for someone else.

When you file a complaint with **CBH**, we will send you a letter. The letter is sent within two (2) working days to tell you we have received your complaint. If we need more information about your complaint, we will tell you if we need an extension. Otherwise, we will make a decision on your case within ten (10) working days. We will tell you our decision in a letter. If you are unhappy with our decision, you can file an appeal. You can do this by calling **CBH** at 1-800-333-5415, or 505-830-5400.

If you think your health is at risk and you cannot wait ten (10) working days for our decision, call **CBH** Customer Services. You can request that CBH shorten the time to decide your complaint. You must tell us *"I want to shorten my complaint"*. You also need to tell us that

you feel that your health is at risk. **We can shorten the decision time on complaints to 72 hours. We will do this if we find that your health would be affected by a delay.**

You can also request a fair hearing with the New Mexico Human Services Department. **You do not have to use the CBH complaint process before you ask the State for a hearing. To request a fair hearing, you should contact the State at:**

Fair Hearing Section
New Mexico Human Services Department
Ark Plaza
Post Office Box 2348
Santa Fe, New Mexico 87504-2348
505- 827-7290 or 1-888-997-2583, extension 7290

Fair Hearings are for members who have a suspension, reduction, termination or denial of benefits. If you meet the hearing standards, you are entitled to this hearing. You can ask for a hearing if you think CBH did not act promptly. You can also ask for a hearing if you think CBH has made an error. You can speak for yourself at the hearing. You can have a friend, relative, spokesperson or attorney speak for you at the hearing, if you prefer. If you cannot afford an attorney, call the Legal Aid Society at 505-243-7871; they may be able to assist you. You can ask the Hearings Bureau to see your file. You have other rights at the hearing, ask the Hearings Bureau about your rights. You will receive whatever help you need in completing the steps necessary to start the hearing process. **You have ninety (90) days from the date of this notice to ask for a fair hearing.**

If you request a fair hearing in ten (10) days from the date of this notice, the health care service in question will continue. If this happens, CBH will continue the service until your hearing is complete. CBH will not extend your service until the State tells us about the hearing request.

Yours truly,

Care Manager

esta carta es acerca de sus beneficios. Si usted tiene preguntas o la necesidad obtener en espanol por fabor llame a los Servicios del Miembro. Nuestro numeros es 1-888-232-2750.

Exhibit D-1

Human Services Department

Physicians Licensed and Practicing in New Mexico

As of January 2000

County of Registration	Salud! Enrollees August 2000	Allopaths	Osteopaths	Total
Bernalillo	50,959	1,951	74	2,025
Catron	290	1	0	1
Chaves	10,100	98	6	104
Cibola	2,802	22	1	23
Colfax	1,700	22	0	22
Curry	6,634	46	6	52
De Baca	271	2	0	2
Dona Ana	29,397	265	11	276
Eddy	7,411	55	9	64
Grant	4,466	59	2	61
Guadalupe	805	2	0	2
Harding	41	0	0	0
Hidalgo	989	1	0	1
Lea	8,273	50	9	59
Lincoln	2,080	23	2	25
Los Alamos	218	49	1	50
Luna	3,935	19	3	22
McKinley	5,485	88	2	90
Mora	922	1	0	1
Otero	5,050	60	10	70
Quay	1,470	6	1	7
Rio Arriba	5,441	38	1	39
Roosevelt	2,985	18	1	19
San Juan	8,030	132	15	147
San Miguel	4,959	50	2	52
Sandoval	6,090	81	7	88
Santa Fe	9,105	367	8	375
Sierra	1,571	12	0	12
Socorro	2,578	14	0	14
Taos	3,885	41	1	42
Torrance	3,707	2	1	3
Union	426	5	0	5
Valencia	9,344	26	1	27
	201,419	**3,606**	**174**	**3,780**

Table 102 (page 1 of 2). Active non-Federal physicians and doctors of medicine in patient care, according to geographic division and State: United States, 1975, 1985, 1995, and 1997

[Data based on reporting by physicians]

Geographic division and State	Total physicians[1]				Doctors of medicine in patient care[2]			
	1975	1985	1995[3]	1997[4]	1975	1985	1995	1997
	Number per 10,000 civilian population							
United States	15.3	20.7	24.2	25.3	13.5	18.0	21.3	22.4
New England	19.1	26.7	32.5	34.2	16.9	22.9	28.8	30.4
Maine	12.8	18.7	22.3	23.9	10.7	15.6	18.2	19.7
New Hampshire	14.3	18.1	21.5	23.4	13.1	16.7	19.8	21.4
Vermont	18.2	23.8	26.9	28.8	15.5	20.3	24.2	26.0
Massachusetts	20.8	30.2	37.5	39.1	18.3	25.4	33.2	34.8
Rhode Island	17.8	23.3	30.4	33.3	16.1	20.2	26.7	29.4
Connecticut	19.8	27.6	32.8	34.0	17.7	24.3	29.5	30.6
Middle Atlantic	19.5	26.1	32.4	33.9	17.0	22.2	28.0	29.3
New York	22.7	29.0	35.3	37.1	20.2	25.2	31.6	33.2
New Jersey	16.2	23.4	29.3	30.6	14.0	19.8	24.9	26.0
Pennsylvania	16.6	23.6	30.1	31.3	13.9	19.2	24.6	25.5
East North Central	13.9	19.3	23.3	24.6	12.0	16.4	19.8	21.0
Ohio	14.1	19.9	23.8	25.1	12.2	16.8	20.0	21.1
Indiana	10.6	14.7	18.4	19.7	9.6	13.2	16.6	17.8
Illinois	14.5	20.5	24.8	26.2	13.1	18.2	22.1	23.4
Michigan	15.4	20.8	24.8	25.9	12.0	16.0	19.0	19.9
Wisconsin	12.5	17.7	21.5	22.8	11.4	15.9	19.6	20.8
West North Central	13.3	18.3	21.8	22.9	11.4	15.6	18.9	19.8
Minnesota	14.9	20.5	23.4	24.5	13.7	18.5	21.5	22.6
Iowa	11.4	15.6	19.2	19.8	9.4	12.4	15.1	15.6
Missouri	15.0	20.5	23.9	24.8	11.6	16.3	19.7	20.5
North Dakota	9.7	15.8	20.5	22.4	9.2	14.9	18.9	20.6
South Dakota	8.2	13.4	16.7	18.2	7.7	12.3	15.7	17.0
Nebraska	12.1	15.7	19.8	21.3	10.9	14.4	18.3	19.8
Kansas	12.8	17.3	20.8	21.9	11.2	15.1	18.0	18.9
South Atlantic	14.0	19.7	23.4	24.8	12.6	17.6	21.0	22.3
Delaware	14.3	19.7	23.4	24.9	12.7	17.1	19.7	21.4
Maryland	18.6	30.4	34.1	35.9	16.5	24.9	29.9	31.2
District of Columbia	39.6	55.3	63.6	69.2	34.6	45.6	53.6	58.6
Virginia	12.9	19.5	22.5	23.7	11.9	17.8	20.8	21.9
West Virginia	11.0	16.3	21.0	22.8	10.0	14.6	17.9	19.3
North Carolina	11.7	16.9	21.1	22.6	10.6	15.0	19.4	20.8
South Carolina	10.0	14.7	18.9	20.5	9.3	13.6	17.6	19.0
Georgia	11.5	16.2	19.7	20.8	10.6	14.7	18.0	19.0
Florida	15.2	20.2	22.9	24.4	13.4	17.8	20.3	21.6
East South Central	10.5	15.0	19.2	20.8	9.7	14.0	17.8	19.3
Kentucky	10.9	15.1	19.2	20.7	10.1	13.9	18.0	19.3
Tennessee	12.4	17.7	22.5	24.3	11.3	16.2	20.8	22.4
Alabama	9.2	14.2	18.4	19.7	8.6	13.1	17.0	18.2
Mississippi	8.4	11.8	13.9	16.0	8.0	11.1	13.0	14.8
West South Central	11.9	16.4	19.5	20.6	10.5	14.5	17.3	18.3
Arkansas	9.1	13.8	17.3	18.8	8.5	12.8	16.0	17.5
Louisiana	11.4	17.3	21.7	23.5	10.5	16.1	20.3	22.1
Oklahoma	11.6	16.1	18.8	19.6	9.4	12.9	14.7	15.5
Texas	12.5	16.8	19.4	20.3	11.0	14.7	17.3	18.1
Mountain	14.3	17.8	20.2	21.0	12.6	15.7	17.8	18.5
Montana	10.6	14.0	18.4	19.2	10.1	13.2	17.1	17.9
Idaho	9.5	12.1	13.9	15.5	8.9	11.4	13.1	14.4
Wyoming	9.5	12.9	15.3	17.1	8.9	12.0	13.9	15.6
Colorado	17.3	20.7	23.7	24.7	15.0	17.7	20.6	21.5
New Mexico	12.2	17.0	20.2	21.3	10.1	14.7	18.0	19.0
Arizona	16.7	20.2	21.4	21.7	14.1	17.1	18.2	18.5
Utah	14.1	17.2	19.2	19.7	13.0	15.5	17.6	18.0
Nevada	11.9	16.0	16.7	18.1	10.9	14.5	14.6	16.0

See footnotes at end of table.

Table 102 (page 2 of 2). Active non-Federal physicians and doctors of medicine in patient care, according to geographic division and State: United States, 1975, 1985, 1995, and 1997

[Data based on reporting by physicians]

Geographic division and State	Total physicians[1]				Doctors of medicine in patient care[2]			
	1975	1985	1995[3]	1997[4]	1975	1985	1995	1997
	Number per 10,000 civilian population							
Pacific	17.9	22.5	23.3	23.8	16.3	20.5	21.2	21.7
Washington	15.3	20.2	22.5	23.4	13.6	17.9	20.2	21.1
Oregon	15.6	19.7	21.6	22.6	13.8	17.6	19.5	20.4
California	18.8	23.7	23.7	24.1	17.3	21.5	21.7	22.0
Alaska	8.4	13.0	15.7	17.2	7.8	12.1	14.2	15.4
Hawaii	16.2	21.5	24.8	26.4	14.7	19.8	22.8	24.1

[1]Includes active non-Federal doctors of medicine and active doctors of osteopathy.
[2]Excludes doctors of osteopathy; States with large numbers are Florida, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, and Texas. Excludes doctors of medicine in medical teaching, administration, research, and other nonpatient care activities.
[3]Data for doctors of osteopathy are as of July 1996.
[4]Data for doctors of osteopathy are as of November 1997.

NOTES: Data for doctors of medicine are as of December 31. See Appendix II for physician definitions.

SOURCES: American Medical Association (AMA). Physician distribution and medical licensure in the U.S., 1975; Physician characteristics and distribution in the U.S., 1986 edition; 1996–97 edition; 1999 edition. Department of Data Survey and Planning, Division of Survey and Data Resources, AMA. (Copyrights 1976, 1986, 1997, 1999: Used with the permission of the AMA); American Osteopathic Association: 1975–76 Yearbook and Directory of Osteopathic Physicians, 1985–86 Yearbook and Directory of Osteopathic Physicians; Rockville, Md. American Association of Colleges of Osteopathic Medicine: Annual Statistical Report, 1996 and 1998.

EXHIBIT D-3

HEALTH CARE PROFESSIONALS SUPPLY

HEALTH CARE PROFESSIONALS' TRENDS [15]

- The number of New Mexico licensed allopathic physicians (MD) increased 5% between 1995 and 1999; while, the number of licensed MDs residing in New Mexico increased 9%. During the same period, the state population increased 3.4%.
- The total number of mid-level health professionals (allopathic and osteopathic physician assistants, nurse practitioners and pharmacist clinicians)** increased 54% from 1995 to 1999.
- The number of licensed registered nurses (RNs) increased 14%, and the number employed in New Mexico increased 37% in the last five years.
- Between 1998 and 1999, the number of licensed dentists residing in New Mexico increased 9% and the number of dental hygienists licensed and residing in New Mexico decreased 2%. The state population grew 0.36% during the same period.

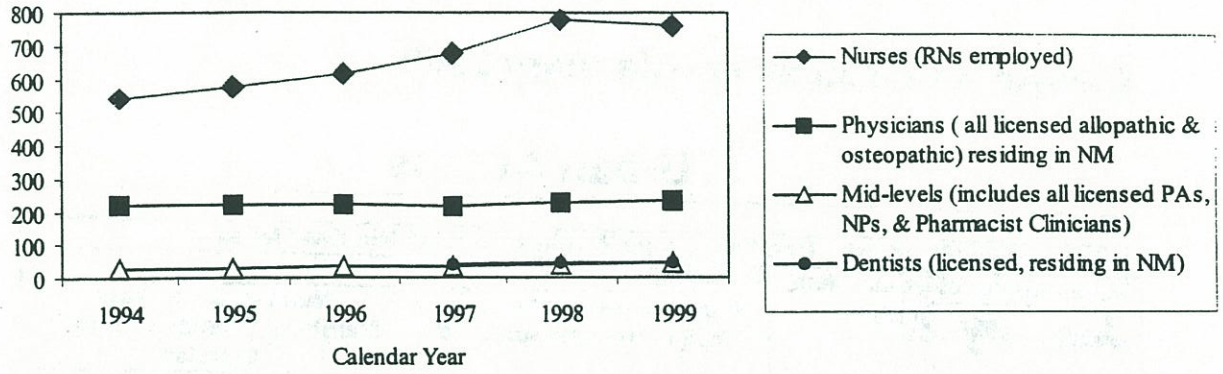
SELECTED HEALTH CARE PROFESSIONALS IN NEW MEXICO										
HEALTH CARE PROFESSIONALS	CALENDAR YEAR									
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Registered Nurses Licensed	11,212	11,298	11,917	12,246	13,531	13,877	15,134	15,258	15,896	15,771
Registered Nurses Employed in NM	7,669	7,990	8,217	8,902	8,961	9,635	10,514	11,666	13,458	13,245
Nurse Practitioners Licensed	287	291	299	286	317	310	340	380	458	578
Nurse Practitioners Licensed & NM Resident**	258	258	264	262	288	285	N/A	336	397	449
Physicians (Allopathic) Licensed*	4,592	4,750	5,097	5,037	5,295	5,382	5,516	5,484	5,613	5,645
Physicians (Allopathic) Licensed & NM Resident*	2,775	2,500	2,995	3,100	3,267	3,318	3,324	3,352	3,554	3,606
Physicians Assistants (Allopathic) Licensed & NM Resident**	138	139	154	172	200	212	207	208	224	235
Physicians (Osteopathic) Licensed & NM Resident	314	325	335	351	358	370	392	376	378	396
Physicians Assistants (Osteopathic) Licensed & NM Resident**	0	1	1	2	2	4	2	4	14	48
Pharmacist Clinician**	0	0	0	0	0	4	6	25	36	46
Emergency Medical Technicians (Total)	--	--	--	--	--	4,863	4,774	5,581	5,928	6,103
Emergency Medical Technicians (Paramedics)	--	--	--	--	--	595	640	689	783	814
Dentists Licensed*	--	--	--	--	--	924	--	--	964	983
Dentists Licensed & NM Resident*	--	--	--	--	--	--	--	704	730	794
Dental Hygienists	--	--	--	--	--	731	--	--	848	828
Dental Hygienists Licensed & NM Resident	--	--	--	--	--	--	--	619	668	654

*Includes Specialties **Mid-level Health Professional

NM Health Policy Commission: Quick Facts 2000

HEALTH CARE PROFESSIONALS[16]

Number of Health Professionals per 100,000 Population



Calendar Year	1994	1995	1996	1997	1998	1999
Nurses (RNs employed in NM)	542	573	616	677	776	761
Physicians (Allopathic & Osteopathic)*Licensed Residing in NM	219	219	218	216	227	230
Physician Assistants & Nurse Practitioners licensed & Resident/Pharmacist Clinicians	30	30	N/A	33	39	45
Dentists* Licensed Residing in NM	--	--	--	41	42	46
Dental Hygienists Licensed Residing in NM	--	--	--	36	39	38

*Includes Specialists

- Registered nurses (RNs) in the NM work force have shown the greatest rate of growth for the five-year period from 1995 to 1999, from 573 to 761 per 100,000 population.
- Since 1996 the number of allopathic physicians (MDs) licensed and residing in New Mexico has increased from 195 to 207 practitioners per 100,000 population in 1999. The number of osteopathic physicians licensed and residing in New Mexico has remained constant at 23 per 100,000 population.
- Since 1994 the number of licensed mid-level providers (allopathic and osteopathic physician assistants, nurse practitioners, & pharmacist clinicians) residing in New Mexico has increased by 15 practitioners per 100,000 population.
- In the past two years, the number of dentists licensed and residing in New Mexico has increased by four practitioners per 100,000 population while the number of dental hygienists licensed and residing in the state has decreased by one practitioner per 100,000 population.

EXHIBIT D-4

Geo-Access Summary – January 2000

Urban Access

Urban Access Standard: One (1) Provider Within Thirty (30) Minutes / Miles		
Total Number of Urban Members: 44,426		
January 2000	Number & Percent Members Within Access Standard	Number & Percent of Members Outside of Access Standard
Psychiatrist	39,267 (88.4%)	5,159 (11.6%)
Psychologist	39,172 (88.2%)	5,254 (11.8%)
Masters Level Clinicians	41,822 (94%)	2,604 (6.0%)

Rural Access

Rural Access Standard: One (1) Provider Within Forty Five (45) Minutes / Miles		
Total Number of Rural Members: 40,834		
January 2000	Number & Percent Members Within Access Standard	Number & Percent of Members Outside of Access Standard
Psychiatrist	26,795 (65.6%)	14,039 (34.4%)
Psychologist	36,807 (90%)	4,027 (10%)
Masters Level Clinicians	38,489 (94.3%)	1,832 (5.7%)

Frontier Access

Frontier Access Standard: One (1) Provider Within Sixty (60) Minutes / Miles		
Total Number of Frontier Members: 24,358		
January 2000	Number & Percent Members Within Access Standard	Number & Percent of Members Outside of Access Standard
Psychiatrist	18,889 (77.5%)	5,469 (22.5%)
Psychologist	18,381 (75.5%)	5,977 (24.5%)
Masters Level Clinicians	23,444 (96%)	914 (4%)

ANALYSIS OF CURRENT SERVICE AVAILABLITY IN THE BERNALILLO COUNTY AREA

LEVEL OF CARE	RTC	TFC	GH (CHILD)	GH (ADULT)	DAY TX	PHP	HB	CM	ECFBP	SOP	PSR	BMS	IOP
FACILITIES													
ALB GIRLS REINTEG	22												
ALL FAITHS	12		**				WL						
CM COLLAB.													
CHARTER	78									24			
COMM SVC. WEST													
CTC													
DESERT HILLS	WL				WL					WL		WL	
HELP													
HOGARES	50									**			
INNOVATIVE	55												
KASEMAN													
LA FAMILIA							**						
MEMORIAL	22												
NAMASTE													
NEW DAY	10		24										
NM PARENT &CHILD										**			
NM SOLUTIONS		**											
PATHWAYS													
PB&J									**				
RAINDANCER													
RHOC													
SEQUOYAH	WL												
ST. MARTINS				WL									
TLS				WL									
UNM	17					WL						WL	
YDI	12		12										

Closed Services (Or licensed but not serving Medicaid)

Reduced Services

Services not provided by facility

Available Services

WL -Wait List

** New Service

RTC-Residential Treatment Center **TFC**- Treatment Foster Care **GH**-Group Home **Day TX**-Day Treatment **PHP**- Partial Hospitilzation Program **HB**- Homebased Therapy **CM**-Case Management **ECFBP**-Early Childhood Family Based Prevention **SOP**-Sex Offender Program **PSR**-Psychosocial Rehabiliation **BMS**-Behavior Management Services **IOP**-Intensive Outpatient Therapy

As per telepone survey of all known providers. Subject to change.

Consortium, Inc. Revised 9.13.00

ANALYSIS OF CURRENT SERVICE AVAILABLITY IN NORTHERN NEW MEXICO

LEVEL OF CARE	RTC	TFC	GH (CHILD)	GH (ADULT)	DAY TX	PHP	HB	CM	ECFBP	SOP	PSR	BMS	IOP
FACILITIES													
CASA DE CORAZON												WL	**
CASA MESITA													
CHILDHAVEN													
FOUR CORNERS	FEDERAL FUNDING FOR NATIVE AMERICAN YOUTH												
HACIENDA VALMORA													
HALVORSON HOUSE													
INTERMOUNTIAN													
KE' PROJECT	NOT FUNDED THROUGH MEDICAID												
LA BUENA VIDA													
LAS VEGAS CARE													
NEW SUNRISE													
OUR LADY MT. CARMEL													
PINION HILLS	35												
PRES MED SVC	18												
RANCHO VALMORA													
RIO RANCHO FAMILY													
SIETE DN COMM DEV													
ST. FRANCIS ACAD													
TAOS/COLFAX													
VILLA SANTA MARIA													
YTH SHLR FAM SVC													

Closed Services (Or licensed but not serving Medicaid)

Reduced Services

Services not provided by facility

No medicaid beds available

Available Services

WL -Wait List

** New Service

RTC-Residential Treatment Center **TFC**- Treatment Foster Care **GH**-Group Home **Day TX**-Day Treatment **PHP**- Partial Hospitilzation Program **HB**- Homebased Therapy **CM**-Case Management **ECFBP**-Early Childhood Family Based Prevention **SOP**-Sex Offender Program **PSR**-Psychosocial Rehabiliation **BMS**-Behavior Management Services **IOP**-Intensive Outpatient Therapy

Exhibit E-1

ANALYSIS OF CURRENT SERVICE AVAILABLITY IN SOUTHERN NEW MEXICO

LEVEL OF CARE	RTC	TFC	GH (CHILD)	GH (ADULT)	DAY TX	PHP	HB	CM	ECFBP	SOP	PSR	BMS	IOP
ALLIANCE													
BORDER AREA MH												**	
GRACE HOUSE			WL										
ASSURANCE HOME			WL										
CARLSBAD COMM	WL												
COUNSELING ASSOC													
DENOVO													
FAMILIES AND YOUTH		WL	WL				WL	**					
FAMILY PRIDE													
GUIDANCE CTR													
LA PLACITA													
MENTAL HEALTH RESO													
MESILLA VALLEY										WL			
OLYMPIA													
PATHWAY HOUSE													
RIVERS BEND													
SOCORRO MEN. HLTH													
S. NM HUMAN DEV.												**	**
SURE HOUSE	14												
SW COUNSELING CTR													
TEAMBUILDERS													
THE ADOL. POINTE													
THE COUNS. CENTER													
VALENCIA CO. COUNS	WL												

Closed Services
(Or licensed but not serving Medicaid)

Reduced Services

Services not provided by facility

No medicaid beds available

Available Services

WL -Wait List

** New Service

RTC-Residential Treatment Center **TFC**- Treatment Foster Care **GH**-Group Home **Day TX**-Day Treatment **PHP**- Partial Hospitilzation Program **HB**- Homebased Therapy
CM-Case Management **ECFBP**-Early Childhood Family Based Prevention **SOP**-Sex Offender Program **PSR**-Psychosocial Rehabiliation **BMS**-Behavior Management Services

Exhibit E-2

Human Services Department
University of New Mexico
Salud! Losses Fiscal Year 1999
(Unaudited)

	Salud!	Other	Total
Children's Psychiatric Hospital			
Gross patient revenue	$ 5,247,225	2,872,713	8,119,938
Discounts and allowances	(4,331,764)	(1,266,495)	(5,598,259)
Other revenue	315,470	3,869,987	4,185,457
Capitated revenue	2,680,400		2,680,400
Total revenue	3,911,331	5,476,205	9,387,536
Managed care provider fees	2,387,184		2,387,184
Other expenses	6,720,767	3,679,437	10,400,204
Total expenses	9,107,951	3,679,437	12,787,388
Net income (loss)	$ (5,196,620)	1,796,768	(3,399,852)
Carrie Tingley Hospital			
Gross patient revenue	$ 4,189,631	3,899,873	8,089,504
Discounts and allowances	(2,153,774)	(1,447,614)	(3,601,388)
Other revenue	118,527	3,888,774	4,007,301
Total revenue	2,154,384	6,341,033	8,495,417
Other expenses	5,323,307	4,955,142	10,278,449
Total expenses	5,323,307	4,955,142	10,278,449
Net income (loss)	$ (3,168,923)	1,385,891	(1,783,032)
Mental Health Center			
Gross patient revenue	$ 1,657,593	8,605,667	10,263,260
Discounts and allowances	(1,278,011)	(3,277,796)	(4,555,807)
Other revenue	591,606	9,002,581	9,594,187
Capitated revenue	1,134,180		1,134,180
Total revenue	2,105,368	14,330,452	16,435,820
Managed care provider fees	94,573		94,573
Other expenses	2,448,608	12,712,350	15,160,958
Total expenses	2,543,181	12,712,350	15,255,531
Net income (loss)	$ **(437,813)**	**1,618,102**	**1,180,289**
Total Salud! (loss)	$ **(8,803,356)**		